A portfolio of study, practice, and research

Submitted for the Doctorate of Psychology (PsychD) in Clinical Psychology Conversion Programme

University of Surrey

Power and depression in marriage – A replication and extension

Michael Byrne

2003
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• Power and depression in marriage (Thesis submitted to the National University of
  Ireland in partial fulfilment of requirements for the degree of Master of Psychological
  Science in Clinical Specialisation in the Faculty of Arts, U.C.D., Belfield, Dublin 4,
  Ireland)
Acknowledgements

I would like to sincerely thank Dr. Alan Carr for his clinical guidance and encouragement in completing my case study, critical reviews, and research thesis. I have no doubt that as a role model in the field of Clinical Psychology he will not be surpassed, and I consider myself fortunate to have had the chance of working with him again.

I would like to thank Dr. Marie Clark for her encouragement and guidance from afar, but above all for her patience and understanding in facilitating the completion of my clinical work over a reasonably lengthy period of time. I would also like to thank Dr. Emma Dunmore, my previous Surrey tutor, for her support. I would like to thank the librarians in Surrey for facilitating my numerous inter-library loan requests.

I would like to thank Mr. Larry Bane (Director of Human Resources, Midland Health Board) for supporting the completion of my doctoral studies. I would like to thank Mr. Barry Crowley who I will always fondly remember, and Carmel Breaden for their support. I would also like to thank the Consultant Psychiatrists with whom I work; the General Practitioners; Martina McElligott (OANDA); Ryan and Eileen; and my other peers who all assisted with recruitment of participants. Without their assistance, data collection would not have been possible. Thank you also to the couples who participated in this study, and to the authors of the scales I have used in this study and for their patience with my many queries.

Thanks to my family and friends for understanding my frequent disappearances when I had to focus on my doctoral work. Thanks to Eva who provided both patience and lively discussion regarding my thesis topic. Yes, ‘talking is key’ and everything must be negotiated.
Summary of the content of this portfolio

Personal study plan

Professional dossier
• Copy of clinical psychology degree qualification
• Curriculum vitae
• 46-year-old woman presenting with complex PTSD secondary to chronic childhood sexual abuse with secondary anxiety / mood disorders

Research dossier
• Power and depression in marriage – A replication and extension

Academic dossier
• The efficacy of couples-based interventions for couple distress and depression
• The efficacy of couples-based interventions for panic disorder with agoraphobia

M.Psych.Sc. thesis
• Power and depression in marriage
PERSONAL STUDY PLAN

NAME: Michael Byrne
DATE: June 2000
DATE OF REGISTRATION: April 1999 – March 2003
STUDENT CARD NO.: 3819175
PERSONAL TUTOR: Dr. Marie Clark

Overview

My Psych.D. portfolio will cover the area of adult mental health presentations, principally mood and anxiety disorders. These two disorders constitute nearly 70% of the referrals to the adult mental health team within which I work. While my case study write-up details how I typically work with such presentations, the remainder of my portfolio will focus predominantly on the interpersonal dynamics of mood and anxiety disorders. I hope that the findings of both my critical reviews and my thesis will add to my existing clinical knowledge and to that of other clinicians working in the field of adult mental health.

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1 This is a revised Personal Study Plan as I changed my initial thesis topic in the summer of 2000 (due to a change of employment).
2 Dr. Marie Clark replaced Dr. Emma Dunmore as my personal tutor in late 2000.
PROFESSIONAL DOSSIER

Curriculum Vitae and Continuous Professional Development
See attached document.

Clinical Work
I intend that the Professional Dossier will include a case study write-up of no more than 5000 words. This case study will detail how I typically work with presenting clients to the adult mental health team within which I work.

The aims of this case study will be to profile good clinical practice in assessing and providing intervention to an adult with a mental health presentation, and to profile how I apply such theory-based practice in my daily work with clients.

Anticipated problems
Given that I see many clients with a variety of mental health presentations, provided that consent is forthcoming from clients, I do not foresee any major problems in writing up a case study.
First critical review: The Efficacy of Couples Based Interventions for Couple Distress and Depression (4500 words).

Second critical review: The Efficacy of Couples Based Interventions for Panic Disorder with Agoraphobia (4500 words).

The Efficacy of Couples Based Interventions for Couple Distress and Depression
My clinical work in the field of Adult Mental Health over the last 4 years impressed upon me just how prevalent mood disorders are amongst treatment-seeking individuals. While couple dissatisfaction is often reported by attending adults with a psychiatric presentation (and/or by their spouses), I have also been taken aback at the degree of such comorbidity in couples where one partner is depressed. Given that major depressive disorder is nearly twice as prevalent in women than in men, the presenting partner is typically the woman in the relationship. Hence, I hope that a critical review of the efficacy of couples-based interventions for both couple distress and depression will add to the existing literature base and to the continuing development of my clinical skills.

The Efficacy of Couples Based Interventions for Panic Disorder with Agoraphobia
Although some studies have suggested that panic disorder with agoraphobia (PDA) may be an ‘individual’ presentation, my clinical experience to date has suggested that couple dynamics may be a primary factor in determining if an individual with PDA responds to treatment. Hence, I would like to investigate if relationship dissatisfaction potentially maintains PDA and if couples-based interventions for PDA are efficacious.
RESEARCH DOSSIER

Title: Power and Depression in Marriage: A Replication and Extension (20,000 words).

Research supervisor: Dr. Alan Carr, Director of Doctorate in Clinical Psychology Programme, Department of Psychology, University College Dublin, Belfield, Dublin 4, Ireland.

Background
My M.Psych.Sc. thesis (Byrne & Carr, 2000) consisted of exploring the power constructs and dynamics in couples where the female partner is presenting with clinical depression. However, I considered the findings of this research quite tentative for a number of reasons.

First, the small cell sizes (n = 14) in Byrne and Carr (2000) may have inhibited against finding subtle power differences in power domains between couples with and without a depressed female partner. In an effort to increase the statistical power of the data in my Psych.D. research thesis, there will be at least 20 couples in each cell in this study.

Second, as there was only one control group in Byrne and Carr (2000), it was unclear if our findings were specific to couples where the female partner is depressed. Hence, my Psych.D. research thesis will include a second control group (i.e., women with PDA) to ascertain if the findings with depressed couples are (or are not) generalisable to couples where one partner has a psychiatric presentation other than a mood presentation.

Third, Byrne and Carr (2000) used self-report questionnaires as the sole means of data collection. As such questionnaires have many limitations, my Psych.D. research thesis will also use semi-structured clinical interviews. These interviews are valuable as there are often discrepancies between partners’ paper-and-pencil (i.e., self-report questionnaire) and verbal (i.e., clinical interview) reports of relationship dynamics. They are also valuable in that incomplete questionnaires can be completed in-session and any queries that participants have (about the questionnaires) can be clarified. Doing so can substantially decrease the problem of missing data items.
**Research questions**

The overall aim of my Psych.D. thesis research is to identify the power bases, processes, and outcomes that characterise couples where the female partner is depressed. We will address the following questions:

1. Compared with control and PDA couples, what power bases, processes, and outcomes characterise couples in which the female partner is depressed?
2. Of the power bases, processes, and outcomes that characterise couples in which the female partner is depressed, which are unique to depression and distinct from factors associated with marital satisfaction?

My first set of hypotheses are that in couples containing a depressed female partner, women’s power bases will be weaker and their power outcomes will be less favourable compared with their partners’ and those of members of control and PDA couples. I also expect that power processes will be less constructive and more problematic in these couples compared with control and PDA couples. My second set of hypothesis will be that a unique profile of variables from the domains of power bases, processes, and outcomes will be associated with depression, quite distinct from any effects of marital satisfaction.

I will attempt to answer these questions by profiling the power that these women perceive they have (or do not have) in various relationship domains as detailed in Table 1.

<table>
<thead>
<tr>
<th>Power bases</th>
<th>Power processes</th>
<th>Power outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>Male demand - female withdraw behaviour</td>
<td>Partner does more household tasks</td>
</tr>
<tr>
<td>Economic dependence on partner</td>
<td>Female demand - male withdraw behaviour</td>
<td>Partner does more decision-making</td>
</tr>
<tr>
<td>Control of surplus spending money</td>
<td>Total demand - withdraw behaviour</td>
<td>Partner more involved in child-care</td>
</tr>
<tr>
<td>Satisfaction with control of surplus spending money</td>
<td>Mutual constructive communication</td>
<td>Dissatisfaction with household task distribution</td>
</tr>
<tr>
<td>Commitment to the relationship</td>
<td>Sexual reciprocity</td>
<td>Dissatisfaction with decision-making distribution</td>
</tr>
<tr>
<td>Sex role attitudes</td>
<td></td>
<td>Dissatisfaction with child-care task distribution</td>
</tr>
<tr>
<td>Desired level of intimacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical aggression from partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overt aggression towards partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Passive aggression towards partner</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Design and Methodology

As outlined in Table 2, my Psych.D. research thesis will use the same basic design (i.e., a case control design) as Byrne and Carr (2000).

Table 2 Proposed design for my Psych. D. research thesis

<table>
<thead>
<tr>
<th>Member of couple</th>
<th>Type of couple</th>
<th>Control</th>
<th>PDA</th>
<th>Depressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>Group 1</td>
<td>Group 2</td>
<td>Group 5</td>
<td></td>
</tr>
<tr>
<td>Women in control couples</td>
<td>PDA women</td>
<td>Depressed women</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>Group 3</td>
<td>Group 4</td>
<td>Group 6</td>
<td></td>
</tr>
<tr>
<td>Men in control couples</td>
<td>Men whose partners have PDA</td>
<td>Men whose partners are depressed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Participants

Twenty control couples (i.e., neither partner has a psychiatric concern) will be recruited via advertisements in local Health Centres. Twenty PDA couples (i.e., the female partner has PDA) where the woman has been referred (to the local Mental Health Service) for treatment of her PDA will be asked to participate in this study.

The third group of 20 couples will be depressed couples or those in which the woman has been referred (to the local Mental Health Service) for treatment of clinical depression by her General Practitioner (or Consultant Psychiatrist) will be asked to participate in this study. Where possible these couples will be matched with the control and PDA couples on variables such as age, length of relationship, and socio-economic status. A diagnosis of depression will require (i) a score of at least 14 on the Beck Depression Inventory (BDI, Beck et al., 1961), (ii) endorsement of 5 (of 9) DSM-IV criteria (APA, 1994) criteria for major depressive episode, and (iii) a diagnosis of depression based on clinical interview using DSM-IV criteria.

Instruments

My Psych.D. thesis questionnaire will contain the following scales:
- Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961).
- Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV) checklist for Major Depressive Episode.
- Satisfaction subscale of the Dyadic Adjustment Scale (DAS; Spanier, 1976).
Social class scale (O'Hare, Whelan, & Commins, 1991).

Spouse-Specific Aggression scale which is a subscale of the Spouse-Specific Assertiveness/Aggression Scale (O'Leary & Curley, 1986).

Physical Assault scale which is a subscale of the Revised Conflict Tactics Scale (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996).

Sex Role attitudes scale (Huber & Spitze, 1983).

Commitment will be measured using item 10 of the DAS Satisfaction subscale (Spanier, 1976).

Closeness and Independence Scale (Christensen, 1987).

The Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960).

Communication Patterns Questionnaire - Short Form (Christensen & Heavey, 1990).


Procedures
Participants will be asked to complete the above questionnaire (along with a consent form) at home. If they leave any items unanswered, they will be asked to complete these items during one of their assessment sessions.

Data Collection
Quantitative analysis of questionnaire data
The data collected in this study will be managed in the following way. First, the raw data will be entered item by item into a data file and verified by checking distributions and ranges. SPSS will used for this and all subsequent analyses. Second, reliability analyses of all psychometric scales will be conducted to ensure that all scales are sufficiently reliable to proceed with further analyses. Third, relationships between all dependent variables and social desirability will be conducted to determine the degree to which the validity of responses are compromised by social desirability response set. Fourth, correlations between all dependent variables and duration of presentation (e.g., PDA or MDD) will be conducted to ascertain if there were any significant relationships between the dependent variables and duration of presentation. Fifth, correlations between all dependent variables and both anxiety sensitivity and (degree of) mobility will be conducted to determine if there are any significant correlations between the dependent variables and these PDA variables. Sixth, to test hypotheses about inter-group differences between male partners and female partners
from clinical and control groups, 3X2 (diagnosis X gender) ANOVAs and Tukey post-hoc comparisons will be conducted for all dependent variables.

Seventh, correlations between all dependent variables and relationship satisfaction and the 3 variables of physical assault by partner, previous physical assault by partner, and psychological aggression towards partner will be computed to ascertain if there are significant relationships between the dependent variables and these 4 variables. Eight, to test the hypotheses about the unique effects of diagnosis on dependent variables by controlling for possible confounding effects of these 4 variables, 4 sets of 3X2 (diagnosis X gender) ANCOVAs will be conducted with these 4 variables as the covariate.

Ninth, to test hypotheses about discrepancies between male and female partners’ scores in clinical and control couples, discrepancy scores will then be computed by subtracting male and female partners’ scores on each variable and comparing using one-way ANOVAs and Tukey post-hoc comparisons. Tenth, to test a similar set of hypotheses about the unique effects of diagnosis on dependent variables by controlling for possible confounding effects of (couple) relationship satisfaction, one-way ANCOVAs and pairwise comparisons will be conducted with diagnosis as the independent variable and (couple) relationship satisfaction as the covariate.

Eleventh, to test hypotheses about the relationship between male and female partners’ scores on each variable for couples in clinical and control groups, correlations between male and female partners’ scores will be computed on all dependent variables for all 3 sets of couples. Thirteenth, correlations between the remaining dependent variables will be conducted.

**Qualitative analysis of interview data**

Informed by the results of my quantitative data, I will interview participants to further explore the power bases, processes, and outcomes in their relationships. Using thematic content analysis I will then informally qualitatively analyse the clinical data from participants’ case notes.

**Synthesis of quantitative and qualitative data**

I will then combine the results of both analyses and profile the unique features of couples containing a depressed female partner.
Proposed Chapter Structure
1. Introduction
2. Aims, design, and hypotheses of current research
3. Methodology
4. Quantitative results
5. Qualitative results
6. Discussion
7. Appendices

Projected Problems
☐ My Psych.D. thesis proposal may not get approval from our Ethics Committee.
☐ Not all male partners will be willing to complete a questionnaire relating to their primary intimate relationship, especially if they are not communicating with their partners or they do not want to change the status quo in the relationship.
☐ Data may be spoiled due to social desirability response set.
☐ Given that I will be profiling 3 sets of couples (as opposed to 2 in my M.Psych.Sc. thesis), I will probably need some guidance with the statistical analysis of my quantitative data.
TIME PLAN

Research dossier

June 2000 – August 2000
☐ Submitting thesis proposal to Ethics Committee
☐ Discussing research with colleagues and referral sources
☐ Constructing self-report questionnaires and drafting consent forms

September 2000 – June 2002
☐ Data collection and quantitative analysis
☐ Literature review

July 2002 - December 2002
☐ Qualitative data collection

January 2003 – March 2003
☐ Thesis write-up

Academic dossier

March 2001 – December 2001
☐ Completion of first critical review (including revisions to various drafts)

☐ Completion of second critical review (including revisions to various drafts)

Professional dossier

June 2000 – December 2000
☐ Assessment and treatment of a mental health presentation

January 2001 – February 2001
☐ Literature search and write-up of case study

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3 This time plan was altered in March 2002 given the slow recruitment of participants for the depressed and PDA groups of couples in my research thesis.
Universitas Hiberniae Nationalis

Testantur hae literae Gradum
Magisterii in Scientia Psychologica
in Universitate Hiberniae Nationali apud
Dublinum, quae Universitas particeps Universitatis
Hiberniae Nationalis vite constituta est
ad
Michael John Byrne
delatum esse

Die xxviii Mensis Octobris mcmxviii
CURRICULUM VITAE

NAME: Michael Byrne
ADDRESS: 101 Ashefield, Mullingar, Co. Westmeath, Ireland
TELEPHONE: 0035344 47996 (H); 0035344 39114 / 39115 (W)
DATE OF BIRTH: 10th April 1968

Education and Training (University College Dublin)

Third level
1996 – 1998 Masters in Psychological Science (Clinical Specialisation; Upper second class honours)
1991 – 1995 Bachelor of Arts degree (First class honours)
1985 – 1989 Bachelor of Mechanical Engineering (Upper second class honours)
(Graduate Association Research of the Year Award).

Continuing professional development
September 1998 European Association for Behavioural and Cognitive Therapies Conference (3 days)
October 1998 Child Care Act workshop (1 day)
November 1998 Psychological Society of Ireland Annual Conference (3 days)
October 2000 Sexuality and relationships workshop (1/2 day)
November 2000 Psychological Society of Ireland Annual Conference (3 days)
November 2001 Psychological Society of Ireland Annual Conference (3 days)
October 2002 British Psychological Society Group of Trainers in Clinical Psychology Trainers’ (GTiCP) Conference (3 days)

Publications
**Professional Practice**

*Post qualification as a Clinical Psychologist (with the Midland Health Board)*

April 2002 – To date  
Clinical Psychology Training Co-ordinator for 11 Psychologists in Clinical Training  
(1/2 time Senior Clinical Psychologist)

July 1999 – To date  
Longford / Westmeath Adult Psychiatry Team  
(1/2 time since April 2002; A/Senior Clinical Psychologist)

October 1998 – June 1999  
Longford / Westmeath Child Psychiatry Team  
(Basic Grade Clinical Psychologist)

*Professional training placements (all in Ireland)*

- **June 1998 - September 1998**  
  Family Guidance Institute and Pro-Consult, Galway  
  (Specialist counselling placement)

- **November 1997 - March 1998**  
  Sisters of Charity of Jesus and Mary, Mullingar  
  (Intellectual disability placement)

- **June 1997 - September 1997**  
  Community Care, North Western Health Board, Sligo  
  (Community Care placement)

- **February 1997 - June 1997**  
  St. Patrick’s Psychiatric Hospital, Dublin  
  (Adult Psychiatry placement)

- **October 1996 - February 1997**  
  Our Lady’s Hospital for Sick Children, Dublin  
  (Paediatric placement)

*Pre-qualification as a Clinical Psychologist (in Washington State, United States of America)*

- **October 1995 - September 1996**  
  Clinical Case Manager with adults with mental health presentations (Family Counseling Services)

- **July 1992 - September 1996**  
  Client Care Technician (on-call) with adults with Prader-Willi Syndrome (Camelot Society)

- **July 1995 - September 1996**  
  Rehabilitation Specialist (on-call) with post-acute neurological clients (Rehab Without Walls)

- **October 1995 - September 1996**  
  Therapeutic Treatment Assistant (on-call) with children and adolescents in care (LifeNet Health)
September 1995 - September 1996  Mental Health Specialist (on-call) with children and adolescents (Seattle Children's Home)

August 1993 - October 1994  Rehabilitation Specialist (on-call) with post-acute neurological clients (Mediplex Rehab)

Membership of Professional Organisations

- Registered Psychologist with the Psychological Society of Ireland.
- The British Psychological Society.

Referees

Dr. Alan Carr,
Director of D.Psych.Sc. Programme,
Psychology Department,
University College Dublin,
Belfield,
Dublin 4,
Ireland.
Tel.: 003531 7062390

Carmel Breaden,
A/Principal Clinical Psychologist,
Midland Health Board,
Health Centre,
Dublin Rd.,
Longford,
Co. Longford,
Ireland.
Tel.: 0035343 50170

Signed: ___________________________  Date: ________

Michael Byrne
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46-year-old woman presenting with Complex PTSD secondary to Chronic Childhood Sexual Abuse with secondary anxiety / mood disorders

Overview
A 45-year-old mother of 4 children (Mary) presented with social phobic tendencies. Following initial progress using cognitive-behavioural principles, further assessment indicated a chronic history of major depressive disorder, other anxiety presentations (e.g., obsessional thoughts, thunder phobia, panic attacks) and a degree of somatisation. There were also tendencies to resort to self-mutilation and psychotropic medication for affect regulation. A 5-year psychiatric hospitalisation in her mid-20s had coincided with multiple episodes of deliberate self-harm. Her presentation appeared to reflect a diagnosis of Complex Post Traumatic Stress Disorder that was secondary to chronic intra-familial childhood sexual abuse (CSA). This case study details the treatment of her anxiety presentations prior to discussion of her abuse experiences (i.e., stabilisation-phase intervention).

Factual information

Background history
Mary was a 45-year-old mother of 4 children (aged 7- through to 15-years). She lived with John, her husband of 17 years, who was a businessman. She was the fourth eldest of 10 children (i.e., 6 brothers and 3 sisters, 6 of who lived in England).

The referral agent
Mary’s short referral letter from her General Practitioner (Appendix A) noted her long history of anxiety, phobia of thunder, obsessional thoughts, and her feeling ‘a little depressed’. Her medications included Largactil, Valium (5 mgs p.r.n.), and a recently commenced trial of Paroxetine (i.e., Seroxat; 20 mgs daily).

History of problem
Mary initially stated that she wanted to explore how to better manage her acute discomfort when interacting socially with others. However, as detailed in the main body of this

4 Pseudonyms are used throughout this document to preserve confidentiality.
document, during the course of therapy she also disclosed a history of chronic CSA, extreme distress relating to obsessive thoughts, a disabling phobia of thunder, an acute fear of anxiety attacks, and regular bouts of low mood.

**Previous treatment**
Following a 5-year period of multiple admissions to a psychiatric hospital in her twenties, Mary had attended a Consultant Psychiatrist who reportedly had tried to manage her symptoms using a variety of combinations of psychotropic medications. While this ongoing intervention enabled Mary to function adequately enough to remain out of hospital, she wanted to explore her extreme discomfort in interpersonal interactions.

**Focus of this case study**
Mary attended an adult mental health service on 28 occasions over a period of 18 months to discuss her multiple concerns. Although she continues to attend for abreactive work relating to her chronic CSA, this case study only focuses on issues that were relevant to her assessment and to her progress during the early (or stabilisation) phase of her treatment. While recognising that her complex presentation may have been due to factors other than her CSA experiences (e.g., family-of-origin dynamics, other personal experiences), the following literature review considers Complex Post Traumatic Stress Disorder (i.e., PTSD with co-morbid presentations) secondary to chronic CSA.

**Literature review**
While Table 1 summarises the literature review findings for Mary’s co-morbid presentations (predominantly from a cognitive-behavioural perspective), a more comprehensive literature review of each of these presentations is contained in Appendix B.

**Chronic childhood sexual abuse and Complex Post-Traumatic Stress Disorder**
**Models of Complex Post-Traumatic Stress Disorder**
Expanding upon the four traumagenic dynamics proposed by Finkelhor and Browne (1985) and arguing that the conceptualisation of the long-term sequelae of chronic CSA as PTSD does not fully capture the psychopathology related to CSA, several theorists have proposed that there is a need to delineate additional symptom clusters including somatisation, dissociation, affect dysregulation, relationship changes, disruption in identity, and repetition of harm (Table 12, Appendix H).
Such symptom clusters may reflect the mobilisation of a variety of strong defences or coping mechanisms (some of which are detailed in Table 9, Appendix C). Being unable to use others for support, some of these defences reflect seeking relief in a variety of dysfunctional behaviours that do not rely on anyone else, including self-mutilation. Of the six functional models of the latter proposed by Suyemoto (1998; Table 13, Appendix I), empirical support is strongest for the affect regulation models and the boundaries models. The former model posits that self-mutilation serves to express and externalise intolerable and overwhelming emotion, as well as to create a sense of control over that emotion (Suyemoto, 1998, p. 543).

**Maintenance of trauma-related symptomatology**

Whilst these defences typically help manage the functional demands of daily living (and prevent psychiatric decompensation), their use may preclude the fulfilment of the intense psychological need for recapitulating trauma experiences and (potentially) mastering them and releasing the related intense affects (i.e., fulfilment of the repetition compulsion; Freud, 1955a). The resultant incomplete emotional processing of abuse experiences may predispose to a chronically benumbed state whereby the individual oscillates between extremes of forgetting (i.e., the numbing phase) and retention (i.e., the intrusion phase of the trauma response) so that there is a simultaneous ‘knowing and not knowing’ (Courtois, 1988).

**Classification of Complex PTSD**

Both DSM-IV (American Psychiatric Association, 1994) and ICD-10 (World Health Organisation, 1992) do not formally diagnose Complex PTSD. DSM-IV includes some features of Complex PTSD as associated features of ‘simple’ PTSD (Courtois, 1999, p.87) while ICD-10 only provides diagnostic guidelines for uncomplicated PTSD (Appendix D.6). The latter includes the diagnosis of Enduring Personality Change after Catastrophic Experience (Appendix D.7), but this diagnosis does not account for much of the symptomatology that emerges following repeated experiences of traumatisation. Hence, some researchers have proposed a new diagnostic category of Complex PTSD or Disorder of Extreme Stress Not Otherwise Specified (as outlined in Table 2).
Table 1 Summary of literature review of Mary’s co-morbid presentations.

<table>
<thead>
<tr>
<th>Presentation</th>
<th>Classification</th>
<th>Prevalence</th>
<th>Major clinical features</th>
<th>Theories</th>
<th>Assessment (with CI)</th>
<th>Major features of CBT</th>
</tr>
</thead>
</table>
| Complex post-traumatic stress disorder | 309.81 | F43.1? | • 50-55% of clinical clients have a history of CSA  
• 20-40% of those with a history of CSA present with PTSD  
• Of those presenting with PTSD, 80% have at least one associated disorder. | Courtois’s (1999) post-trauma model | • Trauma Symptom Inventory;  
• Dissociative Events Scale; | • Establishing safety.  
• Affect work.  
• Life reconsolidation and restructuring. |
| Social phobia                | 300.23 | F40.1 | 3% to 13%  
• Persistent fear of scrutiny in social situations  
• Strong desire to convey a particular favourable impression of oneself to others | Clark & Wells’ (1995a) cognitive model | • Social Cognitions Questionnaire;  
• Social Behaviour Questionnaire. | • Deconstruction of negative image of self in social situations |
| Obsessive-compulsive disorder | 300.3  | F42.0 | 2 ½%  
• Recurrent intrusive thoughts, images, and impulses or compulsive behaviours | Carr’s (1974) cognitive model of OCD | Maudsley Obsessional-Compulsive Inventory | • Habitation.  
• Thought stopping. |
| Specific phobia              | 300.29 | F40.2 | 10% to 11.3%  
• Persistent and excessive fear of an object or situation that is not dangerous | Avoidance conditioning model (e.g., Watson & Rayner, 1920) | - | • Coping skills training (e.g., relaxation training).  
• Graded exposure |
| Panic disorder               | 300.31 | F40.01 | 1 ½% to 3 ½%  
• Repeated unexpected anxiety attacks  
• Hypervigilance  
• Use of safety behaviours to keep safe from experiencing anxiety attacks | Clarke’s (1997) cognitive model | • Beck Anxiety Inventory;  
• Anxiety Sensitivity Index. | • Psycho-education.  
• Behavioural experiments. |
| Major depressive disorder    | 296.32 | F33.1 | • 6% for women who have not been sexually abused;  
• 22% for women who have been sexually abused | Beck’s (1967) cognitive model | Beck Depression Inventory | • Distraction techniques.  
• Monitoring activities, pleasure, and mastery.  
• Scheduling activities.  
• Graded task assignment.  
• Identifying and questioning negative automatic thoughts and assumptions.  
• Behavioural experiments. |

1. CI = Clinical interview  
2. CBT = Cognitive behavioural treatment
Prevalence of PTSD
At a minimum 20-25% of women in the community and 50-55% of clinical populations have a history of CSA (Briere, Woo, McRae, Foltz, & Sitzman, 1997). While lifetime prevalence estimates for PTSD range from 1% to 14%, as many as 20 to 40% of adults who report experiencing CSA also present with PTSD (e.g., Polusny & Follette, 1995). Of those presenting with PTSD, 80% have at least one associated disorder.

Course of PTSD
As long as abuse experiences remain unprocessed, there is a danger that an individual’s brittle defences may shatter in the face of stress (e.g., premature abreaction in the therapeutic process) or changes in their external environment (Chu, 1998). Not uncommonly there is a ‘sleeper effect’, with symptoms emerging in adult life as coping mechanisms break down and/or as post-traumatic reactions are triggered in some way (Courtois, 1988, p.122).

Assessment of PTSD
‘It is well recognised that, early on, abused and traumatised individuals can be difficult to assess accurately...they often present with masked symptoms and/or non-disclosure of their history due to a number of psychological and trauma defences, the most prominent being shame, mistrust, denial, and dissociation...some issues and symptoms become evident or are disclosed only after therapy is underway’ (Courtois, 1999, p. 220). Hence, assessment should be conceptualised as ‘a process that occurs over time rather than as a one-time event’.

The need for an initial comprehensive clinical interview (e.g., Appendix F.3) needs to be balanced with efforts to engage a sometimes-reluctant client. As an adjunct, measures of post-traumatic symptoms can be used. For example, the 28-item Dissociative Experiences Scale (Bernstein & Putman, 1986; Appendix E.5) can indicate the presence (or the extent) of dissociation.

Treatment of Complex PTSD
As with the main theoretical approaches to treating various forms of traumatic stress (Table 14, Appendix J), Chu’s (1998) post-trauma treatment model (Figure 1) proposes that abreactive work with trauma material has ‘secondary importance in the hierarchy of
Table 2 Symptom Categories and Diagnostic Criteria for Complex PTSD

I. Alterations in Regulation of Affect and Impulses
   A. Affect Regulation
   B. Modulation of anger
   C. Self-destructive
   \( A \) and one of \( B-F \) required
   D. Suicidal preoccupation
   E. Difficulty modulating sexual involvement
   F. Excessive risk taking

II. Alterations in Attention or Consciousness
   A. Amnesia
   B. Transient dissociative episodes and personalisation
   \( A \) or \( B \) required

III. Alterations in Self-Perception
   A. Ineffectiveness
   B. Permanent damage
   C. Guilt and responsibility
   \( A-F \) required
   D. Shame
   E. Nobody can understand
   F. Minimising

IV. Alterations in Perception of the Perpetrator
   A. Adopting distorted beliefs
   B. Idealisation of the perpetrator
   \( C \) required
   C. Preoccupation with hurting perpetrator

V. Alterations in Relations with Others
   A. Inability to trust
   B. Revictimisation
   \( A-C \) required
   C. Victimising others

VI. Somatisation
   A. Digestive system
   B. Conversion symptoms
   C. Sexual symptoms
   \( A-E \) required
   A. Cardiopulmonary symptoms

VII. Alterations in Systems of Meaning
   A. Despair and hopelessness
   B. Loss of previously sustaining beliefs
   \( A \) or \( B \) required


'treatment' (p. 94). Although the proposed tri-partite division of the course of treatment is somewhat arbitrary (as clients move back and forth between stages in a recursive fashion rather than progress through them linearly), Chu proposes that prior to abreactive work there is a need to inculcate a sense of safety and stability within the client. Considering the
multiple tasks of the initial phase of treatment, it is often the lengthiest of the 3 phases of treatment and many process issues (i.e., Appendix K) can complicate it.

<table>
<thead>
<tr>
<th>Early (or stabilisation) Phase</th>
<th>Middle Phase</th>
<th>Late Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address co-morbid presentations</td>
<td>De-conditioning</td>
<td>Self and relational development</td>
</tr>
<tr>
<td>Alliance-building</td>
<td>Mourning</td>
<td>Life reconsolidation and restructuring</td>
</tr>
<tr>
<td>Safety</td>
<td>Resolution and integration of the trauma</td>
<td></td>
</tr>
<tr>
<td>Psycho-education</td>
<td>Relapse planning</td>
<td></td>
</tr>
<tr>
<td>Self-care</td>
<td>Stabilisation</td>
<td></td>
</tr>
<tr>
<td>Self functions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Validation of trauma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expression of unspeakable feelings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 1 Stages of the Post Trauma Treatment model (Chu, 1998).

Assessment

As therapy progressed Mary disclosed more of her concerns, each of which was addressed in turn. Her sequenced disclosure was partially a result of the therapist’s failure to undertake a comprehensive initial assessment. Her expanding complicated clinical presentation increasingly supported a diagnosis of Complex PTSD.

Background information

Mary stated that her parents had suffered from chronic depression and that her father regularly physically abused her mother. Like her father, two of her brothers were reportedly alcoholics, and another two younger brothers and a younger sister reportedly suffered from depression. These 2 brothers now lived with her parents in the family home in a rural setting.

Mary failed her A-level equivalent examinations when 17-years-old due to extreme examination anxiety. Having worked thereafter for two years in a large city, she returned home to care for her 5 younger siblings due to her mother’s inability to cope with the demands of parenting. From her early to mid-twenties, she spent approximately 5 years in a psychiatric hospital for treatment of depression. She then met her husband and became a homemaker. She was a devoted follower of the Roman Catholic Church.

Initial or phase 1 of assessment – Social Phobia

Mary stated that she wanted to initially focus on her social phobia. Along with the Social Cognitions Questionnaire (SCQ), the Beck Anxiety Inventory (BAI) and the Beck
Depression Inventory (BDI) were administered to establish a baseline measure of anxiety and depressive symptomatology. These indicated a moderate level of anxiety but a non-clinical level of depressive symptomatology (Figure 8, Appendix L). Mary disclosed that she had an acute fear of thunder and some obsessive thoughts but declined to elaborate on the details of the latter.

In contrast to questionnaire data, Mary stated that since her early twenties she engaged in a variety of safety behaviours to minimise the possibility of others seeing her blush (Table 3). She believed that if others noticed her blushing, they would assume that there was something wrong with her and that they might start asking questions about her (including about her past). She was fearful of their finding out that she felt wholly inadequate about herself. She particularly feared that if her ‘well-to-do’ in-laws knew about her shameful past and her ‘dysfunctional family’, they would reject her and that their rejection might impact negatively on her much cherished marital relationship. She had no long-term friends as she distanced anybody who knew about her past or who tried to get to know her.

Table 3 A list of Mary’s pervasive and situation-specific safety behaviours relating to her social phobic tendencies.

<table>
<thead>
<tr>
<th>Pervasive safety behaviours</th>
<th>Safety behaviours with in-laws</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use tranquillisers</td>
<td>Have something to talk about or be proud of</td>
</tr>
<tr>
<td>Dress up well</td>
<td>Avoid conversing about the past</td>
</tr>
<tr>
<td>Cut conversations short</td>
<td>Have a physical support (e.g., a chair)</td>
</tr>
<tr>
<td>Do not wear glasses (so that she could not see others’ reactions)</td>
<td>Call into their house when she knew they were not there</td>
</tr>
<tr>
<td>Be with strangers or non-perfectionist people</td>
<td></td>
</tr>
<tr>
<td>Gravitate towards dark / dimly lit places</td>
<td></td>
</tr>
<tr>
<td>Wear cool clothing</td>
<td></td>
</tr>
<tr>
<td>Use humour</td>
<td></td>
</tr>
<tr>
<td>Avoid eye contact</td>
<td></td>
</tr>
<tr>
<td>Talk less</td>
<td></td>
</tr>
</tbody>
</table>

Phase 2 of assessment – Obsessional recurring thoughts

Subsequent to her initial success in challenging her social phobia, Mary disclosed that she was highly distressed by the recurrent and persistent thought that she might physically harm her children, so much so that she thought of harming herself (as doing so would prevent her from harming her children for who she sacrificed ‘everything’). She derived considerable self-esteem from being a good mother but believed that her children did not deserve an ‘Unchristian’ mother who had ‘bad thoughts’ about hurting them. The Maudsley Obsessive-Compulsive Inventory indicated a non-clinical level of obsessions/compulsions.
Phase 3 of assessment – Thunder phobia

Mary subsequently asked to focus on her acute fear of thunder. When 6-years-old, she heard her parents describe how an 18-year-old neighbour was ‘struck down’ by lightning. Thereafter she reportedly could not forget the image of the girl’s coffin on the Church altar and she developed a fear of thunder. This fear escalated dramatically in 1985 when she read a newspaper article that reported that a moving statue of Mary (mother of Jesus) had whispered that the bad weather at the time was God’s way of punishing people for their wrongdoings. She believed that two successive thunderstorms were God’s way of trying to punish her for her many wrongdoings. She stated that she had since engaged in many safety behaviours (Table 4) to keep her ‘safe’ from thunderstorms. At the time of attendance, her fear had increased substantially as she believed some media reports that God would seek retribution on the masses before the new Millennium.

Table 4 List of Mary’s pervasive and situation-specific safety behaviours relating to her thunder phobia

<table>
<thead>
<tr>
<th>Pervasive safety behaviours</th>
<th>Safety behaviours when thunder present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use tranquillisers</td>
<td>Close all curtains</td>
</tr>
<tr>
<td>Do not undertake long journeys</td>
<td>Unplug all appliances</td>
</tr>
<tr>
<td>Constantly review weather forecast</td>
<td>Pray (along with children) that thunder will not hit</td>
</tr>
<tr>
<td>Constantly check the skyline for dark clouds</td>
<td>Remain in-doors (preferably own house)</td>
</tr>
<tr>
<td>Read religious books and pray (to keep God’s attention)</td>
<td>Be with as many people as possible</td>
</tr>
</tbody>
</table>

Phase 4 of assessment – Anxiety attacks (and somatisation)

Mary disclosed that she was experiencing abdominal pains and that she had a history of similar intermittent (unexplained) physical pain. When questioned further, she disclosed that an 8-month psychiatric hospitalisation (in her twenties) was precipitated by her trenchant belief that she was suffering the stigmata. She also described the sequence of symptoms (e.g., physiological, cognitive, behavioural, and emotional) that culminated in her first anxiety attack in school when she was 15-years-old. Thereafter, her experience of physical pain typically preceded her anxiety attacks.

Using a semi-structured interview (Appendix F.2), she detailed how her fear had generalised to other environments. She had not travelled on a bus for more than 3 years. She coped with her fear that she would have a heart attack by engaging in a variety of safety behaviours (Table 5). Her use of these behaviours increased following her father’s heart attack when she was 25-years-old.
Table 5 List of Mary’s safety behaviours relating to her anxiety attacks and how they promoted certain beliefs

<table>
<thead>
<tr>
<th>Safety behaviours</th>
<th>Promotes belief that could have a heart attack unless:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of tranquillisers</td>
<td>Have medication</td>
</tr>
<tr>
<td>Avoid crowded and confined environments</td>
<td>Able to escape quickly from situations</td>
</tr>
<tr>
<td>Avoid being away from home</td>
<td>Avoid being left alone</td>
</tr>
<tr>
<td>Insistence on remaining in the company of others</td>
<td>Able to return home quickly to safety</td>
</tr>
</tbody>
</table>

Ongoing assessment – Chronic childhood sexual abuse and depression

Although Mary did not initially present with the emotional affect typical of a major depressive episode, ongoing assessment suggested that she had been depressed since her teenage years. Although many factors contributed to her being depressed (e.g., her numerous memories of neglect, her being witness to domestic/sibling violence, her perceived failure to harmonise relations within her family-of-origin), assessment indicated that her experiences of abuse both precipitated and aggravated her depressive symptoms. She disclosed in session 7 that ‘one of her brothers’ had raped her when she was 7-years-old and that another brother had regularly sexually abused her and her two sisters (i.e., molestation and digital penetration) while they slept together from the time she was 10-years-old to when she was 17. She was highly reluctant to discuss the details of her abuse experiences and which of her brothers had committed these acts. Her indicated non-clinical level of dissociation on the Dissociation Experiences Scale did not support the hypothesis that she had developed partial amnesia for (or dissociated from) these experiences.

Despite her reluctance to discuss the details of her abuse experiences, Mary was open to discussing the many ways in which she believed that the abuse had negatively affected her. She felt great shame and sadness about her resultant ‘defectiveness’. She disclosed that when unable to block out the dysphoric feelings associated with these experiences, feeling overwhelmed she often self-mutilated (‘to relieve her depression’). Her religious beliefs predisposed to her thinking that she had committed ‘many mortal sins’ and that God would punish her for these. It appeared that she had adopted a victim-abuser internal working model of caregiver relationships and that she had generalised this model to her relationship with God. Table 6 indicates some of Mary’s dysfunctional assumptions or maladaptive thoughts that predisposed to feeling down.
Table 6 Some of Mary’s dysfunctional assumptions or maladaptive thoughts

<table>
<thead>
<tr>
<th>Abused-related dysfunctional assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• My family and friends would shun me if they knew the real me or of my abuse</td>
</tr>
<tr>
<td>• I will be forever abnormal as the abuse has left me permanently blackened</td>
</tr>
<tr>
<td>• The abuse was God’s way of punishing me for being bold</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>General dysfunctional assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• As I have sinned many times against God, I need to be punished and to make many sacrifices in life</td>
</tr>
<tr>
<td>• My worth depends on how successfully I can harmonise relations within my family-of-origin</td>
</tr>
<tr>
<td>• I am an unworthy mother and wife as I have thoughts about harming my children</td>
</tr>
</tbody>
</table>

Classification based on assessment data

Reflecting the symptom clusters of Complex PTSD (Table 2) as proposed by Pelcovitz et al. (1997), ongoing assessment indicated that Mary had chronic difficulties in modulating her affect and impulses; she had experienced bouts of major depression since her early twenties, she had often tried to self-harm by overdosing, and she continued to self-mutilate. Assessment did not confirm if she experienced alterations in attention or consciousness. However, alterations in self-perception, in relations with others, and in her systems of meaning were quite apparent. Somatisation was a prominent symptom cluster during her mid twenties (e.g., she believed she was experiencing the stigmata), possibly because she had less well-developed coping mechanisms at that time (e.g., fewer and less severe anxiety presentations). Current assessment indicated less severe somatisation and a variety of anxiety presentations. Table 7 outlines both the DSM-IV and ICD classification of Mary’s presentation as indicated by on-going assessment data.

Table 7 Classification based on assessment data

<table>
<thead>
<tr>
<th>Classification</th>
<th>DSM IV</th>
<th>ICD 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis I</td>
<td>995.5</td>
<td>Sexual abuse of a child</td>
</tr>
<tr>
<td>309.81?</td>
<td>Complex Post Traumatic Stress Disorder</td>
<td>F43.1?</td>
</tr>
<tr>
<td>300.23</td>
<td>Social Phobia</td>
<td>F40.1</td>
</tr>
<tr>
<td>300.3</td>
<td>Obsessive Compulsive Disorder (predominantly obsession thoughts)</td>
<td>F42.0</td>
</tr>
<tr>
<td>300.29</td>
<td>Specific Phobia (natural environment type)</td>
<td>F40.2</td>
</tr>
<tr>
<td>300.31</td>
<td>Panic Disorder (with Agoraphobia)</td>
<td>F40.01</td>
</tr>
<tr>
<td>296.32</td>
<td>Major Depressive Disorder (recurrent, moderate)</td>
<td>F33.1</td>
</tr>
<tr>
<td>Axis II</td>
<td>V71.09</td>
<td>No diagnosis</td>
</tr>
<tr>
<td>Axis III</td>
<td>None to date</td>
<td>-</td>
</tr>
<tr>
<td>Axis IV</td>
<td>Frightening experiences as a child</td>
<td>Z61.8</td>
</tr>
<tr>
<td>Family history of mental disorders</td>
<td>Z81.8</td>
<td></td>
</tr>
<tr>
<td>Personal history of self-harm</td>
<td>Z91.5</td>
<td></td>
</tr>
<tr>
<td>Problems with family-of-origin members</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Axis V</td>
<td>GAF = 60 (initial)</td>
<td>-</td>
</tr>
</tbody>
</table>
Formulation based on assessment data

PREDISPONING FACTORS

Biological
- Family history of psychiatric presentations (e.g., maternal depression, paternal alcohol abuse, anti-social personality disorder)
- Abuse-related physical injuries?

Psychosocial
- Chaotic familial dynamics (e.g., chronic intra-familial child sexual abuse, maternal emotional unavailability, neglect, domestic violence, strong religious beliefs, coping role within family)
- Personal childhood memories (e.g., death of neighbour by lightning, being told that had ‘several mortal sins’ on soul)
- Low self-esteem
- Development of traumagenic dynamics including adoption of victim-persecutor internal working model for relationships (e.g., with God) and belief of generalised personal ineffectiveness; development of poor assertiveness skills
- Poor emotional regulation
- Malevolent view of world

PRECIPITATING FACTORS

Biological
- Panic attack ‘out of the blue’ when 15-years-old and subsequent somatisation

Psychosocial
- Various personal experiences (e.g., chronic intra-familial child sexual abuse, violent thunder storms at time of moving statues when 15-years-old, failure in A-level equivalent examinations, rejection by fiancé, rejection by boss and work colleagues in mid-20s, father’s heart attack, a death threat by “ill” brother, husband going away on business trips)
- Poor emotional regulation (e.g., self-mutilation, suicide attempts by overdosing on medication)

PRIMARY PRESENTATION
- COMPLEX POST TRAUMATIC STRESS DISORDER

SECONDARY PRESENTATIONS
- ANXIETY DISORDERS (E.G., SOCIAL PHOBIA, OBSESSIVE COMPULSIVE DISORDER, SPECIFIC PHOBIA, PANIC DISORDER)
- MAJOR DEPRESSIVE DISORDER

MAINTAINING FACTORS

Personal Psychosocial
- Engagement in various safety behaviours
- Persecutor-victim internal working model of relationships
- Poor emotional regulation (e.g., self-mutilation)
- Fear of rejection by husband if totally honest with him
- Shame of abuse experiences and psychiatric history
- Excessively high standards of performance
- Limited sources of self-esteem
- Insufficient emotional processing of disturbing memories
- Failure of previous therapies to improve functioning
- Fear of “ill” brother exploding at any time
- Well developed ego-defence mechanisms
- External locus of control

Contextual Psychosocial
- Critical ‘well-to-do’ in-laws
- Minimal support network
- Reluctance to give up coping role
- Chaotic family-of-origin dynamics
- Periodic absences of husband (on business)

PROTECTIVE FACTORS

Biological
- Good physical health

Personal Psychosocial
- Acceptance of and motivation to overcome difficulties
- Average intelligence and somewhat insightful
- Resilient
- Functional coping strategies
- High marital satisfaction

Contextual Psychosocial
- Supportive husband
- Medium to high socio-economic status
- Low family stress

Figure 2 Formulation derived from (ongoing) assessment data.
Progress throughout attendance

Using the formulation outlined in Figure 2 and the relevant cognitive behavioural therapy strategies outlined in Appendix B, each of Mary’s presentations were addressed in turn. Her questionnaire data (Figure 8, Appendix L and Table 15, Appendix M) did not accurately represent her progress (or lack thereof). She stated that if feeling good when completing the questionnaires she would endorse favourable items but would endorse unfavourable items if feeling down. A more accurate measure of Mary’s progress in therapy may be her DSM-IV Global Assessment of Functioning Scale (Appendix N) scores as assessed by clinical interview (Table 8).

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>GAF Scale score (0-100)</td>
<td>60</td>
<td>50</td>
<td>60</td>
<td>60</td>
<td>65</td>
<td>40</td>
<td>55</td>
</tr>
</tbody>
</table>

1. GAF Scale scores range from 0-100 with higher scores indicating fewer symptoms and better functioning.

Social Phobia

Serving as a model for dealing with her other anxiety presentations, treatment consisted of a mixture of ongoing psycho-education (about the nature of social phobia and how it developed in Mary) and behavioural experiments. Regarding the latter, her negative thoughts (e.g., about rejection in social situations) were treated as hypotheses that needed testing (via progressively dropping her safety behaviours). In the process, she learned to develop alternative hypotheses; so rather than being an accurate reflection of what might happen, she gradually learned that her negative thoughts were merely ‘fear’ messages. After initial ‘positive’ experiences, her anticipatory anxiety relating to meeting her in-laws increased dramatically but subsequently decreased.

Obsessional recurring thoughts

Success in overcoming her social phobia predisposed to Mary’s entrusting more in the therapeutic relationship, disclosing more in-session (e.g., her CSA experiences), and taking greater in-vivo risks with exposing herself to her obsessional but acutely fearful thought that she might harm her children. In relation to the latter, her suicidal ideation reportedly increased following deliberate thought evocation. Following further habituation to this thought, her related distress reportedly decreased for a period of a few months.
Thunder phobia

Having firstly repeatedly listened to an audio recording of thunder, Mary made rapid progress in disconfirming her fears when she progressively disengaged from her various safety behaviours (Table 4). A lengthy chat with a Roman Catholic Priest confirmed that God was out to support (and not to punish) her and that she was absolved of her sins; this pre-empted her going out in 2 thunder storms (albeit in her car). She was awaiting more thunderstorms so that she could further test out her negative beliefs relating to her fear of thunder.

Anxiety attacks

Upon discussion of the collaboratively-derived formulation of her presentation and the physiology of panic (Appendix G), Mary recognised that her attacks were preceded by a period of physical pains and characterised by the four systems of panic interacting in a sequence. She also recognised that as the number of her safety behaviours increased, more stimuli were avoided and thus became possible future triggers. These behaviours helped to keep her most fearful thoughts at bay. Feared physical sensations were induced in order to demonstrate the possible causes of symptoms, and then her safety behaviours were progressively dropped in-vivo to help disconfirm her negative beliefs about the consequences of these sensations. Following initial ‘positive’ experiences, the frequency of panic attacks decreased but her anticipatory anxiety increased. However, she subsequently entered her most feared situation (i.e., travelling abroad alone on an aeroplane). Additionally, her physical pains appeared to decrease as therapy progressed.

Chronic childhood sexual abuse and depression

As Mary experienced success in overcoming her various anxiety presentations (to different degrees) she began to feel better about herself. However, as indicated by assessment data, possibly the biggest impact on her self-image was her chronic CSA. Although she initially stated that she did not want to discuss her abuse experiences, 14 months after initial disclosure she asked if she could discuss these in a ‘general manner’. Due to her tendency to self-mutilate as a means of regulating the dysphoric affect associated with her abuse experiences, an initial therapeutic focus was agreeing to a safety contract.
Another focus of therapeutic work was psycho-education about trauma. After reading some general literature she stated that she understood for the first time that her ‘hidden’ emotions relating to her sexual abuse (e.g., confusion, fear, shame, guilt, sadness, etc.) were not indicative of her being ‘crazy’. She also gradually came to realise that she was in no way responsible for her abuse and to accept that her psychiatric history was possibly more a product of her severe life circumstances (rather than a reflection of her being ‘morally weak’).

As therapy progressed, the therapist consistently challenged Mary’s dysfunctional assumptions. It appeared that by the end of attendance that she had either rejected or modified many beliefs about herself (Table 6). For example, she realised that she needed to readjust her distorted image of God and her expectation that she had any control over family-of-origin dynamics.

Returning to an external work environment after an absence of 20 years, her ‘positive’ emotional experience of being accepted helped her to process the negative experience of having been ostracised in her previous workplace (i.e., during her mid-twenties).

**Outlook**

By the end of therapy, Mary was functioning quite well, as recognised by her family members (which she experienced as highly reinforcing). She was planning to re-attend to discuss in detail her sexual abuse experiences.

**Things that could have been done differently**

The therapist was possibly overly anxious to engage Mary in the therapeutic relationship as manifested by his not conducting a comprehensive initial assessment. Treatment may have been more focused if such an assessment was conducted. Directly contacting the referral source may have added further information to her formulation as may have meeting with Mary’s husband.

**Conclusions**

Mary was a 45-year-old mother of 4 children who was referred by her General Practitioner for assessment of chronic anxiety, thunder phobia, and obsessional thoughts. Ongoing assessment revealed a variety of presentations including a chronic history of major depression, other anxiety presentations (e.g., obsessional thoughts, thunder phobia, panic
attacks) and a degree of somatisation. There were also tendencies to resort to self-mutilation and to psychotropic medication for affect regulation. A 5-year psychiatric hospitalisation in her mid-20s had coincided with multiple episodes of self-harm. Assessment indicated a diagnosis of Complex Post Traumatic Stress Disorder secondary to chronic intra-familial CSA. During her 28 appointments, each of her secondary presentations was addressed in sequence. She is now in full time employment and is planning to attend this adult mental health service to further discuss her abuse experiences.
References


Appendix A  Letter of referral from Mary’s General Practitioner.

Mr Michael Byrne,
Clinical Psychologist,
St. Martin’s Centre,
Athlone District Hospital,
Athlone, Co. Westmeath

2nd February 2000

RE: DATE OF BIRTH: 30/12/54
TEL:

Dear Michael,

Thank you for seeing this 46 year old married lady with four children aged from 16 to 7. She has a long history of Anxiety, phobic regarding thunder and lightening and has attended St. Patrick’s in the past as an Outpatient for management of this. She has also been on Largactil in a small dose long-term prescribed by Professor Meehan and she takes the occasional Valium 5mg.

She is bothered by obsessional recurring thoughts which she will describe to you herself. She says that these come and go, more likely to occur if she is a little depressed or down. I have started her on anti-depressants today on a trial basis, i.e. Paroxetine 20mg daily.

She has expressed a desire to talk to somebody about her worries. I would be grateful if you could see her.

With kind regards,

Yours sincerely.

DR.
Appendix B.1 Literature review of Social phobia

Classification
Both DSM-IV (APA, 1994) and ICD-10 (WHO, 1992; Appendix D.1) indicate that Social Phobia is characterised by an intense fear of scrutiny by others that may manifest as anticipatory anxiety or panic attacks in certain social situations, and behavioural avoidance of the latter.

Prevalence
Epidemiological and community-based studies have reported lifetime prevalence of Social Phobia ranging from 3% to 13% (APA, 1994, P. 414). The reported prevalence may vary depending on the threshold used to determine distress or impairment and the numbers and types of social situations specifically surveyed. In one study, 20% reported excessive fear of public speaking and performance, but only about 2% appeared to experience enough impairment to warrant a diagnosis of Social Phobia (APA, 1994, p. 415).

Course
Social Phobia typically has an onset in the mid-teens, sometimes emerging out of a childhood history of social inhibition or shyness (APA, 1994, p. 414). Onset may abruptly follow a stressful or humiliating experience, or it may be insidious. Duration is frequently lifelong, although the disorder may attenuate or remit during adulthood.

Clarke and Wells' (1995a) Cognitive model of Social Phobia
Clark and Wells (1995a) contend that the core of social phobia appears to be a strong desire to convey a particular favourable impression of oneself to others and a marked insecurity about doing so. Figure 3 summarises the processes that this popular model assumes occur when an individual with social phobia enters a feared social situation. It is proposed that these individuals will have developed (from experience) a series of assumptions about themselves and social situations. These assumptions lead them to interpret normal social interactions in a negative way, viewing them as signs of danger, which in turn triggers an ‘anxiety programme’ that can be usefully divided into 3 components.

Firstly, the somatic and cognitive symptoms of anxiety that are reflexively triggered (by the perception of danger) can become a further source of perceived danger (thus creating a
vicious circle that maintains the anxiety). Secondly, engagement in safety behaviours (the purpose of which is to reduce social threat and prevent feared outcomes from occurring) prevents the individual from disconfirming unrealistic beliefs. Additionally, engagement in some safety behaviours may elicit less friendly behaviour from others and partly confirm an individual’s fears. Thirdly, the preoccupation with somatic responses and negative social-evaluative thoughts may interfere with the ability to process social cues, thus predisposing to strange or unusual behaviour.

Figure 3 The processes that, it is hypothesised, occur when an individual with social phobia enters a feared situation.

Assessment
Along with a comprehensive clinical interview, several self-report inventories have been developed to measure socially phobic behaviour and treatment outcome. For example, the Social Cognitions Questionnaire (SCQ; Wells, Clark, Stopa, & Papageoriou, 2000; Appendix E.1) has been designed to elicit the cognitions of individuals with social phobia.

Treatment
Clark and Fairburn (1996) describe a cognitive-behavioural model of treatment (i.e., CBT) for individuals with social phobia that involves a systematic elicitation and manipulation of
so called ‘safety behaviours’ and dysfunctional assumptions (or maladaptive beliefs). One of the central components of their approach is the deconstruction of the client’s negative image of themselves in social situations using either verbal or video feedback. Initial results using this comprehensive CBT package report success rates of 1.5 to 2 times greater than traditional approaches (Clark & Wells, 1995b).
Appendix B.2 Literature review on Obsessive Compulsive Disorder

Classification
Both DSM-IV (APA, 1994) and ICD-10 (WHO, 1992; Appendix D.2) indicate OCD to be characterised by obsessions (e.g., anxiety-provoking thoughts, impulses, or images that are recognised by the individual to be his or her own and to not simply be excessive worries about real-life problems) or compulsions (i.e., anxiety-reducing repetitive behaviours or mental acts), both of which cause marked distress.

Prevalence
Although OCD was previously thought to be relatively rare in the general population, recent community studies have estimated a lifetime prevalence of 2.5% and 1-year prevalence of 1.5%-2.1% (APA, 1994, p. 420).

Course
Although OCD usually begins in adolescence or early adulthood, it may begin in childhood. Modal age of onset is earlier in males than in females; between 6 and 15 for males and between 20 and 29 years for females. For the most part, onset is gradual, but acute onset has been noted in some cases. The majority of individuals have a chronic waxing and waning course, with exacerbation of symptoms that may be related to stress (APA, 1994, p. 420).

Cognitive model of Obsessive Compulsive Disorder
Obsessive Compulsive Disorder (OCD) is a problem characterised by (unwanted and highly distressing) recurrent intrusive thoughts, images, and impulses or compulsive behaviours (overt or thoughts). As delineated in Carr’s (1974) cognitive model of OCD, an individual with will have an ‘if anything can wrong, it will’ view of life. When an obsession occurs, an individual typically will experience an urge to neutralise (i.e., put right) the obsession (or it’s consequences) and in so doing temporarily decrease their anxiety related to the obsession (Salkovskis & Kirk, 1989, p.130).

Assessment
A structured clinical interview needs to detail both the obsessive thought(s) and compulsive behaviour(s) in terms of what happens emotionally, behaviourally, cognitively, andphysiologically for the client, as well as the client’s background. Behavioural tests, direct
observation, questionnaires, and self-monitoring are also needed to help formulate the client’s presentation (Table 10, Appendix F.1). The 30-item Maudsley Obsessional-Compulsive Inventory (Hodgson & Rachman, 1977; Appendix E.2) gives a global obsessional score but it only has only two items covering obsessions and it does not assess degree of disability and severity of the presentation.

![Diagram of OCD sequence](image)

Figure 4 The suggested sequence of events in OCD.

**Treatment**

The basis of CBT in the treatment of obsessions without overt compulsive behaviour is habituation training and thought stopping. The early goal of the former is to ‘repeatedly and predictably’ ‘elicit thoughts over the period required for anxiety reduction, while at the same time preventing covert avoidance and neutralising behaviour. Once habituation to predictable stimuli has been achieved (via a combination of deliberate thought evocation, writing down the thought repeatedly, or exposure to a ‘loop tape’), treatment progresses to more unpredictable stimuli and habituation’ whilst the client is anxious (Salkovskis & Kirk, 1989, p. 136).

Research suggests a median outcome success rate of 75% for individuals who complete CBT but that figure is considerably worse for obsessions without overt compulsive behaviour (Salkovskis & Kirk, 1989, p. 167).
Appendix B.3 Literature review on Specific Phobia

Classification
A Specific (or simple) Phobia is a persistent and excessive fear of a (single) object or situation that is not in fact dangerous (Butler, 1989, p. 97). Both DSM-IV (APA, 1994) and ICD-10 (WHO, 1992) include Specific Phobia as a separate diagnostic category (Appendix D.3).

Prevalence
Although phobias are common in the general population, they rarely result in sufficient impairment or distress to warrant a diagnosis of Specific Phobia. The reported prevalence may vary depending on the threshold used to determine impairment or distress and the number of types of phobias surveyed. In community samples, a 1-year prevalence rate of about 9% has been reported, with lifetime rates ranging from 10% to 11.3% (APA, 1994, p. 408).

Course
Specific Phobias, Natural Environment Type, tend to begin primarily in childhood. Phobias that persist into adulthood remit only infrequently (around 20% of cases) (APA, 1994, p. 408).

Origins of Specific Phobias
Predisposing factors to the onset of Specific Phobias include traumatic events (such as being attacked by an animal or trapped in a closet), unexpected Panic Attacks in the to-be-feared situation, observation of others undergoing trauma or demonstrating fearfulness (such as observing others fall from heights or become afraid in the presence of certain animals), and informational transmission (e.g., repeated parental warnings about the dangers of certain animals or media coverage of aeroplane crashes; APA, 1994, p. 408).

Fear usually builds up gradually, as a result of repeated, more or less frightening experiences or through social learning (e.g., Watson and Rayner, 1920). Sometimes this happens at a time of stress or high arousal, when fear responses are easily learned. They may develop gradually out of childhood fears (Butler, 1989, p. 99).
**Maintenance of Specific Phobia**

The primary maintaining factor of a phobia is engagement in behavioural avoidance which prevents the client from disconfirming that the feared object or situation is dangerous, or is not dangerous in the way, or to the same extent that s/he thinks so (Figure 5). A client’s thoughts can also help maintain a phobia (e.g., her/his thoughts about the meaning of the physiological symptoms of anxiety or about the consequences of encountering the phobic object or situation). Loss of confidence and external factors (e.g., the sympathetic reactions of others) can also mitigate against challenging one’s fear (Butler, 1989, p. 100).

**Figure 5** The suggested sequence of events that maintain a phobia (from Butler, 1989, p.101).

**Assessment**

As with assessment of other anxiety disorders, a structured clinical interview needs to detail the precise nature and history of the phobia. The factors that may be maintaining the phobia also need examination; these may include the client’s erroneous fear cognitions, his/her existing coping skills (e.g., behavioural avoidance, self-medication), and his/her motivation to challenge the phobia in question.

**Treatment**

The basis of cognitive-behavioural treatment of phobias is graded exposure, either imaginal or in-vivo. A client’s level of anxiety may be reduced via the (initial) use of relaxation, distraction, and/or answering thoughts. To prepare for exposure, the additional techniques
of role-playing, rehearsal, and modelling may be incorporated into the treatment plan. There is much evidence suggesting that exposure-based treatment is remarkably successful and that there is good maintenance of gains (e.g., Marks, 1987).
Appendix B.4 Literature review on Panic Disorder

Classification
DSM-IV (APA, 1994; Appendix D.4) includes panic disorder with agoraphobia, panic disorder without agoraphobia, and agoraphobia without history of panic disorder as separate diagnostic categories. ICD-10 (WHO, 1992) gives agoraphobia diagnostic precedence over panic disorder by including agoraphobia with panic disorder as a separate diagnostic category.

Prevalence
Between 7% and 28% of the population will experience an occasional panic attack (Clarke, 1997) this figure increasing amongst women who have experienced CSA (partially due to the chronically heightened autonomic arousal that often arises from sexual victimisation). However, only 1.5 to 3.5% of individuals will develop panic disorder (with or without agoraphobia). Panic disorder with agoraphobia is diagnosed three times as often in women as in men. Women who have experienced CSA are more likely to report chronic severe anxiety, sometimes manifesting as anxiety attacks (Briere, 1984).

Course
Age at onset of panic disorder is typically between late adolescence and the mid-30s, usually with a chronic but waxing and waning course. Some may have episodic attacks with years of remission in between, while others may continue to have severe symptomatology. Although agoraphobia may develop at any point, its onset is usually within the first year of occurrence of recurrent panic attacks (APA, 1994, p. 399).

Clarke’s Cognitive model of Panic disorder
Many individuals experience an occasional unexpected panic attack that may be produced by stressful life events, hormonal changes, illness, caffeine, or drugs. What distinguishes individuals who develop panic disorder is that, after their initial attack, they develop a tendency to interpret normal anxiety responses (e.g., palpitations, breathlessness, dizziness etc.) in a catastrophic manner. Such internal stimuli may include thoughts and images. To a lesser extent, external stimuli can provoke attacks. For example, a supermarket can provoke an attack for an individual who has previously had an attack in a similar environment.
Interpreting stimuli as signs of impending danger produces a state of mild apprehension, which is associated with a wide range of body sensations. If these anxiety-producing sensations are interpreted in a catastrophic fashion, a further increase in apprehension occurs, producing more bodily sensations, leading to a vicious cycle that culminates in a panic attack (Clark, 1997, p. 125).

**Figure 6** The suggested sequence of events in a panic attack.

Once individuals begin to interpret certain bodily sensations in a catastrophic fashion, they do two things that help maintain their presentation. Firstly, they become hypervigilant and repeatedly scan their body for evidence of further attacks. Secondly, they also typically engage in various safety behaviours (such as avoiding physical exercise if they fear having a heart attack) that prevent them from disconfirming their negative beliefs about the consequences of their sensations (e.g., not suffering a heart attack although exercising strenuously).

**Assessment**
A structured clinical interview (Appendix F.2) needs to detail the first panic attack, in terms of what was happening emotionally, behaviourally, cognitively, and physiologically for the client, as well as the situational factors, and those factors that helped stop the attack. Assessment of the nature of current attacks and their pattern help determine if a diagnosis of panic disorder is appropriate.

The Beck Anxiety Inventory (BAI; Beck, 1990; Appendix E.3) provides a measure of the degree to which an individual experiences the physical symptoms of panic and associated cognitions. Another self-report measure is the Anxiety Sensitivity Index (Peterson & Reiss,
that measures the strength of beliefs regarding the negative implications of anxiety experiences.

Treatment
Cognitive therapy focuses on changing a client's cognitions regarding physical sensations. This is achieved via a mixture of ongoing education, information about the physiology of panic (Appendix G), and behavioural experiments of two types: those in which feared sensations are induced in order to demonstrate possible causes of symptoms, and those where safety behaviours are dropped in order to help disconfirm negative beliefs about the consequences of the sensations (Clark, 1997). These latter experiments should expose to success experiences. This is most likely if exposure is to tolerable fear levels. Otherwise, the client will be overcome by fear and regress.

Clark et al. (1994) compared cognitive therapy with applied relaxation and with pharmacotherapy. Both pharmacotherapy and cognitive therapy were superior to applied relaxation, but the post-treatment relapse rate with cognitive therapy (5%) was significantly better than that for pharmacotherapy (40%). In another study (Ost & Westling, 1995), 87% of cognitive therapy patients became panic-free and achieved high end-state function at the end of treatment. This compared with a figure of 47% for applied relaxation patients. Taken together, these studies indicate that properly conducted cognitive therapy is associated with 79-94% of clients becoming panic-free and these gains being maintained at follow-up (Clark 1997).
Appendix B.5 Literature review on Major depressive disorder

Classification
Both DSM-IV (APA, 1994) and ICD-10 (WHO, 1992) include major depressive disorder as a separate diagnostic category (Appendix D.5).

Prevalence
Protracted depression is the symptom most commonly reported in the clinical literature on CSA. Research suggests that there is an increased lifetime prevalence of major depression amongst this population. For example, Stein et al. (1988) found a lifetime prevalence rate of 22% amongst this population compared with only 6% for women who were not abused.

Course
Symptoms of a major depressive episode usually develop over days to weeks. An untreated episode typically lasts 6 months or longer, regardless of age at onset. In a majority of cases, there is complete remission of symptoms, and functioning returns to the premorbid level (APA, 1994, p. 325). However, it has been estimated that at least 85% of individuals who become depressed have more than one episode of depression (Keller, 1985) with 20% of one’s lifetime spent in a depressive episode (Angst, 1986) after its onset.

Herman (1992, p. 382) proposes that the majority of survivors of chronic trauma:
‘experience the bitterness of being forsaken by man and God...Protracted depression is reported as the most common finding in virtually all clinical studies of chronically traumatised people...Every aspect of the experience of prolonged trauma combines to aggravate depressive symptoms...The dissociative symptoms of PTSD merge with the concentration difficulties of depression. The paralysis of initiative of chronic trauma combines with the apathy and helplessness of depression. The disruptions in attachments of chronic trauma reinforce the isolation and withdrawal of depression. The debased self-image of chronic trauma fuels the guilty ruminations of depression. And the loss of faith suffered in chronic trauma merges with the hopelessness of depression’.

Beck’s Cognitive Model of Depression
According to Beck’s cognitive model of depression (Beck 1967, 1976; schematically represented in Figure 7), experience leads people to form assumptions or schemata about themselves and the world, which are subsequently used to organise perception and to govern and evaluate behaviour (Fennell, 1989, p. 171). Whilst such assumptions may be adaptive
(in that they help us to make sense of our experiences), they may be 'dysfunctional' in that they, when activated by 'critical incidents' that support these assumptions (e.g., 'If someone thinks badly of me, I cannot be happy'), can lead to an upsurge of negative automatic thoughts. The latter are negative in that they are associated with unpleasant emotions, that in turn leads to other symptoms of depression. As depression develops, these thoughts are reinforced and become more frequent and intense, thus predisposing to an increasingly pervasive depressed mood (Fennell, 1989, p. 172).

**Assessment**
A structured clinical interview needs to be conducted. Questionnaires such as the Beck Depression Inventory (BDI; Beck, Ward, & Mendelson, 1961; Appendix D.4) can complement the clinical interview.
Treatment

Cognitive behavioural therapy for depression aims to deal with negative thoughts, memories, and beliefs that maintain depression and make the person vulnerable to future episodes of depression (Williams, 1997, p. 264). Clinical studies (e.g., Beck et al., 1985) indicate that the mean percentage change across the samples of out-patients who have received CBT alone is 66%; this compares with a mean of 63% in samples of out-patients receiving tri-cyclic antidepressants alone, and 72% for those who have received a combination of tri-cyclic antidepressants and CBT (Williams, 1997, p. 264). However, Beck et al. (1985, p. 147) noted that 'the type of psychotherapy may not prove to be so nearly important as the extent to which it is adapted to a specific symptomatic focus'.

Elaborating on Beck’s cognitive model, Jehu’s cognitive-behavioural treatment (1988) of mood disturbances associated with sexual abuse advocates many treatment components including psycho-education, logical analysis, decastrophising, magnification, distancing, and re-attribution.
Appendix C Some coping mechanisms of adults who have been chronically sexually abused.

Table 9 Some coping mechanisms of adults who have been chronically sexually abused.

<table>
<thead>
<tr>
<th>Coping mechanism</th>
<th>Example</th>
</tr>
</thead>
</table>
| **Avoidance**    | • When faced with any major stressor (internal or external), may flee into isolation as the perceived safest alternative (e.g., relationships may provide little gratification and may perpetuate uncertainty, conflict, and fear) and/or may resort to ingrained and familiar but dysfunctional solutions such as impulsive and destructive acts (e.g., self-mutilation when the dysphoric feelings associated with the trauma intrude into consciousness).  
  • Other co-morbid presentations may offer ways of also coping with the dysphoria of post-traumatic conditions. For example, somatisation (e.g., stigmata) can (unconsciously) help focus away from past distressing events and can structure their lives around preoccupation with bodily concerns. Anxiety, mood, and/or compulsive presentations may provide a distressing but more tolerable distraction.  
  • Excessive use of prescribed medications. |
| **Dissociation/Minimisation** | • In order to protect the psyche from being overwhelmed by the dysphoric feelings associated with the trauma, may develop complete or (more commonly) partial amnesia for the abuse experiences, or may deny the importance of the traumatic events and instead accept that they are inherently defective as individuals.  
  • Bodily sensations or somatic symptoms that have to do with traumatic events can also be dissociated from usual awareness. |
| **Control**       | • Lacking the ability to engage with others in a collaborative way, may continue to rely on control and manipulation as ways of meeting their needs.  
  • May do everything within their power to fulfill expectant roles to a high standard (e.g., that of motherhood, partner, harmoniser within family-of-origin). |

Adapted from Rebuilding Shattered Lives by Chu (1998).
### DSM-IV Diagnostic Criteria for 300.23 Social Phobia

| A. | A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing. |
| B. | Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed Panic Attack. |
| C. | The person recognises that the fear is excessive or unreasonable. |
| D. | The feared social or performance situations are avoided or else are endured with intense anxiety or distress. |
| E. | The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia. |
| F. | The fear or avoidance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., Panic Disorder With or Without Agoraphobia, Separation Anxiety Disorder, Body Dysmorphic Disorder, a Pervasive Developmental Disorder, or Schizoid Personality Disorder). |
| G. | If a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it, e.g., the fear is not of Stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behaviour in Anorexia Nervosa or Bulimia Nervosa. |
| H. | The fear is not limited to concern about its social impact. |

### ICD-10 Diagnostic Criteria for F 40.1 Social Phobia

Social phobias often start in adolescence and are centred around a fear of scrutiny by other people in comparatively small groups (as opposed to crowds), usually leading to an avoidance of social situations. Unlike most other phobias, social phobias are equally common in both men and women. They may be discreet (i.e., restricted to eating in public, or public speaking) or diffuse, involving almost all social situations outside the family circle. A fear of vomiting in public may be important. Direct eye-to-eye confrontation may be particularly stressful in some cultures. Social phobias are usually associated with low self-esteem and fear of criticism. They may present as a complaint of blushing, hand tremor, nausea, or urgency of micturition, the individual sometimes being convinced that one of these secondary manifestations of anxiety is the primary problem; symptoms may progress to panic attacks. Avoidance is often marked, and in extreme cases may result in almost complete social isolation.

**Diagnostic guidelines**

All of the following criteria should be fulfilled for a definite diagnosis:

(a) the psychological, behavioural, or autonomic symptoms must be primarily manifestations of anxiety and not secondary to other symptoms such as delusions or obsessional thoughts;

(b) the anxiety must be restricted to or predominate in particular social situations; and

(c) the phobic situation is avoided whenever possible.
Appendix D.2 Diagnostic criteria for Obsessional Compulsive Disorder

<table>
<thead>
<tr>
<th>DSM-IV Diagnostic Criteria for 300.3 Obsessional Compulsive Disorder</th>
<th>ICD-10 Diagnostic Criteria for F42.0 Obsessive Compulsive Disorder</th>
</tr>
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<tbody>
<tr>
<td>A. Either obsessions or compulsions:</td>
<td>Predominantly obsessional thoughts or ruminations</td>
</tr>
<tr>
<td><strong>Obsessions as defined by (1), (2), (3), and (4):</strong></td>
<td>These may take the form of ideas, mental images, or impulses to act. They are very variable in content but nearly always distressing to the individual. A woman may be tormented, for example, by a fear that she might eventually be unable to resist an impulse to kill the child she loves, or by the obscene or blasphemous and ego-alien quality of a recurrent mental image. Sometimes the ideas are merely futile, involving an endless and quasi-philosophical consideration of imponderable alternatives is an important element in many other obsessional ruminations and is often associated with an inability to make trivial but necessary decisions in day-to-day living.</td>
</tr>
<tr>
<td>(1) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress;</td>
<td>Diagnostic guidelines</td>
</tr>
<tr>
<td>(2) the thoughts, impulses, or images are not simply excessive worries about real-life problems;</td>
<td>For a definite diagnosis, obsessional symptoms (or compulsive acts) must be present on most days for at least 2 successive weeks and be a source of distress or interference with activities. The obsessional symptoms should have the following characteristics:</td>
</tr>
<tr>
<td>(3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralise them with some other thought or action;</td>
<td>(a) they must be recognised as the individual’s own thoughts or impulses;</td>
</tr>
<tr>
<td>(4) the person recognises that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)</td>
<td>(b) there must be at least one thought or act that is still resisted unsuccessfully, even though others may be present which the sufferer no longer resists;</td>
</tr>
<tr>
<td>B. At some point during the course of the disorder, the person has recognised that the obsessions are excessive or unreasonable.</td>
<td>(c) the thought of carrying out the act must not in itself be pleasurable (simple relief or tension or anxiety is not regarded as pleasure in this sense);</td>
</tr>
<tr>
<td>C. The obsessions cause marked distress, are time consuming (take more than 1 hour per day), or significantly interfere with the person’s normal routine, occupational (or academic) functioning, or usual social activities or relationships.</td>
<td>(d) the thoughts, images, or impulses must be unpleasantly repetitive.</td>
</tr>
<tr>
<td>D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it.</td>
<td></td>
</tr>
<tr>
<td>E. The disturbance is not due to the direct physiological effects of a substance (e.g., drug of abuse, a medication) or a general medical condition.</td>
<td></td>
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</table>
Appendix D.3 Diagnostic criteria for Specific Phobia

### DSM-IV Diagnostic Criteria for 300.29 Specific Phobia

A. Marked and persistent fear that is excessive or unreasonable cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).

B. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed Panic Attack.

C. The person recognises that the fear is excessive or unreasonable.

D. The phobic situation(s) is avoided or else is endured with intense anxiety or distress.

E. The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.

F. In individuals under age 18 years, the duration is at least 6 months.

G. The anxiety, Panic Attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder, such as Obsessive-Compulsive Disorder (e.g., fear of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor), Separation Anxiety Disorder (e.g., avoidance of school), Social Phobia (e.g., avoidance of social situations because of fear of embarrassment), Panic Disorder With Agoraphobia, or Agoraphobia Without History of Panic Disorder.

**Specify type:** Animal Type  
Natural Environment Type  
Blood-Injection-Injury Type  
Situational Type  
Other Type

### ICD-10 Diagnostic Criteria for F40.2 (isolated) Phobia

These are phobias restricted to highly specific situations such as proximity to particular animals, heights, thunder, darkness, flying, closed spaces, urinating or defecating in public toilets, eating certain foods, dentistry, the sight of blood or injury, and the fear of exposure to specific diseases. Although the triggering situation is discrete, contact with it can evoke panic as in agoraphobia or social phobias. Specific phobias usually arise in childhood or early adult life and can persist for decades if they remain untreated. The seriousness of the resulting handicap depends on how easy it is for the sufferer to avoid the phobic situation. Fear of the phobic situation tends not to fluctuate, in contrast to agoraphobia. Radiation sickness and venereal infections, and more recently, AIDS are common subjects of disease phobias.

**Diagnostic guidelines**

All of the following should be fulfilled for a definite diagnosis:

(a) the psychological or autonomic symptoms must be primary manifestations of anxiety, and not secondary to other symptoms such as delusion or obsessional thought;

(b) the anxiety must be restricted to the presence of the particular phobic object or situation; and

(c) the phobic situation is avoided whenever possible.
### Appendix D.4 Diagnostic criteria for Panic disorder

<table>
<thead>
<tr>
<th>DSM-IV Diagnostic Criteria for 300.21 Panic Disorder with Agoraphobia</th>
<th>ICD-10 Diagnostic Criteria for F40.01 Agoraphobia with Panic Disorder</th>
</tr>
</thead>
</table>
| **A. Both:**  
(1) recurrent unexpected panic attacks  
(2) at least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:  
(a) persistent concern about having additional attacks  
(b) worry about the implications of the attack or it’s implications (e.g., losing control, having a heart attack, “going crazy”)  
(c) a significant change in behaviour related to the attacks. | **Diagnostic Criteria for Panic Disorder**  
The essential features are recurrent attacks of severe anxiety (panic) which are not restricted to any situation or set of circumstances, and which are therefore unpredictable. As in other anxiety disorders, the dominant symptoms vary from person to person, but sudden onset of palpitations, chest pain, choking sensations, dizziness, and feelings of unreality (depersonalisation or derealisation) are common. There is also, almost invariably, a secondary fear of dying, losing control, or going mad. Individual attacks usually last for minutes only, though sometimes longer; their frequency and the course of the disorder are both rather variable. An individual in a panic attack often experiences a crescendo of fear and autonomic symptoms which result in an exit, usually hurried, from wherever he or she may be. If this occurs in a specific situation, such as a bus or in a crowd, the patient may subsequently avoid that situation. Similarly, frequent and unpredictable panic attacks produce fear of being alone or going into public places. A panic attack is often followed by a persistent fear of having another attack.  
For a definite diagnosis, several severe attacks of autonomic anxiety should have occurred within a period of about one month;  
(a) in circumstances where there is no objective danger;  
(b) without being confined to known or predictable situations; and  
(c) with comparative freedom from anxiety symptoms between attacks (although anticipatory anxiety is common). |
| **B. The presence of Agoraphobia.** | **Diagnostic Criteria for Agoraphobia**  
The term “agoraphobia” is now taken to include fears not only of crowds and the difficulty of immediate easy escape to a safe place (usually home). The term refers to an interrelated and often overlapping cluster of phobias embracing fears of leaving home: fear of entering shops, crowds, and public places, and public places, or of travelling alone in trains, buses, or planes. Although the severity of the anxiety and the extent of avoidance behaviour are variable, this is the most incapacitating of the phobic disorders and some sufferers become completely housebound; they are terrified by the thought of collapsing and being left helpless in public. The lack of an immediately |
| **C. The Panic Attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).** | |
| **D. The Panic Attacks are not better accounted for by another mental disorder, such as Social Phobia (e.g., occurring on exposure to feared social situations), Specific Phobia (e.g., on exposure to a specific phobic situation), Obsessive-Compulsive Disorder (e.g., on exposure to dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., in response to stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., in response to being far away from home or close relatives).** | |

---

**Criteria for Panic Attack**  
A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:  
- palpitations, pounding heart, or accelerated heart rate;  
- sweating  
- trembling or shaking  
- sensations of shortness of breath or smothering  
- feeling of choking  
- chest pain and discomfort  
- nausea or abdominal distress  
- feeling dizzy, unsteady, lightheaded, or faint  
- derealisation (feelings of unreality) or depersonalisation (being detached from oneself)  
- fear of losing control or going crazy  
- fear of dying  
- paresthesias (numbness or tingling sensations)  
- chills or hot flushes
Diagnostic criteria for Agoraphobia

A. Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having an unexpected or situationally predisposed Panic Attack or panic-like symptoms. Agoraphobic fears typically involve characteristic clusters of situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and travelling in a bus, train, or automobile.

B. The situations are avoided (e.g., travel is restricted) or else are endured with marked distress or anxiety about having a Panic Attack or panic-like symptoms, or require the presence of a companion.

C. The anxiety or phobic avoidance is not better accounted for by another mental disorder, such as Social Phobia (e.g., avoidance limited to social situations because of fear of embarrassment), Specific Phobia (e.g., avoidance limited to a single situation like elevators), Obsessive-Compulsive Disorder (e.g., avoidance of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., avoidance of leaving home or relatives).

Diagnostic Criteria for Agoraphobia (continued)

available exit is one of the key features of many of these agoraphobic situations. Most sufferers are women and the onset is usually early in adult life. Depressive and obsessional symptoms and social phobias may also be present but do not dominate the clinical picture. In the absence of effective treatment, agoraphobia becomes chronic, though usually fluctuating.

All of the following criteria should be fulfilled for a definite diagnosis:

a) the psychological or autonomic symptoms must be primarily manifestations of anxiety and not secondary to other symptoms, such as delusions or obsessional thoughts;

b) the anxiety must be restricted to (or occur mainly in) at least two of the following situations: crowds, public places, travelling away from home, and travelling alone;

c) avoidance of the phobic situation must be, or have been, a prominent feature.
Appendix D.5 Diagnostic criteria for Major Depressive Disorder

### DSM-IV Diagnostic Criteria for 296.32 Major Depressive Disorder, Recurrent, Moderate Without Psychotic Features

| A. Presence of two or more Major Depressive Episodes. |
| B. The Major Depressive Episodes are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizotypal Disorder, Delusional Disorder, or Schizophreniform Disorder. |
| C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode. |

**Criteria for Major Depressive Episode**

| A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. |
| (1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful); |
| (2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others); |
| (3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or a decrease or increase in appetite nearly every day; |
| (4) insomnia or hypersomnia nearly every day; |
| (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down); |
| (6) fatigue or loss of energy nearly every day; |
| (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick); |
| (8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others); |

### ICD-10 Diagnostic Criteria for F33.1 Recurrent Depressive Disorder, Current Episode Moderate

**Diagnostic guidelines**

For a definite diagnosis:

(a) the criteria for recurrent depressive disorder should be fulfilled, and the current episode should fulfil the criteria for depressive episode, moderate severity; and

(b) at least two episodes should have lasted a minimum of two weeks and should have been separated by several months without significant mood disturbance.

**Moderate Depressive Episode**

The individual usually suffers from at least two of the three most typical symptoms noted for mild depressive episode (e.g., depressed mood, loss of interest and enjoyment, increased fatigability) plus at least three (and preferably four) of the following symptoms:

(a) reduced concentration and attention; 
(b) reduced self-esteem and confidence; 
(c) ideas of guilt and unworthiness; 
(d) bleak and pessimistic views of the future; 
(e) ideas or acts of self-harm or suicide; 
(f) disturbed sleep; 
(g) diminished appetite.

Several symptoms are likely to be present to a marked degree, but this is not essential if a particularly wide variety of symptoms is present overall. Minimum duration of the whole episode is about 2 weeks.

An individual with a moderately depressive episode will usually have considerable difficulty in continuing with social, work or domestic activities.

**Recurrent Depressive Disorder**

The disorder is characterised by repeated episodes of depression, without any history of independent episodes of mood elevation and overactivity that fulfil the criteria of mania. However, the category should still...
Criteria for Major Depressive Episode (continued)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet the criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterised by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Moderate severity
A major depressive episode is considered moderate if it’s symptoms or (resultant) functional impairment is between that of a ‘mild’ (e.g., 5 or 6 depressive symptoms and mild functional disability) and a ‘severe’ episode.

Recurrent Depressive Disorder (continued)
be used if there is evidence of brief episodes of mild mood elevation and overactivity that fulfill the criteria of hypomania immediately after a depressive episode (sometimes apparently precipitated by treatment of a depression).
### DSM-IV Diagnostic Criteria for 309.81 Post Traumatic Stress Disorder

**A.** The person has been exposed to a traumatic event in which both of the following were present:

1. the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of others;
2. the person's response involved intense fear, helplessness, or horror.

**B.** The traumatic event is persistently re-experienced in one (or more) of the following ways:

1. recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions;
2. recurrent distressing dreams of the event;
3. acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated);
4. intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event;
5. physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.

**C.** Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

1. efforts to avoid thoughts, feelings, or conversations associated with the trauma;
2. efforts to avoid activities, places, or people that arose recollections of the trauma;
3. inability to recall an important aspect of the trauma;
4. markedly diminished interest or participation in significant activities;
5. feeling of detachment or estrangement from others;
6. restricted range of affect (e.g., unable to have loving feelings);
7. sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

**D.** Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1. difficulty falling or staying asleep;
2. irritability or outbursts of anger;
3. difficulty concentrating;
4. hypervigilance;
5. exaggerated startle response.

### ICD-10 Diagnostic Criteria for F43.1 Post Traumatic Stress Disorder

This arises as a delayed and/or protracted response to a stressful event or situation (either short- or long-lasting) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone (e.g., natural or man-made disaster, combat, serious accident, witnessing the violent death of others, or being the victim of torture, terrorism, rape or other crime). Predisposing factors such as personality traits (e.g., compulsive, asthenic) or previous history of neurotic illness may lower the threshold for the development of the syndrome or aggravate its course, but they are neither necessary nor sufficient to explain its occurrence.

Typical symptoms include episodes of repeated reliving of the trauma in intrusive memories ("flashbacks") or dreams, occurring against the persisting background of a sense of "numbness" and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma. Commonly there is fear and avoidance of cues that remind the sufferer of the original trauma. Rarely, there may be dramatic, acute outbursts of fear, panic or aggression, triggered by stimuli arousing a sudden recollection and/or re-enactment of the trauma or of the original reaction to it.

There is usually a state of autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia. Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. Excessive use of alcohol or drugs may be a complicating factor.

The onset follows the trauma with a latency period that may range from a few weeks to months (but rarely exceeds 6 months). The course is fluctuating but recovery can be expected in the majority of cases. In a small proportion of patients the condition may show a chronic course over many years and a transition to an enduring personality change.

### Diagnostic guidelines

This disorder should not generally be diagnosed unless there is evidence that it arose within 6 months of a traumatic event of exceptional severity. A "probable" diagnosis might still be possible if the delay between the event and the
Diagnostic criteria (continued)

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
Acute: if duration of symptoms is less than 3 months.
Chronic: if duration of symptoms is 3 months or more.

Specify if:
With delayed onset: if onset of symptoms is at least 6 months after the stressor.

Diagnostic guidelines (continued)

onset was longer than 6 months, provided that the clinical manifestations are typical and no alternative identification of the disorder (e.g., as an anxiety or obsessive-compulsive disorder or depressive episode) is plausible. In addition to evidence of trauma, there must be a repetitive, intrusive recollection or re-enactment of the event in memories, daytime imagery, or dreams. Conspicuous emotional detachment, numbing of feeling, and avoidance of stimuli that might arouse recollection of the trauma are often present but are not essential for the diagnosis. The autonomic disturbances, mood disorder, and behavioural abnormalities all contribute to the diagnosis but are not of prime importance.
Appendix D.7 ICD-10 Diagnostic Criteria for F62.0 for Enduring Personality Change after Catastrophic Experiences

Enduring personality change may follow the experience of catastrophic stress. The stress must be so extreme that it is unnecessary to consider personal vulnerability in order to explain its profound impact upon the personality. Examples include concentration camp experiences, torture, disasters, prolonged exposure to life-threatening circumstances (e.g., hostage situations – prolonged captivity with an imminent possibility of being killed). Post-traumatic stress disorder (F43.1) may precede this type of personality change, which may then be seen as a chronic, irreversible sequel of stress disorder. In other instances, however, enduring personality change meeting the description given below may develop with an interim phase of a manifest post-traumatic stress disorder. However, a long-term change in personality following short-term exposure to a life-threatening experience such as a car accident should not be included in this category, since research indicates that such a development depends on a pre-existing psychological vulnerability.

Diagnostic guidelines

The personality change should be enduring and manifest as inflexible and maladaptive features leading to an impairment in interpersonal, social, and occupational functioning. Usually the personality change has to be confirmed by a key informant. In order to make the diagnosis, it is essential to establish the presence of features not previously seen, such as:

(a) a hostile or mistrustful attitude towards the world;
(b) social withdrawal;
(c) feelings of emptiness or hopelessness;
(d) a chronic feeling of being “on edge,” as if constantly threatened;
(e) estrangement.

This personality change must have been present for at least 2 years, and should not be attributable to a pre-existing personality disorder or to a mental disorder other than post-traumatic stress disorder (F43.1). The presence of brain damage or disease that may cause similar clinical features should be ruled out.

Includes: personality change after concentration camp experiences, disasters, prolonged captivity with imminent possibility of being killed, prolonged exposure to life-threatening situations such as being a victim of terrorism or torture.
Appendix E.1 Social Cognitions Questionnaire

Listed below are some thoughts that go through peoples’ minds when they are nervous or frightened. Indicate on the LEFT hand side of the form, how often in the last week each thought has occurred; rate each thought from 1-5 using the following scale:

1. Thought never occurs
2. Thought rarely occurs
3. Thought occurs during half of the times when I am nervous
4. Thought usually occurs
5. Thought always occurs when I am nervous

- I will be unable to speak
- I am unlikeable
- I am going to tremble or shake uncontrollably
- People will stare at me
- I am foolish
- People will reject me
- I will be paralysed with fear
- I will drop or spill things
- I am going to be sick
- I am inadequate
- I will babble or talk funny
- I am inferior
- I will be unable to concentrate
- I will be unable to write properly
- People are not interested in me
- People won’t like me
- I am vulnerable
- I will sweat or perspire
- I am going red
- I am weird or different
- People will see that I am nervous
- People think I am boring
- Other thoughts not listed (please specify):

When you feel anxious how much do you believe each thought to be true. Please rate each thought be choosing a number from the scale below, and put the number which applies on the dotted line on the RIGHT hand side of the form.

<table>
<thead>
<tr>
<th>0</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
<th>50</th>
<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100</th>
</tr>
</thead>
<tbody>
<tr>
<td>I do not believe this thought</td>
<td>I am completely convinced this thought is true</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix E.2 The Maudsley Obsessional-Compulsive Inventory (Hodgson & Rachman, 1977)

**Instructions:** Please answer each question by putting a circle around the ‘True’ or ‘False’ following the question. There are no right or wrong answers, and no trick questions. Work quickly and do not think too long about the exact meaning of the question.

<table>
<thead>
<tr>
<th>Question</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I avoid using public telephones because of possible contamination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I frequently get nasty thoughts and have difficulty in getting rid of them</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I am more concerned than most people about honesty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I am often late because I can’t seem to get through everything on time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I don’t worry unduly about contamination if I touch an animal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I frequently have to check things (e.g., gas or water taps, doors, etc.) several times</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I have a strict conscience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. I find that almost every day I am upset by unpleasant thoughts that come into my mind against my will</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. I do not unduly worry if I accidentally bump into somebody</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. I usually have serious doubts about the simple everyday things I do</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Neither of my parents were very strict during my childhood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. I tend to get behind in my work because I repeat things over and over again</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. I use only an average amount of soap</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Some numbers are extremely unlucky</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. I do not check letters over and over again before posting them</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. I do not take a long time to dress in the morning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. I am not excessively concerned about cleanliness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. One of my major problems is that I pay too much attention to detail</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. I can use well-kept toilets without any hesitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. My major problem is repeated checking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. I am not unduly concerned about germs and disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. I do not tend to check things more than once</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. I do not stick to a very strict routine when doing ordinary things</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. My hands do not feel dirty after touching money</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. I do not usually count when doing a routine task</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. I take rather a long time to complete my washing in the morning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. I do not use a great deal of antiseptics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. I spend a lot of time every day checking things over and over again</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. Hanging and folding my clothes at night does not take up a lot of time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Even when I do something very carefully I often feel that it is not quite right</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Appendix E.3 Beck Anxiety Inventory (Beck, 1990)

*Instructions:* Below is a list of common symptoms of anxiety. Please read each item in the list carefully. Indicate how often you experienced each symptom during the PAST WEEK, INCLUDING TODAY by circling the corresponding number in the column next to each symptom.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost all the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Numbness or tingling</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling hot</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Wobbliness in legs</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Unable to relax</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Fear of the worst happening</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Dizzy or light-headed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Heart pounding or racing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Unsteady</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Terrified</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. Nervous</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Feelings of choking</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Hands trembling</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Shaky</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. Fear of losing control</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. Difficulty breathing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. Fear of dying</td>
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<td>18. Indigestion or discomfort in abdomen</td>
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<td>20. Face flushed</td>
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<td>21. Sweating (not due to heat)</td>
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Appendix E.4 Beck Depression Inventory (Beck, Ward, & Mendelson, 1961)

Tick the statement in each group that best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, tick each one.

0 I do not feel sad.
1 I feel sad.
2 I am sad all the time and I can't snap out of it.
3 I am so sad or unhappy that I can't stand it.

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

0 I don't cry anymore than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

0 I am no more irritated now than I ever am.
1 I get annoyed or irritated more easily than I used to.
2 I feel irritated all the time now.
3 I don't get irritated at all by the things that used to irritate me.

0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all anymore.

0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

0 I haven't lost much weight, if any, lately.
1 I have lost more than 5 pounds.
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less.
Yes   No

0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.
Appendix E.5 Dissociative Experiences Scale (Bernstein & Putnam, 1986)

This questionnaire consists of 28 questions about experiences you have had in your daily life. We are interested in how often you have had these experiences. It is important, however, that your answers show how often these experiences happen to you when you are not under the influence of alcohol or drugs. To answer the questions, please determine to what degree the experience described in the question applies to you and circle the appropriate number to show what percentage of the time you have had the experience.

Example: 0% 10 20 30 40 50 60 70 80 90 100%

1. Some people have the experience of driving a car and suddenly realising that they don’t remember what has happened during all or part of the trip. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

2. Some people find that sometimes they are listening to someone talk and they suddenly realise that they did not hear part or all of what was just said. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

3. Some people have the experience of finding themselves in a place and having no idea of how they got there. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

4. Some people have the experience of finding themselves dressed in clothes that they don’t remember putting on. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

5. Some people have the experience of finding new things among their belongings that they don’t remember buying. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

6. Some people sometimes find that they are approached by people that they do not know who call them by another name or insist that they have met them before. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

7. Some people sometimes have the experience of feeling though they are standing next to themselves or watching themselves do something and they actually see themselves as though they were looking at another person. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

8. Some people are told that they sometimes do not recognise friends or family members. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
9. Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation). Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

10. Some people have the experience of being accused of lying when they do not think that they have lied. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

11. Some people have the experience of looking in a mirror and not recognising themselves. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

12. Some people sometimes have the experience of feeling that other people, objects, and the world around them are not real. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

13. Some people sometimes have the experience of feeling that their body does not seem to belong to them. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

15. Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them. Circle a number to show what percentage of time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

16. Some people have the experience of being in a familiar place but finding it strange and unfamiliar. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

17. Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

18. Some people sometimes find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
19. Some people find that they sometimes are able to ignore pain. Circle a number to show what percentage of the time this happens to you.

