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**FACTORS PREDICTING DISTRESS AT  
MARITAL THERAPY ONSET**

**by**

**Joseph J. H. Horak**

**A Dissertation  
Submitted to the  
Faculty of The Graduate College  
in partial fulfillment of the  
requirements for the  
Degree of Doctor of Philosophy  
Department of Counselor Education  
and Counseling