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20. Some people find that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time. Circle a number to show what percentage of the time this happens to you.

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21. Some people sometimes find that when they are alone they talk out loud to themselves. Circle a number to show what percentage of the time this happens to you.

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22. Some people find that in one situation they may act so differently compared to another situation that they feel almost as if they were two different people. Circle a number to show what percentage of the time this happens to you.

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23. Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social interaction). Circle a number to show what percentage of the time this happens to you.

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24. Some people sometimes find that they cannot remember whether they have done something or have just thought about doing that thing (for example, not knowing whether they have just posted a letter or have just thought about posting it). Circle a number to show what percentage of the time this happens to you.

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25. Some people sometimes find evidence that they have done things that they do not remember doing. Circle a number to show what percentage of the time this happens to you.

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26. Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing. Circle a number to show what percentage of the time this happens to you.

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27. Some people sometimes find that they hear voices inside their head that tell them to do things or comment on things that they are doing. Circle a number to show what percentage of the time this happens to you.

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28. Some people sometimes feel as if they are looking at the world through a fog so that people and objects appear far away or unclear. Circle a number to show what percentage of the time this happens to you.

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Appendix F.1 Summary of assessment procedures for OCD

Table 10 Summary of assessment procedures for OCD

**General description of nature of the problem**
- Open questions
- Recent and specific example, described chronologically
- Description of situations in which obsessions are most or least likely, looking for functional links ("triggers or maintaining factors")

**Detailed specific description and behavioural analysis**

(1) **Cognitive and subjective**
- Form of obsessions: thoughts, images, or impulses (urges)
- Content of obsessions
- Cognitive factors triggering obsessions (e.g., other thoughts)
- Cognitively neutralising (mentally checking or 'putting right')
- Perceived alienness and subjective resistance to the obsession

(2) **Emotional**
- Nature of mood changes associated with obsessions (anxiety, depression, discomfort); nature of the Association, i.e., whether mood changes precede or follow obsessions, or both

(3) **Behavioural**
- Triggers for the obsessional thoughts
- Overt avoidance of (not going into) situations in which obsessional thoughts might occur
- Overt active avoidance; behaviours which are intended to control occurrence of the obsession
- Overt ritualising
- Asking for reassurance, asking others to carry out tasks which would otherwise be associated with the obsession

(4) **Physiological**
- Triggers
- Physiological changes consequent on obsessions

**Background to the problem**
- History
- Development of the problem and its components (obsessions, neutralising, avoidance)
- Degree of handicap in work, sexual, social, and domestic functioning
- Significant relationships
- Benefits and costs of change

**Behavioural tests**
- In the clinic
- In target situations

**Direct observation**
- By relatives
- During home visits

**Questionnaires**
- Maudsley Obsessive-Compulsive Inventory (Hodgson & Rachman, 1977)
- Compulsive Activity Checklist
- Beck Depression Inventory
- Beck Anxiety Inventory

**Self-monitoring**
- Diaries of mood, thoughts, ritualising, behavioural by-products


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Appendix F.2 Guidelines for a Structured Interview to assess Panic

The aim of a structured interview is twofold: to assess whether a diagnosis of panic disorder and/or agoraphobia (and any other diagnosis) is appropriate; and to develop a preliminary formulation. Although developing a formulation is a recursive process that continues throughout the course of therapy, the first session should provide enough data for a credible formulation. Typically, data collection for the purpose of presenting a formulation to the client continues into the second session, with much reconfirming of exactly what happens during the client’s panic attacks and how the disorder has developed. The formulation has four main purposes: (1) to explain symptoms, processes, the treatment rationale, why previous coping has not been successful, and so forth; (2) to generate hypotheses about predisposing, precipitating, and maintaining factors, or core beliefs; (3) to put the symptoms into context, so as to identify determining factors or setting conditions for symptoms; and (4) to develop a treatment plan (Butler & Booth, 1991, p.193).

It is critical that the formulation describes exactly what the client experiences. To ensure this outcome, data collection must be comprehensive. The physiological, cognitive, behavioural, and emotional symptoms of each episode need to be detailed. More importantly, the sequence in which these symptoms occur needs to be established. The following questions need to be asked, most importantly about the first panic attack, as this will usually be etched in the memory of the client:

(1) First panic:  • When, where, with who?
   • The trigger?
   • What happened?
   • What stressors?
   • What stopped it?

(2) Typical panic:  • What are the first signs?
   • How long before peak anxiety and how long does it last?
   • Physical symptoms and cognitions (preferably rated for severity)?

(3) Pattern of attacks:  • How often they occurred at different times?
   • How many in the last month / six months?
   • How are they interfering with the client’s life, job, travelling, etc.?
(4) • What stops the client from panicking or things getting even worse?
  • Is there avoidance of certain situations?
  • Is distraction (physiological, psychological, or behavioural) used?

(5) History of involvement with other services: • Who was attended and why?
  • Why was attendance stopped?
  • Why attend now?

(6) Knowledge of illness in family or friends?

(7) Premorbid functioning of client?

(8) Significant life changes?
Appendix F.3 Some areas of inquiry in an intake interview.

Table 11 Some areas of inquiry in an intake interview.

1. Discussion of limits of confidentiality, what service you can offer, your therapeutic stance.

2. Basic demographic information

3. Reason for seeking treatment (the chief complaint) and why now?

4. Mental status examination (presentation: appearance, behaviour, personality traits, general cognitive functioning)

5. Personal and social history
   Overview of major personal events (e.g., significant achievements or losses) and developmental milestones across the lifespan
   Past stressors (e.g., history of abuse, unplanned pregnancies)
   Current stressors (if abuse is evident, current level of safety and risk of violence to or from others)
   Family history and status (e.g., role within family, unspoken rules, psychiatric and medical history, substance abuse)
   Past medical history (including gynaecological/obstetrical history, major illnesses or injury)
   Involvement in the legal/criminal justice system (e.g., has the client undertaken, is currently involved in, or is contemplating a lawsuit or other legal action?)
   Cultural background
   Social class
   Religious beliefs
   Sexual orientation

6. Clinical signs, symptoms, and personality and diagnostic indicators (and their respective onset, duration, intensity, degree of disruption, and subjective level of distress)
   e.g., mood disturbances;
   reality-testing and psychosis;
   predominant defensive operations and characterological structure;
   substance use and abuse;
   personal, relational, sexual, and social/vocational problems;
   anxiety and associated problems;
   suicidality and other forms of self-harm (including self-mutilation);
   risk of interpersonal violence;
   intactness of memory over the years (e.g., for specific events or periods in client’s life).

7. Previous treatment (and a request for a release of information for records)
   e.g., reason for seeking treatment in the past;
   previous diagnoses;
   duration, course, type of therapy, and therapeutic approach (if a talking therapy);
   conditions of termination;

8. Personal assets, strengths, resiliency factors, significant supports.

Adapted from 'Recollections of Sexual Abuse' (p. 221) by C. Courtois (1999). New York; Norton.
Appendix G The Physiology of Panic (adapted from Barlow & Craske, 1988)

While panic, by definition and nature, is an unpleasant experience, it is not in the least bit dangerous. It is an immediate and protective response to danger or threat. Scientifically, panic is termed the fight or flight response or the emergency reaction because all of its effects are aimed toward dealing with an emergency by either fighting or fleeing the danger. When faced with some overwhelming present danger, the automatic response of panic takes over causing us to take immediate action.

When the protective response of panic is working correctly, let us say after you have jumped out of the way of a car speeding towards you (i.e. a true alarm), you will collect yourself and make a mental note and be sure to look both ways at that particular corner of the street in the future. However, if you have this response and there is nothing to fear (i.e. a false alarm), then it is a panic attack. Since you don't know why it's happening, the attack can elicit more anxiety and fear and spiral into a terrifying experience. This is particularly true if something has made you worry about being sick to begin with. For example, did a member of your family recently die of a heart attack? If so, then health related concerns may be in the back of your mind, and it is only natural to start thinking about heart attacks or other physical dangers when your body speeds up and feels out of control during a panic attack. Thus, it is important to understand the physiology of a panic attack.

Nervous and Chemical Effects

When danger is perceived or anticipated, the brain sends messages to a section of your nerves called the autonomic nervous system (ANS) that has two subsections or branches called the sympathetic nervous system (SNS) and the parasympathetic nervous system (PNS). Both of these are directly involved in controlling the body's energy levels in preparation for action. Very simply put, the SNS is the emergency fight/flight response system that releases energy and gets the body primed for action, while the PNS is the restoring system that returns the body to a normal state.

The SNS tends to be largely an all or nothing system. When it is activated, all of its parts respond, so that it is rare to experience changes in only one part of the body. This may explain why most panic attacks involve many symptoms and not just one or two.
Appendix G The Physiology of Panic (continued)

One of the major effects of the SNS is that it releases two chemicals called adrenalin and noradrenalin from the adrenal glands on the kidneys. These chemicals are used as messengers by the SNS to continue activity so that once activity in the SNS begins, it often continues and increases for a period of time. The SNS activity can be stopped in two ways. Firstly, after the body has enough of the emergency response (typically only a few minutes), the PNS (which generally has opposing effects to the SNS) will be activated and restore a relaxed state. In other words, anxiety arousal cannot continue forever and not spiral to ever increasing and possibly damaging levels. The PNS is a built in protector that stops the SNS from getting carried away.

Secondly, adrenalin and noradrenalin are eventually destroyed by other bodily chemicals. However, this takes some time. Thus, even after the immediate danger and accompanying surge of emotion has passed and your SNS has stopped responding, you are likely to feel keyed up or apprehensive for some time because the chemicals are still floating around in your system.

Cardiovascular Effects
PNS activity produces an increase in heart rate and in the strength of the heartbeat. This is vital to preparation for action since it helps speed up the blood flow, thus improving delivery of the oxygen to the tissues. The blood is also redirected away from where it is not needed by a tightening of the blood vessels (usually away from the periphery) and towards the places where it is needed more, by an expansion of blood vessels (usually toward the big muscle groups in the legs, etc.). For example, blood is taken away from the skin, fingers and toes so that the skin looks pale and cold, and the fingers and toes become cold and sometimes feel numb and prickly or tingly.

Respiratory Effects
The emergency response is associated with an increase in the speed and depth of breathing so that the tissues can get more oxygen to prepare for action. The feelings produced by this increase in breathing can include breathlessness, choking or smothering sensations, and even pain and tightness in the chest. A side effect of increased breathing, especially if no
physical activity occurs, is that the blood supply to the head is decreased. While this is only a small amount and is not dangerous, it produces a collection of unpleasant symptoms including dizziness, blurred vision, confusion and light-headedness.

Other Physical Effects
A number of other effects are produced by activation of the arousal system, none of which are in any way harmful. For example, there is an increase in sweating, which has the important adaptive function of cooling the body to stop it from overheating. Additionally, the pupils widen or dilate to let in more light and extend peripheral vision, to look for danger. This may result in sensitivity to light, or spots in front of the eyes. There is often a decrease in salivation and a decrease in digestive processes in general, resulting in a dry mouth. The decrease in the digestive system often produces nausea, a heavy feeling in the stomach and occasionally constipation. Many of the muscle groups tense up which results in feelings of tension, sometimes extending to pains and aches as well as trembling and shaking.

Overall, the emergency response results in general activation of the whole bodily metabolism and an increased sensitivity to stimulation from the external environment. One feels hot and flushed. As the whole process takes a lot of energy, you may feel tired, drained and washed out afterwards.

As mentioned, the emergency response prepares your body to either attack or run. Thus, it is no surprise that the overwhelming urge associated with this response is to escape wherever you are. When escape is not possible, the urges will often become stronger or be shown through such behaviours as foot tapping, pacing or snapping at people.
## Appendix H  Theories about long-term sequelae associated with a history of Child Sexual Abuse.

Table 12  Theories about long-term sequelae associated with a history of Child Sexual Abuse.

<table>
<thead>
<tr>
<th></th>
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<tbody>
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<td>Somatisation</td>
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<td>suicide, tension reducing</td>
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<td></td>
<td>activities including sexual</td>
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<tr>
<td></td>
<td>behaviours including sexual</td>
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<tr>
<td></td>
<td>purging, and self-mutilation)</td>
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<td>and purging, fear of</td>
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<td>weight gain, regulation</td>
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<td>Disturbed relatedness</td>
<td>Social problems</td>
<td>Interpersonal effects</td>
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<td>Self perceptions</td>
<td>Impaired self-</td>
<td>Self-integrity</td>
<td>Cognitive affects</td>
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<td>hopelessness, distrust</td>
<td>nobody can understand, minimising)</td>
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<td>unfounded sense of</td>
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<td>body as ill or weak,</td>
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<td></td>
<td></td>
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<td>separate drug or</td>
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<td></td>
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<td></td>
<td>alcohol identity</td>
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<td>Others</td>
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Adapted from Bradley & Follingstad (2001).
Appendix I Functional Models of Self-Mutilation

Table 13 Functional Models of Self-Mutilation

<table>
<thead>
<tr>
<th>Model</th>
<th>Description</th>
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<tr>
<td>Environmental model</td>
<td>Self-mutilation creates environmental responses that are reinforcing to the individual while simultaneously serving the needs of the environment by sublimating and expressing inexpressible and threatening conflicts and taking responsibility for them.</td>
</tr>
<tr>
<td>Drive models</td>
<td></td>
</tr>
<tr>
<td>Anti-suicide</td>
<td>Self-mutilation is a suicide replacement, a compromise between life and death drives.</td>
</tr>
<tr>
<td>Sexual</td>
<td>Self-mutilation stems from conflicts over sexuality, menarche, and menstruation.</td>
</tr>
<tr>
<td>Affect regulation models</td>
<td></td>
</tr>
<tr>
<td>Affect Regulation</td>
<td>Self-mutilation stems from the need to express or control anger, anxiety, or pain that cannot be expressed verbally or through other means.</td>
</tr>
<tr>
<td>Dissociation</td>
<td>Self-mutilation is a way to end or cope with the effects of dissociation that results from the intensity of affect.</td>
</tr>
<tr>
<td>Interpersonal model</td>
<td></td>
</tr>
<tr>
<td>Boundaries</td>
<td>Self-mutilation is an attempt to create a distinction between self and others. It is a way to create boundaries or identity and protect against feelings of being engulfed or fear of loss of identity.</td>
</tr>
</tbody>
</table>

## Appendix J Comparative Treatment Approaches for Post Traumatic Stress Disorder

### Table 14 Comparative Treatment Approaches for Post Traumatic Stress Disorder

<table>
<thead>
<tr>
<th>Traumatic Stress Category</th>
<th>Dynamic</th>
<th>Cognitive-Behavioural</th>
<th>Pharmacologic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Normal stress response</strong></td>
<td>Debriefing</td>
<td>Debriefing</td>
<td>None</td>
</tr>
<tr>
<td><strong>Acute catastrophic stress reaction</strong></td>
<td>Debriefing, abreaction, support, self-cohesion, adjunctive, pharmacotherapy</td>
<td>Debriefing, restructuring of erroneous ideas, prevention of avoidant behaviour</td>
<td>BZDs for sleep and anxiety, adrenergic blockers for intrusion and arousal</td>
</tr>
<tr>
<td><strong>PTSD without co-morbidity</strong></td>
<td>Time-limited dynamic psychotherapy, establish therapeutic alliance, focus on self-concepts, linkage to prior trauma, attention to transference and counter-transference</td>
<td>Desensitisation to trauma, restructuring of erroneous beliefs, gradual activation of avoidant behaviours</td>
<td>None or BZDs, adrenergic blockers for intrusion/arousal, TCAs/MAOIs for intrusion/arousal serotonin re-uptake inhibitors</td>
</tr>
<tr>
<td><strong>PTSD with DSM-IV Axis I co-morbidity</strong></td>
<td>Time-limited dynamic therapy, treat alcohol and substance abuse first, treat other co-morbidities concurrently</td>
<td>Treat co-morbidity first, then cognitive-behaviour treatments</td>
<td>Treat co-morbidity as usual, then medication for PTSD if needed</td>
</tr>
<tr>
<td><strong>Chronic PTSD with secondary DSM-IV Axis II co-morbidity</strong></td>
<td>Multi-modal; long-term dynamic group and pharmacologic; inpatient at times for uncovering or crises, individual, marital, family treatment; vocational rehabilitation and social skills training</td>
<td>Cognitive-behaviour treatments, chronic intermittent skills training, relapse prevention</td>
<td>TCAs/MAOIs, serotonin re-uptake inhibitors, BZDs, with caution, neuroleptics for hallucinations, lithium/carbamazepine for irritability/aggressiveness</td>
</tr>
</tbody>
</table>

BZDs = benzodiazepines; TCAs = tricyclic antidepressants; MAOIs = monoamine oxidase inhibitors; From Marmar, Foy, Kagan, & Pynoos (1994).
Appendix K  Process issues during the early (or stabilisation) phase of treatment of Complex PTSD

The rate-limiting task of the therapeutic work may be the ability to develop a moderately stable sense of trust in others. Doing so can provide access to social and emotional support, support that is often needed to cope with exposure (or re-exposure) to material that is overwhelming and emotionally intolerable. Indeed, a major crisis during the initial stages of therapy (e.g., resorting to ingrained and often maladaptive coping mechanisms) is usually a sign that the therapy needs to slow down and focus on basic therapeutic relational and coping skills (Chu, 1998).

As therapy involves intimacy and vulnerability, and the potential for arousing painful and overwhelming feelings, the therapist and the therapeutic process are experienced as major stressors and may precipitate negative therapeutic interactions’ (Chu, 1998, p. 50). If the therapy is out of control, it is common for the therapeutic process to feel like a roller coaster ride and there may be a mutual feeling of impending crisis. Due to the client having little sense of her own worth, s/he may (1) find it difficult to engage in relationships that are partnerships between equals and hence may not engage in the therapeutic process; (2) may view the therapist as a potential abuser (e.g., reflecting a persecutor - victim model of care giving relationships) or potential rescuer; or alternatively (3) may be quite motivated to hold on to important nurturing relationships (e.g., the therapeutic relationship), and may use the therapeutic relationship to discharge intolerable feelings and to obtain comfort. Additionally, the therapist may collude in perpetuating clients’ disempowerment through endless cycles of regressive care taking (Chu, 1998).
Appendix L  BDI and BAI values throughout treatment

BDI and BAI values throughout attendance

Figure 8  BDI and BAI values throughout treatment

BDI = Beck Depression Inventory values; the higher the value on the BDI, the greater the level of self-reported depressive symptomatology.

BAI = Beck Anxiety Inventory value; the higher the value on the BAI, the greater the level of self-reported anxiety symptomatology.
### Table 15 Some of the thoughts from the Social Cognitions Questionnaire that were endorsed throughout attendance

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<tbody>
<tr>
<td>I will be unable to speak</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>5 (100)</td>
<td>1 (0)</td>
<td>1 (0)</td>
</tr>
<tr>
<td>I am unlikeable</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>3 (0)</td>
<td>1 (0)</td>
<td>1 (0)</td>
</tr>
<tr>
<td>I am going to tremble or shake uncontrollably</td>
<td>3 (50)</td>
<td>3 (50)</td>
<td>3 (50)</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>1 (0)</td>
</tr>
<tr>
<td>People will stare at me</td>
<td>2 (10)</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>1 (0)</td>
</tr>
<tr>
<td>I am foolish</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>5 (100)</td>
<td>1 (0)</td>
<td>1 (0)</td>
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<tr>
<td>People will reject me</td>
<td>1 (0)</td>
<td>2 (10)</td>
<td>3 (100)</td>
<td>1 (0)</td>
<td>5 (100)</td>
<td>4 (100)</td>
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<td>I will be paralysed with fear</td>
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<td>5 (100)</td>
<td>5 (100)</td>
<td>1 (0)</td>
<td>3 (0)</td>
<td>5 (100)</td>
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<tr>
<td>I will drop or spill things</td>
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<td>1 (0)</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>3 (10)</td>
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<tr>
<td>I am going to be sick</td>
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<td>1 (0)</td>
<td>5 (100)</td>
<td>1 (0)</td>
<td>3 (100)</td>
<td>1 (0)</td>
<td>1 (0)</td>
</tr>
<tr>
<td>I am inferior</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>3 (100)</td>
<td>1 (0)</td>
<td>1 (0)</td>
</tr>
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<td>I will be unable to write properly</td>
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<td>2 (0)</td>
<td>3 (100)</td>
<td>1 (0)</td>
<td>1 (0)</td>
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<td>People are not interested in me</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>1 (0)</td>
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<td>People won’t like me</td>
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<td>1 (0)</td>
<td>3 (100)</td>
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<td>1 (0)</td>
</tr>
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<td>I am going red</td>
<td>3 (40)</td>
<td>2 (50)</td>
<td>3 (50)</td>
<td>1 (0)</td>
<td>2 (100)</td>
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<td>I am weird or different</td>
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<td>1 (0)</td>
<td>1 (0)</td>
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<tr>
<td>People will see that I am nervous</td>
<td>4 (80)</td>
<td>1 (0)</td>
<td>3 (100)</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>5 (100)</td>
<td>5 (50)</td>
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<tr>
<td>People think I am boring</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>4 (50)</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>1 (0)</td>
<td>1 (0)</td>
</tr>
</tbody>
</table>

**Other thoughts:**
- God will punish me                          5 (100)

1. This data may under-represent the degree to which Mary was engaging in thoughts typical of individuals who have social phobic tendencies as she may have tried to present a more favourable picture of herself.
2. This data was collected subsequent to Mary's positive experience with her in-laws during a 4-day visit which was the first chance she had had to drop her safety behaviours in the company of her in-laws.
3. At this data collection point (i.e., September), Mary was feeling quite depressed and suicidal because (1) she was processing painful emotions relating to her chronic childhood sexual abuse; (2) she was living in fear of God because she had distanced herself from him (e.g., she had stopped going to mass and saying the Rosary every day); and (3) she had just visited her parent's home (for their 50th wedding anniversary) and thought that this was the last time everybody would be together. Hence, the apparent worsening of her thoughts may merely reflect a transient increase in her depressive symptomatology.
4. Mary noted on the questionnaire sheet that she was depressed and suicidal when completing the questionnaire at this data collection point. For example, she was quite suicidal as she believed her family did not deserve someone who thought about hurting her children. Hence, this data may present an overly negative picture of Mary's thoughts at this time.
Appendix N DSM-IV Global Assessment of Functioning Scale

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code

91-100 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.

81-90 Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).

71-80 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning.

61-70 Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning, but generally functioning pretty well, has some meaningful interpersonal relationships.

51-60 Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with friends or co-workers).

41-50 Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).

31-40 Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant), OR major impairment in several areas, such as work or school, family relations, judgement, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work).

21-30 Behaviour is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgement (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).

11-20 Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears faeces) OR gross impairment in communication (e.g., largely incoherent or mute).

1-10 Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.

0 Inadequate information
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Abstract

The aim of this thesis was to investigate the associations between depression in women and power within marital or long-term co-habiting relationships. To identify marital power bases, processes, and outcomes uniquely associated with depression, 20 couples in which the female partner was depressed were compared with 20 healthy control couples and also with 20 couples in which the female partner had a disorder other than depression (specifically panic disorder with agoraphobia (PDA)). Couples in which the female partner was depressed had distinctive profiles that distinguished them from PDA couples and healthy controls. Compared with both of these groups, both partners of couples containing a depressed partner reported more problematic communication processes and depressed women reported less commitment to the relationship and greater dissatisfaction with shared decision-making and shared childcare responsibilities. In these couples there were also far greater discrepancies between partners' satisfaction with the relationship as a whole and with the way intimacy and money were managed within the relationship, with depressed women being more dissatisfied than their husbands on all three counts. When the effects of relationship satisfaction were statistically controlled for, the profile of factors that distinguished between the three groups of couples was somewhat different. Couples containing a depressed female partner had higher levels of physical aggression and more demand-withdraw transactions. Depressed women also reported greater dissatisfaction with their control of surplus spending money. In these couples there were also greater discrepancies between partners' relationship satisfaction, commitment to the relationship, dysfunctional demand–withdraw behaviour patterns, and dissatisfaction with the way money were managed within the relationship, with depressed women reporting greater difficulties in all of these areas than their male partners. The degree to which partners held shared perceptions of their relationships was assessed by determining the number of areas in which significant correlations occurred between male and female partners' scores on the same variables. Couples containing a depressed female partner held fewer shared perceptions of power bases, processes, and outcomes within their relationships. Qualitative data indicated that depressed women felt trapped within their problematic relationships.
Chapter 1 Introduction

1.1 Overview of present research

The aim of this thesis was to investigate the associations between depression and power within marital or long-term co-habiting relationships. To identify marital power bases, processes, and outcomes uniquely associated with depression couples in which one spouse was depressed were compared with healthy control couples and also with couples in which one spouse had a disorder other than depression (specifically panic disorder with agoraphobia (PDA)). In chapter 1, theories of depression and its function in marriage are reviewed, and the concept of power is discussed. The findings of empirical studies of dominance, power bases, processes, and outcomes are then reviewed. In chapter 2, the design of the present study is outlined along with the central questions it addresses, and chapter 3 details the methodology. Quantitative results are presented in chapter 4, and in chapter 6 these results and their implications are discussed. Qualitative data are presented in Appendix E.

As 93% of the participant couples in this study were married and the remaining 7% were in long-term cohabiting relationships, the terms ‘relationship’ and ‘marriage’ are used interchangeably throughout this thesis.

1.2 Depression in couple relationships

A recurrent disorder

Diagnostic criteria for major depressive disorder (MDD) are given in Appendix A. MDD is a recurrent disorder with most people who experience a major depressive episode having multiple episodes. The prevalence rate of MDD among women in rural Ireland is 6.9% (Ayuso-Mateos et al., 2001). At least 85% of depressed individuals will have more than one major depression (Keller, 1985) and the average treatment-seeking individual will have 5 or 6 (Hammen, 1995). About 25 to 30% of depressed individuals will have chronic symptoms with 20% of their lifetime spent in a depressive episode (Angst, 1986). A corollary of the extent of recurrence and chronicity of MDD is that most studies of MDD are about relapse, rather than initial onset (Hammen).

A woman’s disorder

Depression ‘is overwhelmingly a woman's disorder’ (Kaplan, 1991, p. 206). The number of depressed women exceeds that of men by an average of 2:1 (Nolen-Hoeksema, 1990). The
incidence of depression among women peaks during the ages 25 to 44, with the average age of onset is in the late twenties (Weissman, Myers, & Thompson, 1981). These are the years of full engagement in whatever roles a woman chooses (or find herself in), typically those of wife and mother (Jack, 1999). Many maintaining factors for depression have been proposed, including a biological sensitising effect, such that the threshold of stress necessary to precipitate further depressive episodes lowers with their repetition (Post, Rubinow, & Bellenger, 1986). However, the evidence for biological factors in women's depression is weak and not well supported (Nolen-Hoeksema, 1990).

Victimisation in interpersonal relationships
The overall presence of interpersonal victimisation is significantly higher for women than for men and is likely to be understated (Ritter, 1993). Depressed women who present for therapy are often involved in the recapitulation of family-of-origin dynamics within their family-of-creation (Kaslow & Carter, 1991a). There may be a history of interpersonal experiences related to loss and unresolved mourning, or rejection and abandonment (Stiver & Miller, 1988). Estimates of childhood sexual assault range from 21.7 to 37 percent of women, and rape between 12 and 46 percent (Nolen-Hoeksema, 1990). As many as 71 percent of working women may experience sexual harassment and many are also subject to partner abuse. Such victimisation in interpersonal relationships is a significant risk factor in the development of depressive symptomatology in women (McGrath, Keita, Strickland, & Russo, 1990).

Relationship dissatisfaction and depression
Among depressed couples more than 50% have been found to include at least one depressed partner (Beach, Jouriles, & O'Leary, 1985). Additionally, amongst clinical samples of individuals presenting for treatment of depression, between 40% and 50% are also experiencing significant couple distress (e.g., Beach & O'Leary, 1993b; Fincham, Beach, Harold, & Osborne, 1997; Whisman & Bruce, 1999). Furthermore, across studies, an average of 44% of the variance between depressed and non-depressed individuals can be accounted for by the degree of marital dissatisfaction (Whisman, 2001). Controlling for genetic factors, serious relationship problems can increase the risk of experiencing depression more than 10-fold in women (Kendler et al., 1995). Such problems may come in the form of severe or humiliating relationship events including an affair, a threat of
separation or divorce, or a physically abusive incident (e.g., Brown, Harris, & Hepworth, 1995; Cano & O'Leary, 2000; Christian-Herman, O'Leary, & Avery-Leaf, 2001).

These figures should not be surprising considering that a couple relationship is an increasingly important part of one’s interpersonal context because it can create or buffer stress, and it can provide or deprive an individual of needed social support. Hence, it is commonly assumed that the positive or negative interactional cycles in relationships may generate, promote, maintain or protect against MDD (Gotlib & Beach, 1995). For those who are married, some authors have argued that there may be 2 marriages in any given relationship (‘his marriage’ and ‘her marriage’) which bestow differential benefit onto the 2 partners (Bernard, 1972). However, rather than marital status per se, it is the quality of a marriage that is most likely to be predictive of the mental health of women (O'Leary, 1998). Indeed, an unhappy marriage is ‘a grave risk’ for a woman’s mental health (McGrath et al., 1990).

Some reasons for relationship dissatisfaction
Partners place importance on companionship in marriage (Rhyne, 1981) and expect emotional involvement, exchange of intimate information, expressions of love, acceptance, and the fulfilment of personal as well as relationship goals (e.g. Rubin, 1976). However, partners do not always have their needs met partly because they do not always have perfectly corresponding desires (Howard, Blumstein & Schwartz, 1986). Consequently, each partner must contend with the dilemma of how to pursue his or her needs and goals, while at the same time dealing with the other’s needs and goals (Kelley, 1979; Rusbult, Olsen, Davies, & Hannon, 2001). This on-going process of trying to balance individuality and coupleness demands well developed relational and conflict resolution skills (e.g., Ball, Cowan, & Cowan, 1995).

However, depressed couples are typically characterised by poor conflict resolution skills (Christensen & Shenk, 1991). Hence, conflict over various domains (e.g., management of often inadequate financial resources, desired intimacy levels, role- and task-distribution) may go unresolved and partners may increasingly perceive their problems as insurmountable incompatibilities (e.g., Christensen & Heavey, 1990). In relation to the latter, in trying to live out a vision of goodness (Jack, 1999), depressed women may feel overburdened trying to fulfil the multiple and often competing caretaking demands which
accompany their ‘dutiful’ roles in the family (i.e. wife and mother) and the community (Carter & Kaslow, 1992). They may also be the recipients of psychological and/or physical abuse (O’Neil & Egan, 1993). If coercive interactional cycles self-perpetuate (and validate and expand on existing self-criticism; Leff & Vaughan, 1985) and if there are no other options available, depressed women may feel ‘trapped’ and become even further depressed.

All of the above reasons are manifestations of a lack of power. Indeed, marriage has been described as a lifelong oppositional play of power masquerading as pleasure (Boone, 1986). Hence, marital dissatisfaction in women may really be dissatisfaction with the power imbalance in marriage (Steil, 1983).

1.3 Panic disorder with agoraphobia (PDA) in couple relationships

PDA

Diagnostic criteria for PDA are given in Appendix A. Panic disorder is characterised by recurrent unexpected panic attacks and a marked fear of these acute episodes of anxiety, ruminations about the possible implications of repeated attacks and in some instances agoraphobia. Agoraphobia entails a fear of leaving the safety of the home and entering situations that might trigger panic attacks. This commonly leads to the development of a restricted housebound lifestyle. The lifetime prevalence of PDA is between 1.5% and 3.5% (Kessler et al., 1994) with a one-year prevalence rate between 1% and 2% (American Psychiatric Association, 1994). Women are twice as likely as men to be diagnosed with panic disorder without agoraphobia and 3 times as likely to be diagnosed with PDA (Kessler et al.).

Although DSM-IV (American Psychiatric Association, 1994) distinguishes between panic disorder, agoraphobia, and panic disorder with or without agoraphobia, it was only with the advent of DSM-III (American Psychiatric Association, 1980) that both panic disorder and agoraphobia were differentiated from other anxiety presentations (Markowitz, Weissman, Quellette, Lish, & Klerman, 1989). Prior to this, studies typically classified individuals who exhibited a marked degree of behavioural avoidance (due to fear of panic attacks) as agoraphobic. Available evidence suggests that agoraphobia is a secondary manifestation of panic disorder and that many individuals with panic disorder may be pre-agoraphobic (Garvey & Tuason, 1984; Klein, 1981). Over 95% of individuals in clinical samples who have agoraphobia also have panic disorder (American Psychiatric Association, 1994).
Relationship dissatisfaction and PDA

In their review of the existing literature concerning couple relationship quality and PDA, Byrne, Carr, & Clark (in press) concluded that PDA is sometimes, but not always, associated with couple relationship problems. They also concluded that the rate of relationship problems is not always higher in couples where one person has PDA than in healthy couples and is probably no higher than in couples with other types of psychological problems such as generalised anxiety disorder. Furthermore, they concluded that in couples where one member has PDA, it is unclear whether relationship problems predispose people to developing PDA or arise as a result of the condition and then contribute to the maintenance of the PDA. Lastly, Byrne et al. (in press) concluded that couple relationship difficulties might be both predisposing and maintaining factors for PDA.

However, whereas relationship factors may play an important role in psychiatric presentations such as depression, even if couple relationship difficulties do contribute to PDA, it may be that this contribution is relatively small. Hence, it may be better to conceive of PDA as an 'individual' disorder rather than as a condition arising from the relationship context (Arrindell, Emmelkamp, & Sanderman, 1986b; Cobb, Mathews, Childs-Clarke, & Blowers, 1984; Monteiro, Marks, & Ramm, 1985). As such, couples in which one member has PDA constitute a useful psychiatric control group in studies that aim to pinpoint the unique marital correlates of depression. It was for this reason that couples in which one member has PDA were included in the design of the study described later in this thesis.

1.4 Interplay between depression and PDA

There is a high degree of comorbidity between depression and PDA. About 50% of individuals with PDA ultimately experience an episode of major depression (Gorman & Coplan, 1996). Between 10% and 59% of individuals with panic disorder have comorbid major depression, and between 20% to 30% of individuals with major depression fulfil diagnostic criteria for panic disorder (Fava et al., 2000; Halle & Dilsaver, 1993; Lydiard, 1991). Both disorders most often occur sequentially or as complications of one another, with simultaneous onset occurring less commonly (Gorman & Coplan), and comorbidity may be associated with poorer long-term psychosocial functioning (Fava et al.).
Although this high degree of comorbidity has led to vibrant debate as to whether these disorders share a functional dependence (e.g., McLean, Woody, Taylor, & Koch, 1998), the nature of the relationship between depression and panic disorder remains unclear. It may be that both disorders are reciprocal risk factors (Rief, Trenkamp, Auer, & Fichter, 2000). Depression can alter the perception of interoceptive signals that may be a risk factor for panic attacks (Ehlers, Breuer, Dohn, & Fiegenbaum, 1995), while the consequences of poor mobility may enhance the risk for depression. A depressive cognitive style may also amplify the ‘fear of fear’, a cardinal feature in the development of panic attacks.

This ‘fear of fear’ or ‘anxiety sensitivity’ pertains to the fear of anxiety-related bodily sensations, arising from beliefs that these sensations have harmful somatic, social, or psychological consequences (Reiss, 1991). It may be that anxiety sensitivity distinguishes between individuals with PDA with and without depression. While phrenophobia (i.e., fear of somatic sensations and of publicly observable arousal-related symptoms) may be associated more with PDA, a fear of a loss of cognitive control (e.g., ‘I’m going mad’) may be associated more with depression (Taylor, Koch, Woody, & McLean, 1996).

A more cognitive argument to differentiating these disorders is that while the critical affective component in depression may be the absence of positive affect, cognition specific to it may comprise self-representations of personal negativity and loss, negative appraisals of self-related information that are pervasive, absolute, and past oriented, and intrusive thoughts of loss and failure. Similarly, whereas the specific affective factor in anxiety may be hyperarousal, the specific cognitive features of anxiety may comprise themes physical or psychological threat to the self, persistent thoughts of threat and danger, and negative self-appraisals that are specific, tentative, and future oriented (Ingram & Malcarne, 1995, p. 51).

### 1.5 Theories of the function of depression in couple relationships

Haley (1963) suggested that there are two predominant types of relationships. A relationship can be symmetrical whereby partners exchange the same type of behaviour. Alternatively, a complementary relationship may exist where 2 people exchange behaviour that complements, or fits together, so that one is in a ‘superior’ position and the other is in a secondary position. No two people would constantly have one type of relationship in all circumstances. Rather, spouses would develop a hierarchy where they would work out
areas of their relationship as either one type or the other, with each spouse adopting
different roles in different areas over time.

Haley described a third type of relationship. When partners cannot reach a satisfactory
agreement on a mutual definition of areas of the relationship, a struggle for power ensues.
If this struggle is not resolved by available means of negotiation (e.g. open battle, sabotage,
passive resistance), a metacomplementary relationship may develop, whereby the over­
functioning and less powerful spouse may choose a psychiatric symptom to change the
hierarchical arrangement with which he/she is dissatisfied. Doing so introduces a
‘hierarchical incongruity’ into the marriage in that ‘the symptomatic person is in an inferior
position to her partner, who tries to help and change her’.

Yet, the symptomatic partner is also in a superior position in that she refuses to be helped
and to change. Symptomatic behaviour in one partner can organise the other’s behaviour in
many ways; how free time will be spent, how much money should be used and how to
relate to the rest of the family. The couple are caught in an interaction that defines
simultaneously each of them as powerful yet also weak in relation to each other’ (Madanes,

Hence, although the index spouse is overtly powerless in his/her illness role, he/she is also
covertly powerful in that the symptom forces the passive and under-functioning spouse to
give more to the relationship, thus creating a healthier balance of power. It is this dynamic
that the phrase ‘depressed people are powerful in their powerlessness’ refers (Coyne,
1986).

Price’s (1991) ‘vertical gap’ model is an elaboration of Haley’s (1963) work. He
postulates that the function of depression is to reconcile the index spouse to an involuntary
‘one-down’ or less powerful position. From clinical observations, Price deduced that the
‘one-up’ spouse tries to keep his spouse’s exercise of control a constant amount below
his/her own. Maintenance of a ‘control gap’, rather than absolute levels of control,
maintains the status quo. Thus, if one spouse, for example the husband, ‘feels securely in
control and requires only a small vertical gap between himself and his wife, the wife’s
mood will be maintained within the normal range, and any tendency on her part to get
depressed will be counteracted by the husband; but if his mood is low or he requires a large
gap, he may need to maintain his wife’s mood within the depressive range, and any efforts to raise it (for instance, in therapy) will be countered’ (Price, p. 336).

Price (1991) distinguishes between 2 types of depression; ‘static’ depression which reconciles to a pre-existing subordinate position, and depression which serves a ‘change’ function, namely to mediate a switch to a subordinate position from a previously dominant position. He further states that a position of lowerness may be adopted willingly, even joyfully, when the ‘one-up’ spouse is highly respected and loved, and is a source of security and praise. If, on the other hand, the more powerful spouse is resented, then the index spouse is coerced into lowerness. Subsequent anger, aggression, and frustration in the less powerful spouse may incite rebellion. However, the ‘involuntary subordinate strategy’ of depression inhibits this rebellion and the likely response of up-hierarchy aggression (Gardner & Price, 2001; Sloman, Price, Gilbert, & Gardner, 1994).

Both theories conceptualise depression as an adaptive process in dealing with unfavourable circumstances, as ‘an almost unavoidable response to an environment which allows’ the ‘one-down’ individual ‘little control over most of the important things in life’ (Belle, 1982, p. 241). A consequence of the resulting marital interaction is that depression makes it possible for both spouses to know where each stands in relation to each other on certain issues without having to explicitly discuss those issues and so endanger the marriage. Thus, many couples ‘walk on the edges’ of their power dynamics in their daily lives without facing the central themes that produce conflict (O’Neil & Egan, 1993).

1.6 Theories of the function of PDA in couple relationships

Both Haley’s (1963) and Price’s (1991) theories of the development of a psychiatric symptom to provide relationship homeostasis apply equally to PDA. Hence, the spawning of PDA symptoms can also function to equalise the power balance in (an increasingly maladaptive) relationship or, alternatively, to reconcile the index partner to an involuntary ‘one-down’ or less powerful position (Goodstein & Swift, 1977; Hafner, 1977a, 1979, 1980; Lazarus, 1966; Quadrio, 1983, 1984; Symonds, 1971).

1.7 The concept of power in relationships

Due partly to there being almost as many definitions of power in couple relationships as there are people who have studied it (Murphy & Meyer, 1991), and a strong taboo against
acknowledging the power imbalance between male and female partners (McGoldrick, 1991), research on relationship power has proven to be extraordinarily difficult. This plethora of definitions of relationship power reflects the huge disagreement as to what it really is and suggests that it is not a unitary construct (Heer, 1963). Most relationship power studies have defined it as ‘the potential ability of one partner to influence the other’s behaviour’ (Blood & Wolfe, 1960, p. 11), this ability being dependent on who contributes the greater resources (or power bases), and manifest as the actual control over decision-making.

Others have argued for a more interpersonal definition of relationship power. It may instead be the capacity (or ability) to compel obedience (e.g. Russell, 1969) or produce intended effects (Gray-Little & Burks, 1983; Robbins, 1989). Power can also be defined as perceptions of potential influence, including expectations for success, and control over outcomes (e.g., Sagrestano, Heavey, & Christensen, 1999).

The lack of a standard conceptual definition of relationship power has resulted in its haphazard measurement and much empirical disunity. As mentioned above, the unit of measurement has traditionally been who makes major decisions but this is only one aspect of power. Additionally, studies comparing self-reports of decision-making power with direct observation of behaviour have shown little correspondence (Gray-Little, 1982). Even studies comparing power measures using the same method (e.g., two self-report questionnaires) have failed to correlate significantly (Gray-Little & Burks, 1983).

In trying to account for its multi-dimensional nature, Cromwell and Olson (1975) in their synthesis of the existing literature at the time, asserted that power is a ‘generic’ construct incorporating 3 analytically distinct but interrelated domains: power bases, processes, and outcomes (Figure 1). They defined power bases as the personal assets that form the basis of one partner’s control over the other. These are synonymous with material resources (as discussed by Blood and Wolfe, 1960) but they are not solely economic: they can be any personal resource that someone brings to a relationship, including knowledge, commitment, and sex role attitudes. Power processes are the interactional techniques such as assertiveness, persuasion, problem solving, or demandingness that individuals use in their attempts to gain control. Power outcomes, on the other hand, concern who has the final say, that is, who determines the outcome in problem solving or decision-making.
This popular conceptualisation of relationship power has its problems though. First, even within each power domain there seems to be a lack of coherence among the disparate variables at both the empirical and conceptual levels (Babcock, Waltz, Jacobson, & Gottman, 1993). For example, the subconstruct of power bases may include economic resources, affective resources (e.g., level of involvement or dependence), personal resources (e.g., physical appearance), and cognitive resources (e.g., the perception of power: Cromwell & Olson).

Second, there is considerable overlap between Cromwell and Olson’s three domains of power. In examining power in terms of outcomes or processes, the issue of power bases is implicit. Some power bases (e.g., aggression, desired level of intimacy) may be considered power processes, and the distinction between outcomes and processes can easily become blurred (Gray-Little & Burks, 1983). Third, their conceptualisation of power also does not recognise that relationships are embedded in a larger social context, a macro-level structure within which women and men do not yet function as equals (e.g., Kaslow & Carter, 1991b; Rampage, 1994).

Fourth, while Cromwell and Olson recognise manifest power (i.e., that which surfaces in visible outcomes such as attempts at change, conflicts, and strategies), it does not address either latent power (i.e., that which is at stake when no changes or no conflicts are reported) or the (mostly unconscious) invisible power (such as legitimations). An example of the latter would be ‘He was born like that so he’ll never change’, and these can contribute forcefully to the perception of daily reality as unchangeable and inevitable (Komter, 1989).

Fifth, Cromwell and Olson’s conceptualisation may masculinise relationship power in that it does not recognise female power domains such as that derived from being the
‘kinkeeper’ in families (e.g., Kranichfeld, 1987) or potential patterns of coalition formation (Szinovacz, 1987).

1.8 Empirical studies of dominance
Most researchers have treated the terms ‘power’ and ‘dominance’ as synonymous with power bases and power outcomes respectively (Millar & Rogers, 1988). Others argue that whereas power is content- and situation-specific, dominance addresses the overall symmetry or asymmetry in relationships and concerns the partners’ relative control rather than their relative power (Huston, 1983). Hence, an individual may be dominant if he or she controls a broader range of the other’s behaviours and outcomes than vice versa. We may, of course, extend assessments of power to a wide range of behaviours. But even then, it is still important to distinguish between asymmetries in power and in control (Szinovacz, 1987). A partner who is able to exert control may not make use of his/her potential, while the less powerful partner may be quite dominant if the other fails to counteract his or her control attempts.

As mentioned above, most researchers use the terms ‘power’ and ‘dominance’ to refer to a hierarchical relationship between partners (Christensen & Pasch, 1993). The more equivalent a couple’s dominance structure, the more flexible their interactions, the more frequently discussions about who is to do what when takes place, the greater the conflict potential of dyadic conversations, but the more understanding experienced in marital negotiations. In contrast, the more dominant one partner is, the more rigid their interactions, the less frequent discussions about who is to do what when, ‘the more apparent harmony in their conversations, but the greater the rebellion potential of marital negotiations and the less understanding experienced by the partners’ (Millar & Rogers, 1988, p. 94).

Consistent findings in the literature on power patterns are that shared power (i.e., egalitarian power pattern) is associated with the highest level of reported marital satisfaction, and that wife-dominant couples are, on the whole, less satisfied than egalitarian or husband-dominant couples (e.g. Gray-Little & Burks, 1983). Husbands and wives in wife-led couples viewing wife dominance as undesirable may explain this latter finding. In contrast to this, husband-led couples are congruent with a traditional norm and egalitarian couples are congruent with a more modern norm of balanced power between the
spouses (Ting-Toomey, 1984). Alternatively, husbands in wife-led marriages may not be able to adequately exercise a power role (i.e., the husband-incapacity role hypothesis), leaving the wife to assume more authority than desired by either partner and causing dissatisfaction in both (Fitzpatrick, 1988).

Using who makes the major decisions as an index of power, an imbalance of power is characteristic of many relationships in which the female is depressed. These women perceive their husbands as dominating (Jack, 1999) and experience themselves as yielding to their male partners' position, whereas their male partners appear to be unaware of their female partners' experience of submission in their relationship (Hoover & Fitzgerald, 1981). On the other hand, there are those who believe that men experience women as powerful (e.g. McGoldrick, 1991). While this may reflect the perception that women are indeed powerful, it may also reflect how dominant groups tend to characterise even subordinates' initial small resistance (to dominant control) as demands for an excessive amount of power (Miller, 1986, p. 117). Thus, it may be that challenging the distribution of power in marriage generally means challenging husbands' privilege (Rampage, 1994).

1.9 Empirical studies of power bases

*Income, economic dependence, and control of surplus spending money*

The predominant cultural legacy has placed men in positions of power and dominance and women in positions of oppression and subservience (Kaslow & Carter, 1991b). An example of this has been the traditional provider / caregiver structure in relationships (Dupuy, 1993). Men have greater earning potential and income (Faludi, 1991) and they have better opportunities for promotion. This may contribute to the priority ascribed to their economic roles (e.g. Laub-Coser & Rokoff, 1971) and the social 'necessity' of their working (rather than their partners doing so). As predicted by social exchange and resource theorists, this economic patriarchal superiority has typically been taken to determine the power balance in most couples (Blood & Wolfe, 1960; Blumstein & Schwartz, 1983; Steil & Turetsky, 1987).

Women of low socio-economic status are characterised by high levels of depressive symptoms (Kahn, Wise, Kennedy, & Kawachi, 2000; McGrath et al., 1990). Thus, it is proposed that 'the feminisation of poverty' puts women at greater risk for depression (Kaslow & Carter, 1991a). Upper-class women may have more freedom to choose
motherhood and domestic responsibility (Komter, 1989). Non-working women may be economically dependent (on their partners), and may have decreased access to opportunities to develop social contacts, work and assertiveness skills (Szinovacz, 1987).

Working women may have more freedom to assume the use of tough (interpersonal) bargaining strategies and to reject previously tolerated outcomes (e.g. Hood, 1983). They may also have an additional (and gratifying) role identity independent of family life (Ritter, 1993), so much so that their risk for depression may be halved (Brown & Harris, 1978). Likewise, PDA has been associated with financial dependency (Markowitz et al., 1989). For partners of PDA women on the other hand, work may provide a ready escape (from their relationship) and characteristically they may work long hours (Quadrio, 1983). Such issues (e.g., working hours and overtime) may be a source of much conflict (Kluwer, Heesink, & Van de Vliert, 1996).

Changes in the accessibility of opportunity structures, as evident in the increasing labour-force participation of married women, are resulting in a shift in partners’ relative material resources and thus possibly in more balanced power relations (e.g. Rank, 1982). However, this change has not been substantial (Dupuy, 1993). Employment is also not always an option as formerly depressed individuals can have considerable occupational difficulties (Mintz, Mintz, Arruda, & Hwang, 1992). On the other hand, while employment may equalise power distribution in their relationships (Blumstein & Schwartz, 1983), women may feel overworked and overburdened by the demands of both roles (of mother and partial provider; Coyne, Kahn, & Gotlib, 1985).

Blumberg’s (1984) general theory of gender stratification holds that the degree of control over surplus allocation (of economic resources) is more important than the degree of control over resources needed for bare subsistence. Hence, while economic dependence may affect a woman’s perceptions of her prerogatives in a relationship (Jack, 1999), if income is pooled (between partners) or controlled by the woman herself (as opposed to her partner controlling it), she may derive considerable power from this relationship domain.
Commitment

Commitment may be derived from a number of sources including the degree of emotional involvement, and physical and structural dependency. In relation to the latter, marriage may equilibrate men’s and women’s commitment because of the social rituals, the common property (i.e., pooling of assets), and the costs of leaving (i.e., legal and social complications of divorce) (Blumstein & Schwartz, 1983). However, critiques of the institution of marriage have argued that because it is difficult to terminate, it may also predispose to greater inequity (Kollock, Blumstein, & Schwartz, 1994). If an individual is unhappy in his/her marriage, he/she may feel ‘trapped’ and may eventually become depressed (O’Leary & Cano, 2001). This applies to both partners. Male partners, for example, may feel a greater obligation to remain in a relationship because of the institutionalised aspects of women’s financial dependence (Howard et al., 1986).

Emotional factors that may predispose to female commitment (or dependency) include concern for the future of one’s children, religious convictions (e.g., ‘Till death do us part’), a desire not to displease parents, relatives, and friends, and a fear that one will be ‘left on the shelf’ (Bagarozzi, 1990). Such concerns may predispose to a reluctance in putting one’s marriage on the line, an action that might be necessary to change the relationship (McGoldrick, 1991). The latter fear is quite understandable considering that the cultural rule is that men marry women who are younger (Glick, 1979) which results in men having an ever-increasing pool of women to choose from and women have an ever-diminishing pool of men to choose from (McGoldrick). Hence, physical attractiveness may translate into added bargaining power in the relationship (Blumberg & Coleman, 1989).

There may also be (dissolution-related) concerns such as financial costs, legal fees, and job considerations. If a relationship is abusive, there may be concern over the threat of more severe violence in the future, guilt that one is somehow responsible for the abuse, fear of confronting the ambivalence inherent in loving the abuser, or possibly a hope that things will improve in time (Dupuy, 1993). So, as per the principle of least interest (i.e., those who want less have more to say; Waller, 1938), women may be more committed to their relationships because they have more to lose. In effect, they may feel less powerful than their partners may.
However, while factors such as shared activities, joint (social) networks, and episodes of self-disclosure nurture the development of commitment (Surra & Hughes, 1997), it may be that empathic accuracy is a more potent relationship maintenance strategy (Simpson, Ickes, & Orina, 2001). But given that depression is 'a form of torment so alien to everyday existence' that it may be beyond the ability of healthy partners to empathise with the experience of a depressed partner (Styron, 1990), depressed women may report relatively less commitment (Byrne & Carr, 2000). Hence, they may feel more powerful than their partners may in this regard.

**Sex role attitudes**

Traditional sex-role attitudes (or beliefs) are a social philosophy that supports the dominance of men in the economic and political realm and justifies the husband’s position as head of the family (Mirowsky, 1985, p. 567). People who have traditional sex-roles think of the husband as his wife’s superior and her as his dependent. Such individuals typically endorse a female stereotypic role of focusing their lives on marriage, home, and children, and their engaging in nurturing and life-preserving activities through childbearing and caretaking behaviours (O’Neil & Egan, 1993).

Women with a non-traditional (or egalitarian) sex role ideology are more satisfied with their relationships than traditional partners (Aida & Falbo, 1991; Gray-Little, 1982; Gray-Little & Burks, 1983). This is despite an increased need to engage in (negotiation and) conflict so that the relationship is structured to their liking (Buunk, Kluwer, Schuurman, & Sicro, 2000) and the risk that they may become trapped in a role that leads them to resort to pressures and demands that may prohibit conflict resolution and the desired change (Kluwer, Heesink, & Van de Vliert, 1997). There is also the danger that they may be criticised for acting ‘like a man’, although if they opt for being traditional they may be seen as weak and ineffective (Johnson, 1978).

As non-traditional women remain pioneers (even after several decades of changing sex roles) and because men continue to support the sex-based specialisation of responsibilities such as homemaking (Herzog, Bachman, & Johnston, 1983), it might be expected that these women struggle with the (interpersonal) conflict and ambiguity regarding their non-traditionalism. Such an ongoing struggle might predispose to feelings of unhappiness (Lueptow, Guss, & Hyden, 1989) and depression (e.g. Elpem & Karp, 1984). A reversal of
the traditional arrangement may also be contrary to a woman’s preferences of male leadership (Nyquist & Spence, 1986). However, these women, especially if working, have alternatives and personal resources to which they can turn when necessary. Hence, in being less dependent upon male support and what marriage has to offer (Ross & Sawhill, 1975), they may have sufficient protective factors (e.g., an internal locus of control or a feeling of power) against becoming depressed.

Traditional women, on the other hand, may have a cognitive set against assertion and independence which predisposes to feeling and acting helpless in effecting change in their lives (Kaslow & Carter, 1991b). Indeed, these women are typically less inclined to confront their spouse because they feel less powerful (Mederer, 1993). This learned helplessness may predispose to feeling down when confronted with difficult situations (Abramson, Metalsky, & Alloy, 1978) such as an unsatisfactory relationship (Faver, 1982).

**Intimacy**

Intimacy refers to a relationship state in which spouses’ innermost feelings, thoughts, and dispositions can be revealed and explored (Prager, 1995). Sex-role conditioning may predispose to women being affiliative and expressive so that a lack of closeness (or too much distance) in a relationship may result in a loss of self (Jack, 1999). They may experience intimacy as holding both a sense of self and closeness. Men, on the other hand, may seek to balance too much closeness with distance out of fear that they may be engulfed by their relationships (Christensen, 1988). Hence, women may move toward their partners to connect, for both the togetherness and their sense of self, while men may move toward their partners for togetherness but away (separateness) for their sense of self (Dupuy, 1993).

Given the principle of least interest, it follows that intimacy may be a commodity in relationships that represents power (Berns, Jacobson, & Gottman, 1999). Women, who want more of it, may be ‘one down’, while men, in their efforts to regulate the level of intimacy, may be the more dominant partner in their relationships (Jacobson, 1989; Jacobson & Gottman, 1998). However, it may be that women’s enhanced relational orientation and capacity for interpersonal caring may have developed in the first place to compensate for a lack of power in other relationship domains (Rampage, 1994). Hence, their ability to be more intimate may be a source of power in their relationship.
That the attainment of intimacy is ‘relatively rare’ (Dupuy, 1993; Wynne, 1988) is understandable. It may mean different things to each sex. Men may equate it with sexuality or substitute it with problem solving, whereas women may want a forum just to have their feelings validated (Rampage, 1994). It is also a meaning that needs to be co-created. Both partners need to exhibit caregiving and attachment behaviours in equal measures so that a ‘cushion of trust and good feeling towards each other’ is created which provides the context within which intimate interactions can occur (Rampage). Without such a context, partners will find it difficult to self-disclose and communicate openly (Van den Broucke, Vandereycken, & Vertommen, 1995).

Deficiencies in the quality and quantity of relationship intimacy are significantly associated with severity of depressive symptoms in both clinical and non-clinical populations (Waring & Patton, 1984; Waring, Reddon, Corvinelli, Chalmers, & Vander Laan, 1983). The ongoing discord that typically characterises depressed relationships may serve to inhibit self-disclosure. Given depressed individuals’ tendency to avoid negative outcomes and their anticipation of negative partner behaviour (Davila, 2001), one might anticipate a general pattern of withdrawal from relationship conflict, which could lead to a deterioration in intimacy (Gottman & Krokoff, 1989). For example, anger may indicate that there is something wrong, but if not expressed, the message that something needs to be changed in the relationship may not be heard (Miller, 1983). Hence, it could be that partners in a depressed relationship may both seek intimacy (Byrne & Carr, 2000).

**Physical assault**

Historically, it was considered a necessary aspect of a husband’s marital obligation to control and chastise his wife through the use of physical force, especially if wives challenged the ‘patriarchal social order’ (Dobash & Dobash, 1977). Although many men use ‘the marriage licence as a hitting license’ (Stets & Straus, 1990b), not every man, even within our patriarchal society, beats his partner. Between 10% to 16% of women in community samples typically report partners engaging in some form of physical aggression against them in the past year (e.g., Stets & Straus, 1990a). That physically abused women are at an elevated risk of depressive symptoms and/or major depressive disorder has been well documented (see O’Leary & Cano, 2001 for a review of the relevant literature). However, it is the degree of physical assault (i.e., whether it is minor or severe) that may well determine if a women becomes depressed (e.g., Stets & Straus, 1990a).
Male- and female-dominated couples experience the highest levels of physical assault, whereas couples who report divided power report lower levels of violence, and couples who report egalitarianism report the lowest levels of violence (e.g., Coleman & Straus, 1986; Frieze & McHugh, 1992). Thus, male batterers may rely on physical force as the ‘ultimate resource’ in seeking further power and control. However, despite the power and control inherent in perpetrating abuse, male batterers may not experience themselves as more powerful or as having what they want.

Batterers may thus use physical violence to compensate for a perception that their partners are still insufficiently controlled (Babcock et al., 1993; Berns et al., 1999; Sagrestano et al., 1999; Stets, 1995). For example, women with relatively higher status jobs are more likely to experience violence (Hornung, McCullough, & Sugimoto, 1981). Men’s physical violence may also be an attempt to compensate for oppression experienced in the relative power hierarchy vis-à-vis other men (Goodrich, 1991). Resource theorists argue that men may experience increasing power loss over their life spans as they age and become less important to the capitalist system (Kahn, 1984). Such emasculation may predispose to efforts to seek out (and exert) further power in other domains.

The majority of women in physically violent relationships also report engaging in acts of physical assault (e.g., Schafer, Caetano, & Clark, 1998). It may be that these women, dissatisfied with their partners’ culturally legitimate prerogatives and struggling against perceived insubordination, may strive for more power or even dominance in their families (Anson & Sagy, 1995). This may predispose to numerous power ‘contests’ within their relationships with both partners playing the demanding role at different times. It may well be that these partners have inadequate conflict resolution skills and see physical assault as the only effective mode of stopping an argument or asserting a dominant position (Babcock et al., 1993).

Johnson (1995) differentiated between the ‘patriarchal terrorism’ of batterers and ‘common couple violence’ which is a relatively less gendered pattern of conflict in which conflict occasionally escalates into the use of physical assault by male and/or female partners. As postulated by conflict theory, it may well be that conflict is an inevitable part of all human association (Straus, Hamby, Boney-McCoy, & Sugarman, 1996) reflecting a continual low-
level struggle for power, and that many couples do not consider it a serious problem resorting occasionally to minor physical assault during conflict.

Psychological aggression

While there are many forms of psychological aggression (or violence) including economic deprivation, social humiliation, role restriction (e.g., attempts to control career roles, educational opportunities, or reproductive rights) and social isolation (e.g., withholding transportation, or limiting access to friendships), verbal aggression may be its most common form. The latter can include temper outbursts, sarcastic and critical exchanges, and recurrent bickering, as well as ridicule, excess criticism, and humiliations (O’Neil & Egan, 1993).

The essence of psychological aggression is a loss of control and powerlessness (Degregoria, 1987). It may represent desperate attempts (by both sexes) to regain power that has been lost during power conflicts or previous abuses of power, or an attempt to maintain stereotypical behaviours (O’Neil & Egan, 1993). For example, a man who feels his power is threatened by his partner’s behaviour (or skills) may seek to re-establish his power base by devaluing her emotionality, intuitive capacities, or attractiveness (Cross & Madson, 1997). Additionally, there may be other times when they project (unrelated) anger from another (insubordinate) domain (e.g., work, family-of-origin relationships) onto their depressed partners (Papp, 1988).

The conflict-escalation theory of couple violence argues that verbal aggression (against a partner), rather than being cathartic and tension reducing, tends to increase the risk of physical assault (Berkowitz, 1993). Various studies (e.g., Murphy & O’Leary, 1989) have supported the escalation (rather than the catharsis) theory by finding a strong association between psychological aggression and the probability of physical assaults. However, in the absence of physical assault, the very threat of violence can serve as an effective influence tactic, especially among couples with a history of violence (Frieze & McHugh, 1992).

Having been burdened with (or disempowered by) new responsibilities such as financial problems, and the burden of full child-care, male partners of depressed women may have doubts that their partners’ impairment is ‘necessary and honorably obtained’ (Coyne & Benazon, 2001, p. 30). This may be so even if they accept that there is ‘a strong biological
component’ to it (Coyne, 1988). Their subsequent social isolation may add to their experiencing resentment and anger towards their depressed partners, and to relationship deterioration (Halgin & Lovejoy, 1991). However, finding themselves in an unpleasant bind (Biglan et al., 1985), they may attempt to inhibit expression of their anger only to overreact in a non-contingent manner later. Thus, their relationships may be characterised by periods of inhibited communication and tension punctuated by arguments involving intense negative affect and then withdrawal, with little constructive problem solving (Coyne, 1986, p. 497).

They may experience high levels of anxiety and over half may be depressed (Spangenberg & Theron, 1999). This may in turn hamper their ability to give emotional and practical support to their depressed partners, thus aggravating their partners’ depression. This may further increase their hopelessness regarding the possibility of improving their relationship (Coyne, Burchill, & Stiles, 1990). Hence, the verbal aggression expressed by partners of depressed women may also represent an expression of their felt sense of powerlessness. However, it may serve as a ‘pay-back’ for the grief caused by the depression (Berg-Cross & Cohen, 1995).

Women, despite trying to conform to the cultural prohibition of anger (Jack, 1999), may also commit acts of psychological violence in response to their feelings of powerlessness. They may be annoyed at their inability to communicate to others the multiple dimensions of their torment and their partners’ inability to accurately empathise with their experience (Styron, 1990). Due to their relational orientation and over-investment in their relationships, depressed women may ordinarily ‘silence’ their selves (Jack) and deny their anger only for it to express itself in one of 2 ways. First, they may develop symptoms of sickness, and this is usually in the form of depression (Hafner, 1986).

Second, if both partners deny their anger, eventually these women may (unjustifiably) ‘emote for two’ (Papp, 1988, p. 211) and, in the process, be labelled as ‘hysterical’, ‘pathological’, and/or ‘castrating’. This usually results from a build-up of anger so that, when confrontations cannot be avoided anymore, they are burdened by the accumulation of unresolved issues and negative feelings (Coyne, 1986). Their anger may manifest as highly emotional and unproductive psychological aggression that is too general, confused, and exaggerated to facilitate open dialogue regarding change (Dupuy, 1993). As on-going
expression of anger is the primary mechanism for monitoring differences, the ‘inhibition-hostile exchange-inhibition’ cycle only serves to strengthen the sense that problems cannot be discussed and therefore the likelihood that they will again accumulate without resolution (Coyne et al., 1990). This in turn typically protects the status quo in the relationship.

It may well be that psychological aggression tends to occur more frequently than physical abuse in physically violent relationships (Follingstad, Rutledge, Berg, Hause, & Polek, 1990). Given that psychological aggression is more detrimental to women’s mental health than physical assault (O’Leary & Maiuro, 1999), it may be more predictive of depressive symptomatology (O’Leary & Cano, 2001). The negative toll that it exacts across time may render the maritally discordant, non-physically abused woman as depressed as women who have been seriously battered (O’Leary & Cano). At the very least, such hostile behaviour will result in the erosion of relationship satisfaction over time and possible relationship dissolution (Pasch & Bradbury, 1998).

1.10 Empirical studies of power processes

Demand – withdraw behaviour

The ‘power war’ (Kahn, 1984) precipitated by the changing gender roles and the influence of feminism since the 1970s has strengthened a traditional gender stereotype during conflict of the ‘nagging, hostile wife’ and the ‘uninvolved, withdrawn husband’ (Roberts, 2000). This has led many theorists to argue that a combination of gender effects (e.g., women are ‘socio-emotional specialists’ wanting relatively more affiliation or intimacy) and our gendered social organisation (i.e., our patriarchal social structure) has resulted in an increasingly polarised gendered interaction. This is one where females pursue change in the (non-egalitarian) status quo of their relationships (Heavey, Layne, & Christensen, 1993) and men, in response, engage in distancing behaviours (e.g., stomping out of the room, giving the silent treatment, defensiveness, avoiding discussion) to protect their vested interest in the status quo. These latter behaviours are powerful tactics, for ‘to not say anything (in particular situations) is to say something very important; that the battle we are engaged in is to be fought by my rules and when I choose to fight’ (Sattel, 1976, p. 474).

Hence, partners may ‘walk on the edges’ of their power dynamics in their daily lives without facing the central themes that produce conflict (O’Neil & Egan, 1993). For example, even when men do engage in conflict, they tend not to express personal vulnerabilities whereas
women do (e.g., Guthrie & Snyder, 1988). Despite evidence supporting this widespread gender communication pattern (e.g., Byrne & Carr, 2000; Gottman, 1994), the roles that both men and women take (during conflict) may be dependent on who is seeking change (Heavey et al., 1993) and who is more verbally competent (Bograd, 1988). Additionally, men have been found to frequently use conflict engagement (Kurdek, 1995; Roberts & Krokoff, 1990), and physically violent relationships are characterised by mutual demand (Babcock et al., 1993).

A number of studies (e.g., Heavey et al., 1993; Roberts & Krokoff, 1990; Smith, Vivian, & O’Leary, 1990) have found an association between withdrawal behaviour of either partner and relationship dissatisfaction. Other studies have found significant associations but only for one partner’s withdrawal behaviour (e.g., Christensen & Heavey, 1990; Gottman & Krokoff, 1989; Heavey, Christensen, & Malamuth, 1995). In contrast, other studies have found that males’ hostile (i.e., demanding) interactional behaviour may be particularly corrosive to their partners’ relationship satisfaction, while female withdrawal may have the same effect on males’ satisfaction (Roberts, 2000). Hence, our traditional gender-based ‘nag-withdraw’ stereotype may be inaccurate and misleading.

**Mutual constructive communication**

The presence of demand – withdraw behaviour may compromise mutual constructive communication which may in turn render conflict resolution difficult. It is well recognised that conflict plays a critical role in the ways in which people come to understand how social interaction functions to promote individual needs within personal relationships (Canary, Cupach, & Messman, 1995, p. 2).

Conflict avoidance may be a stable and functional adaptation for some couples (e.g., when both partners are reciprocally hostile and/or stubborn during conflicts). However, for many couples, while conflict avoidance may ‘keep the peace’ in the short term, it may predispose to a build-up of unresolved critical issues and a ‘coercive cycle’ of relationship dissatisfaction (Koener & Jacobson, 1994). Violent behaviour may also accelerate this cycle, over and above the effects of poor communication (Rogge & Bradbury, 1999). Thus, ‘it may be better to fight a constructive war than to nourish a destructive peace’ (Kluwer et al., 1997, p. 649).
A lack of mutual constructive communication may characterise depressed couples (Byrne & Carr, 2000) whereby uneven, negative, and asymmetrical communication is focused around the depressed partner’s feelings and symptoms rather than discussing relationship problems or real concerns (Hautzinger, Linden, & Hoffman, 1982; Johnson & Jacob, 1997). In effect, the depressed partners’ symptoms may prohibit resolution of conflict issues (Madanes, 1981). This might contribute to these couples never developing a sense of ‘relational efficacy’, that is the confidence that they can weather conflict together (Notarius & Vanzetti, 1983).

A key proposition of general negotiation theory is that the more effective are the negotiations between partners, the more acceptable will be the outcomes of joint decision-making (e.g., Gulliver, 1979). Hence, without adequate negotiation, one or both partners in depressed couples may not accept such outcomes. This in turn may predispose to their becoming further embroiled in a struggle for power. Additionally, as communication is the vehicle through which intimacy can be achieved and maintained (Van den Broucke et al., 1995), the communication deficits of these couples are likely to contribute to an ongoing lack of intimacy.

### 1.11 Empirical studies of power outcomes

**Household task distribution**

Household labour remains highly segregated by sex. Men do about 70% of the traditionally male tasks, whereas women perform about 75% of the traditionally female tasks (Lennon & Rosenfield, 1994). This is often regardless of whether women work (outside the home), whether they have equal status careers, or whether their husbands are unemployed (Biernat & Wortman, 1991; Brayfield, 1992). This often necessitates women having to work the ‘second shift’ (Hochschild & Machung, 1989). The couples that most closely approach an equal distribution of household tasks tend to be those where both partners hold non-traditional (or egalitarian) gender ideologies (Greenstein, 1996a) or those in which the breadwinner role is shared (e.g., Greenstein, 2000).

The non-egalitarian distribution of household tasks might be due to a perceptual bias in men who overestimate their share of such tasks and underestimate their partners’ (Komter, 1989). These men may thus perceive partner requests for a more balanced division of these tasks to be unjustified. On the other hand, if men lose power over their partners in one way (e.g., if
they earn less), they may try to make up for it in another way (e.g., by not doing their fair share of household tasks; Hochschild & Machung, 1989). If women perceive such an inequity, they may become depressed (Byrne & Carr, 2000; Lennon & Rosenfield, 1994).

However, many women might want to maintain their expertise and dominance in this domain (Kranichfeld, 1987). Additionally, ‘having the power to decide about something about which one might prefer not to decide is an empty victory’ (Hood, 1983, p. 178). Hence, the simple index of who decides what may be deceiving (Blumberg & Coleman, 1989). Rather, partners need to be asked their wants and needs, as well as about getting one’s way, when attempting to relate balance of power to division of household tasks. There may also be the influence of having sufficient income to hire others to perform some of the more noxious household tasks. This may contribute to less depression in women with higher incomes (Nolen-Hoeksema, 1990).

**Decision-making task distribution**

The partner who makes the most decisions in a relationship has traditionally been considered to be the partner who has the greater power (Blood & Wolfe, 1960). However, this is a too simplistic an argument. As alluded to above, decision-making is not necessarily a pleasant activity that partners strive to perform at all times. There may be ‘difficult’ or ‘unimportant’ (as opposed to ‘nice’) decisions to be made and these may be delegated to one’s partner, in some cases even against his or her wishes (e.g. Safilios-Rothschild, 1976b). Thus, much of what goes on between partners is not reflected in the final outcome of the decision-making process. It may be that the partner who makes the final decision has even been subtly manoeuvred into doing so (Gray-Little & Burks, 1983).

Hence, power inequality may be best conceptualised as discrepancies between the real and ideal distribution of decision-making (Szinovacz, 1981). Such discrepancies (or role dissatisfaction) appear to be mediated by relationship dissatisfaction, and depressed wives are characterised by large discrepancies in this domain (Byrne & Carr, 2000; Hoover & Fitzgerald, 1981; Whisman & Jacobson, 1989). However, relative to actual decision-making, male partners tend to overestimate their own power and female partners underestimate theirs (Olson & Rabunsky, 1972). Therefore, it is imperative to inquire as to whether decisions are made jointly or independently, and whether this decision-making structure has or has not been mutually agreed upon. The joint decision-making, while
possibly engendering more conflict, may also facilitate the development of intimacy that may in turn contribute to relationship satisfaction (Gray-Little & Burks, 1983).

**Child-care task distribution**

In terms of power and marital satisfaction, motherhood may prove more of a liability for women than an asset (Steil & Turetsky, 1987). The disequilibrium (e.g., career curtailment, loss of the exclusivity of the relationship and of social contacts) that the arrival of a newborn child brings to a relationship may manifest as transition-related stress. While this may result in developmental relationship growth, the stress may be overwhelming and partners may adopt traditionally defined and more differentiated roles (Cowan, Cowan, Coie, & Coie, 1978). A woman may feel further disempowered if her fertility pattern does not reflect her own preferences (Blumberg & Coleman, 1989). Such stresses may predispose to postpartum depression (O’Hara & Swain, 1996).

The relationships of depressed women (relative to control women) are characterised by dissatisfaction in child-care task distribution (Byrne & Carr, 2000; Whisman & Jacobson, 1989). Such child-care stress may both precipitate and maintain a depressive episode by itself or in combination with other stressors such as having children whose behaviour is increasingly difficult to parent (Field, 1992), a high level of relationship dissatisfaction (e.g., McGrath et al., 1990), and having to provide the bulk of caring for elderly parents and/or in-laws (McBride, 1990). There may also be the additional stress of not wanting to ‘let go’ of their child-care and ‘kinkeeper’ expertise (or dominance; Kranichfeld, 1987).

1.12 **Empirical studies of other power sources**

**Medication**

Although antidepressants may help some depressed individuals reduce their feelings of anger and resentment (Whisman & Ubelacker, 1999), it has generally been assumed that antidepressants have little direct effect on the quality of depressed persons’ involvement in their marriages over the long term (e.g., Weissman et al., 1984). One may have suspected that such a reduction would enable depressed individuals to function in a more empowering manner interpersonally.

For PDA women, antidepressants have been found to be as equally effective as benzodiazepines in the short-term (Wilkinson, Balestrieri, Ruggeri, & Bellantuono, 1991).
Increasingly, antidepressants, especially the serotonin selective reuptake inhibitors, are viewed as the treatment of choice for PDA (Gorman & Coplan, 1996). Such medication can often result in a sense of control to enter previously feared (and avoided) situations (Gould, Otto, & Pollack, 1995) and possibly to interact in a more empowering manner.

**Sexuality**

Sexuality is not an easily discussible subject (Komter, 1989). The sexual drive discourse posits that men are relatively weaker (than women) in that they need sex more and are relatively unable to control their sexual urges (Foreman & Dallos, 1992). If physical pleasure is more important to men than to women (Masters, Johnson, & Kolodny, 1982), women may engage in the ‘weak’ influence tactic of sexual sanctions to exert power (Johnson, 1976; Rubin, 1976), especially if the relationship is abusive (Walker, 1984). They may use their sexuality explicitly as a kind of bribe, ‘to get him in a good mood’ or as a reward for good behaviour. It could also be withheld for ‘bad behaviour’ (Foreman & Dallos, p. 360). More subtly, manipulation of the quality of sex can maintain its status as a power base for women. The ultimate sanction may be engagement in extramarital sex, with 24.5% of men and 15% of women doing so (Laumann, Gagnon, Michael, & Michaels, 1994).

However, a poor sexual relationship and non-negotiation around pleasure preferences or around a woman’s fertility pattern (i.e., her reproductive rights) may predispose to a lack of intimacy, to frequent conflict around these issues, to feeling trapped, and ultimately, to feeling depressed (Schaap, Buunk, & Kerkstra, 1988). The latter is particularly problematic for followers of Roman Catholicism which places a strong emphasis in marriage on female duties and male prerogatives in sexual matters (Komter, 1989). However, women with increased interpersonal power (e.g., stabilised economic power; Blumberg & Coleman, 1989) may not experience restricted sexual behaviour and/or use their sexuality as a power base.

1.13 Cycles of interaction in depressed relationships

The empirical literature on power bases, processes, and outcomes would suggest that depressed women and their partners engage in seemingly self-perpetuating (and coercive) behavioural cycles of interaction. For example, a recursive marital sequence may develop whereby either partner may withdraw or demand to affect a change in the status quo or to
exert power (e.g., Rampage, 1994). Demand behaviour might manifest as engagement in psychological (and or physical) aggression to exert power, both of which may play special roles in the developmental course of relationship dysfunction. Poor conflict resolution skills may result in a lack of mutual constructive communication and minimal self-disclosure, both of which may compromise the development of intimacy and increase partners’ hopelessness about the possibility of improving their relationship (e.g., Koerner & Jacobson, 1994).

Self-perpetuating cycles of interaction in depressed couples is not a new concept. As outlined by Teichman and Teichman (1990), Coyne concentrated on reciprocities between the depressed person and her environment in the emotional sphere (1976a, 1976b, 1986). Klerman, Weissman, Rounsaville, and Chevron (1984) outlined reciprocities on the behavioural level, and Feldman (1976) described reciprocities of cognitions and behaviours in the depressed person and her spouse and between them. As illustrated in Figure 2, in a further refinement of her reciprocal model of depression Teichman (1997) outlines how self-perpetuating intrapersonal cycles of cognitions, affects, and behaviours contribute to these self-perpetuating interpersonal cycles.

Hence, there may be positive feedback loops operating in couples where a partner is depressed, such that a lowering of mood causes changes in the environment which in turn cause a further lowering of mood (e.g., Price, 1991). Others (e.g., Hautzinger et al., 1982) have noted how the interactional behaviour of depressed individuals seems to create by itself the antecedents of being or staying depressed. The lack of alternatives (e.g., social skills deficits; Segrin, 2000) may turn depression into a necessity, or the only possibility to control the environment.
1.14 Assessing both partners

Research evidence suggests that women are much more articulate about their close relationships than their male partners and/or are more open to discussing what goes on in their relationships (Harvey, 1987). Hence, many of the studies (on marital power) rely exclusively on one partner's responses (typically the wife’s). However, such an approach is self-limiting, for when wives and husbands are both interviewed, there are large discrepancies in their reports (Hiller & Philliber, 1985). An example of the latter, as outlined in our review of the empirical studies of power outcomes, partners perceive their contributions to decision-making differently (Olson & Rabunsky, 1972). Additionally, not assessing both partners prevents exploring the possibility that the male partners of depressed women may be actively involved in their partners' distress rather than the passive victims of it (Coyne et al., 1985). Hence, this study assessed the perceptions (of relationship dynamics) of both depressed women and their partners.

1.15 Who rules the roost?

It is very difficult to ascertain in what way the 'power cake' is divided in relationships (Komter, 1989). This is partly due to the multiple facets of power. Indeed, as mentioned previously, it is not unusual for the correlations between the different power variables assessed to be non-significant (Babcock et al., 1993). However, without considering the various aspects of power separately, it is difficult to say who is the dominant partner in a relationship.

Control couples

Male partners appear to hold the upper hand economically in many relationships, but this may well be offset if it has been mutually agreed that the female partner has control of surplus spending money. Threatened or actual physical aggression appears to represent an important male power base, although it simultaneously reflects a sense of powerlessness. Similarly, overt anger in males may manifest as a power base. Withdrawing to preclude the possibility of changing the status quo (which presumably favours them) via negotiation, might also be a manifestation of male power in the relationship dyad.

For the most part, most women do not 'walk the talk' of modern sex role ideology. In doing so, they reinforce the cultural legacy of male dominance in our society and in their relationships. At best, non-traditional gender attitudes may facilitate egalitarianism.
Women may be less powerful in seeking greater intimacy, as reflected in their implied demand role in relationship interactions. Their tendency to inhibit anger expression may be self-disabling; due to pent-up anger drowning the subject matter of discussions, problems do not get resolved. On the other hand, in egalitarian relationships, more regular but less intense expression of discontent helps to structure the relationship to their liking. Women may be in a less powerful position in that they do more than their fair share of household tasks, decision-making, and child-care, but a low level of relationship strain or an affirming job, or both, may compensate for this.

As theory (e.g. Haley, 1963) suggests, it may be that relationships where neither partner is symptomatic are balanced or symmetrical (i.e., neutral dominance), with partners alternating in the roles of power subject and power holder as the task and personal qualities of the family members dictate. These non-symptomatic relationships may also be male-dominant. The critical feature is that both partners are satisfied with the balance of relationship power.

Couples where the female has PDA

Price (1991) hypothesises that if a partner, having exhausted all available means of negotiation, is dissatisfied with the hierarchical arrangements of his/her relationship, then he/she may elect an illness role to accommodate to the ‘one-down’ position. So, one would expect the power balance in couples where the female has PDA not to differ from that of control couples where there is a male-dominant or ‘one-up / one-down’ structure. On the other hand, if electing a sickness role is an effort to covertly equalise an overt power imbalance (Haley, 1963; Madanes, 1981), then one would expect a PDA woman’s level of power to be higher than that of a woman in a male-dominant non-depressed relationship, or to equal that of a woman in an egalitarian non-depressed relationship.

However, as indicated previously, it may be better to conceive of PDA as an ‘individual’ disorder rather than as a condition arising from the relationship context (Arrindell et al., 1986b; Cobb et al., 1984; Monteiro et al., 1985). Hence, PDA couples may be more similar to control couples than to couples where one partner has a psychiatric disorder (e.g., depression).
Couples where the wife is depressed

As mentioned above (e.g., Price, 1991), one would expect the power balance in couples where the woman is depressed not to differ from that of control couples where there is a male-dominant or ‘one-up / one-down’ structure. On the other hand, if electing a sickness role is an effort to covertly equalise the overt power imbalance (Haley, 1963; Madanes, 1981), then one would expect a depressed woman’s level of power to be higher than that of a woman in a male-dominant non-depressed relationship, or to equal that of a woman in an egalitarian non-depressed relationship.

An equal relationship power structure due to depression?

If an egalitarian dominance structure replaces a ‘one-up / one-down’ structure when a psychiatric symptom presents in a relationship, it would be expected that the power structure in a relationship where the woman is depressed would mirror that of an egalitarian relationship where there is no depression. One would expect the female partner to become more satisfied because the original cause of her dissatisfaction (i.e., lack of power) is eliminated. However, as the woman’s depression represents considerable distress subjectively (Haley, 1963), her dissatisfaction may increase. Both partners would also be expected to perceive neither as dominant (i.e., neutral dominance).

In depressed relationships, it is unlikely that depression would alter the male partner’s advantage in the economic context of the relationship. If anything, depression in his partner would increase his advantage in this power base due to the possibility of his partner not working. If his partner’s power has increased relative to his, he may try to reassert his dominance by being more physically aggressive. However, if an egalitarian dominance structure has replaced a ‘one-up / one-down’ hierarchy, then physical aggression would not be expected. The level of psychological aggression would be expected to mirror that of male partners in control couples. Additionally, if the male partner is dissatisfied with how his partner’s depression has changed the status quo to his disadvantage, then he might increase his engagement in demand behaviour to restore his advantage.

A female partner’s depression may alter some of her sources of power. It is unlikely that her sex role attitudes would change. The level of desired intimacy would be expected not to differ from that of a non-depressed woman. Similarly, one would expect levels of psychological aggression to compare with those of a non-depressed woman in an egalitarian
relationship. Additionally, female demand behaviour would be expected to mirror that of woman in egalitarian relationships. Lastly, if a woman elects an illness role to escape an over-functioning relationship role, it would be expected that the distribution in household tasks, decision-making, and child-care tasks would mirror that of an egalitarian non-depressed relationship.
Chapter 2 Aims, design, and hypotheses of present research

2.1 Aims and design of present research

Aims of the present research

The central objective of this thesis was to investigate if depression in women was associated with an egalitarian power structure in their couple relationship, as exists in egalitarian relationships where the female partner is not depressed. With the exception of Byrne and Carr (2000), previous empirical studies have not examined this possibility, usually assuming that the helplessness of depression is associated with less relationship power. Thus, the covert power inherent in depression has been, to a large extent, overlooked. To examine if such covert power is specific to depression, a third group of women with PDA was considered.

Previous research examining couple relationship power has typically involved gathering data only from female partners. Hence, the results of these studies have informed only about ‘her marriage’ and not about ‘his marriage’ (Bernard, 1972). To obtain a clearer understanding of the power dynamics within relationships, data were independently collected from both partners using self-report questionnaires.

Although couple relationship power is a complex and multi-faceted concept with many forms, empirical studies examining power in couples have generally examined one variable or aspect of power at a time, typically within one domain. Various aspects of power in couples where there is depression have been neglected both theoretically and empirically. The present study attempted to compare several aspects of power from each of three different domains of power; namely, power bases, processes, and outcomes, as delineated by Cromwell and Olson (1975). Table 1 lists the power variables examined in the present research.

To further investigate the power dynamics of PDA and depressed couples, clinical interview data were qualitatively analysed. These interview data consisted primarily of interview data from depressed and PDA women.
Design of the present research

A case control design was used in this study. Couples containing depressed female partners were compared with control and PDA couples on the variables listed in Table 1.

Table 1 Power variables examined in the present research.

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2.2 Hypotheses

This study addressed the following list of questions and accompanying hypotheses.

**Relationship satisfaction**

1a Compared with control and PDA couples, do members of couples containing depressed female partners report lower relationship satisfaction?

1b Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ level of satisfaction in couples containing depressed female partners?

1c Compared with control and PDA couples, is there a greater correlation between male partners’ and female partners’ level of satisfaction in couples containing depressed female partners?

The hypothesis about relationship satisfaction was that compared to control and PDA couples, members of couples containing depressed female partners would report lower relationship satisfaction.

**Dominance**

2a Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of dominance?

2b Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of dominance when differences in relationship satisfaction have been taken into account?

2c Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ level of dominance in couples containing depressed female partners?

2d Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ level of dominance in couples containing depressed female partners when differences in relationship satisfaction have been taken into account?

2e Compared with control and PDA couples, is there a greater correlation between male partners’ and female partners’ level of dominance in couples containing depressed female partners?
The hypothesis about dominance was that compared to control and PDA female partners, depressed female partners would view their male partners as more dominant.

**Power bases**

*Income*

3a Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of income?

3b Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of income when differences in relationship satisfaction have been taken into account?

3c Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ level of income in couples containing depressed female partners?

3d Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ level of income in couples containing depressed female partners when differences in relationship satisfaction have been taken into account?

3e Compared with control and PDA couples, is there a greater correlation between male partners’ and female partners’ level of income in couples containing depressed female partners?

The hypothesis about income was that depressed female partners would report lower income and that there would be a greater discrepancy between male partners’ and female partners’ reports on this variable in depressed couples relative to control or PDA couples.

**Economic dependence on partner**

4a Compared with control and PDA couples, do members of couples containing depressed female partners report greater economic dependence on their male partners?

4b Compared with control and PDA couples, do members of couples containing depressed female partners report greater economic dependence on their male partners when differences in relationship satisfaction have been taken into account?

4c Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ level of economic dependence in couples containing depressed female partners?
4d Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ level of economic dependence in couples containing depressed female partners when differences in relationship satisfaction have been taken into account?

4e Compared with control and PDA couples, is there a greater correlation between male partners’ and female partners’ level of economic dependence in couples containing depressed female partners?

The hypothesis about economic dependence was that depressed female partners would report greater economic dependence and that there would be a greater discrepancy between male partners’ and female partners’ reports on this variable in depressed couples relative to control or PDA couples.

**Control of surplus spending money**

5a Compared with control and PDA couples, do members of couples containing depressed female partners report greater control of surplus spending money?

5b Compared with control and PDA couples, do members of couples containing depressed female partners report greater control of surplus spending money when differences in relationship satisfaction have been taken into account?

5c Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ control of surplus spending money in couples containing depressed female partners?

5d Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ control of surplus spending money in couples containing depressed female partners when differences in relationship satisfaction have been taken into account?

5e Compared with control and PDA couples, is there a greater correlation between male partners’ and female partners’ control of surplus spending money in couples containing depressed female partners?

The hypothesis about control of surplus spending money was that depressed female partners would report less control of surplus spending money than their male partners or control or PDA female partners.
Desired control of surplus spending money

6a Compared with control and PDA couples, do members of couples containing depressed female partners report greater levels of desired control of surplus spending money?

6b Compared with control and PDA couples, do members of couples containing depressed female partners report greater levels of desired control of surplus spending money when differences in relationship satisfaction have been taken into account?

6c Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ levels of desired control of surplus spending money in depressed couples?

6d Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ levels of desired control of surplus spending money in couples containing depressed female partners when differences in relationship satisfaction have been taken into account?

6e Compared with control and PDA couples, is there a greater correlation between male partners’ and female partners’ levels of desired control of surplus spending money in couples containing depressed female partners?

The hypothesis about desired control of surplus spending money was that depressed female partners would report higher levels of desired control of surplus spending money, and that there would be a greater discrepancy between male partners’ and female partners’ reports on this variable in depressed couples relative to control or PDA couples.

Satisfaction with control of surplus spending money

7a Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of satisfaction with control of surplus spending money?

7b Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of satisfaction with control of surplus spending money when differences in relationship satisfaction have been taken into account?

7c Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ levels of satisfaction with control of surplus spending money in couples containing depressed female partners?

7d Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ levels of satisfaction with control of surplus spending money
in couples containing depressed female partners when differences in relationship satisfaction have been taken into account?

7e Compared with control and PDA couples, is there a greater correlation between male partners’ and female partners’ levels of satisfaction with control of surplus spending money in couples containing depressed female partners?

The hypothesis about satisfaction with control of surplus spending money was that depressed female partners would report lower levels of satisfaction with control of surplus spending money than their male partners or control or PDA female partners, and that there would be a greater discrepancy between male partners’ and female partners’ reports on this variable in depressed couples relative to control or PDA couples.

Commitment to the relationship

8a Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of commitment?

8b Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of commitment when differences in relationship satisfaction have been taken into account?

8c Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ levels of commitment in couples containing depressed female partners?

8d Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ levels of commitment in couples containing depressed female partners when differences in relationship satisfaction have been taken into account?

8e Compared with control and PDA couples, is there a greater correlation between male partners’ and female partners’ levels of commitment in couples containing depressed female partners?

The hypothesis about commitment was that depressed female partners would report higher levels of commitment than their male partners or control or PDA female partners.

Sex role attitudes

9a Compared with control and PDA couples, do members of couples containing depressed female partners report different sex role attitudes?
9b Compared with control and PDA couples, do members of couples containing depressed female partners report different sex role attitudes when differences in relationship satisfaction have been taken into account?

9c Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ sex role attitudes in couples containing depressed female partners?

9d Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ sex role attitudes in couples containing depressed female partners when differences in relationship satisfaction have been taken into account?

9e Compared with control and PDA couples, is there a greater correlation between male partners’ and female partners’ sex role attitudes in couples containing depressed female partners?

The hypothesis about sex role attitudes was that depressed female partners would report more traditional sex role attitudes than their male partners or control or PDA female partners, and that there would be a larger discrepancy in sex role attitudes between members of depressed couples relative to members of control or PDA couples.

Desired level of intimacy

10a Compared with control and PDA couples, do members of couples containing depressed female partners report different desired levels of intimacy?

10b Compared with control and PDA couples, do members of couples containing depressed female partners report different desired levels of intimacy when differences in relationship satisfaction have been taken into account?

10c Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ desired levels of intimacy in couples containing depressed female partners?

10d Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ desired levels of intimacy in couples containing depressed female partners when differences in relationship satisfaction have been taken into account?

10e Compared with control and PDA couples, is there a greater correlation between male partners’ and female partners’ desired levels of intimacy in couples containing depressed female partners?
The hypothesis about desired level of intimacy was that depressed female partners would report higher levels of desired intimacy than their male partners or control or PDA female partners, and that there would be a greater discrepancy between male and female partners’ scores on this variable in depressed couples relative to control or PDA couples.

**Physical assault by partner**

11a Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of physical assault?

11b Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of physical assault when differences in relationship satisfaction have been taken into account?

11c Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ reported levels of physical assault in couples containing depressed female partners?

11d Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ reported levels of physical assault in couples containing depressed female partners when differences in relationship satisfaction have been taken into account?

11e Compared with control and PDA couples, is there a greater correlation between male partners’ and female partners’ reports of physical assault in couples containing depressed female partners?

The hypothesis about physical assault was that depressed female partners would report higher levels of physical assault from their partners relative to control or PDA female partners.

**Previous physical assault by partner**

12a Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of previous physical assault?

12b Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of previous physical assault when differences in relationship satisfaction have been taken into account?

12c Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ reported levels of previous physical assault in couples containing depressed female partners?
12d Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ reported levels of previous physical assault in couples containing depressed female partners when differences in relationship satisfaction have been taken into account?

12e Compared with control and PDA couples, is there a greater correlation between male partners’ and female partners’ reports of previous physical assault in couples containing depressed female partners?

The hypothesis about previous physical assault was that depressed female partners would report higher levels of previous physical assault from their partners relative to control or PDA female partners.

Psychological aggression (towards partner)

13a Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of psychological aggression?

13b Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of psychological aggression when differences in relationship satisfaction have been taken into account?

13c Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ reports of psychological aggression in couples containing depressed female partners?

13d Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ reports of psychological aggression in couples containing depressed female partners when differences in relationship satisfaction have been taken into account?

13e Compared with control and PDA couples, is there a greater correlation between male partners’ and female partners’ reports of psychological aggression in couples containing depressed female partners?

The hypothesis about psychological aggression (towards partner) was that members of couples where the female was depressed would report lower levels of psychological aggression than members of control or PDA couples.
Power processes

Male demand – female withdraw behaviour

14a Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of male demand – female withdraw behaviour?

14b Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of male demand – female withdraw behaviour when differences in relationship satisfaction have been taken into account?

14c Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ reports of male demand – female withdraw behaviour in couples containing depressed female partners?

14d Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ reports of male demand – female withdraw behaviour in couples containing depressed female partners when differences in relationship satisfaction have been taken into account?

14e Compared with control and PDA couples, is there a greater correlation between male partners’ and female partners’ reports of male demand – female withdraw behaviour in couples containing depressed female partners?

The hypothesis about male demand – female withdraw behaviour was that couples containing a depressed female partner would report more male demand – female withdraw behaviour relative to control or PDA couples.

Female demand – male withdraw behaviour

15a Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of female demand – male withdraw behaviour?

15b Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of female demand – male withdraw behaviour when differences in relationship satisfaction have been taken into account?

15c Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ reports of female demand – male withdraw behaviour in couples containing depressed female partners?

15d Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ reports of female demand – male withdraw behaviour in
couples containing depressed female partners when differences in relationship satisfaction have been taken into account?

15e Compared with control and PDA couples, is there a greater correlation between male partners’ and female partners’ reports of female demand – male withdraw behaviour in couples containing depressed female partners?

The hypothesis about female demand – male withdraw behaviour was that couples containing a depressed female partner would report more female demand – male withdraw behaviour relative to control or PDA couples.

**Total demand - withdraw behaviour**

16a Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of total demand - withdraw behaviour?

16b Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of total demand - withdraw behaviour when differences in relationship satisfaction have been taken into account?

16c Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ reports of total demand - withdraw behaviour in couples containing depressed female partners?

16d Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ reports of total demand - withdraw behaviour in couples containing depressed female partners when differences in relationship satisfaction have been taken into account?

16e Compared with control and PDA couples, is there a greater correlation between male partners’ and female partners’ reports of total demand - withdraw behaviour in couples containing depressed female partners?

The hypothesis about total demand - withdraw behaviour was that members of depressed couples would report more total demand - withdraw behaviour than members of control or PDA couples.

**Mutual constructive communication**

17a Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of mutual constructive communication?
17b Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of mutual constructive communication when differences in relationship satisfaction have been taken into account?

17c Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ reports of mutual constructive communication in couples containing depressed female partners?

17d Compared with control and PDA couples, is there a greater discrepancy between male partners’ and female partners’ reports of mutual constructive communication in couples containing depressed female partners when differences in relationship satisfaction have been taken into account?

17e Compared with control and PDA couples, is there a greater correlation between male partners’ and female partners’ reports of mutual constructive communication in couples containing depressed female partners?

The hypothesis about mutual constructive communication was that members of depressed couples would report less mutual constructive communication than members of control or PDA couples.

Power outcomes

Partner does more household tasks

18a Compared with control and PDA couples, do members of couples containing depressed female partners report that their partners do more household tasks?

18b Compared with control and PDA couples, do members of couples containing depressed female partners report that their partners do more household tasks when differences in relationship satisfaction have been taken into account?

18c Compared with control and PDA couples, is there a greater discrepancy in couples containing depressed female partners between male partners’ and female partners’ reports concerning whether their partners do more household tasks?

18d Compared with control and PDA couples, is there a greater discrepancy in couples containing depressed female partners between male partners’ and female partners’ reports concerning whether their partners do more household tasks when differences in relationship satisfaction have been taken into account?
18e Compared with control and couples, is there a greater correlation in couples containing depressed female partners between male partners' and female partners' reports concerning whether their partners do more household tasks?

The hypothesis about partner does more household tasks was that depressed females would report a lower level of partner did more house hold tasks, and that there would be a greater discrepancy between male partners' and female partners' reports on this variable in depressed couples relative to control or PDA couples.

**Partner makes more family decisions**

19a Compared with control and PDA couples, do members of couples containing depressed female partners report that their partners make more family decisions?

19b Compared with control and PDA couples, do members of couples containing depressed female partners report that their partners make more family decisions when differences in relationship satisfaction have been taken into account?

19c Compared with control and PDA couples, is there a greater discrepancy in couples containing depressed female partners between male partners' and female partners' reports concerning whether their partners make more family decisions?

19d Compared with control and PDA couples, is there a greater discrepancy in couples containing depressed female partners between male partners' and female partners' reports concerning whether their partners make more family decisions when differences in relationship satisfaction have been taken into account?

19e Compared with control and PDA couples, is there a greater correlation in couples containing depressed female partners between male partners' and female partners' reports concerning whether their partners make more family decisions?

The hypothesis about partner makes more family decisions was that depressed females would report a higher level of partner makes more decisions, and that there would be a greater discrepancy between male partners' and female partners' reports on this variable in depressed couples relative to control or PDA couples.

**Partner more involved in child-care**

20a Compared with control and PDA couples, do members of couples containing depressed female partners report that their partners are more involved in child-care?
20b Compared with control and PDA couples, do members of couples containing depressed female partners report that their partners are more involved in child-care when differences in relationship satisfaction have been taken into account?

20c Compared with control and PDA couples, is there a greater discrepancy in couples containing depressed female partners between male partners’ and female partners’ reports concerning whether their partners are more involved in child-care?

20d Compared with control and PDA couples, is there a greater discrepancy in couples containing depressed female partners between male partners’ and female partners’ reports concerning whether their partners are more involved in child-care when differences in relationship satisfaction have been taken into account?

20e Compared with control and PDA couples, is there a greater correlation in couples containing depressed female partners between male partners’ and female partners’ reports concerning whether their partners are more involved in child-care?

The hypothesis on this variable was that depressed females would report a higher level of being more involved in child-care, and that there would be a greater discrepancy between male partners’ and female partners’ reports on this variable in depressed couples relative to control or PDA couples.

Satisfaction with household task distribution

21a Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of satisfaction with household task distribution?

21b Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of satisfaction with household task distribution when differences in relationship satisfaction have been taken into account?

21c Compared with control and PDA couples, is there a greater discrepancy in couples containing depressed female partners between male partners’ and female partners’ satisfaction with household task distribution?

21d Compared with control and PDA couples, is there a greater discrepancy in couples containing depressed female partners between male partners’ and female partners’ satisfaction with household task distribution when differences in relationship satisfaction have been taken into account?
21e Compared with control and PDA couples, is there a greater correlation in couples containing depressed female partners between male partners’ and female partners’ satisfaction with household task distribution?

The hypothesis about satisfaction with household task distribution was that depressed couples would report less satisfaction with household task distribution, and that there would be a greater discrepancy between male partners’ and female partners’ reports on this variable in depressed couples relative to control or PDA couples.

*Satisfaction with family decision-making distribution*

22a Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of satisfaction with family decision-making distribution?

22b Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of satisfaction with family decision-making distribution when differences in relationship satisfaction have been taken into account?

22c Compared with control and PDA couples, is there a greater discrepancy in couples containing depressed female partners between male partners’ and female partners’ satisfaction with family decision-making distribution?

22d Compared with control and PDA couples, is there a greater discrepancy in couples containing depressed female partners between male partners’ and female partners’ satisfaction with family decision-making distribution when differences in relationship satisfaction have been taken into account?

22e Compared with control and PDA couples, is there a greater correlation in couples containing depressed female partners between male partners’ and female partners’ satisfaction with family decision-making distribution?

The hypothesis on this variable was that depressed couples would report less satisfaction with the distribution of family decision-making, and that there would be a greater discrepancy between male partners’ and female partners’ reports on this variable in depressed couples relative to control or PDA couples.
Satisfaction with child-care task distribution

23a Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of satisfaction with child-care task distribution?

23b Compared with control and PDA couples, do members of couples containing depressed female partners report different levels of satisfaction with child-care task distribution when differences in relationship satisfaction have been taken into account?

23c Compared with control and PDA couples, is there a greater discrepancy in couples containing depressed female partners between male partners’ and female partners’ satisfaction with child-care task distribution?

23d Compared with control and PDA couples, is there a greater discrepancy in couples containing depressed female partners between male partners’ and female partners’ satisfaction with child-care task distribution when differences in relationship satisfaction have been taken into account?

23e Compared with control and PDA couples, is there a greater correlation in couples containing depressed female partners between male partners’ and female partners’ satisfaction with child-care task distribution?

The hypothesis about satisfaction with child-care task distribution was that depressed couples would report less satisfaction with the distribution of child-care tasks, and that there would be a greater discrepancy between male partners’ and female partners’ reports on this variable in depressed couples relative to control or PDA couples.
Chapter 3 Methodology

3.1 Participants
Over a 2-year period, approximately 400 routine referrals from a small number of General Practitioners and Mental Health Professionals (e.g., Consultant Psychiatrists, Psychiatric Social Workers) to an out-patient Adult Psychology Department were received. Of these, approximately 32 women satisfied the following criteria: (1) presented with either depression and/or PDA; (2) were aged between 25 and 45; (3) were in a stable, cohabiting relationship of at least one year; (4) they had at least one young child (less than 7 years); (5) there was an absence of psychotic symptoms, definite suicidal intentions, and substance dependence; and (6) both partners were willing to participate in the study.

The presenting women were asked to anonymously complete either an 8-page questionnaire (Appendix B) if depressed or an 11-page questionnaire (Appendix B) if they presented with PDA. All male partners were asked to complete the 8-page questionnaire. Both partners were asked to complete their questionnaires independently of each other and to return them in separate stamped, self-addressed envelopes that were provided. The treatment-attending participants (and their partners if they also attended) were asked to complete a consent form (Appendix C) to allow use of their questionnaire and clinical interview data in this study. Control couples were asked to complete the 8-page questionnaire (Appendix B) which was accompanied by a cover letter (Appendix C).

As insufficient numbers of couples completed the questionnaires, inclusion criteria were relaxed to allow women older than 45 years, childless couples, and women using antidepressant medications to qualify for inclusion in the study. Additionally, as has been done in other studies of agoraphobia (e.g., Torpy & Measey, 1974), a Psychologist in another agency that specialised in the assessment and treatment of PDA was asked to seek couples for inclusion in the study. Three couples were recruited via this Psychologist. Of the approximately 150 questionnaires distributed 20 qualifying couples where the woman was depressed and 20 where the woman presented with PDA returned completed questionnaires.

After completed questionnaires were received from both members of a couple, their General Practitioner was again contacted and asked to recruit a matching non-psychiatric (or control)
The matching criteria were that couples: (1) had the same number and ages of children; (2) had the same income levels; and (3) were of a similar age (± 5 years). As recruiting exactly matching couples was difficult to do, ‘best fit’ matches were accepted. Fellow Psychologists also helped to recruit these matching or control couples.

All attending women were asked to sign a consent form allowing for anonymous use of their questionnaire data (for statistical analysis) and clinical notes (for qualitative analysis) in this study (Appendix C). Along with their questionnaires, accompanying letters to their partners and members of control couples (Appendix C) made it clear that their completed questionnaire data were intended for use in this study. Where male partners also attended, they were also asked to sign consent forms for use of their data.

Demographic characteristics of the 3 sets of couples are given in Table 2 (Appendix D). From this table, it may be seen that the control couples were somewhat younger than the PDA couples but similar in age to the depressed couples. Most couples had children. PDA couples had slightly longer relationships and slightly older children than both the control and depressed couples. Most couples were married, and some of the PDA women and nearly all of the depressed women were taking anti-depressant medication.

3.2 Instruments

A set of psychological instruments was assembled to assess depression, PDA, relationship satisfaction, dominance, and a variety of power bases, processes, and outcomes. These are listed below and permission to use them was received from the respective authors (refer to consent form, Appendix C). To assess the internal consistency reliability of all scales, Cronbach’s alpha (Cronbach, 1951) was computed. Where alphas below .7 were obtained, items that had the lowest correlation with the scale were dropped until the alpha reached or exceeded .7. This procedure ensured that all but 2 of the scales included in the study met minimal psychometric criteria for reliability. A summary of the results of the reliability analyses for all psychometric scales is contained in Table 7 (Appendix D) and definitions of all the variables in the study are given in Table 8 (Appendix D).
Social Desirability Scale

The 10-item short form of the Marlowe-Crowne Social Desirability Scale (Reynolds, 1982) was used to measure the social desirability of participants’ responses. This scale is a shorter version of the original 33-item Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960). For the present study, 2 items were dropped from the 10-item scale to increase the Cronbach’s alpha to 0.55.

Depression

Two instruments were used to assess depression; the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and a checklist of the criteria for major depressive episodes from the Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV; American Psychiatric Association, 1994).

**BDI.** The BDI is the standard self-report depression scale used in the field. It consistently correlates with clinical ratings of depression (Beck, Steer, & Garbin, 1988). A BDI score of 14 or higher can be used to indicate the presence of depressive symptomatology or dysphoria (Taylor & Klein, 1989). In this sample, Cronbach’s alpha was .96 for this scale.

Table 3 presents the mean BDI scores of women from several studies (e.g., Beach & O’Leary, 1993b; Cascardi & O’Leary, 1992; Vivian & Malone, 1997). It is evident that women in discordant relationships have elevated depressive symptoms, and the presence of physical aggression increases the likelihood that those depressive symptoms will be even higher (O’Leary & Cano, 2001).

<table>
<thead>
<tr>
<th>Couple type</th>
<th>Satisfactorily married</th>
<th>Discordant</th>
<th>Moderately physically abusive</th>
<th>Severely physically abusive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>4 to 6</td>
<td>12</td>
<td>14.6</td>
<td>16.9</td>
</tr>
</tbody>
</table>

**DSM-IV checklist for Major Depressive Episode.** As high BDI scores may just represent diffuse maladaptive functioning in subclinical populations (Beck et al., 1988; Fechner-Bates, Coyne, & Schwenk, 1994), we constructed a 9-item depression checklist using the DSM-IV criteria for major depressive disorder. A BDI score of 14 or higher coupled with endorsement of five of the DSM-IV criteria was taken to signify the presence of major depressive disorder. The checklist
asked participants to indicate if they had experienced each symptom during the past two weeks. Response categories were either 'yes or no' or 'decrease or same as usual or increase'. Cronbach's alpha for this sample was .90 for this checklist.

**Panic Disorder with Agoraphobia (PDA)**
A semi-structured clinical interview and 2 instruments were used to assess PDA; the Anxiety Sensitivity Index (ASI; Peterson & Reiss, 1987) and the Mobility Inventory (Chambless, Caputo, Jasin, Gracely, & Williams, 1985a).

*Clinical interview*
A semi-structured interview based upon the DSM-IV criteria for PDA (Appendix A; American Psychiatric Association, 1994) was used to determine the presence of PDA.

*Anxiety Sensitivity Index.* The 16-item ASI consists of statements asserting a negative consequence of experiencing anxiety-related symptoms. Anxiety sensitivity (or the fear of anxiety) is calculated as the sum of respondents' ratings of their degree of agreement with each of the 16 statements using a 5-point Likert scale ranging from 'very little' (scored as 0) to 'very much' (scored as 4). An ASI score of 37 or higher (Taylor, Koch, & McNally, 1992) coupled with fulfillment of the DSM-IV criteria for PDA was taken to signify the presence of PDA. In this sample, Cronbach's alpha was .84 for this scale.

*Mobility Inventory.* The Mobility Inventory consists of 27 items. This questionnaire typically yields measures of behavioural avoidance (for 26 situations) when alone and when accompanied by a trusted companion, as well as measures of panic frequency and intensity. It is widely used to assess agoraphobia and has good reliability and validity (Craske, Rachman, & Tallman, 1986). As many PDA women are quite mobile when accompanied (by a significant other) but severely restricted when on their own (Chambless et al., 1985a), this study only asked about avoidance when alone. Other studies (e.g., McLean et al., 1998; Woody, McLean, Taylor, & Koch, 1999) have likewise used this more stringent (i.e., in terms of functioning) of the 2 subscales. In this sample, Cronbach's alpha was .95 for this scale.

**Relationship satisfaction**
Dyadic Satisfaction Scale. The 10-item Dyadic Satisfaction subscale of Dyadic Adjustment Scale (DAS; Spanier, 1976) was used to obtain partners' behavioural measures of relationship satisfaction.
satisfaction. The 32-item DAS has well-established psychometric properties (e.g., Margolin, Michelli, & Jacobson, 1988) and consists of four subscales: Dyadic Consensus, Dyadic Cohesion, Affectional Expression, and Dyadic Satisfaction. To avoid any confounding of satisfaction and communication measures, only the Dyadic Satisfaction subscale was used. This scale has been shown to provide clinicians with a reliable measure of (predominantly behavioural) dyadic satisfaction in community couples (e.g., Aida & Falbo, 1991; Heavey et al., 1993, 1995).

Accepted means for this scale for married (n = 218) and divorced (n = 94) couples are 40.5 and 22.2 respectively (Spanier, 1976). Cronbach’s alpha for this scale was .89 with this sample. For the ANCOVAs reported in the results section, the combined couple relationship satisfaction was used as the covariate. These analyses examined the effects of diagnosis over and above that due to relationship satisfaction on dependent variables.

Dominance

The question ‘Who is the dominant partner in your relationship?’ was answered using a 7-point Likert scale ranging from ‘I am a lot more dominant’ (scored as 1) to ‘My partner is a lot more dominant’ (scored as 7).

Power bases

Income

Participants’ income was graded using an Irish census-based social class scale that identified 6 social classes (Table 4: O’Hare, Whelan, & Commins, 1991). Individuals who were unemployed were classified as belonging to social class or income level 6.

<table>
<thead>
<tr>
<th>Social class</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Higher professional and higher managerial; proprietors and farmers owning 200 or more acres</td>
</tr>
<tr>
<td>2</td>
<td>Lower professional and lower managerial; proprietors and farmers owning 100-199 acres</td>
</tr>
<tr>
<td>3</td>
<td>Other non-manual and farmers owning 50-99 acres</td>
</tr>
<tr>
<td>4</td>
<td>Skilled manual and farmers owning 30-49 acres</td>
</tr>
<tr>
<td>5</td>
<td>Semi-skilled manual and farmers owning less than 30 acres</td>
</tr>
<tr>
<td>6</td>
<td>Unskilled manual</td>
</tr>
</tbody>
</table>
Commitment
Commitment was measured using item number 10 of the DAS Satisfaction subscale (Spanier, 1976), as has been done in other studies (e.g., Scanzoni & Godwin, 1990). This item asks participants what lengths they would go to see that their relationship succeeds using a 6-point Likert scale ranging from 'Would go to almost any length' (scored as 5) to 'There is no more that I can do' (scored as 0). Scanzoni and Godwin reported mean scores of 3.95 for wives and 4.22 for husbands in their random sample of 188 married couples.

Sex Role Attitudes Scale
The Sex Role Attitudes Scale (Huber & Spitze, 1983) was used to assess sex role attitudes. This 6-item scale has been shown to provide a reliable measure of sex role attitudes (e.g., Mirowsky, 1985). For the present study, the response categories were 'strongly disagree' (scored as 1), 'disagree' (2), 'neutral' (3), 'agree' (4), and 'strongly agree' (5). Cronbach’s alpha for this scale with this sample was .82. Using a large population-based and random sample of married couples (n=680), Mirowsky (1985) found sex role ideology means for women and men of −1.26 and 0.55 using their −2 to +2 scoring scheme; this translates to 16.74 and 18.55 using our 1 to 5 scoring scheme.

Closeness and Independence Scale
This is a newly developed 6-item scale (Christensen, 1987) for which there are no established norms. This scale assesses the degree to which partners want independence or intimacy in their relationship. Individuals are asked to answer each item using a 7-point Likert scale (scored as 1 through 7) with higher scores indicating a desire for more intimacy (and less independence). The alpha reliability for this scale with the present sample was .81.

Physical Assault Scale. The Revised Conflict Tactics Scale (CTS2; Straus et al., 1996) is a 78-item scale designed to assess psychological and physical attacks on a partner in a marital, cohabiting, or dating relationship; and also use of negotiation. It was developed primarily to improve on the content validity and reliability of the Conflict Tactics Scale (CTS; Straus, 1979, 1990a). This study used the 12-item physical assault subscale of the CTS2. The reliability of this subscale was .79 for our couple sample.

Adding the midpoints for the response categories chosen by the participant scores the physical assault subscale. The midpoints are the same as the response category numbers for Categories 0,
1, and 2. For category 3 (3-5 times) the midpoint is 4, for Category 4 (6-10 times) it is 8, for Category 5 (11-20 times) it is 15, and for Category 6 (More than 20 times in the past year) the recommended midpoint is 25. Category 7 was used to indicate whether there was previous physical assault (i.e., Not in the past year but it happened before).

In a sample of married couples (n = 42), physical assault means (on the original CTS, Straus, 1979) for both men and women indicated that they both were physically violent towards, and experienced physical violence from, their partner between 2.7 and 3.7 times in the previous 12 months, with a small subset of 4 couples reporting more frequent bi-directional physical violence (Sagrestano et al., 1999). The use of verbal aggression in this sample was approximately 3 to 5 times more prevalent.

**Spouse-Specific Aggression Scale.** The Spouse-Specific Assertiveness/Aggression Scale (O'Leary & Curley, 1986) is a 29-item scale composed of two subscales: Spouse-Specific Aggression (SSAG) and Spouse-Specific Assertiveness. The 12-item SSAG scale (which indicates the degree of psychological aggression towards one's partner) has been found to be associated with both marital discord and spousal abuse (O'Leary & Curley; Rosenbaum & O'Leary, 1981). Scores are coded using a 6-point Likert scale from −3 (‘Not at all like me’) to +3 (‘Very much like me’). Means for both men and women in satisfactorily married (n = 27), discordant (n = 23), and physically abusive (n = 22) relationships are presented in Table 5 (O'Leary & Curley).

<table>
<thead>
<tr>
<th>Couple type</th>
<th>Satisfactorily married</th>
<th>Discordant</th>
<th>Physically abusive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>-15.3</td>
<td>-5.4</td>
<td>1.0</td>
</tr>
<tr>
<td>Men</td>
<td>7.4</td>
<td>12.5</td>
<td>19.1</td>
</tr>
</tbody>
</table>

An alpha of .91 was obtained for the SSAG with the sample in the current study.

**Power processes**

*Communication Patterns Questionnaire - Short Form (CPQSF)*

This 11-item scale is a short version of the 35-item Communication Patterns Questionnaire (CPQ; Christensen, 1987, 1988; Christensen & Sullaway, 1984). The CPQSF assesses both symmetrical and asymmetrical (demand / withdraw) interaction patterns when a problem arises and when discussing relationship problems. The reliability and validity of both the CPQ and the
CPQSF have been demonstrated in numerous studies (e.g., Christensen & Shenk, 1991; Heavey, Larson, Zumtobel, & Christensen, 1996; Klinetob & Smith, 1996; Kluwer et al., 1997). Partners rated the likelihood that each interaction pattern applied to their relationship over the previous year (from 1 = very unlikely to 9 = very likely).

The alpha reliabilities of the demand / withdraw subscales have been found to vary between .50 and .85, with a mean of .75 for female demand – male withdraw interaction and .66 for male demand - female withdraw interaction (Christensen & Heavey, 1990; Christensen & Shenk, 1991; Heavey et al., 1993; Klinetob & Smith, 1996). In this study, alpha reliabilities of .68 for male demand - female withdraw, .72 for female demand - male withdraw interaction, and .82 for total demand-withdraw were obtained. The 3-item mutual constructive communication scale had an alpha reliability of .75.

**Power outcomes**

*Who Does What*

The Who Does What (Cowan et al., 1978) scale is an instrument designed to assess partners’ ideals and perceptions of their relative responsibilities for household tasks, family decision-making, and the caring and rearing of children. It has been used in many studies (e.g., Ball et al., 1995; Byrne & Carr, 2000; Whisman & Jacobson, 1989) to profile the task distribution in couples. For each of the 37 scale items, individuals indicate ‘How it is now’ and ‘How I would like it to be’, on a scale ranging from 1 (‘I do it all’), through 5 (‘We do it equally’), to 9 (‘He/she does it all’). There are 13 items that measure household tasks, 12 items that measure decision-making, and 12 items that measure child rearing.

For each of the 3 domain areas, 3 scores are provided: (i) role arrangement, which is found by averaging the responses to ‘How it is now’ (range: 1-9, with higher scores indicating greater partner involvement); (ii) egalitarianism / task sharing, which is found by averaging the absolute differences between ‘How it is now’ and 5 (we both do this about equally), (range 0-4, with higher scores indicating greater inequality); and (iii) role strain / satisfaction, which is found by averaging the absolute differences between ‘How I would like it to be’ and ‘How it is now’ (range 0-8, with higher scores indicating greater dissatisfaction).

For this study, only role arrangement and role satisfaction were considered for each of the 3 domains. Means for role arrangement and role satisfaction for both men and women in non-
depressed non-distressed couples (n = 25) and depressed couples who were seeking treatment for the wife's depression (n = 50) are presented in Table 6 (Whisman & Jacobson, 1989).

Table 6 Means for role arrangement and role satisfaction in 2 types of couples

<table>
<thead>
<tr>
<th>Couple type</th>
<th>Non-depressed, non-distressed</th>
<th>Depressed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td>Role arrangement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner did more household tasks</td>
<td>5.18</td>
<td>4.79</td>
</tr>
<tr>
<td>Partner did more decision-making</td>
<td>5.14</td>
<td>5.18</td>
</tr>
<tr>
<td>Partner more involved in child-care</td>
<td>3.93</td>
<td>3.19</td>
</tr>
<tr>
<td>Role satisfaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dissatisfaction with household task distribution</td>
<td>0.70</td>
<td>0.63</td>
</tr>
<tr>
<td>Dissatisfaction with decision-making distribution</td>
<td>0.40</td>
<td>0.48</td>
</tr>
<tr>
<td>Dissatisfaction with child-care task distribution</td>
<td>0.69</td>
<td>0.92</td>
</tr>
</tbody>
</table>

1. The child-care task subscale used was the longer 20-item version.

Due to low alpha reliabilities, some items needed to be dropped from the original scales (refer to Table 7, Appendix D). The scales used (and their reliabilities) were: partner did more household tasks (.71), partner did more decision-making (.70), partner more involved in child-care (.94), dissatisfaction with household task distribution (.74), dissatisfaction with decision-making distribution (.82), and dissatisfaction with child-care task distribution (.95). The latter 3 alpha values were computed by averaging the reliabilities for ‘How it is now’ and the ‘How I would like it to be’ scales for each respective domain.
Chapter 4 Quantitative Data Results

This study considered 2 types of data. First, questionnaire data were quantitatively analysed using a statistical software package. Second, clinical data from case notes from the majority of PDA and depressed women in treatment were qualitatively analysed. The latter included analysis of the case notes of those women whose partners did not return completed questionnaires. Third, the combined results of these analyses were summarised (and included in the discussion), by profiling the unique features of couples containing a control, PDA, and depressed female partner.

4.1 Statistical analysis of quantitative results

Questionnaire data were managed in the following way. First, the raw data were entered item-by-item into an SPSS (Version 10.0; SPSS Corporation, 1999) data file so that all subsequent analyses could be conducted using this software package. Second, all data in this file were verified by checking distributions and ranges. Third, reliability analyses of all psychometric scales were conducted to ensure that all scales were sufficiently reliable to proceed with further analyses. The results of these reliability analyses have been presented in the previous chapter where the instruments are described. Fourth, correlations between all dependent variables and social desirability were conducted to determine the degree to which the validity of responses was compromised by social desirability response set. Fifth, correlations between all dependent variables and duration of presentation (e.g., PDA or MDD) were conducted to ascertain if there were any significant relationships between the dependent variables and duration of presentation.

Sixth, correlations between dependent variables and both anxiety sensitivity and (degree of) mobility were conducted to determine if there were any significant correlations between the dependent variables and these PDA variables. Seventh, to test hypotheses about inter-group differences between male and female partners from couples in which women were controls (i.e., no psychiatric presentation), had PDA, or were depressed, 3X2 (diagnosis X gender) ANOVAs and Tukey post-hoc comparisons were conducted for all dependent variables.

Eight, correlations between all dependent variables and relationship satisfaction and the 3 variables of physical assault by partner, previous physical assault by partner, and
psychological aggression towards partner were conducted to ascertain if there were any significant relationships between the dependent variables and these 4 variables. Many of these correlations were quite large.

Ninth, to test the hypotheses about the unique effects of diagnosis on dependent variables by controlling for possible confounding effects of relationship satisfaction, physical assault by partner, previous physical assault by partner, and psychological aggression towards partner, 4 sets of 3X2 (diagnosis X gender) ANCOVAs were conducted with these 4 variables as the covariate.

Tenth, to test hypotheses about discrepancies between male and female partners’ scores in couples containing a control, PDA, and depressed female partner, discrepancy scores were then computed by subtracting male and female partners’ scores on each variable and comparing the three groups using one-way ANOVAs and Tukey post-hoc comparisons.

Eleventh, to test a similar set of hypotheses about the unique effects of diagnosis on dependent variables by controlling for possible confounding effects of (couple) relationship satisfaction, one-way ANCOVAs and pairwise comparisons were conducted with diagnosis as the independent variable with (couple) relationship satisfaction as the covariate.

Twelfth, to test a similar set of hypotheses about the unique effects of diagnosis on dependent variables by controlling for possible confounding effects of physical assault by partner, previous physical assault by partner, and psychological aggression towards partner, one-way ANCOVAs were conducted with diagnosis as the independent variable with these 3 variables as the covariate.

Thirteenth, to test hypotheses about the relationship between male and female partners’ scores on each variable across couples containing a control, PDA, and depressed female partner, correlations between male and female partners’ scores were computed on all dependent variables for all 3 sets of couples. Finally, correlations between the remaining dependent variables were conducted.

4.2 Results from statistical analysis of quantitative data
The results will be presented, broadly speaking, in the order in which the analyses were conducted. First, correlations between all variables and social desirability and duration of presentation (Table 9, Appendix D) will be given. Second, correlations between all
variables and anxiety sensitivity and mobility (Table 10, Appendix D) will be given. Third, the results of the 3X2 ANOVAs and Tukey post-hoc comparisons will be presented (Table 11, Appendix D). Fourth, correlations between all variables and the 4 variables of relationship satisfaction, physical assault by partner, previous physical assault by partner, and psychological aggression towards partner (Table 12, Appendix D) will be given. Fifth, ANCOVAs using the above-mentioned 4 variables (as the covariate) will be given (Table 13, Appendix D). The results of the discrepancy analyses will be given next, including ANCOVAs using the above-mentioned 4 variables (as the covariate) (Table 14, Appendix D). Fifth, the correlational analyses (Table 15, Appendix D) will be described. Sixth, correlations between the remaining dependent variables (Table 16) will be included in Appendix D.

Following the above tables, there will be a verbal description of significant findings from these tables, complete with graphs (Figures 3 through 7) depicting significant interactions from the ANOVAs.

Results of correlations with social desirability and duration of presentation
From Table 9 (Appendix D), it can be seen that correlations between the 28 dependent variables and social desirability ranged from -.17 to .22. This suggests that responses were valid and uncontaminated by social desirability response set. Although, the correlations between the dependent variables and duration of presentation ranged from -.27 to .36, only 5 of these correlations were significant at the p < .05 level and the only correlation that was significant at the p < .01 level was with previous physical assault by partner.

Duration of presentation, if not indicated from the questionnaire, was taken from the clinical notes of women with depression and women with PDA. From Table 11 (Appendix D), it can be seen that previous physical assault by partner was the variable that correlated most significantly with duration of presentation.

Results of correlations with anxiety sensitivity and mobility
From Table 10 (Appendix D), it can be seen that for PDA women, apart from mobility, only one of the 27 dependent variables (i.e., partner did more household tasks) significantly correlated with anxiety sensitivity and, apart from anxiety sensitivity, none significantly correlated with mobility.
Results of ANOVAs and Tukey post-hoc comparisons

For all dependent variables, 3 X 2 (diagnosis X gender) ANOVAs and Tukey post-hoc comparisons were conducted to evaluate the impact of gender and diagnosis status on power bases, processes, and outcomes. From Table 11 (Appendix D), it may be seen that main effects for diagnosis (in the absence of a significant diagnosis X gender interaction) were obtained on the following variables:

<table>
<thead>
<tr>
<th>Variable</th>
<th>Difference exists between</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration of presentation</td>
<td>Depressed and PDA couples</td>
</tr>
<tr>
<td>Duration of relationship problems</td>
<td>PDA &amp; control couples</td>
</tr>
<tr>
<td>Income</td>
<td>Control &amp; other couples</td>
</tr>
<tr>
<td>Commitment to the relationship</td>
<td>Depressed &amp; control couples</td>
</tr>
<tr>
<td>Physical assault by partner</td>
<td>Depressed &amp; other couples</td>
</tr>
<tr>
<td>Previous physical assault by partner</td>
<td>Depressed &amp; other couples</td>
</tr>
<tr>
<td>Male demand – female withdraw behaviour</td>
<td>Depressed &amp; other couples</td>
</tr>
<tr>
<td>Female demand – male withdraw behaviour</td>
<td>Depressed &amp; other couples</td>
</tr>
<tr>
<td>Total demand – withdraw behaviour</td>
<td>Depressed &amp; other couples</td>
</tr>
<tr>
<td>Mutual constructive communication</td>
<td>All couples</td>
</tr>
<tr>
<td>Dissatisfaction with child-care task distribution</td>
<td>Depressed &amp; other couples</td>
</tr>
</tbody>
</table>

With the exception of duration of relationship problems and income, members of relationships in which the female was depressed scored more extremely on all these variables. Thus, compared with members of control and PDA couples, members of depressed couples reported more physical assault by partner, more previous physical assault by partner, more male demand – female withdraw behaviour, more female demand – male withdraw behaviour, more total demand - withdraw behaviour, and less mutual constructive communication. Depressed women reported more chronic presentations than PDA women did, and they also reported less commitment to their relationship and more dissatisfaction with child-care task distribution than their partners or members of control and PDA couples.

While PDA and depressed women reported relationship problems of similar duration, the male partners of PDA women reported the lengthiest duration of relationship problems. This most probably accounts for the finding that members of PDA couples reported lengthier duration of relationship problems than members of control couples did.

From Table 11 (Appendix D), it may be seen that significant diagnosis X gender interactions were obtained on the following variables:
Table 18  Variables for which significant diagnosis X gender interactions were found in the ANOVAs.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Power bases</th>
<th>Power outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beck depression inventory</td>
<td>Dissatisfaction with control of surplus</td>
<td>Dissatisfaction with decision-</td>
</tr>
<tr>
<td></td>
<td>spending money</td>
<td>making distribution</td>
</tr>
<tr>
<td>DSM checklist for MDD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship satisfaction</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

These significant diagnosis X gender interactions are graphed in Figures 3 through 7. From Figures 3 and 4 it may be seen that depressed females reported significantly higher levels of depressive symptomatology while PDA females reported marked but non-significant levels. From Figure 5 it may be seen that depressed women reported significantly higher levels of relationship dissatisfaction when compared to their own partners and members of PDA and control couples. In contrast, PDA women reported similar levels of relationship dissatisfaction to their partners but significantly lower levels when compared with the members of control couples. From Figure 6 it may be seen that both depressed women and the male partners of control women reported more dissatisfaction with control of surplus spending money compared to their partners or PDA couples. From Figure 7 it may be seen that depressed women reported more dissatisfaction with decision-making distribution than their male partners and members of control and PDA couples.

Gender effects found in the analyses (Table 11, Appendix D) will not be discussed because they are not relevant to the questions addressed in this thesis.
Figure 3 Beck depression inventory across couples

Figure 4 DSM IV based depression scale across couples

Figure 5 Marital satisfaction across couples

Figure 6 Dissatisfaction with control of surplus spending money across couples

Figure 7 Dissatisfaction with decision making distribution across couples
Results of correlations with relationship satisfaction, physical assault by partner, previous physical assault by partner, and psychological aggression towards partner

From Table 12 (Appendix D), it can be seen that 17 (or 16 at the p < .01 level) of the 27 dependent variables significantly correlated with relationship satisfaction, thus justifying the plan to conduct a set of ANCOVAs to evaluate the unique effects of diagnosis independent of relationship satisfaction.

Similarly, it can be seen that 14 (or 11 at the p < .01 level) of the 27 dependent variables significantly correlated with physical assault by partner, thus justifying the plan to conduct a set of ANCOVAs to evaluate the unique effects of diagnosis independent of physical assault by partner.

Similarly, it can be seen that 12 (or 6 at the p < .01 level) of the 27 dependent variables significantly correlated with previous physical assault by partner, thus justifying the plan to conduct a set of ANCOVAs to evaluate the unique effects of diagnosis independent of previous physical assault by partner. Likewise, it can be seen that 17 (or 15 at the p < .01 level) of the 27 dependent variables significantly correlated with psychological aggression towards partner, thus justifying the plan to conduct a set of ANCOVAs to evaluate the unique effects of diagnosis independent of psychological aggression towards partner.

It can be seen from Table 12 (Appendix D) that of the 3 ‘aggression’ variables for which correlations were computed (with all other dependent variables), the largest correlations were with psychological aggression towards partner. These correlations are reproduced in Table 19.

Thus, expressed psychological aggression was prevalent to a greater degree if relationships were characterised by depression, higher income levels, economic reliance on partner, previous physical assault by partner, demand-withdraw behaviour, and dissatisfaction with the distribution of household tasks, decision-making, and child-care tasks. In contrast, expressed psychological aggression was less prevalent in relationships characterised by relationship satisfaction, desired control of surplus spending, commitment, mutual constructive communication, and partner involved more in household tasks and child-care. The finding that lower relationship quality was associated with higher levels of
psychological aggression would support the findings of other studies (e.g., Gavazzi, McKenry, Jacobson, Julian, & Lohman, 2000).

Table 19 Significant correlations between dependent variables and psychological aggression towards partner

<table>
<thead>
<tr>
<th>Variable</th>
<th>Positive correlation</th>
<th>Negative correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beck Depression Inventory</td>
<td>DSM-IV based depressive scale</td>
<td>Relationship satisfaction</td>
</tr>
<tr>
<td>Power bases</td>
<td>Income</td>
<td>Desired control of surplus spending money</td>
</tr>
<tr>
<td></td>
<td>Economic dependence on partner</td>
<td>Commitment to the relationship</td>
</tr>
<tr>
<td></td>
<td>Previous physical assault by partner</td>
<td></td>
</tr>
<tr>
<td>Power processes</td>
<td>Male demand – female withdraw behaviour</td>
<td>Mutual constructive communication</td>
</tr>
<tr>
<td></td>
<td>Female demand – male withdraw behaviour</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total demand - withdraw behaviour</td>
<td></td>
</tr>
<tr>
<td>Power outcomes</td>
<td>Dissatisfaction with household task distr.</td>
<td>Partner did more household tasks</td>
</tr>
<tr>
<td></td>
<td>Dissatisfaction with decision-making distr.</td>
<td>Partner more involved in child-care</td>
</tr>
<tr>
<td></td>
<td>Dissatisfaction with child-care distr.</td>
<td></td>
</tr>
</tbody>
</table>

Results of ANCOVAs

For all dependent variables, 4 sets of 3 X 2 (diagnosis X gender) ANCOVAs were conducted to evaluate the impact of gender and diagnosis status, independently of the effects associated with the 4 variables of relationship satisfaction, physical assault by partner, previous physical assault by partner, and psychological aggression towards partner. In the first set of these analyses, the combined male and female partners' relationship satisfaction scores was the covariate.

The results of these ANCOVAs are given in Table 13 (Appendix D). Of central concern are significant effects of diagnosis or diagnosis X gender on power bases, processes and outcomes, since these indicate those power variables influenced by diagnosis (alone or in combination with gender) when the effects of relationship satisfaction and aggression within the relationship are controlled for. These analyses yielded four important findings.

(1) In all 4 ANCOVAs a significant main effect of diagnosis on income was obtained. Thus when the effects of couple satisfaction, physical assault by partner, previous physical assault by partner, and psychological aggression towards partner were partialled out, depressed and PDA couples reported lower incomes.
A significant main effect of diagnosis on all three demand-withdraw power processes and constructive communication occurred in the ANCOVAs where physical assault by partner, previous physical assault by partner, and psychological aggression towards partner were the covariates. Thus, when the effect of these three covariates was held constant, depressed couples reported more demand-withdraw power processes and less constructive communication than other couples.

For dissatisfaction with control of surplus spending money in the ANCOVAs where relationship dissatisfaction, physical assault by partner, and previous physical assault by partner were the covariates, significant diagnosis X gender interactions occurred. Thus, when the effect of these three covariates was held constant, depressed women reported greater dissatisfaction with control of surplus spending money.

For dissatisfaction with the distribution of decision-making in the ANCOVAs where physical assault by partner, previous physical assault by partner, and psychological aggression towards partner were the covariates, significant diagnosis X gender interactions occurred. Thus, when the effect of these three covariates was held constant, depressed women reported greater dissatisfaction with the distribution of decision-making.

Results of ANOVAs and Tukey post-hoc comparisons on discrepancy scores
To evaluate the effects of diagnosis on differences between male and female partners’ scores on dependent variables, male-female discrepancy scores were calculated for all variables and compared using ANOVAs and Tukey post-hoc comparisons. From Table 14 (Appendix D) it may be seen that control, PDA, and depressed couples differed on 9 variables (at the p < .05 level). These results are summarised in Table 20.

Thus, relative to control couples, in depressed couples there was a larger discrepancy between male and female partners’ scores on desired level of intimacy, psychological aggression towards partner, and dissatisfaction with child-care task distribution. Relative to both control and PDA couples, discrepancy scores in depressed couples were also larger on depressive symptomatology, relationship satisfaction, and commitment to the relationship. Relative to PDA couples, there was a larger discrepancy between male and female partners’ scores on physical assault by partner in depressed couples. Relative to both control and
Table 20 Variables on which control, PDA, and depressed couples differed in the ANOVAs.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Difference existed between...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beck Depression Inventory</td>
<td>All couples</td>
</tr>
<tr>
<td>DSM IV-based depression scale</td>
<td>Depressed &amp; other couples</td>
</tr>
<tr>
<td>Duration of relationship problems</td>
<td>PDA &amp; other couples</td>
</tr>
<tr>
<td>Relationship satisfaction</td>
<td>Depressed &amp; other couples</td>
</tr>
<tr>
<td>Commitment to the relationship</td>
<td>Depressed &amp; other couples</td>
</tr>
<tr>
<td>Desired level of intimacy</td>
<td>Depressed &amp; control couples</td>
</tr>
<tr>
<td>Physical assault by partner</td>
<td>Depressed &amp; PDA couples</td>
</tr>
<tr>
<td>Psychological aggression towards partner</td>
<td>Depressed &amp; control couples</td>
</tr>
<tr>
<td>Dissatisfaction with child-care task distribution</td>
<td>Depressed &amp; control couples</td>
</tr>
</tbody>
</table>

depressed couples, there was a larger discrepancy score in PDA couples on duration of relationship problems.

Results of the ANCOVAs on discrepancy scores

ANCOVAs were conducted to evaluate the effects of diagnosis on male – female discrepancy scores independently of the effects associated with (couple) relationship satisfaction, physical assault on partner, previous physical assault on partner, and psychological aggression towards partner (Table 14, Appendix D). These analyses yielded four important findings.

(1) In all 4 ANCOVAs a significant main effect of diagnosis on duration of relationship was obtained. Thus when the effects of couple satisfaction, physical assault by partner, previous physical assault by partner, and psychological aggression towards partner were partialled out, there was a bigger discrepancy in PDA couples between male partners’ and female partners’ scores on how long they had relationship problems.

(2) In all 4 ANCOVAs a significant main effect of diagnosis on income was obtained. Thus, when the effect of couple satisfaction, physical assault by partner, previous physical assault by partner, and psychological aggression towards partner were partialled out, there was a bigger discrepancy in depressed couples between male partners’ and female partners’ level of commitment.
(3) A significant main effect of diagnosis on desired level of intimacy occurred in the ANCOVAs where physical assault by partner, previous physical assault by partner, and psychological aggression were the covariates. Thus, when the effect of these three covariates was held constant, there was a bigger discrepancy in depressed couples between male partners’ and female partners’ desired level of intimacy.

(4) A significant main effect of diagnosis on dissatisfaction with child-care task distribution occurred in the ANCOVAs where physical assault by partner, previous physical assault by partner, and psychological aggression were the covariates. Thus, when the effect of these three covariates was held constant, there was a bigger discrepancy in depressed couples between male partners’ and female partners’ scores on dissatisfaction with child-care task distribution.

Results of the correlational analyses
To evaluate the degree to which partners’ status on dependent variables were correlated for control, PDA, and depressed couples, correlations between males’ and females’ scores on each variable were computed (Table 15, Appendix D). These correlations are summarised in Table 21.

Members of control couples were characterised by similar levels of reported relationship satisfaction ($r = .80$), relationship commitment ($r = .52$), and desired level of intimacy ($r = .64$). On the other hand, there were similar levels of reported psychological aggression towards partner ($r = .72$), of male demand – female withdraw behaviour ($r = .48$), and of female demand – male withdraw behaviour ($r = .55$). The latter demand – withdraw behaviour was complemented by similar levels of reported mutual constructive communication ($r = .45$). Members of these couples also reported similar levels of mutual dissatisfaction with both decision-making ($r = .64$) and child-care task distribution ($r = .51$). The former may be accounted for by the marked degree of disagreement in relation to who did more of the decision-making in these couples ($r = -.72$).

Members of PDA couples reported similar levels of relationship satisfaction ($r = .77$) and relationship commitment ($r = .65$). There was significant disagreement as to who was the dominant partner ($r = -.89$), who controlled surplus spending money ($r = -.49$), and in
Table 21  Couple types for which there were large correlations between partners’ scores on variables.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Significant correlations in various couples</th>
<th>Positive or negative correlations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beck Depression Inventory</td>
<td>Control</td>
<td>+</td>
</tr>
<tr>
<td>Relationship satisfaction</td>
<td>Control, PDA</td>
<td>+</td>
</tr>
<tr>
<td>Dominance</td>
<td>PDA, depressed</td>
<td>-</td>
</tr>
<tr>
<td>Control of surplus spending money</td>
<td>PDA, depressed</td>
<td>-</td>
</tr>
<tr>
<td>Dissatisfaction with control of surplus spending money</td>
<td>PDA</td>
<td>+</td>
</tr>
<tr>
<td>Commitment to relationship</td>
<td>Control, PDA</td>
<td>+</td>
</tr>
<tr>
<td>Desired level of intimacy</td>
<td>Control</td>
<td>+</td>
</tr>
<tr>
<td>Physical assault by partner</td>
<td>PDA</td>
<td>+</td>
</tr>
<tr>
<td>Previous physical assault by partner</td>
<td>PDA</td>
<td>+</td>
</tr>
<tr>
<td>Psychological aggression towards partner</td>
<td>Control, PDA</td>
<td>+</td>
</tr>
<tr>
<td>Male demand – female withdraw behaviour</td>
<td>Control</td>
<td>+</td>
</tr>
<tr>
<td>Female demand – male withdraw behaviour</td>
<td>Control</td>
<td>+</td>
</tr>
<tr>
<td>Total demand – withdraw behaviour</td>
<td>Control</td>
<td>+</td>
</tr>
<tr>
<td>Mutual constructive communication</td>
<td>Control</td>
<td>+</td>
</tr>
<tr>
<td>Partner did more household tasks</td>
<td>PDA, depressed</td>
<td>-</td>
</tr>
<tr>
<td>Partner did more decision-making</td>
<td>Control, PDA</td>
<td>-</td>
</tr>
<tr>
<td>Dissatisfaction with household task distribution</td>
<td>Depressed</td>
<td>+</td>
</tr>
<tr>
<td>Dissatisfaction with decision-making distribution</td>
<td>Control</td>
<td>+</td>
</tr>
<tr>
<td>Dissatisfaction with child-care task distribution</td>
<td>Control</td>
<td>+</td>
</tr>
</tbody>
</table>

relation to who did more household tasks ($r = -.62$) and decision-making ($r = -.57$). On the other hand, members of these couples reported similar levels of dissatisfaction with control of surplus spending money ($r = .54$), physical assault by partner ($r = .44$), previous physical assault by partner ($r = .66$), and psychological aggression towards partner ($r = .58$).

Members of depressed couples reported disagreement as to who was the dominant partner ($r = -.46$) and who controlled the surplus spending money ($r = -.48$). There was also disagreement as to who did more household tasks ($r = -.62$). The latter may account for dissatisfaction with task distribution in this domain ($r = .47$) in these couples.

Significant positive correlations would suggest a degree of relational rigidity whereby a similar type of perception in the other partner reflects the presence of one type of relational perception in a partner. While such rigidity can be conceptualised as maladaptive, if both partners have similar perceptions (or views) of how their relationship functions or ‘consensually valid perceptions’ of it (Knudson, Sommers, & Golding, 1980), this will predispose to clarity of the ‘map’ of a relationship. Such a map may predispose to realistic relationship expectations and consequently to fewer disappointed expectations regarding
interactions with one’s partner (or what he or she should or should not be doing). In essence, such positive correlations may indicate the presence of adaptive relational rigidity. On the other hand, significant negative correlations might indicate a different type of relational rigidity whereby one partner’s view of the relationship differs significantly from the other partner’s view. In essence, such denial may indicate a struggle for control between partners.

Hence, control partners may have been content, committed, and seeking intimacy to similar degrees. It may have been that mutual recognition and meeting of emotional needs in their relationships predisposed to contentment and commitment. However, such relationships may also have involved a significant degree of demand – withdraw behaviour and psychological aggression towards partner, which in turn may have been balanced by mutual constructive communication. There may also have been mutual dissatisfaction with both decision-making and child-care task distribution, the former possibly due to disagreement in relation to who did more of the decision-making in these couples ($r = -.72$).

Similarly, members of PDA couples, while slightly less content than members of control couples, may have been equally committed to their relationship. However, members of these couples may have significantly disagreed as to whom was the dominant partner, who controlled surplus spending money, and who did more household tasks and decision-making. They may also have been both dissatisfied with control of surplus spending money. Such divergent perceptions of what happens in their relationship may have predisposed to (or resulted from) physical assault by one’s partner and psychological aggression towards one’s partner.

Similar to PDA couples, members of depressed couples may also have disagreed as to who was the dominant partner in the relationship and who controlled the surplus spending money. These members may additionally have disagreed as to who did more household tasks.

**Summary of statistical analysis of quantitative data**

As can be seen from the summary of the statistical analysis of quantitative data in Table 22, depressed couples reported more physical assault by partner, more demand – withdraw behaviour, and more dissatisfaction with decision-making and child-care task distribution.
They also reported shorter duration of relationship problems, and less relationship satisfaction, income, commitment, and mutual constructive communication. However, of these differences, only (less) income and (more) physical assault by partner were independent of the effects of relationship satisfaction.

With the exception of duration of relationship problems, discrepancy scores were significantly large for depressed partners on relationship satisfaction, dissatisfaction with control of surplus spending money, commitment, desired level of intimacy, physical assault by partner, psychological aggression towards partner, and dissatisfaction with child-care task distribution. Even when the influence of (couple) relationship satisfaction was partialled out, depressed female partners reported less relationship satisfaction, a desire for increased control of surplus spending money, more dissatisfaction with control of surplus spending money, less commitment, and less mutual constructive communication than their male partners.

Correlational data were remarkable in that there were few significant correlations for members of depressed couples. While there were negative correlations for these couples on dominance, control of surplus spending money, and partner did more household tasks, there was only one positive correlation on dissatisfaction with household task distribution. These findings were in stark contrast to the large number of predominantly positive correlations in control couples (i.e., 11 of) and, to a lesser extent, in PDA couples (i.e., 5 of).

Coupled with the above discrepancy findings, these correlational data would suggest that partners of depressed couples did not have a consensually valid perception of their relationship. Lack of clarity regarding their 'relationship map' may have resulted from a competition for power (either to get to control or exit from control) in various domains of their relationships (e.g., financial matters, distribution of household and child-rearing tasks, intimate relations). The means by which this (predominately covert) conflict was played out may have included mutual demand-withdraw behaviour with little constructive communication and physical assault. This in turn may have predisposed to relationship dissatisfaction and a lack of commitment.
<table>
<thead>
<tr>
<th>Variable</th>
<th>Couple differences on raw scores</th>
<th>Couple differences on raw scores independent of relationship satisfaction</th>
<th>Couple differences on discrepancy scores</th>
<th>Couple differences on discrepancy scores independent of couple relationship satisfaction</th>
<th>Significant positive correlations (unless otherwise indicated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beck Depression Inventory</td>
<td>Depressed &gt; PDA &gt; Control</td>
<td>Depressed &gt; PDA &gt; Control</td>
<td>Depressed &gt; PDA &gt; Control</td>
<td>Depressed &gt; PDA &gt; Control</td>
<td>Control</td>
</tr>
<tr>
<td>DSM IV based depressive scale</td>
<td>Depressed &gt; PDA &gt; Control</td>
<td>Depressed &gt; PDA &gt; Control</td>
<td>Depressed &gt; Control = PDA</td>
<td>Depressed &gt; Control = PDA</td>
<td></td>
</tr>
<tr>
<td>Duration of presentation</td>
<td>Depr sen &gt;= PDA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship problems and satisfaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration of relationship problems</td>
<td>PDA &gt; Depressed</td>
<td></td>
<td>PDA &gt; Depressed equals Control</td>
<td>PDA &gt; Control</td>
<td>Control, PDA</td>
</tr>
<tr>
<td>Relationship satisfaction</td>
<td>Control &gt; PDA &gt; Depressed</td>
<td></td>
<td>Control &gt; PDA &gt; Depressed</td>
<td></td>
<td>PDA, Depressed (-)</td>
</tr>
<tr>
<td>Dominance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Power bases</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>Control &gt; PDA = Depressed</td>
<td>Control &gt; PDA = Depressed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Economic dependence on partner</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Control of surplus spending money</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Desired control of surplus spending money</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Dissatisfaction with control of surplus spending money</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commitment to relationship</td>
<td>Control = PDA &gt; Depressed</td>
<td></td>
<td>Depressed &gt; Control = PDA</td>
<td>Depressed &gt; PDA</td>
<td>Control, PDA</td>
</tr>
<tr>
<td>Sex role attitudes</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Desired level of intimacy</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Physical assault by partner</td>
<td></td>
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</tr>
<tr>
<td>Previous physical assault by partner</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Psychological aggression towards partner</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Power processes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male demand – female withdraw behaviour</td>
<td>Depressed &gt; Control = PDA</td>
<td></td>
<td></td>
<td></td>
<td>Control</td>
</tr>
<tr>
<td>Female demand – male withdraw behaviour</td>
<td>Depressed &gt; Control = PDA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total demand - withdraw behaviour</td>
<td>Depressed &gt; Control = PDA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mutual constructive communication</td>
<td>Control &gt; PDA = Depressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Power outcome</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner did more household tasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PDA, Depressed (-)</td>
</tr>
<tr>
<td>Partner did more decision-making</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Control, PDA</td>
</tr>
<tr>
<td>Partner more involved in child-care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dissatisfaction with household task distribution</td>
<td>Depressed &gt; Control = PDA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dissatisfaction with decision-making distribution</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Dissatisfaction with child-care task distribution</td>
<td>Depressed &gt; Control = PDA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Chapter 5 Qualitative Data Results

Tables 23 and 24 respectively summarise the qualitative data of both PDA and depressed women that is contained in Appendix D. A short written summary of these findings follows.

**PDA couples**

PDA couples, while slightly less content than members of control couples, were equally as committed to their relationship as control couples with 95% of them willing to do their fair share of work (or more) to keep their relationship alive. While 45% of the 20 PDA women reported that they were more dominant in their relationship, 40% reported that they were equally as dominant. In terms of sex role ideology, 30% of these women were classified as non-traditional, 65% as neutral, and 5% as traditional. In terms of desired level of intimacy, 50% of these women were classified as wanting no change and 50-55% as wanting more intimacy, with some women wanting both more intimacy and more independence.

One PDA woman reported a recent history of physical assault (by her partner) severe enough to be classified as domestically violent (DV) while the male partners of 4 PDA women reported non-DV levels of physical assault (by their female partners). 45% of these women reported expressing a high degree of psychological aggression and being confused as to why they did so. This may account for the high mean for this group of this on this variable relative to their partners and to control female partners. However, upon investigation, they identified numerous sources of anger principal among which were their partners' (apparent) inability to understand their presentation and not having a 'fulfilling relationship' with their partners. 10% of these women also reported that verbal aggression from their partner was a problem.

Quantitative data indicated that these women’s relationships were characterised by a non-significant equal amount of bi-directional demand – withdraw behaviour. However, qualitative data indicated that 30% of these women reported male demand – female withdraw behaviour while 55% of them reported female demand – male withdraw behaviour, and that these interactions were influenced by which partner wanted relationship
Table 23  Summary of qualitative data for PDA women

| Variable                                      | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | Total |
|-----------------------------------------------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|     |
| **Power bases**                                |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| Dissatisfaction with control of financial resources |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| Perceive self as more dominant                |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| Want more intimacy                            |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| History of physical assault by partner        |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| Verbal aggression from partner                |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |
| Psychological aggression towards partner      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| **Power processes**                           |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| Male demand – female withdraw behaviour       |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| Female demand – male withdraw behaviour       |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| Mutual constructive communication            |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| **Power outcomes**                            |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| Dissatisfaction with household task distribution |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| Dissatisfaction with decision-making distribution |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| Dissatisfaction with child-care task distribution |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| **Other relationship variables**              |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| Relationship problems                         |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| Don't discuss attending Psychologist with partner |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| Partner generally supportive                  |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| Partner overly invested in work               |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| Sexual difficulties in relationship           |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| Disagreements regarding parenting strategies  |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| **Stressors / Supports**                      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| Medical concerns                              |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| Poor childhood                                |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| Ongoing coping role within family-of-origin   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| Death of child / close relative               |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| Stress of having a young child                |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| **Other variables**                           |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| Sociotropic orientation                       |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| Autonomic orientation                         |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |
| God as a source of support / punishment       |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |     |

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Table 24 Summary of qualitative data for depressed women

| Variable | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | Total |
| **Power bases** |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 8   |
| Dissatisfaction with control of financial resources |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 8   |
| Perceive self as more dominant |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 9   |
| Want more intimacy |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 15  |
| History of physical assault by partner |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 9   |
| Verbal aggression from partner |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 7   |
| Psychological aggression towards partner |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 13  |
| **Power processes** |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 7   |
| Male demand – female withdraw behaviour |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 7   |
| Female demand – male withdraw behaviour |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 13  |
| Mutual constructive communication |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 4   |
| **Power outcomes** |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 11  |
| Dissatisfaction with household task distribution |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 11  |
| Dissatisfaction with decision-making distribution |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 10  |
| Dissatisfaction with child-care task distribution |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 11  |
| **Other relationship variables** |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 16  |
| Relationship problems |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 16  |
| Don’t discuss attending Psychologist with partner |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 4   |
| Partner generally supportive |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 8   |
| Partner overly invested in work |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 11  |
| Sexual difficulties in relationship |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 10  |
| Disagreements regarding parenting strategies |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 7   |
| **Stressors / Supports** |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 3   |
| Medical concerns |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 3   |
| Poor childhood |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 9   |
| Ongoing coping role within family-of-origin |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 7   |
| Death of child / close relative |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 7   |
| Stress of having a young child |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 11  |
| **Other variables** |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 14  |
| Sociotropic orientation |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 14  |
| Autonomic orientation |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 17  |
| God as a source of support / punishment |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 6   |
issues addressed. The motivations underlying female withdrawal behaviour included self-protection, a belief that it was pointless engaging in discussion, and a belief that their demands were ‘over the top’, unjustified, or unreasonable. On the other hand, some of these women wanted to punish their male partners by withdrawing from interactions with them.

The motivations underlying female demandingness included wanting change in the relationship (and believing that there was no other way to achieve this but by ‘nagging’ or shouting), and wanting emotional connection with their partners (e.g., wanting their partner to understand them more via chatting). As for mutual constructive communication, 65% of PDA women reported regular episodes of this.

While PDA women reported equivalent levels of dissatisfaction with household task distribution to that of treatment-seeking depressed women (Table 6), only 8 (or 40%) of them reported this to be a problem area in their relationship. With regard to family decision-making distribution, PDA women reported similar levels of dissatisfaction with this domain as control women in this study and non-distressed non-depressed women in other studies (Table 6). Only 5 (or 25%) of the PDA women reported this domain to be an ongoing source of dissatisfaction within their relationship.

Male partners across all 3 groups of women indicated that their partners were significantly more involved in child-care. This may indicate that they saw themselves as relatively uninvolved in this domain. PDA women reported (slightly higher but) similar levels of dissatisfaction in this domain than control couples in this study or non-distressed non-depressed women in other studies (Table 6). Indeed, only 6 (or 30%) of the PDA women reported this domain to be an ongoing source of dissatisfaction within their relationship.

Qualitative analysis also revealed that the PDA in this study were characterised by (1) a sensitivity to loss (and unpredictability); (2) a strengthened belief that one must try to remain in control of self and of interactions with the world in general (e.g., generalised control beliefs); (3) ever increasing and excessive levels of stress (e.g., 35% of these women reported having an ongoing coping role within their family-of-origin); (4) limited sources of self-esteem with an over-investment in what one can do to define self (e.g., 50% of these women reported that a significant source of self-esteem was doing many things to a high
standard); and (5) an inadequate amount of sources of support and a reluctance to avail of such sources.

**Depressed couples**

Seventy per cent of the 20 depressed women were unhappy to some degree in their relationship. Although 75% of them reported that they would do their fair share of work (or more) to keep their relationship alive, 40% reported feeling trapped in their relationship but had not separated due to a variety of reasons. While 40% of these depressed women reported that they were more dominant in their relationship, 25% reported that they were equally as dominant. Some of them reported that they wanted their partners to take a more dominant role in their relationship. These women were evenly classified as having either a non-traditional or a neutral sex role ideology. In terms of desired level of intimacy, 5% of these women were classified as wanting no change and 70-75% as wanting more intimacy, with some women wanting both more intimacy and more independence.

Eight (or 40%) of the depressed women reported a recent history of physical assault (by their partners) severe enough to be classified as domestically-violent (DV) while the male partners of 3 and 5 of these 8 women respectively reported DV and non-DV levels of physical assault (by their female partners). Based upon male reports, 1 other depressed couple could be classified as DV. Sixty-five per cent of these women reported expressing a high degree of psychological aggression and being confused as to why they did so.

This may account for the high mean for this group of this on this variable relative to their own partners and to control female partners. However, as with PDA women, they identified numerous sources of anger principal among which were their partners’ (apparent) inability to understand their presentation and not having a ‘fulfilling relationship’ with their partners. The build-up of their anger and subsequent expression of it contributed to a coercive cycle of interaction. Contributing to their anger may have been verbal aggression (from their partners). Fifty per cent of these depressed women highlighted this as a significant problem area in their relationships as the aggression was often highly personal and deprecating.

Quantitative data indicated that these women’s relationships were characterised by significant equal amounts of bi-directional demand – withdraw behaviour. However, qualitative data indicated that 35% of these women reported male demand – female
withdraw behaviour while 65% of them reported female demand – male withdraw behaviour, and that these interactions were influenced by which partner wanted relationship issues addressed. Similar to PDA women, the motivations underlying female withdrawal behaviour included self-protection (i.e., de-escalation of a potentially physically abusive situation), a belief that it was pointless engaging in discussion, and a belief that their demands were ‘over the top’, unjustified, or unreasonable.

Again, similar to PDA women, the motivations underlying female demandingness included wanting change in the relationship (and believing that there was no other way to achieve this but by ‘nagging’ or shouting), and wanting emotional connection with their partners (e.g., wanting their partner to understand them more via chatting). However, depressed women’s demandingness was often greeted with angry withdrawal (e.g., prolonged silence), conflict avoidance (e.g., failing to bring up a disagreement), and intimacy avoidance.

Only 25% of depressed women reported regular episodes of mutual constructive communication. Many factors contributed to this finding including time constraints, the burden of unprocessed emotions (when communication did happen), a poor negotiation history and consequent beliefs that communication would ‘not work’, an excessive focus on the female partner’s depressive symptoms, a fear that vulnerabilities disclosed would be subsequently used against them, and partners discussing their relationship concerns with significant others outside their relationship.

While quantitative data (Table 11, Appendix D) indicated that depressed women reported similar levels of partner does more household tasks and dissatisfaction in this domain to that of control and PDA women (and to that of other treatment-seeking depressed women; Table 6), qualitative data revealed that 55% of these depressed women reported this domain to be an ongoing source of dissatisfaction within their relationship. In contrast, while depressed women reported similar levels of partner does more decision-making to that of control and PDA women, their level of dissatisfaction in this domain was significantly higher than that of these other women. This was reflected in qualitative data that indicated that 50% of depressed women reported this to be an ongoing source of dissatisfaction within their relationship.
With respect to child-care task distribution, male partners of depressed perceived their partners to be significantly more involved in child-care task. While depressed women reported similar (low) levels of partner more involved in child-care to that of control and PDA women, they reported significantly higher dissatisfaction in this domain. Indeed, 55% of the depressed women reported this to be an ongoing source of dissatisfaction within their relationship. While it is difficult to reconcile this greater dissatisfaction among depressed women with their performing a similar level of child-care tasks relative to control and PDA women, they may simply have wanted equality with their partners in this domain. They may also have been dissatisfied not with the amount of child-care they did but with the amount of appreciation (or criticism) they received for their efforts.

Qualitative data also revealed that these women were also characterised by (1) a sensitivity to loss (and unpredictability); (3) a strengthened belief that one must try to remain in control of self and of interactions with the world in general (e.g., generalised control beliefs); (4) ever increasing and excessive levels of stress (e.g., 40% of these women reported having an ongoing coping role within their family-of-origin); (5) limited sources of self-esteem with an over-investment in what one can do to define self (e.g., 85% of depressed women reported that a significant source of self-esteem was doing many things to a high standard); and (6) an inadequate amount of sources of support and a reluctance to avail of such sources.
Chapter 6 Discussion

6.1 Overview of results

A summary of the characteristics of members of couples containing control, PDA, and depressed women is presented in Table 25.

Quantitative data

PDA couples were significantly older than control couples (and slightly older than depressed couples). Their relationships were significantly longer in duration than control and depressed couples. Ninety-five per cent of both PDA and depressed women had children, and 75% of control women had children. While all 3 groups of couples had a similar mean number of children, PDA couples had older children. While all PDA couples were married, 95% and 85% of control and depressed couples respectively were married. PDA women reported clinical levels of both anxiety sensitivity and decreased mobility.

The main effects for diagnosis (in the absence of a significant gender X diagnosis interaction) were that PDA women reported relationship problems and presentations of longer duration than depressed women did. Depressed and PDA couples were of lower socio-economic status than control couples. Depressed couples were less committed than control couples, and they experienced more physical assault and displayed more psychological aggression than other couples. Depressed couples also reported more male demand – female withdraw behaviour, female demand – male withdraw behaviour, total demand – withdraw behaviour, and more dissatisfaction with child-care task distribution than other couples. They also reported less mutual constructive communication than other couples (and PDA women reported less of this behaviour than control couples).

A number of significant gender X diagnosis interactions were found (Figures 3 through 7). Depressed females reported significantly higher levels of depressive symptomatology while PDA females reported significant but sub-clinical levels of depressive symptomatology. Depressed women reported significantly higher levels of relationship dissatisfaction when compared to their own partners and members of PDA and control couples. In contrast, PDA women reported similar levels of relationship dissatisfaction to their partners but significantly lower levels when compared with the members of control couples. Both depressed women and the male partners of control women reported more dissatisfaction
with control of surplus spending money compared to their partners or the members of PDA couples. Depressed women reported more dissatisfaction with decision-making distribution than their male partners and members of control and PDA couples.

Excluding variables where significant gender X diagnosis interactions occurred and controlling for the effects of relationship satisfaction, only income distinguished depressed and PDA couples from control couples, and only physical assault (by partner) distinguished depressed couples from PDA and control couples. Similarly, when the effects of physical assault by partner, previous physical assault by partner, and psychological aggression towards partner were respectively held constant, depressed couples reported more demand-withdraw power processes and less constructive communication than other couples.

The results of ANOVAs on discrepancy scores indicated that in depressed couples, there was a bigger discrepancy between male and female partners’ scores on dissatisfaction with control of surplus spending money (relative to PDA couples), commitment to relationship (relative to both control and PDA couples), desired level of intimacy (relative to control couples), physical assault by partner (relative to PDA couples), psychological aggression towards partner (relative to control couples), and dissatisfaction with child-care task distribution (relative to control couples).

Controlling for the effects of relationship satisfaction on discrepancy scores, depressed couples differed from control couples only on desired control of surplus spending money and commitment to relationship, while PDA couples differed from control couples on dissatisfaction with control of surplus spending money. Additionally, both depressed and PDA couples differed from control couples on total demand – withdraw behaviour when the effect of relationship satisfaction was taken into account.

From correlations between male partners’ and female partners’ scores on each variable, it was evident that members of control couples reported similar levels of relationship satisfaction and commitment; desired level of intimacy; psychological aggression towards partner; male demand – female withdraw behaviour; female demand – male withdraw behaviour; mutual constructive communication; and dissatisfaction with both decision-
making and child-care task distribution. There was only disagreement on one variable (i.e., who did more of the decision-making) in these control couples.

Members of PDA couples reported similar levels of relationship satisfaction and commitment; dissatisfaction with control of surplus spending money; physical assault by partner; previous physical assault by partner; and psychological aggression towards partner. The members of these couples also reported significant disagreement as to who was the dominant partner; who controlled surplus spending money; and who did more household tasks and decision-making. In contrast, members of depressed couples reported agreement on only one variable (i.e., dissatisfaction with household task distribution) and disagreement as to whom was the dominant partner; who controlled the surplus spending money; and who did more household tasks.

Significant positive correlations indicate that both partners have similar perceptions (or views) of how their relationship functions or ‘consensually valid perceptions’ of it (Knudson et al., 1980). In contrast, significant negative correlations may indicate a different type of relational rigidity whereby one partner may deny the other partner’s perception of the relationship variable. Control, PDA, and depressed couples were characterised by significant positive correlations on 11, 6, and 1 variable respectively, while these couples were respectively characterised by 1, 4, and 3 significant negative correlations. Hence, these data would suggest that members of control couples had the most accurate relational maps while members of depressed couples had the least accurate relational maps.

**Qualitative data**

Thirty-five per cent of PDA women were taking antidepressant medication at the time of this study and 10% reported that they were unhappy to some degree in their relationship. Only 15% of their relationships were categorised as male-dominant, although partners had highly discrepant views on this variable. Only 45% of these women were working (outside the home) and of the 25% who were dissatisfied with the control of finances, 20% were dissatisfied with having too much control. While 95% of them reported that they would do their fair share of work (or more) to keep their relationship alive, only 5% of their relationships were categorised as traditional. Fifty to fifty-five per cent of these women were categorised as wanting more intimacy, with some women wanting both more intimacy and more independence.
Only 5% of the PDA women reported a recent history of physical assault (by partner) severe enough to be classified as domestically violent (DV) while the male partners of 4 PDA women reported non-DV levels of physical assault (by their female partners). Forty-five per cent of these women reported expressing a high degree of psychological aggression and prominent sources of anger were their partners’ (apparent) inability to understand their presentation and not having as ‘fulfilling relationship’ with their partners as they would have liked. Ten per cent of these women also reported that verbal aggression from their partner was a problem in their relationships.

PDA women’s relationships were characterised by a non-significant amount of bi-directional demand – withdraw behaviour, with 30% of these women reporting male demand – female withdraw behaviour and 55% reporting female demand – male withdraw behaviour. These interactions were influenced by which partner wanted relationship issues addressed. Sixty-five per cent of these women reported regular episodes of mutual constructive communication.

While PDA women reported equivalent levels of dissatisfaction with household task distribution to that of treatment-seeking depressed women, only 40% of them reported this to be a problem area in their relationships. With regard to family decision-making distribution, PDA women reported similar levels of dissatisfaction with this domain as control women and only 25% of them reported this domain to be an ongoing source of dissatisfaction within their relationship. Male partners across all 3 groups of women indicated that their partners were significantly more involved in child-care. This may indicate that they saw themselves as relatively uninvolved in this domain. PDA women reported (slightly higher but) similar levels of dissatisfaction in this domain than control couples with only 30% of these women reporting this domain to be an ongoing source of dissatisfaction within their relationship.

Qualitative analysis also revealed that the PDA in this study were characterised by a sensitivity to loss; generalised control beliefs; ever increasing and excessive levels of stress; sociotropic and autonomous tendencies; and an inadequate amount of sources of support and a reluctance to avail of such sources.
Eighty-five per cent of the 20 depressed women were taking antidepressant medication at the time of this study. Seventy per cent of these women were unhappy to some degree in their relationship. While 40% of these women reported that they were more dominant in their relationship, 25% reported that they were equally as dominant and some of them reported that they wanted their partners to take a more dominant role in their relationship. Only 35% of these women were working (outside the home) and of the 40% who were dissatisfied with the control of finances, 25% were dissatisfied with having too much control.

While 75% of these depressed women reported that they would do their fair share of work (or more) to keep their relationship alive, 40% reported feeling trapped in their relationship but had not separated due to a variety of reasons. None of their relationships were categorised as traditional. Seventy to seventy-five per cent of these women were categorised as wanting more intimacy, with some women again wanting both more intimacy and more independence.

Forty per cent of the depressed women reported a recent history of physical assault (by their partners) severe enough to be classified as domestically-violent (DV) while the male partners of 3 and 5 of these 8 women respectively reported DV and non-DV levels of physical assault (by their female partners). Based upon male reports, 1 other depressed couple could be classified as DV. Sixty-five per cent of these women reported expressing a high degree of psychological aggression and prominent sources of anger included their partners’ (apparent) inability to understand their presentation and not having a ‘fulfilling relationship’ with their partners. The build-up of their anger and subsequent expression of it contributed to a coercive cycle of interaction. Contributing to their anger may have been verbal aggression (from their partners). Fifty per cent of these depressed women highlighted this as a significant problem area in their relationships as the aggression was often highly personal and deprecating.

Quantitative data indicated that these women’s relationships were characterised by significant amounts of bi-directional demand – withdraw behaviour, with 35% of these women reporting male demand – female withdraw behaviour and 65% of them reporting female demand – male withdraw behaviour. These interactions were influenced by which
partner wanted relationship issues addressed. Only 25% of depressed women reported regular episodes of mutual constructive communication.

While quantitative data indicated that depressed women reported similar levels of partner does more household tasks and dissatisfaction in this domain to that of control and PDA women, qualitative data revealed that 55% of these depressed women reported this domain to be an ongoing source of dissatisfaction within their relationship. In contrast, while depressed women reported similar levels of partner does more decision-making to that of control and PDA women, their level of dissatisfaction in this domain was significantly higher than that of other women. This was reflected in qualitative data that indicated that 50% of depressed women reported this to be an ongoing source of dissatisfaction within their relationship.

With respect to child-care task distribution, male partners of depressed women perceived their partners to be significantly more involved in child-care task. While depressed women reported similar (i.e., low) levels of partner more involved in child-care to that of control and PDA women, they reported significantly higher dissatisfaction in this domain. Indeed, 55% of the depressed women reported this to be an ongoing source of dissatisfaction within their relationship.

Qualitative data also revealed that these depressed women were also characterised by a sensitivity to loss; generalised control beliefs; ever increasing and excessive levels of stress; sociotropic and autonomous tendencies; limited sources of self-esteem; and an inadequate amount of sources of support and a reluctance to avail of such sources.
Table 25  Summary of characteristics of members of couples containing control, PDA, and depressed women

<table>
<thead>
<tr>
<th>Variable</th>
<th>Significant after Controlling for relationship satisfaction</th>
<th>Control Male (N=20)</th>
<th>Control Female (N=20)</th>
<th>PDA Male (N=20)</th>
<th>PDA Female (N=20)</th>
<th>Depressed Male (N=20)</th>
<th>Depressed Female (N=20)</th>
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Note: + : This is perceived as a significant problem area. - : This is not perceived as a significant problem area.
0 : This is perceived as a mildly problematic area. * : After controlling for differences in relationship satisfaction, members of control, PDA, and depressed couples differed on variables marked with an asterisk. Significant (p < .05) effects for diagnosis or the interaction between diagnosis and gender were obtained in ANCOVAs where relationship satisfaction was the covariate.
6.2 How findings relate to hypotheses and exploratory questions

Relationship satisfaction

Contrary to our hypothesis, only depressed women reported significant levels of relationship dissatisfaction ($F = 22.73, p < .01$). The male partners of these women reported similar levels of relationship satisfaction to that of members of PDA couples who themselves reported decreased but non-significant levels of relationship dissatisfaction. It followed that, relative to control and PDA couples, there was a significant discrepancy between the relationship satisfaction scores of depressed women and their partners ($F = 20.28, p < .01$) and this discrepancy was independent of the composite measure of couple relationship satisfaction ($F = 9.29, p < .01$).

The finding that partners of depressed women did not report significant relationship dissatisfaction contradicts previous research (e.g., Bauserman, Arias, & Craighead, 1995; Byrne & Carr, 2000; Sacco, Dumont, & Dow, 1993). Although it is possible that our sample of depressed women just happened to have partners who were satisfied (e.g., with the status quo), this finding was surprising given that many of the 20 depressed women detailed difficult relationship dynamics (e.g., poor constructive communication punctuated with episodes of sometimes explosive anger). Given that male and female partners may be equally effected by events within their relationships (Wethington, McLeod, & Kessler, 1987), the presence of such dynamics would have suggested that the male partners of the depressed women were also dissatisfied with their relationships.

Individual analyses of depressed women’s male partners’ relationship satisfaction scores indicated that 7 (or 35%) of them registered in the dissatisfied range. This figure may have been higher. The self-report measure of relationship satisfaction of 2 of the 4 male partners who attended for further assessment differed significantly from their verbal reports of how satisfied they were in their relationships. On the other hand, given that the magnitude of the association between relationship discord and depression is typically comparable for male and female partners (e.g., Phelan et al., 1991), that male partners reported that they were not depressed might be an indication that they, or some of them, were satisfied in their relationships.
In summary, it might be that, as suggested by quantitative data, male partners were neither dissatisfied in their relationships nor depressed. In contrast, they may have been both dissatisfied and depressed and were either unaware of this or purposefully did not disclose this. Alternatively, it might have been the case that some of them were satisfied while others were dissatisfied. Hence, the relationship satisfaction scores of the depressed women’s male partners need to be interpreted cautiously.

**Dominance**

Contrary to our hypothesis, but supportive of the findings of Byrne and Carr (2000), depressed women did not perceive their male partners as more dominant. Quantitative data indicated that depressed women saw themselves as slightly more dominant relative to the view that their partners held (e.g., means of 4.20 and 3.70 respectively) but this difference was not significant. However, these partners had significantly discrepant perceptions as to whom was more dominant ($r = -.46$). Qualitative data indicated 40% of the depressed women reported that they were more dominant in their relationships, 25% reported that they were as equally dominant as their partners, while 35% stated that their partners were more dominant. Hence, it appears that while some male partners of depressed women were controlling, a substantial number of these women perceived themselves to be more dominant in their relationships.

However, some depressed women resented having to be the dominant partner (or ‘leader’) in their relationship but felt they had to assume this role because their partners would ‘not take care of things’. Supporting this argument, from Table 16 (Appendix D) it can be seen that dominance correlated highest with control of surplus spending money ($r = -.42$). This finding would indicate that dominance was associated with exercising less control of the surplus spending money for the couples in our sample. It may be that this activity was considered to be an unwanted responsibility that accompanied a (disempowering) over-functioning role. On the other hand, the only other 2 variables that dominance correlated significantly with (at the $p < .01$ level) were partner did more decision-making ($r = -.41$) and physical assault by partner ($r = -.26$). Therefore, it may be more accurate to conclude that those partners who made more family decisions or who engaged in physical assault were perceived to be the dominant partner in their relationships.
The above findings would suggest that the presence of depression was associated with approximate egalitarianism and not with a ‘one-down’ position for the index partner. As highlighted by Byrne and Carr (2000) however, another interpretation of these findings is possible. The male partners, although more powerful and able to exert control, may have chosen not to exercise their potential, whereas their depressed female partners, although less powerful, appeared dominant because their male partners failed to counteract these women’s control attempts (Szinovacz, 1987). This may have been particularly true of our sample of depressed couples who engaged in high levels of physical assault, psychological aggression, and demand behaviour. However, similar scores for these women’s male partners on these variables would suggest that these male partners did choose to exercise whatever potential they had.

**Power bases**

*Income*

As hypothesised, depressed women had lower levels of income than their partners or members of control couples ($F = 9.87, p < .05$). This finding was independent of the effects of relationship satisfaction ($F = 8.90, p < .05$). However, PDA women had a similar level of income to that of depressed women (i.e., means of 5.45 and 5.50 respectively) but less than that of control women (i.e., a mean of 4.80). Male partners’ income differed across control, PDA, and depressed couples (i.e., means of 3.10, 4.10, and 4.35 respectively). Contrary to our hypothesis, there was not a greater discrepancy between male partners’ and female partners’ reports on this variable in depressed couples relative to that of control and PDA couples.

Hence, quantitative data indicated that depressed (and PDA) couples had significantly less income than control couples and that depressed (and PDA) women had the least (independent) income. As highlighted by Byrne and Carr (2000), resource theorists would argue that such economic advantages alone afford male partners a greater portion of the relationship ‘power cake’, partly due to their having the potential to deprive their female partners economically (Walker, 1984).

Thirty-five percent of the depressed women (and 45% of the PDA women) reported that they enjoyed working in (predominantly) low-paid jobs. While it could be argued that depressed...
(and PDA) women were therefore in a position of structural weakness (relative to their partners), it is possible that their depression forced their reluctant male partners into an over-functioning role, whereby they had to become the primary breadwinner in the family. This may have led to resentment in male partners, particularly if their depressed female partners had been contributing financially before becoming depressed.

Economic dependency on partner

Contrary to our hypothesis, but supportive of the findings of Byrne and Carr (2000), quantitative data indicated that depressed women did not report greater economic dependence on their partners than did control and PDA women. These data also did not indicate a greater discrepancy between male and female partners’ reports on this variable in depressed couples relative to both control and PDA couples. For many depressed (and PDA) women, financial resources were pooled and managed jointly. However, on occasion, male partners reportedly unilaterally rescinded these power-sharing arrangements.

Likewise, some male partners deprived their depressed female partners of equal access to financial resources. This small subset of women received a weekly allocation (from their partners) to cover sundry expenses (e.g., food purchases, clothing and medical expenses, house repairs). In contrast, some depressed women controlled all monies and gave their male partners a cash allowance for items such as petrol for the family car and social activities (e.g., going out for a drink).

It can be seen from Table 16 (Appendix D) that economic dependency (across all couples) was most highly correlated with low income (or lower socio-economic status; r = .62). This finding suggested that the more a partner earned the less that partner felt economically dependent on his/her partner. As mentioned above, resource theory would suggest that this economic advantage alone afforded male partners a greater portion of the relationship ‘power cake’ (Walker, 1984). Additionally, given that economic dependency was also correlated highly with both partner more involved in child-care (r = -.58) and partner did more household tasks (r = -.47), there may have been a traditional gendered division of domestic labour with women occupying the ‘one-down’ position.

Such findings would suggest that relationships were traditional, within which partners’ relative power was primarily a function of the partners’ performance of instrumental tasks.
(Szinovacz, 1987). However, as highlighted by Byrne and Carr (2000), due to the institutionalised aspects of female partners’ financial dependence, their male partners may have felt a greater obligation to remain in their relationships and may have felt burdened with having to support their families (Howard et al., 1986). On the other hand, work may have provided a ‘ready escape’ (for the male partners of the depressed women) from having to ‘constantly look at a downward grimace’ and listen to ‘the pessimistic conversations’ of their partners (Berg-Cross & Cohen, 1995, p. 17). As such, working long hours may have been quite empowering for some male partners. It may have been even more empowering for some of them if they knew that withdrawing into work significantly bothered their depressed partners.

Control of surplus spending money
Contrary to our hypothesis, quantitative data indicated that depressed women did not report lower levels of control or higher levels of desired control of surplus spending money than their male partners or control or PDA female partners. A similar finding was found in Byrne and Carr (2000). There also was not a greater discrepancy between male partners’ and female partners’ reports on the latter variable in depressed couples relative to control or PDA couples. However, there was a greater discrepancy between male partners’ and female partners’ reports on dissatisfaction with control of surplus spending money in depressed couples relative to PDA couples at the $p < .06$ level (i.e., $F = 3.08$) and this finding was independent of the effects of couple relationship satisfaction ($F = 3.22$, $p < .05$).

Control of surplus spending money data have to be interpreted cautiously due to the significant (i.e., $p < .05$) negative correlations of partners’ scores in both depressed and PDA couples (i.e., $r = -.48$ and -.49 respectively). However, qualitative data indicated that 60% of the depressed women (and 75% of the PDA women) wanted no change in relation to the control of family finances. Of these depressed women, 45% (and 60% of PDA women) wanted to continue their shared responsibility arrangement with their partners, 10% wanted to maintain relatively greater control, while 5% (and 5% of PDA women) wanted their partner to maintain control in this domain.

Of the 40% of depressed women (and 25% of PDA women) who reported dissatisfaction in this domain, 25% (and 20% of PDA women) were dissatisfied with having too much control
and with their partners' not recognising their efforts to make ends meet, and all of them wanted shared responsibility (e.g., Komter, 1989). Hence, in a significant subset of depressed (and PDA) couples, it may have been the female partner who occupied the over-functioning role in relation to control of surplus spending money.

Qualitative data also revealed that whether a depressed woman had or had not shared control of finances, lack of finances increased their worries in relation to providing the basic necessities for their family, and limited their socialising options and other activities (e.g., shopping).

Commitment to relationship
Contrary to our hypothesis regarding relationship commitment, but supportive of the findings of Byrne and Carr (2000), quantitative data indicated that depressed women reported significantly lower levels of relationship commitment than their partners or members of control couples did (F = 3.88, p < .05). However, this finding was an artefact of the influence of relationship satisfaction. The discrepancy between male partners' and female partners' commitment was significantly larger in depressed couples relative to both control and PDA couples (F = 5.83, p < .01), and this finding was independent of the effects of relationship satisfaction (F = 3.46, p < .05). The significantly correlated commitment levels of partners in both control and PDA couples (r = .52 and .65 respectively) contrasted with that of depressed couples (r = -.13).

Qualitative data indicated that 95% of PDA women reported they would do their fair share of work (or more) to keep their relationship alive. This figure was slightly lower for depressed women (i.e., 75%), indicating a higher percentage of less committed depressed women (relative to PDA women). However, upon closer scrutiny of these data, at least 40% of the depressed women (and only 10% of the PDA women) did 'not see the point' of trying to resurrect their 'failing' and 'unrewarding' relationships having tried for many years to appeal to their 'disconnected' partners for a better relationship.

However, these women did not exercise the option of initiating a separation for a number of reasons including not having enough money to live independently, not wanting to displease parents (and/or in-laws), remaining fearful of partner 'retaliation', not wanting to break
(Roman Catholic) marriage vows, the belief that they were responsible for the poor state of their relationship, a fear of being alone (‘Who’ll take me then?’), and the belief that children need two parents. Hence, the (relatively low) commitment of a substantial number of depressed women might better be described as ‘feeling trapped’. Supporting this argument is the high correlation ($r = .60$) between commitment and relationship satisfaction (Table 16, Appendix D).

Hence, while the quantitative data may have suggested that depressed women were in a ‘one-up’ position (in being less committed to their relationships), the qualitative data indicated that a substantial number of depressed women felt very much disempowered in that they felt trapped in an unfulfilling relationship (e.g., O’Leary & Cano, 2001).

**Sex role ideology**

Contrary to our hypothesis regarding sex role ideology, but supportive of the findings of Byrne and Carr (2000), quantitative data indicated that depressed women did not report more traditional sex role attitudes than their partners or control or PDA female partners did (i.e., means of 14.10, 13.30, and 15.95 respectively). Additionally, there was not a larger discrepancy in sex role attitudes between members of depressed couples relative to members of control or PDA couples. However, qualitative data indicated that 50% of depressed women (and 30% of PDA women) would be classified as non-traditional, and 50% (and 65% of PDA women) would be classified as having a neutral (or egalitarian) sex role ideology.

Given that control women reported lower levels of traditionalism relative to previous studies (e.g., Mirowsky, 1985), it may be that modern women have, in general, become slightly more oriented towards a non-traditional sex role ideology since the inception of the Sex Role Attitudes Scale (Huber & Spitz, 1983). However, qualitative data also indicated that, while many women might have espoused a neutral sex role ideology, they (especially those that were depressed) had tendencies towards a traditional sex role ideology. This was partly due to the sociotropic orientation of many of these women.

As highlighted by Byrne and Carr (2000), depression in women is correlated with adopting the characteristics, attitudes, and behaviours associated with a traditional (or feminine) sex role (e.g. Elpem & Karp, 1984). However, there is also the possibility, as supported by the present findings, that if a ‘one-down’ woman with an egalitarian sex role ideology cannot
negotiate with her male partner an egalitarian balance of relationship power, lacking options to equalise the power balance, she may become symptomatic (Madanes, 1981).

**Desired level of intimacy**

The hypothesis that depressed wives would report higher levels of desired intimacy than their male partners or control or PDA female partners was not supported. This supports the findings of Byrne and Carr (2000). The hypothesis that there would be a greater discrepancy between male partners’ and female partners’ scores on this variable in depressed couples relative to control couples was supported ($F = 4.34, p < .05$). However, no such discrepancy was found relative to PDA couples, and the former finding was an artefact of the influence of couple relationship satisfaction. Additionally, desired intimacy level scores of members of control couples correlated significantly ($r = .62$), whereas those for both PDA and depressed couples did not ($r = .21$ and $.25$ respectively).

Inspection of cell means (Table 11, Appendix D) indicates that members of all couples wanted strikingly similar levels of intimacy as their partners did (i.e., more of it). This finding would suggest that spouses believed that intimacy had not already been attained, an attainment which many researchers believe to be relatively rare (Dupuy, 1993; Schaef, 1989; Wynne, 1988). Qualitative data also revealed that a higher proportion of depressed women (75%) wanted more intimacy in their relationships compared to PDA women (55%). These findings (relating to greater affiliative needs) are congruent with writings relating to PDA (e.g., Chambless et al., 1985a) and depressed women (e.g., Beach, 2001).

Thus, depressed women were not in a ‘one-down’ position in that they were seeking more intimacy. Rather, both partners of depressed couples wanted more of the same thing, suggesting egalitarianism in relation to this aspect of power. This contradicts much research (e.g., Christensen, 1987; Christensen & Shenk, 1991; Margolin, Talovic, & Weinstein, 1983) that has suggested that women want more intimacy in relationships, especially if they are distressed. However, with the exception of Byrne and Carr (2000), previous research did not consider desired levels of intimacy in depressed couples.

Many of the relationships of the 20 depressed women were characterised by the absence of a ‘generosity of spirit’ and caregiving behaviours (Rampage, 1994). Additionally, as is evident
from Table 16 (Appendix D; e.g., the significant correlations between desired levels of intimacy and demand – withdraw behaviour and constructive communication), these relationships were also characterised by patterns of poor communication, thus depriving these depressed couples of the means to develop intimacy (e.g., Van den Bourcke et al., 1995).

Some depressed (and PDA) women stated that they wanted a mixture of more intimacy and more independence. For example, while a depressed woman may have wanted more time with her partner (i.e., more intimacy), she may also have wanted more social time with her female friends (i.e., more independence). This indicates that rather than intimacy and independence being mutually exclusive properties (e.g. Christensen, 1987; Christensen & Heavey, 1990), it may be important to balance ‘connection’ and ‘separateness’ needs. Fulfilment of these needs may respectively enhance maintenance of one’s relational sense of self and one’s own sense of self (Dupuy, 1993).

In support of the above findings, Fruzzetti (1996) suggested that intimacy and independence covary except at very extreme levels. Periods of intimacy (e.g., being in the ‘one-down’ position) may be interspersed with periods of independence (e.g., being in the ‘one-up’ position) as needs or desires for intimacy change differentially in and between relationship partners. Thus, intimacy and independence may be dynamic rather than static properties (Prager, 1995). As highlighted by Byrne and Carr (2000), such a perception would concur with the psychoanalytic perspective of simultaneously needing intimacy and attaining an adequate degree of separateness (Birtchnell, 1986). Hence, the value of measuring intimacy and independence as if they were orthogonal constructs appears to be highly questionable.

Physical assault by partner
The hypotheses that depressed female partners would report higher levels of physical assault \( (F = 5.82, p < .01) \) and previous physical assault \( (F = 6.27, p < .05) \) from their partners relative to control or PDA female partners were both supported. Only the former finding was independent of the effects of relationship satisfaction \( (F = 3.76, p < .05) \). Likewise, the discrepancy between male partners’ and female partners’ scores on this variable was greater for depressed couples than that of control (but not PDA) couples \( (F = 4.70, p < .05) \), but this finding was an artefact of the influence of couple relationship satisfaction.
Significant correlations between partners’ scores were found for physical assault and previous physical assault (by partner) only in PDA couples ($r = .44$ and $.66$ respectively). Such correlations were not found in control couples because neither partner in these couples reported physical assault of any kind. As for the depressed couples, the non-significant correlations for physical assault ($r = .21$) and previous physical assault ($r = .26$) may reflect that men who engage in severe assaults may under-report their violence relative to their partners (e.g., Browning & Dutton, 1986). However, most studies have found a substantial correlation between the violence reported by both partners (e.g., Babcock et al., 1993). Hence, it may just be that partners in depressed couples engaged in physical assault to different degrees.

While it was evident from qualitative data that some depressed relationships were domestically violent (DV), it could be argued that others were not so, even though they satisfied the criteria for DV (e.g., Babcock et al., 1993; Berns et al., 1999). As highlighted by Sagrestano et al. (1999, p. 77), Johnson (1995) differentiated between ‘patriarchal terrorism’ or a systematic pattern of battering that some men use to control their partners, and ‘common couple violence’ which is a relatively less gendered pattern of conflict in which conflict occasionally escalates into the use of violence by male and/or female partners. There is strong qualitative evidence to indicate that some of the 40% of depressed couples that qualified to be categorised as DV, may have been more accurately characterised by relatively less serious and mutual ‘common couple violence’.

First, some of these depressed women reported that they would ‘give as good as’ they would ‘get’ and that their partners would sometimes not reciprocate their physical assault. This would be in keeping with research that suggests that physical assault by female partners is a major social problem (Straus, 1993). Second, quantitative data indicated an almost identical level of reported physical assault by both partners (Table 11, Appendix D), and third, this level was quite low (e.g., a mean of 1.85). Fourth, not all of the aforementioned depressed women perceived the degree of physical assault in their relationship to be problematic. While such women may have not disclosed their distress in relation to this dynamic, it may be that they considered a certain degree of physical assault (e.g., throwing items, pushing, shoving, grabbing) to be the norm in their relationship. They thus may have been quite happy to accept this status quo once the degree of physical assault did not escalate to more serious acts of physical assault (e.g., beating, kicking, punching). This highlights the need to
not only profile the degree of physical assault in a relationship but also to enquire about whether partners see it as a problem.

Alternatively, it may be that the very threat of physical assault in and of itself was enough to serve as a potent means of control, especially in those couples with a history of physical assault (e.g., Frieze & McHugh, 1992). Hence, it may be academic to classify some couples as DV based upon the number of (minor, moderate, or life-threatening) violent acts during the previous 12 months; the memory of a previous episode of physical assault might have been enough to feel controlled by one’s partner. This latter argument is supported by the significant correlation (r = .24) between previous physical assault by partner and psychological aggression towards partner (Table 12, Appendix D). A number of depressed women reported such memories and a fear that such episodes might be repeated. These women’s coping efforts were conditioned by the threat of violence. For example, they expended considerable energy in not angering their partners.

As mentioned previously, the (overall) correlation (Table 16, Appendix D) between dominance and physical assault (by partner) was significant (r = -.26). This supports the hypothesis that those male partners who engaged in physical assault may not have experienced themselves as more powerful or as having what they wanted (e.g., Stets, 1995). Thus, while some male partners may have relied on physical force as the ‘ultimate resource’, such a display of force may have been a manifestation of powerlessness in these partners.

On the other hand, a relatively small percentage of depressed female partners may have felt in the ‘one-down’ position in being the target of their partners’ physical assault. Having no option of escape from such relationships may have exacerbated such powerlessness and predisposed to becoming depressed (e.g., O’Leary & Cano, 2001). However, another subset of depressed women may have reciprocated physical assault so that their relationships were characterised by distressing although more palatable ‘common couple violence’.

**Psychological aggression (towards partner)**
The hypotheses that members of couples where the female was depressed would report higher levels of psychological aggression (towards partner) than members of control or PDA couples was not supported. However, the discrepancy between male partners’ and female partners’ scores on this variable was greater for depressed couples than that of control (but
not PDA) couples (F = 3.20, p < .05), even if this finding was an artefact of the influence of couple relationship satisfaction. Significant correlations between partners’ scores were found for this variable in both control (r = .72) and PDA couples (r = .58), but not in depressed couples.

Statistical analysis of the quantitative data indicated that control, PDA, and depressed women experienced similarly low levels (or quantities of) psychological aggression from their partners. However, in considering verbal aggression (which is the most common form of psychological aggression), the qualitative data indicated that a higher proportion of depressed women (relative to PDA women) considered verbal aggression to be a substantial problem in their relationships. These depressed women experienced more ‘cutting’ and personalised comments from their partners than did PDA women. Hence, it may not be the quantity of verbal aggression per se that is important but the degree of malice inherent in it.

Such ‘personalised’ and emotive comments are reminiscent of the concept of expressed emotion (EE). This consists of the 2 primary components of over-involvement and critical comments. Family members engage in the latter in their interactions with the identified ‘sick’ family member depending on their emotional reaction to the his/her psychological distress, their views regarding the legitimacy of the symptomatology surrounding that distress, and their expectations of his/her behaviour (Vaughn & Leff, 1981). While each of these factors create conditions that are associated with displays of hostility and aggression (Gavazzi et al., 2000), research (e.g., Hayhurst, Cooper, Paykel, Vearnals, & Ramana, 1997) now suggests that EE is not an antecedent of depression but a concomitant, with levels of EE declining as clients remit.

The qualitative data suggested that the above-mentioned factors were highly problematic areas for some depressed couples, and to a lesser extent, for some PDA couples. This manifested in many forms on the part of male partners (and family-of-origin members) including displays of anger, subtle pressure to ‘get on with it’ and to start taking control of one’s life (instead of ‘willingly remaining paralysed’; e.g., Coyne & Benazon, 2001). There was also pressure to be ‘normal’ or for these women to be their old selves (e.g., fulfil a care-taking role, do the majority of the household and child-care tasks, not to make mistakes, socialise in the ‘appropriate manner’).
Partners' resultant resentment or anger may have accounted for the reported cycle (in some couples) of periods of inhibited communication and tension punctuated by (non-contingent) emotionally laden arguments. This may partially explain why depressed women had a tendency to catastrophise negative relationship events. Additionally, their depression may have rendered recall of negative exchanges as more salient and consequential for their evaluation of their relationships (Bower, 1981).

Alternatively, while the empirical literature would suggest that women might be more adversely affected by overt expressions of hostility than men might be (e.g., Kiecolt-Glaser et al., 1996), the depressed (and PDA) women in this study may have internalised verbal abuse to different degrees. Contributing to this, the male partners of depressed women might have attributed their female partners' verbal aggression to their 'illness' and in the process made their female partners feel worse about themselves.

In contrast to depressed women, PDA women reported that they were 'reasonably able' to deal with (albeit less personal) verbal aggression, partly because they recognised that 'things are often said in the heat of the moment'. Such differences may have reflected how depressed women had become sensitised to psychological aggression over time such that they had a lower tolerance or threshold for such aggression. These observations are important considering that males' (verbal) hostile interactional behaviour may the primary longitudinal predictor of relationship satisfaction or outcomes for females (Roberts, 2000).

**Power processes**

*Male demand – female withdraw behaviour*

As hypothesised, couples containing a depressed female partner reported more male demand – female withdraw behaviour relative to control or PDA couples ($F = 10.73, p < .01$). However, this finding was an artefact of the influence of relationship satisfaction. The level of this behaviour in depressed couples was similar to that reported by distressed couples seeking marital therapy ($n = 15$; Christensen & Shenk, 1991). Only the partners of control couples had significant correlations on this variable ($r = .48$). Qualitative data indicated that 35% of depressed women (and 30% of PDA women) reported this interactional behaviour and that it was most prevalent when male partners wanted to address some relationship issue.
Qualitative data further indicated that of the various combinations of demand – withdraw behaviour reported, the interactional cycle of male demand – female withdraw – male withdraw – female demand was common. This cycle reportedly predisposed to increasingly poor conflict engagement or resolution, and poor ‘connection’ (or intimacy). The duration of the different phases of this cycle varied amongst the group of depressed women. For example, some depressed women would only withdraw (in response to male demandingness) for a matter of minutes while others would withdraw for a matter of weeks.

The motivations underlying such withdrawal in some depressed women included self-protection, a belief that it was pointless engaging in discussion, and a belief that their own demands were ‘over the top’, unjustified, or unreasonable. On the other hand, some depressed (and PDA) women wanted to punish their male partners (e.g., for their lack of empathic accuracy) by withdrawing from interactions with them. Some men reportedly would ‘explode’ after prolonged female withdrawal.

**Female demand – male withdraw behaviour**

As hypothesised, couples containing a depressed female partner reported more female demand – male withdraw behaviour relative to control or PDA couples ($F = 11.02, p < .01$). However, this finding was an artefact of the influence of relationship satisfaction. Again, the level of this behaviour in depressed couples was similar to that reported by distressed couples seeking marital therapy (Christensen & Shenk, 1991). Only the partners of control couples had significant correlations on this variable ($r = .55$). Qualitative data indicated that 65% of depressed women (and 55% of PDA women) reported this interactional behaviour and that it was most prevalent when female partners wanted to address some relationship issue.

Motivations for depressed female demandingness included getting their partners ‘to do things’, re-negotiation of domains within which there were existing undefendable inequalities that favoured their male partners (e.g., household task distribution), and wanting emotional connection with their partners. In relation to the latter, the brief periods of intense closeness (i.e., during conflict) may have reinforced such conflict (Fruzzetti, 1996).

Male withdrawal (from their depressed female partners) reportedly took many forms including angry withdrawal (e.g., stomping out of the room, partial or complete silence ‘for
as long as it took’ for the female partner to ‘back off’) and staying away from the family home. Other forms of this included verbal aggression, defensiveness, avoiding discussion, attempts to lead an independent social life, or legitimations. It might be that male withdrawal was also motivated by a desire to protect their vested interest in the status quo.

In contrast to the latter ‘one-up’ maintenance strategy, male withdrawal may just have been a manifestation of their (‘one-down’) frustration in dealing with an ‘under-functioning’ depressed partner with whom productive and logical negotiation seemed impossible. Additionally, these males, not wanting to show any dependency, may have expected their partners to read their feelings. Anger over such disappointed expectations may have predisposed to arguing over other superficial issues (Papp, 1988) and their subsequent withdrawal.

Total demand – withdraw behaviour
As hypothesised, couples containing a depressed female partner reported more total demand – withdraw behaviour relative to control or PDA couples (F = 13.59, p < .01). Although this finding was an artefact of relationship satisfaction, there was a significant gender X diagnosis effect even when the influence of relationship satisfaction was controlled for (F = 3.51, p < .05). Only the partners of control couples had significant correlations on this variable (r = .56).

In summary, our findings indicated that depressed women reported a similar level of male demand – female withdraw and female demand – male withdraw behaviour, and that their interactions were influenced by which partner wanted relationship issues addressed. Depressed women reported a higher level of these behaviours than control or PDA women did. As with the findings from other studies (e.g., Roberts, 2000), our findings do not support traditional gender stereotypes of the ‘nagging, hostile wife’ and the ‘uninvolved, withdrawn husband’. Additionally, qualitative data indicated that both female and male partners engaged in withdrawal behaviour, mostly in response to ‘hostile’ (or demanding) behaviour. The former behaviour took many forms including angry withdrawal (e.g., giving the ‘silent treatment’, stomping out of the room), conflict avoidance (e.g., failing to bring up a disagreement), and intimacy avoidance (Roberts, p. 696).
As supported by the high level of demand – withdraw behaviour in depressed couples, much of the lack of resolution surrounding conflict in these couples may have been generated by partners not respecting that it is impossible to ‘control anybody unless they let us’ and that ‘at best we can try to control ourselves but not others’ (L’Abate, 1984, p. 12). In dismissing attempts to unilaterally determine relational outcomes and processes, both partners may be ‘freed from the obligation of dictating to others and healed of the pains of blaming or being blamed by others’. Each partner ‘is responsible for what happens between them, but neither is exploitatively accountable to the other for neither can unilaterally dictate relational dynamics and outcomes. Lack of such recognition is part of the feeling of powerlessness (L’Abate) and uncontrollability (Watzlawick, Beavin, & Jackson, 1967) of symptomatic behaviours and dysfunctional relational patterns’ (Millar & Rogers, 1988, p. 95).

**Mutual constructive communication**

As hypothesised, couples containing a depressed female partner reported less mutual constructive communication relative to control or PDA couples and there was a significant difference on this variable between control and PDA couples (F = 15.56, p < .01). However, this finding was an artefact of the influence of relationship satisfaction. The discrepancy in male partners’ and female partners’ perceptions on this variable was significantly greater in depressed (and PDA) couples relative to control couples independent of the effects of couple relationship satisfaction (F = 3.05, p < .06). Additionally, only the members of control couples had significant correlations on this variable (r = .45).

Qualitative data indicated that only 25% of depressed women (but 65% of PDA women) reported regular episodes of constructive communication. A variety of factors contributed to this lack of constructive communication including how unresolved critical relationship issues (and associated unprocessed emotions in both partners) burdened these couples’ communication and the degree to which both partners engaged in demand – withdraw behaviour. Other contributory factors included a lack of time together, the absence of ‘relational efficacy’, an excessive focus on the symptomatology of the depressed partner, and either one or both partners discussing their concerns with significant others outside of their relationship.
Such a lack of constructive communication most probably predisposed to consensually *invalid* perceptions of relationships (e.g., inaccurate relationship expectations). This most likely further predisposed to increasing frustration and dissatisfaction (i.e., a communication deficit explanation of relationship discord; Christensen & Shenk, 1991), and an ever-increasing belief that relationship issues could not be worked out (e.g., development of a sense of relational *inefficacy*). The resultant lack of commitment to ‘working things out’ may have further contributed to this coercive cycle of a lack of resolution and unmet needs.

As highlighted by Byrne and Carr (2000), given that members of depressed couples desired similar levels of intimacy (i.e., slightly more than they currently had), these couples may have been more compatible than incompatible. These couples also reported egalitarian sex-role ideologies. One would expect such couples to be characterised by a certain degree of conflict in their attempts to structure their relationships to their liking (Kluwer et al., 1997). However, one would also expect such conflict to be complemented by a significant degree of constructive communication. The dynamic nature of intimacy (or independence) needs might also necessitate having a balance between conflict and constructive communication in egalitarian couples. However, such a balance seemed to be lacking in the depressed couples in this study.

While some depressed couples may merely have wanted to improve the quality of their relationships, it may be that many were facing insurmountable incompatibilities. Some of these couples may have chosen ‘to nourish a destructive peace rather than to fight a constructive war’(De Dreu, 1997). In contrast, others may have believed that they needed to fight ‘tooth and nail’ to protect what little power they had, to possibly ‘win’ some more power (over their partners), or to regain ‘lost ground’ in the power stakes. The combination of high levels of ‘negative’ (e.g., physical assault, psychological aggression, demand – withdraw behaviour) and low levels of ‘positive’ behaviour (e.g., constructive communication) would partially support these latter arguments. Indeed, it was quite apparent in many couples that the issue of power had not been openly discussed and that this led to a (covert) power struggle on many different fronts (e.g., saying nothing about cleaning around the house).
Power outcomes

Partner does more household tasks
The hypotheses that depressed females would report a lower level of partner does more household tasks, and that there would be a greater discrepancy between male partners’ and female partners’ reports on this variable in depressed couples relative to control and PDA couples were not supported. Partners’ correlations on this variable were highly discrepant in PDA and depressed couples (both $r = -.62$).

Partner makes more family decisions
The hypotheses that depressed females would report a higher level of partner makes more family decisions, and that there would be a greater discrepancy between male partners’ and female partners’ reports on this variable in depressed couples relative to control and PDA couples were not supported. Partners’ correlations on this variable were highly discrepant in control ($r = -.72$) and PDA couples ($r = -.57$).

Partner more involved in child-care
The hypotheses that depressed females would report a higher level of being more involved in child-care, and that there would be a greater discrepancy between male partners’ and female partners’ reports on this variable in depressed couples relative to control and PDA couples were not supported.

Dissatisfaction with household task distribution
Significant gender effects indicated that household task distribution was highly segregated by sex (Lennon & Rosenfield, 1994). However, the hypothesis that depressed couples would report more dissatisfaction with household task distribution was not supported. There was also no support for the hypothesis that there would be a greater discrepancy between male partners’ and female partners’ reports on this variable in depressed couples relative to control and PDA couples. Partners’ perceptions on this variable were highly correlated in depressed couples ($r = .47$). Qualitative data also revealed that 55% of depressed women (and 40% of PDA) women reported this domain to be an ongoing source of dissatisfaction within their relationship.
Dissatisfaction with decision-making distribution

The hypothesis that depressed couples would report less satisfaction with the distribution of family decision-making was supported (F = 5.00, p < .01). There was also a greater discrepancy between male partners' and female partners' reports on this variable in depressed couples relative to control and PDA couples (F = 3.06, p < .06). However, both of these findings were artefacts of the influence of relationship satisfaction.

Partners' perceptions on this variable were highly correlated in control couples (r = .64), a finding that does not support that male partners may overestimate their own power and female partners may underestimate their power in this domain (Olson & Rabunsky, 1972). As can be seen from Table 6, male scores on this variable were significantly elevated relative to other samples (e.g., Byrne & Carr, 2000; Whisman & Jacobson, 1989) indicating that they perceived themselves to be relatively uninvolved in this domain. However, their relatively low dissatisfaction scores indicated that this was not a source of dissatisfaction for them (Table 11, Appendix D). Hence, these findings may indicate that male partners were in a 'one-up' position in this domain.

Qualitative data revealed that 50% of depressed women (and 25% of PDA) women reported this domain to be an ongoing source of dissatisfaction within their relationship. Hence, although depressed female partners reported a similar level of decision-making relative to control and PDA women, they were more dissatisfied with this domain than these latter women. Although depressed women may have underestimated their share of such tasks in this domain (e.g., Komter, 1989), many of them may merely have wanted equal power regarding who made family decisions. Alternatively, rather than being dissatisfied with the overall balance of who made these decisions, some of them may have been dissatisfied with who made particular (high profile) decisions. For example, the 'God-given right' of some men in unilaterally deciding how they spent their Sundays was a significant source of annoyance and anger for some of the depressed women.

Dissatisfaction with child-care task distribution

The hypothesis that depressed couples would report less satisfaction with the distribution of child-care tasks was supported (F = 3.13, p < .05). There were also discrepancies between male partners' and female partners' reports on this variable in depressed couples relative to
control (but not PDA) couples ($F = 3.44, p < .05$). However, both of these findings were artefacts of the influence of relationship satisfaction. Partners’ perceptions on this variable were highly correlated in control couples ($r = .51$). Qualitative data revealed that 55% of depressed women (and 30% of PDA) women reported this domain to be an ongoing source of dissatisfaction in their relationships.

Hence, although depressed female partners reported doing a similar level of child-care tasks to control and PDA women, they more dissatisfied with this domain than these latter women. Many of the depressed women, while willing to accept doing more household tasks, may merely have wanted equal power in this domain. These findings may indicate that male partners were in a ‘one-up’ position in this domain.

**Further discussion of task distribution findings**

These findings suggest that although role differentiation was consistent across couples, the presence of depression in the female partner introduced a significant degree of dissatisfaction with regard to the distribution of family decision-making and child-care tasks. As highlighted by Byrne and Carr (2000), it may have been that depressed couples were immersed in a ‘power war’, one that was instigated by depression-enforced changes in the relationship power structure.

Hence, depressed partners who experienced low levels of power and who were seeking an egalitarian power structure may have performed family decision-making and child-care tasks in a begrudging manner. They may have tolerated (or even welcomed) their doing more than their equal share of the household tasks because this was a (controllable) source of self-esteem for them (as opposed to other relatively uncontrollable domains such as child-care) and a source of power in their relationships.

**6.3 Other sources of power (and lack of power) in depressed couples**

Given that most conceptualisations of power are ‘masculinised and static’ (Ball et al., 1995), it is not surprising that our qualitative analysis highlighted how depressed women had access to other power bases and processes both within and outside their relationships. However, some of these power sources also invariably were intermittently experienced as sources of stress.
Sexuality and physical attractiveness

As not all depressed women were open to discussing the details of their sexual relationship with their partners (e.g., Komter, 1989), qualitative data related to this domain had to be interpreted cautiously. Up to 50% of depressed women reported difficulties in their sexual relationship with their partners. Some ‘gave’ their male partners sex because they believed it was their duty. Those with a sociotropic orientation did so to increase their chances of being loved and to decrease their chances of being abandoned. Such thinking is a manifestation of a ‘one-down’ position.

A number of depressed women (and the male partners of some of these women) reported extra-marital affairs. While their adulterous behaviour may be representative of being in a ‘one-up’ position, the argument could also be made that they were in a ‘one-down’ position in that they had to seek sexual gratification outside of their relationships. This may have been particularly true of the depressed women, some of whom were ‘terrified’ that they would become pregnant again by their partners and become ‘even more trapped’ in their relationships. Such unexpected pregnancies actually precipitated episodes of depression in a small number of these women. Other depressed women believed that they were responsible for their partners’ adulterous behaviour as they had not ‘satisfied’ them sufficiently (i.e., sexually and interpersonally) and/or because they did not feel ‘up to’ socialising with them on a regular basis.

Sleeping in separate bedrooms was a regular feature of some of the depressed relationships. Some male partners insisted on such an arrangement, whereas some women purposefully slept apart to keep their partners (sexually) frustrated and dissatisfied (e.g., Foreman & Dallos, 1992). Other women simply did not want to have sex, particularly in the period after having a child, even though all other areas of their relationship were reportedly ‘working well’. There was also dissatisfaction with the quality of sex. For example, one depressed woman explicitly stated that she wanted her husband to regain control of initiating lovemaking.

Physical attractiveness is a power base that establishes an individual’s ease of movement into alternative relationships. Whether such alternatives are exercised is unimportant as this commodity still enters into the accounting system of the relationship. This capacity of attractiveness to signal the individual’s access to alternative relationships may help to make it
a source of power for it’s possessor and a marker of dependency for the partner (Kollock et al., 1994, p. 344). Those depressed women who disclosed having an extra-marital affair were strikingly physically attractive.

Education

Education is an investment that makes its possessor feel that he or she is generally entitled to greater rewards (Kollack et al., 1994). Some male partners of depressed women in this study occasionally highlighted how ‘stupid’ their less-educated female partners were (both in private and socially). Hence, this may well have served as a power base for male partners of some of the depressed women.

Strong religious faith

It is not surprising that a number of depressed women had strong religious beliefs given that the Irish are predominantly Roman Catholic and that it is ‘only with the aid of the sacred can we understand the incomprehensible, manage the unmanageable, and endure the unendurable’ (Pargament and Brant, 1998, p. 112). Indeed, an individual’s representation of God (e.g., as loving, protective, or responsive) can be a continuation of childhood attachment experiences or a compensation for them if they have gone awry (Sorenson, 1997). Hence, having a strong faith represented a considerable power base for 30% of the depressed women.

However, these women also experienced significant anxiety about the prospects of punishment or guilt about previous acts (Pargament & Brant, 1998). Some also believed that it was their duty to bear children and to stay in their ‘failed’ relationship. Their religious beliefs may also have accounted for their (sometimes non-contingent) punishment of their children (e.g., Carone & Barone, 2001). Additionally, hooked into the idea of helping others via self-sacrifice and self-denial (with the prospect that God would help them in return; Sloman et al., 1994), some of these women were highly sociotropic (Beck, 1983) in orientation. But, as highlighted elsewhere in this thesis, such an orientation inevitably predisposed to feeling down when the stress of ‘doing’ for others (and ‘being there’ for them) reached a critical overwhelming threshold.
Medication

Both depressed and PDA women reported that medication (typically antidepressants or benzodiazepines) empowered them in their daily functioning. It may be that this increased independence eased dependence on their partners and subsequently improved relational interactions.

The stress of a supportive social network and of a sociotropic orientation

It has long being recognised that connection to a supportive social network may compensate for the lack of closeness in one’s primary relationship (e.g., Fitzpatrick 1988) or may provide an avenue of support when something goes wrong in this relationship (e.g., Barnett & Gotlib, 1988). However, it can be difficult to cultivate such a network given the social skills deficits of depressed individuals (e.g., Segrin, 2000), the apparent intractability of their problems (Coyne et al., 1985), and that the ‘communication of distress’ function of depression (e.g., Klerman, 1974) does not mobilise social resources. On the contrary, others typically avoid depressed individuals over the long term. As the old saying goes, ‘Laugh, and the world laughs with you; weep, and you weep alone’ (Price, 1991, p. 333).

Despite their best efforts, the depressed women in this study were characterised by limited social networks. This may not be too surprising considering that women typically invest in a small number of close relationships and men may invest in a large sphere of social relationships (Baumeister & Sommer, 1997). However, up to 70% of these depressed women appeared to try to seek out and maintain a wide array of approving (or sociotropic) relationships. This possibly was a manifestation of their strivings to live out their vision of goodness (Jack, 1999). They may also have done this to compensate for a self-perception of being less socially skilful in interpersonal interactions (Beach & O’Leary, 1993b). When non-depressed they put great effort into cultivating relationships that were based predominantly on their (conditional) ‘giving’ to others.

However, an expectation inherent in their care giving role may have been that they ‘respond to the pain and needs of others, whether or not their own needs for support and validation’ were met (McGrath et al., 1990, p. 22). These women appeared to suffer from a ‘contagion of stress’ whereby they ‘took on’ other people’s worries which ‘literally’ ground down their ‘spirit’ (Bernard, 1972, p. 8). This process reportedly eventually precipitated episodes of
depression (and temporary suspension of their care-giving role). Hence, their efforts to cultivate a support network often came at a high price (i.e., recurrence of their depression).

Kinkeepers and parenting
As mentioned previously, it may be that the interpersonal base from which women derive power in families has escaped recognition (Ball et al., 1995). While men may hold more ‘horizontal’ (or conjugal) power (e.g., financial resources) in families, women may dominate the position of ‘kinkeeper’ in families (Rosenthal, 1985). Such ‘vertical’ power in determining the outcome of each new generation may be ‘unparalleled’ (Raphael, 1975). As children get older, maternal coalitions with them may weaken the fathers’ control potential and increase the mothers’ power (Szinovacz, 1987). Some depressed women in this study reported deriving great esteem (and power) from their kinkeeper role.

However, for others this role was a poisoned chalice as when they could not parent up to their ‘high standards’ they became consumed with guilt. Their subsequent withdrawal from parenting only reinforced their perception that they were ‘bad’ mothers who needed to parent better ‘the next time’. However, this was made even more difficult by both their partners and their children gradually coming to learn that ‘daddy was boss’ so that they were more inclined to ignore or belittle the parenting efforts of these women. This process often resulted in polarised parenting strategies.

Complicating this dynamic was the sometimes over-investment of depressed mothers in trying to ensure good behaviour in their children. This was a welcome compensation for some depressed women who had little power in other domains. These women often effectively excluded their partners from the parenting process. For other women, overly-equating their self-worth with their children’s (good) behaviour was disempowering in that their children could assume a ‘one-up’ position simply by misbehaving. In the process, their male partners also assumed a ‘one-up’ position but they often resented being burdened with too much parenting. Hence, such dynamics reportedly put substantial strain on these relationships. Indeed, 35% of depressed women reported that disagreement regarding parenting strategies was a major source of conflict in their relationships.
Lack of multiple roles and self-restriction

Not overlooking the stresses involved in engaging in multiple roles (e.g., the dual role hypothesis; Coyne et al., 1985), such roles can compensate for one another in times of difficulty (Ritter, 1993). Hence, the more complex one’s self-definition is (e.g., by having multiple roles), the more independent sources of gratification there may be, and the less vulnerable one may be to feeling down if one of these roles is non-rewarding (Niedenthal, Setterlund, & Wherry, 1992). It appeared that many of the depressed women in this study had a limited number of independent roles. Those that were full-time homemakers often relied on their partners and children as their primary sources of gratification, while those who were satisfactorily employed had the advantage of having a source of self-esteem independent of the latter. However, of those that did have multiple roles, these roles were often mutually exclusive and these women’s adequate functioning in these roles was often contingent on the ‘goodwill’ of others.

For example, many depressed (and PDA) women were invested in an ideal of family (-of-origin) unity and took it upon themselves to bring about ‘harmony’ in their family. However, such a role often clashed with their duties to their family-of-creation. This resulted in an ongoing and highly stressful ‘battle of loyalties’. Some were still ‘tied to the apron strings’ of their family-of-origin and continued to seek parental and sibling approval by ‘being there’ for their family members. The burden of helping older parents was particularly stressful for some women (e.g., Brody, 1981). However, their partners (and sometimes their own children) often made similar but conflicting demands of their (limited) resources and helpful behaviour. Some of these male partners went so far as to actively limit the contact of their depressed partners with their families-of-origin (e.g., not making the family car available to travel to one’s family-of-origin).

Most depressed women in this study were characterised by a lack of assertiveness, limited goal-setting skills, and fears about taking risks. They might have feared the negative consequences of their own success, possibly because they perceived their (potential) success as mutually exclusive to their sociotropic orientation (Kaplan, 1991). Such dysfunctional assumptions may have predisposed to self-restriction and kept these women in a position of powerlessness (O’Neil & Egan, 1993). Additionally, some of these women may have been expressing loyalty invisibly (Boszormenyi-Nagy & Krasner, 1986) by not succeeding too far.
beyond the success of their family by covertly remaining bound to their family or by adopting similarly negative ways of thinking (Perlmutter, 1996, p. 59).

**Autonomic orientation**

Up to 85% of depressed women equated their self-worth with the product (or quality) of their efforts. This autonomous- or task-orientation (or 'I am what I do' dysfunctional assumption) was often esteem-enhancing (Beck, 1983). However, it was also quite maladaptive in that it predisposed to feeling under intense pressure to 'produce the goods', and when this did not happen, to feeling 'like a failure'. Their 'doing' was also often in the service of others. Hence, when they became depressed, these women not only found it difficult to produce; they also felt like they were failing others. To counteract the former, one depressed woman stated that she would 'dilute the possibility of failure by taking up lots of different projects'.

Having experienced depression once, some depressed women reportedly organised their lives to reduce (or minimise) the possibility of being unable to meet the demands of previously esteeming domains (e.g., work, parenting, friendships). However, in doing so, they forewent the satisfactions that these involvements previously brought (e.g., Coyne & Calarco, 1995). Such self-restriction may have served both as a predisposing and maintaining factor to depression in these women (Coyne & Benazon, 2001).

### 6.4 Power across the various domains in depressed couples

Euphemisms such as the 'power of powerless' have confused the issue of power dynamics in depressed couples. Such euphemisms, for example, equate the attempted influence of a back-seat driver with the actual power of controlling a steering wheel (Rampage, 1994). It has long been recognised that the particular power measure used will determine which power pattern is found to be most frequent in relationships (e.g., Gray-Little, 1982). In keeping with this tradition, the findings of this study showed that quantitative and qualitative data sometimes produce different answers to the question of 'Who rules the roost?' The latter also has highlighted the fluidity of power so much so that it may be more appropriate to ask 'Is it explicitly recognised who rules the roost in the various domains of a depressed relationship, are both partners satisfied with this status quo, and to what extent do contextual circumstances influence this status quo?' While ordinarily partners might struggle with finding a balance between needing power and wanting one's partner to be powerful, the findings from this study indicate that depression may intensify this struggle and result in a more complex 'power war'.
With the exception of income and physical assault by partner, depressed couples were similar to control and PDA couples with regard to power bases. This suggests that the power structure in relationships in which the female was depressed was similar to that of control women or of those with PDA. However, the 'feminisation of poverty' (Kaslow & Carter, 1991a) may have been sufficient in and of itself to shift the balance of power in relationships in favour of male partners, even if there was equality in relation to control of surplus spending money. However, many of the apparently 'one-down' depressed women perceived themselves as more dominant in their relationship (i.e., a 'one-up' position). But these women may not have welcomed the 'over-functioning role' of being 'the leader' (i.e., a 'one-down' position).

Significantly, dominance correlated negatively with physical assault by partner. Hence, in relying on physical force as the 'ultimate resource', male partners may have been in a 'one-up' position and their female partners in a 'one-down' position. However, 'patriarchal terrorism' may reflect patriarchal powerlessness (e.g., Sagrestano et al., 1999). Additionally, male partners reported that they experienced an equal amount of physical assault. Hence, these findings suggest that, although there were some couples characterised by battering, other couples engaged in 'common couple violence' (Johnson, 1995). Such violence may have reflected non-problematic levels of relationship conflict whereby both partners felt simultaneously powerful (in that they could express themselves in this manner) and powerless (in that they had to resort to this manner of expression).

Qualitative data also suggested that verbal aggression (from partner) was a major source of dissatisfaction for up to 50% of the depressed women in this study. This suggests that these women may have experienced a high level of 'critical' and personalised comments, the purpose of which was to partially invalidate their experience of depression and to accommodate them to a 'one-down' position. Alternatively, these women may merely have been more sensitive to such comments because they had a tendency to catastrophise negative relationship events. This is an important finding considering that males' (verbal) hostile interactional behaviour may be the primary longitudinal predictor of relationship satisfaction or outcomes for females (Roberts, 2000).

There were no quantitative differences found in power processes or outcomes between control, PDA, and depressed couples in this study that were independent of relationship
satisfaction. However, depressed couples with relationship dissatisfaction did show problematic demand—withdraw power processes. Also, qualitative data indicated that depressed couples may have been characterised by a competition for power (either to get to control or exit from control) in various domains (e.g., management of financial resources, task distribution, parenting, partners' attempts to lead independent social lives). These data also indicated that the means by which this 'power war' (Kahn, 1984) might have been played out included coercive cycles of demand—withdraw behaviour, and, as mentioned above, physical assault and verbal aggression. These means may have predisposed to (or were consequent of) poor conflict resolution, a lack of constructive communication, and increasing frustration.

In terms of power outcomes, depressed women's tendencies to self-restrict their sources of self-esteem (out of fear of not meeting the demands of these sources) did not appear to necessitate a restructuring of task distribution different to that of other couples. Rather, depressed women's dissatisfaction with task distribution may have indicated their 'one-down' position in these domains. However, dissatisfaction with this domain may just have been an artefact of relationship dissatisfaction.

Correlational data suggested that members of control couples had consensually valid perceptions of their relationships and that PDA couples had less consensually valid perceptions. These findings were in stark contrast to those of depressed couples where there was a conspicuous absence of such valid perceptions. On the contrary, in depressed couples there were significantly discrepant perceptions as to who was the dominant partner, who controlled surplus spending money, and who did more household tasks. Such discrepancies may have reflected a power struggle and/or a lack of clear communication between partners in these couples.

Qualitative data highlighted other variables (both intra- and interpersonal) pertinent to the question of who holds more power in depressed relationships. However, although most of these variables may have been somewhat empowering, they ultimately may have been disempowering. For example, while sociotropic and autonomic tendencies may have bolstered self-esteem and the feeling of being powerful, in essence such tendencies may have
both reflected and predisposed to feeling powerless (i.e., because of the burden of these tendencies).

Similarly, a strong religious faith may have empowered some depressed women with a secure attachment to ‘endure the unendurable’. However, it may also have disempowered them in predisposing to depression due to the doctrine of self-sacrifice (in the service of others) and guilt and (expected) punishment if one failed to do the latter. Parenting may have provided ‘unparalleled’ power but the burden of it may also have disempowered depressed women. Sexuality in relationships may also have been a seldom-talked about power dynamic between partners.

The original question of this thesis was whether depression accommodates to the ‘one-down’ position (Price, 1991) or whether it provides an escape route from an ‘over-functioning’ and dissatisfying role (Madanes, 1981). While resource theorists would argue that the males in our depressed couples held the ‘one-up’ position due to their greater income levels, the equality in control of surplus spending money and the financial management arrangements of many couples may have made this latter finding superfluous.

While some male batterers may have overtly held the ‘one-up’ position, they themselves may have felt that their female partners were insufficiently controlled. However, the depression of their partners may have not shielded against physical assault indicating that it may have accommodated these women to the ‘one-down’ position in the relationship. Other couples may merely have been engaged in an egalitarian ‘power war’ as indicated by their ‘common couple violence’.

The qualitative data suggested that as with all relationship dynamics (Birnchnell, 1986), power in depressed couples was ‘fluid’ in nature (rather than a static property). This was most evident in the reported cycles of interaction that seemingly were self-perpetuating. Some depressed couples were characterised by a cycle of a build-up of resentment, an (eventual) eruption of anger, feelings of self-blame and guilt (over failing to be a ‘good’ partner and/or mother), and a redoubling of efforts to please others (with a resultant build-up of resentment again). This manifested as demand – withdraw behaviour, verbal aggression, and/or common couple violence, while a subset of these relationships was characterised by battering.
It is difficult to ascertain if such cycles support Price’s (1991) hypothesis that depression accommodates to a ‘one-down’ position or whether it brings egalitarianism to an imbalanced power system (Madanes, 1981). Ordinarily, one would expect a well-functioning relationship to have an adequate degree of equilibrium brought about by a healthy balance between rigidity (or structure or ‘relationship rules’) and flexibility. While life events might result in a temporary state of disequilibrium, such relationships typically revert back to a mutually satisfying homeostasis.

The self-perpetuating cycles in depressed couples may have reflected depressed women’s efforts to maintain their egalitarianism (or their dominance) and how their depression brought about a state of equilibrium in their otherwise partially chaotic relationships. Their male partners may have had no other option to respond in the way they did to maintain some level of egalitarianism. Alternatively, the motivation of some of the male partners’ behaviour may have been to maintain their ‘one-upness’.

6.5 How this research built upon that of Byrne and Carr (2000)

*Larger number of participants*

Byrne and Carr (2000) compared the power dynamics in 14 depressed couples with 14 control (or non-psychiatric) couples. Such a low number of participants may have inhibited against finding subtle power differences in power domains between couples with and without a depressed female partner. In an effort to increase the statistical power of the data in this study, there were 20 couples in each cell in this study.

*Inclusion of a second control group*

As there was only one control group in Byrne and Carr (2000), it was unclear if their findings were specific to couples where the female partner is depressed. Hence, this study included a second control group (i.e., women with PDA) to ascertain if the findings with depressed couples were (or were not) generalisable to couples where one partner had a psychiatric presentation other than a mood presentation.

*Qualitative analysis of clinical interviews*

Byrne and Carr (2000) used self-report questionnaires as the sole means of data collection. As highlighted below in the methodological limitations section of this study, such
questionnaires have many limitations. Hence, this study used semi-structured clinical interviews. These were valuable as such interviews often highlighted discrepancies between the participants’ paper-and-pencil (i.e., self-report questionnaire) and verbal (i.e., clinical interview) reports of relationship dynamics. They were also valuable in that incomplete questionnaires were completed in-session and any queries that participants had (about the questionnaires) were clarified. Doing so substantially decreased the problem of missing data items.

As therapy progressed and as the strength of the therapeutic relationship increased, for many depressed and PDA women the clinical data from their treatment sessions gave a greater insight into the dynamic nature of power in their relationships. The clinical data became ‘richer’ and allowed for greater scope in assessing cycles of interaction between partners and issues that participants were reluctant to discuss when they initially attended. For those few depressed couples where male partners also attended, the qualitative data relating to ‘his’ relationship (Bernard, 1972) was insightful.

6.6 Methodological limitations of this study

Due to its many methodological shortcomings (as detailed below), the results of this study need to be interpreted cautiously.

Socially desirable responding

Given that the Cronbach’s alpha (Cronbach, 1951) for the Marlowe-Crowne Social Desirability Scale (Reynolds, 1982) was only .55 in this study’s sample of couples, it may be that socially desirable responding compromised participants’ data somewhat.

Experimenter bias

A serious methodological limitation was that the experimenter was the sole data collector and sole clinician providing treatment to both the PDA and the depressed women. The emotional investment and enthusiasm in achieving certain findings may have predisposed to selective sampling, and biased clinical interviewing, interpretation and coding of answers, and description of participants (e.g., Arrindell & Emmelkamp, 1986a).
Biased sample of couples

The method of data collection predisposed to a biased sample of couples. There may have been a selection bias whereby only moderately well-adjusted couples and/or those in which the male partner was 'reasonable', may have agreed to participate in this research. Such a selection bias may have skewed our sample toward appearing less interpersonally dysfunctional than may actually have been the case (e.g., Carter et al., 1994). Supporting this hypothesis was the fact that only about 40% of all couples returned their questionnaires and the findings that control couples were characterised by a relative absence of physical assault and psychological aggression, and a level of demand – withdraw behaviour significantly less than that of non-distressed couples (Christensen & Shenk, 1991).

The possibility that depressed couples in this study included only the unique subset of depressed couples where the male partners are reasonably satisfied (and willing to co-operate with completing questionnaires) is unlikely given that at least 9 of these male partners registered in the dissatisfied range. Given that ‘couples are usually attracted by shared developmental failures’ (Skynner, 1976, p. 43), it is not surprising that over 50% of depressed women in clinical samples might have partners with a history of psychiatric disturbance (Spangenberg & Theron, 1999). Given that only 10% of our depressed women reported mental health difficulties in their partners (e.g., substance abuse) and that these partners did not report any psychopathology, it is likely that our depressed couples were moderately well-functioning relative to other depressed couples.

Some of the PDA women may also have been depressed. Approximately 25% of individuals with scores of 12 or 13 on the BDI may meet criteria for current major depressive disorder (Craighead, Craighead, DeRosa, & Allen, 1993). Given that the mean BDI score for PDA women in this study was approximately 12, it may be that a significant number of these women were also depressed. This would be in keeping with research that suggests that between 10% and 59% of PDA individuals have comorbid major depressive disorder (e.g., Fava et al., 2000). Although a DSM-IV major depressive disorder checklist was also used to categorise women as depressed, given that only approximately half of the individuals who have BDI scores of 19-20 meet the criteria for major depressive disorder (Craighead et al.), some of the depressed women in this study may not have been depressed (i.e., false positives).
The sample of depressed women in this study was also biased in that epidemiological studies have indicated that only approximately 20% of individuals with a recent or active (i.e., 6- or 12-month) disorder obtain help for their disorder (Kessler et al., 1994). Therefore, it is not known how much the results obtained from the treatment-seeking depressed women in this study would generalise to all depressed women. That is, it is unclear to what extent the findings of this study are artefacts of treatment-seeking in the depressed women versus the presence of depression per se (Whisman, 2001, p. 9).

As control couples were not recruited using nonrandom methods, the sample of control couples in this study might not be representative of the (normal) population of such couples (Whisman, 2001). The members of such couples may have had subclinical pathology (Westen & Morrison, 2001). Furthermore, as it was not assessed for, some of the control women (and some of the depressed women) may have had PDA and/or were taking benzodiazepines. It is also a possibility that the use of diagnostic categories predisposed to sub-threshold symptoms of depression and/or dysthymia in the control, PDA, or depressed (i.e., ‘double depression’) groups of women not being taken into consideration (McLean et al., 1998). Lastly, sampling may have been biased in that ‘established’ relationships (i.e., mean duration of 13- to 20-years) as opposed to ‘younger’ relationships were only considered.

Less than ideal statistical analysis of quantitative data
The statistical analysis of data did not include a power calculation. Therefore, cell sizes may have been too small to detect differences between cells (e.g., at the p < .05 level). Additionally, given that 2 sets of tests of statistical significance were conducted on 17 dependent variables, there was an inflated chance of Type 1 error in the statistical analysis of our quantitative data, i.e. obtaining significant results by chance. Hence, greater confidence could have been put into the results of this study if it included initial power calculations to determine appropriate cell sizes and subsequent use of more stringent statistical analysis (e.g., testing for differences only at the p < .01 level).

Paucity of qualitative data
The qualitative analysis of treatment-session data was quite unstructured in this research. Although there was an implicit focus on power dynamics (as informed by the results of the
quantitative analysis), it could be argued that this study’s ‘exploratory data analysis’ was akin to the severely frowned upon ‘fishing trip’ (Robson, 1993). Ideally, the qualitative analysis would have been more formalised, possibly following either a content analysis (Krippendorff, 1980) or a grounded theory strategy (Glaser &Strauss, 1967; Willig, 2001). The latter could have ideally been conducted by an independent researcher (i.e., one ‘blind’ to the purpose of the study) and have included either open-ended or focused questioning, scripts of treatment-session data, an agreed upon sampling strategy, and potentially the use of themes as the recording unit. While such a content analysis may have further explored the more common interpersonal dynamics unique to couples where the female is depressed, the use of a grounded theory strategy may have revealed other patterns of interaction that may have heretofore gone unrecognised.

Although the views of 4 partners of depressed women were obtained, this study’s qualitative analysis consisted predominantly of female partners’ perceptions of their relationships. Given that there may be 2 marriages (i.e., ‘his’ and ‘her’) in any given relationship, the qualitative data overly represented ‘her’ relationship and under represented ‘his’ relationship (Bernard, 1972).

Cross-sectional data
The cross-sectional nature of this study’s data only provided a snapshot of each partners’ perceptions of couple dynamics. Although the qualitative data provided some indicators as to causes and effects of different variables, longitudinal data would be needed to provide a more complete analysis of this issue. For example, from the predominantly unilateral qualitative data in this study, it is still unclear whether demand – withdraw behaviour was a cause, an effect, a setting event, a marker, or an artefact of domestic violence (Berns et al., 1999).

Use of self-report questionnaires
Although it appears unlikely that self-report relationship dissatisfaction is an artefact of the cognitive biases inherent in depression (Beach, Smith, & Fincham, 1994; Whisman, 2001), there are many shortcomings in using self-report questionnaires. As highlighted by Van den Broucke et al. (1995, p. 230), these include vulnerability to influences of social desirability, defensiveness, acquiescence, carelessness, and (because they are measuring couple properties) pseudomutuality (Metts, Sprecher, & Cupach, 1991).
Self-report questionnaires also cannot assess power behaviours that are largely outside of the consciousness of the respondents nor can they discover sequences of interaction different to the ones that the questionnaire author(s) knew and wrote into items (Christensen, 1988; Komter, 1989). Hence, they may not do justice to the underlying nature of relationship power. Some aspects of psychological experience are also difficult to tap in a questionnaire (Milden, 1987). Hence, partners may be poor reporters of their own behaviours.

However, within the context of clinical practice, the use of these self-report questionnaires may represent a pragmatic strategy in obtaining information about the partners’ perceptions of their relationship dynamics (Van den Broucke et al., 1995). Albeit subjective, these perceptions are not necessarily less important than the ‘real’ interactions (Duck & Montgomery, 1991). An alternative is the use of clinical observation, but this too has its shortcomings. For example, partners may avoid open discussion of conflict areas, and the clinical setting may never see ‘true’ conflict given that it is typically devoid of the events that usually precipitate such conflict and because such conflict is usually quite spontaneous (Christensen, 1987).

Albeit well-established, some of the self-report questionnaires used in this study also have shortcomings. For example, the Dyadic Adjustment Scale (DAS; Spanier, 1976) in using descriptive questions makes a number of assumptions about what makes a relationship a happy one. As highlighted by Byrne and Carr (2000), the DAS assumes a high frequency of quarrelling to be indicative of dysfunction. However, behaviours that are functional in ‘keeping the peace’ in the present may leave unresolved critical areas of conflict that might undermine the relationship over time (Gottman & Krokoff, 1989, p. 47). Additionally, although they appear willing and able to report specific relationship stresses, there is a general ‘marital conventionalisation’ bias whereby partners tend not to report themselves or their relationships as unhappy overall (Gray-Little & Burks, 1983; Fitzpatrick, 1988).

Certain self-report questionnaires were also lacking in that they only focused on a particular aspect of a dynamic. For example, the Communication Patterns Questionnaire – Short Form (CPQSF; Christensen, 1987, 1988; Christensen & Sullaway, 1984) focuses almost exclusively on withdrawal from conflict or withdrawal in the context of a ‘disagreement’. Furthermore, ‘it has not been established that respondents are capable of accurately estimating the probability of the joint frequency of their own and their partner’s
communicative behaviour. Yet this is what the CPQSF requires respondents to do. Additionally, the joint frequency of demand – withdraw behaviour is highly correlated with the base rate of each independent behaviour. That is, the perception of a high likelihood of female demanding behaviour alone may be sufficient to lead the respondent to estimate the likelihood of female demand – male withdraw as high’ (Roberts, 2000. p. 695).

In constructing this study’s self-report questionnaire, the authors wanted to minimise the possibility of response sets and demand characteristics. Hence, where possible, scale items were interspersed so that participants did not know which items were scored on each subscale, thus forcing them to think about each item more than would be the case if they were in groups of similar items (e.g., Dahlstrom, Brooks, & Peterson, 1990). An example of the latter was the interspersing of the Marlowe-Crowne Social Desirability Scale (Reynolds, 1982) items throughout the self-report questionnaire. However, due to concerns that respondents would only partially complete a 230- (i.e., 8-page) or 310-item (i.e., 11-page) questionnaire if subsequently ordered items were totally unrelated, many similar items were grouped together (i.e., many of the scales were left intact).

The latter predisposed to a response set in some respondents whereby they blindly marked all items in some scales with the same response (e.g., ‘never’). Item ordering also predisposed to some respondents becoming irritated. For example, having indicated that they had not experienced the first (and most socially acceptable) of the physical assault acts on the Revised Conflict Tactics Scale (Straus et al., 1996), some partners reported that they were more than a little irritated to be subsequently asked about 11 other physical assault acts. This may have predisposed to disengagement, and a negative response set and an underestimation of the degree of physical assault experienced.

The use of one-item scales may also have given skewed results. The 2 important variables of dominance and commitment were both assessed using one-item scales. The latter may have been better assessed using the 12-item Commitment Inventory (Stanley & Markman, 1992). However, using the latter inventory would have increased the length of the questionnaire and the probability that partners would not have completed the questionnaire. Lastly, the construction of new scales using an odd number of poles, instead of an even number, may have encouraged non-committal responses (Converse & Presser, 1986).
Reading level of respondents

As with Byrne and Carr (2000), this study did not make any allowances for the reading ability of respondents. At least 2 women in session admitted that they did not completely understand some of the questions on the questionnaire due to their poor reading skills. It is possible that some potential respondents may have decided against returning their questionnaires because they could not complete all the questionnaire items. Hence, the findings of this study may only pertain to that subset of individuals who have functional literacy skills.

Less than ideal matching of couples

Although great efforts were made to match control, PDA, and depressed couples, the relaxing of inclusion criteria to facilitate an increase in the number of respondents may have compromised this matching process. Indeed, as can be seen from Table 2 (Appendix D), members of PDA couples were significantly older than members of control couples (F = 6.15, p < .01), their relationships were longer in duration (F = 9.19, p < .01), their youngest child was older than that of other couples (F = 18.26, p < .01), and PDA women were younger than control women when they had their first child (F = 3.80, p < .05). This poor matching of couples may have predisposed to skewed results.

For example, many couples reported that having a young child was quite stressful. The PDA women may have had less parenting stress because their youngest child was not so young (i.e., approximately 8 years). At the time of assessment they were not having to deal with the (stressful) transition into parenthood, one which typically involves a re-negotiation of the balance of power in many couples (e.g., White, Booth, & Edwards, 1986) and one which may compound existing difficulties (Falicov, 1988). Rather, these older (and presumably more mature) PDA women in their relationships of longer duration may have had a more settled power structure relative to other couples. Alternatively, they may have developed social networks to compensate for less-than-adequate relationship satisfaction (Beach et al., 1994). However, as detailed earlier in this study, such networks were sometimes more stressful than supportive over the long term.

The older age profile of PDA couples may also have predisposed to greater differential earnings potential in these couples. Such a ‘one-up’ resource position for (middle-aged)
males may have resulted in their achieving a performance differential in many areas of their relationships (Baumeister, 1981). However, income for PDA (and depressed couples) was much less than that of control couples \( (F = 9.87, p < .05) \), and this finding was independent of the effects of relationship satisfaction. Additionally, the older PDA women may have had more opportunities to further establish their kinkeeper roles and any empowering coalitions they may have made with their children (Szinovacz, 1987).

The finding that control couples were of higher socio-economic status (relative to other couples) may alone have ensured skewed results from this study. These women may have been less prone to depression (e.g., Kahn et al., 2000; McGrath et al., 1990), may have had more freedom to choose motherhood and domestic responsibility (Komter, 1989), and may have had potentially more sources of gratification independent of their family lives (Ritter, 1993).

Although control, PDA, and depressed couples were matched for number of children (i.e., means of 2.38, 2.65, and 2.75 respectively), couples were not matched according to the ages of their children. As mentioned above, the greater involvement of mothers in child rearing may have translated the presence of very young children into more maternal power. However, such women may have resented their loss of personal freedom, as was reported by a number of women. The presence of teenage children and young adults may have both increased women’s coalitional power (with their children) but simultaneously presented them with the (sometimes) unsavoury dilemma (or prospect) of living alone with their (sometimes partially estranged) partners.

6.7 Areas for potential future research

In-depth qualitative assessment

Given that depression is a heterogeneous disorder that is often superimposed upon couples with a variety of relational histories and dynamics, summary statistics of relationship dynamics of a group of depressed couples may be misleading. Hence, possibly along with appropriate analysis of statistical data and naturalistic observation, there is a need for independent and rigorous qualitative assessment of the similarities and differences in relationship dynamics between depressed and control couples. While both partners’ views would ideally be represented, this may only be (at best) possible with treatment-attenders.
This may not be possible with the other (approximately) 80% of depressed individuals who do not attend for treatment. Such analysis may be best achieved using a semi-structured interview format, an example of which is the useful Power Equity Guide (Haddock, Zimmerman, & MacPhee, 2000).

*Physical assault and psychological aggression*

The findings of this study suggested that physical assault (by partner) and psychological aggression (from partner) might both play a role in the ‘power war’ in, or in the conflict resolution of, depressed couples. It would be important, in the couples where it is relevant, to qualitatively analyse if the former is a form of ‘patriarchal terrorism’ that is used as a coercive means to control depressed women and condition their coping efforts (Johnson, 1995). Alternatively, it may be that physical assault is (non-problematic) ‘common couple violence’ perpetrated by both partners. It would also be important to objectively quantify the amount of psychological aggression, the quality of it (i.e., how personal it is and the degree of intent inherent in it), and, most importantly, the degree to which it affects depressed women.

*More than just micro-level power sources / influences*

The findings of this study indicated that cycles of interaction involved a complex interplay between intrapersonal, inter-partner, and environmental factors (e.g., Teichman, 1997). While the quantitative portion of this study considered the former (or micro-interpersonal power dynamics), the qualitative analysis indicated that wider environmental influences were at play. These included each partners’ interpersonal interactions with their respective family-of-origin (e.g., parents, siblings), their own children, and with their social support network. Future research must recognise that many other domains apart from what goes on between partners influence couple dynamics. Where possible, it may also be beneficial to assess for macro-societal influences (O’Neil & Egan, 1993).

*Sexuality*

This study highlighted a number of domains that may represent significant sources of power for women in relationships, one of which might be sexuality. While it is a difficult domain to assess in depth, this domain may remain a bastion of power for women (Jacobson, 1989). As highlighted by Byrne and Carr (2000), most research articles concerning sexuality as a female power base have been either theoretical, a review of clinical case histories, or a
mixture of both of these (e.g., Foreman & Dallos, 1992; Hare-Mustin, 1991; Johnson, 1976). Hence, empirical research into whether women use sexual favours, symptoms, or withdrawal to covertly regulate the balance in relationship power is warranted.

**Sociotropic and autonomic orientations**

This study indicated that up to 70% and 85% of depressed treatment-attending women respectively had sociotropic and autonomic orientations. It might be that some subtypes of depression may be (reciprocally) linked to relationship stressors. For example, as highlighted by Beach et al. (1994), women with ‘endogenous’ depression may be more autonomous and less sociotropic than other women are. This may predispose to their being somewhat less vulnerable to relationship stressors and to their not attributing their depression to such stressors (e.g., Peselow, Robins, Sanfilipo, Block, & Fieve, 1992). Hence, future qualitative analysis needs to assess for these intrapersonal characteristics and how they may influence coping efforts with relationship (and other) stressors.

**Cognitions and expectations of relationships**

The above-mentioned autonomic and sociotropic orientations of many of the depressed women may have been manifestations of generalised control beliefs. They may have believed that they needed to structure their interpersonal world sufficiently to compensate for a felt lack of control by achieving and having others approve of them (e.g., Beck, 1983). It may be that such beliefs (or expectations) predisposed to inevitable failure to control certain domains (outside of their remit of control) and to subsequent depressogenic feelings of powerlessness.

Alternatively, control may have come in the form of expectations of ‘getting’ certain things from their relationships. For example, they may have expected an unrealistic degree of ‘empathic accuracy’ (Simpson et al. 2001) which predisposed to depressogenic feelings of rejection. Similarly, they may not have sufficiently appreciated that their partners may have had both ‘connection’ and ‘separateness’ needs (Jack, 1999), and that conflict is an inevitable part of relationships given that the goal of the latter is the reciprocal fulfilment of (sometimes conflicting) emotional gratifications. Hence, these women may have interpreted both their partners’ ‘pulling away’ and relationship conflict in a catastrophic (and disempowering) manner.
Depressed women's over-investment in their relationships may have interfered with individual self-care skills. They may have not appreciated that 'no relationship can fulfil every individual need and desire completely', and that they 'must be willing and able to supplement' their relationship with outside resources (e.g., outside friendships, activities; Cordova & Gee, 2001, p. 198). If these women's sole source of self-esteem was the adaptive functioning of their relationships (as opposed to having multiple sources of self-esteem and a complex self-definition), relationship difficulties most probably predisposed to 'one-down' depressogenic thoughts such as 'I'm worthless', 'I'm so difficult to get on with').

Additionally, their (and their male partners) not having appropriate expectations of sadness may have led to a pathologising of the slightest hint of it. However, trying to hard to be happy might have turned 'temporary' states of sadness into 'prolonged' states of depression (Weeks & L'Abate, 1982). Hence, qualitative research profiling the interaction between sociotropic, autonomic, self-care, relationship, and generalised control beliefs, and the degree of complexity of self-definitions in depressed women may be beneficial. However, such research may be difficult given that many cognitions (e.g., those relating to relationship functioning; Fincham, 1997) may be automatic and outside of conscious awareness.

Longitudinal research
It is well recognised that major depression is a heterogeneous concept (i.e., not all major depressive episodes are the same) and no model should assume that there is only one aetiological pathway to it (Joiner, Coyne, & Blalock, 1999). Although this study has made reference to the fact that depression and relationship discord often co-occur (see Whisman, 2001 for a discussion of this issue), this study threw little light on which comes first. The study's cross-sectional design in collecting quantitative data ensured that statistical analysis of this data would be purely correlational in nature, and no matter how robust such data was, they not speak of the issue of causation.

The qualitative data (including informal path analysis) alluded to which came first. However, these data were not detailed enough to support the hypothesis that depression was an adaptive response to an uncontrollable interpersonal environment (i.e., whether it accommodated to a 'one-down' position). These data did not highlight if relationship discord was possibly (unconsciously) manufactured to maintain a negative self-view (i.e.,
self-verification theory; Katz, 2001), the first step of which may have been assortative mating or trying to escape a difficult family-of-origin environment.

Hence, there is a need for multi-modal longitudinal research to investigate the relationship between depression and relationship discord. Such research could also investigate the influence of moderating variables on this relationship such as self-esteem (e.g., Culp & Beach, 1998), attachment style (e.g., Davila, 2001), race and ethnicity (e.g., Kaslow, Twomey, Brooks, Thompson, & Reynolds, 2001), and the behavioural cycles associated with conflict engagement (e.g., Coyne & Benazon, 2001).

In relation to the attachment styles, children with anxious avoidant relationships marked by caregiver insensitivity, rejection, and abuse may organise their behaviour around the expression of anger and hostility in the roles of either victimiser or victim (Sloman et al., 1994, p. 409). Is it possible that depressed women bring such tendencies into their adult relationships? In relation to behavioural cycles, some of the depressed women in this study detailed an increasing polarisation of partner roles over time (e.g., homemaker and parent versus provider), so much so that some partners lived separate ‘emotional’ lives. This may have been more likely with ‘matured’ (McLeod, 1994) or chronic depressive presentations. It may be that such interactions have a formative, triggering, or sustaining influence on the onset of depression, as well as being consequences of it (Coyne et al., 1985).

6.8 Implications for treatment of depression in women

The findings of this study highlight a number of important treatment considerations. First, the degree of depressive symptomatology and co-morbid presentations must be assessed. The latter is important given that treatment length doubles across therapeutic modalities in the presence of comorbid conditions (Westen & Morrison, 2001). As not all depressed individuals report substantial relationship discord, initial assessment must also explore whether the depressed individual is experiencing a significant degree of relationship dissatisfaction (if in a relationship). It is also important to elicit the individual’s views on why he/she is depressed and whether he/she can identify the temporal relationship between his/her depression and relationship discord.

If assessment indicates that relationship discord is a primary maintaining factor of depression, the findings of this study would indicate that it is important to facilitate a
couples’ understanding of their potentially coercive cycles of interaction. This will most likely include challenging dysfunctional expectations of how relationships ‘work’ or do not work. In their place, appropriate and healthy expectations such as the necessity for negotiation and conflict (De Dreu, 1997) and for communicating emotional needs (or grievances) to facilitate partners having empathic accuracy and ‘consensually valid’ perceptions of their relationship need to be discussed. That intimacy may fluctuate or ‘dance’ with independence (Lerner, 1989) and sadness with happiness might also be worthy of discussion. In doing so, partners may learn how expression of moderate levels of anger is often a manifestation of unmet needs, and, if relevant, how physical assault and psychological aggression are ultimately futile and damaging to long-term relationship functioning. Such challenging (or psycho-education) is typically highly empowering.

The findings of this study would suggest that assessment of sociotropic, autonomic, and generalised control beliefs is important, as is the profiling of the complexity of self-definition (e.g., sources of self-esteem) and of the priority ascribed to taking care of oneself so as not to suffer from ‘a contagion of stress’. Unfortunately, relationship dissatisfaction is often harder to change than depression (e.g., Trapp, Pace, & Stoltenberg, 1997) given that changes in 2 individuals rather than 1 are necessary. Hence, if both partners are not motivated to change, then aiming for improvement in relationship satisfaction may not be the best goal in treatment for depression.

Although there are various marital therapies used to treat depression (see Kung, 2000 for a review of these), the 2 most prominent treatment models are Traditional Behavioral Marital Therapy (TBMT) or its more recent derivative of Integrative Couple Therapy (ICT), and Emotionally Focused Couples Therapy (EFT). The efficacy of these treatments with both couple distress and depression is well documented (e.g., Byrne, Carr, & Clark, in press). Both ICT (Jacobson, Christensen, Prince, Cordova, & Eldridge, 2000) and EFT (Johnson, Hunsley, Greenberg, & Schindler, 1999) integrate some of the above-mentioned findings into their respective treatments. However, it appears that the integrated feminist / EFT practice model of Vatcher and Bogo (2001) is the treatment model that most explicitly addresses the potential ‘hierarchical incongruity’ (Madanes, 1981) in relationships.
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Appendices
Appendix A
Diagnostic criteria for major depressive disorder
and panic disorder with agoraphobia
**Diagnostic criteria for Major Depressive Disorder**

<table>
<thead>
<tr>
<th>DSM-IV Diagnostic Criteria for 296.32</th>
<th>ICD-10 Diagnostic Criteria for F33.1</th>
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<tbody>
<tr>
<td>Major Depressive Disorder, Recurrent, Moderate Without Psychotic Features</td>
<td>Recurrent Depressive Disorder, Current Episode Moderate</td>
</tr>
<tr>
<td><strong>A.</strong> Presence of two or more Major Depressive Episodes.</td>
<td><strong>Diagnostic guidelines</strong></td>
</tr>
<tr>
<td><strong>B.</strong> The Major Depressive Episodes are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.</td>
<td>(a) the criteria for recurrent depressive disorder should be fulfilled, and the current episode should fulfil the criteria for depressive episode, moderate severity; and</td>
</tr>
<tr>
<td><strong>C.</strong> There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode.</td>
<td>(b) at least two episodes should have lasted a minimum of two weeks and should have been separated by several months without significant mood disturbance</td>
</tr>
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**Criteria for Major Depressive Episode**

| **A.** Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. | **Moderate Depressive Episode** |
| (1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful); | The individual usually suffers from at least two of the three most typical symptoms noted for mild depressive episode (e.g., depressed mood, loss of interest and enjoyment, increased fatigability) plus at least three (and preferably four) of the following symptoms: |
| (2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others); | (a) reduced concentration and attention; |
| (3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or a decrease or increase in appetite nearly every day; | (b) reduced self-esteem and confidence; |
| (4) insomnia or hypersomnia nearly every day; | (c) ideas of guilt and unworthiness; |
| (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down); | (d) bleak and pessimistic views of the future; |
| (6) fatigue or loss of energy nearly every day; | (e) ideas or acts of self-harm or suicide; |
| (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick); | (f) disturbed sleep; |
| (8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others); | (g) diminished appetite. |

Several symptoms are likely to be present to a marked degree, but this is not essential if a particularly wide variety of symptoms is present overall. Minimum duration of the whole episode is about 2 weeks.

An individual with a moderately depressive episode will usually have considerable difficulty in continuing with social, work or domestic activities.

**Recurrent Depressive Disorder**

The disorder is characterised by repeated episodes of depression, without any history of independent episodes of mood elevation and overactivity that fulfil the criteria of mania. However, the category should still be considered as...
Criteria for Major Depressive Episode (continued)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet the criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterised by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Moderate severity
A major depressive episode is considered moderate if it’s symptoms or (resultant) functional impairment is between that of a ‘mild’ (e.g., 5 or 6 depressive symptoms and mild functional disability) and a ‘severe’ episode.

Recurrent Depressive Disorder (continued)

be used if there is evidence of brief episodes of mild mood elevation and overactivity that fulfil the criteria of hypomania immediately after a depressive episode (sometimes apparently precipitated by treatment of a depression).
### DSM-IV Diagnostic Criteria for 300.21 Panic Disorder with Agoraphobia

A. Both:
   (1) recurrent unexpected panic attacks
   (2) at least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:
   (a) persistent concern about having additional attacks
   (b) worry about the implications of the attack or it's implications (e.g., losing control, having a heart attack, “going crazy”)
   (c) a significant change in behaviour related to the attacks.

B. The presence of Agoraphobia.

C. The Panic Attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).

D. The Panic Attacks are not better accounted for by another mental disorder, such as Social Phobia (e.g., occurring on exposure to feared social situations), Specific Phobia (e.g., on exposure to a specific phobic situation), Obsessive-Compulsive Disorder (e.g., on exposure to dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., in response to stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., in response to being far away from home or close relatives).

### ICD-10 Diagnostic Criteria for F40.01 Agoraphobia with Panic Disorder

#### Diagnostic Criteria for Panic Disorder

The essential features are recurrent attacks of severe anxiety (panic) which are not restricted to any situation or set of circumstances, and which are therefore unpredictable. As in other anxiety disorders, the dominant symptoms vary from person to person, but sudden onset of palpitations, chest pain, choking sensations, dizziness, and feelings of unreality (depersonalisation or derealisation) are common. There is also, almost invariably, a secondary fear of dying, losing control, or going mad. Individual attacks usually last for minutes only, though sometimes longer; their frequency and the course of the disorder are both rather variable. An individual in a panic attack often experiences a crescendo of fear and autonomic symptoms which result in an exit, usually hurried, from wherever he or she may be. If this occurs in a specific situation, such as a bus or in a crowd, the patient may subsequently avoid that situation. Similarly, frequent and unpredictable panic attacks produce fear of being alone or going into public places. A panic attack is often followed by a persistent fear of having another attack.

For a definite diagnosis, several severe attacks of autonomic anxiety should have occurred within a period of about one month;
   (a) in circumstances where there is no objective danger;
   (b) without being confined to known or predictable situations; and
   (c) with comparative freedom from anxiety symptoms between attacks (although anticipatory anxiety is common).

#### Diagnostic Criteria for Agoraphobia

The term “agoraphobia” is now taken to include fears not only of crowds and the difficulty of immediate easy escape to a safe place (usually home). The term refers to an interrelated and often overlapping cluster of phobias embracing fears of leaving home: fear of entering shops, crowds, and public places, and public places, or of travelling alone in trains, buses, or planes. Although the severity of the anxiety and the extent of avoidance behaviour are variable, this is the most incapacitating of the phobic disorders and some sufferers become completely housebound; they are terrified by the thought of collapsing and being left helpless in public. The lack of an immediately available exit is one of the key features of many of these agoraphobic situations. Most sufferers are women and the onset is usually early in adult life.
<table>
<thead>
<tr>
<th>Diagnostic criteria for Agoraphobia</th>
<th>Diagnostic Criteria for Agoraphobia (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong> Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having an unexpected or situationally predisposed Panic Attack or panic-like symptoms. Agoraphobic fears typically involve characteristic clusters of situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and travelling in a bus, train, or automobile.</td>
<td>Depressive and obsessional symptoms and social phobias may also be present but do not dominate the clinical picture. In the absence of effective treatment, agoraphobia becomes chronic, though usually fluctuating.</td>
</tr>
<tr>
<td><strong>B.</strong> The situations are avoided (e.g., travel is restricted) or else are endured with marked distress or anxiety about having a Panic Attack or panic-like symptoms, or require the presence of a companion.</td>
<td>All of the following criteria should be fulfilled for a definite diagnosis:</td>
</tr>
<tr>
<td><strong>C.</strong> The anxiety or phobic avoidance is not better accounted for by another mental disorder, such as Social Phobia (e.g., avoidance limited to social situations because of fear of embarrassment), Specific Phobia (e.g., avoidance limited to a single situation like elevators), Obsessive-Compulsive Disorder (e.g., avoidance of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., avoidance of leaving home or relatives).</td>
<td>(a) the psychological or autonomic symptoms must be primarily manifestations of anxiety and not secondary to other symptoms, such as delusions or obsessional thoughts;</td>
</tr>
</tbody>
</table>

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Appendix B

Self-report questionnaires
8-page self-report questionnaire

**Instructions:** Please read all of the questions/statements and either circle the answer that applies to you or write your answer in the space provided.

**About you**

<table>
<thead>
<tr>
<th>Are you</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>How old are you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship situation</td>
<td>Married and living with partner</td>
<td>Not married and living with partner</td>
</tr>
<tr>
<td>How long have you had a relationship with your partner?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many years have you been living with your partner?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have any children?</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>I never hesitate to go out of my way to help someone in trouble.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have never intensely disliked anyone.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Financial situation**

| What is your occupation (If a farmer, what is the size of your farm)? | | |
| What is your income? | Have you been working? |
| To what degree were you economically dependent upon your partner? | Completely dependent | Very dependent | Somewhat dependent | Slightly dependent | Not dependent |
| Who decided how surplus spending money was used? | I did all of the time | I did most of the time | My partner and I did equally | My partner did most of the time | My partner did all of the time |
| Who would you liked to have deciding how surplus spending money was used? | Myself all of the time | Myself most of the time | My partner and I did equally | My partner most of the time | My partner all of the time |

**Thinking about your recent mood**

**In the past 2 weeks, have you:**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>...been feeling very down for most of the day?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>...had little interest in most activities and felt little pleasure in doing activities?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>...had an increase or a decrease in your appetite?</td>
<td>Decrease</td>
<td>Same as usual</td>
</tr>
<tr>
<td>...had an increase or decrease in your weight?</td>
<td>Decrease</td>
<td>Same as usual</td>
</tr>
<tr>
<td>...slept more than usual or had trouble sleeping?</td>
<td>Less than usual</td>
<td>Same as usual</td>
</tr>
<tr>
<td>...been more or less active than usual?</td>
<td>Less active</td>
<td>Same as usual</td>
</tr>
<tr>
<td>...had more or less energy than usual?</td>
<td>Less energy</td>
<td>Same as usual</td>
</tr>
<tr>
<td>...felt worthless?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>...felt guilty?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>...found it difficult to concentrate?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
Your general mood

Tick the statement in each group which best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, tick each one.

<table>
<thead>
<tr>
<th>Group</th>
<th>Statement</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood</td>
<td>I do not feel sad.</td>
<td>I feel sad.</td>
<td>I am sad all the time and I can't snap out of it.</td>
<td>I am so sad or unhappy that I can't stand it.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I don't have any thoughts of killing myself.</td>
<td>I have thoughts of killing myself, but I would not carry them out.</td>
<td>I would like to kill myself.</td>
<td>I would kill myself if I had the chance.</td>
<td></td>
</tr>
<tr>
<td>Future</td>
<td>I am not particularly discouraged about the future.</td>
<td>I feel discouraged about the future.</td>
<td>I feel I have nothing to look forward to.</td>
<td>I feel the future is hopeless and that things cannot improve.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I don't cry anymore than usual.</td>
<td>I cry more now than I used to.</td>
<td>I cry all the time now.</td>
<td>I used to be able to cry, but now I can't cry even though I want to.</td>
<td></td>
</tr>
<tr>
<td>Discouraged</td>
<td>I am no more irritated now than I ever am.</td>
<td>I get annoyed or irritated more easily than I used to.</td>
<td>I feel irritated all the time now.</td>
<td>I don't get irritated at all by the things that used to irritate me.</td>
<td></td>
</tr>
<tr>
<td>Satisfaction</td>
<td>I don't feel like a failure.</td>
<td>I feel I have failed more than the average person.</td>
<td>As I look back on my life, all I can see is a lot of failures.</td>
<td>I feel I am a complete failure as a person.</td>
<td></td>
</tr>
<tr>
<td>Guilty</td>
<td>I don't feel I am being punished.</td>
<td>I feel I may be punished.</td>
<td>I expect to be punished.</td>
<td>I feel I am being punished.</td>
<td></td>
</tr>
<tr>
<td>Disappointed</td>
<td>I don't feel I look any worse than I used to.</td>
<td>I am worried that I am looking old or unattractive.</td>
<td>I feel that there are permanent changes in my appearance that make me look unattractive.</td>
<td>I believe that I look ugly.</td>
<td></td>
</tr>
<tr>
<td>Weight</td>
<td>I haven't lost much weight, if any, lately.</td>
<td>I have lost more than 5 pounds.</td>
<td>I have lost more than 10 pounds.</td>
<td>I have lost more than 15 pounds.</td>
<td></td>
</tr>
<tr>
<td>Appetite</td>
<td>My appetite is no worse than usual.</td>
<td>My appetite is not as good as it used to be.</td>
<td>My appetite is much worse now.</td>
<td>I have no appetite at all anymore.</td>
<td></td>
</tr>
<tr>
<td>Tired</td>
<td>I don't get more tired than usual.</td>
<td>I get tired more easily than I used to.</td>
<td>I get tired from doing almost anything.</td>
<td>I am too tired to do anything.</td>
<td></td>
</tr>
</tbody>
</table>

Yes No
### More about your mood

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this your first time that your “nerves” have been at you very badly or that you been feeling very low?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How long have your “nerves” been at you or how long have you been feeling very low?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you think anything in particular has made you feel this way?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had repeated thoughts of death or of harming yourself?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Are you taking antidepressant tablets?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

### Satisfaction

Please answer the following questions as they relate to the past year.

<table>
<thead>
<tr>
<th>Question</th>
<th>All the time</th>
<th>Most of the time</th>
<th>More often than not</th>
<th>Occasionally</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often did you discuss or consider divorce, separation, or terminating your relationship?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often did you or your partner leave the house after a fight?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In general, how often did you think that things between you and your partner were going well?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you confide in your partner?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you ever regret that you were in a relationship with your partner?</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>How often did you and your partner quarrel?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often did you and your partner “get on each other’s nerves?”</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How happy were you in your relationship?</th>
<th>Extremely unhappy</th>
<th>Fairly unhappy</th>
<th>A little unhappy</th>
<th>Happy</th>
<th>Very happy</th>
<th>Extremely happy</th>
<th>Perfect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you kiss your partner?</td>
<td>Every day</td>
<td>Almost every day</td>
<td>Occasionally</td>
<td>Rarely</td>
<td>Never</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Which of the following statements best describes how you felt about the future of your relationship during the past year?

- I want desperately for my relationship to succeed, and **would go to almost any length to see that it does.**
- I want very much for my relationship to succeed, and **will do all I can to see that it does.**
- I want very much for my relationship to succeed, and **will do my fair share to see that it does.**
- It would be nice if my relationship succeeded, but **I can’t do much more than I am doing now to help it succeed.**
- It would be nice if it succeeded, but I **refuse to do any more than I am doing now to keep the relationship going.**
- My relationship can never succeed, and **there is no more that I can do to keep the relationship going.**

If there are relationship problems, how long ago did they begin?
**Who did what?**

Using the numbers on our 1 to 9 scale, show how you and your partner divided responsibilities during the past year and secondly, how you would like them to have been divided.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>I did it all</td>
<td>We did it equally</td>
<td>He/she did it all</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How it has been during the past year</th>
<th>How I would have liked it to be</th>
</tr>
</thead>
</table>

Planning and preparing meals
Cleaning up after meals
Repairs around the home
House cleaning
Taking out the garbage
Buying groceries, household needs
Paying bills
Laundry: washing, folding, ironing.
Writing letters/making calls to family and friends
Looking after the car
Providing income for our family
Caring for plants, garden, yard
Working outside the family

Deciding how we spend time at home
Deciding how we spend time out of the house
Deciding which friends and family to see and when
Deciding about vacations: when, where, how
Deciding about major expenses: house, etc.
Deciding about financial planning: insurance, loans, taxes, plans for savings
Deciding when and how much time both partners should work outside the family
Initiating lovemaking
Determining the frequency of lovemaking
Deciding about religious practices in our family
Deciding about involvement in community activities
Deciding how people should behave toward one another in our family

Deciding about meals for our child(ren)
Preparing meals for our child
Dressing our child
Cleaning or bathing our child
Deciding whether or how to respond to our child’s crying
Getting up at night with our child
Taking our child out: walking, driving, visiting, etc.
Choosing toys for our child
Playing with our child
Doing our child’s laundry
Arranging for baby-sitters or child care
Dealing with the doctor regarding our child’s health

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### Aggression

How descriptive is each of the following statements of you during the last year?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very much like me</th>
<th>Rather like me</th>
<th>Somewhat like me</th>
<th>Somewhat unlike me</th>
<th>Rather unlike me</th>
<th>Not at all like me</th>
</tr>
</thead>
<tbody>
<tr>
<td>I often yelled back when my partner yelled at me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When my partner tried to boss me around, I frequently did the opposite</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I often took my time “just to show” my partner, when he/she tried to</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>I often made threats to my partner that I really didn’t intend to carry</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>When I was feeling insecure and jealous, I often picked a fight with</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Starting arguments with my partner when he/she disagreed with me was</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I often said nasty things to my partner, especially when I was angrily</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slapping doors was something I often did when I got mad at my partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I often did something on purpose to annoy my partner and then apologised</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I often broke a “rule” my partner had made to spite him/her</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When my partner did something that I didn’t like, I often made a point</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I often did not do what my partner asked me to do if he/she asked in a</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Your attitudes

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men are born with more drive to be ambitious and successful than women.</td>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Neutral</td>
<td>Agree</td>
<td>Strongly agree</td>
</tr>
<tr>
<td>By nature women are happiest when they are making a home and caring for</td>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Neutral</td>
<td>Agree</td>
<td>Strongly agree</td>
</tr>
<tr>
<td>It is more important for a husband to have a good job than for a wife to</td>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Neutral</td>
<td>Agree</td>
<td>Strongly agree</td>
</tr>
<tr>
<td>It would be better for Irish society if fewer women worked.</td>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Neutral</td>
<td>Agree</td>
<td>Strongly agree</td>
</tr>
<tr>
<td>It is much better for everyone involved if the man is the achiever outside</td>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Neutral</td>
<td>Agree</td>
<td>Strongly agree</td>
</tr>
<tr>
<td>Women have just as much chance to get big and important jobs but they are</td>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Neutral</td>
<td>Agree</td>
<td>Strongly agree</td>
</tr>
</tbody>
</table>

### About you

<table>
<thead>
<tr>
<th>Statement</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am always courteous, even to people who are disagreeable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There have been times when I was quite jealous of the good fortunes of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I sometimes feel resentful when I do not get my way.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Communication**

Using the numbers on our 1 to 9 scale, indicate how likely or unlikely each of the following statements applies to your relationship (with your partner) **over the past year**.

<table>
<thead>
<tr>
<th>When some problem in the relationship arose:</th>
<th>Very Unlikely</th>
<th>Very Likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both my partner and I avoided discussing the problem.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>I tried to start a discussion while he/she tried to avoid a discussion.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>Both my partner and I tried to discuss the problem.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>My partner tried to start a discussion while I tried to avoid a discussion.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When discussing relationship problems:</th>
<th>Very Unlikely</th>
<th>Very Likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both my partner and I expressed our feelings to each other.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>Both my partner and I blamed, accused, and criticised each other.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>Both my partner and I suggested possible solutions and compromises.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>I pressured, nagged or demanded while he/she withdrew, became silent, or refused to discuss the matter further.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>My partner criticised while I defended myself.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>My partner pressured, nagged or demanded while I withdrew, became silent, or refused to discuss the matter further.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>I criticised while my partner defended him/herself.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
</tbody>
</table>

**Dominance**

Who is the dominant partner in your relationship?

<table>
<thead>
<tr>
<th>I am a lot more dominant</th>
<th>I am more dominant</th>
<th>I am a little more dominant</th>
<th>Neutral</th>
<th>My partner is a little more dominant</th>
<th>My partner is more dominant</th>
<th>My partner is a lot more dominant</th>
</tr>
</thead>
</table>

**About You**

There have been times when I felt like rebelling against people in authority even though I knew they were right.

<table>
<thead>
<tr>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When I do not know something, I do not at all mind admitting it.

<table>
<thead>
<tr>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I can remember “playing sick” to get out of something.

<table>
<thead>
<tr>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Physical aggression

Please indicate how many times during the past year your partner did the following things.

<table>
<thead>
<tr>
<th>Action</th>
<th>Frequency Options</th>
<th>Times Options</th>
<th>More Than Times Options</th>
<th>Not in Past Year</th>
<th>Happened Before</th>
<th>This Has Never Happened</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threw something at me that could hurt.</td>
<td>Once, Twice</td>
<td>3-5 times</td>
<td>6-10 times</td>
<td>11-20 times</td>
<td>More than 20 times</td>
<td>Not in the past year but it happened before</td>
</tr>
<tr>
<td>Twisted my arm or hair.</td>
<td>Once, Twice</td>
<td>3-5 times</td>
<td>6-10 times</td>
<td>11-20 times</td>
<td>More than 20 times</td>
<td>Not in the past year but it happened before</td>
</tr>
<tr>
<td>Pushed or shoved me.</td>
<td>Once, Twice</td>
<td>3-5 times</td>
<td>6-10 times</td>
<td>11-20 times</td>
<td>More than 20 times</td>
<td>Not in the past year but it happened before</td>
</tr>
<tr>
<td>Used a knife or gun on me.</td>
<td>Once, Twice</td>
<td>3-5 times</td>
<td>6-10 times</td>
<td>11-20 times</td>
<td>More than 20 times</td>
<td>Not in the past year but it happened before</td>
</tr>
<tr>
<td>Punched or hit me with something that could hurt.</td>
<td>Once, Twice</td>
<td>3-5 times</td>
<td>6-10 times</td>
<td>11-20 times</td>
<td>More than 20 times</td>
<td>Not in the past year but it happened before</td>
</tr>
<tr>
<td>Choked me.</td>
<td>Once, Twice</td>
<td>3-5 times</td>
<td>6-10 times</td>
<td>11-20 times</td>
<td>More than 20 times</td>
<td>Not in the past year but it happened before</td>
</tr>
<tr>
<td>Slammed me against a wall.</td>
<td>Once, Twice</td>
<td>3-5 times</td>
<td>6-10 times</td>
<td>11-20 times</td>
<td>More than 20 times</td>
<td>Not in the past year but it happened before</td>
</tr>
<tr>
<td>Beat me up.</td>
<td>Once, Twice</td>
<td>3-5 times</td>
<td>6-10 times</td>
<td>11-20 times</td>
<td>More than 20 times</td>
<td>Not in the past year but it happened before</td>
</tr>
<tr>
<td>Grabbed me.</td>
<td>Once, Twice</td>
<td>3-5 times</td>
<td>6-10 times</td>
<td>11-20 times</td>
<td>More than 20 times</td>
<td>Not in the past year but it happened before</td>
</tr>
<tr>
<td>Slapped me.</td>
<td>Once, Twice</td>
<td>3-5 times</td>
<td>6-10 times</td>
<td>11-20 times</td>
<td>More than 20 times</td>
<td>Not in the past year but it happened before</td>
</tr>
<tr>
<td>Burned or scolded me on purpose.</td>
<td>Once, Twice</td>
<td>3-5 times</td>
<td>6-10 times</td>
<td>11-20 times</td>
<td>More than 20 times</td>
<td>Not in the past year but it happened before</td>
</tr>
<tr>
<td>Kicked me.</td>
<td>Once, Twice</td>
<td>3-5 times</td>
<td>6-10 times</td>
<td>11-20 times</td>
<td>More than 20 times</td>
<td>Not in the past year but it happened before</td>
</tr>
</tbody>
</table>

### About you

<table>
<thead>
<tr>
<th>Statement</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am sometimes irritated by people who ask favours of me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would never think of letting someone else be punished for my wrong doings.</td>
<td>True</td>
<td>False</td>
</tr>
</tbody>
</table>
**Independence**

Given the limited amount of free time you have, would you prefer to spend more time with your partner or more time alone or with friends?

<table>
<thead>
<tr>
<th>A lot more time with my partner</th>
<th>Some more time with my partner</th>
<th>A little more time with my partner</th>
<th>No change</th>
<th>A little more time alone or with friends</th>
<th>Some more time alone or with friends</th>
<th>A lot more time alone or with friends</th>
</tr>
</thead>
</table>

Would you like to have more sharing of feelings with your partner or more respect for privacy in your relationship?

<table>
<thead>
<tr>
<th>A lot more sharing of feelings</th>
<th>Some more sharing of feelings</th>
<th>A little more sharing of feelings</th>
<th>No change</th>
<th>A little more respect for privacy</th>
<th>Some more respect for privacy</th>
<th>A lot more respect for privacy</th>
</tr>
</thead>
</table>

Would you like to spend more of your free time in independent activities without your partner or in shared activities with your partner?

<table>
<thead>
<tr>
<th>A lot more independent activities</th>
<th>Some more independent activities</th>
<th>A few more independent activities</th>
<th>No change</th>
<th>A few more shared activities</th>
<th>Some more shared activities</th>
<th>A lot more shared activities</th>
</tr>
</thead>
</table>

Would you like to ask your partner more or less often what he/she is thinking and how he/she is feeling?

<table>
<thead>
<tr>
<th>Ask him/her a lot more often</th>
<th>Ask him/her more often</th>
<th>Ask him/her a bit more often</th>
<th>No change</th>
<th>Ask him/her a bit less often</th>
<th>Ask him/her less often</th>
<th>Ask him/her a lot less often</th>
</tr>
</thead>
</table>

Would you like to spend more or less time talking with your partner about his/her thoughts and feelings?

<table>
<thead>
<tr>
<th>A lot more time</th>
<th>More time</th>
<th>A little more time</th>
<th>No change</th>
<th>A little less time</th>
<th>Less time</th>
<th>A lot less time</th>
</tr>
</thead>
</table>

On the whole, would you like more independence or more closeness in your relationship?

<table>
<thead>
<tr>
<th>A lot more independence</th>
<th>More independence</th>
<th>A little bit more independence</th>
<th>No change</th>
<th>A little bit more closeness</th>
<th>More closeness</th>
<th>A lot more closeness</th>
</tr>
</thead>
</table>

**Additional comments**

Before posting your questionnaire, please check that you have not accidentally omitted to answer any questions.
Thank you.
11-page self-report questionnaire

**Instructions:** Please read all of the questions/statements and either circle the answer that applies to you or write your answer in the space provided.

**About you**

<table>
<thead>
<tr>
<th>Are you</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>How old are you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship situation</td>
<td>Married and living with partner</td>
<td>Not married and living with partner</td>
</tr>
<tr>
<td>How long have you had a relationship with your partner?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many years have you been living with your partner?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have any children?</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

| I never hesitate to go out of my way to help someone in trouble. | True | False |
| I have never intensely disliked anyone. | True | False |

**Financial situation**

| What is your occupation (If a farmer, what is the size of your farm)? | What is your income? | Have you been working? |
| To what degree were you economically dependent upon your partner? | Completely dependent | Very dependent | Somewhat dependent | Slightly dependent | Not dependent |
| Who decided how surplus spending money was used? | I did all of the time | I did most of the time | My partner and I did equally | My partner did most of the time | My partner did all of the time |
| Who would you liked to have deciding how surplus spending money was used? | Myself all of the time | Myself most of the time | My partner and I did equally | My partner most of the time | My partner all of the time |

**Thinking about your recent mood**

| In the past 2 weeks, have you: | | |
| ...been feeling very down for most of the day? | Yes | No |
| ...had little interest in most activities and felt little pleasure in doing activities? | Yes | No |
| ...had an increase or a decrease in your appetite? | Decrease | Same as usual | Increase |
| ...had an increase or decrease in your weight? | Decrease | Same as usual | Increase |
| ...slept more than usual or had trouble sleeping? | Less than usual | Same as usual | More than usual |
| ...been more or less active than usual? | Less active | Same as usual | More active |
| ...had more or less energy than usual? | Less energy | Same as usual | More energy |
| ...felt worthless? | Yes | No |
| ...felt guilty? | Yes | No |
| ...found it difficult to concentrate? | Yes | No |
◆ Your general mood

Tick the statement in each group which best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, tick each one.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I do not feel sad.</td>
<td>1 I feel sad.</td>
</tr>
<tr>
<td>2 I am sad all the time and I can’t snap out of it.</td>
<td>3 I am so sad or unhappy that I can’t stand it.</td>
</tr>
<tr>
<td>0 I am not particularly discouraged about the future.</td>
<td>1 I feel discouraged about the future.</td>
</tr>
<tr>
<td>2 I feel I have nothing to look forward to.</td>
<td>3 I feel that the future is hopeless and that things cannot improve.</td>
</tr>
<tr>
<td>0 I do not feel like a failure.</td>
<td>1 I feel I have failed more than the average person.</td>
</tr>
<tr>
<td>2 As I look back on my life, all I can see is a lot of failures.</td>
<td>3 I feel I am a complete failure as a person.</td>
</tr>
<tr>
<td>0 I get as much satisfaction out of things as I used to.</td>
<td>1 I don’t enjoy things the way I used to.</td>
</tr>
<tr>
<td>2 I don’t get real satisfaction out of anything anymore.</td>
<td>3 I am dissatisfied or bored with everything.</td>
</tr>
<tr>
<td>0 I don’t feel particularly guilty.</td>
<td>1 I feel guilty a good part of the time.</td>
</tr>
<tr>
<td>2 I feel quite guilty most of the time.</td>
<td>3 I feel guilty all of the time.</td>
</tr>
<tr>
<td>0 I don’t feel I am being punished.</td>
<td>1 I feel I may be punished.</td>
</tr>
<tr>
<td>2 I expect to be punished.</td>
<td>3 I feel I am being punished.</td>
</tr>
<tr>
<td>0 I don’t feel disappointed in myself.</td>
<td>1 I am disappointed in myself.</td>
</tr>
<tr>
<td>2 I am disgusted with myself.</td>
<td>3 I hate myself.</td>
</tr>
<tr>
<td>0 I don’t feel I look any worse than I used to.</td>
<td>1 I am worried that I am looking old or unattractive.</td>
</tr>
<tr>
<td>2 I feel that there are permanent changes in my appearance that make me look unattractive.</td>
<td>3 I believe that I look ugly.</td>
</tr>
<tr>
<td>0 I haven’t lost much weight, if any, lately.</td>
<td>1 I have lost more than 5 pounds.</td>
</tr>
<tr>
<td>2 I have lost more than 10 pounds.</td>
<td>3 I have lost more than 15 pounds.</td>
</tr>
<tr>
<td>I am purposely trying to lose weight by eating less.</td>
<td>Yes</td>
</tr>
<tr>
<td>0 My appetite is no worse than usual.</td>
<td>1 My appetite is not as good as it used to be.</td>
</tr>
<tr>
<td>2 My appetite is much worse now.</td>
<td>3 I have no appetite at all anymore.</td>
</tr>
<tr>
<td>0 I don’t get more tired than usual.</td>
<td>1 I get tired more easily than I used to.</td>
</tr>
<tr>
<td>2 I get tired from doing almost anything.</td>
<td>3 I am too tired to do anything.</td>
</tr>
<tr>
<td>0 I don’t have any thoughts of killing myself.</td>
<td>1 I have thoughts of killing myself, but I would not carry them out.</td>
</tr>
<tr>
<td>2 I would like to kill myself.</td>
<td>3 I would kill myself if I had the chance.</td>
</tr>
<tr>
<td>0 I don’t cry anymore than usual.</td>
<td>1 I cry more now than I used to.</td>
</tr>
<tr>
<td>2 I cry all the time now.</td>
<td>3 I used to be able to cry, but now I can’t cry even though I want to.</td>
</tr>
<tr>
<td>0 I am no more irritated now than I ever am.</td>
<td>1 I get annoyed or irritated more easily than I used to.</td>
</tr>
<tr>
<td>2 I feel irritated all the time now.</td>
<td>3 I don’t get irritated at all by the things that used to irritate me.</td>
</tr>
<tr>
<td>0 I have not lost interest in other people.</td>
<td>1 I am less interested in other people than I used to be.</td>
</tr>
<tr>
<td>2 I have lost most of my interest in other people.</td>
<td>3 I have lost all of my interest in other people.</td>
</tr>
<tr>
<td>0 I make decisions about as well as I ever could.</td>
<td>1 I put off making decisions more than I used to.</td>
</tr>
<tr>
<td>2 I have greater difficulty in making decisions than before.</td>
<td>3 I can’t make decisions at all anymore.</td>
</tr>
<tr>
<td>0 I can work about as well as before.</td>
<td>1 It takes an extra effort to get started at doing something.</td>
</tr>
<tr>
<td>2 I have to push myself very hard to do anything.</td>
<td>3 I can’t do any work at all.</td>
</tr>
<tr>
<td>0 I can sleep as well as usual.</td>
<td>1 I don’t sleep as well as I used to.</td>
</tr>
<tr>
<td>2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.</td>
<td>3 I wake up several hours earlier than I used to and cannot get back to sleep.</td>
</tr>
<tr>
<td>0 I am no more worried about my health than usual.</td>
<td>1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.</td>
</tr>
<tr>
<td>2 I am very worried about physical problems and it’s hard to think of much else.</td>
<td>3 I am so worried about my physical problems that I cannot think about anything else.</td>
</tr>
<tr>
<td>0 I have not noticed any recent change in my interest in sex.</td>
<td>1 I am less interested in sex than I used to be.</td>
</tr>
<tr>
<td>2 I am much less interested in sex now.</td>
<td>3 I have lost interest in sex completely.</td>
</tr>
</tbody>
</table>
**More about your mood**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this your first time that your “nerves” have been at you very badly or that you been feeling very low?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How long have your “nerves” been at you or how long have you been feeling very low?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you think anything in particular has made you feel this way?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had repeated thoughts of death or of harming yourself?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Are you taking antidepressant tablets?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Satisfaction**

Please answer the following questions as they relate to the past year.

<table>
<thead>
<tr>
<th>Question</th>
<th>All the time</th>
<th>Most of the time</th>
<th>More often than not</th>
<th>Occasionally</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often did you discuss or consider divorce, separation, or terminating your relationship?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often did you or your partner leave the house after a fight?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In general, how often did you think that things between you and your partner were going well?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you confide in your partner?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you ever regret that you were in a relationship with your partner?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often did you and your partner quarrel?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often did you and your partner “get on each other’s nerves”?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How happy were you in your relationship?</td>
<td>Extremely unhappy</td>
<td>Fairly unhappy</td>
<td>A little unhappy</td>
<td>Happy</td>
<td>Very happy</td>
<td>Extremely happy</td>
</tr>
<tr>
<td>Did you kiss your partner?</td>
<td>Every day</td>
<td>Almost every day</td>
<td>Occasionally</td>
<td>Rarely</td>
<td>Never</td>
<td></td>
</tr>
</tbody>
</table>

Which of the following statements best describes how you felt about the future of your relationship during the past year?

- I want desperately for my relationship to succeed, and would go to almost any length to see that it does.
- I want very much for my relationship to succeed, and will do all I can to see that it does.
- I want very much for my relationship to succeed, and will do my fair share to see that it does.
- It would be nice if my relationship succeeded, but I can’t do much more than I am doing now to help it succeed.
- It would be nice if it succeeded, but I refuse to do any more than I am doing now to keep the relationship going.
- My relationship can never succeed, and there is no more that I can do to keep the relationship going.

If there are relationship problems, how long ago did they begin?
**Who did what?**

Using the numbers on our 1 to 9 scale, show how you and your partner divided responsibilities during the past year and secondly, how you would like them to have been divided.

<table>
<thead>
<tr>
<th>Planning and preparing meals</th>
<th>How it has been during the past year</th>
<th>How I would have liked it to be</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleaning up after meals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repairs around the home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>House cleaning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking out the garbage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buying groceries, household needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paying bills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laundry: washing, folding, ironing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Writing letters/making calls to family and friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Looking after the car</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing income for our family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caring for plants, garden, yard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working outside the family</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deciding how we spend time at home</th>
<th>How it has been during the past year</th>
<th>How I would have liked it to be</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deciding how we spend time out of the house</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deciding which friends and family to see and when</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deciding about vacations: when, where, how</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deciding about major expenses: house, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deciding about financial planning: insurance, loans, taxes, plans for savings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deciding when and how much time both partners should work outside the family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initiating lovemaking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determining the frequency of lovemaking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deciding about religious practices in our family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deciding about involvement in community activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deciding how people should behave toward one another in our family</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deciding about meals for our child(ren)</th>
<th>How it has been during the past year</th>
<th>How I would have liked it to be</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparing meals for our child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing our child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning or bathing our child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deciding whether or how to respond to our child’s crying</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting up at night with our child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking our child out: walking, driving, visiting, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choosing toys for our child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Playing with our child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doing our child’s laundry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arranging for baby-sitters or child care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dealing with the doctor regarding our child’s health</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

255
## Aggression

How descriptive is each of the following statements of you during the last year?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very much like me</th>
<th>Rather like me</th>
<th>Somewhat like me</th>
<th>Somewhat unlike me</th>
<th>Rather unlike me</th>
<th>Not at all like me</th>
</tr>
</thead>
<tbody>
<tr>
<td>I often yelled back when my partner yelled at me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When my partner tried to boss me around, I frequently did the opposite</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I often took my time “just to show” my partner, when he/she tried to</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I often made threats to my partner that I really didn’t intend to carry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When I was feeling insecure and jealous, I often picked a fight</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting arguments with my partner when he/she disagreed with me was</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I often said nasty things to my partner, especially when I was</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slaming doors was something I often did when I got mad at my partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I often did something on purpose to annoy my partner and then apologised</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I often broke a “rule” my partner had made to spite him/her</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When my partner did something that I didn’t like, I often made a point</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I often did not do what my partner asked me to do if he/she asked in a</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Your attitudes

Men are born with more drive to be ambitious and successful than women. Strongly disagree Disagree Neutral Agree Strongly agree

By nature women are happiest when they are making a home and caring for children. Strongly disagree Disagree Neutral Agree Strongly agree

It is more important for a husband to have a good job than for a wife to have a good job. Strongly disagree Disagree Neutral Agree Strongly agree

It would be better for Irish society if fewer women worked. Strongly disagree Disagree Neutral Agree Strongly agree

It is much better for everyone involved if the man is the achiever outside the home and family. Strongly disagree Disagree Neutral Agree Strongly agree

Women have just as much chance to get big and important jobs but they are just are not interested. Strongly disagree Disagree Neutral Agree Strongly agree

## About you

I am always courteous, even to people who are disagreeable. True False

There have been times when I was quite jealous of the good fortunes of others. True False

I sometimes feel resentful when I do not get my way. True False
\textbf{Communication}

Using the numbers on our 1 to 9 scale, indicate how likely or unlikely each of the following statements applies to your relationship (with your partner) \textit{over the past year}.

<table>
<thead>
<tr>
<th>When some problem in the relationship arose:</th>
<th>Very Unlikely</th>
<th>Very Likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both my partner and I avoided discussing the problem.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>I tried to start a discussion while he/she tried to avoid a discussion.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>Both my partner and I tried to discuss the problem.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>My partner tried to start a discussion while I tried to avoid a discussion.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When discussing relationship problems:</th>
<th>Very Unlikely</th>
<th>Very Likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both my partner and I expressed our feelings to each other.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>Both my partner and I blamed, accused, and criticised each other.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>Both my partner and I suggested possible solutions and compromises.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>I pressured, nagged or demanded while he/she withdrew, became silent, or refused to discuss the matter further.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>My partner criticised while I defended myself.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>My partner pressured, nagged or demanded while I withdrew, became silent, or refused to discuss the matter further.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>I criticised while my partner defended him/herself.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
</tbody>
</table>

\textbf{Dominance}

Who is the dominant partner in your relationship?

<table>
<thead>
<tr>
<th>I am a lot more dominant</th>
<th>I am more dominant</th>
<th>I am a little more dominant</th>
<th>Neutral</th>
<th>My partner is a little more dominant</th>
<th>My partner is more dominant</th>
<th>My partner is a lot more dominant</th>
</tr>
</thead>
</table>

\textbf{About You}

There have been times when I felt like rebelling against people in authority even though I knew they were right. True False
When I do not know something, I do not at all mind admitting it. True False
I can remember “playing sick” to get out of something. True False
Physical aggression

Please indicate how many times during the past year your partner did the following things.

<table>
<thead>
<tr>
<th>Physical aggression</th>
<th>Once</th>
<th>Twice</th>
<th>3-5 times</th>
<th>6-10 times</th>
<th>11-20 times</th>
<th>More than 20 times</th>
<th>Not in the past year but it happened before</th>
<th>This has never happened</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threw something at me that could hurt.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Twisted my arm or hair.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pushed or shoved me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Used a knife or gun on me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Punched or hit me with something that could hurt.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choked me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slammed me against a wall.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beat me up.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grabbed me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slapped me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burned or scolded me on purpose.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kicked me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

About you

I am sometimes irritated by people who ask favours of me. True False
I would never think of letting someone else be punished for my wrong doings. True False
**Independence**

Given the limited amount of free time you have, would you prefer to spend more time with your partner or more time alone or with friends?

<table>
<thead>
<tr>
<th>A lot more time with my partner</th>
<th>Some more time with my partner</th>
<th>A little more time with my partner</th>
<th>No change</th>
<th>A little more time alone or with friends</th>
<th>Some more time alone or with friends</th>
<th>A lot more time alone or with friends</th>
</tr>
</thead>
</table>

Would you like to have more sharing of feelings with your partner or more respect for privacy in your relationship?

<table>
<thead>
<tr>
<th>A lot more sharing of feelings</th>
<th>Some more sharing of feelings</th>
<th>A little more sharing of feelings</th>
<th>No change</th>
<th>A little more respect for privacy</th>
<th>Some more respect for privacy</th>
<th>A lot more respect for privacy</th>
</tr>
</thead>
</table>

Would you like to spend more of your free time in independent activities without your partner or in shared activities with your partner?

<table>
<thead>
<tr>
<th>A lot more independent activities</th>
<th>Some more independent activities</th>
<th>A few more independent activities</th>
<th>No change</th>
<th>A few more shared activities</th>
<th>Some more shared activities</th>
<th>A lot more shared activities</th>
</tr>
</thead>
</table>

Would you like to ask your partner more or less often what he/she is thinking and how he/she is feeling?

<table>
<thead>
<tr>
<th>Ask him/her a lot more often</th>
<th>Ask him/her more often</th>
<th>Ask him/her a bit more often</th>
<th>No change</th>
<th>Ask him/her a bit less often</th>
<th>Ask him/her less often</th>
<th>Ask him/her a lot less often</th>
</tr>
</thead>
</table>

Would you like to spend more or less time talking with your partner about his/her thoughts and feelings?

<table>
<thead>
<tr>
<th>A lot more time</th>
<th>More time</th>
<th>A little more time</th>
<th>No change</th>
<th>A little less time</th>
<th>Less time</th>
<th>A lot less time</th>
</tr>
</thead>
</table>

On the whole, would you like more independence or more closeness in your relationship?

<table>
<thead>
<tr>
<th>A lot more independence</th>
<th>More independence</th>
<th>A little bit more independence</th>
<th>No change</th>
<th>A little bit more closeness</th>
<th>More closeness</th>
<th>A lot more closeness</th>
</tr>
</thead>
</table>

**Your medical history**

Do you have any medical conditions (e.g., hyperthyroidism, mitral valve prolapse)? If you have, please detail them:

Do you think that your medical history may have predisposed to experiencing panic attacks? If yes, please detail how:

**History of panic attacks**

How long do you think you have had a problem with panic attacks?

Do you think your problem (with panic attacks) has remained the same, worsened, or got better over the years?

Has there been a significant change in your behaviour since your first panic attack? If so, please detail:

Over the past year how often did you have panic attacks?
◆ Previous treatment

Have you previously attended a Service to explore how you might better manage your panic attacks? If so, what did this involve?

Was your partner (or anybody else important to you) involved?

◆ Current panic attacks

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you concerned about having additional panic attacks?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you worry about the implications of having a panic attack or its consequences (e.g., losing control, having a heart attack, “going crazy”)?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If you do worry, what is the specific nature of your worry?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

◆ Agoraphobia

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you anxious about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having an unexpected or situationally predisposed panic attack or panic-like symptoms?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If you are anxious in relation to the above, please detail:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

◆ Coping strategies

If you do experience panic attacks, how do you cope with them? Below is a list of some coping strategies that some people often use. Please indicate the ones you might use and add if you use other strategies that are not listed below:

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deep breathing?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioural avoidance (e.g., of certain places)?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Ensuring your heart rate does not rise (e.g., avoiding strenuous exercise)?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Ensuring that you are always with someone you trust?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Praying to God (or a Higher power)?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

◆ Other mental health concerns

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have any other mental health concerns (e.g., depression, social phobia, alcoholism)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If so, what are they and how long have you had them?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you currently taking medication for these other concerns (e.g., antidepressants, tranquilisers)?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If so, what are they?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Degree of mobility

Please indicate the degree to which you avoid the following places or situations because of discomfort or anxiety. Rate your amount of avoidance **when you are alone** by circling the number that applies to you. You may use half numbers between those listed when you think it is appropriate; for example, 3 1/2, 4 1/2.

<table>
<thead>
<tr>
<th>Places</th>
<th>Never avoid</th>
<th>Rarely avoid</th>
<th>Avoid about half the time</th>
<th>Avoid most of the time</th>
<th>Always avoid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theatres</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Supermarkets</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Classrooms</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Department stores</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Restaurants</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Museums</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Elevators</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Stadiums</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Parking garages</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>High places</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Tell how high:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enclosed spaces (e.g., tunnels)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Open spaces</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Outside (e.g., fields, wide streets, courtyards)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>(b) Inside (e.g., large rooms, lobbies)</td>
<td>1</td>
<td>2</td>
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<td>4</td>
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<td>Riding in</td>
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<td>2</td>
<td>3</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>2</td>
<td>3</td>
<td>4</td>
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<td>Driving or riding in car:</td>
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<td>(a) At any time</td>
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<td>(b) On dual-carriage ways</td>
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We define a panic attack as:
1) a high level of anxiety accompanied by
2) strong body reactions (heart palpitations, sweating, muscle tremors, dizziness, nausea) with
3) the temporary loss of the ability to plan, think, reason and
4) the intense desire to escape or flee the situation. (Note: This is different from high anxiety or fear alone).

Please indicate the total number of panic attacks you have had in the last 7 days: __________
More about your anxiety
Please respond to each statement by circling the number that applies to you. Try to be as accurate as possible. There are no right or wrong answers.

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<th>Statement</th>
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<th>A little</th>
<th>Some</th>
<th>Much</th>
<th>Very much</th>
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<td>When I cannot keep my mind on a task, I worry that I might be going crazy</td>
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<td>It scares me when I feel “shaky” (trembling)</td>
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<td>It scares me when I feel faint</td>
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<td></td>
</tr>
<tr>
<td>It is important to me to stay in control of my emotions</td>
<td></td>
<td></td>
<td></td>
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<td>It scares me when my heart beats rapidly</td>
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<td>It embarrasses me when my stomach growls</td>
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<td></td>
<td></td>
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<td>It scares me when I am nauseous</td>
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<td>When I notice that my heart is beating rapidly, I worry that I might have a heart attack</td>
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<td>It scares me when I become short of breath</td>
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<td>Other people notice when I feel shaky</td>
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<td>Unusual body sensations scare me</td>
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<tr>
<td>When I am nervous, I worry that I might be mentally ill</td>
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<tr>
<td>It scares me when I am nervous</td>
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</tbody>
</table>

Additional comments

Before posting your questionnaire, please check that you have not accidentally omitted to answer any questions.
Thank you.
Appendix C

Consent forms
Consent form to participants (treatment-attenders)

I, ________________________________, hereby grant Michael Byrne permission to use data from my completed questionnaire for the purposes of the ongoing Midland Health Board research into couple dynamics and depression. I also grant Michael permission to use details from his clinical interviews with me regarding the dynamics of my relationships with significant others (e.g., those with my partner). This I agree to on the conditions that the data pertaining to me is treated confidentially and that there is no identifying information contained in the write-up of the research.

Signatures: ___________________________ Date: __________
Michael Byrne

_____________________________
Participant

Date: __________
Cover letter to control participants

Date

Dear participant,

The Midland Health Board is researching how the relationship dynamics between couples were the female is depressed differs from those of control couples (i.e., where neither partner has a psychiatric disorder including depression) or couples where the female partner has panic disorder with agoraphobia. Hence, if both you and your partner do not have a psychiatric disorder, we would be grateful if you would each complete the enclosed questionnaire.

Please answer all the questions as best you can but do not include any identifying information; respondents are being asked to remain strictly anonymous. You can then send off your completed questionnaire in the stamped addressed envelope provided.

The answers you provide to each question on this questionnaire will be scored and then entered into a computer to be analysed using a statistical software program.

A second copy of the questionnaire is attached for your partner. It would be best not to discuss your answers with him/her. As it is critical that the views of both partners are represented, please encourage your partner to return his/her questionnaire.

The results of this research will help us to help other individuals with mood difficulties. Your effort in completing this questionnaire will therefore help others.

If you have any queries in relation to the questionnaire (or the purpose of the research), please do contact me at any of the above numbers.

Thanking you again.

Yours sincerely,

Michael Byrne,
A/Senior Clinical Psychologist,
Midland Health Board.
Consent form to authors of psychometric scales

I, ____________________________, hereby grant Michael Byrne permission to use the following scale of which I am the sole / principal author:

________________________________________________________ in his Doctoral research. This research, entitled ‘Power and depression in marriage – A replication and extension’, is to be supervised by Dr. Alan Carr, Clinical Psychology Programme Director at University College Dublin, Ireland.

If Michael does not intend to carry out and publish a psychometric analysis of his data (such as factor analysis, and construction of normative tables), he will provide me with a copy of his data, together with as much as possible of a list of demographic information.

Signatures: ____________________________ Date: __________

Michael Byrne
Midland Health Board,
Community Mental Health Centre,
Green Rd.,
Mullingar,
Co. Westmeath.
Ireland.

__________________________ Date: __________
Dr. Alan Carr.

__________________________ Date: __________
Scale Author.
Appendix D

Quantitative data and statistical data tables
Table 2: Demographic characteristics of participants

<table>
<thead>
<tr>
<th>Variable</th>
<th>Control Male (N = 20)</th>
<th>Control Female (N = 20)</th>
<th>PDA Male (N = 20)</th>
<th>PDA Female (N = 20)</th>
<th>Depressed Male (N = 20)</th>
<th>Depressed Female (N = 20)</th>
<th>ANOVA Effects Gen.</th>
<th>Dx</th>
<th>G X Dx</th>
<th>Differences between</th>
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<td>43.35</td>
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<td>*4.83</td>
<td>**6.15</td>
<td>.34</td>
<td>Control &amp; PDA</td>
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<td>SD 4.86</td>
<td>4.60</td>
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<td>8.15</td>
<td>8.85</td>
<td>4.74</td>
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<td>5.25</td>
<td>5.25</td>
<td>.14</td>
<td>**18.26</td>
<td>.14</td>
<td>PDA &amp; other couples</td>
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<td>SD 2.34</td>
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<td>6.11</td>
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<td>Age at birth of first child</td>
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<td>25.16</td>
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<td>*3.70</td>
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<td>Childless couples</td>
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<td>1</td>
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<td>100</td>
<td>85</td>
<td>85</td>
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<td>F 19</td>
<td>19</td>
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<td>20</td>
<td>17</td>
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<td>0</td>
<td>25</td>
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<td>**22.17</td>
<td>Depressed &amp; other couples</td>
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<td>5</td>
<td>0</td>
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<td>Working (external to home)</td>
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<td>70</td>
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<td>45</td>
<td>100</td>
<td>35</td>
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Note: ** : Significant difference at the p < .01 level. * : Significant difference at the p < .05 level. * : Significant difference at the p < .06 level.
Table 7 Reliabilities of scales

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<th>Variable</th>
<th>No. of items in scale</th>
<th>Modification to original scale</th>
<th>Cronbach’s alpha</th>
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<td>Control of surplus spending money</td>
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<td>Desired control of surplus spending money</td>
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<td>Dissatisfaction with control of surplus spending money</td>
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<td>Commitment to relationship</td>
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<td>Sex role attitudes</td>
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<td>Desired level of intimacy</td>
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<td>Power processes</td>
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<td>Male demand – female withdraw behaviour</td>
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<td>Partner did more household tasks</td>
<td>9</td>
<td>Dropped 4 of the original 13 items</td>
<td>.71</td>
</tr>
<tr>
<td>Partner did more decision-making</td>
<td>9</td>
<td>Dropped 3 of the original 12 items</td>
<td>.70</td>
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<td>Partner more involved in child-care</td>
<td>12</td>
<td>None</td>
<td>.94</td>
</tr>
<tr>
<td>Dissatisfaction with household task distribution</td>
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<td>Dropped 3 of the original 13 items</td>
<td>* .74</td>
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<tr>
<td>Dissatisfaction with decision-making distribution</td>
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<td>None</td>
<td>* .82</td>
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<tr>
<td>Dissatisfaction with child-care task distribution</td>
<td>12</td>
<td>None</td>
<td>* .95</td>
</tr>
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</table>

Note: * : These are composite reliabilities derived from two scales (the actual and the desired distribution of tasks).
<table>
<thead>
<tr>
<th>Variable</th>
<th>No. of items in scale</th>
<th>Range</th>
<th>Variable Definition</th>
<th>High score signifies</th>
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<td>8</td>
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<td>Degree of socially desirable responding</td>
<td>A higher level of socially desirable responding</td>
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<tr>
<td>Beck Depression Inventory</td>
<td>21</td>
<td>0-63</td>
<td>Depressive symptomatology</td>
<td>A higher level of depressive symptomatology</td>
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<tr>
<td>DSM-IV based depressive scale</td>
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<td>0-9</td>
<td>DSM-IV criteria for major depressive disorder</td>
<td>More DSM IV criteria for major depressive disorder met</td>
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<td>16</td>
<td>0-64</td>
<td>Degree of sensitivity to anxiety symptoms</td>
<td>Greater sensitivity of anxiety symptoms</td>
</tr>
<tr>
<td>Mobility inventory</td>
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<td>Degree of mobility (alone)</td>
<td>Less mobility</td>
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<td><strong>Relationship problems and satisfaction</strong></td>
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<td></td>
<td></td>
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<td>Duration of relationship problems</td>
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<td>Duration of relationship problems (if any)</td>
<td>More chronic relationship problems</td>
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<td>Satisfaction with relationship</td>
<td>A higher level of relationship satisfaction</td>
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<td>Dominance</td>
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<td>Who is the dominant partner in the relationship</td>
<td>A higher degree of dominance in the relationship</td>
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<td><strong>Power bases</strong></td>
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<tr>
<td>Income</td>
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<td>0-6</td>
<td>Income available as defined by socio-economic class</td>
<td>A lower socio-economic class</td>
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<td>Economic dependence on partner</td>
<td>A higher level of economic dependence on partner</td>
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<tr>
<td>Control of surplus spending money</td>
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<td>Less personal control of spending of surplus money</td>
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<tr>
<td>Desired control of surplus spending money</td>
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<td>Desired control of surplus spending money</td>
<td>Less personal control of spending of surplus money desired</td>
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<td>0-4</td>
<td>Dissatisfaction with control of surplus spending money</td>
<td>More dissatisfaction with control of surplus spending money</td>
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<td>Commitment to relationship</td>
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<td>Commitment to the relationship</td>
<td>High level of commitment</td>
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<td>Sex role attitudes</td>
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<td>6-30</td>
<td>Belief in traditional sex roles</td>
<td>A stronger belief in traditional sex roles</td>
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<tr>
<td>Desired level of intimacy</td>
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<td>7-42</td>
<td>Desired intimacy with partner</td>
<td>A greater desire for intimacy</td>
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<td>Physical assault by partner in the past year</td>
<td>Recipient of a higher level of physical assault</td>
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<td>Previous physical assault by partner</td>
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<td>Previous physical assault by partner not in the past year but in the period before this</td>
<td>Recipient of a higher level of physical assault previously</td>
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<td>-36-36</td>
<td>Psychological aggression towards partner</td>
<td>A higher level of psychological aggression utilised</td>
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<td>Male demand - female withdraw behaviour</td>
<td>3</td>
<td>3-27</td>
<td>Male demand - female withdraw behaviour</td>
<td>More husband demand - wife withdraw behaviour</td>
</tr>
<tr>
<td>Female demand - male withdraw behaviour</td>
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<td>3-27</td>
<td>Female demand - male withdraw behaviour</td>
<td>More husband demand - wife withdraw behaviour</td>
</tr>
<tr>
<td>Total demand - withdraw behaviour</td>
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<td>6-54</td>
<td>Total amount of demand - withdraw behaviour</td>
<td>More husband demand - wife withdraw behaviour</td>
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<td>3-27</td>
<td>Mutual constructive communication</td>
<td>More mutual constructive communication</td>
</tr>
<tr>
<td><strong>Power outcome</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Partner did more household tasks</td>
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<td>1-9</td>
<td>Partner involvement in household tasks</td>
<td>A higher degree of partner involvement in household tasks</td>
</tr>
<tr>
<td>Partner did more decision-making</td>
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<td>1-9</td>
<td>Partner involvement in decision-making</td>
<td>A higher degree of partner involvement in decision-making</td>
</tr>
<tr>
<td>Partner more involved in child-care</td>
<td>12</td>
<td>1-9</td>
<td>Partner involvement in child-care</td>
<td>A higher degree of partner involvement in child-care tasks</td>
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<td>Dissatisfaction with household task distribution</td>
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<td>0-8</td>
<td>Dissatisfaction with household task distribution</td>
<td>A greater dissatisfaction with distribution of household tasks</td>
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<tr>
<td>Dissatisfaction with decision-making distribution</td>
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<td>0-8</td>
<td>Dissatisfaction with decision-making distribution</td>
<td>A greater dissatisfaction with distribution of decision-making</td>
</tr>
<tr>
<td>Dissatisfaction with child-care task distribution</td>
<td>12</td>
<td>0-8</td>
<td>Dissatisfaction with child-care task distribution</td>
<td>A greater dissatisfaction with distribution of child-care tasks</td>
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Table 9 Correlations between all variables and social desirability and duration of presentation

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<thead>
<tr>
<th>Variable</th>
<th>Correlation with social desirability</th>
<th>Correlation with duration of presentation</th>
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<tbody>
<tr>
<td>Depression</td>
<td></td>
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</tr>
<tr>
<td>Beck Depression Inventory</td>
<td>-0.11</td>
<td>0.18</td>
</tr>
<tr>
<td>DSM IV based depressive scale</td>
<td>-0.15</td>
<td>0.18</td>
</tr>
<tr>
<td>Anxiety sensitivity</td>
<td>0.01</td>
<td>0.11</td>
</tr>
<tr>
<td>Mobility</td>
<td>0.21</td>
<td>-0.07</td>
</tr>
<tr>
<td>Relationship problems and satisfaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration of relationship problems</td>
<td>0.02</td>
<td>0.11</td>
</tr>
<tr>
<td>Relationship satisfaction</td>
<td>0.10</td>
<td>*-0.27</td>
</tr>
<tr>
<td>Dominance</td>
<td>-0.15</td>
<td>-0.01</td>
</tr>
<tr>
<td>Power bases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>0.03</td>
<td>0.10</td>
</tr>
<tr>
<td>Economic dependence on partner</td>
<td>0.15</td>
<td>0.17</td>
</tr>
<tr>
<td>Control of surplus spending money</td>
<td>0.02</td>
<td>0.09</td>
</tr>
<tr>
<td>Desired control of surplus spending money</td>
<td>*0.22</td>
<td>-0.04</td>
</tr>
<tr>
<td>Dissatisfaction with control of surplus spending money</td>
<td>-0.07</td>
<td>0.13</td>
</tr>
<tr>
<td>Commitment to relationship</td>
<td>0.16</td>
<td>-0.20</td>
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<tr>
<td>Sex role attitudes</td>
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<td>0.06</td>
<td>0.11</td>
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<td>Physical assault by partner</td>
<td>0.04</td>
<td>*0.27</td>
</tr>
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<td>Previous physical assault by partner</td>
<td>-0.05</td>
<td>**0.36</td>
</tr>
<tr>
<td>Psychological aggression towards partner</td>
<td>-0.18</td>
<td>0.16</td>
</tr>
<tr>
<td>Power processes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male demand – female withdraw behaviour</td>
<td>-0.09</td>
<td>*0.28</td>
</tr>
<tr>
<td>Female demand – male withdraw behaviour</td>
<td>-0.17</td>
<td>0.17</td>
</tr>
<tr>
<td>Total demand – withdraw behaviour</td>
<td>-0.14</td>
<td>*0.24</td>
</tr>
<tr>
<td>Mutual constructive communication</td>
<td>0.10</td>
<td>-0.09</td>
</tr>
<tr>
<td>Power outcome</td>
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<td></td>
</tr>
<tr>
<td>Partner did more household tasks</td>
<td>-0.06</td>
<td>0.01</td>
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<tr>
<td>Partner did more decision-making</td>
<td>-0.07</td>
<td>0.01</td>
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<tr>
<td>Partner more involved in child-care</td>
<td>-0.11</td>
<td>-0.05</td>
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<tr>
<td>Dissatisfaction with household task distribution</td>
<td>-0.16</td>
<td>0.18</td>
</tr>
<tr>
<td>Dissatisfaction with decision-making distribution</td>
<td>-0.17</td>
<td>*0.25</td>
</tr>
<tr>
<td>Dissatisfaction with child-care task distribution</td>
<td>-0.14</td>
<td>0.13</td>
</tr>
</tbody>
</table>

Note: **: Significant at the p < .01 level. *: Significant at the p < .05 level.
Table 10 Correlations between all variables for PDA women and anxiety sensitivity and mobility

<table>
<thead>
<tr>
<th>Variable</th>
<th>Correlation with anxiety sensitivity</th>
<th>Correlation with mobility</th>
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<td><strong>Depression</strong></td>
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<tr>
<td>Beck Depression Inventory</td>
<td>.30</td>
<td>.32</td>
</tr>
<tr>
<td>DSM IV based depressive scale</td>
<td>.26</td>
<td>.23</td>
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<tr>
<td><strong>Anxiety</strong></td>
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<tr>
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<td>*.48</td>
</tr>
<tr>
<td>Mobility</td>
<td>*.48</td>
<td>-</td>
</tr>
<tr>
<td><strong>Relationship problems and satisfaction</strong></td>
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<td></td>
</tr>
<tr>
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<td>-.03</td>
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<td>Relationship satisfaction</td>
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<td><strong>Dominance</strong></td>
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<td></td>
</tr>
<tr>
<td>Income</td>
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<td>.21</td>
</tr>
<tr>
<td>Economic dependence on partner</td>
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<td>.07</td>
</tr>
<tr>
<td>Control of surplus spending money</td>
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<td>-.07</td>
</tr>
<tr>
<td>Desired control of surplus spending money</td>
<td>-.12</td>
<td>-.09</td>
</tr>
<tr>
<td>Dissatisfaction with control of surplus spending money</td>
<td>-.02</td>
<td>.09</td>
</tr>
<tr>
<td>Commitment to relationship</td>
<td>.19</td>
<td>.28</td>
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<td>Sex role attitudes</td>
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<td>.28</td>
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<td>-.32</td>
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<td>Previous physical assault by partner</td>
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<td>.31</td>
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<tr>
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<td>.11</td>
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<td>.21</td>
</tr>
<tr>
<td>Economic dependence on partner</td>
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<tr>
<td>Control of surplus spending money</td>
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<td>-.07</td>
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<td>Desired control of surplus spending money</td>
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<td><strong>Power processes</strong></td>
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<td>Male demand – female withdraw behaviour</td>
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</table>

Note: *: These correlations are considered significant at p < .05.
Table 11 Status of the members of couples containing control, PDA, and depressed women on dependent variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Control Males (N=20)</th>
<th>Control Females (N=20)</th>
<th>PDA Males (N=20)</th>
<th>PDA Females (N=20)</th>
<th>Depressed Males (N=20)</th>
<th>Depressed Females (N=20)</th>
<th>Gender</th>
<th>Dx</th>
<th>G X Dx</th>
<th>Differences between</th>
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<td>11.95</td>
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<td>**80.05</td>
<td>**34.26</td>
<td>**36.13</td>
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<tr>
<td></td>
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<td>3.36</td>
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<td>9.24</td>
<td>2.85</td>
<td>11.53</td>
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<td>3.00</td>
<td>0.85</td>
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<td>**74.16</td>
<td>**33.91</td>
<td>**42.66</td>
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<td>1.75</td>
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<td>1.75</td>
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Note: **: Significance difference at the p < .01 level. *: Significant difference at the p < .05 level. #: Significant difference at the p < .06 level.
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Note: **: Significant difference at the p < .01 level. *: Significant difference at the p < .05 level. °: Significant difference at the p < .00 level.
Table 12 Correlations between all variables and physical assault by partner, previous physical assault by partner, and psychological aggression towards partner

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Note: ** : Significant at the p < .01 level. * : Significant at the p < .05 level.
Table 13 ANCOVAs on dependent variables using couple satisfaction, physical assault by partner, previous physical assault by partner, and psychological aggression towards partner

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<th>ANCOVA Effects</th>
<th>Couple satisfaction</th>
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Note: **: Significance difference at the p < .01 level. *: Significant difference at the p < .05 level. °: Significant difference at the p < .06 level.
Table 13 ANCOVAs on dependent variables using couple satisfaction, physical assault by partner, previous physical assault by partner, and psychological aggression towards partner (continued)

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<td>**92.03 0.24 1.59</td>
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<td>**233.59 0.09 0.00</td>
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Note: **: Significance difference at the p < .01 level. *: Significant difference at the p < .05 level. #: Significant difference at the p < .06 level.
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Note: ****: Effects of diagnosis significant at the p < .01 level. *: Effects of diagnosis significant at the p < .05 level. *: Effects of diagnosis significant at the p < .06 level.
Table 14 Status of members of couples containing controls, PDA, and depressed women on discrepancy variables reflecting the difference between male and female partners’ scores (continued)

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<tr>
<th>Variable</th>
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<th>ANOVA</th>
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**Note:** ****: Effects of diagnosis significant at the p < .01 level. *: Effects of diagnosis significant at the p < .05 level. ° : Effects of diagnosis significant at the p < .06 level.

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Table 15 Correlations between male and female partners’ scores for couples containing control, PDA, and depressed women

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<th>PDA</th>
<th>Depressed</th>
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Note: ****: These correlations are considered significant at the p < .01 level. *: These correlations are considered significant at the p < .05 level.

°: These correlations considered significant at the p < .06 level.
Table 16 Correlations between all dependent variables

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<th>Correlation with dominance</th>
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Note: **: Significant at the p < .01 level. *: Significant at the p < .05 level.
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Note: ** : Significant at the p < .01 level. * : Significant at the p < .05 level.
Table 16 Correlations between all dependent variables (continued)

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*Note: ** : Significant at the p < .01 level. * : Significant at the p < .05 level.*
Table 16 Correlations between all dependent variables (continued)

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Table 16 Correlations between all dependent variables (continued)

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<td>Psychological aggression towards partner</td>
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<td><strong>Power processes</strong></td>
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<td>Male demand – female withdraw behaviour</td>
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<td>Female demand – male withdraw behaviour</td>
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<tr>
<td><strong>Power outcome</strong></td>
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<tr>
<td>Partner did more household tasks</td>
<td><strong>-.38</strong></td>
<td>*-.20</td>
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<tr>
<td>Partner did more decision-making</td>
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<td>-.06</td>
<td>-.06</td>
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<tr>
<td>Partner more involved in child-care</td>
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<td>*-.18</td>
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<td><strong>.50</strong></td>
<td>-</td>
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Note: **: Significant at the p < .01 level. *: Significant at the p < .05 level. °: Significant at the p < .06 level.
Appendix E

Qualitative data
Qualitative data

Presentations

Of the 20 PDA women in this study, 11 (or 55%) had taken antidepressant medication at some point in the past, typically in the 12-month period after their first panic attack (50%). An exception was one PDA woman who took her first antidepressant 12 years after her first panic attack. Five (or 25%) of the PDA women were still taking an antidepressant at the time of this study. One woman with PDA reported that her husband was a binge alcoholic and another that her husband also had a history of PDA. None of the partners of the 20 PDA women attended for interview.

Of the 20 depressed women, clinical interview revealed that 4 (or 20%) of them had secondary PDA. The criteria for establishing depression as the primary presentation were that the woman reported a more chronic history of depression (relative to PDA), and that her primary concern was feeling very down. Two (or 10% of) depressed women also reported consuming moderate amounts of alcohol to 'get through the day', and 1 of these reported a past history of bulimia. Two (or 10% of) depressed women reported that their partners consumed a moderate degree of alcohol. Although the partners of each of the 20 depressed women were asked to attend for interview, only 4 (or 20%) did so.

Seventeen (or 85%) of the depressed women were taking antidepressant medication at the time of this study. Of the other 3 depressed women, one stated that she ‘hid’ her depression from her General Practitioner (although she had a DSM-IV depression checklist score of 9 and a BDI score of 27). The second of these women refused to take medication. The remaining depressed woman was taking a mood stabiliser despite their being no current or historical indications of mania or other psychopathology (e.g., schizoaffective disorder). Her DSM-IV depression checklist score was 7 and her BDI score 38.

At least another 50 PDA and depressed women could not get their partners to complete the research questionnaire. The questionnaire responses of only a handful of these 50 women and the interview data of the partners of the above 20 PDA and 20 depressed women were included in this qualitative analysis.
Relationship satisfaction

When asked to what degree they were happy in their relationship, 6 (or 30%) of the 20 PDA women reported that they were ‘extremely happy’, 7 (or 35%) reported that they were ‘very happy’, 5 (or 25%) reported that they were ‘happy’, 1 (or 5%) reported that she was ‘fairly unhappy’, while another woman (or 5%) reported that she was ‘extremely unhappy’.

When asked to what degree they were happy in their relationship, 1 (or 5%) of the 20 depressed women reported that they were ‘extremely happy’, 4 (or 20%) reported that they were ‘very happy’, 1 (or 5%) reported that she was ‘happy’, 5 (or 25%) reported that they were ‘a little unhappy’, 8 (or 40%) reported that they were ‘fairly unhappy’, while one woman (or 5%) reported that she was ‘extremely unhappy’.

Thus, while only 10% of PDA women reported that they were unhappy to some degree, this figure was 70% for depressed women.

Dominance

Nine (or 45%) of the 20 PDA women reported that they were more dominant in their relationship, 8 (or 40%) reported that they were as equally dominant as their partners, while only 3 (or 15%) stated that their partners were more dominant. While some PDA women reported that they liked assuming control in their relationships (as they were accustomed to doing so in their other relationships/domains in their life), others wanted an egalitarian arrangement. The most common form of the latter was a negotiated arrangement whereby some domains were jointly controlled or managed (e.g., parenting) while others were (primarily) managed by either partner.

Eight (or 40%) of the 20 depressed women reported that they were more dominant in their relationship, 5 (or 25%) reported that they were as equally dominant as their partners, while 7 (or 35%) stated that their partners were more dominant. Some depressed women stated that they would get their way because their partners were easy-going and ‘could be got around’. Others reported that they did not want to be ‘the leader’ in their relationship but felt they were forced to be so. Others reported that their partners were simply controlling. One depressed woman considered her partner to be ‘overly-possessive’ in that he would actively disrupt her attempts to befriend others (especially men). She also reported that he
would order her to go shopping. Her partner, on the other hand, stated that ‘I am overpowering but really that’s me trying to protect her from doing things wrong’.

Reverting back to the quantitative data (Table 16, Appendix D), dominance correlated highest with both control of surplus spending money \( r = -0.42 \) and partner did more decision-making \( r = -0.41 \), indicating that dominance may be associated with who exercises less control of the surplus spending money and who makes less family decisions. It may be that such activities were considered to be unwanted responsibilities that were characteristic of a (disempowering) over-functioning role.

**Qualitative data for power bases**

**Financial status quo**

Both PDA and depressed couples detailed a variety of different arrangements with regard to management (or control) of financial resources. Many couples pooled their resources and deposited all monies (e.g., salaries, State benefits, rental income) into one (mutually accessible) savings account from which both partners withdrew needed monies at will or from which (mutually negotiated) direct debits went into separate current accounts for individual use. However, such arrangements were sometimes unilaterally rescinded. For example, one depressed woman (who had such an arrangement) reported an incident whereby her husband burnt her charge and credit cards following an argument.

Slightly more prevalent in depressed couples (relative to PDA couples), a small number of women saw no monies other than receiving a weekly ‘cash allowance’ from their partner to cover sundry expenses (e.g., food purchases, clothing and medical expenses, house repairs). Some of these women’s partners would further exert control by not allowing access to investments (e.g., property, land). To counteract this, some of these women took up part-time employment. This controlling arrangement contrasted with some PDA and depressed women controlling all monies and giving their male partners a cash allowance for items such as petrol for the car and social activities (e.g., going out for a drink).

Nine (or 45%) of the 20 PDA women were working. Fifteen (or 75%) of them wanted no change in relation to control of finances. Twelve (or 60%) wanted a shared responsibility arrangement with their partners, 2 (or 10%) wanted to maintain their (relatively) greater control, while another woman wanted her partner to maintain control in this domain. Of the
5 (or 25% of) PDA women who reported dissatisfaction in this domain, 4 (or 20%) were dissatisfied with having too much control. All of these 5 women wanted their partners to become more aware of their efforts to make ends meet, 4 of them wanted their partners to assume a shared responsibility for management of finances, and one woman wanted her partner to assume more control.

Seven (or 35%) of the 20 depressed women were working. Like the PDA women who were working, these women reported that they gladly worked even though it was stressful at times to fulfil the dual roles of provider and housekeeper/parent. Twelve (or 60%) of the depressed women wanted no change in relation to control of finances. Of these 12 women, 9 (or 45%) wanted to continue their shared responsibility arrangement with their partners, 2 (or 10%) wanted to maintain their (relatively) greater control, while another woman wanted her partner to maintain control in this domain. Of the 8 (or 40% of) depressed women who reported dissatisfaction in this domain, 5 (or 25%) were dissatisfied with having too much control and their partners’ not recognising their efforts to make ends meet, and all of them wanted shared responsibility. Whether a depressed woman had or had not shared control of finances, lack of finances increased their worries over providing the basic necessities for their family, limited their socialising options and other activities (e.g., shopping).

Quantitative data (Table 16, Appendix D) indicated that economic dependency was most highly correlated with lower income (or socio-economic class; r = .62), partner more involved in child-care (r = -.58), and partner did more household tasks (r = -.47). Hence, these data suggest that economic dependence was associated with earning less, being more involved in child-care, and doing more household tasks. Taken together, these data indicated a traditional gendered division of domestic work with the working partner being less economically dependent (as hypothesised by resource theory).

**Commitment**

When asked to what lengths they would go to see that their relationship would succeed, 6 (or 30%) of the 20 PDA women reported that they would go to almost any length, 8 (or 40%) reported that they would do all that they could, 5 (or 25%) reported that they would do their fair share, while 1 woman (or 5%) reported that she was not prepared to do much more than she was already doing.
When asked this same question, 4 (or 20%) of the 20 depressed women reported that they would go to almost any length, 5 (or 25%) reported that they would do all that they could, 6 (or 30%) reported that they would do their fair share, 4 women (or 20%) reported that they would not prepared to do much more than they were already doing, and one woman (or 5%) stated that there was no more that she could do to keep her relationship going.

Hence, 95% of PDA women reported they would do their fair share of work (or more) to keep their relationship alive. This figure was slightly lower for depressed women (i.e., 75%), indicating a higher percentage of less committed depressed women (relative to PDA women). Nichols (1996) presented another way to gauge commitment and the extent to which partners value the relationship and their intentions concerning maintaining it. He described 3 categories of commitment: (i) pre-ambivalent (or positively committed and have not considered ending the relationship); (ii) post-ambivalent positive (have considered leaving but concluded will remain in the relationship); or (iii) post-ambivalent negative (have considered leaving but concluded will leave the relationship).

Using Nichols’s (1996) categorisations, most PDA and depressed women were rated as post-ambivalent positive. Upon closer scrutiny, at least 8 (or 40%) of the depressed women were actually post-ambivalent negative. These women did ‘not see the point’ of trying to resurrect their ‘failing’ and ‘unrewarding’ relationships having tried for many years to appeal to their ‘disconnected’ partners for a better relationship. However, they did not exercise the option of initiating a separation for a number of reasons including not having enough money to live independently, not wanting to displease parents (and/or in-laws), remaining fearful of partner ‘retaliation’, not wanting to break (Roman Catholic) marriage vows, the belief that they were responsible for the poor state of their marriage, a fear of being alone (‘Who’ll take me then?’), and the belief that children need two parents. Hence, the commitment of some depressed women might better be described as ‘feeling trapped’. Supporting this argument is the high correlation (r = .60) between commitment and relationship satisfaction (Table 16, Appendix D).

Whilst two (or 10%) of PDA women expressed similar sentiments to those above, there appeared to be less resignation among these women that their relationships could not improve and prosper.
Sex role ideology

Our quantitative data means (Table 11, Appendix D) indicated that both groups of PDA and depressed women had an approximately neutral (or bordering on a non-traditional) sex role ideology (i.e., scores of 15.95 and 14.10 respectively on the Sex Role Attitudes Scale; Huber & Spitze, 1983). Further analysis of this quantitative sex role ideology data using the arbitrary (tri-partite) criterion of non-traditional (a score of <14 on the Sex Role Attitudes Scale), traditional (>22), and neutral otherwise, 6 (or 30%) of PDA women would be classified as non-traditional, 13 (or 65%) as neutral, and 1 (or 5%) as traditional. Using this same criterion, depressed women would be evenly classified as having either a non-traditional or a neutral sex role ideology.

It is noteworthy that the mean sex role ideology score for control women was 13.30 indicating a (weak) non-traditional sex role ideology for these 20 women (using the above-mentioned arbitrary criterion). This figure contrasts with that of Mirowsky’s (1985) population-based findings of mean of 16.74 for women (n = 680). Hence, it may be that modern women have, in general, become slightly more oriented towards a non-traditional sex role ideology since the inception of the Sex Role Attitudes Scale 18 years ago. However, interview data also indicated that, while most women espoused a neutral sex role ideology, some women had tendencies towards a traditional sex role ideology (e.g., sociotropy). This tendency was slightly more evident among the depressed women (relative to the PDA women).

Desired level of intimacy

Our statistical analysis of our quantitative data (Table 11, Appendix D) revealed similar means for control, PDA, and depressed women on desired level of intimacy. Further analysis of our quantitative desire for intimacy data using the arbitrary (tri-partite) criterion of more independence desired (a score of <18 on the Closeness and Independence Scale), more intimacy desired (>30), and otherwise no change in intimacy / independence desired, 50% of PDA women would be classified as wanting no change and 50% would be classified as wanting more intimacy in their relationships. Using this same criterion, 1 (or 5%) of depressed women would be classified as wanting more independence, 5 (or 25%) as wanting no change in intimacy, and 14 (or 70%) as wanting more intimacy.
Qualitative data also revealed that a higher proportion of depressed women (75%) wanted more intimacy in their relationships compared to PDA women (55%). The depressed women in our sample highlighted more sharing of feelings and more time together as their most pressing concerns. For a small number of depressed women, their husbands sleeping by themselves was a major concern; these husbands apparently claimed that they wanted ‘a good night’s sleep’ before the following day’s work. In contrast, a similarly small number of depressed women purposefully slept by themselves against their partners’ wishes.

A number of depressed women also believed that they were responsible for their ‘intimacy problem’ in that they ‘could not talk’ about their emotions. There appeared to be little awareness that this tendency to not self-disclose may have been due to an understandable dearth of trust in the relationship. In support of the intimacy – communication hypothesis (e.g., Van den Bourcke et al., 1995), the (overall) correlational analyses (Table 16, Appendix D) showed significant correlations between desired level of intimacy and male demand – female withdraw behaviour ($r = .27$), female demand – male withdraw behaviour ($r = .24$), and mutual constructive communication ($r = -.23$).

*Physical assault by partner*

The majority of women were initially quite reluctant to discuss physical assault by their partner and even when they did discuss this issue, they did not do so in depth. However, in contrast to just one PDA woman (or 5%) reporting a recent history of physical assault by her partner, 9 (or 45%) of the depressed women reported this dynamic. Forms of physical assault included different degrees of sexual coercion, being pinned up against walls or down on the bed (‘so that I’d listen’), punching (so as ‘not to leave visible bruises’), kicking, slapping, pulling by the hair, and shoving. Some women also reported property destruction. An example of the latter was an incident where the partner of a depressed woman put his fist through a glass coffee table because their 8-year-old was unable to independently complete his homework.

Couples were informally categorised as domestically violent (DV) if the male partner had reportedly engaged in a minimum of 6 or more minor violent acts (i.e., pushing or hitting with something), 2 or more moderately violent acts (i.e., slapping, twisting hair or an arm), or at least 1 life-threatening violent act (i.e., beating up or threatening with a knife or gun) in the past year (e.g., Babcock et al., 1993; Berns et al., 1999).
Of the 9 depressed women who reported physical assault by their partners, the relationships of 8 (or 40%) of these women could (just about) be categorised as DV. Questionnaire data indicated that the male partner in 5 of these 8 couples also reported physical assault (by their female partners) with the level of physical assault severe enough that 3 of these couples could be classified as DV. Based upon male reports of physical assault, 1 other depressed couple could be classified as DV and another as having a history of physical assault. An example of the latter relationship was an incident whereby the depressed woman (uncharacteristically) chased her husband around the kitchen with a knife (after he disclosed an extra-marital affair).

Fearing their partner’s superior physical strength and an escalation in violence, some depressed women in DV relationships reported (to different degrees) a hyper-vigilance around eliciting anger in their partners. Where possible they would try to ‘not to make a fuss’ and to minimise their requests to their partners (e.g., by enlisting the help of other family members / friends). They would also try to please their partners in a number of ways including having the house clean and the shopping done, and by trying to ensure that their children behaved well. These women were also vigilant of behavioural cues that their partner might be angry (e.g., ‘If I ask him to do something and then he licks his lips, I know that he’s angry and saying to me stop bossing me around so I back off’).

Only 1 PDA couple (or 5%) met the above criteria for DV based on interview data. Questionnaire data indicated that in 4 (or 20% of) PDA couples, the male partner also reported a history of physical assault (by the female partner) but the level of physical assault was not severe enough to be classified as DV.

Of the women in the 8 depressed / DV couples (but not the PDA woman), all of them reported a greater desired level of intimacy and 4 of them reported being the more dominant partner. In relation to the latter, (overall) correlational data (Table 16, Appendix D) indicated that dominance was significantly correlated with physical assault by partner (r = -.26). This may support the hypothesis that male batterers may not experience themselves as more powerful or as having what they want (e.g., Stets, 1995).
Psychological aggression (towards partner)

From Table 11 (Appendix D), it can be seen that group means for both partners of control couples (i.e., -17.75 and -17.65), the partners of PDA women (i.e., -17.10), and the partners of depressed women (i.e., -17.45) were remarkably similar. These means contrasted with those of PDA and depressed women who indicated expressing much more psychological aggression (i.e., means of -7.95 and -4.80 respectively). These findings would suggest that control, PDA, and depressed women experienced a similar level (or quantity of) psychological aggression from their partners (as reported by these partners). In response, findings suggest that while control women expressed a similar level of psychological aggression towards their partners as they experienced themselves, both PDA and depressed women expressed a much higher degree of psychological aggression.

Comparing the above means with the normative means for the SSAG (Table 4), it would appear that control women utilised a similar level of psychological aggression to that used by satisfactorily married women in the normal population. Cross comparisons would also indicate that the male partners in the 3 couple groups in our sample used substantially less psychological aggression than normal population male partners. As mentioned previously, this may reflect a selection bias due to our sample consisting only of couples that agreed to participate in this study. Those couples that did not complete our questionnaires or give us permission to use their data in this research were not included. Such a selection bias may have skewed our sample towards appearing less interpersonally dysfunctional than may actually be the case (Carter, Turovsky, & Barlow, 1994).

Our qualitative data indicated that 9 (or 45% of) PDA women and 13 (or 65% of) depressed women reported expressing psychological aggression towards their partners on a regular basis. These women reported that they did not understand their psychological aggression. This consisted primarily of expressing an ‘excessive’ or ‘unjustified’ degree of anger (Miller, 1986). A sequential cycle of a build-up of resentment (against one’s partner), an (eventual) eruption of anger, feeling self-blame and guilt (over failing to be a ‘good’ partner and/or mother), a redoubling of one’s efforts to please one’s partner with a resultant build-up of resentment was quite common in some depressed women’s relationships.

Upon investigation, the sources of their anger were multiple and included their partners’ apparent inability to understand their presentation, not having a ‘fulfilling relationship’ with
their partners, not asserting oneself with (or 'standing up against') their partners (e.g., in arguments), a self-perception of inability to cope (with their presentation and daily tasks), their thinking that they had become 'just like' one or both parents (e.g., controlling), and anger relating to past events.

In relation to the latter, a number of depressed women reported that they displaced their high level of anger towards life in general onto their partners. One woman detailed a poignant story of disclosing intra-familial CSA and of falling in love. Her mother did not want to lose 'the best worker in the house' via her becoming pregnant. This mother reportedly became so enraged at this woman’s 'whistle blowing' (i.e., her disclosure of the CSA) and an episode of deliberate self-harm that the mother had her ‘committed’ to a psychiatric hospital over a period of 6 years in her early twenties. This woman’s siblings also reportedly disowned her (e.g., she was not invited to their weddings because she was a 'mental patient'). She reported that she harboured an immense deal of anger towards her family and the State (because of 'a regime of excessive medication' and encouragement that she should give up her children) but that she had no where to (safely) express it except to her husband.

As mentioned above, an ongoing and primary source of anger in many of the PDA women and nearly all of the depressed women was a lack of partner understanding of their presentation and what they were going through. This lack of empathic accuracy (Simpson et al., 2001) manifested in comments from partners such as ‘It’s just your low behaviour’ (when these women expressed anger). Such non-validating comments only served to fuel these women’s anger so that some of them were ‘easily pushed to being angry’. Others reported that they had learned that they needed to scream at their ‘distant’ partners ‘in order to get’ them ‘to do anything’. Other depressed women reported that they had given up getting angry, as it had ‘no effect’ on their partners’ behaviour.

Verbal aggression (from partner)

As noted above, statistical analysis of our quantitative data (of male partners) indicated that control, PDA, and depressed women experienced similarly low levels (or quantities of) psychological aggression from their partners. In contrast, qualitative data (of female partners) suggested that only 3 (or 15%) of the PDA women but 10 (or 50%) of the depressed women reported that verbal aggression from their partners was a problem.
Verbal aggression included comments such as ‘You’re a narky bitch to live with’, ‘Take your medication’, ‘You’re fat’, ‘You’re stupid because you left school early and you don’t work’ (outside the home), ‘You’re missing the drink’, ‘I’ll take the kids away’ (from you), ‘I’ll get you signed in’ (to the psychiatric hospital), ‘Your mother is sick’ (directed towards the children), ‘You’ve got fibromyalgia’, ‘You’re a prophet of doom’, ‘You’re no good as a mother’, ‘I got a vasectomy for you’, ‘Stop nagging’, ‘There’s still nothing in the fridge’, ‘You’re schizophrenic’, ‘I’ve talked with my solicitor and he’s pretty sure I’ll get the kids’, ‘You’re not a normal person because you don’t want to be with your children’, ‘We (our family) would be better off without you’, and ‘You could not even take care of your child (even before he/she came into this world)’.

Verbal aggression also took more subtle forms. One depressed women detailed how her husband would regularly comment on how ‘the toilet looked like it hadn’t been cleaned out in weeks’ even though she would clean it spotlessly. Another depressed women reported how her husband would reply to her requests for him to help out more with ‘There’s no man around as good as me’, while another partner reportedly often said ‘I am the perfect partner’.

It was quite apparent that depressed women experienced many more ‘cutting’ and personalised comments from their partners than did PDA women. Hence, it may not be the quantity of verbal aggression per se that is important but the degree of viciousness inherent in it. Alternatively, while the empirical literature would suggest that women might be more adversely affected by overt expressions of hostility than men might be (e.g., Kiecolt-Glaser et al., 1996), the PDA and depressed women in our study may have internalised verbal abuse to different degrees. For example, a depressed woman may have been made to feel worse if her partner attributed her verbal aggression to her ‘illness’.

Additionally, it may be that for depressed women, their depression rendered recall of negative exchanges as more salient and consequential for their evaluation of the relationship (Bower, 1981). However, as indicated in the literature (e.g., Coyne & Benazon, 2001), it was noteworthy that some partners of depressed women communicated (to these women) specific doubts about the validity of their depressive symptoms. This may have translated into increased anger (and eventual expression of same) in these partners.
PDA women, on the other hand, reported that they were ‘reasonably able’ to deal with (albeit less personal) verbal aggression, partly because they recognised that ‘things are often said in the heat of the moment’. Such differences may reflect how depressed women may have become sensitised to psychological aggression over time such that they had lower tolerances or thresholds for such aggression. These observations are important considering that males’ (verbal) hostile interactional behaviour may the primary longitudinal predictor of relationship satisfaction or outcomes for females (Roberts, 2000).

Other (non-verbal) ‘control tactics’ used by the partners of depressed women included (1) asking their kids to ask their mother questions about their Irish homework (although it was generally accepted that these mothers had no knowledge of Irish); (2) using ‘big words’ in conversation; (3) writing down everything that these women would say in arguments and then going over it the following day; and (4) checking the mileage on the family car to ensure that these women did not go ‘anywhere unusual’.

**Qualitative data for power processes**

*Male demand – female withdraw behaviour*

Statistical analysis of quantitative data (Table 11, Appendix D) indicated that depressed couples were characterised by more male demand – female withdraw behaviour relative to both control and PDA couples. However, PDA and depressed women both reported similar levels of this dynamic (i.e., means of both 12.18 and 14.21 respectively), with the latter reporting a similar amount of this dynamic as their partners (i.e., mean of 13.42). Further inspection of sample means indicated that the degree of this dynamic reported by our control couples was significantly less than that reported by non-distressed couples (n = 25), and that reported by our depressed couples was comparable to that reported by distressed couples seeking marital therapy (n = 15; Christensen & Shenk, 1991).

Qualitative data indicated that a similar number of PDA (i.e., 30% of) and depressed (i.e., 35% of) women reported this interactional behaviour, and that these interactions took many forms. This dynamic typically was reported when male partners wanted to address some relationship issue (as opposed to their female partners wanting to address an issue). Some male partners of (silent and avoidant) depressed women, concerned about their partner’s (physical and mental) health, would try to ‘force the issue’ and engage in ‘problem solving’
discussion. One man reported that his partner would get headaches in the middle of almost every discussion (regardless of who started the discussion).

As mentioned previously, some depressed women reported that they had 'an intimacy problem' or that they could not tell their partners their concerns. These same women added that they tended to withdraw because (1) their partners appeared not to understand them (i.e., lack of empathic accuracy); (2) they believed their male partners should know them better ('after being together for so long'); (3) they did not want to give in to their male partners' demands; and (4) because they 'feared losing' their 'dignity' if they asked for their needs to be met (by their male partners).

Furthermore, as has been found in other studies (e.g., Sagrestano et al., 1999), some depressed women reported that they would 'back down' (or withdraw) from conflictual interactions when their partners began using coercive influence tactics (such as verbal aggression). This they did as a means of trying to deescalate the conflict and prevent it from leading to physical assault (as had happened previously in their relationship). This included consenting to have sex.

One depressed woman reported that she lived in fear that her partner would shoot her or himself; on one occasion the local police force reportedly had to confiscate his gun. Another depressed woman reported that the rule in their relationship was 'be seen but not heard' so that she 'shut up' when disagreements arose. These women would 'tip-toe' around their partners so as not to displease them. Even the tone of a partner's voice would hurt or really affect some of these women. Some other women, not knowing how to say things like asking their partners to clean up 'in a nice way', often decided to 'say nothing and suffer in silence'.

Some women were also afraid to say anything (in response to a male demand), as sometimes their response would be 'overly emotional'. They would therefore 'say nothing' only for their 'logical' male partners to also withdraw. This would continue up until the depressed woman would get so frustrated (i.e., angry) as to 'explode' with emotion. The length of this period differed amongst the group of depressed women. However, such intense emotional expression typically precipitated male withdrawal. This manifested as a prolonged male silence (and/or resulted in everything being done in the male partner's 'own
time”) or the male partner ‘storming out’. Feeling down and increasingly angry, the depressed women would then try to re-engage with their partners (i.e., female demand behaviour) only for their male partners to possibly withdraw again.

One PDA woman reported that she believed that ‘bad’ behaviour needed to be punished. Hence, she tended to withdraw from her husband when she perceived that he was ‘bad’ (e.g., if was unreasonable in an argument). Another depressed woman reported how she was ‘devastated’ that her husband never noticed that over a 2-month period she withdrew (from their relationship) in order to ‘give him a taste of what it was like’ to be with a withdrawing partner (i.e., as she experienced him to be).

Female demand – male withdraw behaviour
Statistical analysis of quantitative data (Table 11, Appendix D) indicated that depressed couples were also characterised by more female demand – male withdraw behaviour relative to both control and PDA couples. Both depressed women and their partners reported similarly high levels of this behaviour, the former reporting more than that reported by PDA women (i.e., means of 15.74 and 11.65 respectively). The degree of this dynamic reported by our control couples was significantly less than that reported by non-distressed couples (n = 25), and that reported by our depressed couples was comparable to that reported by distressed couples seeking marital therapy (Christensen & Shenk, 1991).

Qualitative data indicated that a similar number of PDA (55% of) and depressed (65% of) women reported this dynamic, and that this dynamic typically was reported when female partners wanted to address some relationship issue (as opposed to their partners wanting to address an issue). These interactions took various forms including both PDA and depressed women screaming at their male partners to get them to ‘do anything’, or simply their asking to talk about their feelings or other matters (e.g., family finances, the progression of a pregnancy). Two depressed women reported that they ‘took a drink’ in order to feel ‘powerful enough’ to confront their husbands.

Many depressed women believed that their partners did not want to sometimes engage in discussion (or conflict) for a number of reasons. These included not wanting to respond to an ‘irate’ or ‘overly-emotional’ (female) partner, and knowing that doing so might result in net losses (in power) for their male partners. Although these losses sometimes accrued from
negotiation with a member of the more verbally skilful sex, some depressed women stated that their partners were much more verbally skilled (and intelligent) than they were themselves. More typically, losses would result from simple discussion of undefendable inequalities in domains such as management of finances, and household and child-care task distribution.

Male partners reportedly responded in a variety of ways to female demandingness including ‘walking away’ (for periods of up to 3 to 4 days), or replying with comments such as ‘I’ll come home when you stop arguing’. Other women reported that they might be left sitting by themselves when out socialising (as a couple) for lengthy periods of time (despite explicit requests that this not happen). Other men, subsequent to their female requests to help them out more with domestic or child-care tasks, would respond with ‘I can’t look after everything inside and out’ (-side the house). Another women reported that her partner would just turn completely silent ‘for as long as it took’ for her to ‘give in’ to him.

Hence, the motivations underlying female demandingness in some PDA and depressed women included wanting change in the relationship (and believing that there was no other way to achieve this but by ‘nagging’ or shouting), and wanting emotional connection with their partners (e.g., wanting their partner to understand them more via chatting). Their male partners used a variety of withdrawal methods in response. However, they sometimes reportedly responded with physical assault if they were being out-manoeuvred in discussion by their depressed partners.

*Mutual constructive communication*

Given the approximately similar levels of demand – withdraw behaviour in both PDA and depressed couples, it was somewhat surprising that qualitative analysis indicated that only 5 (or 25% of) depressed women, in contrast to 11 (or 65% of) PDA women, reported regular episodes of mutual constructive communication. Respective quantitative means for women (Table 11, Appendix D) of 18.35 and 12.42 supported this finding. However, there are a number of reasons that may explain this finding.

Some male partners of depressed women indicated unsuccessful attempts at communicating constructively partially because their partners would often ‘bring up (unprocessed) stuff’ from the past (as manifest in ‘emotional explosions’). A possible contributory factor to the
latter may have been attempts of some depressed women to live in the past because of ‘an acute fear that the future’ would ‘be likewise’. Another potential contributory factor may have been the couples’ lack of willingness to ‘stick with’ an argument until its resolution. Most depressed couples were not characterised by a fair and reasonable negotiating history and this may have predisposed to decreased expectations of the value of trying to successfully resolve an issue. Other male partners reported how there was just no time to communicate with their partners. After working all day, doing odd jobs around the house, facilitating completion of homework, and getting the children to bed, these men were just too tired or had no time together with their partners to talk ‘meaningfully’ at length.

Similarly, many depressed women reported that there was an excessive focus on their feelings and (depressive) symptoms to the point that there was not enough time to adequately address relationship difficulties. Some depressed women reported that rather than disclose and discuss their personal concerns with their immediate partners, they sometimes did so with their mothers (or alternatively with their girlfriends, in-laws, or neighbours). This served the dual purpose of ingratiating themselves to their (sometimes critical and rejecting) mothers but also to (relatively safely) vent their frustrations about the dynamics of their relationships (with their partners). One male partner of a depressed woman also reported doing likewise and for similar motivations.

Some depressed women reported fearing disclosing intimacies to their partners as these might be used against them subsequently. Others did not want to do so as this would reinforce the impression that they were highly inadequate (or ‘weak’) due to their being ‘topsy-turvy’ relative to their ‘stable’ partners. These women also reported that they believed that their partners had become dishonest in communicating with them. Other women had learned through repeated episodes of ‘not getting any real reaction’ from their male partners to not disclose their personal concerns.

One particular depressed woman reported a fear that if she began to praise her husband’s attempts to help out around the house, he might ‘get lazy’ and not help out in the future.
Qualitative data for power outcomes

Dissatisfaction with household task distribution

Quantitative data (Table 11, Appendix D) indicated that control, PDA, and depressed women all reported similar levels of dissatisfaction with household task distribution (i.e., means of 1.27, 1.46, and 1.37 respectively). These figures compare with means of 0.63 for non-depressed non-distressed women (n = 25) and 1.61 for treatment-seeking depressed women (n = 50; Table 6). Qualitative data revealed that 8 (or 40% of) PDA and 11 (or 55% of) depressed women reported this domain to be an ongoing source of dissatisfaction within their relationship.

One depressed woman reported that her partner would order her to go shopping and that she no longer asked him to clean up, as her previous requests to him to do so would elicit ‘a tantrum’ from him. A number of other depressed women reported that they believed that their partners ‘needed’ them (e.g., for parenting, doing household chores) but did not ‘want’ them. One depressed woman summed up this belief when she stated ‘I see myself as a housekeeper and a meal maker but not as a wife’.

Another depressed woman stated that her husband was ‘old-fashioned’, liked her to ‘stay at home’, ‘for everything to be spotless’ and for him ‘to have his few pints’ (of alcohol) because he worked hard. Some women reported that repairs never got done ‘except for everybody else’. Others reported that their male partners were of the opinion that they should be working at home all the time (and ‘not take a break for a rest’) if they were not working an equal amount outside the home and equally contributing to the family finances. Some women, despite discrepancies in household task distribution, begrudgingly accepted this status quo because their partners did shift work.

In contrast, one depressed woman reported that her husband did his own cooking because he did not like her cooking. This contrasted with other men being told to stay out of the kitchen. One depressed woman went on a partial ‘domestic strike’ in that she refused to no longer iron her husband’s shirts, something that she knew he highly valued. Some men were also frustrated with what they saw as their partners’ excessive cleaning efforts in their homes. These women valued their cleaning as a way of constructively venting their anger and ‘of regaining some control’.
Dissatisfaction with decision-making distribution

Quantitative data (Table 11, Appendix D) indicated that control, PDA, and depressed women reported similarly high levels of partner more involved in decision-making (i.e., means of 4.82, 4.96, and 5.15). These figures compare with means of 5.18 for non-depressed non-distressed women (n = 25) and 5.46 for treatment-seeking depressed women (n = 50; Table 6). Male partners of each group of women also reported similarly high levels of partner more involved in decision-making (i.e., means of 5.09, 4.97, and 5.14). These figures compare with means of 5.14 for non-depressed non-distressed men (n = 25) and 4.88 for male partners of depressed women (n = 50; Table 6). However, while control and PDA women reported similar levels of dissatisfaction with decision-making distribution (i.e., means of 0.61 and 0.79), the mean for depressed women was significantly higher (i.e., 1.55). These figures compare with means of 0.48 for non-depressed non-distressed women (n = 25) and 1.41 for treatment-seeking depressed women (n = 50; Table 6).

Reflecting the trend in these figures, qualitative data revealed that 5 (or 25% of) PDA women and double this number (or 50%) of depressed women reported this to be an ongoing source of dissatisfaction within their relationship. While it is difficult to reconcile the greater dissatisfaction of depressed women (with decision-making distribution) with their performing a similar level of decision-making tasks relative to control and PDA women, a number of reasons may account for this difference. First, some of these women may simply have wanted equality with their partners in this domain. Some women reportedly experienced their relational dynamics to be fraught with (perceived) inequities and they therefore remained vigilant at not letting their partners 'score points' against them (in any domain) or to wield any extra power.

Second, some women reported that these decisions were 'simply not discussed' and that they wanted them discussed for the dual purpose of ensuring equality and instigating (previously absent) mutually respectful discussion. This contrasted with satisfied couples whereby there was mutual agreement (either implicit or explicit) on decision-making strategies.

Third, these women were often dissatisfied with who made particular high profile decisions (rather than being dissatisfied with every decision made). For example, while a number of depressed women reported that they were more than happy to allow their partners manage
domains such as their finances and other non-pleasant activities, their desire for family-oriented activities, especially at the weekends, was not always facilitated. Some depressed women reported how their partners would exit the house at the weekend to enjoy themselves (e.g., by going to the pub and/or participating in sport) or to get away for a break (e.g., 'I work 6 days a week and I want Sundays off'). This non-negotiated and 'God-given right' to socialise on Sundays particularly irked some depressed women and, for them, symbolised just how emotionally non-functional their relationship had become.

*Dissatisfaction with child-care task distribution*
Quantitative data (Table 11, Appendix D) indicated that control, PDA, and depressed women reported similarly low levels of partner more involved in child-care (i.e., means of 3.39, 3.29, and 3.31). These figures compare with means of 3.19 for non-depressed non-distressed women (n = 25) and 3.17 for treatment-seeking depressed women (n = 50; Table 6). However, male partners of each group of women reported similarly high levels of partner more involved in child-care (i.e., means of 6.36, 6.46, and 6.30). These figures are in stark contrast with means of 3.93 for non-depressed non-distressed men (n = 25) and 3.88 for the male partners of treatment-seeking depressed women (n = 50; Table 6). This unusual finding that men across all 3 couple groups in this study perceived their partners to be significantly more involved in child-care may suggest that they saw themselves as relatively uninvolved in this domain.

While control and PDA women reported (different but) similar levels of dissatisfaction with child-care task distribution (i.e., means of 0.91 and 1.25), the mean for depressed women was significantly higher (i.e., 1.71). These figures compare with means of 0.93 for non-depressed non-distressed women (n = 25) and 1.53 for treatment-seeking depressed women (n = 50; Table 6). Reflecting the trend in these figures, qualitative data revealed that 6 (or 30% of) PDA women and 11 (or 55% of) depressed women reported this to be an ongoing source of dissatisfaction within their relationship.

Again, while it is difficult to reconcile the greater dissatisfaction of depressed women (with child-care task distribution) with their performing a similar level of child-care tasks relative to control and PDA women, a number of reasons may account for this difference. First, these women simply may have wanted equality with their partners in this domain. A number of depressed women reported that their partners gave them all the 'responsibility of
keeping the house running and the kids happy’. Another woman reported that her husband got ‘the man works a lot whereas the woman does housework a lot’ idea from his parents. One depressed woman reported that her partner believed that because he worked hard outside of the home (to give his family ‘a good life’), he was not obliged to do his fair share of domestic chores (including parenting).

Second, some depressed women reported that their child-care efforts were not appreciated by their partners and that they questioned themselves at the end of (typically long and difficult) days why they bothered to continue to put in so much effort. Furthermore, some women’s child-care efforts were harshly criticised by their male partners and this was sometimes reinforced by the behaviour of ‘bold’ children who stated that ‘daddy is the boss’. Third, some women believed that they had become a second-class citizen when their children were born as this had given their partners what they had always wanted. This understandably engendered some resentment in these women and may have predisposed to a ‘power struggle’ in this domain. Fourth, some depressed women simply may not have had the energy to perform more than their equal amount of child-care tasks due to their depressive symptomatology.

From a male partner’s perspective, they may have feared fostering dependency in their partners. For example, when a PDA woman asked her partner to remain at home with her for a couple of weeks after she gave birth to their second child, he said ‘no’ apparently because he did not want her ‘to get dependent on him’.

Qualitative data for other variables

Relationship problems

Quantitative data (Table 11, Appendix D) indicated that PDA and depressed women reported relationship problems of similar duration (i.e., means of 0.91 and 1.25 respectively), while the partners of PDA women reported lengthier relationship problems relative to the partners of depressed women (i.e., means of 3.75 and 1.75 respectively). However, in contrast to these figures, qualitative data revealed that only 7 (or 35% of) PDA women reported relationship problems while 16 (or 80% of) depressed women reported such problems. The latter may explain the significantly high level of relationship dissatisfaction among depressed women (Table 11, Appendix D).
**Partner generally supportive**

While 16 (or 80% of) PDA women reported that their partners were generally supportive, only 8 (or 40% of) depressed women reported likewise. As mentioned previously, lack of understanding from one’s partner (e.g., what it was like to feel very low) was highlighted as an area of considerable dissatisfaction even if one’s partner was ‘extra-terrestrial nice’ otherwise. Some depressed women stated that their male partners had never listened to them when they had ‘got sick’ and that they might not have ‘gotten sick’ in the first place if they felt supported by their partners. Other partners were reportedly quite unsympathetic of their wives’ plight stating that whereas they (the male partners) just ‘got on with life’, their wives did not want to work or socialise (merely because they ‘believed that everybody had a bad opinion of’ them).

Likewise, some PDA women stated that their partners just did not understand their seemingly ‘attention-seeking’ immobility and avoidance of certain places (e.g., churches, pubs, theatres, and airplanes). One PDA woman reported that her partner believed that she ‘over-reacted to (objectively) safe situations’ and that her anxiety would go away if she ‘just got on with it’. An example of a lack of understanding for one PDA woman was her husband’s stated belief that her PDA was due to her being unhappy in their relationship. Another women reported that her partner ignored her needs for conversation or companionship because he focused excessively on her ‘problem’. On the other hand, some PDA women stated that they could not cope without their partners (even though these partners did not fully understand their ‘condition’).

The depressed women sometimes attributed their partners’ ‘selfish ways’ to having had mothers whom went out of their way not to upset their sons (when they were growing up). These selfish ways were manifest in many ways including exclamations that they were unable to change (e.g., ‘I simply can’t get up in the morning to help with getting the children to school’, ‘I can’t communicate my feelings or show affection’). In relation to the latter, a common complaint from some depressed women was that their partners rarely communicated that they loved them, whereas others stated that they felt they needed ‘to beg for appreciation’.

Some depressed women also appeared to be actively grieving for the loss of how they (as a person) and their relationship used to be. Similarly, some PDA women appeared to be
grieving for the loss of the person they once were. This 'bereavement' was also an issue for their partners who reportedly were under 'an immense burden' in trying to care for their partners 'along with everything else'.

Another manifestation of a lack of partner support was male partners not asking about their partners' attendance at the Psychological Service they attended. While this was due sometimes to both PDA (15% of) and depressed (20% of) women not disclosing their attendance to their partner, other women stated that their partners would refuse to discuss their ongoing concerns as discussed in-session.

Yet another manifestation of a lack of partner support was over-investment of male partners in their work. While only 3 (or 15%) of PDA women reported that their partners were overly-invested in work, 11 (or 55%) of depressed women reported that their partners were so. These depressed women reported that they were lonely (to different degrees) and that they did not feel like the 'number one' priority in their partners' lives (e.g., they were often third in line behind their work and their children).

A variety of factors including (an insidious or abrupt) emotional breakdown in their relationship, the necessity of assuming extra financial responsibilities (e.g., financing a larger house, having to care for more children), and/or reverting to self-employment or an on-call status often precipitated male partners investing heavily in their work. Such factors also precipitated some depressed and PDA women doing likewise. On the other hand, many PDA and depressed women welcomed their partners' investment in their work (even if it meant 'some disconnection'). For example, a partner of one depressed woman stated that he kept out of his partner's way because she perceived this as him working, but this same woman, although she wanted her partner to work hard, also complained of sometimes being ignored by him and feeling lonely.

**Sexual difficulties in relationship**

Although many women were uncomfortable talking honestly about their sexual relationship with their partner, others were quite forthcoming. While only 3 (or 15% of) PDA couples reported sexual difficulties with their partner, half of the depressed women reported similar difficulties. With the exception of one depressed couple, no sexual difficulties as such (e.g., erectile dysfunction, frigidity) were disclosed. Rather, the reported sexual difficulties
related to the degree to which they wanted or were having ongoing sexual relations and/or whether they were sleeping together.

One depressed woman reported that she tried her ‘best to satisfy’ her ‘horny partner out of fear’ that he would ‘seek sexual gratification elsewhere’. She added that she sometimes felt guilty having said ‘no’ to sex and then, wanting to relieve her conscience, would initiate sex to satisfy her partner but that this would then precipitate a greater degree of guilt and self-deprecation.

Two depressed women partially blamed themselves for their partners’ infidelities. Lacking confidence during sex with their partners, they reasoned that they did not fulfil their male partners’ sexual needs. They also believed that their reluctance to socialise with their male partners also predisposed to their partners ‘going off’ with other women. One woman reported a series of affairs by her partner over a number of years while another woman reported that her husband had an extra-marital affair with her own sister 10 years previously.

Another depressed woman identified her having an affair and possibly bearing a child from this relationship as the primary cause of her depression. Although she admitted that her relationship was emotionally non-functional long before the affair began, she did not want to leave her relationship until her children were more ‘grown up’. Another depressed woman reported a recent affair after 20 years of marriage. She stated that the primary motivation for her affair was her poor ‘sex life’ with her partner (‘How could we have a good marriage when our sexual relationship is poor?’). Upon discussing this issue in session, this woman concluded that she prioritised ‘good sex’ as one of the most important issues in her marriage and that this reflected how she derived much self-esteem from her sexuality. The latter was possibly a consequence of her history of CSA.

However, like a number of other depressed women, she did not want to have further sex with her husband out of fear that she would become pregnant again and be ‘even more trapped’ in her marriage. Indeed, becoming unexpectedly pregnant after one’s children had grown up was a precipitant for depression in a number of women. The aforementioned woman’s husband reported in session that he did not mind his wife ‘going off’ with other men so long as she stayed living in the family home and was available to help him parent
their children. He also faulted himself for not previously ‘giving’ his wife sex ‘when she wanted it’.

Some depressed women highlighted that while they valued psychological intimacy, their partners valued physical intimacy, and that the former would have be ‘right’ or ‘working’ to even consider ‘wanting’ the latter. However, even if there was psychological intimacy, some women just did not want to have sex. For example, a husband of a PDA woman reported that they had not had sex since their 18-month-old child was born, while his partner reported having not had sex for 5 years although she considered her husband to be a good husband and father.

Disagreements regarding parenting strategies
Some depressed women, fearing that something (e.g., abuse) would happen to their children if left alone, would not allow them out of their sight if they were not old enough to talk (i.e., if they had not the ability to report abuse). Likewise, some PDA women would not allow their children out of their sight because they also feared for the safety of their children. However, another motivation for wanting to remain with their children was that if these women ‘suffered’ a panic attack and ‘got into trouble’ (e.g., passed out, had a heart attack), their children, if old enough, could get help. In essence, the children’s presence was a safety behaviour for these women. If their children were too young to fend for themselves, some PDA women would ensure that they were not left alone with their children. Some depressed women also reported similar concerns.

While only 3 (or 15% of) PDA couples reported disagreements regarding parenting strategies as a major source of conflict, 7 (or 35% of) depressed women reported likewise. Some depressed women reported how they would disagree with what they perceived as ‘heavy-handed’ parenting strategies (especially of the older children) by their partners and how they themselves were ‘easy’ on their children to compensate for such perceived lack of paternal nurturance.

Some depressed and PDA women reported experiencing a considerable amount of stress and anxiety over trying to balance ‘being there’ for their children all the time (as outlined above) with facilitating the development of good coping skills (by allowing their children enough ‘space’ to confront difficult situations and, in the process, learn good coping skills).
This ‘facilitation of growth’ (as opposed to ‘demise’) concern in some women was sometimes complicated by a dynamic whereby the woman was the primary disciplinarian and the father virtually excluded himself from the process of parenting (except where children’s behaviour became totally unacceptable).

Complicating this dynamic was the sometimes (stress-inducing) over-investment (on the part of depressed mothers) in trying to ensure good behaviour in their children, and their sometimes excluding their partners from parenting if they perceived their partners to not ‘parent well enough’ (i.e., up to their own high standards). Their rigid expectations of their children’s behaviour (and their associated ‘best’ parenting strategies) were often an attempt to compensate for (and express anger over) a lack of power or control in other domains of their life. An example of the latter was one woman who admitted that she was not going to let her children walk all over her ‘like everybody else did’. The added stress of some children not talking with their father (partially because of heavy-handed parenting strategies) was also evident in some of these women.

Other depressed women reported that their parenting efforts often went unappreciated by their partners or that their partners were slow to see the value of their remaining at home so that they could nurture their children’s emotional development. Some also disclosed a long-standing fear of being left alone with their partners (after their children had grown up).

Some partners of depressed women actively undermined their wives’ attempts to parent by openly disagreeing with their parenting (e.g., allowing their children to eat upstairs when it was previously agreed that this was not allowed) so that their children progressively came to learn to ignore these women’s parenting efforts. Some husbands also threatened physical abuse if their depressed wives shouted at their children (in their efforts to control their children’s behaviour). On the other hand, some male partners reported frustration over their partners’ apparent inability to tolerate mistakes by their children, to allow them to be more playful, and to conseuate their behaviour (rather than asking for explanations as to why they did or did not do something in a particular way or during a particular time frame). Some male partners were also resentful of being forced into the roles of the ‘tough’, the ‘over-functioning’, or the ‘token’ parent.
The members of some depressed couples often reportedly became more entrenched and polarised in their respective parenting strategies as their children grew up. For example, some mothers sometimes became stricter (but more loving) while their partners became more laissez-faire (but tougher when absolutely necessary). However, some depressed couples also reported a reversal of parenting roles between them as their children aged. For example, while some depressed women’s tolerance (and degree of involvement in management) of their children’s behaviour reportedly decreased, their partners’ had increased. This gradual (and sometimes total) withdrawal (from parenting) on the part of the depressed women was often reflective of an overall (self-protective) withdrawal from the relationship and was typically associated with a chronic history of depression. However, for these women, having to parent (and tend to their children’s immediate needs), although subjectively stressful, often had the adaptive function of ‘jolting’ them out of their depression (and back into reality).

Stressors and supports from the qualitative data

Medical concerns
Twice as many PDA women (i.e., 30% of) reported significant medical concerns relative to depressed women (15%). While this difference may reflect how PDA women are often predisposed to worry about physiological issues, many PDA women had good reason for their medical concerns. Seven years after her initial anxiety attack, one PDA woman reported worrying over having to undergo infertility treatment. Another reported how she worried about the health of her 33-year-old husband who had had 3 previous heart attacks. Another woman reported how she overcame breast cancer 15 years previously but was fearful of it returning. Yet another reported having Chronic Fatigue Syndrome subsequent to a total hysterectomy. Another 2 PDA women, who subsequently underwent Hormone Replacement Therapy (HRT), believed that an early menopause probably triggered their initial anxiety attacks. One depressed woman also reported that she was worried about her family’s history of hysterectomies and removal of ovaries.

Poor childhood
Seven (or 35% of) and nine (or 45% of) PDA and depressed women respectively reported what they believed were poor childhoods. These women reported a chaotic family-of-origin environment characterised by a varied mixture of witnessing (ongoing) paternal domestic violence (and needing to protect their mothers and younger siblings), parental depression
(more so maternal) and alcoholism (more so paternal), (extended) parental absences, and parental separation. Others reported numerous geographical relocations, being ‘left’ to live with grandparents, emotional needs going unmet (e.g., buying a doll for company), rigid and extreme family rules (e.g., ‘You’re either with me or against me’, ‘If you let the family down, you’ll be disowned’, ‘I’m always right and you can’t have an opinion’, ‘Mistakes are not allowed in this family’), and having to do excessive amounts of child rearing and housework.

In relation the latter, lacking self-esteem and wanting to assume some control in their lives, these women either assumed or were forced into a ‘caring’ role (‘to keep the peace’ within their family-of-origin). Overwhelmed, abdicating, and/or demanding parents typically vacated this caring role. One depressed woman summarised the former in stating that ‘All of my life I have been controlling in order to survive’. This translated into having ‘everything sound and structured’ but also feeling resentful in ‘having responsibility for everything that happens’. Additionally, while only 1 PDA women (5% of) disclosed a history of Childhood Sexual Abuse (CSA), 4 (or 20% of) depressed women reported similar abuse.

Thus, these women’s respective childhoods may have predisposed to low self-esteem, anxious attachment, and efforts to (overly) control their lives (and as detailed below, those of others). The latter included a tendency to develop both sociotropic (i.e., having dysfunctional beliefs centred on the need for approval or love) and autonomic (i.e., having dysfunctional beliefs centred on perfection) tendencies.

**Ongoing coping role within family-of-origin**

Seven (or 35% of) PDA women and eight (or 40% of) depressed women reported having an ongoing coping role within their family-of-origin or their continuing to be the ‘go-to’ person (i.e., the person others could go to if they needed anything). The parents of depressed women reportedly would often try to suppress the attempts of women to change either the nature of their relationships (e.g., ‘You’ll just have to put up with the way things are’, ‘You have to continue to be there for us’) or their mood levels (‘Just get on with it’). Some parents did the extreme opposite and tried to pressure depressed women to change their mood levels (‘You’re a disgrace to the family’, ‘You’re an attention seeker’, ‘You’re the cause of our mother’s nerves’) or to change their parenting strategies (‘Your son’s behaviour is
One depressed woman reported that although she was quite unhappy in her marriage and wanted to separate, she did not do so as her ‘parents would have died’ (with the shame of having a separated daughter) and because she ‘had nowhere to go’.

One depressed woman stated that her siblings ‘encroached on’ her (psychological) ‘space’ but that she did not want to offend them by telling them not to call to her house or not to contact her by telephone. The siblings of many depressed women often ushered in extended and ‘hurtful’ periods of ‘cool silence’ when, for example, these women attempted to talk honestly with a parent about things that happened in the distant past (e.g., ‘Why go and upset dad now? He didn’t know any better then. It definitely won’t help you, him, or us’). Some siblings also tended to withdraw (their support and approval) when these women attempted to disengage from their well-established caretaking role within their families (e.g., ‘You’ve to continue bringing mum to mass everyday. The rest of us can’t because we’re all very busy’, ‘Who else will baby-sit for our kids? We don’t trust anybody else and they really like you’).

Some PDA and depressed women reported being ‘caught in the middle’ of not wanting to displease their families or their partners (and risk potential abandonment). A source of arguments in their relationships was their partners not agreeing with the degree of support these women gave to their families-of-origin, the impact their ‘giving’ had upon their own families, and their not ‘standing up to’ their parents and/or siblings. Some men actively curtailed the efforts of their partners to ‘give’ to their families-of-origin by intentionally not making the family car available as requested. This was particularly devastating for women on low incomes living in the countryside. Similarly, some male partners continued to allow themselves to be influenced by their own families-of-origin. For example, one depressed woman detailed how her partner used to come home from his mother’s house and call her a ‘domineering bitch’.

One depressed woman reported how her brother’s ‘foul mouthed’ wife had ‘torn’ her ‘family (-of-origin) apart’. The ideal of a unified family was important to her. Another depressed woman reported that she had to contend with her father supporting her while her mother supported her ‘non-supportive’ husband. In contrast, one depressed woman detailed how she no longer allowed her in-laws to enter her home as they were previously non-
supportive of her when she was ‘sick’ and, more so, because she knew this greatly annoyed her (similarly critical) husband.

Thus, still invested in an ideal of family unity and harmony, many PDA and depressed women were confronted with a continuing and highly stressful ‘battle of loyalties’. Some were still ‘tied to the apron strings’ of their families-of-origin and continued to seek parental and sibling approval by ‘being there’ for these family members. However, their partners (and sometimes their own children) often made similar but conflicting demands of their (limited) resources and helpful behaviour. Some partners went so far as to actively limit the contact of their female partners with their families-of-origin.

**Death of child or close relative**

While only 7 (or 35% of) depressed women reported the loss of a loved one (e.g., parent, sibling, miscarriage), 12 (or 60%) of PDA women reported such a loss. Additionally, these and other women had experienced a variety of ‘near’ losses. This was reflected in comments from these women such as ‘If had not worked during pregnancy, my child that miscarried would have been healthy’, ‘I gave life to my youngest but could not to my still-born child’, and ‘When living with my grandparents I saw too many people die’. It is probable that all of these women were overly sensitised to loss (e.g., ‘Anything can happen’). The higher percentage of PDA women (relative to depressed women) who experienced loss may have predisposed to a belief that they needed to increase their efforts to control life events, including one’s physiology. The subsequent tendency to catastrophise and attempt to control physical symptoms of anxiety may have predisposed these women to develop PDA subsequent to their initial anxiety attacks.

**Stress of having a young child**

Seven (or 35% of) PDA women and eleven (or 55% of) depressed women reported feeling quite stressed in dealing with their young children. Having young children also involved other losses such as career curtailment, having to remain in a sometimes unfulfilling relationship for a longer period of time (to cater for their children’s needs), reduction of social contacts, and excessive body weight in the postpartum period. Having a young child also reportedly exasperated existing dissatisfaction with household and child-care task distribution.
God as punisher / protector

Similar numbers of PDA (25% of) and depressed (30% of) women looked upon God as a source of comfort but also as a source of punishment. Some depressed women who pre-morbidly believed in God had ceased contact with the (Roman Catholic) Church because they believed that God had not given them a good life and because they no longer wanted ‘to be answerable to anyone’. Some depressed and PDA women reported that they believed God was punishing them for not having previously been a good person. For example, one PDA woman believed that her PDA was a punishment from God because she did not breast-feed her only child years earlier.

In contrast, some PDA and depressed women perceived God to be a great comfort in consistently helping them with what they perceived as ‘unmanageable’ and ‘unbearable’ afflictions. These women also identified with the Roman Catholic teachings of self-sacrifice (in the service of others), and punishment (as mentioned above). Paradoxically, some women were more accepting and tolerant of their presentation due to the belief that they were being punished by God (who was otherwise benevolent).

Other themes from the qualitative data

Sociotropic orientation

As mentioned previously, nine (or 45% of) PDA women and fourteen (or 70% of) depressed women reported efforts to ‘get others to love’ them. These women went out of their way to ‘keep people happy’ and ‘be easy on others’. This manifested in many ways including not picking one’s partner up on not doing their fair share of household tasks, baby-sitting for others (even when it was personally inconvenient), and not behaving assertively with others. In relation to the latter, a subset of PDA and depressed women, although unassertive with others, were in contrast quite assertive within their homes (i.e., with their partners and/or children). One PDA woman reported that her partner likewise tried to please everybody. Where couples differed in their degree of assertiveness with others, this was an asset in that the assertive partner could deal with the outside world. However, this was a liability when they disagreed as to how assertive (or non-assertive) they needed to be (as a couple) with the outside world.

Another depressed woman espoused self-blame for her husband’s ‘demise’ (in his assertiveness with her) and queried if she had made him ‘weak’ over the years. One woman
with PDA stated that her tendency as a child to want to be a ‘goody goody’ (along with her high standards and her being hard on herself) had stayed with her into adulthood.

Autonomic orientation

Half of the PDA women but seventeen (or 85%) of depressed women reported efforts to define themselves by their actions (typically directed towards pleasing others). This tendency typically had its origins in their childhoods. For example, one depressed woman stated that as a child the family rule was ‘You’ll be loved if you’re good’. Other depressed women stated that during their childhoods they adopted rules such as ‘Be good and keep out of the way because there is enough trouble already’, and ‘I cannot let anybody else see my hurt because it is my only defence’.

Autonomic behaviour manifested in many ways including an expectation that their children’s behaviour was indicative of whether their parenting was good or bad (e.g., ‘I am no use to my family as I cannot even control my child’s behaviour’, ‘I’m a bad mother because I did not parent my child properly when she was younger’). In relation to the latter, one depressed woman reported that her husband would comment on how bad her parenting was when their children misbehaved. Other manifestations were excessive protection (or worry) of their children’s safety (as mentioned previously), possibly because they viewed parenting as among the last remaining sources of self-esteem.

Autonomic tendencies were also evident in trying to be the perfect partner (e.g., ‘I feel I should be able to satisfy my partner’s sexual needs’), and trying to listen to others’ difficulties and providing help (‘to ease their pain’). However, such expectations often were not realised by both PDA women (e.g., when consumed by ongoing anticipatory anxiety about socialising or performing a task) and depressed women (e.g., when feeling no energy or a desire to withdraw socially). Such disappointed expectations predisposed to feeling down.

One depressed woman stopped working outside the home because she became ‘sick of listening to how everybody else’s partners were so generous and good with the kids’. A potent trigger for panic attacks for one woman with PDA was criticism of what she was doing which was possibly her largest remaining source of self-esteem. Another threat-sensitive source of self-esteem was a public image of good functioning.
However, the PDA and depression of these women prohibited their doing (or producing) for others. One depressed woman stated that she would ‘dilute the possibility of failure by taking up lots of different projects’ only to again become depressed when the cumulative burden of her multiple demands became too great for her. This same woman reported that while she was a ‘task’ person, her partner was a ‘process’ person, and that this often caused friction in their relationship. Other women reported that they found themselves unable to communicate with others, which in turn predisposed to relational disconnection. A number of both PDA and depressed women reported how they no longer felt able to initiate and maintain contact with neighbours. This represented another domain within which there was a loss of self-esteem.

**Self-restriction**

The efforts of both PDA and depressed women to please everybody (i.e., to preserve relational ties) by doing (i.e., by engaging in productive behaviour or that which produced a tangible result) appeared to compete (or conflict) with their own strivings and actions (e.g., developing and maintaining friendships, interests, or one’s career). This effectively resulted in an ongoing process of (disempowering) self-restriction so that their lives felt empty and unfulfilled. This was summed up succinctly by one depressed woman who stated that ‘I feel like my brain is bigger than my life’. Furthermore, it was apparent that these women depended on an ever-decreasing and limited amount of sources of self-esteem.

**Inappropriate expectations of happiness**

Another theme that was manifest in some PDA and depressed women was the expectation that they should reject the slightest experience of being unhappy. Trying too hard to be happy (as reinforced by significant others) often reportedly predisposed to turning a temporary state of sadness into a prolonged state of depression (Weeks & L’Abate, 1982).

**Precipitating factors**

The mean age at which PDA women had a first panic attack was 33 (range 18 to 53). Of these 20 PDA women, precipitating factors for 9 women (45%) could be categorised as ‘random acts of stressfulness’ or ‘events caused by external factors’ over which these women had no control (Ingram, 2001, p. 501). These acts included road-traffic accidents, medical concerns about self (e.g., waking up covered in blood having bit one’s tongue and believing death was imminent, diagnosis of cancer), house moves (and feeling ‘stranded’ in
a new house), wedding preparations, and losing one’s automatic teller machine (or ATM) card while on holiday.

Another 6 precipitating factors for PDA women were ‘family-dependent’ stress. These included the stress of parenting an infant, medical concerns about one’s infant, significant arguments with one’s partner, providing support for a friend whose child just died, caring for an elderly but abusive parent, and one’s partner becoming unemployed.

Of the 20 depressed women, half of them reported having mood swings before their relationship with their partner began. Twelve (or 60%) of them reported that they committed to their relationships (e.g., by getting married, cohabiting) to escape previously difficult circumstances such as those in one’s family-of-origin (e.g., controlling parents, burden of care-taking role, abusive parent(s) or sibling(s)) or in other relationships (e.g., abusive partner). Of the 10 women who reported that their depression first emerged during their relationship, precipitating events included death of a child (e.g., miscarriage, still born) or a close relative, experiencing a traumatic incident (e.g., disclosure from a partner of infidelity, physical assault by one’s partner or in work), not coping with parenting a young child, and unplanned pregnancies.

Cycles of interaction

Our qualitative analysis indicated that depressive patterns of interaction probably seldom occur only once, but persist, overlap, and recur with overwhelming complexity. Thus, a circular causal model is more appropriate than a linear one that artificially delimits sequences from the intricate patterns in which they occur (Coyne & Holroyd, 1982). Relationship (and family) interactions while most probably contributing to the maintenance of depression, might in some cases have predisposed to and triggered its onset. Rather than assigning responsibility to either partner (or to significant others), qualitative analysis indicated that unmet needs in one partner may have manifested as behaviour (or lack thereof) which triggered (or predisposed to) behaviour in the other partner.

The most salient example of such coercive interactional reciprocity was the demand—withdraw cycle between partners, with each partner assuming the demanding role when each considered it necessary to do so. One depressed woman described how her tolerance for her husband’s silence (which she experienced as being excluded) would eventually reach
its limit and precipitate efforts on her part to force her partner to talk. Feeling resentful of her efforts to control him, her husband would reportedly withdraw further. This in turn merely intensified her feelings of exclusion and her efforts to get her partner talking. Similarly, another depressed woman stated how her sadness would eventually manifest as explosive anger whereby she would physically shake her partner only for him to further withdraw. This in turn increased her feelings of isolation and hopelessness.

Another chronically depressed woman reported a cycle whereby her husband would disclose details of her mental health to their young children, she would get angry, he would then call her a ‘mad woman’, and she would subsequently go silent again until he (inevitably) began to disclose to their children again. It is also likely that over time such cycles predisposed to increasing polarisation in partners. For example, the members of one PDA couple detailed how over time, following arguments, they both withdrew into the roles of provider (e.g., the male partner overly-investing in work) and parenting (e.g., the female partner overly-investing in their children’s well-being) to the detriment of their relationship.
ACADEMIC DOSSIER
The Efficacy of Couples-Based Interventions for
Couple Distress and Depression

ABSTRACT
From this systematic literature review it was concluded that between one and two thirds of (predominantly moderately to severely) distressed couples are likely to achieve a non-distressed state of functioning following Traditional Behavioural Couple Therapy (TBCT), and that this figure may decrease considerably over follow-up periods. It is as efficacious as other individual therapies in improving relationship satisfaction and its efficacy is not enhanced by the integration of supplementary techniques. However, integrative couple therapy (which is an enhancement of TBCT) may promote greater gains. Emotionally Focused Couples Therapy (EFT) results in impressive effect sizes with 50% or more of (mildly to moderately) distressed couples reporting clinically significant change. This change may increase slightly over follow-up periods. Couple distress is sometimes, but not always, associated with depression. With distressed-depressed couples, a variety of couples-based treatments for depression tend to be as efficacious as individual treatments in alleviating depression, may have greater maintenance of gains over follow-up periods, and may result in greater improvements in relationship satisfaction. With nondistressed-depressed couples, when compared with individual-based treatments, these couples-based treatments achieve comparable reductions in depression but do not affect comparable gains in relationship satisfaction.

INTRODUCTION
The primary aim of this paper is to review the efficacy of TBCT and of EFT in alleviating couple distress. A second aim is to consider the efficacy of the limited number of couples-based treatment outcome studies for depression in couples. Before considering these topics, there is a short discussion of couple distress and the evolution of these treatment approaches.

Couple distress
A review of DSM-IV (1994, American Psychiatric Association) will reveal that marital distress or the more inclusive term of ‘couple’ distress is not a psychiatric disorder per se. However, couple distress is a risk factor for many psychiatric disorders including mood
disorders (Whisman, 2001), anxiety disorders (McLeod, 1994), alcohol abuse (Halford & Osgarby, 1993), and psychoses (Tienari et al., 1987). Additionally, couple distress increases the risk of problems in children including attachment and behavioural difficulties (Erel & Burman, 1995), the development of poor coping responses (Laumakis, Margolin, & Ross, 1998), lower social competence with peers, and academic-related problems (Grych & Fincham, 1990). Many distressed couples opt for divorce, with over 50% of marriages ending in divorce in the USA (Bray & Jouriles, 1995). This life event can in turn put both adults and children at greater risk for detrimental mental, emotional, physical, and financial consequences (Stroup & Pollock, 1994).

Either one or both partners of a couple reporting couple distress and scoring below a cut-off point on one of several self-report measures has typically defined couple distress. The most commonly used measure has been the 32-item Dyadic Adjustment Scale (Spanier, 1976) with a score of 97 or less usually taken to signify couple distress. However, the latter can sometimes vary (e.g., Jacobson, 1984b). Unfortunately, although separation or divorce in the course of a couples-based therapy can represent a positive resolution to an unhealthy relationship, such couples are considered dropouts (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998).

**Couple distress and depression**

Most studies have used the diagnostic criteria for major depressive disorder (see Table 1) as indicating the presence of depression. Clinical interview is typically complemented by individuals having to score above a cut-off point on one of several self-report measures (e.g., a score of 20 or greater on the Beck Depression Inventory; Beck, Ward, & Mendelson, 1961). Depression is characterised by a cluster of symptoms including depressed mood, loss of interest or pleasure in activities, feelings of worthlessness or inappropriate guilt, and significant changes in weight, appetite, and sleep. The point prevalence of major depressive disorder in community samples has varied from 5% to 9% for women and from 2% to 3% for men (American Psychiatric Association, 1994). However, distressed spouses may be nearly 3 times more likely than non-distressed spouses to develop a major depressive episode during a 12-month period (Whisman & Bruce, 1999).

Among distressed couples more than 50% have been found to include at least one spouse who is depressed (Beach, Jouriles, & O’Leary, 1985). Additionally, amongst clinical
samples of individuals presenting for treatment for depression, between 40% and 50% are also experiencing significant couple distress (e.g., Jacobson, Dobson, Fruzzetti, Schmaling, & Salusky, 1991). These findings might be expected considering how the context of a close intimate relationship can create or buffer stress, and can provide or deprive a partner of social support. Such a relationship can also validate or diminish one's sense of self worth through participation in the partner role, and can generate positive or negative interactional cycles (Kung, 2000, p. 52). Hence, it is commonly assumed that couple distress may generate, promote, or maintain depression (Gotlib & Beach, 1995).

**Treatment models of couple distress and depression**

Although there are many treatment models for couple distress (Dattilio & Bevilacqua, 2000), TBCT is the most widely studied couple therapy. It is based on a social theory of human behaviour and emphasises faulty behavioural exchange operations as important determinants of couple distress (Wesley & Waring, 1996, p. 423). In addition to its original focus on behavioural contracting or behavioural exchange (BE) to provide mutual reinforcement for both partners, communication and problem solving skills training (CPT) was introduced in the early 1970s to further help both partners to constructively deal with their inevitable differences. While later versions of TBCT included the integration of cognitive restructuring (e.g., Baucom & Epstein, 1990), most of the studies reviewed in this paper used a variant of Jacobson and Margolin's (1979) couple therapy which emphasises BE and CPT.

In developing EFT, Greenberg and Johnson (1988) conceptualised couples distress as resulting from the disruption of attachment bonds for one or both partners. Such disruption evokes emotions such as fear of abandonment and possibly consequent angry withdrawal. This struggle for secure attachment ultimately predisposes to negative interactional cycles. Hence, integrating Gestalt and client-centred therapy (e.g., Rogers, 1951) with systems theory (e.g., Minuchin & Fishman, 1981), EFT aims to re-establish attachment bonds and to substitute dysfunctional reciprocities with more adaptive interaction patterns.

The use of couple therapy to treat depression was a natural development considering the high comorbidity rates of depression and couple distress, and the widely accepted belief that the former contributed to the latter (Christensen & Heavey, 1999). This has been particularly true for TBCT and a number of other couple therapies (Kung, 2000). Although there are indications that EFT may also reduce depressive symptoms (MacPhee, Johnson, & Van der
Veer, 1995), to date there are no published EFT outcome studies in the treatment of depression.

Conclusions of previous reviews
From previous narrative reviews and meta-analyses of the literature on couples-based treatment of couple distress and depression a number of tentative conclusions may be drawn (Baucom et al., 1998; Dunn & Schwebel, 1995; Hahlweg & Markman, 1988; Johnson, Hunsley, Greenberg, & Schindler, 1999; Kung, 2000; Wesley & Waring, 1996; Whisman & Uebelacker, 1999). First, the skills-based emphasis of TBCT can be viewed as efficacious for treating (moderate to severe) couple distress for a significant proportion of cases (e.g., mean effect size of 0.90; Dunn & Schwebel, 1995) but there is a tendency for some couples to relapse over long-term follow-up. Second, TBCT’s efficacy with this population is not enhanced by the integration of supplementary techniques. Third, EFT is efficacious in reducing (mild to moderate) couple distress (e.g., mean effect size of 1.28; Johnson et al., 1999) and there is a tendency for couples to continue to improve after treatment has ended.

Fourth, couples-based treatments improve both depression and couple distress in distressed-depressed couples. Fifth, with nondistressed-depressed couples these couples-based treatments improve depression (but not couple distress) to a comparable level as the individual treatments would. The aim of the present review was to attempt to refine these tentative conclusions, by systematically evaluating outcome studies of TBCT and EFT for couple distress, and by reviewing outcome studies of the effects of couples-based treatments on couple depression.

METHOD
A series of computer-based literature searches of the PsychInfo database were conducted. A variety of terms were used to search for articles pertaining to distress including distress, distressed, functioning, discord, adjustment, satisfaction, conflict, quality, and disputes. To identify studies of couple distress, these terms were combined with terms such as marriage, marital, couple, family, relationship, interpersonal, conjoint, systemic, and spouse. To identify studies that evaluated the efficacy of TBCT and EFT for couple distress, terms that defined couple distress (as listed above) were combined with terms that defined these interventions such as TBCT, EFT, treatment, therapy, marital therapy, behavioural marital therapy, spouse-assisted therapy, and behaviour therapy. To find studies that evaluated the
effect of couples-oriented treatment on depression, this search strategy was modified to include the word *depression*.

The searches, which were confined to English language journals and some book chapters, covered the period 1982 to 2002. A manual search through the bibliographies of major recent review papers on couple distress and depression and couple interventions for these presentations was also conducted. Descriptive studies that included at least 3 cases (per treatment condition) were selected for review. Both controlled and uncontrolled treatment outcome studies were selected for review provided they included reliable and valid pre- and post-treatment assessment instruments. While some yet-to-be-published dissertations were included in this review, single-case designs and studies reported in convention papers were not included.

**RESULTS**

Thirteen studies that investigated the efficacy of TBCT (or components thereof) for couple distress were identified. Seven outcome studies involving EFT studies were also identified. The features and findings of these twenty studies are presented in Tables 2, 3, and 4. Ten studies that evaluated the efficacy of couples-based interventions for depression were identified. The features and findings of these studies are presented in Table 5.

**TBCT and EFT outcome studies for couple distress**

Six TBCT studies compared either TBCT or variants thereof with each other (Baucom, 1982; Bennun, 1985; Emmelkamp, van der Helm, MacGillavry, & van Zanten, 1984; Jacobson, 1984b; Jacobson & Follette, 1985; Jacobson, Follette, et al., 1985; Jacobson, Schmaling, & Holtzworth-Munroe, 1987; Mehlman, Baucom, & Anderson, 1983; Wilson, Bornstein, & Wilson, 1988). Another 7 TBCT studies compared either TBCT or variants thereof with other treatments (including TBCT or components thereof in combination with these other treatments) (Baucom & Lester, 1986; Baucom, Sayers, & Sher, 1990; Emmelkamp et al., 1988; Hahlweg, Schindler, Revenstorff, & Brengelmann, 1984; Halford, Sanders, & Behrens, 1993; Jacobson, Christensen, Prince, Cordova, & Eldridge, 2000; Snyder & Wills, 1989; Snyder, Wills, & Grady-Fletcher, 1991a). Included in this latter group of studies is an outcome study of integrative couple therapy (ICT; Jacobson et al., 2000), which is an enhanced version of TBCT with an emphasis on emotional acceptance between partners (Jacobson & Christensen, 1996).
Four EFT studies compared EFT with a waiting-list control condition (Johnson & Greenberg, 1985b; Gordon Walker, Johnson, Manion, & Cloutier, 1996; Cloutier, Manion, Gordon Walker, & Johnson, 2002; Johnson & Talitman, 1997; Denton, Burleson, Clark, Rodriguez, & Hobbs, 2000). Another 3 compared EFT with both another treatment (including EFT in combination with other treatments) and a waiting list control condition (Johnson & Greenberg, 1985a; James, 1991; Goldman & Greenberg, 1992). All of the above mentioned outcome studies for couple distress are summarised in Tables 2, 3, and 4.

**General characteristics of TBCT and EFT outcome studies for couple distress**

From Table 2 it may be seen that of the 827 couples that participated in these 20 studies, 578 (or 70%) of couples participated in TBCT outcome studies while 249 (or 30%) of couples participated in EFT outcome studies. At least 85% of the TBCT couples and at least 83% of the EFT couples were married, and the remainder were either married and/or cohabiting. TBCT participants’ ages ranged from 19- to 59-years, their mean age ranging from 31- to 43-years with an average mean age of 36-years across these studies. EFT participants’ ages ranged from 22- to 60-years, their mean age ranging from 33- to 42-years with an average mean age of 37-years across these studies. Referrals included self-referrals, those from community agencies, and solicited referrals that were received via advertisements or resulted from screening parents of chronically-ill children. The mean degree of couple distress ranged from mild to severe. Dropout rates from the 13 TBCT studies ranged from 0% to 39% with a mean of 12%. Dropout rates from the 7 EFT studies ranged from 0% to 35% with a mean of 7%.

**Conclusion.** Overall these 20 studies focused on evaluating the effects of couple for a large group of couples with relatively debilitating levels of couple distress in stable long-term relationships. The results of these studies may probably be generalised to this population with a fair degree of confidence.

**Methodological features of couples-based treatment outcome studies for couple distress**

From Table 3 it may be seen that the 20 studies varied in methodological rigour. Eighteen studies included comparison groups, 12 of which had a waiting-list (or treatment on demand) control condition, and 2 studies were single treatment outcome studies where treated couples served as their own controls. In 17 of the 18 comparative group studies, cases were randomly assigned to groups. In all 20 studies diagnostically homogeneous groups were used and
participants were evaluated before and after treatment with reliable and valid assessment instruments. Medication was controlled for in only 1 of the 20 studies. In 15 studies follow-up data up to at least 3 months was collected and from Table 4 it may be seen that follow-up periods ranged from 1 month to 53 months. In all 20 studies assessment included both self- and partner-report data. Therapist evaluations were made in only 1 study while researcher ratings were made in 11 studies. The quality of the couple’s relationship was assessed in all 20 studies and the clinical significance of treatment effects (on relationship quality) was assessed in 12 studies. Experienced therapists rather than graduate students in training conducted treatment in 7 studies and in 16 studies treatment was manualised. Therapist supervision was provided in 13 studies and treatment integrity was checked in 11 studies.

**Conclusion.** Using the checklist for methodological robustness in Table 3, scores of studies ranged from 9 to 15 out of 17, indicating that this was a fairly robust group of treatment outcome studies, so a fair degree of confidence may be placed in the reliability and validity of the results of these studies.

**Key findings from couples-based treatment outcome studies for couple distress**

From Table 4 it may be seen that this review used 4 indices to indicate the extent to which couples-based treatments influenced relationship satisfaction post-treatment and at follow-up. The first index is the ‘effect size’ statistic. This indicates how well an average treated couple fares compared with untreated couples. Where not provided, this index was computed using primary couple satisfaction measure data by subtracting the mean of the control group from the mean of the main treatment condition (i.e., either TBCT or EFT) and dividing by the standard deviation of the control group. The reliable change index (or percentage ‘improved’) indicates the percentage of couples that experienced a statistically significant increase (in relationship satisfaction). The third index is the percentage of couples that reached the non-distressed range (of relationship satisfaction). The more stringent clinical change index indicates the clinical significance of change. Introduced and later expanded upon by Jacobson (e.g., Jacobson, Follette, & Revenstorf, 1984; Jacobson, Roberts, Berns, & McGlinchey, 1999; Jacobson & Truax, 1991), this index combines the reliable change index (as above) and whether the client has ‘recovered’ to the functional or non-distressed range (of relationship satisfaction).
From Table 4 it may be seen that the number of participants per treatment condition ranged from 5 to 30 (TBCT studies) and from 13 to 34 (EFT studies). The duration of treatment ranged from 10 weekly 1- to 1 ½-hour sessions to 21 sessions (TBCT studies) and from 8 weekly 50-minute sessions to 12 weekly 1-hour sessions (EFT studies).

Five TBCT studies (Baucom, 1982; Bennun, 1985; Emmelkamp et al., 1984; Mehlman et al., 1983; Wilson et al., 1988) indicated that TBCT was no more effective than its constituent components (e.g., behavior exchange, problem-solving training, communication skills training) in alleviating couple distress up to 12-months follow-up. TBCT effect sizes for these studies ranged from 0.68 (Baucom, 1982) to 0.18 (Mehlman et al., 1983). However, as the latter study involved excessively small sample sizes (n=5), its findings may not be generalisable.

The only long-term follow-up (non-comparative) TBCT study (Jacobson, 1984b; Jacobson & Follette, 1985; Jacobson, Follette, et al., 1985; Jacobson et al., 1987) indicated that (12-16 weekly sessions of) behavior exchange produced the highest percentage of non-distressed couples post-treatment (i.e., 79%). This compared with 40% of TBCT couples reaching the non-distressed range. However, by 6-month follow-up there was a tendency for behavior exchange couples to reverse their progress (29% non-distressed at follow-up) and for TBCT couples to maintain or improve treatment gains (60% non-distressed at follow-up). This supports the expectation that behavior exchange produces relatively strong immediate change but does not facilitate the learning of skills that couples need to maintain treatment gains. However, over a 24-month follow-up period, 30% of the couples that improved during TBCT (to happily married status) relapsed leaving only 50% of couples in the non-distressed range.

Considering the 7 TBCT studies that compared either TBCT or variants thereof with other treatments, Emmelkamp et al. (1988) found that although conversational skills training and cognitive restructuring resulted in significant improvements in target problems, both appeared to have little impact on the relationship satisfaction of the couples. TBCT resulted in comparable improvements in couple distress with both conjoint and group cognitive therapy (Hahlweg et al., 1984) and insight-oriented marital therapy (Snyder & Wills, 1989). Although the TBCT in the latter study may not have been state-of-the-art (Jacobson, 1991a), the effect size and percentage of TBCT participants who had achieved non-distressed end state functioning post-treatment was 0.85 and 48% respectively. This compared to 1.10 and 81% in...
Hahlweg et al.'s (1984) study. In terms of reporting clinically significant change, just over half of the TBCT participants did so in the Snyder & Wills (1989) study. Follow-up indicated that in these 2 studies, the percentage of TBCT participants registering as non-distressed was 64% (Hahlweg et al., 1984) and 50% (Snyder et al., 1991). However, regarding the latter study, 38% of TBCT couples reportedly divorced during the 53-month follow-up as compared with only 3% of insight-oriented marital therapy couples doing so.

TBCT and TBCT with cognitive behavioural therapy were equally effective in increasing couple adjustment (Baucom & Lester, 1986), the former producing a post-treatment effect size of 1.00, and percentage non-distressed rates of 62.5% (post-treatment) and 50% (at 6-month follow-up). TBCT, alone and with different supplementary techniques (e.g., cognitive restructuring, emotional expressiveness training) resulted in comparable improvements in couple distress, with an effect size of 0.57 and a percentage non-distressed rate of 62.5% for TBCT participants (Baucom et al., 1990). In a similar type of study, Halford et al. (1993) found percentage non-distressed rates of 48% (post-treatment) and 29% (at 3-month follow-up). Jacobson et al.'s (2000) ICT treatment development study found percentage non-distressed rates of 55% and 70% respectively for TBCT and ICT.

Effect sizes for the EFT outcome studies comparing EFT with a waiting-list condition were 0.94 (Johnson & Greenberg, 1985b), 1.26 (Johnson & Talitman, 1997), and 0.99 (Denton et al., 2000), the 2 lowest figures subsequent to the shorter 8-session format of EFT. The percentage of participants reporting clinically significant change post-treatment was 15% (46% at 24-month follow-up) in Gordon Walker et al. (1996) and 50% (70% at 3-month follow-up) in Johnson & Talitman (1997), thus suggesting an enhancement of the clinical treatment effects over time. The latter study also suggested that EFT might be more effective with partners over 35-years-old.

In the only study to compare EFT and (a component of) TBCT, EFT resulted in greater gains on dyadic adjustment (effect size of 2.19) relative to problem-solving training (effect size of 1.12) (Johnson & Greenberg, 1985a). However, the TBCT condition in this study was incomplete (i.e., it lacked a behavioural exchange component). The percentage of EFT participants reporting clinically significant change was 46% (post-treatment) and 47% (at 2-month follow-up). Working with couples reporting moderate to severe couple distress Goldman & Greenberg (1992) found that although both integrated systemic therapy and EFT
were superior to a waiting list condition, integrated systemic therapy showed the greater maintenance of gains at 4-month follow-up on relationship satisfaction. James (1991) found that a 4-session cognitive therapy did not enhance the efficacy of 8-session EFT (effect size of 0.70) and that the percentage of participants reporting clinically significant change decreased from 79% (post-12-session EFT) to 50% over a 4-month follow-up period.

Conclusions. While between one and two thirds of (predominantly moderately to severely) distressed couples are likely to achieve non-distressed end state functioning following TBCT, this figure may decrease to approximately 50% over the short-term (e.g., up to 12-months post-treatment). The long-term gains from TBCT are not as promising as those from insight-oriented marital therapy, where only 3% of couples were divorced at 4.5 years follow-up compared with more than a third of TBCT couples. TBCT produces similar gains in relationship satisfaction when compared to its constituent components and to other treatments (e.g., cognitive therapy and insight-oriented couple therapy) and its efficacy is not enhanced by the integration of supplementary techniques. However, the enhanced version of TBCT (i.e., ICT) may give better gains.

EFT appears to result in impressive effect sizes (relative to waiting-list conditions) with 50% or more of couples reporting clinically significant change, with this change sometimes increasing slightly over the follow-up period. However, it is notable that the distress level of the couples reviewed in these studies was predominantly in the mild to moderate range. In the only EFT study that involved severely to moderately distressed couples (i.e., 57% were in the severe range), while 67% of EFT couples reported clinically significant change at post-treatment, many couples experienced significant relapse during the 4-month follow-up period (Goldman & Greenberg, 1992). It may be that the emotional bond is so damaged in these couples that the experience or expression of vulnerability is not likely to be adaptive or respected (Johnson & Greenberg, 1985a, p. 264).

Couple outcome studies for depression
From Table 5 it may be seen that of the 311 couples involved in the 10 studies involving couple treatment of depression, at least 61% of couples were also distressed in terms of relationship satisfaction. Two studies evaluated the efficacy of TBCT with this population (Jacobson et al., 1991; Jacobson, Fruzzetti, Dobson, Whisman, & Hops, 1993; Sher, Baucom,
& Larus, 1990). Another study evaluated the efficacy of ICT (Trapp, Pace, & Stoltenberg, 1997; Miller, 2000).

Two studies adapted individual therapies for depression into couple formats and compared them with the individual format. These were spouse-aided (behavioural-cognitive) therapy for non-distressed couples (Emanuels-Zuurveen & Emmelkamp, 1997) and interpersonal psychotherapy-conjoint marital treatment (Foley, Rounsaville, Weissman, Sholomaskas, & Chevron, 1989). Another 3 studies compared Beach’s behavioural marital treatment with cognitive therapy (Beach & O’Leary, 1986, 1992; O’Leary & Beach, 1990) and behavioural-cognitive therapy (Emanuels-Zuurveen & Emmelkamp, 1996). One study evaluated the efficacy of enhancing marital intimacy therapy (Waring, Chamberlaine, Carver, Stalker, & Schaefer, 1995) and another that of cognitive marital therapy (Teichman, Bar-El, Shor, Sirota, & Elizur, 1995) that was developed specifically to treat depression.

Both of the TBCT studies indicated that TBCT (alone and with different supplementary techniques) was successful both in significantly decreasing the level of depression and in increasing the couple adjustment of depressed-distressed couples. This contrasted with TBCT’s failure to positively impact on depression in non-distressed couples (as was also found with spouse-aided behavioural-cognitive treatment in Emanuels-Zuurveen & Emmelkamp, 1996) and cognitive therapy’s failure to significantly increase relationship satisfaction in distressed couples (Jacobson et al., 1991; Sher et al., 1990). Both brief cognitive-behavioural therapy and a combination treatment of this and ICT were as efficacious as ICT alone in reducing depression and in improving couple distress (Trapp et al., 1997). However, at 27-month follow-up, despite similar mean couple adjustment scores across all treatment groups, the ICT couples were the only couples who were not depressed (Miller, 2000), a finding which contrasts with that of Jacobson et al.’s (1993) shorter-term (i.e., 12-month) follow-up data. Miller (2000) also highlighted how the existence of a robust social support system significantly influenced how participants responded to likely difficulties with emerging post-treatment depression.

Beach & O’Leary (1986) found that both 14-session behavioural marital therapy and cognitive therapy produced clinically significant decreases in depression, and that the rate and size of improvement in couple functioning was greater in the former. However, as with Foley et al.’s (1989) pilot study of a conjoint format of interpersonal psychotherapy (n=9), it is probable
that excessively small cell sizes (n=3) compromised the study's statistical power to detect outcome differences between the 2 treatment conditions. However, in their subsequent studies (O'Leary & Beach, 1990; Beach & O'Leary, 1992) with n=12, the above findings were replicated up to 12-months follow-up. Furthermore, reductions in depression were mediated by increases in couple adjustment. Emanuels-Zuurveen & Emmelkamp (1996) also found similar results.

Without differentiating participants according to whether they reported couple distress, Teichman et al. (1995) found that although cognitive marital therapy was the only condition to significantly reduce depression, by 6-month follow-up (individual) cognitive behavioural therapy had produced comparable and significant reductions in depression. Finally, Waring et al.'s (1995) pilot study found that with women who attributed their depression to couple discord, enhanced marital intimacy therapy had a significant impact on reducing depressive symptomatology. However, the treatment cell size in this study was excessively small (n=5).

**Conclusions.** With distressed-depressed couples, couples-based treatments for depression tend to produce comparable reductions in depression compared to individual treatments. While the latter may have a slower manifestation of improvement in depression over the short-term, the couples-based treatments may have greater maintenance of gains over longer-term follow-up periods. The couples-based treatments tend to result in greater gains in the rate and size of improvement in couple functioning when compared to the individual treatments. However, with non-distressed-depressed couples, couples-based treatments may achieve comparable reductions in depression but they do not yield comparable gains in couple satisfaction when compared to individual treatments.

**DISCUSSION**

The following conclusions can be drawn from this review. First, between one and two thirds of (predominantly moderately to severely) distressed couples are likely to achieve a non-distressed state of functioning following TBCT, and this figure may decrease considerably over follow-up periods. It is as effective as other therapies (e.g., cognitive therapy and insight-oriented marital therapy) in improving relationship satisfaction and its efficacy is not enhanced by the integration of supplementary techniques. There appears to be a growing acceptance that TBCT's skills-based approach does not capture the complexity of issues raised by distressed couples (Baucom et al., 1998, p. 62). This is reflected in the development of
ICT which one study has indicated promotes relatively greater treatment gains than TBCT. However, the long-term gains from TBCT are not as promising as those from insight-oriented marital therapy, where the only available study showed that on 3% of couples were divorced at 4.5 years follow-up compared with more than a third of TBCT couples. Second, EFT results in impressive effect sizes with 50% or more of (mildly to moderately) distressed couples reporting clinically significant change. This change may increase slightly over follow-up periods and is likely to be highly influenced by the robustness of the index person's social support system.

Third, couple distress is sometimes, but not always, associated with depression. Fourth, with distressed-depressed couples, a variety of couples-based treatments for depression tend to be as efficacious as individual treatments in alleviating depression, may have greater maintenance of gains over follow-up periods, and may result in greater improvements in relationship satisfaction. Fifth, with non-distressed-depressed couples, when compared with individual-based treatments, these couples-based treatments achieve comparable reductions in depression but do not affect comparable gains in relationship satisfaction. These conclusions are consistent with those from previous narrative reviews and meta-analyses of the literature on couples-based treatment of couple distress and depression (Baucom et al., 1998; Dunn & Schwebel, 1995; Hahlweg & Markman, 1988; Johnson et al., 1999; Kung, 2000; Wesley & Waring, 1996; Whisman & Uebelacker, 1999).

Given the above findings and that presenting individuals are often poly-symptomatic (Westen & Morrison, 2001), it is important that distressed couples are routinely assessed for comorbid presentations (e.g., depression) while a systems approach for assessing and treating comorbid depression be adopted. As to whether couples-based treatment is indicated for depression this will also depend on the partners’ perceived reasons for the depression and their perceived temporal relationship between couple distress and depression. It is also worth remembering that couple distress is often harder to address than depression as the former necessitates change in two individuals rather than one (O’Leary & Beach, 1990).

Future research on couples-based treatment should include reasonably lengthy follow-up periods. This is important considering that an intervention's ability to prevent recurrence and divorce is at least as important as it's capacity to alleviate current symptoms (Prince &
The idea that a brief time-limited intervention can yield a permanent solution to long-standing relationship problems has been questioned by some (Jacobson, Follette, et al., 1985, p. 555), but the outstanding success of insight-oriented marital therapy in preventing divorce over a 4.5 year follow-up period deserves replication. The processes underpinning the treatment's long-term efficacy deserve intensive investigation. Additionally, considering the complex issues inherent in couple distress and given the suggested intrinsic limits of one-size-fits-all interventions (Johnson & Lebow, 2000), combination treatments that individualise treatment to the unique presentation of each couple need to be empirically examined. For example, rather than comparing (individual) cognitive behavioural therapy with a couples-based treatment, future outcome studies could evaluate the effects of these 2 types of treatment in combination, either in sequence or concurrently.

Future treatment outcome studies need to meet all of the methodological criteria listed in Table 3. The contentious issue of researcher allegiance effects needs to be addressed possibly by including methodological checks such as manualising treatments so that treatment integrity can be assessed, the use of blind raters, and the reporting of clinical significance so that comparisons can be made more easily across treatment outcome studies. Additionally, an intention-to-treat analysis whereby all assigned couples are analysed should be considered (e.g., including those that refused treatment or dropped out) (Flick, 1988). Considering the similarities between couples-based treatments (e.g., EFT and ICT; Halford, 1998), rather than focus on the differences between such treatments, future outcome studies could possibly focus on the communal factors inherent in these treatments that increase participants' couple distress and/or depression.
References


Table 1 DSM-IV and ICD-10 diagnostic criteria for major depressive disorder.

<table>
<thead>
<tr>
<th>DSM-IV</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Presence of two or more Major Depressive Episodes.</strong></td>
<td><strong>Diagnostic guidelines</strong></td>
</tr>
<tr>
<td>**B. The Major Depressive Episodes are not better accounted for by</td>
<td>(a) the criteria for recurrent depressive disorder should be fulfilled,</td>
</tr>
<tr>
<td>Schizoaffective Disorder and are not superimposed on Schizophrenia,</td>
<td>and the current episode should fulfil the criteria for depressive</td>
</tr>
<tr>
<td>Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder</td>
<td>episode, moderate severity; and</td>
</tr>
<tr>
<td>Not Otherwise Specified.</td>
<td>(b) at least two episodes should have lasted a minimum of two weeks</td>
</tr>
<tr>
<td>**C. There has never been a Manic Episode, a Mixed Episode, or a</td>
<td>and should have been separated by several months without significant</td>
</tr>
<tr>
<td>Hypomanic Episode.</td>
<td>mood disturbance</td>
</tr>
<tr>
<td><strong>Criteria for Major Depressive Episode</strong></td>
<td><strong>Moderate Depressive Episode</strong></td>
</tr>
<tr>
<td>**A. Five (or more) of the following symptoms have been present during</td>
<td>The individual usually suffers from at least two of the three most</td>
</tr>
<tr>
<td>the same 2-week period and represent a change from previous functioning;</td>
<td>typical symptoms noted for mild depressive episode (e.g., depressed</td>
</tr>
<tr>
<td>at least one of the symptoms is either (1) depressed mood or (2) loss</td>
<td>mood, loss of interest and enjoyment, increased fatigability) plus at</td>
</tr>
<tr>
<td>of interest or pleasure.</td>
<td>least three (and preferably four) of the following symptoms:</td>
</tr>
<tr>
<td>(1) depressed mood most of the day, nearly every day, as indicated by</td>
<td>(a) reduced concentration and attention;</td>
</tr>
<tr>
<td>either subjective report (e.g., feels sad or empty) or observation made</td>
<td>(b) reduced self-esteem and confidence;</td>
</tr>
<tr>
<td>by others (e.g., appears tearful);</td>
<td>(c) ideas of guilt and unworthiness;</td>
</tr>
<tr>
<td>(2) markedly diminished interest or pleasure in all, or almost all,</td>
<td>(d) bleak and pessimistic views of the future;</td>
</tr>
<tr>
<td>activities most of the day, nearly every day (as indicated by either</td>
<td>(e) ideas or acts of self-harm or suicide;</td>
</tr>
<tr>
<td>subjective account or observation made by others);</td>
<td>(f) disturbed sleep;</td>
</tr>
<tr>
<td>(3) significant weight loss when not dieting or weight gain (e.g., a</td>
<td>(g) diminished appetite.</td>
</tr>
<tr>
<td>change of more than 5% of body weight in a month), or a decrease or</td>
<td>Several symptoms are likely to be present to a marked degree, but this</td>
</tr>
<tr>
<td>increase in appetite nearly every day;</td>
<td>is not essential if a particularly wide variety of symptoms are</td>
</tr>
<tr>
<td>(4) insomnia or hypersomnia nearly every day;</td>
<td>present overall. Minimum duration of the whole episode is about 2</td>
</tr>
<tr>
<td>(5) psychomotor agitation or retardation nearly every day (observable</td>
<td>weeks.</td>
</tr>
<tr>
<td>by others, not merely subjective feelings of restlessness or being</td>
<td>An individual with a moderately depressive episode will usually have</td>
</tr>
<tr>
<td>slowed down);</td>
<td>considerable difficulty in continuing with social, work or domestic</td>
</tr>
<tr>
<td>(6) fatigue or loss of energy nearly every day;</td>
<td>activities.</td>
</tr>
<tr>
<td>(7) feelings of worthlessness or excessive or inappropriate guilt (which</td>
<td><strong>Recurrent Depressive Disorder</strong></td>
</tr>
<tr>
<td>may be delusional) nearly every day (not merely self-reproach or guilt</td>
<td>The disorder is characterised by repeated episodes of depression,</td>
</tr>
<tr>
<td>about being sick);</td>
<td>without any history of independent episodes of mood elevation and</td>
</tr>
<tr>
<td>(8) diminished ability to think or concentrate, or indecisiveness,</td>
<td>overactivity that fulfil the criteria of mania. However, the category</td>
</tr>
<tr>
<td>nearly every day (either by subjective account or as observed by others);</td>
<td>should still be used if there is evidence of brief episodes of mild</td>
</tr>
<tr>
<td>(9) recurrent thoughts of death (not just fear of dying), recurrent</td>
<td>mood elevation and overactivity that fulfil the criteria of</td>
</tr>
<tr>
<td>suicidal ideation without a specific plan, or a suicide attempt or a</td>
<td>hypomania immediately after a depressive episode (sometimes</td>
</tr>
<tr>
<td>specific plan for committing suicide.</td>
<td>apparently precipitated by treatment of a depression).</td>
</tr>
</tbody>
</table>

B. The symptoms do not meet the criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterised by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.
<table>
<thead>
<tr>
<th>Study no.</th>
<th>Authors</th>
<th>Year</th>
<th>Age Mean &amp; Range</th>
<th>Marital status</th>
<th>Referral</th>
<th>Primary measure of relationship distress</th>
<th>Mean degree of relationship distress</th>
<th>Main Treatment (or elements of) Evaluated</th>
<th>Drop outs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Baucom</td>
<td>1982</td>
<td>32 y 20-39 y</td>
<td>M</td>
<td>Media or self-referrals</td>
<td>MAS</td>
<td>Moderate</td>
<td>TBCT</td>
<td>0%</td>
</tr>
<tr>
<td>2</td>
<td>Baucom &amp; Lester</td>
<td>1986</td>
<td>m: 33.5 y, 24-52 y; f: 30.0 y, 23-41 y</td>
<td>M</td>
<td>Self-referral</td>
<td>DAS</td>
<td>Mild to moderate</td>
<td>TBCT</td>
<td>12%</td>
</tr>
<tr>
<td>3</td>
<td>Baucom et al.</td>
<td>1990</td>
<td>m: 35.1 y; f: 33.0 y</td>
<td>M</td>
<td>Self-/ MHP-referrals</td>
<td>DAS</td>
<td>Moderate</td>
<td>TBCT</td>
<td>-</td>
</tr>
<tr>
<td>4</td>
<td>Bennun</td>
<td>1985</td>
<td>-</td>
<td>Cohabiting &gt; 1 y</td>
<td>GP-/ clinic referrals</td>
<td>MMQ</td>
<td>Moderate to severe</td>
<td>TBCT</td>
<td>-</td>
</tr>
<tr>
<td>5</td>
<td>Emmelkamp et al.</td>
<td>1984</td>
<td>31.4 y 22-48 y</td>
<td>Cohabiting</td>
<td>CMH referrals</td>
<td>MMQ</td>
<td>Moderate to severe</td>
<td>TBCT</td>
<td>35%</td>
</tr>
<tr>
<td>6</td>
<td>Emmelkamp et al.</td>
<td>1988</td>
<td>35.5 y</td>
<td>91% M</td>
<td>CMH referrals</td>
<td>MMQ</td>
<td>Severe</td>
<td>TBCT</td>
<td>32%</td>
</tr>
<tr>
<td>7</td>
<td>Hahlweg et al.</td>
<td>1984</td>
<td>33.7 y 25-40 y</td>
<td>90% M</td>
<td>Media / MHP referrals</td>
<td>GHRS</td>
<td>Mild to moderate</td>
<td>TBCT</td>
<td>9%</td>
</tr>
<tr>
<td>8</td>
<td>Halford et al.</td>
<td>1993</td>
<td>m: 43.2 y; f: 40.1 y</td>
<td>M</td>
<td>-</td>
<td>DAS</td>
<td>Moderate to severe</td>
<td>TBCT</td>
<td>0%</td>
</tr>
<tr>
<td>9</td>
<td>Jacobson et al.</td>
<td>1984</td>
<td>m: 39.1 y 35.7 y</td>
<td>M &amp; cohabiting</td>
<td>Media / MHP / self-referrals</td>
<td>DAS</td>
<td>Moderate</td>
<td>TBCT</td>
<td>-</td>
</tr>
<tr>
<td>10</td>
<td>Jacobson et al.</td>
<td>2000</td>
<td>m: 43.0 y; f: 40.0 y</td>
<td>M &amp; cohabiting</td>
<td>-</td>
<td>DAS, GDS</td>
<td>Mild to moderate</td>
<td>TBCT</td>
<td>5%</td>
</tr>
<tr>
<td>11</td>
<td>Mehlman et al.</td>
<td>1983</td>
<td>35 y 19-59 y</td>
<td>M</td>
<td>-</td>
<td>MAS</td>
<td>Moderate</td>
<td>TBCT</td>
<td>0%</td>
</tr>
<tr>
<td>12</td>
<td>Snyder &amp; Wills et al.</td>
<td>1989</td>
<td>m: 40.1 y 37.1 y</td>
<td>M &amp; cohabiting</td>
<td>Media referrals</td>
<td>DAS, GDS</td>
<td>Moderate to severe</td>
<td>TBCT</td>
<td>&lt; 5%</td>
</tr>
<tr>
<td>13</td>
<td>Wilson et al.</td>
<td>1988</td>
<td>33.0 y 25-56 y</td>
<td>M</td>
<td>-</td>
<td>DAS</td>
<td>Moderate to severe</td>
<td>TBCT</td>
<td>-</td>
</tr>
<tr>
<td>14</td>
<td>Johnson &amp; Greenberg</td>
<td>1985</td>
<td>-</td>
<td>M &amp; cohabiting</td>
<td>Media</td>
<td>DAS</td>
<td>Mild to moderate</td>
<td>EFT</td>
<td>0%</td>
</tr>
<tr>
<td>15</td>
<td>Johnson &amp; Greenberg</td>
<td>1985</td>
<td>33 y</td>
<td>M &amp; cohabiting</td>
<td>Media</td>
<td>DAS</td>
<td>Mild</td>
<td>EFT</td>
<td>0%</td>
</tr>
<tr>
<td>16</td>
<td>James et al.</td>
<td>1991</td>
<td>-</td>
<td>M &amp; cohabiting</td>
<td>Media</td>
<td>DAS</td>
<td>Moderate</td>
<td>EFT</td>
<td>0%</td>
</tr>
<tr>
<td>17</td>
<td>Goldman &amp; Greenberg</td>
<td>1992</td>
<td>m: 39.4 y (26-57 y); f: 37.6 y (23-52 y)</td>
<td>M &amp; cohabiting</td>
<td>Cohabiting &gt; 1½ y</td>
<td>DAS</td>
<td>Moderate to severe</td>
<td>EFT</td>
<td>0%</td>
</tr>
<tr>
<td>18</td>
<td>Gordon Walker et al.</td>
<td>1996</td>
<td>m: 38.1 y 35.7 y</td>
<td>M</td>
<td>Screening couples with a CIC; Posters</td>
<td>DAS</td>
<td>Moderate</td>
<td>EFT</td>
<td>3%</td>
</tr>
<tr>
<td>19</td>
<td>Johnson &amp; Talitman</td>
<td>1997</td>
<td>42 y 22-60 y</td>
<td>M &amp; cohabiting</td>
<td>Media</td>
<td>DAS</td>
<td>Moderate</td>
<td>EFT</td>
<td>6%</td>
</tr>
<tr>
<td>20</td>
<td>Denton et al.</td>
<td>2000</td>
<td>36 y 23-59 y</td>
<td>M &amp; cohabiting</td>
<td>Clinician referrals;</td>
<td>DAS</td>
<td>Moderate</td>
<td>EFT</td>
<td>39%</td>
</tr>
</tbody>
</table>

Table 3  Methodological features of couple treatment outcome studies for couple distress.

| Design Feature                      | S1 | S2 | S3 | S4 | S5 | S6 | S7 | S8 | S9 | S10 | S11 | S12 | S13 | S14 | S15 | S16 | S17 | S18 | S19 | S20 | Total |
|-------------------------------------|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-------|
| 1 Comparison group                  | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1    | 18   |
| 2 Random assignment                 | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 0   | 1   | 1   | 1   | 0   | 1   | 0   | 1   | 1    | 17   |
| 3 Diagnostic homogeneity            | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1   | 1   | 1   | 1   | 1   | 1   | 0   | 1   | 1    | 20   |
| 4 Not on medication                 | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0   | 0   | 1   | 0   | 0   | 0   | 0   | 0   | 0    | 1    |
| 5 Pre-treatment assessment          | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1    | 20   |
| 6 Post-treatment assessment         | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1    | 20   |
| 7 Follow-up assessment at 3 months or later | 1  | 1  | 1  | 1  | 1  | 0  | 1  | 1  | 1  | 1   | 1   | 1   | 0   | 0   | 0   | 1   | 1   | 1    | 15   |
| 8 Client self-report                | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1    | 20   |
| 9 Partner self-report               | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1    | 20   |
| 10 Therapist ratings                | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 1    | 1    |
| 11 Researcher ratings               | 1  | 1  | 1  | 0  | 0  | 1  | 1  | 1  | 1  | 1   | 1   | 1   | 0   | 0   | 0   | 0   | 0   | 1    | 11   |
| 12 Quality of couples relationship assessed | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1    | 20   |
| 13 Clinical significance of change assessed | 0  | 1  | 1  | 1  | 0  | 0  | 1  | 1  | 0  | 1   | 0   | 1   | 0   | 0   | 1   | 0   | 0   | 0    | 12   |
| 14 Experienced therapists used      | 0  | 0  | 0  | 1  | 1  | 0  | 1  | 1  | 0  | 0   | 1   | 0   | 0   | 1   | 0   | 0   | 0   | 0    | 7    |
| 15 Treatments were manualised       | 0  | 0  | 1  | 1  | 0  | 0  | 1  | 1  | 1  | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1    | 16   |
| 16 Therapy supervision was provided | 1  | 0  | 1  | 0  | 1  | 0  | 1  | 0  | 0  | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1    | 13   |
| 17 Treatment integrity checked      | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 1  | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1    | 11   |

Total: 11 12 14 11 10 11 12 15 11 11 15 11 13 13 9 13 14 14 12 10

Key 0 = design feature was absent. 1 = design feature was present. S = study.
### Table 4 Key findings from couple treatment outcome studies for couple distress

<table>
<thead>
<tr>
<th>Study no.</th>
<th>Authors</th>
<th>Year</th>
<th>N per group</th>
<th>No. of sessions or hours of contact</th>
<th>Group differences</th>
<th>Follow-up period</th>
<th>After treatment</th>
<th>Longest follow-up</th>
<th>Key findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Baucom</td>
<td>1982</td>
<td>1. PS/C + CON = 18</td>
<td>10 weekly 1 = 2 &gt; 3</td>
<td>3 m a. 0.68</td>
<td>a. -</td>
<td>a. -</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. PS/C = 18</td>
<td>1-1/2 h</td>
<td>4</td>
<td>b. -</td>
<td>b. -</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3. CON = 18</td>
<td>sess</td>
<td></td>
<td>c. -</td>
<td>c. -</td>
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<td></td>
<td></td>
<td></td>
<td>4. WL = 18</td>
<td></td>
<td></td>
<td>d. -</td>
<td>d. -</td>
<td></td>
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</tr>
<tr>
<td>2</td>
<td>Baucom &amp; Lester</td>
<td>1986</td>
<td>1. TBCT = 8</td>
<td>12 weekly 1 = 2 &gt; 3</td>
<td>6 m a. 1.00</td>
<td>a. -</td>
<td>a. -</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>2. TBCT + CBT = 8</td>
<td>1½ h sess</td>
<td></td>
<td>b. -</td>
<td>b. -</td>
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<td></td>
<td></td>
<td></td>
<td>3. WL = 8</td>
<td></td>
<td></td>
<td>c. 62.5%</td>
<td>c. 50%</td>
<td></td>
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</tr>
<tr>
<td>3</td>
<td>Baucom et al.</td>
<td>1990</td>
<td>1. TBCT = 12</td>
<td>12 weekly 1 = 2 &gt; 3</td>
<td>6 m a. 0.57</td>
<td>a. -</td>
<td>a. -</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>2. TBCT + CR = 12</td>
<td>4 &gt; 5 sess</td>
<td></td>
<td>b. 75%</td>
<td>b. -</td>
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<td></td>
<td></td>
<td></td>
<td>3. TBCT + EET = 12</td>
<td></td>
<td></td>
<td>c. 62.5%</td>
<td>c. -</td>
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<td></td>
<td></td>
<td></td>
<td>4. TBCT + CR + EET = 12</td>
<td></td>
<td></td>
<td>d. -</td>
<td>d. -</td>
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<td></td>
<td></td>
<td></td>
<td>5. WL = 12</td>
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<tr>
<td>4</td>
<td>Bennun</td>
<td>1985</td>
<td>1. TBCT = 19</td>
<td>10 weekly 1 = 2 &gt; 3</td>
<td>6 m a. -</td>
<td>a. -</td>
<td>a. -</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>2. TBCT with 1 partner = 19</td>
<td>1h sess</td>
<td></td>
<td>b. -</td>
<td>b. -</td>
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<td></td>
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<td></td>
<td>3. Group TBCT = 19</td>
<td></td>
<td></td>
<td>c. -</td>
<td>c. -</td>
<td></td>
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</tr>
<tr>
<td>5</td>
<td>Emmelkamp et al.</td>
<td>1984</td>
<td>n = 17</td>
<td>14 weekly 1 = 2</td>
<td>12 m a. -</td>
<td>a. -</td>
<td>a. -</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>1. CPT + BC</td>
<td>1h sess</td>
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<td>b. -</td>
<td>b. -</td>
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<td></td>
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<td></td>
<td>2. BC + CPT</td>
<td></td>
<td></td>
<td>c. -</td>
<td>c. -</td>
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<td></td>
<td>d. -</td>
<td>d. -</td>
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<tr>
<td>6</td>
<td>Emmelkamp et al.</td>
<td>1988</td>
<td>1. CST = 18</td>
<td>9 weekly 1 = 2</td>
<td>1 m a. -</td>
<td>a. -</td>
<td>a. -</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>2. CR = 14</td>
<td>1½ h sess</td>
<td></td>
<td>b. -</td>
<td>b. -</td>
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<td></td>
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<td>c. -</td>
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<td></td>
<td></td>
<td></td>
<td>d. -</td>
<td>d. -</td>
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<tr>
<td>7</td>
<td>Hahlweg et al.</td>
<td>1984</td>
<td>1. TBCT = 17</td>
<td>10 sess up to 2½ 1 = 2 &gt; 3</td>
<td>6 &amp; 12 m a. 1.10</td>
<td>a. 1.25</td>
<td>a. -</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>2. Group TBCT = 16</td>
<td>4 &gt; 5 h each</td>
<td></td>
<td>b. -</td>
<td>b. -</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>3. Conjoint CT = 16</td>
<td></td>
<td></td>
<td>c. 81%</td>
<td>c. 64%</td>
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<td></td>
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<td></td>
<td>4. Group CT = 19</td>
<td></td>
<td></td>
<td>d. -</td>
<td>d. -</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>5. WL = 17</td>
<td></td>
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<tr>
<td>8</td>
<td>Halford et al.</td>
<td>1993</td>
<td>1. TBCT = 13</td>
<td>12-15 weekly 1 = 2</td>
<td>3 m a. -</td>
<td>a. -</td>
<td>a. -</td>
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<td></td>
<td></td>
<td></td>
<td>2. EBMT = 13</td>
<td>1½ h sess</td>
<td></td>
<td>b. 69%</td>
<td>b. 40.5%</td>
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<td>c. 48%</td>
<td>c. 29%</td>
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<td>d. -</td>
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</tr>
</tbody>
</table>

- The 3 behaviour therapy conditions of TBCT, problem-solving/communication training alone, and qui pro quo contracting alone resulted in comparable improvements in marital distress, and all 3 were more effective than a waiting-list condition in doing so.
- Both TBCT, and TBCT with cognitive behavioral therapy, resulted in comparable improvements in marital distress, and both were more effective than a waiting-list condition in doing so.
- These improvements were maintained at 6-month follow-up.
- Although individual, conjoint, and group TBCT resulted in comparable and significant reductions in target problems, couples were still experiencing some distress post-treatment and at 6-month follow-up.
- Both behavioral contracting and communication skills training were equally effective in alleviating relationship distress, and the order in which they were given did not influence outcome.
- Treatment gains were maintained at 12-month follow-up.
- While both CT and CST resulted in significant improvements in target problems, the Communication Questionnaire (Arrindell et al 1983), and the Relationship Beliefs Inventory (Eidelson & Epstein, 1982), both appeared to have little impact on the marital satisfactio of the couples.
- While couples in both modalities of TBCT and those in conjoint communication training reported a significant increase in general happiness, this increase was most significant for couples in the conjoint modality of TBCT.
- Couples in the conjoint-group modality of communication training and those in the waiting list condition remained unchanged on reports of general happiness.
- Both TBCT and EBMT resulted in comparable improvements in marital satisfaction.
- Only about 50% of these improvements were sustained at 3-month follow-up.
<table>
<thead>
<tr>
<th>Study no.</th>
<th>Authors</th>
<th>Year</th>
<th>N per group</th>
<th>No. of sessions or hours of contact</th>
<th>Group differences</th>
<th>Follow-up period</th>
<th>After treatment</th>
<th>Longest follow-up</th>
<th>Key findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Jacobson</td>
<td>1984b</td>
<td>1. TBCT = 15</td>
<td>12-16 weekly 1 = 2 = 3 &gt; 4 6, 12, &amp; 24 m</td>
<td>a. -</td>
<td>a. -</td>
<td>b. 60%</td>
<td>c. 40%</td>
<td>- d. Recovered • Compared to both TBCT and CPT, BE produced the highest percentage of non-distressed couples post-treatment.</td>
</tr>
<tr>
<td></td>
<td>Jacobson &amp; Follette</td>
<td>1985</td>
<td>2. BE = 14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- d. Recovered • However, at 6-month follow-up there was a tendency for BE couples to reverse their progress and for TBCT couples to maintain their treatment gains or to continue to improve.</td>
</tr>
<tr>
<td></td>
<td>Jacobson, Follette, et al.</td>
<td>1985</td>
<td>3. CPT = 14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- d. Recovered • At 1-y and 2-y follow-up, there were no differences between treatment groups, but TBCT couples were most likely to be happily married, although for many of these couples, marital satisfaction was in the process of decline.</td>
</tr>
<tr>
<td></td>
<td>Jacobson et al.</td>
<td>1987</td>
<td>4. WL = 17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- d. Recovered • While 55% of TBCT couples recovered by the end of therapy, 70% of ICT couples did.</td>
</tr>
<tr>
<td>10</td>
<td>Jacobson et al.</td>
<td>2000</td>
<td>1. TBCT = 11</td>
<td>13-26 sess 1 &lt; 2 -</td>
<td>a. -</td>
<td>a. -</td>
<td>b. -</td>
<td>c. -</td>
<td>- d. Recovered • TBCT was more effective than no treatment on self-report measures (including marital adjustment) and on 1 of 2 behavioral measures.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>2. ICT = 11</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>- d. Recovered • A cotherapy team and single therapists were equally effective in producing treatment changes.</td>
</tr>
<tr>
<td>11</td>
<td>Mehlman et al.</td>
<td>1983</td>
<td>1. TBD by Ther. A = 5</td>
<td>10 weekly 1 = 2 = 3 = 3 m</td>
<td>a. 0.18</td>
<td>a. 0.21</td>
<td>b. -</td>
<td>c. -</td>
<td>- d. Recovered • Both at termination and 6-month follow-up, TBCT and insight-oriented marital therapy resulted in comparable improvements in marital distress, and both were more effective than a waiting-list condition in doing so.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. TBD by Ther. B = 5</td>
<td></td>
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<td></td>
<td>- d. Recovered • By 4-year follow-up, a larger proportion (i.e., 38%) of the TBCT couples had experienced divorce relative to the insight-oriented marital therapy couples (i.e., 3%).</td>
</tr>
<tr>
<td>12</td>
<td>Snyder &amp; Wills</td>
<td>1989</td>
<td>1. TBCT = 29</td>
<td>19 sess 1 = 2 &gt; 3 6 &amp; 53 m</td>
<td>a. 0.85</td>
<td>a. -</td>
<td>b. 62%</td>
<td>c. 50%</td>
<td>- d. Recovered • Both conjoint- and group-TBCT resulted in significantly greater resolution of marital distress relative to a waiting-list condition.</td>
</tr>
<tr>
<td></td>
<td>Snyder et al.</td>
<td>1991</td>
<td>2. IOMT = 30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- d. Recovered • While both problem-solving intervention and EFT were superior to a waiting-list condition, compared to the former, EFT achieved greater gains on dyadic adjustment, intellectual intimacy, conventionality, and on target complaints.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>3. WL = 20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- d. Recovered • At 2-months follow-up, the first 3 above measures continued to differentiate between treatment groups.</td>
</tr>
</tbody>
</table>

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Table 4  Key findings from couple treatment outcome studies for couple distress (continued).

<table>
<thead>
<tr>
<th>Study no.</th>
<th>Authors</th>
<th>Year</th>
<th>N per group</th>
<th>No. of sessions or hours of contact</th>
<th>Group differences</th>
<th>Follow-up period</th>
<th>After treatment</th>
<th>Longest follow-up</th>
<th>Key findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Johnson et al. 1985b</td>
<td>1. EFT = 14 2. WL = Same couples</td>
<td>8 weekly 1½ h sess</td>
<td>1 &gt; 2</td>
<td>2 m</td>
<td>a. 0.94  b. -  c. -  d. -</td>
<td>a. -</td>
<td>-</td>
<td>• Using the same sample as their own controls, EFT achieved superior gains to a waiting-list condition and at 2-month follow-up</td>
</tr>
<tr>
<td>16</td>
<td>James 1991</td>
<td>1. EFT = 14 2. EFT + CT = 14 3. WL = 14</td>
<td>12 weekly 1h sess</td>
<td>1 = 2 &gt; 3</td>
<td>4 m</td>
<td>a. 0.70  b. 86%  c. -  d. -</td>
<td>a. -  b. 71%  c. -  d. 50%</td>
<td>• A 4-session cognitive therapy component did not enhance the effectiveness of 8-session EFT. • At 4-month follow-up, a significant number of couples had regressed back into the distressed range of marital satisfaction.</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Goldman &amp; Greenberg 1992</td>
<td>1. EFT = 14 2. IST = 14 3. WL = 14</td>
<td>10 weekly 1h sess</td>
<td>1 = 2 &gt; 3</td>
<td>4 m</td>
<td>a. 1.52  b. 71%  c. -  d. 67%</td>
<td>a. -  b. -  c. -  d. -</td>
<td>• While both integrated systemic therapy and EFT were superior to a waiting list condition, integrated systemic therapy showed the greater maintenance of gains at 4-month follow-up on marital satisfaction and goal attainment.</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Gordon Walker et al. Cloutier et al. 2002</td>
<td>1. EFT = 13 2. WL = 13</td>
<td>10 weekly/bi-weekly 1½ h sess</td>
<td>1 &gt; 2 5 &amp; 24 m</td>
<td>a. -  b. 62%  c. -  d. 15%</td>
<td>a. -  b. 15%  c. -  d. 46%</td>
<td>• EFT couples demonstrated significantly greater marital adjustment than a waiting list condition and at 5-month follow-up. • Improvements in marital functioning were not only maintained but in some cases, enhanced at 24-month follow-up.</td>
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</tr>
<tr>
<td>19</td>
<td>Johnson &amp; Talitman 1997</td>
<td>1. EFT = 34 2. WL = Same couples</td>
<td>12 weekly 1½ h sess</td>
<td>-</td>
<td>3 m</td>
<td>a. 1.26  b. 79%  c. -  d. 50%</td>
<td>a. -  b. 82%  c. -  d. 70%</td>
<td>• 50% of the sample was satisfied at post-treatment and 70% at 3-month follow-up, whereas 79% exhibited a clinically significant change at post-treatment and 82% at follow-up. • Initial levels of marital satisfaction accounted for 12% and 4% of variance at post-treatment and 3-month follow-up respectively.</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Denton et al. 2000</td>
<td>1. EFT = 22  r 14</td>
<td>8 weekly 50-minute sess</td>
<td>1 &gt; 2</td>
<td>-</td>
<td>a. 0.99  b. -  c. -  d. -</td>
<td>a. -</td>
<td>-</td>
<td>• Controlling for initial scores, the EFT group had significantly higher scores on a composite measure of marital satisfaction.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Authors</th>
<th>Year</th>
<th>Study design</th>
<th>Treatment duration</th>
<th>Treatment couples distressed</th>
<th>Severity of couple distress</th>
<th>Key findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jacobson et al.</td>
<td>1991</td>
<td>1. TBCT = 19</td>
<td>20 sess</td>
<td>38%</td>
<td>Moderate</td>
<td>• While TBCT had little impact on depression with non-distressed couples and cognitive therapy did, both treatments resulted in comparable improvements in depression in distressed couples.</td>
</tr>
<tr>
<td></td>
<td>1993</td>
<td>2. CT = 20</td>
<td></td>
<td></td>
<td></td>
<td>• TBCT was the only treatment to have a significant positive impact on relationship satisfaction in distressed couples, 75% of who improved.</td>
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<td></td>
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<td>3. TBCT + CT = 21</td>
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<td></td>
<td>• The combination of TBCT and cognitive therapy was the only treatment to enhance the marital satisfaction of nondistressed couples.</td>
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<td></td>
<td>• Depressive relapse rates did not discriminate between treatments at any follow-up point up to 12 months.</td>
</tr>
<tr>
<td>Sher et al.</td>
<td>1990</td>
<td>TBCT, TBCT + CR, TBCT + EET, &amp; TBCT + CR + EET with: 1. Depressed = 14</td>
<td>12 weekly sess</td>
<td>100%</td>
<td>Mild to severe</td>
<td>• Relative to a waiting list condition TBCT (alone and with different supplementary techniques) was successful both in significantly increasing marital adjustment for all 3 groups of distressed couples and in significantly decreasing the level of depression among depressed spouses.</td>
</tr>
<tr>
<td>Emanuels-Zuurveen &amp; Emmelkamp</td>
<td>1996</td>
<td>1. MT = 13</td>
<td>16 weekly 1h sess</td>
<td>100%</td>
<td>Moderate</td>
<td>• Marital therapy was as effective as (individual) behavioural-cognitive therapy in improving depressed mood</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. BCT = 14</td>
<td></td>
<td></td>
<td></td>
<td>• Marital therapy was significantly more effective than (individual) behavioural-cognitive therapy in improving marital satisfaction.</td>
</tr>
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<td></td>
<td>• There was a comparable and moderate relationship between changes in depressed mood and changes in the relationship satisfaction in both treatments.</td>
</tr>
<tr>
<td>Emanuels-Zuurveen &amp; Emmelkamp</td>
<td>1997</td>
<td>1. SAT = 13</td>
<td>16 weekly 1h sess</td>
<td>0%</td>
<td>-</td>
<td>• Spouse-aided therapy and individual behavioural-cognitive treatment produced comparable reductions in level of reported depression.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. BCT = 10</td>
<td></td>
<td></td>
<td></td>
<td>• Spouse-aided therapy did not increase marital satisfaction.</td>
</tr>
<tr>
<td>Beach &amp; O’Leary</td>
<td>1986</td>
<td>1. BMT = 3</td>
<td>14 sess</td>
<td>100%</td>
<td>Mild to severe</td>
<td>• Both behavioural marital therapy and cognitive therapy produced clinically significant decreases in wives’ level of depression.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. CT = 3</td>
<td></td>
<td></td>
<td></td>
<td>• The wives in behavioural marital therapy showed more rapid and greater gains in marital functioning during treatment and at 3-month follow-up than did wives receiving cognitive therapy.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. WL = 2</td>
<td></td>
<td></td>
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<tr>
<td>O’Leary &amp; Beach</td>
<td>1990</td>
<td>1. BMT = 12</td>
<td>15-16 weekly sess</td>
<td>100%</td>
<td>Mild to moderate</td>
<td>• Marital therapy and (individual) cognitive therapy were both associated with clinically significant and comparable reductions in depression.</td>
</tr>
<tr>
<td>Beach &amp; O’Leary</td>
<td>1992</td>
<td>2. CT = 12</td>
<td></td>
<td></td>
<td></td>
<td>• Relative to women in the waiting list and cognitive therapy conditions, only those who received marital therapy showed consistent patterns of improved marital satisfaction up to 12 months follow-up.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. WL = 12</td>
<td></td>
<td></td>
<td></td>
<td>• Reductions in level of depression among wives in the marital therapy condition were mediated by increases in marital adjustment.</td>
</tr>
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</table>

351
<table>
<thead>
<tr>
<th>Authors</th>
<th>Year</th>
<th>Study design</th>
<th>Treatment duration</th>
<th>Treatment couples distressed</th>
<th>Severity of couple distress</th>
<th>Key findings</th>
</tr>
</thead>
</table>
| Trapp et al.     | 1997 | 1. ICT = 14           | 12 weekly          | 87%                          | Moderate to severe            | • Integrative couple therapy, brief cognitive-behavioural therapy, and a combination of these treatments yielded comparable and significant improvement both in depression and marital distress, with the greatest improvement in marital distress.  
• At 27-month follow-up, women in the integrative couple therapy format reported symptoms that did not meet criteria for depression, while those in both the cognitive behavioural and combined treatment formats were endorsing mild levels of depression.  
• Mean marital adjustment scores at follow-up were similar across all 3 treatment groups.  
• Social support systems and ambivalence regarding seeking future services may both significantly influence how clients respond to likely difficulties with emerging depression post-treatment. |
| Miller           | 2002 | 2. CBT = 14           | 50 minute sess     |                              |                              |                                                                                                                                            |
|                  |      | 3. ICT + CBT = 11     |                    |                              |                              |                                                                                                                                            |
| Foley et al.     | 1989 | 1. IPT-CM = 9         | 16 weekly sess     | 100%                         | Moderate                     | • 50% of the spouses of the identified patients reported previous episodes of depression.  
• Two formats of interpersonal psychotherapy (conjoint and individual) produced significant and comparable reductions in symptoms of depression.  
• The conjoint format of interpersonal psychotherapy produced greater gains in marital satisfaction when compared to the individual format of this treatment (as measured on the DAS and the MAT). |
|                  |      | 2. IPT = 9            |                    |                              |                              |                                                                                                                                            |
| Teichman et al.  | 1995 | 1. CMT = 15           | 7-15 weekly sess   | -                            | -                            | • Comparing cognitive behavioural therapy, a wait-list condition, and cognitive marital therapy, the latter was the only condition to significantly reduce depression.  
• However, relative to cognitive marital therapy patients, those in the cognitive behavioural therapy format produced comparable and significant reductions in depression by 6-month follow-up. |
|                  |      | 2. CBT = 15           |                    |                              |                              |                                                                                                                                            |
|                  |      | 3. WL = 15            |                    |                              |                              |                                                                                                                                            |
| Waring et al.    | 1995 | 1. EMIT = 5           | 10 weekly sess     | 100%                         | -                            | • Relative to a waiting list control condition, enhanced marital intimacy therapy had a significant impact on reducing depressive symptomatology even though significant changes in overall marital intimacy were not found.  
• Wives appeared to perceive their relationships as improved after enhanced marital intimacy therapy. |
|                  |      | 2. WL = 3             |                    |                              |                              |                                                                                                                                            |

Notes: D=depression. BCT=Behavioral cognitive therapy. BMT=Behavior marital therapy. CMT=Cognitive marital therapy. CR=Cognitive restructuribng. CT=(Individual) cognitive therapy. EET=Emotional expressiveness training. EMIT=Enhancing marital intimacy therapy. h=hour. ICT=Integrative Couples Therapy. IPT=(Individual) interpersonal psychotherapy. IPT-CM=Interpersonal psychotherapy-conjoint marital treatment. d=day. m=month. MT=Marital therapy. SAT=Spouse-aided therapy. TBCT=(Conjoint) traditional behavioral couple therapy. w=week. WL=waiting list control condition.
The Efficacy of Couples Based Interventions for Panic Disorder with Agoraphobia

ABSTRACT
From this systematic literature review it was concluded that panic disorder with agoraphobia (PDA) can sometimes occur in conjunction with marital problems. Couples-based treatments for PDA – partner-assisted exposure and marital therapy - can be an effective treatment for the condition. It is as effective as individually based cognitive behaviour therapy. Involving partners of people with PDA in therapy may be appropriate in some cases, particularly those in which there are marital difficulties. Couple-focused interventions may enhance the maintenance of treatment gains by facilitating interactions that positively reinforce and perpetuate attempts by people with PDA to enter feared situations and cope with these effectively. People with PDA who have good marital relationships show a better response to both individual and couples-based treatment programmes. In some instances effective couples-based treatment leads to improvement in marital adjustment as well as in PDA symptomatology.

INTRODUCTION
The primary aim of this paper is to review evidence for a link between panic disorder with agoraphobia (PDA) and marital problems and the efficacy of couple-based treatment programmes for people with PDA. Both partner-assisted interventions and marital-therapy interventions will be reviewed. Before considering the rationale for such programmes, the features and epidemiology of PDA deserve mention.

Panic disorder and agoraphobia
Diagnostic criteria for PDA are given in Table 1. Panic disorder is characterised by recurrent unexpected panic attacks and a marked fear of these acute episodes of anxiety, ruminations about the possible implications of repeated attacks and in some instances agoraphobia. Agoraphobia entails a fear of leaving the safety of the home and entering situations that might trigger panic attacks. This commonly leads to the development of a restricted housebound lifestyle. The lifetime prevalence of PDA is between 1.5% and 3.5% (Kessler et al., 1994) with a one-year prevalence rate between 1% and 2% (American Psychiatric
Women are twice as likely as men to be diagnosed with panic disorder without agoraphobia and 3 times as likely to be diagnosed with PDA (Kessler et al., 1994).

Although DSM-IV (1994, American Psychiatric Association) distinguishes between panic disorder, agoraphobia, and panic disorder with or without agoraphobia, it was only with the advent of DSM-III (American Psychiatric Association, 1980) that both panic disorder and agoraphobia were differentiated from other anxiety presentations (Markowitz, Weissman, Quellette, Lish, & Klerman, 1989). Prior to this, studies typically classified individuals who exhibited a marked degree of behavioural avoidance (due to fear of panic attacks) as agoraphobic. Available evidence suggests that agoraphobia is a secondary manifestation of panic disorder and that many individuals with panic disorder may be pre-agoraphobic (Garvey & Tuason, 1984; Klein, 1981). Over 95% of individuals in clinical samples who have agoraphobia also have panic disorder (American Psychiatric Association, 1994).

**Rationale for couples-based treatment for panic disorder and agoraphobia**

Both empirical and theoretical factors have contributed to the development of couple-based approaches to the treatment of PDA. From an empirical perspective, it is now widely accepted that the more established psychological and pharmacological treatments for PDA are not effective in all cases. More than 25% of cases do not respond to cognitive behavioural interventions or antidepressant medication and both treatment approaches entail significant dropout and relapse rates (Fava, Zielezny, Savron, & Grandi, 1995; Gould, Otto, & Pollack, 1995; Mavissakalian & Perel, 1992; van Balkom, de Beurs, Keole, Lange, & van Dyck, 1997).

From a theoretical perspective, cognitive-behaviour therapists argue that spouses can make a significant contribution to treatment, by ceasing to inadvertently reinforce agoraphobia through excessive care-taking and actively reinforcing the development of anxiety management skills and the completion of exposure-based homework assignments (Oatley & Hodgson, 1984). This is the rationale for spouse-assisted therapy.

A variety of systemic formulations have inspired marital therapy approaches to the treatment of PDA (Chambless & Goldstein, 1981; Fry, 1962; Hafner, 1977a; Haley, 1963; Minuchin & Fishman, 1981; Skynner, 1976). From these disparate sources, an integrative systemic hypothesis may be derived. In PDA a circular homeostatic pattern develops in which the
dependent role of the person with PDA is complemented by their partner's care-taking role. These complementary roles entail benefits for both partners. The apparently healthy partner is permitted to avoid addressing anxiety provoking personal issues such as low self-esteem or fear of psychological and sexual intimacy. The person with PDA is protected from having to face the challenges of individuation. These difficulties with self-esteem, intimacy, and individuation are rooted in unresolved developmental difficulties in partners' families of origin. These complementary developmental difficulties may have initially been a significant factor in attracting members of the couple to each other. This systemic formulation provides a rationale for marital therapy in which partners develop alternatives to their complementary care-giving and agoraphobic roles and address unresolved issues such as low self-esteem, fear of intimacy, and individuation. This systemic formulation also entails the view that the apparently healthy partner may show deterioration in functioning if their agoraphobic partner receives effective individual therapy. This in turn may lead the apparently healthy partner to undermine their agoraphobic partner's recovery. This aspect of the systemic formulation of PDA provides a further rationale for including both members of the couple in marital therapy for the effective and lasting treatment of PDA.

**Conclusions of previous reviews**

From previous narrative reviews and meta-analyses of the literature on couples-based approaches to PDA a number of tentative conclusions may be drawn (Carter, Turovsky, & Barlow, 1994; Daiuto, Baucom, Epstein, & Dutton, 1998; Dewey & Hunsley, 1990; Emmelkamp & Gerlsma, 1994; Kleiner & Marshall, 1985; Vandereycken, 1983). First, PDA is sometimes, associated with marital problems. Second, both individually-oriented and couples-based treatments for PDA can be effective for a significant proportion of cases. All effective treatment programmes involve exposure to anxiety provoking situations that typically trigger panic attacks and remaining in such situations until the anxiety subsides. Third, people with PDA who have good marital relationships show a better response to treatment. Fourth, involving partners of people with PDA in therapy may be appropriate in some cases, particularly those in which there are marital difficulties. Fifth, individual treatment involving exposure does not have a negative impact on the adjustment of non-agoraphobic partners or the quality of the marital relationship, as suggested by marital and family systems theory. The aim of the present review was to attempt to refine these tentative conclusions, by systematically evaluating (1) descriptive studies of PDA and marital problems; (2) evaluation studies of couple-based treatment programmes for PDA; (3) studies
that evaluated the effect of couples' relationship quality on response to psychological treatment; and (4) evaluation studies of the effects of psychological treatment on relationship quality.

METHOD
A series of computer-based literature searches of the PsychInfo database were conducted. A variety of terms were used to define PDA including anxiety, fears, phobias, panic attacks, panic disorder, and agoraphobia. To identify studies of marital problems and PDA, these terms were combined with terms such as marriage, relationship and interpersonal. To identify studies that evaluated the efficacy of couple-based treatment programmes for PDA, terms that defined PDA (as listed above) were combined with terms that defined interventions such as treatment, therapy, marriage, couple, relationship, marital therapy, couple therapy, family therapy, spouse-assisted therapy, spouse-assisted exposure, behaviour therapy, cognitive behaviour therapy, exposure and response prevention. This search strategy was also used to find studies that evaluated the effect of couples’ relationship quality on response to psychological treatment and evaluation studies of the effects psychological treatment on relationship quality. The searches, which were confined to English language journals and some book chapters, covered the period 1950 to 2001. A manual search through the bibliographies of major recent review papers on PDA and marital adjustment and psychological interventions for PDA was also conducted. Descriptive studies that included at least 4 cases were selected for review. Both controlled and uncontrolled treatment outcome studies were selected for review provided they included reliable and valid pre- and post-treatment assessment instruments. Single-case designs and studies reported in dissertations or convention papers were not included in the review.

RESULTS
Twenty-four studies that investigated the relationship between marital problems and PDA were identified and the features and findings of these are presented in Table 2. Twelve studies that evaluated the efficacy of couples-oriented interventions for PDA were identified and the features and findings of these are presented in Tables 3, 4, and 5. Seventeen studies that evaluated the impact of the couples’ relationship quality on response to treatment (both individually-based and couples-oriented) were identified and the features and findings from these studies are presented in Table 6. Thirteen studies that evaluated the impact of the treatment (both individually-based and couples-oriented) on the quality of the marital
relationship were identified and the features and findings from these studies are presented in Table 7.

**Couples’ relationship quality and PDA**

Of the twenty-four studies of marital problems and PDA summarised in Table 2, ten were retrospective reviews of case records and in 9 of these high rates of relationship problems in cases with PDA were found (Fry, 1962; Goldstein & Chambless, 1978; Goodstein & Swift, 1977; Holmes, 1982; Kleiner & Marshall, 1987; Quadrio, 1984; Roberts, 1964; Symonds, 1971; Webster, 1953). In both recording data in case files and coding these unstandardised data, clinicians’ and coders’ biases may have influenced the findings of these studies. Thus while these findings suggest that there is an association between relationship quality and PDA symptomatology, the reliability and validity of this conclusion is relatively weak.

Fourteen prospective studies on the quality of couples’ relationships and the severity of PDA symptomatology are reported in Table 2. In these studies, data were collected using standardised assessment procedures and in some instances these were normed on the general population. Findings from these prospective studies on the relationship between couples problems and PDA symptoms were more varied than those from the retrospective studies mentioned above.

In 6 of these studies, relationship quality and PDA symptomatology were negatively correlated, with relationship difficulties being more common in couples where there was more severe PDA symptomatology. Four of these were uncontrolled studies (Hand & Lamontagne, 1976; Hafner, 1983; Kleiner, Marshall, & Spevack, 1987; Torpy & Measey, 1974) and a control group was included in the design of two of these (Markowitz et al., 1989; McLeod, 1994). In the four uncontrolled studies, 40-66% of couples in which one partner had PDA reported significant relationship problems. In one of the controlled studies, compared with normal controls, couples in which one partner had PDA were 7 times more likely to say that they did not get along with their partner (Markowitz et al., 1989). In the other controlled study, asymptomatic husbands but not symptomatic wives reported greater marital adjustment problems than normal controls (McLeod, 1994).

In 7 of the prospective studies, no association was found between PDA symptomatology and relationship quality or spouse’s psychological adjustment (Arrindell & Emmelkamp, 1986a;
Buglass, Clarke, Henderson, Kreitman, & Presley, 1977; Emmelkamp et al., 1992; Fisher & Wilson, 1985; Friedman, 1990; Hafner, 1977a; Lange & van Dyck, 1992). All of these studies included either a control group or normed measures of relationship adjustment or partner’s psychological adjustment that permitted comparison with a normative sample. From a methodological perspective, these were particularly robust studies.

In both studies where couples in which one member had PDA were compared with couples in which one member had generalised anxiety disorder, those with PDA showed similar (Massion, Warshaw, & Keller, 1993) or better (Friedman, 1990) levels of marital adjustment.

**Conclusions.** From the foregoing it may be concluded that PDA is sometimes, but not always, associated with couple relationship problems. The rate of relationship problems is not always higher in couples where one person has PDA than in healthy couples and is probably no higher than in couples with other types of psychological problems such as generalised anxiety disorder. In couples where one member has PDA, it is unclear whether marital problems predispose people to developing PDA or arise as a result of the condition and then contribute to the maintenance of the PDA. However, it may be that couple relationship difficulties are both predisposing and maintaining factors for PDA.

**Couples-based PDA treatment outcome studies**

The 12 PDA treatment outcome studies of couples-based interventions summarised in Tables 3, 4, and 5 were published between 1977 and 1993.

**General characteristics of couples-based PDA treatment outcome studies**

From Table 3 it may be seen that of the 291 participants in these studies, approximately 95% were women. About 61% were married and the remainder were married, planning marriage, or cohabiting and/or involved in a stable relationship for longer than 6 months. Participants’ ages ranged from 18- to 64-years, with the mean age of participants ranging from 32- to 44-years across studies. Referrals included routine referrals to a hospital clinic, those from self-help organisations and community agencies, and referrals received via advertisements. The duration of agoraphobic symptoms ranged from 6 months to 25 years and the mean duration of agoraphobic symptoms ranged from greater than 1-year to 18-years across studies. Two of these studies evaluated the efficacy of marital therapy (Chemen & Friedman, 1993; Cobb, McDonald, Marks, & Stern, 1980) and 10 evaluated the effects of partner-assisted exposure.
Drop-out rates from the 12 studies ranged from 3% to 25%.

**Conclusion.** Overall these 12 studies focused on evaluating the effects of marital therapy and partner-assisted exposure for a large group of women with relatively debilitating levels of PDA in stable long-term relationships. The results of these studies may probably be generalised to this population with a fair degree of confidence.

**Methodological features of couples-based PDA treatment outcome studies**

From Table 4 it may be seen that the 12 studies varied in methodological rigour. Eight studies included comparison groups and 4 were single group outcome studies. In 7 of the 8 comparative group studies, cases were randomly assigned to groups. None of the studies included a no-treatment control group, so it was not possible to calculate meaningful effect-sizes for this group of studies. In 11 of the 12 studies diagnostically homogeneous groups were used and in all 12 studies participants were evaluated before and after treatment with reliable and valid assessment instruments. Assessments based on self-report data were conducted in 12 studies. Partner self-report assessments were used in 8 studies, researcher ratings were made in 8 studies, and therapist evaluations were made in 2 studies. PDA symptomatology was assessed in all studies and the quality of the couple’s relationship was assessed in 10 studies. The clinical significance of change was evaluated in only 3 studies. In 8 studies treatment was conducted by experienced therapists rather than graduate students in training and in 7 studies treatment was manualised. Therapist supervision was provided in only 2 studies. Medication was controlled for in only 2 studies. In 6 (or 50%) of the studies, participants were on medication, either antidepressants or anxiolytics, during the psychological treatment programmes. In the remaining 4 studies, there is no indication that medication was controlled for. Follow-up data were collected in 9 studies and from Table 5 it may be seen that follow-up periods ranged from 3 months to two years.

**Conclusion.** Using the checklist for methodological robustness in Table 4, scores of studies ranged from 6 to 14 out of 16, indicating that this was a fairly robust group of treatment
outcome studies, so a fair degree of confidence may be placed in the reliability and validity of the results of these studies.

**Key findings from couples-based PDA treatment outcome studies**

From Table 5 it may be seen that the number of participants per treatment condition ranged from 4 to 30. The duration of treatment ranged from 5 to 35 hours over periods from a month to a year.

In the first of two studies of marital therapy in Table 5, Chemen and Friedman (1993) found that behavioural marital therapy led to significant improvements in relationship quality and PDA symptomatology for couples from discordant marriages, but had little impact on couples without significant relationship difficulties. Behavioural marital therapy in this study focused on coaching couples in communication, problem-solving, and behavioural exchange skills (Jacobson & Margolin, 1979). In the second marital therapy study in Table 5, Cobb et al. (1980) evaluated the efficacy of a systems approach to marital therapy where the focus was on helping couples understand how their patterns of interaction and belief systems maintained PDA symptomatology and how alternatives to these interaction patterns and beliefs might be developed. This form of marital therapy was particularly effective in enhancing the quality of couples' relationships but had little impact on PDA symptomatology. In contrast, cases in the comparison group who participated in partner-assisted exposure therapy showed significant symptomatic improvement post-treatment and at follow-up.

In the 6 studies that evaluated partner-assisted exposure therapy, this treatment programme was found to be effective. Using Mathews et al.'s (1977) data, it can be concluded that this treatment yielded a percentage improvement rate of 58% if an item ranked 8 or above (out of 15 on this fear hierarchy) is taken to indicate clinically significant improvement. In two studies partner-assisted exposure therapy and individual exposure therapy were compared and in both studies, these two treatments were found to be equally effective (Cobb et al., 1984; Emmelkamp et al., 1992). In the single study where partner-assisted exposure therapy and female friend-assisted exposure therapy were compared, these two treatments were found to be equally effective (Oatley & Hodgson, 1987). In the single study where partner-assisted exposure therapy and partner-assisted problem-solving therapy were compared, partner-assisted exposure therapy was found to be more effective (Jannoun et al., 1980).
Cognitive therapy combined with partner-assisted exposure appears to have produced gains in all 6 of Barlow et al.'s (1981) couples and resulted in 54% or participants being rated as treatment responders based on a composite criterion in Craske et al. (1989). In two other studies group-based partner-assisted exposure therapy combined with cognitive therapy was found to be more effective in alleviating PDA symptoms than group-based individual exposure therapy combined with cognitive therapy (Barlow et al., 1984; Himadi et al., 1986; Cerny et al., 1987). In the Barlow et al. (1984) study, as many as 86% of the participants were rated as treatment responders to the partner-assisted exposure/cognitive therapy combination, whilst this figure was 82% at 24-month follow-up in the original Himadi et al. (1986) sample.

Arnow et al. (1985) found that group-based individual exposure therapy followed by partner-assisted exposure therapy combined with couples-based communication training was more effective than group-based individual exposure therapy followed by partner-assisted exposure therapy combined with couples-based relaxation training in alleviating PDA symptoms. These gains were maintained at 8-month follow-up. From Table 5 it may be seen that in five of the 11 studies that included partner-assisted exposure as a treatment component, a group therapy format was used. The size of these groups ranged from 3 to 9 individuals. Although data is limited, it appears that both couples-based and group-couples-based treatment formats for partner-assisted exposure therapy were comparable in their treatment effects.

**Conclusions.** In couples in which one partner has PDA, marital therapy is effective in improving the quality of marital relationships and in ameliorating PDA symptoms in distressed couples. Partner-assisted exposure therapy, whether conducted with couples on their own or in groups, leads to symptomatic improvement for 23% to 45% of cases. It is as effective as individual exposure therapy and female friend-assisted exposure therapy and is more effective than partner-assisted problem-solving therapy and marital therapy. Combining it with cognitive therapy that addresses problematic belief systems underlying avoidant behaviour may enhance the efficacy of partner-assisted exposure therapy. When group-based individual and partner-assisted exposure therapy are combined with cognitive therapy, the latter is more effective than the former. Combining it with couples-based communication training but not couples-based relaxation training may enhance the efficacy
of a combined programme involving group-based individual and partner-assisted exposure therapy.

**The effect of relationship quality on the psychological treatment of PDA**

From Table 6 it may be seen that in 6 of 17 studies the quality of couples' relationship at the outset of therapy was associated with symptomatic improvement after treatment or during the follow-up periods of up to 5 years (Bland & Hallam, 1981; Hafner, 1976; Hudson, 1974; Mathews et al., 1977; Milton & Hafner, 1979; Monteiro, Marks, & Ramm, 1985; Lelliott, Marks, Monteiro, Tsakiris, & Noshirvani, 1987). In five of these studies, individual treatments such as individual exposure therapy were evaluated and in only one study, was a couples-based intervention evaluated. This was Mathews et al.'s (1977) study of partner-assisted exposure.

In the remaining 11 studies, no association was found between the initial quality of couples' relationships and their immediate response to treatment or the severity of PDA symptoms during the follow-up periods of up to 16 months (Arrindell, Emmelkamp, & Sanderman, 1986b; Barlow et al., 1981; Chambless & Gracely, 1988a; Chambless & Gracely, 1988b; Cobb et al., 1984; Craske et al., 1989; Emmelkamp, 1980; Emmelkamp et al., 1992; Himadi et al., 1986; Peter & Hand, 1983; Thomas, Jones, Sinnott, & Fordham, 1983). In 8 of these studies individually-based treatment conditions such as individual exposure therapy were evaluated and in 5 studies couples-based treatment conditions such as partner-assisted exposure were evaluated. While some studies included a placebo versus medication feature in their designs, it appears that only 2 studies involving individual exposure (Arrindell et al., 1986b; Emmelkamp, 1980) and only 1 partner-assisted exposure therapy study (Cerney et al., 1987; Himadi et al., 1986) controlled for medication.

**Conclusion.** In some instances the initial quality of couples' relationship at the outset of individually- or couples-based treatment programmes for PDA affects their response to treatment, with better relationship quality being associated with a better response to treatment.

**The effect of psychological treatment of PDA on relationship quality**

From Table 7 it may be seen that in 6 of 13 studies, psychological treatment of PDA had a positive effect on the quality of couples' relationships (Bland & Hallam, 1981; Cobb et al.,

In these 13 studies, whether treatment was couples-based or individually-based had no deleterious effect on the quality of couples’ relationships. From Table 7 it may be seen that in 3 of 7 (43%) studies where treatment had a positive effect on relationship quality, couples-based treatment conditions such as partner-assisted exposure or marital therapy were evaluated. Only 2 (or 33%) of the remaining 6 studies found no treatment effect or only a partial effect on relationship quality involving partner-assisted exposure. This figure could be even smaller considering that 1 of these 2 studies (e.g., Barlow et al., 1981) had a cell size of only 6 and hence its findings may not be generalisable.

**Conclusion.** Couples-based treatment programmes such as partner-assisted exposure or marital therapy tend to have a more positive effect on the quality of couples relationships than individually-based treatment conditions such as individual exposure therapy

**DISCUSSION**

From this review the following conclusions may be drawn. First, PDA is sometimes, but not always, associated with couple relationship problems. In couples where one member has PDA, it is unclear whether couple relationship difficulties are predisposing or maintaining factors for PDA or both. Second, in some instances the initial quality of couples’ relationship affects their response to couples-based or individual treatment, with non-distressed couples deriving greater benefits from treatment. Third, partner-assisted exposure therapy, whether conducted with couples on their own or in groups, leads to symptomatic improvement for 23% to 45% of cases. It is as effective as individual exposure therapy and female friend-assisted exposure therapy and is more effective than partner-assisted problem-solving therapy and marital therapy. Fourth, combining it with cognitive therapy, which addresses problematic belief systems underlying avoidant behaviour, and with couples-based
communication training, which empowers couples to address relationship issues, may 
enhance the efficacy of partner-assisted exposure therapy. A treatment combination of 
group-based partner-assisted therapy and cognitive therapy can result in as many as 84% of 
participants being rated as treatment responders.

Fifth, couples-based treatment programmes such as partner-assisted exposure or marital 
therapy tend to have a more positive effect on the quality of couples relationships than 
individually-based treatment conditions such as individual exposure therapy. It may be that 
while exposure is a critical aspect of all effective therapeutic approaches to PDA, couple-
focused interventions may enhance maintenance of treatment gains by facilitating 
interactions that positively reinforce and perpetuate exposure attempts. These conclusions 
are consistent with those from previous narrative reviews and meta-analyses of the literature 
on the quality couples and PDA (Carter et al., 1994; Daiuto et al., 1998; Dewey & Hunsley, 

The most important implication of these conclusions for practice is that the quality of 
couples’ relationships should be routinely assessed as part of a preliminary evaluation of 
people with PDA in stable long-term relationships and couples-oriented treatment 
programmes should be routinely used particularly in the case of distressed couples. From 
this review it may be concluded that partner-assisted exposure combined with cognitive 
therapy and couples communication training or marital therapy is the treatment package of 
choice for distressed couples.

With respect to future research, there are a number of areas that deserve urgent attention. 
Considering that men’s roles traditionally require greater independence, it seems reasonable 
to hypothesise that husband’s phobias would influence marital quality at least as strongly as 
wives’ phobias (McLeod, 1994, p. 767). Hence, there is a need to evaluate couples-based 
treatment programmes for men with PDA. Other special populations that need to be 
considered include gay couples or those who are poor treatment responders such as people 
who meet the diagnostic criteria for personality disorders as well as PDA. There is also a 
need to evaluate programmes designed for members of different ethnic groups that entail 
sensitivity to cultural and personal characteristics of participants. Studies that examine the 
impact of design features that may make programmes more effective are also required. For
example, there is a need for studies that compare the impact of programmes in which partner-assisted exposure is combined with a variety of other relationship-oriented interventions such as systemic marital therapy or behavioural marital therapy. Studies that evaluate the impact of treatment duration, location, and therapist training also require evaluation.

Future treatment outcome studies should meet the methodological criteria listed in Table 4. In addition, future evaluation studies should routinely include assessments of programme integrity into the research design. In such studies, treatment sessions are recorded and blind raters use programme integrity checklists to evaluate the degree to which sessions approximate manualised training curricula. Such integrity checks allow researchers to state with confidence the degree to which a pure and potent version of their programme has been evaluated.

Studies are also required that investigate the mechanisms and processes that underpin treatment efficacy. It is clear that there is wide variability in couples’ responses to treatment. The determinants of these different outcomes require careful investigation.
References


Table 1 DSM-IV and ICD-10 diagnostic criteria for panic disorder with agoraphobia (PDA).

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<th>DSM-IV</th>
<th>ICD-10</th>
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<td><strong>Criteria for Panic Disorder with Agoraphobia</strong></td>
<td><strong>Criteria for Panic Disorder</strong></td>
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<td>A. Both: (1) recurrent unexpected panic attacks; and (2) at least one of the attacks has been followed by 1 month (or more) of one (or more) of the following: a) persistent concern about having additional attacks; b) worry about the implications of the attack or it's implications (e.g., losing control, having a heart attack, “going crazy”); c) a significant change in behaviour related to the attacks.</td>
<td>The essential features are recurrent attacks of severe anxiety (panic) that are not restricted to any situation or set of circumstances, and that are therefore unpredictable. As in other anxiety disorders, the dominant symptoms vary from person to person, but sudden onset of palpitations, chest pain, choking sensations, dizziness, and feelings of unreality (depersonalisation or derealisation) are common. There is also, almost invariably, a secondary fear of dying, losing control, or going mad. Individual attacks usually last for minutes only, though sometimes longer; their frequency and the course of the disorder are both rather variable. An individual in a panic attack often experiences a crescendo of fear and autonomic symptoms that result in an exit, usually hurried, from wherever he or she may be. If this occurs in a specific situation, such as a bus or in a crowd, the patient may subsequently avoid that situation. Similarly, frequent and unpredictable panic attacks produce fear of being alone or going into public places. A panic attack is often followed by a persistent fear of having another attack. For a definite diagnosis, several severe attacks of autonomic anxiety should have occurred within a period of about one month; a) In circumstances where there is no objective danger; b) Without being confined to known or predictable situations; and c) With comparative freedom from anxiety symptoms between attacks (although anticipatory anxiety is common).</td>
</tr>
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<td>B. The presence of agoraphobia.</td>
<td><strong>Criteria for Agoraphobia</strong></td>
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<td>C. The panic attacks are not due to the direct physiological effects of a substance or a general medical condition.</td>
<td>The term “agoraphobia” refers to an interrelated and often overlapping cluster of phobias embracing fears of leaving home: fear of entering shops, crowds, and public places, and public places, or of travelling alone in trains, buses, or planes. Whilst the severity of the anxiety and the extent of avoidance behaviour are variable, some sufferers become completely housebound; they are terrified by the thought of collapsing and being left helpless in public. The lack of an immediately available exit is one of the key features of many of these agoraphobic situations. All of the following criteria should be fulfilled for a definite diagnosis: a) The psychological or autonomic symptoms must be primarily manifestations of anxiety and not secondary to other symptoms, such as delusions or obsessional thoughts; b) The anxiety must be restricted to (or occur mainly in) at least two of the following situations: crowds, public places, travelling away from home, and travelling alone; c) Avoidance of the phobic situation must be, or have been, a prominent feature.</td>
</tr>
<tr>
<td>D. The panic attacks are not better accounted for by another mental disorder.</td>
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**Criteria for Panic Attack**

A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:

a) palpitations, pounding heart, or accelerated heart rate
b) sweating
c) trembling or shaking
d) sensations of shortness of breath or smothering
e) feeling of choking
f) chest pain and discomfort
g) nausea or abdominal distress
h) feeling dizzy, unsteady, light-hearted, or faint
i) derealisation (feelings of unreality) or depersonalisation (being detached from oneself)
j) fear of losing control or going crazy
k) fear of dying
l) paresthesias (numbness or tingling sensations)
m) chills or hot flushes

**Criteria for Agoraphobia**

All of the following criteria should be fulfilled for a definite diagnosis:

a) Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having an unexpected or situationally predisposed panic attack or panic-like symptoms. Agoraphobic fears typically involve characteristic clusters of situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and travelling in a bus, train, or automobile.
b) The situations are avoided (e.g., travel is restricted) or else are endured with marked distress or anxiety about having a panic attack or panic-like symptoms, or require the presence of a companion.
c) The anxiety or phobic avoidance is not better accounted for by another mental disorder.
<table>
<thead>
<tr>
<th>Study No.</th>
<th>Authors</th>
<th>Year</th>
<th>N per group</th>
<th>Study Type</th>
<th>PDA linked to relationship satisfaction</th>
<th>Key findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Webster</td>
<td>1953</td>
<td>PDA=25</td>
<td>Retrospective</td>
<td>Yes</td>
<td>• Husbands of partners with PDA had psychological problems including inadequacy, emotional withdrawal and psychopathy.</td>
</tr>
<tr>
<td>2</td>
<td>Fry</td>
<td>1962</td>
<td>PDA=7</td>
<td>Retrospective</td>
<td>Yes</td>
<td>• Both members of couples in which one partner had PDA feared psychological autonomy.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Husbands of partners with PDA were emotionally distant, over-compliant with wives’ demands and covertly encouraged dependency.</td>
</tr>
<tr>
<td>3</td>
<td>Roberts</td>
<td>1964</td>
<td>PDA=41</td>
<td>Retrospective</td>
<td>Yes</td>
<td>• 53% of women with PDA reported difficulties in their sexual relationships.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• 22% of women with PDA reported marital difficulties.</td>
</tr>
<tr>
<td>4</td>
<td>Symonds</td>
<td>1971</td>
<td>PDA=12</td>
<td>Retrospective</td>
<td>Yes</td>
<td>• The development of PDA arose from women’s declaration of dependence on their marital partners and frustration of unmet needs for psychological intimacy and independence within the marriage.</td>
</tr>
<tr>
<td>5</td>
<td>Goodstein &amp; Swift</td>
<td>1977</td>
<td>PDA=3</td>
<td>Retrospective</td>
<td>Yes</td>
<td>• Women who had expectations that their spouses would compensate for their lack of parental nurturance in childhood were vulnerable to developing PDA.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• PDA arose from the conflict between these women’s wishes to assert their autonomy and challenge their partners’ authoritarianism on the one hand and their dependency needs and abandonment fears on the other.</td>
</tr>
<tr>
<td>6</td>
<td>Goldstein &amp; Chambless</td>
<td>1978</td>
<td>PDA=32</td>
<td>Retrospective</td>
<td>Yes</td>
<td>• The increased dependency associated with PDA caused marital adjustment problems.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• PDA symptoms were maintained by partners’ social reinforcement of dependency and ‘sick role’ behaviour.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Improvement in PDA symptoms was not reinforced creating pressure for partners with PDA to return to dependent behaviour.</td>
</tr>
<tr>
<td>7</td>
<td>Holmes</td>
<td>1982</td>
<td>PDA=12</td>
<td>Retrospective</td>
<td>Yes</td>
<td>• Couples in which one partner had PDA used the constraints that PDA placed on their relationship as a compromise by which to control their fears and inadequacies.</td>
</tr>
<tr>
<td>8</td>
<td>Quadrio</td>
<td>1984</td>
<td>PDA=4</td>
<td>Retrospective</td>
<td>Yes</td>
<td>• Couples in which one partner had PDA used the constraints that PDA placed on their relationship to manage conflicts about needs for dependency and needs for autonomy.</td>
</tr>
<tr>
<td>9</td>
<td>Kleiner &amp; Marshall</td>
<td>1987</td>
<td>PDA=50</td>
<td>Retrospective</td>
<td>Yes</td>
<td>• In 84% of cases, PDA was preceded by severe and prolonged marital or relationship conflicts.</td>
</tr>
<tr>
<td>10</td>
<td>Agulnik</td>
<td>1970</td>
<td>PDA=48 NC=27</td>
<td>Retrospective</td>
<td>No</td>
<td>• Compared with normal controls, spouses of partners with PDA had no major psychological problems.</td>
</tr>
<tr>
<td>11</td>
<td>Torpy &amp; Measey</td>
<td>1974</td>
<td>PDA=28</td>
<td>Prospective</td>
<td>Yes</td>
<td>• 43% of couples in which one partner had PDA had significant marital problems (based upon a median split) and these partners tended to misperceive each other.</td>
</tr>
<tr>
<td>12</td>
<td>Hand &amp; Lamontagne</td>
<td>1976</td>
<td>PDA=25</td>
<td>Prospective</td>
<td>Yes</td>
<td>• Two thirds of couples in which one partner had PDA had marital problems.</td>
</tr>
<tr>
<td>13</td>
<td>Hafner</td>
<td>1983</td>
<td>PDA=33</td>
<td>Prospective</td>
<td>Yes</td>
<td>• In 50% of cases PDA symptoms were maintained by partners’ habitual denial of affect and of personal problems.</td>
</tr>
</tbody>
</table>
Table 2: Key findings from studies of the correlation between PDA and relationship adjustment (continued).

<table>
<thead>
<tr>
<th>Study No.</th>
<th>Authors</th>
<th>Year</th>
<th>N per group</th>
<th>Study Type</th>
<th>PDA linked to relationship satisfaction</th>
<th>Key findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Kleiner, Marshall et al.</td>
<td>1987</td>
<td>PDA=26</td>
<td>Prospective</td>
<td>Yes</td>
<td>Compared with normal controls, couples in which one partner had PDA reported poorer marital adjustment on the Marital Adjustment Test (Locke &amp; Wallace, 1959).</td>
</tr>
<tr>
<td>15</td>
<td>Markowitz et al.</td>
<td>1989</td>
<td>PDA=254 NC=17113</td>
<td>Prospective</td>
<td>Yes</td>
<td>Compared with normal controls, couples in which one partner had PDA reported poorer marital adjustment and were 7 times more likely to say that they did not to get along with their partner.</td>
</tr>
<tr>
<td>16</td>
<td>McLeod</td>
<td>1994</td>
<td>PD=39 P=66 NC=339</td>
<td>Prospective</td>
<td>Yes</td>
<td>Compared with normal controls, husbands of partners with PD reported poorer marital adjustment. Compared with normal controls, women of partners with P reported slightly better marital adjustment.</td>
</tr>
<tr>
<td>17</td>
<td>Buglass et al.</td>
<td>1977</td>
<td>PDA=30 NC=30</td>
<td>Prospective</td>
<td>No</td>
<td>The husbands of partners with PDA did not differ from normal controls and the partner's premorbid sexual adjustment did not differ from normal controls. Both groups were similar in terms of decision making, assertion-compliance, and affection-dislike.</td>
</tr>
<tr>
<td>18</td>
<td>Hafner</td>
<td>1977a</td>
<td>PDA=33</td>
<td>Prospective</td>
<td>No</td>
<td>Husbands of partners with PDA had no major psychological problems on the Middlesex Hospital Questionnaire (Crown &amp; Crisp, 1966). There were two types of couples in which one partner had PDA. In one type the woman with PDA symptoms had personality abnormality with some complementarity in husbands, whilst in other couples there was less comorbidity.</td>
</tr>
<tr>
<td>19</td>
<td>Fisher &amp; Wilson</td>
<td>1985</td>
<td>PDA=17 NC=11</td>
<td>Prospective</td>
<td>No</td>
<td>Couples in which one partner had PDA did not differ from normal controls in their marital adjustment on the Marital Adjustment Test (Locke &amp; Wallace, 1959).</td>
</tr>
<tr>
<td>20</td>
<td>Arrindell &amp; Emmelkamp</td>
<td>1986a</td>
<td>PDA=30 NC=38 DC=14 NP=11</td>
<td>Prospective</td>
<td>No</td>
<td>Couples in which the woman had PDA were more like normal controls than maritally-distressed controls on the Maudsley Marital Questionnaire (Crowe, 1978; Cobb et al., 1980) and on measures of the quality of marital communication.</td>
</tr>
<tr>
<td>21</td>
<td>Friedman</td>
<td>1990</td>
<td>PDA=19 GAD=10</td>
<td>Prospective</td>
<td>No</td>
<td>Compared with questionnaire norms and scores of couples in which one partner has GAD, couples in which one partner had PDA reported less family conflict on the Family Environment Scale (Moos &amp; Moos, 1981).</td>
</tr>
<tr>
<td>22</td>
<td>Emmelkamp et al.</td>
<td>1992</td>
<td>PDA=60</td>
<td>Prospective</td>
<td>No</td>
<td>Scores for couples in which one partner had PDA on the Maudsley Marital Questionnaire (Crowe, 1978; Cobb et al., 1980) fell within the norms of maritally non-distressed couples. Husbands of partners with PDA had no major psychological problems.</td>
</tr>
<tr>
<td>23</td>
<td>Lange &amp; van Dyck</td>
<td>1992</td>
<td>PDA=25</td>
<td>Prospective</td>
<td>No</td>
<td>The scores of couples in which one partner had PDA fell within the normal range on the Interpersonal Problem Solving Inventory (Lange, 1983).</td>
</tr>
<tr>
<td>24</td>
<td>Massion et al.</td>
<td>1993</td>
<td>PDA=186 PD=48 GAD=63</td>
<td>Prospective</td>
<td>No</td>
<td>Couples in which one partner had PDA did not differ from couples in which one partner had PD or GAD.</td>
</tr>
</tbody>
</table>

Note: DC = distressed couples control group. GAD = Generalised Anxiety Disorder. NC = normal control group. NP = non-phobic psychiatric control group. P = phobic control group (including agoraphobia, social and simple phobia). PD = Panic Disorder. PDA = Panic Disorder with Agoraphobia.
<table>
<thead>
<tr>
<th>Study No.</th>
<th>Authors</th>
<th>Year</th>
<th>Age Mean &amp; Range</th>
<th>Gender</th>
<th>Duration of PDA Mean &amp; Range</th>
<th>Main Treatment Evaluated</th>
<th>Dropouts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Chernen &amp; Friedman</td>
<td>1993</td>
<td>38 y 29-45 y</td>
<td>f 4</td>
<td>10 y 2-18 y</td>
<td>MT</td>
<td>25%</td>
</tr>
<tr>
<td>2</td>
<td>Cobb et al.</td>
<td>1980</td>
<td>32 y m 4</td>
<td>f 7</td>
<td>8 y</td>
<td>MT</td>
<td>8%</td>
</tr>
<tr>
<td>3</td>
<td>Mathews et al.</td>
<td>1977</td>
<td>36 y 20-49 y</td>
<td>f 12</td>
<td>9.3 y 1.5-20 y</td>
<td>PAE</td>
<td>8%</td>
</tr>
<tr>
<td>4</td>
<td>Barlow et al.</td>
<td>1981</td>
<td>41 y 30-62 y</td>
<td>f 6</td>
<td>12 y 4-20 y</td>
<td>PAE</td>
<td>25%</td>
</tr>
<tr>
<td>5</td>
<td>Craske et al.</td>
<td>1989</td>
<td>-</td>
<td>f 22</td>
<td>-</td>
<td>PAE</td>
<td>15%</td>
</tr>
<tr>
<td>6</td>
<td>Cobb et al.</td>
<td>1984</td>
<td>36 y m 4</td>
<td>f 15</td>
<td>-</td>
<td>PAE</td>
<td>21%</td>
</tr>
<tr>
<td>7</td>
<td>Emmelkamp et al.</td>
<td>1992</td>
<td>35.5 y 21-64 y</td>
<td>f 53</td>
<td>6.5 y 1-25 y</td>
<td>PAE</td>
<td>17%</td>
</tr>
<tr>
<td>8</td>
<td>Oatley &amp; Hodgson</td>
<td>1987</td>
<td>43.5 y m 7</td>
<td>f 30</td>
<td>16 y</td>
<td>PAE</td>
<td>10%</td>
</tr>
<tr>
<td>9</td>
<td>Jannoun et al.</td>
<td>1980</td>
<td>32 y 18-53 y</td>
<td>f 28</td>
<td>6 y 6 m-20 y</td>
<td>PAE</td>
<td>4%</td>
</tr>
<tr>
<td>10</td>
<td>Barlow et al.</td>
<td>1984</td>
<td>40 y 23-63 y</td>
<td>f 29</td>
<td>-</td>
<td>PAE</td>
<td>3%</td>
</tr>
<tr>
<td>11</td>
<td>Himadi et al.</td>
<td>1986</td>
<td>-</td>
<td>f 45</td>
<td>-</td>
<td>PAE</td>
<td>12%</td>
</tr>
<tr>
<td>12</td>
<td>Arnow et al.</td>
<td>1985</td>
<td>39 y 22-63 y</td>
<td>f 25</td>
<td>-</td>
<td>PAE</td>
<td>4%</td>
</tr>
</tbody>
</table>

Notes: f = female. m = male. MT = Marital Therapy. no. = number. PAE = Partner assisted exposure. PDA = Panic Disorder with Agoraphobia. y = year.
<table>
<thead>
<tr>
<th>Design Feature</th>
<th>Study Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>S1</td>
</tr>
<tr>
<td>1 Comparison group</td>
<td>0</td>
</tr>
<tr>
<td>2 Random assignment</td>
<td>0</td>
</tr>
<tr>
<td>3 Diagnostic homogeneity</td>
<td>1</td>
</tr>
<tr>
<td>4 Not on medication</td>
<td>0</td>
</tr>
<tr>
<td>5 Pre-treatment assessment</td>
<td>1</td>
</tr>
<tr>
<td>6 Post-treatment assessment</td>
<td>1</td>
</tr>
<tr>
<td>7 Follow-up assessment at 3 months or later</td>
<td>1</td>
</tr>
<tr>
<td>8 Client self-report</td>
<td>1</td>
</tr>
<tr>
<td>9 Partner self-report</td>
<td>0</td>
</tr>
<tr>
<td>10 Therapist ratings</td>
<td>0</td>
</tr>
<tr>
<td>11 Researcher ratings</td>
<td>0</td>
</tr>
<tr>
<td>12 Quality of the couples relationship assessed</td>
<td>0</td>
</tr>
<tr>
<td>13 Clinical significance of change assessed</td>
<td>0</td>
</tr>
<tr>
<td>14 Experienced therapists used</td>
<td>1</td>
</tr>
<tr>
<td>15 Treatments were manualised</td>
<td>0</td>
</tr>
<tr>
<td>16 Therapy supervision was provided</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6</td>
</tr>
</tbody>
</table>

**Note:** 0 = design feature was absent. 1 = design feature was present. S = study.
Table 5 Key findings from outcome studies of couple treatment for PDA.

<table>
<thead>
<tr>
<th>Study no.</th>
<th>Authors</th>
<th>Year</th>
<th>N per group</th>
<th>Group format (no. per group)</th>
<th>No. of sessions or hours of contact</th>
<th>Group differences</th>
<th>Follow-up period</th>
<th>Percentage of cases improved post-treatment</th>
<th>Percentage of cases improved at longest follow-up</th>
<th>Key findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Chernen &amp; Friedman</td>
<td>1993</td>
<td>1. BMT + IE = 4</td>
<td>No</td>
<td>23 X 1.5h over 23w</td>
<td>-</td>
<td>3m</td>
<td>66%</td>
<td>-</td>
<td>Participants from discordant marriages showed improvement in marital adjustment and a decrease in PDA symptoms after behavioural marital therapy.</td>
</tr>
<tr>
<td>2</td>
<td>Cobb et al.</td>
<td>1980</td>
<td>1. MT = 5 2. PAE = 6</td>
<td>No</td>
<td>10 X .8 h over 10w</td>
<td>2 &gt; 1</td>
<td>20m</td>
<td>-</td>
<td>-</td>
<td>Marital therapy led to improvement in marital adjustment.</td>
</tr>
<tr>
<td>3</td>
<td>Mathews et al.</td>
<td>1977</td>
<td>1. PAE = 12</td>
<td>No</td>
<td>7h over 4 w</td>
<td>-</td>
<td>6m</td>
<td>-</td>
<td>67%</td>
<td>In comparison with results from previous clinic-based IE studies, a home-based partner-assisted exposure therapy programme produced at least equivalent change with a reduced expenditure of therapist time.</td>
</tr>
<tr>
<td>4</td>
<td>Barlow et al.</td>
<td>1981</td>
<td>1. PAE + CT = 6</td>
<td>Yes (3)</td>
<td>13 over 13w</td>
<td>-</td>
<td>16m</td>
<td>-</td>
<td>-</td>
<td>Most participants made further gains during a 6-month follow-up period.</td>
</tr>
<tr>
<td>5</td>
<td>Craske et al.</td>
<td>1989</td>
<td>1. PAE + CT = 22</td>
<td>Yes (3-6)</td>
<td>12 over 16w</td>
<td>-</td>
<td>-</td>
<td>54%</td>
<td>-</td>
<td>The PDA symptoms of all 6 couples improved after partner-assisted exposure therapy with cognitive therapy.</td>
</tr>
<tr>
<td>6</td>
<td>Cobb et al.</td>
<td>1984</td>
<td>1. PAE = 9 2. IE = 10</td>
<td>No</td>
<td>5h</td>
<td>1 = 2</td>
<td>6m</td>
<td>-</td>
<td>-</td>
<td>After partner assisted-exposure therapy with cognitive therapy, marital adjustment improved in 4 couples but deteriorated in 2 couples.</td>
</tr>
<tr>
<td>7</td>
<td>Emmelkamp et al.</td>
<td>1992</td>
<td>1. PAE = 30 2. IE = 30</td>
<td>No</td>
<td>6 over 4 w</td>
<td>1 = 2</td>
<td>8w</td>
<td>-</td>
<td>-</td>
<td>Treatment responders rated themselves &amp; their partners as more communicative regarding their fears (than treatment non-responders) and this was inversely related to anxiety in trigger situations.</td>
</tr>
<tr>
<td>8</td>
<td>Oakley &amp; Hodgson</td>
<td>1987</td>
<td>1. PAE = 15 2. FAE = 15</td>
<td>No</td>
<td>6 X 1h &amp; 26 phone calls over 52w</td>
<td>1 = 2</td>
<td>12m</td>
<td>-</td>
<td>-</td>
<td>Partner-assisted exposure therapy was as effective as individual exposure therapy in alleviating PDA symptoms.</td>
</tr>
</tbody>
</table>

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Table 5  Key findings from outcome studies of couple treatment for PDA (continued).

<table>
<thead>
<tr>
<th>Study no.</th>
<th>Authors</th>
<th>Year</th>
<th>N per group</th>
<th>Group format</th>
<th>No. of sessions or hours of contact</th>
<th>Group differences</th>
<th>Follow-up period</th>
<th>Percentage of cases improved post-treatment</th>
<th>Percentage of cases improved at longest follow-up</th>
<th>Key findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Jammoun et al.</td>
<td>1980</td>
<td>1. PAE = 14</td>
<td>No</td>
<td>1 X 1.5h &amp; 4 X .5h over 4 w</td>
<td>1 &gt; 2</td>
<td>6 m</td>
<td>-</td>
<td>-</td>
<td>• Home-based partner-assisted exposure therapy was superior to a partner-assisted problem-solving treatment condition in alleviating PDA symptoms.</td>
</tr>
<tr>
<td>10</td>
<td>Barlow et al.</td>
<td>1984</td>
<td>1. PAE + CT = 14</td>
<td>Yes (3-6)</td>
<td>12 X 1.5h over 12w</td>
<td>1 &gt; 2</td>
<td>-</td>
<td>1.86%</td>
<td>2.43%</td>
<td>• Group-based partner-assisted exposure therapy combined with cognitive therapy was more effective than individual exposure therapy combined with cognitive therapy in alleviating PDA symptoms.</td>
</tr>
<tr>
<td>11</td>
<td>Himadi et al.</td>
<td>1986</td>
<td>1. PAE + CT = 28</td>
<td>Yes (3-6)</td>
<td>12 over 12w</td>
<td>1 &gt; 2</td>
<td>24 m</td>
<td>64%</td>
<td>1.82%</td>
<td>• Group-based partner-assisted exposure therapy combined with cognitive therapy was more effective than individual exposure therapy combined with cognitive therapy in alleviating PDA symptoms.</td>
</tr>
<tr>
<td></td>
<td>Cerny et al.</td>
<td>1987</td>
<td>2. IE + CT = 14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Arnow et al.</td>
<td>1985</td>
<td>1. PAE + IE + CCST = 12</td>
<td>Yes (3-6)</td>
<td>IE: 3 X 4h over 3d PAE: 3 X 1.5h over 3w CCST &amp; CRT: 8 over 8w</td>
<td>1 &gt; 2</td>
<td>8 m</td>
<td>1.83%</td>
<td>2.67%</td>
<td>• Group-based individual exposure therapy followed by partner-assisted exposure therapy combined with couples-based communication training was more effective than group-based individual exposure therapy followed by partner-assisted exposure therapy combined with couples-based relaxation training in alleviating PDA symptoms.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. PAE + IE + CRT = 12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• These gains were maintained at 8-month follow-up.</td>
</tr>
</tbody>
</table>

Notes: BMT = Behavior Marital Therapy. CCST = Couples communication skills training. CRT = Couples relaxation training. CT = Cognitive Therapy. d = day. FAE = Female friend-assisted exposure. h = hour. IE = Individual exposure. m = month. MT = Marital Therapy. PAE = Partner-assisted exposure. PDA = Panic Disorder with Agoraphobia. w = week.
Table 6: Studies of the effect of relationship quality on the psychological treatment of PDA.

<table>
<thead>
<tr>
<th>Authors</th>
<th>Year</th>
<th>Study Design</th>
<th>Treatment Duration</th>
<th>Positive initial relationship improved treatment response</th>
<th>Key findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hudson</td>
<td>1974</td>
<td>IE + M = 18</td>
<td>5d</td>
<td>Yes</td>
<td>After individual exposure treatment with medication and a year later, people with PDA from well-adjusted families improved more than those from families with adjustment problems.</td>
</tr>
<tr>
<td>Hafner</td>
<td>1976</td>
<td>IE = 39</td>
<td>12h over 4d</td>
<td>Yes</td>
<td>Over a one-year follow-up period, people with PDA with good marital adjustment at the start of individual exposure treatment had fewer relapses compared with those with initial marital adjustment problems.</td>
</tr>
<tr>
<td>Mathews et al</td>
<td>1977</td>
<td>PAE = 12</td>
<td>8h over 4w</td>
<td>Yes</td>
<td>People with PDA with good marital adjustment showed the best response to partner-assisted exposure treatment. Treatment failure was associated with initial marital adjustment problems.</td>
</tr>
<tr>
<td>Milton &amp; Hafner</td>
<td>1979</td>
<td>IE + M = 14</td>
<td>14h over 3d 4h over 4w</td>
<td>Yes</td>
<td>During a 6-month follow-up period after individual exposure treatment and medication, 71% of people with PDA with initial marital adjustment problems relapsed compared with only 14% of those who initially reported good marital adjustment.</td>
</tr>
<tr>
<td>Bland &amp; Hallam</td>
<td>1981</td>
<td>IE = 12</td>
<td>12h over 2w</td>
<td>Yes</td>
<td>During a 3-month follow-up period after individual exposure treatment with medication, people with PDA with initial marital adjustment problems on the Marital Pre-Counselling Inventory (Stuart &amp; Stuart, 1973) relapsed, whereas those with good initial marital adjustment did not.</td>
</tr>
<tr>
<td>Monteiro et al, Lelliott et al.</td>
<td>1985, 1987</td>
<td>IE + M = 27, IE + M = 27</td>
<td>28w</td>
<td>Yes</td>
<td>People with PDA with initial good marital adjustment on the Maudsley Marital Questionnaire (Crowe, 1978; Cobb et al., 1980) showed greater improvement after individual exposure treatment with medication and maintained this at 2 and 5 years follow-up.</td>
</tr>
<tr>
<td>Emmelkamp</td>
<td>1980</td>
<td>IE = 17</td>
<td>8h over 4w</td>
<td>No</td>
<td>One month after individual exposure treatment, for people with PDA, those with and without initial marital adjustment problems showed similar levels of symptomatic improvement.</td>
</tr>
<tr>
<td>Barlow et al</td>
<td>1981</td>
<td>PAE + CT = 6</td>
<td>13h over 13w</td>
<td>No</td>
<td>Over follow-up periods from 6 to 16 months, for people with PDA who participated in partner assisted exposure therapy with cognitive therapy, there was no overall correlation between initial marital satisfaction on the Marital Happiness Scale (Azrin, Naster, &amp; Jones, 1973) and symptomatic improvement.</td>
</tr>
<tr>
<td>Thomas et al</td>
<td>1983</td>
<td>IE = 17</td>
<td>10h over 10w</td>
<td>No</td>
<td>For people with PDA, there was no overall correlation between initial marital satisfaction on the Marital Patterns Test (Ryle, 1966) and symptomatic improvement after individual exposure treatment. Those with supportive partners who encouraged &amp; reinforced independent activity showed greater improvement.</td>
</tr>
<tr>
<td>Cobb et al.</td>
<td>1984</td>
<td>PAE = 10 IE = 9</td>
<td>5h</td>
<td>No</td>
<td>For people with PDA who participated in individual and partner assisted exposure therapy, there was no overall correlation between initial marital satisfaction on the Maudsley Marital Questionnaire (Crowe, 1978; Cobb et al., 1980) and symptomatic improvement post-treatment and at 6-months follow-up.</td>
</tr>
<tr>
<td>Arrindell et al.</td>
<td>1986b</td>
<td>IE = 23</td>
<td>30h over 4w</td>
<td>No</td>
<td>At 3 months follow-up, for people with PDA who participated in individual exposure therapy, there was no overall correlation between initial marital satisfaction on the Maudsley Marital Questionnaire (Crowe, 1978; Cobb et al., 1980) and symptomatic improvement.</td>
</tr>
</tbody>
</table>

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Table 6  Studies of the effect of relationship quality on the psychological treatment of PDA (continued)

<table>
<thead>
<tr>
<th>Authors</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Study Design</th>
<th>Treatment Duration</th>
<th>Positive Initial relationship improved treatment response</th>
<th>Key findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Himadi et al.</td>
<td>1986</td>
<td>1987</td>
<td>PAE + CT = 28</td>
<td>12 over 12w</td>
<td>No</td>
<td>• For people with PDA who participated in individual and partner assisted exposure therapy with cognitive therapy, there was no overall correlation between initial marital satisfaction on the Marital Adjustment Test (Locke &amp; Wallace, 1959) or Marital Happiness Scale (Azrin, Naster, &amp; Jones, 1973) and symptomatic improvement after therapy.</td>
</tr>
<tr>
<td>Chambless et al.</td>
<td>1988a</td>
<td></td>
<td>IE = 134</td>
<td>27h over 2w</td>
<td>No</td>
<td>• People with PDA with initial poor marital adjustment showed greater improvement after treatment but not at 1-year follow-up.</td>
</tr>
<tr>
<td>Chambless et al.</td>
<td>1988b</td>
<td></td>
<td>IE = 30</td>
<td>10 X 1.5h</td>
<td>No</td>
<td>• For people with PDA, there was no overall correlation between initial marital satisfaction and symptomatic improvement.</td>
</tr>
<tr>
<td>Peter &amp; Hand</td>
<td>1988</td>
<td></td>
<td>IE = 25</td>
<td>4w with</td>
<td>No</td>
<td>• For people with PDA, there was no overall correlation between initial marital satisfaction and symptomatic improvement.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5 in-office</td>
<td>No</td>
<td>• People with PDA with critical spouses improved more than those with less critical spouses.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>contacts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Craske et al</td>
<td>1989</td>
<td></td>
<td>PAE + CT = 22</td>
<td>12h over 16w</td>
<td>No</td>
<td>• For people with PDA, there was no overall correlation between initial marital satisfaction on the Marital Happiness Scale (Azrin, Naster, &amp; Jones, 1973) or the Marital Interaction Coding System (Hops, Wills, Paterson, &amp; Weiss, 1972) and symptomatic improvement after partner assisted exposure treatment and cognitive therapy.</td>
</tr>
<tr>
<td>Emmelkamp et al.</td>
<td>1992</td>
<td></td>
<td>PAE = 30</td>
<td>6h over 4w</td>
<td>No</td>
<td>• At 2 months follow-up, for people with PDA who participated in individual and partner assisted exposure therapy, there was no overall correlation between initial marital adjustment on the Maudsley Marital Questionnaire (Crowe, 1978; Cobb et al., 1980) or the Marital Quality Scale (Arrindell et al., 1986b) and symptomatic improvement.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>IE = 30</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes:  CT = Cognitive therapy.  d = day.  h = hour.  IE = Individual exposure.  m = month.  MT = Marital therapy.  PAE = Partner-assisted exposure.  PDA = Panic Disorder with Agoraphobia.  w = week.  +M = With medication.
### Table 7: Studies of the effect of the psychological treatment of PDA on relationship quality.

<table>
<thead>
<tr>
<th>Study No.</th>
<th>Authors</th>
<th>Year</th>
<th>Study design</th>
<th>Treatment duration</th>
<th>Treatment has positive effect on relationship quality</th>
<th>Key findings</th>
</tr>
</thead>
</table>
| 1         | Cobb et al.     | 1980 | MT = 5       | 10h over 10w       | Yes                                                 | • For people with PDA and their partners, marital therapy and partner-assisted therapy did not lead to improvement in marital adjustment on the Maudsley Marital Questionnaire (Crowe, 1978; Cobb et al., 1980) or on the Marital Adjustment Test (Locke & Wallace, 1959) but did lead to significant improvement in marital targets.  
• PAE but not MT led to improvement in PDA symptomatology. |
| 2         | Bland & Hallam  | 1981 | IE = 16      | 12h over 2w        | Yes                                                 | • For people with PDA and their partners with high levels of relationship satisfaction on the Marital Pre-Counselling Inventory (Stuart & Stuart, 1973), significant improvements in relationship satisfaction occurred subsequent to individual exposure treatment.  
• Couples with low levels of relationship satisfaction on the Marital Pre-Counselling Inventory (Stuart & Stuart, 1973) showed non-significant improvement in relationship satisfaction after treatment. |
| 3         | Cobb et al.     | 1984 | PAE = 10     | 5h                 | Yes                                                 | • On the Maudsley Marital Questionnaire (Crowe, 1978; Cobb et al., 1980), people with PDA showed some improvements in relationship quality after partner-assisted therapy and individual exposure therapy. |
| 4         | Monteiro et al. | 1985 | IE + M = 27  | 28w                | Yes                                                 | • Over a 5-year follow-up period after treatment with individual exposure therapy with medication, reports of improvements in marital adjustment on the Maudsley Marital Questionnaire (Crowe, 1978; Cobb et al., 1980) of people with PDA occurred and these were correlated with symptomatic improvement. |
| 5         | Arrindell et al.| 1986b| IE = 23      | 30h over 4w        | Yes                                                 | • Over a 2-year follow-up period after treatment with individual exposure therapy, symptomatic improvement in people with PDA correlated with stable marital quality scores on Maudsley Marital Questionnaire (Crowe, 1978; Cobb et al., 1980) but with moderate improvements on observer-ratings of marital quality.  
• Partners of improved PDA patients reported no significant changes in marital adjustment during the follow-up period. |
| 6         | Himadi et al.   | 1986 | PAE + CT = 28| 12 sess over 12w   | Yes                                                 | • After treatment with partner-assisted or individual exposure therapy and cognitive therapy, reports of improvements in marital adjustment on the Marital Adjustment Test (Locke & Wallace, 1959) of people with PDA were correlated with symptomatic improvement. |
|           | Cerny et al.    | 1987 | IE + CT = 14 |                    |                                                     |                                                                                                                                               |
| 7         | Kleiner, Marshall, & Spevack | 1987 | IE = 13     | 24h over 12w       | Yes                                                 | • Compared with PDA patients who received individual exposure therapy only, those who received this treatment along with problem-solving therapy showed greater improvement during follow-up in relationship quality on the Marital Adjustment Test (Locke & Wallace, 1959). |
| 8         | Barlow et al.   | 1981 | PAE + CT = 6 | 13h over 13w       | Partly                                              | • After group-based treatment of PDA with partner-assisted exposure therapy and cognitive therapy, in 66% of cases where symptomatic improvement occurred, improvement in marital adjustment also occurred.  
• In the remaining 34% of cases, symptomatic improvement was associated with deterioration in marital adjustment. |

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<table>
<thead>
<tr>
<th>Study No.</th>
<th>Authors</th>
<th>Year</th>
<th>Study design</th>
<th>Treatment duration</th>
<th>Treatment has positive effect on relationship</th>
<th>Key findings</th>
</tr>
</thead>
</table>
| 9        | Hand & Lamontagne     | 1976 | IE = 25      | 12h over 3d        | Partly                                        | • After treatment of PDA with individual exposure therapy, in 50% of cases where symptomatic improvement occurred, deterioration in marital adjustment also occurred.  
• In the remaining 50% of cases symptomatic improvement was associated with stable or improved marital adjustment. |
| 10       | Milton & Hafner       | 1979 | IE + M = 14  | 14h over 3d 4 X 1.5h over 4w | No                                            | • After treatment of PDA with individual exposure therapy and medication, in 60% of cases where symptomatic improvement occurred, deterioration in marital adjustment also occurred. |
| 11       | Emmelkamp et al.      | 1992 | PAE = 30 IE = 30 | 6 sess over 4w | No                                            | • After treatment with partner-assisted or individual exposure therapy, there was no evidence for improvements or deterioration in marital adjustment on the Maudsley Marital Questionnaire (Crowe, 1978; Cobb et al., 1980) of people with PDA, and their partners did not show positive or negative changes in psychological adjustment. |
| 12       | Emmelkamp             | 1980 | IE = 17      | 8h                 | No                                            | • After treatment with individual exposure therapy and at one-month follow-up, there was no evidence for improvements or deterioration in marital adjustment of people with PDA on the Marital Attitude Evaluation Scale (Schutz, 1973). |
| 13       | Hafner                | 1976 | IE = 39      | 12h over 4d        | No                                            | • After group-based treatment of PDA with exposure therapy and at 3 months follow-up, in couples where husbands obtained high hostility scores on the Hostility & Direction of Hostility Questionnaire (Caine, Foulks, & Hope, 1967), improvement in wives' PDA symptoms coincided with a deterioration in the psychological adjustment of their husbands.  
• Some husbands tried to sabotage their wives symptomatic improvement. |

Notes: CT = Cognitive therapy. d = day. FAE = Female-assisted exposure. h = hour. IE = Individual exposure. m = month. MT = Marital therapy. PAE = Partner-assisted exposure. PDA = Panic Disorder with Agoraphobia. w = week. +M = With medication.
Power and depression in marriage

by

Michael Byrne, B.A.

A research thesis submitted to the Department of Psychology, University College Dublin, in partial fulfilment of the Masters in Psychological Science (Clinical Specialisation)

Supervisor: Dr. Alan Carr

Head of Department: Dr. Ciaran Benson.

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Abstract

To investigate the association between wives depression and power within marriage, 14 couples in which the wife was depressed were compared with 14 non-depressed couples on variables assessing power bases, processes and outcomes. Compared with members of non-depressed couples, members of depressed couples reported longer relationship problems, greater disagreement about the duration of their problems, greater marital dissatisfaction, less commitment, and greater overt and passive aggression. There was also a bigger discrepancy between husband and wives scores on how surplus money was spent and how they would like it to be spent. In terms of power outcomes, they reported greater dissatisfaction with decision making and household task distribution. There was also a bigger discrepancy between husband and wives scores on how much partners were involved in child care and dissatisfaction with household task distribution. When differences due to marital dissatisfaction across depressed and non-depressed couples were taken into account, members of depressed couples reported using more passive aggression and more dissatisfaction with decision making. There was a bigger discrepancy between husbands’ and wives’ use of passive aggression and perception of who made decisions and satisfaction with decision making. Depressed wives were of lower socio-economic status, reported more husband demand - wife withdraw behaviour, reported that their husbands did fewer household and child care tasks, and were less satisfied with child care task distribution. Within depressed couples, it was more likely that one partner’s level of satisfaction was associated with the other; that one partner’s reported desire to spend surplus money was associated with another’s denial of this wish; that one partner’s physical aggression was associated with the other’s level of aggression; and that dissatisfaction with child care for one partner was related to dissatisfaction with this issue in the other partner. In contrast, in non-depressed couples, there was a less rigid relationship between one partner’s status on these variables and the status of the other partner, suggesting greater relational flexibility.
Acknowledgements

I would like to thank Dr. Richard Booth whose supervision in marital therapy got me interested in investigating depression and marital dynamics. Many people helped to nurture and develop my initial ideas into a topic worthy of, and amenable to, a research thesis. These people include Richard, Brendan, and our workshop presenters. To these people I say thank you. Thank you also to the authors of the many scales I have used.

I would like to thank those General Practitioners who co-operated with recruitment of participants. Without their assistance, data collection would not have been practical. My thanks also to John Convoy and Suzanne Guerin for their timely assistance.

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Many thanks to Dr. Alan Carr, who supported me in researching a difficult area of study. His guidance, understanding, and encouragement contributed greatly to the completion of what I think is an interesting piece of research.
Chapter 1. Introduction

1.1 Overview of present research

The aim of this thesis was to investigate the associations between depression and power bases, processes, and outcomes in couples in which the wife was and was not depressed. In chapter 1, theories of depression and its function in marriage are reviewed, and the concept of power is discussed. The findings of empirical studies of dominance, power bases, processes, and outcomes are then reviewed. In chapter 2, the design of the present study is outlined along with the central questions it addresses. The methodology is described in chapter 3 and the results are presented in chapter 4. In chapter 5, these results and their implications are discussed.

1.2 Depression in marriage

A recurrent disorder

Major depression is a recurrent disorder. It has been estimated that at least 85% of depressed individuals have more than one major depression (Keller, 1985). One quarter will experience six or more depressive episodes in their lifetimes, and after its onset, 20% of each index person’s lifetime will be spent in a depressive episode (Angst, 1986). A corollary of the extent of recurrence and chronicity of depression is that most studies of depression are about relapse, rather than initial onset (Hammen, 1995).

A woman's disorder

Depression “is overwhelmingly a woman's disorder” (Kaplan, 1991, p. 206). The number of depressed women exceeds that of men by an average of 2:1 (Nolen-Hoeksema, 1990). The incidence of depression among women peaks during the ages 25 to 44, with the average age of onset is in the late twenties (Weissman, Myers, & Thompson, 1981). These are the years of full engagement in whatever roles a woman chooses, typically those of wife and mother (Jack, 1987b). Many maintaining factors for depression have been proposed, including a biological sensitising effect, such that the threshold of stress necessary to precipitate further depressive episodes lowers with their repetition (Post, Rubinow, & Bellenger, 1986). However, the evidence for biological factors in women's depression is weak and not well supported (Nolen-Hoeksema, 1990).
Marital discord and depression

Rather than sensitising an individual's biological composition, it has been suggested that repeated episodes may sensitise his/her interpersonal environment, causing support and tolerance for dysfunctional behaviour to decrease progressively (Coyne, Burchill, Stiles, 1990). The marital relationship is an important aspect of the interpersonal environment. Indeed, depression often occurs in the context of ongoing marital discord that may exacerbate, maintain, or increase the probability of relapse following the depressive episode (Beach, Whisman, & O'Leary, 1994).

In discordant, unhappy marriages there is a 50% chance that one of the partners is depressed (Beach, Sandeen, & O'Leary, 1990). The odds ratio for depression associated with being married and not being able to talk to one's spouse is 28.1 for women (Weissman, 1987). This compares with a 10-fold increase in risk for depression in newlywed maritally discordant couples (O'Leary, Christian, & Mendell, 1994). Furthermore, relapse is more likely for those depressed patients who return to unsatisfying marriages (Hooley & Teasdale, 1989).

Jessie Bernard (1972) stated that marriage is not as good for women as it is for men, and that there are 2 marriages in any given relationship: 'his marriage' and 'her marriage'. To support her view, she highlighted the low agreement between husbands and wives on marital quality, typically indexed by marital satisfaction. Indeed, it is the quality of a marriage, rather than the marital state per se, that is most likely to be predictive of the mental health of women (O'Leary, 1998); it is typically the “unhappy marriage” which is “a grave risk for a woman’s mental health” (McGrath, Keita, Strickland, & Russo, 1990, p. 23).

Some reasons for marital dissatisfaction

There are many reasons as to why a wife may be unhappy in a marriage. She may feel overworked trying to fulfil the multiple and often competing caretaking demands which accompany her ‘dutiful’ roles in the family (i.e. wife and mother) and the community (Carter & Kaslow, 1992). She may want her husband to take a greater share in financial matters and to become more aware of her efforts to make ends meet (Komter, 1989). She may want more support and intimacy from an uncommunicative
spouse (Christensen & Heavey, 1990). She may also be the recipient of psychological and/or physical abuse (O’Neil & Egan, 1993).

All of the above reasons are manifestations of a lack of power. Indeed, marriage has been described as a lifelong oppositional play of power masquerading as pleasure (Boone, 1986). Hence, marital dissatisfaction in women may really be dissatisfaction with the power imbalance in marriage (Steil, 1983).

### 1.3 Theories of the function of depression in marriage

Haley (1963) suggested that there are two predominant types of relationships. A relationship can be symmetrical in that partners exchange the same type of behaviour. Alternatively, a complementary relationship may exist where 2 people exchange behaviour which complements, or fits together, so that one is in a ‘superior’ position and the other is in a secondary position. No two people would constantly have one type of relationship in all circumstances. Rather, spouses would develop a hierarchy where they would work out areas of their relationship as either one type or the other, with each spouse adopting different roles in different areas over time.

Haley described a third type of relationship. When partners cannot reach a satisfactory agreement on a mutual definition of areas of the relationship, a struggle for power ensues. If this struggle is not resolved by available means of negotiation (e.g. open battle, sabotage, passive resistance), a metacomplementary relationship may develop, whereby the over-functioning and less powerful spouse may choose a psychiatric symptom to change the hierarchical arrangement with which he/she is dissatisfied. Doing so introduces a hierarchical incongruity into the marriage in that “the symptomatic person is in an inferior position to her partner, who tries to help and change her. Yet, the symptomatic partner is also in a superior position in that she refuses to be helped and to change. Symptomatic behaviour in one partner can organise the other’s behaviour in many ways; how free time will be spent, how much money should be used and how to relate to the rest of the family. The couple are caught in an interaction that defines simultaneously each of them as powerful yet also weak in relation to each other” (Madanes, 1981; p.30).
Hence, although the index spouse is overtly powerless in his/her illness role, he/she is also covertly powerful in that the symptom forces the passive and under-functioning spouse to give more to the relationship, thus creating a healthier balance of power. It is this dynamic that the phrase ‘depressed people are powerful in their powerlessness’ refers (Coyne, 1986).

Price’s (1991) ‘vertical gap’ model is an elaboration of Haley’s (1963) work. He postulates that the function of depression is to reconcile the index spouse to an involuntary ‘one-down’ or less powerful position. From clinical observations, Price deduced that the ‘one-up’ spouse tries to keep his spouse’s exercise of control a constant amount below his/her own. Maintenance of a ‘control gap’, rather than absolute levels of control, maintains the status quo. Thus, if one spouse, for example the husband, “feels securely in control and requires only a small vertical gap between himself and his wife, the wife’s mood will be maintained within the normal range, and any tendency on her part to get depressed will be counteracted by the husband; but if his mood is low or he requires a large gap, he may need to maintain his wife’s mood within the depressive range, and any efforts to raise it (for instance, in therapy) will be countered” (Price, 1991, p. 336).

Price (1991) distinguishes between 2 types of depression; ‘static’ depression which reconciles to a pre-existing subordinate position, and depression which serves a ‘change’ function, namely to mediate a switch to a subordinate position from a previously dominant position. He further states that a position of lowemess may be adopted willingly, even joyfully, when the ‘one-up’ spouse is highly respected and loved, and is a source of security and praise. If, on the other hand, the more powerful spouse is resented, then the index spouse is coerced into lowemess. Subsequent anger, aggression, and frustration in the less powerful spouse may incite rebellion. However, the ‘involuntary subordinate strategy’ of depression inhibits this rebellion and the likely response of up-hierarchy aggression (Sloman, Price, Gilbert, & Gardner, 1994).

Both theories conceptualise depression as an adaptive process in dealing with unfavourable circumstances, as “an almost unavoidable response to an environment which allows” the ‘one-down’ individual “little control over most of the important things in life” (Belle, 1982, p. 241). A consequence of the resulting marital interaction
is that depression makes it possible for both spouses to know where each stands in relation to each other on certain issues without having to explicitly discuss those issues and so endanger the marriage. Thus, many couples walk on the edges of their power dynamics in their daily lives without facing the central themes that produce conflict (O'Neil & Egan, 1993).

1.4 The concept of marital power

Due partly to there being almost as many definitions of power in intimate relationships as there are people who have studied it (Murphy & Meyer, 1991), research on marital power has proven to be extraordinarily difficult. This plethora of definitions reflects the huge disagreement as to what marital power really is and suggests that it is not a unitary construct. Some researchers view it as a potential, for example, by the amount of resources available for distribution or exchange. Others view it as the actual control exercised over outcomes (DuBrin, 1990). It has also been described as the ability to compel obedience (e.g. Russell, 1969). Others define it as the capacity or ability to produce intended effects (Gray-Little & Burks, 1983; Robbins, 1989). French (1985), in trying to bring about some consensus in the field, distinguished between 2 types of power: ‘power to’, which refers to capacity or ability, and ‘power over’ or domination.

To complicate matters further, there is confusion between the terms ‘power’ and ‘dominance’. Most researchers treat these as synonymous, typically equating dominance with power outcome (Rogers-Millar & Millar, 1979). Others, argue that they are divergent concepts. For example, Szinovacz (1987) defines power as the net ability or capability of actors to produce or cause (intended) outcomes or effects. Thus, he views power as content- and situation-specific. He states that dominance addresses the overall symmetry or asymmetry in relationships and concerns the partners’ relative control rather than their relative power. He argues that an individual may be dominant if he or she controls a broader range of the other’s behaviours and outcomes than vice versa. We may, of course, extend assessments of power to a wide range of behaviours. But even then, Szinovacz argues that it is still important to distinguish between asymmetries in power and in control; a spouse who is able to exert control may not make use of his/her potential, whilst the less powerful partner may be quite dominant if the other fails to counteract his or her control attempts.
The lack of a standard conceptual definition of marital power has resulted in its haphazard measurement and much empirical disunity. Traditionally, the unit of measurement has been who makes major decisions but this is only one aspect of power. Additionally, studies comparing self-reports of decision-making power with direct observation of behaviour have shown little correspondence (Gray-Little, 1982). Even studies comparing power measures using the same method (e.g., two self-report questionnaires) have failed to correlate significantly (Gray-Little & Burks, 1983).

In trying to account for its multi-dimensional nature, Cromwell and Olson (1975) asserted that power is a 'generic' construct incorporating 3 analytically distinct but interrelated domains: power bases, processes, and outcomes (Figure 1). Power bases are the personal assets that form the basis of one partner's control over the other (Gray-Little & Burks, 1983). They are synonymous with material resources, as discussed by Blood and Wolfe (1960), but they are not solely economic: they can be any personal resource that someone brings to a relationship, including knowledge, commitment, and sex role attitudes. Power processes are the interactional techniques such as assertiveness, persuasion, problem-solving, or demandingness that individuals use in their attempts to gain control. Power outcomes, on the other hand, concern who has the final say, that is, who determines the outcome in problem solving or decision making.

![Figure 1. The construct of marital power.](image)

This popular conceptualisation of power is not without its problems. Even within each power domain there seems to be a lack of coherence among the disparate variables at both the empirical and conceptual levels (Babcock, Waltz, Jacobson, & Gottman, 1993). For example, the subconstruct of power bases may include economic resources, affective resources (e.g., level of involvement or dependence), personal
resources (e.g., physical appearance), and cognitive resources (e.g., the perception of power: Cromwell & Olson, 1975). Additionally, there is considerable overlap between Cromwell and Olson’s 3 domains of power. In examining power in terms of outcome or process, the issue of power bases is implicit. Some power bases (e.g. aggression, desired level of intimacy) may be considered power processes, and the distinction between outcomes and processes can easily become blurred (Gray-Little & Burks, 1983).

1.5 Empirical studies of dominance

As mentioned above, most researchers use the terms ‘power’ and ‘dominance’ to refer to a hierarchical relationship between partners (Christensen & Pasch, 1993). Millar and Rogers (1988) highlighted how the more equivalent a couple’s dominance structure, the more flexible their interactions, the more frequently discussions about who is to do what when takes place, the greater the conflict potential of dyadic conversations, but the more understanding experienced in marital negotiations. In contrast, the more dominant one spouse is, the more rigid their interactions, the less frequent discussions about who is to do what when, “the more apparent ‘harmony’ in their conversations, but the greater the ‘rebellion’ potential of marital negotiations and the less understanding experienced by the partners” (Millar & Rogers, 1988, p. 94).

Consistent findings in the literature on power patterns are that shared power (egalitarian power pattern) is associated with the highest level of reported marital satisfaction, and that wife-dominant couples are, on the whole, less satisfied than egalitarian or husband-dominant couples (e.g. Gray-Little & Burks, 1983). The latter finding may be explained by husbands and wives in wife-led couples viewing wife dominance as undesirable. In contrast to this, husband-led couples are congruent with a traditional norm and egalitarian couples are congruent with a more modern norm of balanced power between the spouses (Ting-Toomey, 1984). Alternatively, husbands in wife-led marriages may not be able to adequately exercise a power role (i.e., the husband-incapacity role hypothesis), leaving the wife to assume more authority than desired by either partner and causing dissatisfaction in both (Fitzpatrick, 1988).

Using who makes the major decisions as an index of power, an imbalance of power is characteristic of many marriages in which there is a depressed wife. These women
perceive their husbands as dominating (Jack, 1987b) and experience themselves as yielding to their husbands' position, whereas their husbands appear to be unaware of their wives' experience of submission in the marital relationship (Hoover & Fitzgerald, 1981). On the other hand, there are those (e.g. McGoldrick, 1991) who believe that men experience women as powerful.

1.6 Empirical studies of power bases

Income
Since Blood and Wolfe (1960) posited that "the balance of power will be on the side of that partner who contributes the greater resources to the marriage" (p. 12), most research studies on marital power have been based on resource theory (Aida & Falbo, 1991). Indeed, numerous investigators have linked people's influence within their marriage to their employment outside of the family. Research suggests that the greater a husband's occupational prestige, the more he dominates domestic decisions (Ericksen, Yancey, & Ericksen, 1979). Employed wives have been found to have more say at home and be less depressed than housewives (e.g. Crosby, 1982). This may be because being employed provides more social contact and a source of instrumentality or gratification independent of family life (Ritter, 1993).

Economic dependence on partner
Men derive power from their economic independence, whereas the economic dependence of wives on their husbands has long been recognised as one of the most important barriers to wives' equality in marital relations (Blumstein & Schwartz, 1983). Depressed women describe their relationships as characterised by financial dependence, something which affects their perceptions of their prerogatives within marriage, as well as their ability to leave unsatisfactory relationships (Jack, 1987b).

Control of surplus spending money
It has been hypothesised that independent control of surplus spending money brings greater leverage than control over what is needed for everyday subsistence (Blumberg & Coleman, 1989). Thus, even though a wife may have less income and be economically dependent on her husband, she may still derive considerable power from having control over surplus spending money, as negotiated with her husband.
Commitment

The principle of least interest (Waller, 1938) posits that those who want less have more to say. Thus, it is hypothesised that the partner who is less committed to a relationship (i.e., more willing to leave it) has more leverage than the committed partner - who is afraid that the former will exercise the option. Hence, commitment is an important power base. However, it may be that marriage tends to equilibrate men's and women's commitment because of the social rituals, the common property (i.e., pooling of assets), and the costs of leaving (i.e., the legal and social complications of separation: Blumstein & Schwartz, 1983). Bagarozzi (1990) also argues that other factors unrelated to power may influence a spouse not to leave a relationship experienced as unrewarding. These include commitment to keeping marriage vows (e.g., “till death do us part”), religious convictions, moral values, ethical standards, concerns for one's children, and desire not to displease parents, relatives, and friends.

Sex role attitudes

There have been substantial changes in sex role attitudes over the past few decades, primarily reflecting changes in attitudes about women's role (e.g., McBroom, 1984). With these changes has come the expectation that women with a modern sex role ideology, in challenging the general pattern of male power and male needs for dominance, yield more power in marriage than traditional women. However, non-traditional women may be less happy than those who adopt the characteristics, attitudes, and behaviours associated with the feminine sex role. Non-traditional women are still pioneers. They continue to experience conflict and ambiguity regarding the integration of their many different roles, especially since males continue to resist their strivings for increased power (Lueptow, Guss, & Hyden, 1989). These women may also represent a threat to males that could make them less desirable. Also, a reversal of the traditional arrangement may be contrary to the wife's preferences of male leadership (Nyquist & Spence, 1986).

The extent to which couples differ in their sex role attitudes affects spousal interaction. For example, less conflict engagement and negotiation takes place in traditional marriages because there is an existing consensus about roles, rules, and norms within the relationship (VanYperen & Buunk, 1991). Spouses with egalitarian gender role ideologies need to explicitly negotiate gender roles because these roles have not yet
been clearly established within the relationship. They perceive each other as equals and engage in comparisons with each other (Van Yperen & Buunk, 1991). This results in feelings of deprivation, dissatisfaction, and aggravation among egalitarian women (Buunk, Kluwer, Schuurman, & Siero, cited in Kluwer, Heesink, & Van de Vliert, 1997) so that they ventilate their discontent more often in order to structure the relationship to their liking.

Depression has been found to correlate with femininity scores in both clinical (e.g. Tinsley, Sullivan-Guest, & McGuire, 1984) and non-clinical women (e.g., Elpern & Karp, 1984), and to inversely correlate with masculinity (Whisman & Jacobson, 1989). This may be because traditional women demonstrate a tendency to develop characteristics of learned helplessness and loss-of-control experiences (e.g. Baucom & Weiss, 1986). Indeed, they are less inclined to confront their spouse because they feel less powerful (e.g., Hochschild, 1989; Mederer, 1993) or because they feel discouraged by their traditional husband. However, Alspach (1982) found a relation between happiness and traditionalism among married women, even when work status and education were controlled for. Thus, both non-traditionalism and egalitarian gender role ideologies in women appear to be associated with increased power but less happiness, while it remains unclear if traditionalism in women is associated with less power and depression.

**Intimacy**

Lerner (1989) described an intimate relationship as one in which “we can be who we are in a relationship, and allow the other person to do the same” (p. 3). However, the attainment of intimacy is relatively rare (Dupuy, 1993; Schaefer, 1989; Wynne, 1988). This may be because women are socialised to be highly relationship-oriented and to seek closeness and intimacy, whereas men are socialised to be independent and achievement-oriented (e.g. Rubin, 1983). Indeed, women, ‘socio-emotional specialists’ that they are (Kelley et al., 1978), have a tendency to possess relationships characterised by greater intimacy, emotional disclosure, and empathy (Turner, 1994).

Many studies have indicated that women want more intimacy in their marital relationships (e.g. Margolin, Talovic, & Weinstein, 1983). Given the principle of least interest, men’s inclination to avoid intimacy may be “inherently empowering
especially when pitted against a partner who wants more intimacy” (Jacobson, 1989, p. 31). On the other hand, intimacy may not be possible given even subtle inequities in a relationship. If both partners do not have parity, then they are not equally able to influence the meaning of their encounters, and cannot feel free to collaborate on action, thus precluding the development of intimacy (Rampage, 1994). This may be particularly difficult to do when one member of the dyad is depressed, where the depression may serve to regulate distance between partners (Jessee & L’Abate, 1983).

Hence, women, relative to men, may ordinarily be in a ‘one-down’ position due to their desire for greater marital intimacy. However, absence of parity may preclude the development of intimacy, so that intimacy is only possible in a marriage that is perceived as egalitarian.

**Physical aggression**

Men are often deemed to be more powerful in the marital dyad because they can rely on physical force as the ultimate resource to maintain their dominance (Yllo & Straus, 1982). Almost one third of married women report violence in their current marriage (Koss, 1988). Such abuse typically escalates in severity over time (Walker, 1984) and is a significant risk factor in the development of depressive symptoms in women (McGrath, Keita, Strickland, & Russo, 1990). There are many reasons why battered women may be reluctant to seek help and leave abusive partners. These include economic dependency on the abuser, the threat of more severe violence in the future, the belief that oneself is responsible, the fear of confronting the ambivalence inherent in loving someone who is brutal toward oneself, and a hope that things will get better in time (Dupuy, 1993).

Physical violence may be an abuse of power but it reflects, paradoxically, a sense of powerlessness, not one of power (McGoldrick, 1991). In a review of studies on the effect of economic power bases on domestic violence, Hotalling and Sugarman (1986) concluded that if the wife has more education or higher income than the husband, the likelihood of husband-to-wife violence increases. Bograd (1988) also reported that one of the most common justifications husbands give for their violence is that they have no other way to handle the conflict. As men’s status in either career or family life decreases, they are more likely to use violence (coercive power) to compensate for
the loss (Kahn, 1984). Additionally, Coleman and Straus (1986) reported a greater incidence of minor violence in both husband- and wife-dominant marriages than in egalitarian ones.

Thus, physical aggression may be a compensatory power base for men, one which is only used when the husband feels otherwise powerless in the marital relationship (or other settings). Its effect on a wife may be to invoke depression.

**Overt psychological aggression**

In their efforts to preserve their relational self, women often attempt to over-invest in their spouse to their own neglect. This leads to feelings of self-betrayal, powerlessness, and anger. However, the only acceptable voice for women is a ‘relational’ voice that does not directly express anger (Hayles, 1986). Prolonged denial of anger may lead to “deep anger” (Jack, 1991, p. 139) which may take on two common patterns: symptoms or explosions.

Typically, couples find it easier to deal with sickness than anger (Lerner, 1985), with this sickness in women manifesting as depression (Hafner, 1986; Miller, 1983). Depressed individuals report higher levels of anger and greater suppression of anger but no differences in level of anger expression relative to non-depressed individuals (Riley, Treiber, & Woods, 1989). However, this same research suggests that moderate anger in depressed individuals may tend to be suppressed whereas severe anger may tend to result in overt expression. Thus, it may be that a strong feeling of powerlessness in depressed women is associated with overt expression of anger, whereas weaker feelings of powerlessness are associated with its suppression.

Coyne (1988) reports a study in which the spouses of depressed patients accepted a strong biological component to the patients’ disturbance but were nonetheless quite angry at them for being symptomatic. In couples where the wife is depressed, the husband’s anger may arise from having to function for two people, from viewing his wife’s unspoken misery as an accusation (Bullock, Siegel, Weissman, & Paykel, 1972), and/or from believing that her withdrawal is a deliberate and aggressive act. However, although the expression of anger is the one emotional display considered natural and appropriate for males (Birnbaum & Croll, 1984), husbands are reluctant to
express their anger, believing such expression to be a show of powerlessness (Guthrie & Snyder, 1988). Additionally, a woman’s depressive behaviour may aversively control the inhibition of hostile behaviour in the husband (Biglan et al., 1985).

Explosions, rather than symptoms, may reflect denial of anger in a woman. Denial leads to a build up of anger. When it becomes necessary to confront problems, interactions with her spouse are burdened by the accumulation of unresolved issues and negative feelings. The resultant emotional outbursts eclipse the possibility of open dialogue regarding change. What is heard is her hurt and anger, and not the specifics of the problems that ail her. If her husband remains ‘inexpressive’ (Sattel, 1976), the woman often ends up “emoting for two” (Papp, 1988, p.211) and may be labelled as ‘hysterical’ and/or ‘castrating’. Thus, the belief that problems cannot be discussed is reinforced which increases the likelihood that problems (and anger) will again accumulate without resolution.

Alternatively, if anger is recognised and expressed, couples can negotiate the area of conflict and resolve the area of difference, and the anger will typically dissipate (Dupuy, 1993). Indeed, women’s self-reported strategies for dealing with relationship problems are more likely to include direct discussion or patience and less likely to include displays of anger and disappointment (Rusbult, Johnson, & Morrow, 1986). Thus, there are at least 3 types of interaction involving power and anger. Firstly, if a spouse, typically the wife, feels powerless, prolonged denial of anger may manifest as depression. When depressed, moderate anger may be suppressed, but severe anger overtly expressed. A husband may be reluctant to regularly express his anger due to the aversive control of his wife’s behaviour and because doing so may facilitate negotiation and change in the relationship’s status quo. Secondly, a woman’s denial of anger coupled with a male’s inexpressiveness may result in the establishment of an ‘inhibition - hostile exchange - inhibition’ cycle which protects the status quo, usually to the benefit of the husband. Thus, in husband-dominant marriages, overt female anger is minimal, whilst the husband may on occasion use overt aggression to condition his wife’s expression of anger. Thirdly, in an egalitarian or wife-dominant relationship, anger may be overtly expressed on a regular basis but this anger is of low intensity.
Passive aggression
Following on from the above, depressed women with low levels of anger may suppress most of it. Alternatively, her anger may be expressed passively, as might some of the anger in women experiencing severe levels of anger. Passive aggression would also be expected from their husbands as explained above. Egalitarian women, in overtly expressing anger to ensure that their relationships are structured in a way that meets their needs, may have little need to be passively aggressive. Their husbands may have little cause to be angry, other than having to express anger overtly on occasions when the status quo of the relationship is challenged. Thus, ordinarily, there might be little need for passive aggression, but some husbands may choose to use it to ‘keep a woman in her place’. On the other hand, women in husband-dominant relationships may only be able to express anger passively, whereas husbands may experience no anger.

1.7 Empirical studies of power processes
Demand - withdraw behaviour
Since Watzlawick, Beavin, and Jackson (1967) described a ‘nag-withdraw’ pattern of interaction, many theorists (e.g. Christensen & Heavey, 1990; Fogarty, 1976; Napier, 1978; Wile, 1981) have described how the less powerful spouse, dissatisfied with the status quo, assumes a demanding role to create change in the relationship. The more powerful spouse, who has a vested interest in preserving the status quo as it benefits him/her, engages in withdrawing behaviours to avoid change. Thus emotional requests, criticism, and complaints from the ‘one-down’ spouse, may be met with defensiveness, irrelevant comments, passive inaction, or ‘stonewalling’ from the ‘one-up’ spouse. The latter behaviours are powerful tactics, for “to not say anything (in particular situations) is to say something very important; that the battle we are engaged in is to be fought by my rules and when I choose to fight” (Sattel, 1976, p. 474).

Gottman’s (1994) review of research in which partners are free to choose the topic of discussion, suggests that women’s engagement and men’s withdrawal in the face of conflict resolution discussions appears to be a widespread, gendered communication pattern, particularly in unhappy marriages. In contrast to Gottman’s suggestions, it has be shown that both husbands and wives are more likely to be demanding when discussing a change they want and are more likely to be withdrawing when discussing
a change their partner wants (Heavey, Layne, & Christensen, 1993). This latter finding supports the argument that women’s role as the demander in marriage (Margolin, Talovic, & Weinstein, 1983) results from her ‘one-down’ position in the social structure as a seeker of change, rather than any inherent gender difference in demandingness (Christensen & Heavey, 1990).

There also appears to be strong correlations between the ‘demand-withdraw’ pattern and both a structural asymmetry in the level of intimacy and independence desired in the relationship, with the spouse wanting more intimacy assuming the demand role (Christensen, 1987), and with relationship dissatisfaction (Christensen & Shenk, 1991). So, it may be that in general, women are more likely to be demanding and men are more likely to be withdrawing during conflictual discussions, but when the structure of the marital conflict supports this gender linkage (i.e., when women's greater propensity to engage in conflict is combined with the opportunity to pursue a desired change in the relationship), the roles become highly stereotyped (Heavey, Layne, & Christensen, 1993).

Therefore, being in the demanding role appears to be associated with dissatisfaction with being in the ‘one-down’ position. However, using time-series analyses to examine the relationship of withdrawal and hostility during conflicts, Roberts and Krokoff (1990) found no mean differences in the amount of withdrawal exhibited by men and women or by satisfied and dissatisfied couples. Gray-Little and Burks (1983) also suggested that the woman in a wife-dominant marriage may be especially demanding because of the wish to force her husband to take a demanding role. If her husband resists, she may use more control tactics than couples who share power and use more than a dominant husband who has role expectations and tradition on his side. Hence, a high-powered wife may more frequently resort to demanding and negative communications. This may be reciprocated by the husband, resulting in marital dissatisfaction.

**Mutual constructive communication**

All of the above studies have found low correlations between mutual constructive communication and both the demand-withdraw pattern of behaviour and, where it was studied, desired levels of intimacy and independence. However, these studies
involved distressed and non-distressed couples, and not couples where one partner was depressed. It remains to be seen if such patterns are descriptive of depressed couples. If as theory suggests, depression is a safety net mechanism to ensure symmetry (Haley, 1963) or asymmetry (Price, 1991) when other methods of negotiation have been exhausted, one would expect little mutual constructive communication in couples where the wife is depressed.

1.8 Empirical studies of power outcomes

Who does what

Decision making has long been considered to measure the power distribution of a couple (Blood & Wolfe, 1960), with inequality in the distribution of decision making conceived of as inequality in power. These researchers categorised couples as husband-dominant, wife-dominant, or egalitarian in decision making. They further divided egalitarian couples into ‘syncratic’ couples, where most decisions are made jointly, and ‘autonomic’ couples, in which equal numbers are made by both partners. They found that wives who reported a syncratic decision structure reported the highest levels of satisfaction, whereas those in the wife-dominant group were the least satisfied. Wives in syncratic marriages were more satisfied than those in autonomic marriages suggesting that equality per se is less important for the wife’s satisfaction than being included in the decision process.

However, this study, like others, did not consider the views of husbands. Other methodological shortcomings of studies using who does what as a measure of power are apparent. Considering that relative to decision making, husbands tend to overestimate their own power and wives underestimate theirs (Olson & Rabunsky, 1972), reports of decision making do not reflect the true dominance structure but present marriages as fitting the traditional pattern of male dominance. Much of what goes on between spouses is not reflected in the final outcome of the decision-making process, and it may be that the person who makes the final decision has been subtly manoeuvred into that choice (Gray-Little & Burks, 1983). Additionally, couples have been shown to be inaccurate in their recall of who made a particular decision, especially when the decision is uncommon or requires multiple acts (Douglas & Wind, 1978).
Many power outcome studies also do not take into account idealised as well as perceived distribution of sex role behaviours (e.g., Margolin, Talovic, & Weinstein, 1983): it is highly likely that the arrangement of who does what is not as important as how satisfied one is with the arrangement. For example, there may be delegation of unimportant decisions to the less powerful spouse, in some cases even against his or her wishes (e.g., Safilios-Rothschild, 1976b). Szinovacz (1981) expanded upon Blood and Wolfe’s (1961) definition and operationalised power inequality as discrepancies between the real and ideal distribution of decision making. This discrepancy, measured as role dissatisfaction, has been shown to be associated with lower levels of marital satisfaction and higher levels of depression in wives. Specifically, couples where the wife is depressed show greater dissatisfaction with the distribution of decision making and household tasks relative to control couples, and depressed wives indicate greater dissatisfaction with child rearing tasks. However, such dissatisfaction appears to be largely mediated by marital dissatisfaction (Whisman & Jacobson, 1989).

A consistent research finding is lower marital satisfaction among subjects reporting wife-dominant decision making (Corrales, 1975; Gray-Little, 1982). Husbands are more likely to dominate decision making when the woman is depressed than when she is not (Hoover & Fitzgerald, 1981). With egalitarian couples, the fact that two persons, rather than one, make decisions may necessitate more negotiation and bargaining, thus engendering more tensions. However, this need and desire for continued interpersonal contact and involvement is likely to contribute to the apparent high level of satisfaction in egalitarian couples (Gray-Little & Burks, 1983) possibly because it facilitates the development of intimacy. Other factors may influence the relationship between dominance structure and role satisfaction. Most significantly, dissatisfaction with role overload can be offset by a low level of marital strain, an affirming job, or both (McGrath, Keita, Strickland, & Russo, 1990). Additionally, higher income housewives, who can afford to hire others to perform some of the noxious household tasks, are less prone to experience depression than low-income wives (Nolen-Hoeksema, 1990).
1.9 Who rules the roost?

Control couples

Without considering the various aspects of power separately, it is difficult to say who is the dominant partner in a relationship. Husbands appear to hold the upper hand economically, but this may well be offset if it has been mutually agreed that the wife has control of surplus spending money. Threatened or actual physical aggression appears to represent an important male power base, although it simultaneously reflects a sense of powerlessness. Similarly, overt anger in males may manifest as a power base, but husbands may think otherwise. Withdrawing to preclude the possibility of changing the status quo (which presumably favours them) via negotiation, may also be a manifestation of male power in the marital dyad.

For the most part, most women do not ‘walk the talk’ of modern sex role ideology. In doing so, they reinforce traditional male dominance in society and in their marriage. At best, non-traditional gender attitudes may facilitate egalitarianism. Women may be less powerful in seeking greater intimacy, as reflected in their demand role in marital interactions. Their tendency to inhibit anger expression may be self-disabling; due to pent-up anger drowning the subject matter of discussions, problems do not get resolved. On the other hand, in egalitarian marriages, more regular but less intense expression of discontent helps to structure the relationship to their liking. Women may be in a less powerful position in that they do more than their fair share of housework, decision making, and child care, but a low level of marital strain or an affirming job, or both, may compensate for this.

As theory (e.g. Haley, 1963) suggests, it may be that marriages where neither spouse is symptomatic are balanced or symmetrical (i.e., neutral dominance), with spouses alternating in the roles of power subject and power holder as the task and personal qualities of the family members dictate. These non-symptomatic marriages may also be husband-dominant. The critical feature is that both spouses are satisfied with the balance of marital power.

Couples where the wife is depressed

Price (1991) also suggests that if a spouse, having exhausted all available means of negotiation, is dissatisfied with the hierarchical arrangements of his/her marriage, then
he/she may elect an illness role to accommodate to the ‘one-down’ position. So, one would expect the marital power balance in couples where the wife is depressed not to differ from that of control couples where there is a husband-dominant or ‘one-up / one-down’ structure.

On the other hand, if electing a sickness role is an effort to covertly equalise the overt power imbalance (Haley, 1963; Madanes, 1981), then one would expect a depressed woman’s level of power to be higher than that of a wife in a husband-dominant non-depressed marriage, or to equal that of a woman in an egalitarian non-depressed marriage.

An equal marital power structure due to depression?
If an egalitarian dominance structure replaces a ‘one-up / one-down’ structure when a psychiatric symptom presents in a marriage, it would be expected that the power structure in a marriage where the wife is depressed would mirror that of an egalitarian marriage where there is no depression. One would expect the wife to become more satisfied because the original cause of her dissatisfaction (i.e., lack of power) is eliminated. However, as the woman’s depression represents considerable distress subjectively (Haley, 1963), her dissatisfaction may increase. Both spouses would also be expected to perceive neither as dominant (i.e., neutral dominance).

In depressed marriages, it is unlikely that depression would alter the husband’s advantage in the economic context of the marriage. If anything, spousal depression would increase his advantage in this power base due to the possibility of the wife not working. If his wife’s power has increased relative to his, he may try to reassert his dominance by being more physically aggressive. However, if an egalitarian dominance structure has replaced a ‘one-up / one-down’ hierarchy, then physical aggression would not be expected. Levels of overt and passive aggression would be expected to mirror those of husbands in control couples. Additionally, if the husband is dissatisfied with how his wife’s depression has changed the status quo to his disadvantage, then he might increase his engagement in demand behaviour to restore his advantage.
A wife's depression may alter some of her sources of power. It is unlikely that her sex role attitudes would change. The level of desired intimacy would be expected not to differ from that of a non-depressed women. Similarly, one would expect levels of both overt and passive aggression to compare with those of a non-depressed wife in an egalitarian marriage. Additionally, wife demand behaviour would be expected to mirror that of wives in egalitarian marriages. Lastly, if a woman elects an illness role to escape an over-functioning marital role, it would be expected that the distribution in household tasks, decision making, and child care tasks would mirror that of an egalitarian non-depressed marriage.
Chapter 2. Aims, design, and hypotheses of present research

2.1 Aims and design of present research

Aims of the present research

The central objective of this thesis was to investigate if depression in married women was associated with an egalitarian dominance structure in marriage, as exists in egalitarian marriages where the wife is not depressed. Previous empirical studies have not examined this possibility, usually assuming that the helplessness of depression is associated with less marital power. Thus, covert power of depression has been, to a large extent, overlooked.

Previous research examining marital power has typically involved gathering data only from wives. Hence, the results of these studies have informed only about ‘her marriage’ and not about ‘his marriage’ (Bernard, 1972). To obtain a clearer understanding of the power dynamics within marriage, data was independently collected from both spouses using self-report questionnaires.

Although marital power is a complex and multi-faceted concept with many forms, empirical studies examining power in couples have generally examined one variable or aspect of power at a time, typically within one domain. Various aspects of power in couples where there is depression have been neglected both theoretically and empirically. The present study attempted to compare several aspects of power from each of three different domains of power; namely, power bases, processes, and outcomes, as delineated by Cromwell and Olson (1975). Table 1 lists the power variables examined in the present research.

Design of the present research

A case control design was used in this study. Couples containing a depressed female spouse were compared with couples in which the female partner was not depressed on the variables listed in Table 1.
Table 1  Power variables examined in the present research

<table>
<thead>
<tr>
<th>Power bases</th>
<th>Power processes</th>
<th>Power outcomes</th>
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<tbody>
<tr>
<td>Income</td>
<td>Husband demand - wife withdraw behaviour</td>
<td>Partner does more household tasks</td>
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<tr>
<td>Economic dependence on partner</td>
<td>Wife demand - husband withdraw behaviour</td>
<td>Partner does more decision making</td>
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<td>Control of surplus spending money</td>
<td>Total demand - withdraw behaviour</td>
<td>Partner more involved in child care</td>
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<td>Satisfaction with control of surplus spending money</td>
<td>Mutual constructive communication</td>
<td>Dissatisfaction with household task distribution</td>
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<tr>
<td>Commitment to the relationship</td>
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<td>Dissatisfaction with decision making distribution</td>
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<tr>
<td>Sex role attitudes</td>
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<td>Dissatisfaction with child care task distribution</td>
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<tr>
<td>Desired level of intimacy</td>
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<td>Physical aggression from partner</td>
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<td>Overt aggression towards partner</td>
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<td>Passive aggression towards partner</td>
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2.2 Hypotheses

This study addressed the following list of questions and accompanying hypotheses.

**Marital satisfaction**

1a Compared with non-depressed couples, do members of couples containing depressed wives report lower marital satisfaction?

1b Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ level of satisfaction in couples containing depressed wives?

1c Compared with non-depressed couples, is there a greater correlation between husbands’ and wives’ level of satisfaction in couples containing depressed wives?

The hypothesis about marital satisfaction was that in couples containing depressed wives, members would report lower marital satisfaction.

**Dominance**

2a Compared with non-depressed couples, do members of couples containing depressed wives report different levels of dominance?

2b Compared with non-depressed couples, do members of couples containing depressed wives report different levels of dominance when differences in marital satisfaction have been taken into account?

2c Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ level of dominance in couples containing depressed wives?
2d Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ level of dominance in couples containing depressed wives when differences in marital satisfaction have been taken into account?

2e Compared with non-depressed couples, is there a greater correlation between husbands’ and wives’ level of dominance in couples containing depressed wives?

The hypothesis about dominance was that depressed wives would view their husbands as more dominant.

**Power bases**

**Income**

3a Compared with non-depressed couples, do members of couples containing depressed wives report different levels of income?

3b Compared with non-depressed couples, do members of couples containing depressed wives report different levels of income when differences in marital satisfaction have been taken into account?

3c Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ level of income in couples containing depressed wives?

3d Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ level of income in couples containing depressed wives when differences in marital satisfaction have been taken into account?

3e Compared with non-depressed couples, is there a greater correlation between husbands’ and wives’ level of income in couples containing depressed wives?

The hypothesis about income was that depressed wives would report lower income and that there would be a greater discrepancy between husbands’ and wives’ reports on this variable in depressed couples relative to non-depressed couples.

**Economic dependence on partner**

4a Compared with non-depressed couples, do members of couples containing depressed wives report greater economic dependence on their husbands?

4b Compared with non-depressed couples, do members of couples containing depressed wives report greater economic dependence on their husbands when differences in marital satisfaction have been taken into account?

4c Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ level of economic dependence in couples containing depressed wives?
4d Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ level of economic dependence in couples containing depressed wives when differences in marital satisfaction have been taken into account?

4e Compared with non-depressed couples, is there a greater correlation between husbands’ and wives’ level of economic dependence in couples containing depressed wives?

The hypothesis about economic dependence was that depressed wives would report greater economic dependence and that there would be a greater discrepancy between husbands’ and wives’ reports on this variable in depressed couples.

Control of surplus spending money

5a Compared with non-depressed couples, do members of couples containing depressed wives report greater control of surplus spending money?

5b Compared with non-depressed couples, do members of couples containing depressed wives report greater control of surplus spending money when differences in marital satisfaction have been taken into account?

5c Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ control of surplus spending money in couples containing depressed wives?

5d Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ control of surplus spending money in couples containing depressed wives when differences in marital satisfaction have been taken into account?

5e Compared with non-depressed couples, is there a greater correlation between husbands’ and wives’ control of surplus spending money in couples containing depressed wives?

The hypothesis about control of surplus spending money was that depressed wives would report lower control of surplus spending money than their husbands or non-depressed wives.

Desired control of surplus spending money

6a Compared with non-depressed couples, do members of couples containing depressed wives report greater levels of desired control of surplus spending money?

6b Compared with non-depressed couples, do members of couples containing depressed wives report greater levels of desired control of surplus spending money when differences in marital satisfaction have been taken into account?

6c Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ levels of desired control of surplus spending money in depressed couples?
6d Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ levels of desired control of surplus spending money in couples containing depressed wives when differences in marital satisfaction have been taken into account?

6e Compared with non-depressed couples, is there a greater correlation between husbands’ and wives’ levels of desired control of surplus spending money in couples containing depressed wives?

The hypothesis about desired control of surplus spending money was that depressed wives would report higher levels of desired control of surplus spending money, and that there would be a greater discrepancy between husbands’ and wives’ reports on this variable in depressed couples.

**Satisfaction with control of surplus spending money**

7a Compared with non-depressed couples, do members of couples containing depressed wives report different levels of satisfaction with control of surplus spending money?

7b Compared with non-depressed couples, do members of couples containing depressed wives report different levels of satisfaction with control of surplus spending money when differences in marital satisfaction have been taken into account?

7c Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ levels of satisfaction with control of surplus spending money in couples containing depressed wives?

7d Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ levels of satisfaction with control of surplus spending money in couples containing depressed wives when differences in marital satisfaction have been taken into account?

7e Compared with non-depressed couples, is there a greater correlation between husbands’ and wives’ levels of satisfaction with control of surplus spending money in couples containing depressed wives?

The hypothesis about desired control of surplus spending money was that depressed wives would report lower levels of satisfaction with control of surplus spending money than their husbands or non-depressed wives.

**Commitment to the relationship**

8a Compared with non-depressed couples, do members of couples containing depressed wives report different levels of commitment?

8b Compared with non-depressed couples, do members of couples containing depressed wives report different levels of commitment when differences in marital satisfaction have been taken into account?
8c Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ levels of commitment in couples containing depressed wives?

8d Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ levels of commitment in couples containing depressed wives when differences in marital satisfaction have been taken into account?

8e Compared with non-depressed couples, is there a greater correlation between husbands’ and wives’ levels of commitment in couples containing depressed wives?

The hypothesis about commitment was that depressed wives would report higher levels of commitment than their husbands or non-depressed wives.

*Sex role attitudes*

9a Compared with non-depressed couples, do members of couples containing depressed wives report different sex role attitudes?

9b Compared with non-depressed couples, do members of couples containing depressed wives report different sex role attitudes when differences in marital satisfaction have been taken into account?

9c Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ sex role attitudes in couples containing depressed wives?

9d Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ sex role attitudes in couples containing depressed wives when differences in marital satisfaction have been taken into account?

9e Compared with non-depressed couples, is there a greater correlation between husbands’ and wives’ sex role attitudes in couples containing depressed wives?

The hypothesis about sex role attitudes was that depressed wives would report more feminine sex role attitudes and that there would be a larger discrepancy in sex role attitudes between members of depressed couples relative to members of non-depressed couples.

*Desired level of intimacy*

10a Compared with non-depressed couples, do members of couples containing depressed wives report different desired levels of intimacy?

10b Compared with non-depressed couples, do members of couples containing depressed wives report different desired levels of intimacy when differences in marital satisfaction have been taken into account?

10c Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ desired levels of intimacy in couples containing depressed wives?
Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ desired levels of intimacy in couples containing depressed wives when differences in marital satisfaction have been taken into account?

Compared with non-depressed couples, is there a greater correlation between husbands’ and wives’ desired levels of intimacy in couples containing depressed wives?

The hypothesis about desired level of intimacy was that depressed wives would report higher levels of desired intimacy, and that there would be a greater discrepancy between husbands and wives on this variable in depressed couples relative to non-depressed couples.

**Physical aggression from partner**

Compared with non-depressed couples, do members of couples containing depressed wives report different levels of physical aggression?

Compared with non-depressed couples, do members of couples containing depressed wives report different levels of physical aggression when differences in marital satisfaction have been taken into account?

Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ reported levels of physical aggression in couples containing depressed wives?

Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ reported levels of physical aggression in couples containing depressed wives when differences in marital satisfaction have been taken into account?

Compared with non-depressed couples, is there a greater correlation between husbands’ and wives’ reports of physical aggression in couples containing depressed wives?

The hypothesis about physical aggression was that depressed wives would report higher levels of physical aggression from their partners.

**Overt psychological aggression towards partner**

Compared with non-depressed couples, do members of couples containing depressed wives report different levels of overt aggression?

Compared with non-depressed couples, do members of couples containing depressed wives report different levels of overt aggression when differences in marital satisfaction have been taken into account?

Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ reports of overt aggression in couples containing depressed wives?
Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ reports of overt aggression in couples containing depressed wives when differences in marital satisfaction have been taken into account?

Compared with non-depressed couples, is there a greater correlation between husbands’ and wives’ reports of overt aggression in couples containing depressed wives?

The hypothesis about overt psychological aggression towards partner was that members of couples where the wife was depressed would report lower levels of overt aggression than members of couples where the wife was not depressed.

**Passive psychological aggression towards partner**

Compared with non-depressed couples, do members of couples containing depressed wives report different levels of passive aggression?

Compared with non-depressed couples, do members of couples containing depressed wives report different levels of passive aggression when differences in marital satisfaction have been taken into account?

Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ reports of passive aggression in couples containing depressed wives?

Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ reports of passive aggression in couples containing depressed wives when differences in marital satisfaction have been taken into account?

Compared with non-depressed couples, is there a greater correlation between husbands’ and wives’ passive aggression in couples containing depressed wives?

The hypothesis about passive aggression was that couples containing a depressed wife would report higher levels of passive aggression relative to non-depressed couples.

**Power processes**

*Husband demand - wife withdraw behaviour*

Compared with non-depressed couples, do members of couples containing depressed wives report different levels of husband demand - wife withdraw behaviour?

Compared with non-depressed couples, do members of couples containing depressed wives report different levels of husband demand - wife withdraw behaviour when differences in marital satisfaction have been taken into account?
14c Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ reports of husband demand - wife withdraw behaviour in couples containing depressed wives?

14d Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ reports of husband demand - wife withdraw behaviour in couples containing depressed wives when differences in marital satisfaction have been taken into account?

14e Compared with non-depressed couples, is there a greater correlation between husbands’ and wives’ reports of husband demand - wife withdraw behaviour in couples containing depressed wives?

The hypothesis about husband demand - wife withdraw behaviour was that couples containing a depressed wife would report more husband demand - wife withdraw behaviour relative to non-depressed couples.

Wife demand - husband withdraw behaviour

15a Compared with non-depressed couples, do members of couples containing depressed wives report different levels of wife demand - husband withdraw behaviour?

15b Compared with non-depressed couples, do members of couples containing depressed wives report different levels of wife demand - husband withdraw behaviour when differences in marital satisfaction have been taken into account?

15c Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ reports of wife demand - husband withdraw behaviour in couples containing depressed wives?

15d Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ reports of wife demand - husband withdraw behaviour in couples containing depressed wives when differences in marital satisfaction have been taken into account?

15e Compared with non-depressed couples, is there a greater correlation between husbands’ and wives’ reports of wife demand - husband withdraw behaviour in couples containing depressed wives?

The hypothesis about wife demand - husband withdraw behaviour was that couples containing a depressed wife would report more wife demand - husband withdraw behaviour relative to non-depressed couples.
Total demand - withdraw behaviour

16a Compared with non-depressed couples, do members of couples containing depressed wives report different levels of total demand - withdraw behaviour?

16b Compared with non-depressed couples, do members of couples containing depressed wives report different levels of total demand - withdraw behaviour when differences in marital satisfaction have been taken into account?

16c Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ reports of total demand - withdraw behaviour in couples containing depressed wives?

16d Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ reports of total demand - withdraw behaviour in couples containing depressed wives when differences in marital satisfaction have been taken into account?

16e Compared with non-depressed couples, is there a greater correlation between husbands’ and wives’ reports of total demand - withdraw behaviour in couples containing depressed wives?

The hypothesis about total demand - withdraw behaviour was that members of depressed couples would report more total demand - withdraw behaviour than members of non-depressed couples.

Mutual constructive communication

17a Compared with non-depressed couples, do members of couples containing depressed wives report different levels of mutual constructive communication?

17b Compared with non-depressed couples, do members of couples containing depressed wives report different levels of mutual constructive communication when differences in marital satisfaction have been taken into account?

17c Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ reports of mutual constructive communication in couples containing depressed wives?

17d Compared with non-depressed couples, is there a greater discrepancy between husbands’ and wives’ reports of mutual constructive communication in couples containing depressed wives when differences in marital satisfaction have been taken into account?

17e Compared with non-depressed couples, is there a greater correlation between husbands’ and wives’ reports of mutual constructive communication in couples containing depressed wives?

The hypothesis about mutual constructive communication was that members of depressed couples would report less mutual constructive communication than members of non-depressed couples.
Power outcomes

Partner does more household tasks

18a Compared with non-depressed couples, do members of couples containing depressed wives report that their partners do more household tasks?

18b Compared with non-depressed couples, do members of couples containing depressed wives report that their partners do more household tasks when differences in marital satisfaction have been taken into account?

18c Compared with non-depressed couples, is there a greater discrepancy in couples containing depressed wives between husbands’ and wives’ reports concerning whether their partners do more household tasks?

18d Compared with non-depressed couples, is there a greater discrepancy in couples containing depressed wives between husbands’ and wives’ reports concerning whether their partners do more household tasks when differences in marital satisfaction have been taken into account?

18e Compared with non-depressed couples, is there a greater correlation in couples containing depressed wives between husbands’ and wives’ reports concerning whether their partners do more household tasks?

The hypothesis about partner does more household tasks was that there would be a greater discrepancy between husbands’ and wives’ reports on this variable in depressed couples relative to non-depressed couples.

Partner makes more family decisions

19a Compared with non-depressed couples, do members of couples containing depressed wives report that their partners make more family decisions?

19b Compared with non-depressed couples, do members of couples containing depressed wives report that their partners make more family decisions when differences in marital satisfaction have been taken into account?

19c Compared with non-depressed couples, is there a greater discrepancy in couples containing depressed wives between husbands’ and wives’ reports concerning whether their partners make more family decisions?

19d Compared with non-depressed couples, is there a greater discrepancy in couples containing depressed wives between husbands’ and wives’ reports concerning whether their partners make more family decisions when differences in marital satisfaction have been taken into account?
19e Compared with non-depressed couples, is there a greater correlation in couples containing depressed wives between husbands’ and wives’ reports concerning whether their partners make more family decisions?

The hypothesis about partner makes more family decisions was that there would be a greater discrepancy between husbands’ and wives’ reports on this variable in depressed couples relative to non-depressed couples.

**Partner more involved in child care**

20a Compared with non-depressed couples, do members of couples containing depressed wives report that their partners are more involved in child care?

20b Compared with non-depressed couples, do members of couples containing depressed wives report that their partners are more involved in child care when differences in marital satisfaction have been taken into account?

20c Compared with non-depressed couples, is there a greater discrepancy in couples containing depressed wives between husbands’ and wives’ reports concerning whether their partners are more involved in child care?

20d Compared with non-depressed couples, is there a greater discrepancy in couples containing depressed wives between husbands’ and wives’ reports concerning whether their partners are more involved in child care when differences in marital satisfaction have been taken into account?

20e Compared with non-depressed couples, is there a greater correlation in couples containing depressed wives between husbands’ and wives’ reports concerning whether their partners are more involved in child care?

The hypothesis about partner more involved in child care was that there would be a greater discrepancy between husbands’ and wives’ reports on this variable in depressed couples relative to non-depressed couples.

**Satisfaction with household task distribution**

21a Compared with non-depressed couples, do members of couples containing depressed wives report different levels of satisfaction with household task distribution?

21b Compared with non-depressed couples, do members of couples containing depressed wives report different levels of satisfaction with household task distribution when differences in marital satisfaction have been taken into account?
21c Compared with non-depressed couples, is there a greater discrepancy in couples containing depressed wives between husbands’ and wives’ satisfaction with household task distribution?

21d Compared with non-depressed couples, is there a greater discrepancy in couples containing depressed wives between husbands’ and wives’ satisfaction with household task distribution when differences in marital satisfaction have been taken into account?

21e Compared with non-depressed couples, is there a greater correlation in couples containing depressed wives between husbands’ and wives’ satisfaction with household task distribution?

The hypothesis about satisfaction with household task distribution was that depressed couples would report less satisfaction with household task distribution, and that there would be a greater discrepancy between husbands’ and wives’ reports on this variable in depressed couples relative to non-depressed couples.

Satisfaction with family decision making distribution

22a Compared with non-depressed couples, do members of couples containing depressed wives report different levels of satisfaction with family decision making distribution?

22b Compared with non-depressed couples, do members of couples containing depressed wives report different levels of satisfaction with family decision making distribution when differences in marital satisfaction have been taken into account?

22c Compared with non-depressed couples, is there a greater discrepancy in couples containing depressed wives between husbands’ and wives’ satisfaction with family decision making distribution?

22d Compared with non-depressed couples, is there a greater discrepancy in couples containing depressed wives between husbands’ and wives’ satisfaction with family decision making distribution when differences in marital satisfaction have been taken into account?

22e Compared with non-depressed couples, is there a greater correlation in couples containing depressed wives between husbands’ and wives’ satisfaction with family decision making distribution?

The hypothesis about satisfaction with family decision making distribution was that depressed couples would report less satisfaction with the distribution of family decision making, and that there would be a greater discrepancy between husbands’ and wives’ reports on this variable in depressed couples relative to non-depressed couples.
Satisfaction with child care task distribution

23a Compared with non-depressed couples, do members of couples containing depressed wives report different levels of satisfaction with child care task distribution?

23b Compared with non-depressed couples, do members of couples containing depressed wives report different levels of satisfaction with child care task distribution when differences in marital satisfaction have been taken into account?

23c Compared with non-depressed couples, is there a greater discrepancy in couples containing depressed wives between husbands’ and wives’ satisfaction with child care task distribution?

23d Compared with non-depressed couples, is there a greater discrepancy in couples containing depressed wives between husbands’ and wives’ satisfaction with child care task distribution when differences in marital satisfaction have been taken into account?

23e Compared with non-depressed couples, is there a greater correlation in couples containing depressed wives between husbands’ and wives’ satisfaction with child care task distribution?

The hypothesis about satisfaction with child care task distribution was that depressed couples would report less satisfaction with the distribution of child care tasks, and that there would be a greater discrepancy between husbands’ and wives’ reports on this variable in depressed couples relative to non-depressed couples.
Chapter 3. Methodology

3.1 Participants

Both urban and rural General Practitioners were contacted initially by telephone and then by letter. They were asked to recruit couples who would be willing to anonymously complete an 8-page questionnaire (Appendix A). Of 520 questionnaires sent to 126 General Practitioners, 14 couples who fulfilled the following criteria returned completed questionnaires: (1) the woman’s age was between 25 and 45; (2) there was at least one young child (less than 5 years) in the family; (3) the woman was experiencing an episode of major depression; (4) there was an absence of psychotic symptoms, definite suicidal intentions, and substance dependence; (5) both spouses were willing to co-operate in the study.

Spouses were instructed to complete questionnaires independently of each other and to return their questionnaire in separate stamped, self-addressed envelopes that were provided. After completed questionnaires were received from both members of a couple, their General Practitioner was again contacted and asked to recruit a matching couple. The matching criteria were that couples: (1) had the same number and ages of children; (2) had the same income levels; and (3) were of a similar age (±5 years). As recruiting exactly matching couples was difficult to do, ‘best fit’ matches were accepted.

Demographic characteristics of both sets of couples are given in Table 2. From this table, it may be seen that the depressed couples were somewhat older and had been together longer.
Table 2  Demographic characteristics

<table>
<thead>
<tr>
<th>Variable</th>
<th>Non-depressed</th>
<th>Depressed</th>
<th>ANOVA Effects or chi-square</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>M 34.64</td>
<td>33.21</td>
<td>40.29</td>
</tr>
<tr>
<td></td>
<td>SD 5.93</td>
<td>5.66</td>
<td>6.21</td>
</tr>
<tr>
<td>Duration of relationship</td>
<td>M 11.29</td>
<td>11.29</td>
<td>17.00</td>
</tr>
<tr>
<td></td>
<td>SD 5.06</td>
<td>5.06</td>
<td>7.37</td>
</tr>
<tr>
<td>Number of children</td>
<td>M 1.93</td>
<td>1.93</td>
<td>2.21</td>
</tr>
<tr>
<td></td>
<td>SD 0.92</td>
<td>0.92</td>
<td>1.42</td>
</tr>
<tr>
<td>SES</td>
<td>Professional or managerial 1</td>
<td>% 0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>F 0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Professional or managerial 2</td>
<td>% 28.6</td>
<td>21.4</td>
<td>14.3</td>
</tr>
<tr>
<td></td>
<td>F 4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Clerical or skilled 3</td>
<td>% 7.1</td>
<td>28.6</td>
<td>35.7</td>
</tr>
<tr>
<td></td>
<td>F 1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Skilled manual</td>
<td>% 64.3</td>
<td>21.4</td>
<td>14.3</td>
</tr>
<tr>
<td></td>
<td>F 9</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Semi-skilled manual</td>
<td>% 0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>F 0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unskilled manual /Unemployed</td>
<td>% 0</td>
<td>28.6</td>
<td>28.6</td>
</tr>
<tr>
<td></td>
<td>F 0</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

Note: *: Significant difference at the p < .05 level. **: Significance difference at the p < .01 level.
2.2 Instruments

A set of psychological instruments were assembled to assess depression, marital satisfaction, dominance, and a variety of power bases, processes, and outcomes. These are listed below and permission to use them was received from the respective authors (refer to consent form, Appendix B). To assess the internal consistency reliability of all scales, Cronbach’s alpha (Cronbach, 1951) was computed. Where alphas below .7 were obtained, items that had the lowest correlation with the scale were dropped until the alpha reached or exceeded .7. This procedure ensured that all but one of the scales included in the study met minimal psychometric criteria for reliability. A summary of the results of the reliability analyses for all psychometric scales is contained in Table 4 and definitions of all the variables in the study are given in Table 5.

**Depression**

Two instruments were used to assess depression; the Beck Depression Inventory and a checklist of the criteria for depression from the Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition.

*Beck Depression Inventory (BDI).* The BDI (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) is the standard self-report depression scale used in the field. The BDI consistently correlates with clinical ratings of depression (Beck, Steer, & Garbin, 1988). A score of 14 or higher can be used to indicate the presence of depressive symptomatology or dysphoria (Taylor & Klein, 1989). In this sample, Cronbach’s alpha was .94 for this scale.

*Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV) checklist for Major Depressive Episode.* Using the DSM-IV (American Psychiatric Association, 1994) criteria for major depressive disorder, a 9-item depression checklist was constructed. Participants were asked to indicate if they had experienced each symptom during the past two weeks. Response categories were either ‘yes or no’ or ‘decrease or same as usual or increase’. A BDI score of 14 or higher coupled with endorsement of five DSM-IV criteria was taken to signify the presence of major depressive disorder. Cronbach’s alpha for this sample was .94 for this checklist.
Marital satisfaction

*Dyadic Satisfaction scale.* The 10-item Dyadic Satisfaction subscale of Dyadic Adjustment Scale (DAS; Spanier, 1976) was used to obtain spouses’ behavioural measures of marital satisfaction. The 32-item DAS has four subscales: Dyadic Consensus, Dyadic Cohesion, Affectional Expression, and Dyadic Satisfaction. To avoid any confounding of satisfaction and communication measures, only the Dyadic Satisfaction subscale was used. This scale has been shown to provide clinicians with a reliable measure of dyadic satisfaction in community couples (e.g., Aida & Falbo, 1991; Heavey, Christensen, & Malamuth, 1995). Cronbach’s alpha for this scale was .89 with this sample. For the ANCOVAs reported in the results section, the combined couple marital satisfaction was used as the covariate. These analyses examined the effects of depression over and above that due to marital satisfaction on dependent variables.

Dominance

The question ‘Who is the dominant partner in your relationship?’ was answered using a 7-point Likert scale ranging from ‘I am a lot more dominant’ to ‘My partner is a lot more dominant’.

Power bases

*Income*

Participants’ income was graded using an Irish census-based social class scale which identified 6 social classes (Table 3: O’Hare, Whelan, & Commins, 1991). Individuals who were unemployed were classified as belonging to social class or income level 6.

Table 3. Social class scale

<table>
<thead>
<tr>
<th>Social class</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Higher professional and higher managerial; proprietors and farmers owning 200 or more acres</td>
</tr>
<tr>
<td>2</td>
<td>Lower professional and lower managerial; proprietors and farmers owning 100-199 acres</td>
</tr>
<tr>
<td>3</td>
<td>Other non-manual and farmers owning 50-99 acres</td>
</tr>
<tr>
<td>4</td>
<td>Skilled manual and farmers owning 30-49 acres</td>
</tr>
<tr>
<td>5</td>
<td>Semi-skilled manual and farmers owning less than 30 acres</td>
</tr>
<tr>
<td>6</td>
<td>Unskilled manual</td>
</tr>
</tbody>
</table>
Spouse-Specific Aggression scale. The Spouse-Specific Assertiveness/Aggression Scale (O’Leary & Curley, 1986) is a 29-item scale composed of two subscales: Spouse-Specific Aggression (SSAG) and Spouse-Specific Assertiveness. The SSAG scale has been found to be associated with both marital discord and spousal abuse (O’Leary & Curley, 1986; Rosenbaum & O’Leary, 1981). Although an alpha of .92 was obtained for the SSAG with the sample in the present study, it was suspected that the scale was not unidimensional. A principal component analysis with varimax rotation was conducted to identify the main factors constituting the 12-item instrument. A two factor solution which accounted for 65.6 of the variance was obtained. Factor 1 accounted for 55% of the variance and factor 2 accounted for 11% of the variance. Eight items (1, 2, 3, 4, 5, 6, 7, and 12) loaded on factor 1 which was interpreted as an index of overt psychological aggression. Three items (9, 10, 11) loaded on factor 2 which was interpreted as an index of passive aggression. As Cronbach’s alphas for psychological aggression and passive aggression scales were robust for the sample under investigation (.91 and .85 respectively), they were included in place of the original aggression scale in subsequent analyses.

Physical Assault scale. The Revised Conflict Tactics Scale (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) is a 78-item scale designed to assess psychological and physical attacks on a partner in a marital, cohabiting, or dating relationship; and also use of negotiation. It was developed primarily to improve on the content validity and reliability of the Conflict Tactics Scale (Straus, 1979, 1990a). This study used the 12-item physical aggression subscale of the CTS2, and its reliability was .93 for the sample studied.

The physical aggression subscale is scored by adding the midpoints for the response categories chosen by the participant. The midpoints are the same as the response category numbers for Categories 0, 1, and 2. For category 3 (3-5 times) the midpoint is 4, for Category 4 (6-10 times) it is 8, for Category 5 (11-20 times) it is 15, and for Category 6 (More than 20 times in the past year) the recommended midpoint is 25. Category 7 is typically scored as 0.
Sex Role Attitudes
The Sex Role Attitudes Scale (Huber & Spitze, 1983) was used to assess sex role attitudes. This 6-item scale has been shown to provide a reliable measure of sex role attitudes (e.g., Mirowsky, 1985). For the present study, the response categories were strongly disagree (coded 1), disagree (2), neutral (3), agree (4), and strongly agree (5). Cronbach’s alpha for this scale with this sample was .84.

Commitment
Commitment was measured using item number 10 of the DAS Satisfaction subscale (Spanier, 1976), as has been done in other studies (e.g., Scanzoni & Godwin, 1990).

Closeness and Independence Scale
This is a newly-developed 6-item scale (Christensen, under development) which assesses the degree to which partners want independence or intimacy in their relationship. The alpha reliability for this scale with the present sample was .82.

Social Desirability Scale
The 10-item short form of the Marlowe-Crowne Social Desirability Scale (Reynolds, 1982) was used to measure the social desirability of participants’ responses. This scale is a shorter version of the original 33-item Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960). For the present study, the alpha reliability for the short form of this scale was .89.

Power processes
Communication Patterns Questionnaire - Short Form (CPQSF)
This scale contains 11 items that describe both symmetrical interaction patterns and asymmetrical (demand / withdraw) interaction patterns when a problem arises and when discussing relationship problems. The reliability and validity of both the 35-item Communication Patterns Questionnaire and the CPQSF have been demonstrated in numerous studies (e.g., Heavey, Larson, Zumtobel, & Christensen, 1996; Klinetob & Smith, 1996). Spouses rated the likelihood that each interaction pattern applied to their relationship over the previous year (from 1 = very unlikely to 9 = very likely).
The alpha reliabilities of the demand / withdraw subscales have been found to vary between .50 and .85, with a mean of .75 for wife demand - husband-withdraw interaction and .66 for husband demand - wife withdraw interaction (Christensen & Heavey, 1990; Christensen & Shenk, 1991; Heavey, Layne, & Christensen, 1993; Klinetob & Smith, 1996). In this study, alpha reliabilities of .69 for wife demand - husband withdraw and of .74 for husband demand - wife withdraw interaction were obtained by omitting 1 item in each scale. Consequently, 2 items were left out of the total demand-withdraw scale to give an alpha reliability of .70. The 3 item mutual constructive communication scale had an alpha reliability of .71.

**Power outcomes**

*Who Does What (WDW)*

The Who Does What (WDW: Cowan, Cowan, & Coysh, 1983) scale is an instrument designed to assess husbands’ and wives’ ideals and perceptions of their relative responsibilities for household tasks, family decision making, and the caring and rearing of children. For each of the 37 scale items, individuals indicate “how it is now” and “how I would like it to be,” on a scale ranging from 1 (“I do it all”), through 5 (“we do it equally”), to 9 (“he/she does it all”). There are 13 items which measure household tasks, 12 items which measure decision making, and 12 items which measure child rearing. For each of the 3 domain areas, 3 scores are provided: (i) role arrangement, which is found by averaging the responses to “how it is now” (range: 1-9, with higher scores indicating greater partner involvement); (ii) egalitarianism / task sharing, which is found by averaging the absolute differences between “how it is now” and 5 (we both do this about equally), (range 0-4, with higher scores indicating greater inequality); and (iii) role strain / satisfaction, which is found by averaging the absolute differences between “how I would like it to be” and “how it is now” (range 0-8, with higher scores indicating greater dissatisfaction).

For this study, only role arrangement and role satisfaction were considered for each of the 3 domains. Due to low alpha reliabilities, some items needed to be dropped from the original scales (refer to Table 4). The scales used (and their reliabilities) were: partner did more household tasks (.76), partner did more decision making (.70), partner more involved in child care (.92), dissatisfaction with household task distribution (.75), dissatisfaction with decision making distribution (.70), and
dissatisfaction with child care task distribution (.87). The latter 3 alpha values were computed by averaging the reliabilities for “how it is now” and the “how I would like it to be” scales for each respective domain.
Table 4  Reliabilities of scales

<table>
<thead>
<tr>
<th>Variable</th>
<th>No. of items in scale</th>
<th>Modification to original scale</th>
<th>Cronbach's alpha</th>
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<td>.94</td>
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<tr>
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<td>9</td>
<td>DSM IV diagnostic criteria for major depressive disorder</td>
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<tr>
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<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
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<tr>
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</tr>
<tr>
<td>Income</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Economic dependence on partner</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control of surplus spending money</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Desired control of surplus spending money</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dissatisfaction with control of surplus spending money</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commitment to relationship</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex role attitudes</td>
<td>6</td>
<td>None</td>
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<td>None</td>
<td>.82</td>
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<tr>
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<td>12</td>
<td>None</td>
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</tr>
<tr>
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<td>8</td>
<td>Factor analysed the original 12-item scale and dropped 4 items</td>
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</tr>
<tr>
<td>Passive aggression towards partner</td>
<td>3</td>
<td>Factor analysed the original 12-item scale and dropped 9 items</td>
<td>.85</td>
</tr>
<tr>
<td>Power processes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husband demand - wife withdraw behaviour</td>
<td>2</td>
<td>Dropped 1 of the original 3 items</td>
<td>.69</td>
</tr>
<tr>
<td>Wife demand - husband withdraw behaviour</td>
<td>2</td>
<td>Dropped 1 of the original 3 items</td>
<td>.74</td>
</tr>
<tr>
<td>Total demand - withdraw behaviour</td>
<td>4</td>
<td>Dropped 2 of the original 6 items</td>
<td>.70</td>
</tr>
<tr>
<td>Mutual constructive communication</td>
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<td>None</td>
<td>.71</td>
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<td>Power outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner did more household tasks</td>
<td>10</td>
<td>Dropped 3 of the original 13 items</td>
<td>.76</td>
</tr>
<tr>
<td>Partner did more decision making</td>
<td>8</td>
<td>Dropped 4 of the original 12 items</td>
<td>.70</td>
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<td>Partner more involved in child care</td>
<td>12</td>
<td>None</td>
<td>.92</td>
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<td>Dropped 6 of the original 26 items</td>
<td>*.75</td>
</tr>
<tr>
<td>Dissatisfaction with decision making distribution</td>
<td>16</td>
<td>Dropped 8 of the original 24 items</td>
<td>*.70</td>
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<tr>
<td>Dissatisfaction with child care task distribution</td>
<td>24</td>
<td>None</td>
<td>*.87</td>
</tr>
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</table>

Note: *: These are composite reliabilities derived from two scales (the actual and the desired distribution of tasks).
<table>
<thead>
<tr>
<th>Table 5 Definitions of all variables</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Variable</strong></td>
</tr>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>Beck Depression Inventory</td>
</tr>
<tr>
<td>DSM IV based depressive scale</td>
</tr>
<tr>
<td>Marital duration, problems, and satisfaction</td>
</tr>
<tr>
<td>Duration of relationship problems</td>
</tr>
<tr>
<td>Marital satisfaction</td>
</tr>
<tr>
<td>Dominance</td>
</tr>
<tr>
<td>Power bases</td>
</tr>
<tr>
<td>Income</td>
</tr>
<tr>
<td>Economic dependence on partner</td>
</tr>
<tr>
<td>Control of surplus spending money</td>
</tr>
<tr>
<td>Desired control of surplus spending money</td>
</tr>
<tr>
<td>Dissatisfaction with control of surplus spending money</td>
</tr>
<tr>
<td>Commitment to relationship</td>
</tr>
<tr>
<td>Sex role attitudes</td>
</tr>
<tr>
<td>Desired level of intimacy</td>
</tr>
<tr>
<td>Physical aggression from partner</td>
</tr>
<tr>
<td>Overt psychological aggression towards partner</td>
</tr>
<tr>
<td>Passive aggression towards</td>
</tr>
<tr>
<td>Power processes</td>
</tr>
<tr>
<td>Husband demand - wife withdraw behaviour</td>
</tr>
<tr>
<td>Wife demand - husband withdraw behaviour</td>
</tr>
<tr>
<td>Total demand - withdraw behaviour</td>
</tr>
<tr>
<td>Mutual constructive communication</td>
</tr>
<tr>
<td>Power outcome</td>
</tr>
<tr>
<td>Partner did more household tasks</td>
</tr>
<tr>
<td>Partner did more decision making</td>
</tr>
<tr>
<td>Partner more involved in child care</td>
</tr>
<tr>
<td>Dissatisfaction with household task distribution</td>
</tr>
<tr>
<td>Dissatisfaction with decision making distribution</td>
</tr>
<tr>
<td>Dissatisfaction with child care task distribution</td>
</tr>
</tbody>
</table>
Chapter 4 Results

4.1 Data Analysis

The data collected in this study was managed in the following way. First, the raw data was entered item by item into a data file and verified by checking distributions and ranges. SPSS 6.1 was used for this and all subsequent analyses. Second, reliability analyses of all psychometric scales were conducted to ensure that all scales were sufficiently reliable to proceed with further analyses. The results of these reliability analyses (Table 4) have been presented in the previous chapter where the instruments are described. Third, relationships between all dependent variables and social desirability were conducted to determine the degree to which the validity of responses were compromised by social desirability response set. Fourth, to test hypotheses about inter-group differences between husbands and wives from marriages in which wives were and were not depressed, 2X2 (Depression X Gender) ANOVAs were conducted for all dependent variables. Fifth, a series of correlations between dependent variables and marital satisfaction were computed, many of which were quite large. Sixth, to test the hypotheses about the unique effects of depression on dependent variables by controlling for possible confounding effects of marital satisfaction, 2X2 (Depression X Gender) ANCOVAs were conducted with marital satisfaction as the covariate.

To test hypotheses about discrepancies between husbands and wives scores in couples containing a depressed member and those where there was no depression, discrepancy scores were then computed by subtracting husband and wives scores on each variable and comparing using t-tests. Eight, to test a similar set of hypotheses about the unique effects of depression on dependent variables by controlling for possible confounding effects of marital satisfaction, one-way ANCOVAs were conducted with depression as the independent variable with (couple) marital satisfaction as the covariate. Ninth, to test hypotheses about the relationship between husbands and wives scores on each variable across couples containing depressed and non-depressed wives, correlations between husbands’ and wives’ scores were computed on all dependent variables for the couples containing a depressed wife and those in which no partner was depressed. Finally, the results of these analyses were summarised, by profiling the unique features of couples containing a depressed wife, relative to control couples.
4.2 Results
The results will be presented, broadly speaking, in the order in which the analyses were conducted. First, correlations between all variables and social desirability and marital satisfaction (Table 6) will be given. Second, the results of the 2X2 ANOVAs and ANCOVAs (Table 7) will be presented. The results of the discrepancy analyses (Table 8) will be given next. Fourth, the correlational analyses (Table 9) will be described.

Following the above tables, there will be a verbal description of significant findings from these tables, complete with graphs (Figures 2 through 6) depicting significant interactions from the ANOVAs.

Summary profiles (Tables 13 & 14) will be presented in the discussion.
Table 6 Correlations between all variables and social desirability and marital satisfaction

<table>
<thead>
<tr>
<th>Variable</th>
<th>Correlation with social desirability</th>
<th>Correlation with marital satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Depression</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beck Depression Inventory</td>
<td>-.03</td>
<td>*-.47</td>
</tr>
<tr>
<td>DSM IV based depressive scale</td>
<td>.09</td>
<td>*-.44</td>
</tr>
<tr>
<td><strong>Marital duration, problems, and satisfaction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration of relationship problems</td>
<td>-.31</td>
<td>*-.52</td>
</tr>
<tr>
<td>Marital satisfaction</td>
<td>.18</td>
<td>*</td>
</tr>
<tr>
<td>Dominance</td>
<td>.18</td>
<td>-.20</td>
</tr>
<tr>
<td><strong>Power bases</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>.07</td>
<td>-.21</td>
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<tr>
<td>Economic dependence on partner</td>
<td>-.09</td>
<td>-.10</td>
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<tr>
<td>Control of surplus spending money</td>
<td>-.04</td>
<td>.17</td>
</tr>
<tr>
<td>Desired control of surplus spending money</td>
<td>.00</td>
<td>.15</td>
</tr>
<tr>
<td>Dissatisfaction with control of surplus spending money</td>
<td>.15</td>
<td>*-.35</td>
</tr>
<tr>
<td>Commitment to relationship</td>
<td>.14</td>
<td>*-.74</td>
</tr>
<tr>
<td>Sex role attitudes</td>
<td>-.03</td>
<td>*-.32</td>
</tr>
<tr>
<td>Desired level of intimacy</td>
<td>.06</td>
<td>.16</td>
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<tr>
<td>Physical aggression from partner</td>
<td>.08</td>
<td>-.29</td>
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<tr>
<td>Overt psychological aggression towards partner</td>
<td>.03</td>
<td>*-.42</td>
</tr>
<tr>
<td>Passive aggression towards partner</td>
<td>.11</td>
<td>*-.37</td>
</tr>
<tr>
<td><strong>Power processes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husband demand - wife withdraw behaviour</td>
<td>-.09</td>
<td>*-.48</td>
</tr>
<tr>
<td>Wife demand - husband withdraw behaviour</td>
<td>-.12</td>
<td>*-.35</td>
</tr>
<tr>
<td>Total demand - withdraw behaviour</td>
<td>-.13</td>
<td>*-.50</td>
</tr>
<tr>
<td>Mutual constructive communication</td>
<td>.06</td>
<td>*-.53</td>
</tr>
<tr>
<td><strong>Power outcome</strong></td>
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<td></td>
</tr>
<tr>
<td>Partner did more household tasks</td>
<td>-.21</td>
<td>.21</td>
</tr>
<tr>
<td>Partner did more decision making</td>
<td>.11</td>
<td>.01</td>
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<tr>
<td>Partner more involved in child care</td>
<td>-.21</td>
<td>.16</td>
</tr>
<tr>
<td>Dissatisfaction with household task distribution</td>
<td>-.01</td>
<td>*-.55</td>
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<td>-.25</td>
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<tr>
<td>Dissatisfaction with child care task distribution</td>
<td>-.06</td>
<td>*-.39</td>
</tr>
</tbody>
</table>

**Note:** *These correlations are considered significant (r > |.3 |) at p < .05.

From this table, it can be seen that correlations between the dependent variables and social desirability ranged from -.31 to .18 which suggests that responses were valid and uncontaminated by social desirability response set. However, 14 of the 25 dependent variables correlated with marital satisfaction (r > |.3 |), thus justifying the plan to conduct a set of ANCOVAs to evaluate the unique effects of depression independent of marital satisfaction.
<table>
<thead>
<tr>
<th></th>
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<tbody>
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<td>2.30</td>
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<td>**48.65</td>
<td>**94.22</td>
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<td>**49.55</td>
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<td>4.21</td>
<td>1.25</td>
<td>4.09</td>
<td>1.05</td>
<td>**79.83</td>
<td>**123.97</td>
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<td>3.93</td>
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<td>3.93</td>
<td>1.05</td>
<td>3.93</td>
<td>1.05</td>
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</table>

Note: *: Significant difference at the p < 0.05 level. **: Significant difference at the p < 0.01 level.
Table 7 Status of members of couples containing depressed and non-depressed wives on dependent variables (continued)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Non-depressed</th>
<th>Depressed</th>
<th>ANOVA Effects</th>
<th>ANCOVA Effects</th>
</tr>
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<tbody>
<tr>
<td>-----------------------------------------</td>
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<td>-----------</td>
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<tr>
<td><strong>Power processes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husband demand - wife withdraw behaviour</td>
<td>M: 7.00</td>
<td>4.64</td>
<td>7.29</td>
<td>11.29</td>
</tr>
<tr>
<td>SD: 4.74</td>
<td>3.13</td>
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<td>4.18</td>
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</tr>
<tr>
<td>Wife demand - husband withdraw behaviour</td>
<td>M: 7.29</td>
<td>6.21</td>
<td>11.79</td>
<td>8.07</td>
</tr>
<tr>
<td>SD: 5.24</td>
<td>4.82</td>
<td>3.75</td>
<td>4.71</td>
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</tr>
<tr>
<td>Total demand - withdraw behaviour</td>
<td>M: 14.29</td>
<td>10.85</td>
<td>19.08</td>
<td>19.36</td>
</tr>
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<td>SD: 9.55</td>
<td>6.84</td>
<td>4.67</td>
<td>6.39</td>
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<tr>
<td>Mutual constructive communication</td>
<td>M: 20.07</td>
<td>19.86</td>
<td>16.50</td>
<td>14.43</td>
</tr>
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<td>SD: 5.06</td>
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<td>6.14</td>
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<td><strong>Power outcome</strong></td>
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<td></td>
</tr>
<tr>
<td>Partner did more household tasks</td>
<td>M: 4.97</td>
<td>4.60</td>
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<tr>
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<td>Partner more involved in child care</td>
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<td>4.29</td>
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<tr>
<td>Dissatisfaction with household task distribution</td>
<td>M: 0.92</td>
<td>1.28</td>
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</tr>
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<td>SD: 0.62</td>
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<td>0.97</td>
<td>1.24</td>
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<tr>
<td>Dissatisfaction with decision making distribution</td>
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<td>0.49</td>
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<td>SD: 0.40</td>
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<td>Dissatisfaction with child care task distribution</td>
<td>M: 0.64</td>
<td>0.89</td>
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<td>SD: 0.77</td>
<td>0.70</td>
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</tbody>
</table>

Note: *: Significant difference at the p < .05 level. **: Significant difference at the p < .01 level.
Table 8  Status of members of couples containing depressed and non-depressed wives on discrepancy variables reflecting the difference between husbands and wives scores

<table>
<thead>
<tr>
<th>Variable</th>
<th>Non-depressed</th>
<th>Depressed</th>
<th>t test t</th>
<th>ANCOVA F</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Depression</strong></td>
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</tr>
<tr>
<td>Beck Depression Inventory</td>
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<tr>
<td></td>
<td>SD 1.44</td>
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<tr>
<td>DSM IV based depression scale</td>
<td>M 57</td>
<td>5.00</td>
<td><strong>73.44</strong></td>
<td><strong>60.78</strong></td>
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<td>SD 8.5</td>
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<td><strong>Marital duration, problems, and satisfaction</strong></td>
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<tr>
<td>Duration of relationship problems</td>
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<td>Marital satisfaction</td>
<td>M 4.29</td>
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<tr>
<td></td>
<td>SD 1.07</td>
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<td><strong>Power bases</strong></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Income</td>
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<td>2.21</td>
<td>1.98</td>
<td>.74</td>
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<tr>
<td></td>
<td>SD 1.21</td>
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<tr>
<td>Economic dependence on partner</td>
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<td>.77</td>
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<tr>
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<tr>
<td>Control of spending surplus money</td>
<td>M .50</td>
<td>1.29</td>
<td><strong>8.12</strong></td>
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<tr>
<td></td>
<td>SD .76</td>
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<td>Desired control of spending surplus money</td>
<td>M .21</td>
<td>.79</td>
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<tr>
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<td>SD .43</td>
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<td>Dissatisfaction with control of spending surplus money</td>
<td>M .29</td>
<td>.64</td>
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<td></td>
<td>SD .47</td>
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<td>SD .65</td>
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<td>3.86</td>
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<td>Desired level of intimacy</td>
<td>M 4.79</td>
<td>6.50</td>
<td>0.03</td>
<td>2.36</td>
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<tr>
<td></td>
<td>SD 7.00</td>
<td>5.65</td>
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<td>Physical aggression from partner</td>
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<td>3.36</td>
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<td></td>
<td>SD 1.08</td>
<td>8.70</td>
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<tr>
<td>Overt psychological aggression towards partner</td>
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<td>9.86</td>
<td>.23</td>
<td>.09</td>
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<tr>
<td></td>
<td>SD 6.77</td>
<td>8.23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Passive aggression towards partner</td>
<td>M 1.71</td>
<td>3.93</td>
<td><strong>8.58</strong></td>
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<td></td>
<td>SD 1.07</td>
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</table>

Note: *: Effects of depression significant at the p < .05 level. **: Effects of depression significant at the p < .01 level.
Table 8  Status of members of couples containing depressed and non-depressed wives on discrepancy variables reflecting the difference between husbands and wives scores (continued)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Non-depressed</th>
<th>Depressed</th>
<th>t test t</th>
<th>ANCOVA F</th>
</tr>
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<tr>
<td><strong>Power processes</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husband demand - wife withdraw behaviour</td>
<td>M 3.93</td>
<td>5.86</td>
<td>.12</td>
<td>.59</td>
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<td>SD</td>
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<td>3.53</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wife demand - husband withdraw behaviour</td>
<td>M 3.64</td>
<td>4.86</td>
<td>.81</td>
<td>.00</td>
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<tr>
<td>SD</td>
<td>4.53</td>
<td>3.51</td>
<td></td>
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<tr>
<td>Total demand - withdraw behaviour</td>
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<td>5.14</td>
<td>3.87</td>
<td>.21</td>
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<tr>
<td>SD</td>
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<td></td>
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<tr>
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<td>.21</td>
<td>.01</td>
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<tr>
<td>SD</td>
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<td>4.29</td>
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<tr>
<td><strong>Power outcome</strong></td>
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<tr>
<td>Partner did more household tasks</td>
<td>M 2.14</td>
<td>2.57</td>
<td>.11</td>
<td>.26</td>
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<td>SD</td>
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<td>Partner did more decision making</td>
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<td>.98</td>
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<td>SD</td>
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<td>1.13</td>
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<td></td>
</tr>
<tr>
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<td>**3.74</td>
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<tr>
<td>SD</td>
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<td>2.20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dissatisfaction with household task distribution</td>
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<td>1.43</td>
<td>**14.39</td>
<td>.50</td>
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<tr>
<td>SD</td>
<td>.68</td>
<td>1.14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dissatisfaction with decision making distribution</td>
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<td>.81</td>
<td>1.85</td>
<td>*6.56</td>
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<tr>
<td>SD</td>
<td>.46</td>
<td>.96</td>
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<td></td>
</tr>
<tr>
<td>Dissatisfaction with child care task distribution</td>
<td>.74</td>
<td>1.42</td>
<td>.00</td>
<td>.03</td>
</tr>
<tr>
<td>SD</td>
<td>.76</td>
<td>.81</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: *: Effects of depression significant at the p < .05 level. **: Effects of depression significant at the p < .01 level. : Effects of depression significant at the p = .06 level.
Table 9 Correlations between husbands and wives scores for couples containing depressed and non-depressed wives

<table>
<thead>
<tr>
<th>Variable</th>
<th>Non-depressed</th>
<th>Depressed</th>
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</thead>
<tbody>
<tr>
<td><strong>Depression</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beck Depression Inventory</td>
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<td>-.02</td>
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<td>DSM IV based depressive scale</td>
<td>.19</td>
<td>.37</td>
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<tr>
<td><strong>Marital duration, problems, and satisfaction</strong></td>
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<tr>
<td>Duration of relationship problems</td>
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<td>1.00</td>
</tr>
<tr>
<td>Marital satisfaction</td>
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<td>.60</td>
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<tr>
<td><strong>Dominance</strong></td>
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<td></td>
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<tr>
<td>Control of surplus spending money</td>
<td>.59</td>
<td>.64</td>
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<tr>
<td>Desired control of surplus spending money</td>
<td>.11</td>
<td>-.81</td>
</tr>
<tr>
<td>Dissatisfaction with control of surplus spending money</td>
<td>.34</td>
<td>.62</td>
</tr>
<tr>
<td>Commitment to relationship</td>
<td>.50</td>
<td>.26</td>
</tr>
<tr>
<td>Sex role attitude</td>
<td>.17</td>
<td>.26</td>
</tr>
<tr>
<td>Desired level of intimacy</td>
<td>.25</td>
<td>.08</td>
</tr>
<tr>
<td>Physical aggression from partner</td>
<td>-.08</td>
<td>.52</td>
</tr>
<tr>
<td>Overt psychological aggression towards partner</td>
<td>.30</td>
<td>.39</td>
</tr>
<tr>
<td>Passive aggression towards partner</td>
<td>.70</td>
<td>.11</td>
</tr>
<tr>
<td><strong>Power processes</strong></td>
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<td></td>
</tr>
<tr>
<td>Husband demand - wife withdraw behaviour</td>
<td>.18</td>
<td>-.08</td>
</tr>
<tr>
<td>Wife demand - husband withdraw behaviour</td>
<td>.34</td>
<td>.38</td>
</tr>
<tr>
<td>Total demand - withdraw behaviour</td>
<td>.27</td>
<td>.32</td>
</tr>
<tr>
<td>Mutual constructive communication</td>
<td>.29</td>
<td>.46</td>
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<tr>
<td><strong>Power outcome</strong></td>
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<td></td>
</tr>
<tr>
<td>Partner did more household tasks</td>
<td>-.79</td>
<td>-.76</td>
</tr>
<tr>
<td>Partner did more decision making</td>
<td>-.54</td>
<td>-.61</td>
</tr>
<tr>
<td>Partner more involved in child care</td>
<td>-.45</td>
<td>-.90</td>
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<tr>
<td>Dissatisfaction with household task distribution</td>
<td>.25</td>
<td>-.01</td>
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<tr>
<td>Dissatisfaction with decision making distribution</td>
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<td>.21</td>
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<tr>
<td>Dissatisfaction with child care task distribution</td>
<td>-.02</td>
<td>.52</td>
</tr>
</tbody>
</table>

Note: *: These correlations are considered significant ($r > |.3|$) at the p < .05 level.
**Results of ANOVAs**

For all dependent variables, 2 X 2 (Depression X Gender) ANOVAs were conducted to evaluate the impact of gender and depressed status on power bases, processes, and outcomes. From Table 7, it may be seen that main effects for depression (in the absence of a significant gender X depression interaction) were obtained on the following variables:

<table>
<thead>
<tr>
<th>Table 10 Main effects for depression</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Variable</strong></td>
</tr>
<tr>
<td>---------------</td>
</tr>
<tr>
<td>Duration of relationship problems</td>
</tr>
<tr>
<td>Marital satisfaction</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

In all instances, members of marriages in which the female was depressed scored more extremely on these variables (Table 10). Thus, compared with members of non-depressed couples, members of depressed couples reported relationship problems of longer duration, less commitment, and more overt and passive aggression. In addition, they reported more wife demand - husband withdraw and total demand - withdraw behaviour and less constructive communication. In terms of power outcomes, they reported greater dissatisfaction with decision making and household task distribution.

From Table 7, it may be seen that significant gender X depression interactions were obtained on the following variables:

<table>
<thead>
<tr>
<th>Table 11 Variables for which significant gender X depression interactions were found.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Power bases</strong></td>
</tr>
<tr>
<td>-----------------</td>
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<tr>
<td>Income</td>
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<td></td>
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</tbody>
</table>

These interactions are graphed in Figures 2 through 6.
Figure 2 Income across couples

Figure 3 Husband demand - wife withdraw behaviour across couples

Figure 4 Partner does more household tasks across couples

Figure 5 Partner more involved in child care across couples

Figure 6 Dissatisfaction with child care task distribution across couples
From Figure 2 it may be seen that depressed wives were of lower socio-economic status than non-depressed wives or husbands from either group. From Figure 3 it may be seen that while husbands in both types of couples reported similar levels of husband demand-wtife withdraw behaviour, depressed wives reported significantly more of this behaviour than non-depressed wives. From Figures 4 and 5, it may be seen that depressed wives reported that their husbands did fewer household tasks and less child care than non-depressed wives. From Figure 6 it may be seen that depressed wives were less satisfied with child care task distribution than their husbands or members of non-depressed couples.

Gender effects found in the analyses (Table 7) will not be discussed because they are not relevant to the questions addressed in this thesis.

Results of ANCOVAs
For all dependent variables, 2 X 2 (Depression X Gender) ANCOVAs were conducted to evaluate the impact of gender and depression status, independently of the effects associated with marital satisfaction, on power bases, processes, and outcomes. In these analyses, the combined husband and wives marital satisfaction scores was the covariate. Excluding variables where significant gender X depression interactions occurred, from Table 7 it may be seen that the main effects for depression, when those due to differences in marital satisfaction were controlled for through the inclusion of marital satisfaction as a covariate, were obtained for only passive aggression towards partner and dissatisfaction with distribution of decision making.

From Table 7 it may be seen that significant gender X depression interactions were obtained in the ANCOVAs on the same variables as found in the ANOVAs (Table 11). Thus, when differences due to marital dissatisfaction across depressed and non-depressed couples were taken into account, depressed wives were of lower socio-economic status, reported more of husband demand - wife withdraw behaviour, reported that their husbands did fewer household and child care tasks, and were less satisfied with child care task distribution.
Results of the t-tests on discrepancy scores

To evaluate the effects of depression on differences between husbands’ and wives’ scores on dependent variables, husband-wife discrepancy scores were calculated for all variables and compared using t-tests. From Table 8 it may be seen that depressed and non-depressed couples differed on six variables:

Table 12 Variables on which depressed and non-depressed couples differed.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Power bases</th>
<th>Power outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration of relationship problems</td>
<td>Actual control of surplus spending money</td>
<td>Partner more involved in child care</td>
</tr>
<tr>
<td></td>
<td>Desired control of surplus spending money</td>
<td>Dissatisfaction with household task distribution</td>
</tr>
<tr>
<td></td>
<td>Passive aggression towards partner</td>
<td></td>
</tr>
</tbody>
</table>

Thus, in depressed couples, there was a bigger discrepancy between husbands’ and wives’ scores on how long they had marital problems, how surplus spending money was controlled and how they would have liked it to be controlled, the amount of passive aggression used, how much partners were involved in child care, and in dissatisfaction with household task distribution.

Results of the ANCOVAs on discrepancy scores

ANCOVAs were conducted to evaluate the effects of depression on husband-wife discrepancy scores independently of the effects associated with marital satisfaction. In these analyses the combined husbands’ and wives’ satisfaction scores was the covariate. From Table 8 it may be seen that depressed and non-depressed couples differed on passive aggression, partner contribution to decision making, and dissatisfaction with decision making distribution.

Results of the correlational analyses

To evaluate the degree to which marital partners’ status on dependent variables were correlated for both depressed and non-depressed couples, correlations between husbands’ and wives’ scores on each variable were computed. High correlations would suggest a degree of rigidity where the presence of one type of behaviour in a partner is strongly related to a similar type of behaviour (although not necessarily a similar level of behaviour) in the other partner. These correlations are presented in
Table 9. In the area of relationship difficulties, there was a much greater correlation between marital satisfaction in depressed \((r = .6)\) compared with non-depressed \((r = .3)\) couples. For desire to control surplus spending money, a large correlation between husbands' and wives' in depressed couples was evident \((r = -.81)\), whereas for non-depressed couples, the correlation was negligible \((r = .11)\). For physical aggression towards partner, the correlation for depressed couples \((r = .52)\) was far greater than that for non-depressed couples \((r = -.08)\). For passive aggression, the opposite pattern was evident, with non-depressed couples \((r = .70)\) obtaining a large correlation and depressed couples obtaining a negligible correlation \((r = .11)\). For dissatisfaction with child care task distribution, depressed couples obtained a large correlation \((r = .5)\) compared with non-depressed couples.

Taken together, these results suggest that certain rigid predictable relational patterns characterised depressed couples, these patterns differing from those of non-depressed couples. Within depressed couples, it was more likely that one partner's level of satisfaction was associated with that of the other; that one partner's reported desire to have control of surplus spending money was associated with another's denial of this wish; that one partner's aggression was associated with the other's level of aggression; and that dissatisfaction with child care on the part of one partner was related to the level of dissatisfaction with this issue in the other partner. In contrast, in non-depressed couples, there was a less rigid relationship between one partner's status on these variables and the status of the other partner, suggesting greater relational flexibility.
Chapter 5 Discussion

5.1 Overview of results

Depressed wives and their husbands reported more depressive symptomatology, were more dissatisfied with their marriages, and had relationship problems of longer duration than their non-depressed counterparts.

Regardless of whether the wife was depressed or not, both wives and husbands believed that wives were slightly more dominant in marriage.

The main effects found for depression (in the absence of a significant gender X depression interaction) were that members of couples where the wife was depressed reported less commitment to their marriages, and greater overt and passive aggression. In addition, they reported more wife demand - husband withdraw and total demand - withdraw behaviour and less constructive communication. In terms of power outcomes, they reported greater dissatisfaction with decision making and household task distribution.

A number of significant gender X depression interactions were found (Figures 2 through 6). Depressed wives were of lower socio-economic status than non-depressed wives or husbands from either group. While husbands in both types of couples reported similar levels of husband demand - wife withdraw behaviour, depressed wives reported significantly more of this behaviour than non-depressed wives. Depressed wives also reported that their husbands did fewer household tasks and less child care than non-depressed wives, and that they were less satisfied with child care task distribution than their husbands or members of non-depressed couples.

Excluding variables where significant gender X depression interactions occurred and controlling for the effects of marital satisfaction, only passive aggression towards partner and dissatisfaction with distribution of decision making distinguished depressed couples from non-depressed couples.
The results of t-tests on discrepancy scores indicate that in depressed couples, there was a bigger discrepancy between husbands’ and wives’ scores on how long they had marital problems, how surplus spending money was controlled and how they would have liked it to be controlled, the amount of passive aggression used, how much partners were involved in child care, and in dissatisfaction with household task distribution. Controlling for the effects of marital satisfaction on discrepancy scores, depressed and non-depressed couples differed only on passive aggression, partner contribution to decision making, and dissatisfaction with decision making distribution.

From correlations between husbands’ and wives’ scores on each variable, it is evident that within depressed couples, it was more likely that one partner’s level of satisfaction was associated with that of the other; that one partner’s reported desire to have control of surplus spending money was associated with another’s denial of this wish; that one partner’s physical aggression was associated with the other’s level of physical aggression; and that dissatisfaction with child care on the part of one partner was related to the level of dissatisfaction with this issue in the other partner. In contrast, in non-depressed couples, there was a less rigid relationship between one partner’s status on these variables and the status of the other partner, suggesting greater relational flexibility.

Summary profiles of the unique features of couples containing both depressed and non-depressed wives are presented in Tables 13 and 14.

5.2 How findings relate to hypotheses and exploratory questions

Marital satisfaction
As hypothesised, members of couples containing depressed wives reported lower levels of marital satisfaction (F = 28.71, p < .01), their reports being highly correlated (r = .6).

Dominance
Combined husband and wife means of 3.50 (non-depressed couples) and 3.86 (depressed couples) on the dominance scale (4 = neutral dominance on a scale of 1 to 7) indicate that spouses reported that wives had slightly more dominance in marriage
This difference remained significant even when marital satisfaction was controlled for \( F = 5.14, p < .05 \). More significantly, that there was no difference in perceived dominance in couples where the wife was depressed suggests that the presence of depression was associated with approximate egalitarianism and not with a ‘one-down’ position for the index spouse as is typically assumed. Hence, this finding does not support the hypothesis that depressed wives would view their husbands as more dominant.

However, another interpretation of this finding is possible. The husbands, although more powerful and able to exert control, may have chose not to exercise their potential, whereas the wives, although less powerful, appeared dominant because the husbands failed to counteract their wives’ control attempts (Szinovacz, 1987). This may have been particularly true of depressed couples; high wife scores for demand behaviour (reported by husbands), and for overt and passive aggression support the possibility that depressed wives engaged in a high level of control behaviours relative to their spouses. However, the moderate scores for husbands on these variables suggests that husbands did choose to exercise whatever potential they had.

**Power bases**

**Income**

As hypothesised, in both depressed and non-depressed couples, wives had a lower level of income than their husbands independent of the effects of marital satisfaction \( F = 17.38, p < .01 \), this discrepancy being larger in depressed couples (Figure 2). Resource theorists argue that such economic advantages alone afford husbands a greater portion of the marital ‘power cake’, partly due to having the husbands’ potential to deprive their wives economically (Walker, 1979). Furthermore, depressed wives lack of stabilised economic power may have compromised their personal preferences with regard to their fertility patterns (Blumberg, 1984).

However, it could be argued that depressed women, although acting from a position of structural weakness in being unemployed (all but one of them were unemployed), they were able to avoid the possibility of ‘role overload’. Indeed, it is possible that spousal depression forced reluctant husbands into an over-functioning role, whereby they had
to become the sole breadwinner in the family. This may have led to resentment in husbands, particularly if their wives had been contributing financially before becoming depressed.

**Economic dependence on partner**

Both depressed and non-depressed wives were more economically dependent on their husbands ($F = 12.10, p < .05$), but contrary to the hypothesis on economic dependence, depressed wives were no more economically dependent than non-depressed wives. Economic independence appears to represent a generic power base for men. However, due to the institutionalised aspects of wives' financial dependence, husbands may have felt a greater obligation to remain in their marriages and may have felt burdened with having to support their families (Howard, Blumstein, & Schwartz, 1986).

**Control of surplus spending money**

There were no differences across couples in perceptions of who made decisions as to how surplus money would be spent. There was a large difference in discrepancy scores across couples ($t = 8.12, p < .01$), but was an artefact of the influence of marital satisfaction. That there were large negative correlations for both non-depressed and depressed couples ($r = -59$ and $-64$ respectively) suggests that there was a high degree of rigidity with regard to control of surplus spending money.

There were no differences across couples in desired level of control of surplus spending money. There was a large difference in discrepancy scores across couples ($t = 7.31, p < .05$), but this finding was also due to the influence of marital satisfaction. That there was a low correlation for this variable in non-depressed couples ($r = .11$) and a high correlation for depressed couples ($r = -.81$) suggests that there was a high degree of rigidity with regard to desired control of surplus spending money in depressed couples.

With respect to satisfaction with control of surplus spending money, as hypothesised, depressed wives reported more dissatisfaction ($F = 4.43, p < .05$), but this finding was not independent of the effects of marital satisfaction. High correlations between spouses' reports of satisfaction with control of surplus spending money, especially in
Table 13 Summary of characteristics of members of couples containing depressed and non-depressed wives

<table>
<thead>
<tr>
<th>Variable</th>
<th>Significant after controlling for marital satisfaction</th>
<th>Non-depressed</th>
<th>Depressed</th>
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<tbody>
<tr>
<td><strong>Depression</strong></td>
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<tr>
<td>Beck Depression Inventory</td>
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<td>DSM IV based depressive scale</td>
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<tr>
<td><strong>Marital duration, problems, and satisfaction</strong></td>
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<tr>
<td>Duration of relationship problems</td>
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<td>Marital satisfaction</td>
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<td>Dominance</td>
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<td><strong>Power bases</strong></td>
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<td>Income</td>
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<td>Economic dependence on partner</td>
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<td>Control of surplus spending money</td>
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<td>Commitment to relationship</td>
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<td><strong>Power processes</strong></td>
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<td>Husband demand - wife withdraw behaviour</td>
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<td>Dissatisfaction with child care task distribution</td>
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**Note:** + : This is perceived as a significant problem area. - : This is not perceived as a significant problem area.
0 : This is perceived as a mildly problematic area. * : After controlling for differences in marital satisfaction, members of depressed and non-depressed couples differed on variables marked with an asterisk. Significant (p<.05) effects for depression or the interaction between depression and gender were obtained in ANCOVAs where marital satisfaction was the covariate.
Table 14 Summary of characteristics of couples containing depressed and non-depressed wives on discrepancy variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Significant after marital satisfaction was controlled for</th>
<th>Non-depressed</th>
<th>Depressed</th>
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depressed couples \((r = .62)\), suggests again that interactions surrounding control of surplus spending money were rigid and that one spouse had was trying to control this area of marital interaction.

**Commitment to relationship**

Contrary to the hypothesis concerning commitment, depressed women and their husbands reported lower levels of commitment to their marriages than did control spouses \((F = 7.12, p < .05)\). However, this significant difference was due to the effects of marital dissatisfaction. Members of non-depressed couples reported higher correlations \((r = .5)\) than members of depressed couples.

The finding that there was no difference in commitment across couples is surprising because self-verification theory proposes that spouses with negative self-concepts are more committed to their marriages to the extent that their partners think unfavourably of them (Swann, Hixon, & De La Ronde, 1992). However, it could be argued that marriage tends to equilibrate spousal commitment because of the social rituals, the common property, and the costs of leaving (i.e., the legal and social complications of separation: Blumstein & Schwartz, 1983). Thus, depressed women were not in a ‘one-down’ position relative to their husbands with regard to commitment, which in effect was really commitment to the family.

**Sex role attitudes**

Depressed wives did not report more feminine sex role attitudes, and the discrepancy in sex role attitudes between members of depressed couples was no larger than that for members of non-depressed couples. Mean ratings of attitudes ranged from approximately 12 to 15 on a scale of 0-30, where a rating of 0 signified a strong non-traditional attitude, a rating of 15 signified a neutral attitude, and a rating of 30 signified a strong traditional attitude. Hence, spouses in both non-depressed and depressed couples reported approximate neutral or egalitarian gender role ideologies.

Research has suggested that depression in women is correlated with adopting the characteristics, attitudes, and behaviours associated with a feminine sex role (e.g. Elpem & Karp, 1984; Tinsley, Sullivan-Guest, & McGuire, 1984). However, there is also the possibility, as supported by the present findings, that if a ‘one-down’ woman
with an egalitarian sex role ideology cannot negotiate with her husband (irrespective of his gender role beliefs) an egalitarian balance of marital power, lacking options to equalise the power balance, she may become symptomatic (Madanes, 1981).

Desired level of intimacy
The hypothesis that depressed wives would report higher levels of desired intimacy and that there would be a greater discrepancy between husbands and wives on this variable in depressed couples relative to non-depressed couples was not supported. Correlations of desired levels of intimacy were also low between members of both non-depressed and depressed couples.

On a scale of 7-42, with lower scores indicating a desire for more independence and higher scores indicating a desire for more intimacy, mean ratings ranged from 27 to 29. Both husbands and wives desired more intimacy rather than more independence. This finding would suggest that spouses believed that intimacy had not already been attained, an attainment which many researchers believe to be relatively rare (Dupuy, 1993; Schaeft, 1989; Wynne, 1988).

Thus, women were not in a 'one-down' position in that they were seeking more intimacy. Rather, both spouses wanted more of the same thing, suggesting egalitarianism in relation to this aspect of power. This contradicts much research (Christensen, 1987; Christensen & Shenk, 1991; Margolin, Talovic, & Weinstein, 1983) which suggests that women want more intimacy in marriage, especially if they are distressed. However, previous research has not considered levels of intimacy in depressed individuals and their spouses.

Most researchers (e.g. Christensen, 1987; Christensen & Heavey, 1990) have considered intimacy and independence to be inversely related i.e., the presence of one precludes the presence of the other. However, a recent model by Fruzzetti (1996) suggests that intimacy and independence covary except at very extreme levels. Periods of intimacy may be interspersed with periods of independence as needs or desires for intimacy change differentially in and between spouses. Thus, intimacy and independence may be dynamic rather than static properties. Such a view would concur with the psychoanalytic perspective of simultaneously needing intimacy and
attaining an adequate degree of separateness (Birtchnell, 1986). Hence, the value of measuring intimacy and independence as if they were orthogonal constructs appears to be highly questionable.

**Physical aggression from partner**

No differences in levels of physical aggression were found across couples. Although this finding suggests that men did not resort to physical aggression to wield power, that the correlations between reports from members of depressed couples were large and negative, suggests that one or other of the spouses did not accurately report the degree of physical aggression.

That no significant differences were found between couples on this variable does not preclude the possibility that threats of violence were used to exert power, even if the husbands' sex roles were egalitarian (Yllo & Straus, 1982). More importantly, there is the possibility that the method of data collection ensured that physical aggression would not be reported. Perpetrators of abuse are unlikely to complete self-report questionnaires, albeit anonymously. As data was only considered if questionnaires from both spouses were returned, it is possible that physical aggression was a characteristic of marriages where the wife is depressed. This would coincide with the verbal accounts of a number of General Practitioners who reported that many husbands perceived marriage as a 'hitting license'.

**Overt psychological aggression**

The hypothesis that members of couples where the wife was depressed would report lower levels of overt aggression than members of couples where the wife was not depressed was not supported. Instead, a higher level of overt aggression was found in depressed couples ($F = 10.39, p < .01$), but this difference was largely mediated by the impact of marital distress.

The significantly high levels of anger expressed by depressed women suggests that they felt powerless to some degree in their marriages. Furthermore, there may have been much suppression of anger by these women (Riley, Treiber, & Woods, 1989). It is also likely that subsequent dialogue regarding change was unproductive due to the high level of expressed emotion. That husbands reported significantly less anger
expression ($F = 5.01, p < .05$), suggests that they were more likely the conservative
force in their marriages, with a vested interest in preserving the status quo, presumably
because it favoured them.

However, before making such conclusions, it would be important to remember that
anger expression may be related to previous learning history or situational
determinants, as well as anger intensity (Riley, Treiber, & Woods, 1989). For
example, it is possible that the threat of violence may have conditioned the use of
overt anger, even in the husbands (Coyne & Downey, 1991). It may also have been
the case that husbands did experience severe levels of anger but that this anger was
expressed passively.

**Passive psychological aggression**
As hypothesised, depressed couples engaged in significantly higher levels of passive
aggressive behaviour than did non-depressed couples ($F = 5.75, p < .05$). The
discrepancy between husbands’ and wives’ reports on this variable was larger in
depressed couples than non-depressed couples ($t = 5.92, p < .05$). Both of these
findings were independent of the effects of marital satisfaction. The correlation
between husbands’ and wives’ passive aggression was large in couples containing
non-depressed wives ($r = .70$).

The high level of passive aggression in depressed couples suggests that both depressed
wives and their husbands may have felt powerless to some degree in their marriages.
The depressed wives possibly resorted to passive aggression when their overt
aggression did not affect any change in the marital power structure, or because
aggression expressed passively did not threaten their ‘relational’ self (Hayles, 1986).

It may be that husbands were equally as angry as their depressed wives due to feeling
powerless; their wives’ depressive behaviour may have controlled their own behaviour
in many ways. These husbands may also have felt angry due to the implicit
assumption that they were responsible for their wives unspoken misery (Bullock,
Siegel, Weissman, & Paykel, 1972). Alternatively, they may have felt that their
wives’ withdrawal was a deliberate and aggressive act. Feeling uncomfortable with
overtly raging against a helpless spouse (Biglan et al., 1985), or believing that expressing anger was, in itself, an admission of powerlessness (Guthrie & Snyder, 1988), husbands may have chosen to express their anger in a passive manner.

**Power processes**

*Husband demand - wife withdraw behaviour*

As hypothesised, depressed couples reported significantly more husband demand - wife withdraw behaviour than non-depressed couples ($F = 10.83, p < .01$), this difference largely due to the influence of marital satisfaction.

*Wife demand - husband withdraw behaviour*

As hypothesised, depressed couples reported significantly more wife demand - husband withdraw behaviour than non-depressed couples ($F = 6.51, p < .05$), this difference being largely mediated by the impact of marital distress.

*Total demand - withdraw behaviour*

Similarly, the hypothesis that members of depressed couples would report more total demand - withdraw behaviour than members of non-depressed couples was supported ($F = 12.31, p < .01$). This difference was also largely mediated by the impact of marital distress.

**Discussion of findings concerning demand - withdraw behaviour**

The above findings, coupled with the findings of low correlations between members’ scores in both non-depressed and depressed couples, may be interpreted to suggest that depressed wives and their husbands were both dissatisfied with various aspects of the status quo; the demand role was assumed when a particular change was sought, and the withdrawal role assumed when resisting a particular change desired by one’s spouse. It may be that both spouses played different roles at different times, albeit to a higher degree than control couples (Babcock, Waltz, Jacobson, & Gottman, 1993). This dynamic interaction could have provided the seeds for a great deal of conflict and suggests the potential for numerous power struggles. This view of intermittent conflict engagement would provide support for the psychoanalytic perspective of the
'dance' between partners in wanting different needs to be met at different times in a relationship (Birchnell, 1986).

Another possible explanation for the high levels of both husband demand - wife withdraw behaviour and wife demand - husband withdraw behaviour is that the marriage structure was wife-dominant with wives having to be demanding because of their wish to force their husbands to take a demanding role. Such behaviour may have been reciprocated by their husbands (Gray-Little & Burks, 1983). However, given spouses' approximate egalitarian dominance ratings and reported sex role ideologies, this interpretation is unlikely.

The difference between couples was more significant for husband demand - wife withdraw behaviour than for wife demand - husband withdraw behaviour (F = 10.83 as opposed to F = 6.51). This could indicate that depression had equalised marital power balance in the wives' favour; these women may have wanted to protect their newly acquired power gains by withdrawing, whilst their husbands may have assumed the demanding role in an effort to regain enforced power concessions. Alternatively, it is possible that husbands’ frequent use of conflict engagement simply reflects a high level of involvement in their marriages (e.g., Babcock, Waltz, Jacobson, & Gottman, 1993).

Controlling for the effects of marital discord, a gender difference in wife demand - husband withdraw behaviour was found (F = 4.97, p < .05). This is surprising given that there was no structural asymmetry in the level of intimacy and independence desired in the relationship, as would be expected given this behavioural pattern (Christensen, 1987). Inspection of cell means suggests that this finding is an artifact of wives reporting lower levels of this pattern than did their husbands. Additionally, depressed wives reported more husband demand - wife withdraw behaviour than wife demand - husband withdraw behaviour, whilst husbands reported an opposite pattern. These socially desirable findings indicate that spouses were biased in under-reporting their own 'negative' behaviours whilst over-reporting similar behaviours in their spouses.
It is possible that the difference in total demand-withdraw behaviour across couples was due to depressed couples never having had developed a sense of ‘relational efficacy’, that is the confidence that they could weather conflict together (Notarius & Vanzetti, 1983). Without such confidence, couples typically choose to avoid or withdraw from conflict. However, this typically leads to a build-up of unresolved problems which may then necessitate increased demanding behaviour.

Considering that marital discord may precede depression (Beach & O’Leary, 1993b; Christian, O’Leary, & Avery, 1993; O’Leary, Risso, & Beach, 1990), it is possible that the depressed couples had many problem areas which were never negotiated successfully before the onset of depression in the index spouse. This may have resulted in conflict-avoidance as a preferred manner of dealing with problems. This may then have led to an accumulation of unresolved problems, subsequently forcing spouses into a demanding role more often, a role which alternated with a tendency towards avoidance. Support for this hypothesis comes from the findings that overt anger levels in depressed couples were significantly higher than in control couples (F = 10.39, p < .01), whilst there were significantly lower levels of mutual constructive communication in couples where wives were depressed (F = 9.60, p < .01).

**Mutual constructive communication**

That depressed couples reported less mutual constructive communication relative to non-depressed couples suggests that they may have been facing deeper incompatibilities and had chosen to nourish a destructive peace rather than to fight a constructive war (De Dreu, 1997). However, given that desired levels of intimacy were consistent across couples, they may have been more compatible than incompatible. On the other hand, given what has already been mentioned with reference to the dynamic nature of intimacy needs and engagement in demand/withdraw behaviour patterns, it is quite possible that serious incompatibilities were present.

Couples with egalitarian sex role attitudes typically have to continually redefine the consensus regarding roles, rules, and norms within the relationship (VanYperen & Buunk, 1991). This leads to a certain amount of conflict due to spouses expressing their discontent more often in order to structure the relationship to their liking.
(Kluwer, Heesink, & Van de Vliert, 1997). However, the combination of significantly higher levels of demand - withdraw behaviour and significantly low levels of mutual constructive communication would not be expected. Therefore, as suggested above, couples may not have had developed a sense of 'relational' efficacy.

Alternatively, it may have been that couples, feeling powerless in many areas of their marriage, believed they needed to fight 'tooth and nail' to protect what little power they had, and to possibly 'win' some more power. Again, the significantly higher levels of overt anger in depressed couples would support this hypothesis. Additionally, if depressed couples did perceive marital struggles as highly aversive, then one might expect them not to desire significantly higher levels of intimacy, as was found. Yet another interpretation of the combination of high levels of 'negative' and low levels of 'positive' communication, is that depression equalised the marital power balance, after which spouses either attempted to hold on to what power they had 'won' or tried to regain 'lost ground'.

**Power outcomes**

*Partner does more household tasks*

The hypothesis that there would be a greater discrepancy between husbands' and wives' reports on this variable in depressed couples relative to non-depressed couples was not supported.

*Partner makes more family decisions*

The hypothesis that there would be a greater discrepancy between husbands' and wives' reports on this variable in depressed couples relative to non-depressed couples was not supported ($F = 5.25, p < .05$).

*Partner more involved in child care*

The hypothesis that there would be a greater discrepancy between husbands' and wives' reports on this variable in depressed couples relative to non-depressed couples was supported, but only at the $p = .06$ level of significance. Furthermore, this finding was dependent on marital satisfaction levels.
Dissatisfaction with household task distribution
The hypothesis that depressed couples would report less satisfaction with household task distribution was not supported ($F = 8.56, p < .01$), but this finding was due to the effects of marital satisfaction. Support for the hypothesis that there would be a greater discrepancy between husbands' and wives' reports on this variable in depressed couples relative to non-depressed couples was found ($t = 14.39, p < .01$), but this finding was also largely mediated by the impact of marital satisfaction.

Dissatisfaction with decision making distribution
The hypothesis that depressed couples would report less satisfaction with the distribution of family decision making was supported ($F = 5.18, p < .05$). There was also a greater discrepancy between husbands' and wives' reports on this variable in depressed couples relative to non-depressed couples ($F = 6.56, p < .05$). Both of these findings were independent of the effects of marital satisfaction.

Dissatisfaction with child care task distribution
The hypothesis that depressed couples would report less satisfaction with the distribution of child care tasks was supported ($F = 6.19, p < .05$), but this finding was dependent on the effects of marital satisfaction. Discrepancies between husbands' and wives' reports on this variable in depressed couples relative to non-depressed couples did not differ.

Discussion of power outcome findings
These findings suggest that although role differentiation was consistent across couples, the presence of depression in the wife introduced a significant degree of dissatisfaction with regard to the distribution of tasks, particularly decision making. It may have been that depressed couples were immersed in a 'power war', one which was instigated by depression-enforced changes in the marital power structure. Hence, tasks may have been done in a begrudging manner by powerless spouses who were trying to protect or trying to come to terms with a new egalitarian power structure.

Women were, in general, in a 'one-down' position, tending to do more than their fair share of household and child care tasks, a situation with which they were dissatisfied.
That this 'role overload' did not translate into marital dissatisfaction for non-depressed women may have been due to their having power elsewhere in the marriage or having other sources of gratification outside of the marriage (McGrath, Keita, Strickland, & Russo, 1990; Nolen-Hoeksema, 1990).

Relative to decision making, husbands tend to overestimate their own power and wives to underestimate theirs (Olson & Rabunsky, 1972). That husband means were lower than those of their wives, and that no gender difference in dissatisfaction with decision making in couples was reported, together suggest that there may indeed have been equality in this domain. Additionally, although there were no differences between couples in decision making distribution, depressed spouses reported significantly higher levels of dissatisfaction. This suggests that depressed wives and their husbands may have had a perceptual bias in overestimating their input and underestimating their spouses' input into decision making. Such a bias is not uncommon (Komter, 1989) and may suggest that these spouses were involved in an intense power struggle.

### 5.3 Did depression force an equalising of marital power?

With the exception of income and passive aggression, depressed couples did not differ from non-depressed couples with regard to power bases. This would suggest that the power structures in both types of marriage were similar. However, if resource theorists are to be believed, income, in and of itself, may dictate the power balance in marriage. Thus, husbands may have been in the 'one-up' position in both types of marriage. But husbands with depressed wives may have resented being in this 'one-up' position due to having being forced into the over-functioning role of sole income earner. Overtly more powerful, they may have felt less powerful, as indicated by their (and their spouses') ratings of dominance structure.

High levels of passive aggression may represent depressed wives' anger over their being depressed and/or being in a 'one-down' marital position. Alternatively, given their 'relational' tendencies, wives' passive anger may have been a more comfortable way to protect power gains derived from becoming depressed. In contrast, husbands' passive aggression may have indicated their resentment of having to move into an over-functioning role (relative to what they were used to), a move which they possibly
perceived as orchestrated by their wives deliberate withdrawal through depression. Husbands may also have chosen to express anger passively due to their discomfort at raging against an overtly ‘helpless’ spouse.

No differences in power processes were found between couples. The only difference between couples on power outcomes was a greater dissatisfaction with decision making distribution in depressed couples, despite couples reporting no distribution differences in this domain across couples. This would suggest that expectations were biased about who should do what, possibly due to women feeling that they were entitled to extra leeway in this domain given their larger responsibility for both household and child care tasks.

Correlational data suggest that certain rigid predictable relational patterns characterised depressed couples, these patterns differing from those of non-depressed couples. Within depressed couples, it was more likely that one partner’s level of satisfaction was associated with that of the other; that one partner’s reported desire to have control of surplus spending money was associated with another’s denial of this wish; that one partner’s aggression was associated with the other’s level of aggression; and that dissatisfaction with child care on the part of one partner was related to the level of dissatisfaction with this issue in the other partner. In contrast, in non-depressed couples, there was a less rigid relationship between one partner’s status on these variables and the status of the other partner, suggesting greater relational flexibility.

Has the conundrum of who holds more power in a marriage where the wife is depressed been resolved? Does depression accommodate to the ‘one-down’ position (Price, 1991) or does it provide an escape route from an ‘over-functioning’ and highly dissatisfying role (Madanes, 1981)? This study has failed to answer this question. If anything, more questions have been generated. What has been learned is that, relative to control couples, the presence of depression in a relationship is associated with a dynamic power war between spouses. Husbands may hold the upper-hand economically, yet they may also resent this, and there are abnormally high levels of anger in both spouses, much of which is expressed passively. A high degree of rigidity also characterises depressed couples.
The focus and design of the present study may have precluded answering the question of whether depression was associated with an equal division of the 'power cake' between spouses. Some important aspects of power were not considered, and there were a number of methodological flaws.

*Which come first, power inequality or depression?*

An implicit assumption in this study is that dissatisfaction or discord with the marital power structure precedes depression. There is much research to support this assumption. Longitudinal research in a large sample of newly married couples indicates that marital discord is predictive of later depressive symptomatology, whereas depressive symptomatology is not predictive of later marital discord (Beach & O'Leary, 1993b). Both retrospective data (Brown & Harris, 1978; Christian, O'Leary, & Avery, 1993, O'Leary, Risso, & Beach, 1990) and data from prospective studies (Beach & Nelson, 1990; Monroe, Bromet, Connell, & Steiner, 1986) also suggest that discord comes first.

However, some research suggests that depression precedes marital discord (Barling, MacEwen, & Kelloway, 1991; Beach & O'Leary, 1993a). Additionally, self-verification theory (Swann, 1983) posits that depressed people will gravitate toward people who evaluate them unfavourably and are more likely both to solicit unfavourable feedback and to be rejected (Swann, Wenzlaff, Krull, & Pelham, 1992). This could generate significant marital discord. Women high in tendencies toward self-criticism tend to date men who place little value on intimacy, thereby ensuring a less nurturant environment (Zuroff & de Lorimier, 1989).

Assortative mating, whereby spouses of depressed persons may bring their own liabilities and vulnerabilities to the marriage, may contribute to female depression. Indeed, in one study, over half the depressed women from clinical samples had husbands with a history of psychiatric disturbance, mostly affective disorders (Merikangas & Spiker, 1982). Even when depressed, women may intentionally contribute towards the creation and/or maintenance of a hostile and critical environment as a means of validating and expanding on existing self-criticism (Leff & Vaughn, 1985).
Female power domains not examined

This study may have measured predominantly ‘masculinised’ power. For example, the interpersonal base from which women may derive considerable power in families was not examined (Ball, Cowan, & Cowan, 1995). What was considered was conjugal or ‘horizontal’ power between spouses, which is distinct from family power. It has been argued that the ‘vertical’ power in parent-child relationships is intrinsically more complex, enduring and significant than power in the conjugal relationship. As women invest in and rely more on vertical bonds than do men, and send and receive more intergenerational influence than do men, they dominate the positions of ‘kinkeeper’ in families (Rosenthal, 1985).

If power is defined as the ability to change the behaviour of others intentionally, then power is at the core of much of what women do (Kranichfeld, 1987). So women, in having the power to nurture and shape whole generations of families, may be more powerful than husbands. Thus, it appears that family power, only one aspect of which is conjugal power, stems from a variety of sources differentially accessible by gender (Anson & Sagy, 1995).

Neither was sexuality, possibly a female power base, examined. If clinical lore is to be believed, women withhold sex because it is their last bastion of power in marriage, where they have little else to withhold (Jacobson, 1989). That women may potentially use their sexuality to exert influence may be true if, as the sexual drive discourse posits, men need sex more than women, are unable to control their urges, and hence, are in a ‘one-down’ position in this area of marriage (Foreman & Dallos, 1992). Even without recourse to extremes such as withdrawing sex, manipulation of the quality of sex or the development of a sexual symptom can covertly maintain the status of sexuality as a power base (Johnson, 1976). In contrast, it has been argued by Jacobson (1989) that sex is gratifying for women because it establishes and reaffirms emotional intimacy, and is unappealing with a partner where that intimacy is lacking to begin with. Due to the sensitive nature of sexuality, it was decided not to inquire about sexuality in this study.

A number of depressed women referred to the enormous strength they derived from being ‘close to God’. However, the benefits of strong religious beliefs were not examined. Neither were the possible drawbacks associated with a strong Faith
examined. While a strong Faith may have helped to cope with depression, it may also have predisposed to onset of depression. Catholics have the terrible burden of wanting to help others. Most Irish people are hooked as children into thinking that the way to help others is by suffering and self-denial, and that if you help others, then God will reach in and make things better. Roman Catholicism also places a strong emphasis on female duties (Komter, 1989). Therefore, the religious beliefs of depressed women may have led them to believe that they needed to do many things for many people but themselves, thus increasing the likelihood of self-alienation, role-overload, and, subsequent onset of depression.

Women may have been in a 'one-up' position with regard to their verbal skills. Gender-role differences in socialisation typically hinder the development of expressive skills in men. Husbands may have felt that they had to make up for their (learned) inability to express emotions or to demonstrate affection by providing other rewards for their wives. Other factors which may or may not have increased women's marital power levels include access to a support network outside of their families, and/or well-developed social / coping skills, although this is unlikely (Coyne, 1991).

Methodological limitations of the present study
The results of this study need to be interpreted with caution due to its methodological shortcomings. Most significantly, each cell only contained 14 individuals. Such a low number of subjects may have inhibited against finding subtle differences in power domains between couples with / without a depressed wife. Such differences may be uncovered if a larger sample is studied.

Secondly, the method of data collection may have predisposed towards a biased sample. It is highly likely that only couples who were communicating in a sufficiently co-operative manner completed and returned the self-report questionnaires. Of note was the lack of reported physical aggression. Thus, couples which are characterised by even low levels of physical abuse, or even the threat of physical abuse, were not represented.

Thirdly, due to the length of the questionnaire, spouses possibly adopted a response set, especially towards end of questionnaire. Answering questions in this way may
also have been encouraged by the grouping together of subscale items, whereas normally they would have been mixed in with items from other subscales. For example, there were 12 physical aggression items grouped together which may have encouraged responding to items in a perfunctory manner. Fourthly, no account was taken of the reading level of spouses. Thus, possibly working class couples were under-represented in the sample of couples studied.

The ages and number of children were not examined in the data analysis. According to the traditional ideal, low fertility is undesirable because it increases the family’s vulnerability to economic risk. Consequently, high fertility provides leverage in decision making and reduces domestic violence by legitimating claims for authority and power (Wilson, 1991). It is possible that women with more children had both increased ‘horizontal’ and ‘vertical’ power, the latter including power derived from parent-child coalitions. However, high numbers of children would have increased the likelihood of post-natal depression (Ritter, 1993) and may have reflected powerlessness; some women reported resenting loss of personal freedom when their husbands ‘trapped’ them into marriage by intentionally getting them pregnant. Further control may have included attempts to control women’s career roles / educational opportunities, their reproductive rights, and to limit their social contacts (O’Neil & Egan, 1993). Additionally, symptomatic children may have served to regulate marital power in non-depressed couples (Haley, 1963).

Mood can have considerable impact on the retrieval of information (Bower, 1981). Individuals with chronically depressed mood may have facilitated recall of negative relationship events which have occurred relative to those with more positive mood. This may render negative exchanges more salient. Thus, the depressed women in this study may have over-reported their marital discord or negative interactional patterns. Ideally, observational measures could have validated the use of the some of the scales used.

No account was taken of the developmental context of marital power. One way of achieving this would have been to locate the couple within the family life cycle. For example, the frequency of joint, pleasant activities shared by spouses often decreases in the transition to parenthood (Belsky, 1990), while disagreements over division of
labour may intensify (White, Booth, & Edwards, 1986). This may be due to couples having to re-negotiate the balance of marital power during such periods of transition, a process which may be experienced as extremely stressful, particularly if there are existing difficulties (Falicov, 1988). It comes as no surprise that research indicates that the impact of marital strain may interact with age (Phelan et al., 1991), and that the probability of depression relapse is greater for younger than for older people (Coryell, Endicot, & Keller, 1991). Longer established relationships, despite initial discord, may have settled down and some consensus regarding the sharing of power either explicitly or implicitly agreed upon. Alternatively, social networks may have been established to compensate for deficiencies in the marriage (Beach, Smith, & Fincham, 1994).

However, although couples were matched for number of children and geographical location, they were not accurately matched for duration of relationship and/or level of income. That the duration of depressed couples’ relationships were significantly longer in duration than those of non-depressed couples, may indicate that depression was only elected after many years of unsuccessful negotiation using all available means. It may also have been the case that the differential earnings potential (favouring the husbands) in couples where the wife was depressed increased as the spouses got older. Such an imbalance may have resulted in husbands achieving a performance differential in many areas of their marriages (Baumeister, 1981). In response, women possibly reassessed these same areas as being less central to their self-definition. Over time, such exclusion of a large range of performance domains from women’s self-definition may have rendered them more vulnerable to subsequent challenges (e.g., marital discord) by limiting the complexity of their future selves (Niedenthal, Setterlund, & Wherry, 1992). In contrast to this argument, some researchers reason that husbands’ marital power decreases as they age and become less important to the capitalist system (Kahn, 1984), whereas women gain in power due to patterns of coalition with their children (Kranichfeld, 1987). The cross-sectional design of the present study did not permit examination of these different hypotheses.

There are a number of limitations with the use of self-report questionnaires. Milden (1987) argued that there are aspects of psychological experience that are difficult to tap in a questionnaire. Related to this is Komter’s (1989) argument that there are 3
types of power: 'manifest' or visible power; 'latent' power, or that which is derived from preventing change or overt conflict; and 'invisible' power, which he defined as "the result of social or psychological mechanisms that do not necessarily surface in overt behaviour, or in latent grievances, but that may be manifest in systematic gender differences in mutual and self-esteem, differences in perceptions of, and legitimations concerning, everyday reality" (p. 192). An example of the latter is a perceptual bias in who makes the decisions, something which was actually found in this study. It is the nature of latent and invisible power that they cannot be directly asked about. Hence, self-reports may not pay justice to the underlying nature of marital power.

As with other scales, Spanier, in using descriptive questions in his Dyadic Adjustment Scale (DAS; Spanier, 1976), makes a number of assumptions about what makes a marriage happy. For example, a high frequency of quarrelling is interpreted to be indicative of marital unhappiness. Yet, research suggests that behaviours that are functional for "keeping the peace" in the present may leave unresolved critical areas of conflict that might undermine the relationship over time (Gottman & Krokoff, 1989, p. 47). Additionally, very few people report themselves or their marriages as unhappy overall, although individuals appear willing and able to report specific stresses and strains in the marriage (Fitzpatrick, 1988). It is therefore possible that marital satisfaction ratings were inflated. Such structured questionnaires were also unable to assess non-verbal interpersonal behaviour, and their use eclipsed the possibility of discovering new sequences of interaction; only sequences that the questionnaire authors knew and wrote into items were examined (Christensen, 1988).

The assessment of the economic context in marriages was inadequate. Couples may or may not have had agreements as to who had responsibility for earning and managing income. There was no inquiry as to whether resources were pooled together or individually controlled, or whether there were individual (possibly hidden) or joint bank accounts. A number of spouses reported that they kept some income to themselves, but this information was volunteered. The assessment of who did what was also inadequate. No questions addressed whether agreements had been made about who was to do what. It may have been that spouses were unhappy, not with the task distributions, but with the agreements made as to who would do what. More
details would also have helped to differentiate between ‘syncratic’ or ‘autonomic’ marriages (Blood and Wolfe, 1960).

As mentioned, some of the scales used (e.g., intimacy, demand/withdraw behaviour) conceptualised power as a static property, similar to structural resources. However, power is also a partly dynamic property, with needs for power within and between spouses changing over time. Therefore, self-report scales may be totally inadequate in attempting to quantify some aspects of power. Some of the scales also had to be modified in order to increase their reliabilities. Thus, they may not have measured as accurately the power variables which they were designed to measure. More problematic is the tendency of spouses’ to be poor reporters of their own behaviours (Fruzzetti, Alioto, & Serafin, cited in Fruzzetti, 1996). What was reported is possibly an inaccurate representation of what went on in the sample couples. Additionally, the construction of new scales using an odd number of poles, instead of an even number, may have encouraged non-committal responses (Converse & Presser, 1986).

Using self-report inventories to diagnose depression is problematic. The diagnosis of depression is based on the presence of a constellation of symptoms. Given the content of BDI items, it is possible to have a high score above the cut-off point without having a single symptom that would count toward a diagnosis of major depressive disorder (Coyne, Schwenk, & Smolinski, 1991). Whether this cut-off point is 10 (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), 14 (Taylor & Klein, 1989), or even 20 (Kendall, Hollon, Beck, Hammen, & Ingram, 1987), high BDI total scores may just represent diffuse maladaptive functioning or depressive symptomatology in subclinical populations (Beck, Steer, & Garbin, 1988). In the present study, there is the possibility that some of the index women were not depressed (i.e., false positives) whilst some of the women in control couples may have had significant depressive symptomatology or even a depressive disorder (i.e., false negatives). Indeed, Craighead, Craighead, DeRosa, and Allen (1993) found that approximately one quarter of individuals with scores of 12 or 13 met DSM III-R criteria for current major depressive disorder (American Psychiatric Association, 1987), whilst at BDI scores of 19-20, approximately half of the individuals met criteria for current major depressive disorder. Although use of the DSM IV depression scale may have avoided false classification, a doubt remains as to whether index women were really depressed.
Depression would have been best operationalised with a semi-structured interview (Fechner-Bates, Coyne, & Schwenk, 1994).

A number of General Practitioners agreed to participation in this study on the basis that the word depression not be mentioned in the questionnaire. They feared that some of their patients would be reluctant to complete a depression questionnaire. It was also thought unethical to suggest to patients that some of their symptoms were indicative of depression, and that that these symptoms were in some way suggestive of, or a reflection of, unhealthy marital interactions. Hence, it was agreed to use the word ‘nerves’ instead of the word depression. The problem is that some patients may have taken this to mean various things, including anxiety which frequently presents with depression (Hammen, 1995).

Lastly, the statistical package used (SPSS Version 6.1) did not allow computation of adjusted means when computing ANCOVAs. Thus, variable means remained diluted by the effects of marital satisfaction.

### 5.4 Areas for potential future research

**Cognitions**

There is a well-developed field of research which highlights the importance of marital cognitions. It has been shown in clinically depressed women that depressogenic cognitions (e.g., selective abstraction, catastrophising) predict only depression and does so independently of attributions for partner behaviour, which in turn, predicts only marital satisfaction and does so independently of depressogenic cognitions (Townsley, Beach, Fincham, & O'Leary, 1991). Given the indicated emphasis on power games in couples where there is depression, could it be that there are also other ‘power-specific’ attributions or expectations regulating spousal behaviour? Do such spouses operate according to cognitions such as, ‘I have to fight tooth and nail to hold onto or get back my power’? Alternatively, could it be that spouses fear that they will lose power from their roles if they share these roles with their partners (O’Neil & Egan, 1993)? Some research has already addressed cognitions which influence certain ‘power’ behaviours. For example, Kurdek (1995) has indicated that avoidance (and withdrawal) may be an outgrowth of problematic cognitions related to marital
functioning. However, it may prove difficult researching such cognitions as most are automatic and outside of conscious awareness (Fincham, 1997).

**Female sources of power**

As mentioned above, most conceptualisations of marital power have been 'masculinised and static', thus failing to capture the kinds of influence that women have in family life (Kranichfeld, 1987). Therefore, future studies of marital power must involve an examination of the power that women derive from intergenerational bonds, based on their nurturant and kinkeeping roles. Could it be that such 'vertical' power is more enduring and significant than 'horizontal' conjugal power? Is there an optimum number of children up to which the power derived from being a mother is counter-balanced by the demands of rearing them? And, does such power fluctuate over the life-cycle of a marriage? For example, does a mother's power decrease when her children leave home?

As to whether sexuality remains a bastion of power for women also needs to be researched. Most research articles concerning sexuality as a female power base have been either theoretical, or a review of clinical case histories, or a mixture of both of these (e.g., Foreman & Dallos, 1992; Hare-Mustin, 1991; Johnson, 1976). Empirical research into whether women use sexual favours, symptoms, or withdrawal to covertly regulate the balance in marital power is long overdue.

Given the supposedly high rates of Catholicism in Ireland, could it be that deriving strength from one's relationship with a 'Higher power' is a fundamental power base for spouses, particularly wives? Indications from the present study is that it is. More interestingly though might be the role of such Faith in onset of depression. Could it be that the 'self-sacrifice' ideology of Catholicism predisposes to role overload and subsequent depression, or might such one's Faith help persevere even in adversity, depression-inducing circumstances?

**Longitudinal research**

The controversy as to whether depression precedes marital discord, or vice versa, remains unresolved. There is no doubt that these correlate. However, no matter how robust the correlation, it does not speak of the issue of causation. Hence, longitudinal
research is needed to examine if depression is an adaptive response to an uncontrollable social environment, or whether marital discord is possibly manufactured to maintain a negative self-view, the first step of which might be assortative mating.

So to clarify this issue, although first episodes of depression are relatively rare, at-risk women and their partners could be asked about their marital power dynamics at regular intervals in the life-cycles of their relationships. If, and when, these women do become depressed, post-depression power ratings could be compared with pre-depression power ratings. Ideally, assessment would be multi-modal, consisting of self-report questionnaires followed by semi-structured interviews. This potentially expensive and time-consuming research could address other issues such as whether conflict engagement of a specific kind may be functional for a marriage longitudinally, as has been suggested (Gottman & Kroff, 1989).

5.5 Implications for treatment of depression in women

Address conjugal power imbalance

Madanes (1981) stated that “the presenting problem in a spouse can be solved when the hierarchical incongruity in the marriage is resolved” (p. 33). How might this be achieved? A first step might be to facilitate a couples’ understanding of their patterns of interaction. This would involve highlighting the cyclical, as opposed to linear, nature of their interactions which are likely to be burdened by the accumulation of unresolved issues and negative feelings and attitudes towards each other. Recognition by the couple of these feelings and attitudes would be an important second step.

Thirdly, couples would need to understand that their denial of anger ensures that the very mechanism for monitoring differences is non-functional, and that potential negotiation is aborted (Dupuy, 1993). Negative attitudes towards overt expression of anger and conflict need to be challenged, and the idea that it is better to fight a constructive war than to nourish a destructive peace inculcated (De Dreu, 1997). That both spouses are probably expressing anger in a passive manner needs emphasising. In particular, it must be pointed out that the resourceful partner needs to guard
against giving ‘pay backs’ for the grief caused by the depression (Berg-Cross & Cohen, 1985). Most importantly, spouses need to realise that “at best, we can only control ourselves but not others” (L’Abate, 1984, p. 12) and that neither spouse can unilaterally determine relational outcomes and processes.

The couple may then be ready to experiment behaviourally in a manner were neither has any privileged rights, so that absolutely everything in the relationship is negotiated. This would expose fears that spouses might have such as, ‘If I give her joint access to our savings, she will spend it all’, fears that inhibit their entering into the circle of negotiation. In doing so, all areas of the relationship are negotiated to each spouses’ satisfaction, so that neither has any cause to elect a symptom to equalise a perceived power imbalance in the marital relationship and, in the process, create a ‘hierarchical incongruity’, which would simultaneously define both as powerless yet powerful.

If one spouse is unwilling to negotiate, the ‘one-down’ spouse may for the first time consider separation. Although such a threat may be used as a power tactic, this option must be considered. Strong religious beliefs which have kept a spouse in an unsatisfactory marriage may also need to be addressed.
References


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Appendix A  Self-report questionnaire
**Instructions:** Please read all of the questions/statements and either circle the answer that applies to you or write your answer in the space provided.

### About you

<table>
<thead>
<tr>
<th>Are you</th>
<th>Male</th>
<th>Female</th>
</tr>
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<tbody>
<tr>
<td>How old are you?</td>
<td></td>
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<table>
<thead>
<tr>
<th>Relationship situation</th>
<th>Married and living with partner</th>
<th>Not married and living with partner</th>
<th>Married but living with new partner</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>How long have you had a relationship with your partner?</td>
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<tr>
<td>How many years have you been living with your partner?</td>
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<tr>
<td>Do you have any children?</td>
<td>No</td>
<td>Yes</td>
<td>If yes, what are their ages?</td>
<td></td>
</tr>
</tbody>
</table>

I never hesitate to go out of my way to help someone in trouble.

I have never intensely disliked anyone.

### Financial situation

| What is your occupation (If a farmer, what is the size of your farm)? | | |
|---------------------------------------------------------------|-----------------|-----------------|-----------------|--------|
| Have you been working? | | | | |

<table>
<thead>
<tr>
<th>To what degree were you economically dependent upon your partner?</th>
<th>Completely dependent</th>
<th>Very dependent</th>
<th>Somewhat dependent</th>
<th>Slightly dependent</th>
<th>Not dependent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who decided how surplus spending money was used?</td>
<td>I did all of the time</td>
<td>I did most of the time</td>
<td>My partner and I did equally</td>
<td>My partner did most of the time</td>
<td>My partner did all of the time</td>
</tr>
<tr>
<td>Who would you liked to have deciding how surplus spending money was used?</td>
<td>Myself all of the time</td>
<td>Myself most of the time</td>
<td>My partner and I did equally</td>
<td>My partner most of the time</td>
<td>My partner all of the time</td>
</tr>
</tbody>
</table>

### Thinking about your recent mood

**In the past 2 weeks, have you:**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>...been feeling very down for most of the day?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>...had little interest in most activities and felt little pleasure in doing activities?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>...had an increase or a decrease in your appetite?</td>
<td>Decrease</td>
<td>Same as usual</td>
</tr>
<tr>
<td>...had an increase or decrease in your weight?</td>
<td>Decrease</td>
<td>Same as usual</td>
</tr>
<tr>
<td>...slept more than usual or had trouble sleeping?</td>
<td>Less than usual</td>
<td>Same as usual</td>
</tr>
<tr>
<td>...been more or less active than usual?</td>
<td>Less active</td>
<td>Same as usual</td>
</tr>
<tr>
<td>...had more or less energy than usual?</td>
<td>Less energy</td>
<td>Same as usual</td>
</tr>
<tr>
<td>...felt worthless?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>...felt guilty?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>...found it difficult to concentrate?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
**Your general mood**

Tick the statement in each group which best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, tick each one.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I do not feel sad.</td>
<td>0</td>
</tr>
<tr>
<td>1 I feel sad.</td>
<td>1</td>
</tr>
<tr>
<td>2 I am sad all the time and I can’t snap out of it.</td>
<td>2</td>
</tr>
<tr>
<td>3 I am so sad or unhappy that I can’t stand it.</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statement</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I don’t have any thoughts of killing myself.</td>
<td>0</td>
</tr>
<tr>
<td>1 I have thoughts of killing myself, but I would not carry them out.</td>
<td>1</td>
</tr>
<tr>
<td>2 I would like to kill myself.</td>
<td>2</td>
</tr>
<tr>
<td>3 I would kill myself if I had the chance.</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statement</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I don’t cry anymore than usual.</td>
<td>0</td>
</tr>
<tr>
<td>1 I cry more now than I used to.</td>
<td>1</td>
</tr>
<tr>
<td>2 I cry all the time now.</td>
<td>2</td>
</tr>
<tr>
<td>3 I used to be able to cry, but now I can’t even though I want to.</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statement</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I am not particularly discouraged about the future.</td>
<td>0</td>
</tr>
<tr>
<td>1 I feel discouraged about the future.</td>
<td>1</td>
</tr>
<tr>
<td>2 I feel I have nothing to look forward to.</td>
<td>2</td>
</tr>
<tr>
<td>3 I feel that the future is hopeless and that things cannot improve.</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statement</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I do not feel like a failure.</td>
<td>0</td>
</tr>
<tr>
<td>1 I feel I have failed more than the average person.</td>
<td>1</td>
</tr>
<tr>
<td>2 As I look back on my life, all I can see is a lot of failures.</td>
<td>2</td>
</tr>
<tr>
<td>3 I feel I am a complete failure as a person.</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statement</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I get as much satisfaction out of things as I used to.</td>
<td>0</td>
</tr>
<tr>
<td>1 I don’t enjoy things the way I used to.</td>
<td>1</td>
</tr>
<tr>
<td>2 I don’t get real satisfaction out of anything anymore.</td>
<td>2</td>
</tr>
<tr>
<td>3 I am dissatisfied or bored with everything.</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statement</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I don’t feel particularly guilty.</td>
<td>0</td>
</tr>
<tr>
<td>1 I feel guilty a good part of the time.</td>
<td>1</td>
</tr>
<tr>
<td>2 I feel quite guilty most of the time.</td>
<td>2</td>
</tr>
<tr>
<td>3 I feel guilty all of the time.</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statement</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I don’t feel I am being punished.</td>
<td>0</td>
</tr>
<tr>
<td>1 I feel I may be punished.</td>
<td>1</td>
</tr>
<tr>
<td>2 I expect to be punished.</td>
<td>2</td>
</tr>
<tr>
<td>3 I feel I am being punished.</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statement</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I don’t feel disappointed in myself.</td>
<td>0</td>
</tr>
<tr>
<td>1 I am disappointed in myself.</td>
<td>1</td>
</tr>
<tr>
<td>2 I am disgusted with myself.</td>
<td>2</td>
</tr>
<tr>
<td>3 I hate myself.</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statement</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I don’t feel I look any worse than I used to.</td>
<td>0</td>
</tr>
<tr>
<td>1 I am worried that I am looking old or unattractive.</td>
<td>1</td>
</tr>
<tr>
<td>2 I feel that there are permanent changes in my appearance that make me look unattractive.</td>
<td>2</td>
</tr>
<tr>
<td>3 I believe that I look ugly.</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statement</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I haven’t lost much weight, if any, lately.</td>
<td>0</td>
</tr>
<tr>
<td>1 I have lost more than 5 pounds.</td>
<td>1</td>
</tr>
<tr>
<td>2 I have lost more than 10 pounds.</td>
<td>2</td>
</tr>
<tr>
<td>3 I have lost more than 15 pounds.</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statement</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I am no more worried about my health than usual.</td>
<td>0</td>
</tr>
<tr>
<td>1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.</td>
<td>1</td>
</tr>
<tr>
<td>2 I am very worried about physical problems and it’s hard to think of much else.</td>
<td>2</td>
</tr>
<tr>
<td>3 I am so worried about my physical problems that I cannot think about anything else.</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statement</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 My appetite is no worse than usual.</td>
<td>0</td>
</tr>
<tr>
<td>1 My appetite is not as good as it used to be.</td>
<td>1</td>
</tr>
<tr>
<td>2 My appetite is much worse now.</td>
<td>2</td>
</tr>
<tr>
<td>3 I have no appetite at all anymore.</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statement</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I don’t get more tired than usual.</td>
<td>0</td>
</tr>
<tr>
<td>1 I get tired more easily than I used to.</td>
<td>1</td>
</tr>
<tr>
<td>2 I get tired from doing almost anything.</td>
<td>2</td>
</tr>
<tr>
<td>3 I am too tired to do anything.</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statement</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I have not noticed any recent change in my interest in sex.</td>
<td>0</td>
</tr>
<tr>
<td>1 I am less interested in sex than I used to.</td>
<td>1</td>
</tr>
<tr>
<td>2 I am much less interested in sex now.</td>
<td>2</td>
</tr>
<tr>
<td>3 I have lost interest in sex completely.</td>
<td>3</td>
</tr>
</tbody>
</table>
**More about your mood**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this your first time that your “nerves” have been at you very badly or that you been feeling very low?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How long have your “nerves” been at you or how long have you been feeling very low?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you think anything in particular has made you feel this way?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had repeated thoughts of death or of harming yourself?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Are you taking antidepressant tablets?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Satisfaction**

Please answer the following questions as they relate to the past year.

<table>
<thead>
<tr>
<th>Question</th>
<th>All the time</th>
<th>Most of the time</th>
<th>More often than not</th>
<th>Occasionally</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often did you discuss or consider divorce, separation, or terminating your relationship?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often did you or your partner leave the house after a fight?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In general, how often did you think that things between you and your partner were going well?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you confide in your partner?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you ever regret that you were in a relationship with your partner?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often did you and your partner quarrel?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often did you and your partner “get on each other’s nerves?”</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**How happy were you in your relationship?**

<table>
<thead>
<tr>
<th>Extremely unhappy</th>
<th>Fairly unhappy</th>
<th>A little unhappy</th>
<th>Happy</th>
<th>Very happy</th>
<th>Extremely happy</th>
<th>Perfect</th>
</tr>
</thead>
</table>

**Did you kiss your partner?**

<table>
<thead>
<tr>
<th>Every day</th>
<th>Almost every day</th>
<th>Occasionally</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
</table>

Which of the following statements best describes how you felt about the future of your relationship during the past year?

- I want desperately for my relationship to succeed, and would go to almost any length to see that it does.
- I want very much for my relationship to succeed, and will do all I can to see that it does.
- I want very much for my relationship to succeed, and will do my fair share to see that it does.
- It would be nice if my relationship succeeded, but I can’t do much more than I am doing now to help it succeed.
- It would be nice if it succeeded, but I refuse to do any more than I am doing now to keep the relationship going.
- My relationship can never succeed, and there is no more that I can do to keep the relationship going.

If there are relationship problems, how long ago did they begin?
**Who did what?**

Using the numbers on our 1 to 9 scale, show how you and your partner divided responsibilities during the past year and secondly, how you would like them to have been divided.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I did it all</strong></td>
<td><strong>We did it equally</strong></td>
<td><strong>He/she did it all</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Task</th>
<th>How it has been during the past year</th>
<th>How I would have liked it to be</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning and preparing meals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning up after meals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repairs around the home.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>House cleaning.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking out the garbage.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buying groceries, household needs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paying bills.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laundry: washing, folding, ironing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Writing letters/making calls to family and friends.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Looking after the car.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing income for our family.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caring for plants, garden, yard.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working outside the family.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Task</th>
<th>How it has been during the past year</th>
<th>How I would have liked it to be</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deciding how we spend time at home.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deciding how we spend time out of the house.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deciding which friends and family to see and when.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deciding about vacations: when, where, how.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deciding about major expenses: house, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deciding about financial planning: insurance, loans, taxes, plans for savings.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deciding when and how much time both partners should work outside the family.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initiating lovemaking.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determining the frequency of lovemaking.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deciding about religious practices in our family.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deciding about involvement in community activities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deciding how people should behave toward one another in our family.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Task</th>
<th>How it has been during the past year</th>
<th>How I would have liked it to be</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deciding about meals for our child(ren)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preparing meals for our child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing our child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning or bathing our child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deciding whether or how to respond to our child’s crying.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting up at night with our child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking our child out: walking, driving, visiting, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choosing toys for our child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Playing with our child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doing our child’s laundry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arranging for baby-sitters or child care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dealing with the doctor regarding our child’s health</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Aggression

How descriptive is each of the following statements of you **during the last year**?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very much like me</th>
<th>Rather like me</th>
<th>Somewhat like me</th>
<th>Somewhat unlike me</th>
<th>Rather unlike me</th>
<th>Not at all like me</th>
</tr>
</thead>
<tbody>
<tr>
<td>I often yelled back when my partner yelled at me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When my partner tried to boss me around, I frequently did the opposite</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of what he/she asked.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I often took my time “just to show” my partner, when he/she tried to</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>boss me around</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I often made threats to my partner that I really didn’t intend to</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>carry out</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When I was feeling insecure and jealous, I often picked a fight with</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>my partner rather than tell him/her directly what was on my mind</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting arguments with my partner when he/she disagreed with me was</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>something I often did</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I often said nasty things to my partner, especially when I was angrily</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>discussing something with him/her</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slamming doors was something I often did when I got mad at my partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I often did something on purpose to annoy my partner and then apologised</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>excessively when he/she accused me of it</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I often broke a “rule” my partner had made to spite him/her</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When my partner did something that I didn’t like, I often made a point</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of getting even later</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I often did not do what my partner asked me to do if he/she asked in a</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>nasty way.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Your attitudes

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men are born with more drive to be ambitious and successful than women.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>By nature women are happiest when they are making a home and caring for</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>children.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is more important for a husband to have a good job than for a wife to</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>have a good job.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It would be better for Irish society if fewer women worked.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is much better for everyone involved if the man is the achiever</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>outside the home and family.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women have just as much chance to get big and important jobs but they</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>are just not interested.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### About you

<table>
<thead>
<tr>
<th>Statement</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am always courteous, even to people who are disagreeable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There have been times when I was quite jealous of the good fortunes of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>others.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I sometimes feel resentful when I do not get my way.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Communication

Using the numbers on our 1 to 9 scale, indicate how likely or unlikely each of the following statements applies to your relationship (with your partner) over the past year.

When some problem in the relationship arose:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very Unlikely</th>
<th>Very Likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both my partner and I avoided discussing the problem.</td>
<td>1  2  3  4  5  6  7  8  9</td>
<td></td>
</tr>
<tr>
<td>I tried to start a discussion while he/she tried to avoid a discussion.</td>
<td>1  2  3  4  5  6  7  8  9</td>
<td></td>
</tr>
<tr>
<td>Both my partner and I tried to discuss the problem.</td>
<td>1  2  3  4  5  6  7  8  9</td>
<td></td>
</tr>
<tr>
<td>My partner tried to start a discussion while I tried to avoid a discussion.</td>
<td>1  2  3  4  5  6  7  8  9</td>
<td></td>
</tr>
</tbody>
</table>

When discussing relationship problems:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very Unlikely</th>
<th>Very Likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both my partner and I expressed our feelings to each other.</td>
<td>1  2  3  4  5  6  7  8  9</td>
<td></td>
</tr>
<tr>
<td>Both my partner and I blamed, accused, and criticised each other.</td>
<td>1  2  3  4  5  6  7  8  9</td>
<td></td>
</tr>
<tr>
<td>Both my partner and I suggested possible solutions and compromises.</td>
<td>1  2  3  4  5  6  7  8  9</td>
<td></td>
</tr>
<tr>
<td>I pressured, nagged or demanded while he/she withdrew, became silent, or refused to discuss the matter further.</td>
<td>1  2  3  4  5  6  7  8  9</td>
<td></td>
</tr>
<tr>
<td>My partner criticised while I defended myself.</td>
<td>1  2  3  4  5  6  7  8  9</td>
<td></td>
</tr>
<tr>
<td>My partner pressured, nagged or demanded while I withdrew, became silent, or refused to discuss the matter further.</td>
<td>1  2  3  4  5  6  7  8  9</td>
<td></td>
</tr>
<tr>
<td>I criticised while my partner defended him/herself.</td>
<td>1  2  3  4  5  6  7  8  9</td>
<td></td>
</tr>
</tbody>
</table>

Dominance

Who is the dominant partner in your relationship?

<table>
<thead>
<tr>
<th>I am a lot more dominant</th>
<th>I am more dominant</th>
<th>I am a little more dominant</th>
<th>Neutral</th>
<th>My partner is a little more dominant</th>
<th>My partner is more dominant</th>
<th>My partner is a lot more dominant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

About You

<table>
<thead>
<tr>
<th>Statement</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>There have been times when I felt like rebelling against people in authority even though I knew they were right.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When I do not know something, I do not at all mind admitting it.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can remember “playing sick” to get out of something.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Physical aggression

Please indicate how many times during the **past year** your partner did the following things.

<table>
<thead>
<tr>
<th>Action</th>
<th>Once</th>
<th>Twice</th>
<th>3-5 times</th>
<th>6-10 times</th>
<th>11-20 times</th>
<th>More than 20 times</th>
<th>Not in the past year but it happened before</th>
<th>This has never happened</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threw something at me that could hurt.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Twisted my arm or hair.</td>
<td>Once</td>
<td>Twice</td>
<td>3-5 times</td>
<td>6-10 times</td>
<td>11-20 times</td>
<td>More than 20 times</td>
<td>Not in the past year but it happened before</td>
<td>This has never happened</td>
</tr>
<tr>
<td>Pushed or shoved me.</td>
<td>Once</td>
<td>Twice</td>
<td>3-5 times</td>
<td>6-10 times</td>
<td>11-20 times</td>
<td>More than 20 times</td>
<td>Not in the past year but it happened before</td>
<td>This has never happened</td>
</tr>
<tr>
<td>Used a knife or gun on me.</td>
<td>Once</td>
<td>Twice</td>
<td>3-5 times</td>
<td>6-10 times</td>
<td>11-20 times</td>
<td>More than 20 times</td>
<td>Not in the past year but it happened before</td>
<td>This has never happened</td>
</tr>
<tr>
<td>Punched or hit me with something that could hurt.</td>
<td>Once</td>
<td>Twice</td>
<td>3-5 times</td>
<td>6-10 times</td>
<td>11-20 times</td>
<td>More than 20 times</td>
<td>Not in the past year but it happened before</td>
<td>This has never happened</td>
</tr>
<tr>
<td>Choked me.</td>
<td>Once</td>
<td>Twice</td>
<td>3-5 times</td>
<td>6-10 times</td>
<td>11-20 times</td>
<td>More than 20 times</td>
<td>Not in the past year but it happened before</td>
<td>This has never happened</td>
</tr>
<tr>
<td>Slammed me against a wall.</td>
<td>Once</td>
<td>Twice</td>
<td>3-5 times</td>
<td>6-10 times</td>
<td>11-20 times</td>
<td>More than 20 times</td>
<td>Not in the past year but it happened before</td>
<td>This has never happened</td>
</tr>
<tr>
<td>Beat me up.</td>
<td>Once</td>
<td>Twice</td>
<td>3-5 times</td>
<td>6-10 times</td>
<td>11-20 times</td>
<td>More than 20 times</td>
<td>Not in the past year but it happened before</td>
<td>This has never happened</td>
</tr>
<tr>
<td>Grabbed me.</td>
<td>Once</td>
<td>Twice</td>
<td>3-5 times</td>
<td>6-10 times</td>
<td>11-20 times</td>
<td>More than 20 times</td>
<td>Not in the past year but it happened before</td>
<td>This has never happened</td>
</tr>
<tr>
<td>Slapped me.</td>
<td>Once</td>
<td>Twice</td>
<td>3-5 times</td>
<td>6-10 times</td>
<td>11-20 times</td>
<td>More than 20 times</td>
<td>Not in the past year but it happened before</td>
<td>This has never happened</td>
</tr>
<tr>
<td>Burned or scolded me on purpose.</td>
<td>Once</td>
<td>Twice</td>
<td>3-5 times</td>
<td>6-10 times</td>
<td>11-20 times</td>
<td>More than 20 times</td>
<td>Not in the past year but it happened before</td>
<td>This has never happened</td>
</tr>
<tr>
<td>Kicked me.</td>
<td>Once</td>
<td>Twice</td>
<td>3-5 times</td>
<td>6-10 times</td>
<td>11-20 times</td>
<td>More than 20 times</td>
<td>Not in the past year but it happened before</td>
<td>This has never happened</td>
</tr>
</tbody>
</table>
**Independence**

Given the limited amount of free time you have, would you prefer to spend more time with your partner or more time alone or with friends?

<table>
<thead>
<tr>
<th>A lot more time with my partner</th>
<th>Some more time with my partner</th>
<th>A little more time with my partner</th>
<th>No change</th>
<th>A little more time alone or with friends</th>
<th>Some more time alone or with friends</th>
<th>A lot more time alone or with friends</th>
</tr>
</thead>
</table>

Would you like to have more sharing of feelings with your partner or more respect for privacy in your relationship?

<table>
<thead>
<tr>
<th>A lot more sharing of feelings</th>
<th>Some more sharing of feelings</th>
<th>A little more sharing of feelings</th>
<th>No change</th>
<th>A little more respect for privacy</th>
<th>Some more respect for privacy</th>
<th>A lot more respect for privacy</th>
</tr>
</thead>
</table>

Would you like to spend more of your free time in independent activities without your partner or in shared activities with your partner?

<table>
<thead>
<tr>
<th>A lot more independent activities</th>
<th>Some more independent activities</th>
<th>A few more independent activities</th>
<th>No change</th>
<th>A few more shared activities</th>
<th>Some more shared activities</th>
<th>A lot more shared activities</th>
</tr>
</thead>
</table>

Would you like to ask your partner more or less often what he/she is thinking and how he/she is feeling?

<table>
<thead>
<tr>
<th>Ask him/her a lot more often</th>
<th>Ask him/her more often</th>
<th>Ask him/her a bit more often</th>
<th>No change</th>
<th>Ask him/her a bit less often</th>
<th>Ask him/her less often</th>
<th>Ask him/her a lot less often</th>
</tr>
</thead>
</table>

Would you like to spend more or less time talking with your partner about his/her thoughts and feelings?

<table>
<thead>
<tr>
<th>A lot more time</th>
<th>More time</th>
<th>A little more time</th>
<th>No change</th>
<th>A little less time</th>
<th>Less time</th>
<th>A lot less time</th>
</tr>
</thead>
</table>

On the whole, would you like more independence or more closeness in your relationship?

<table>
<thead>
<tr>
<th>A lot more independence</th>
<th>More independence</th>
<th>A little bit more independence</th>
<th>No change</th>
<th>A little bit more closeness</th>
<th>More closeness</th>
<th>A lot more closeness</th>
</tr>
</thead>
</table>

**About you**

I am sometimes irritated by people who ask favours of me.  
I would never think of letting someone else be punished for my wrong doings.

<table>
<thead>
<tr>
<th>True</th>
<th>False</th>
</tr>
</thead>
</table>

**Additional comments**

Before posting your questionnaire, please check that you have not accidentally omitted to answer any questions. Thank you.
Appendix B  Consent form
Consent Form

I, _________________________________, hereby grant Michael Byrne permission to use the following scale of which I am the sole / principal author:

____________________________________________________ in his Masters research. This research, entitled ‘Power and depression in marriage’, is to be supervised by Dr. Alan Carr, Clinical Psychology Programme Director at University College Dublin, Ireland.

If Michael does not intend to carry out and publish a psychometric analysis of his data (such as factor analysis, and construction of normative tables), he will provide me with a copy of his data, together with as much as possible of a list of demographic information.

Signatures: __________________________ Date: ___________

Michael Byrne

Clinical Psychology Department,

Science Building, University College Dublin,

Belfield, Dublin 4, Ireland.

_________________________ Date: ___________

Dr. Alan Carr.

_________________________ Date: ___________

Scale Author.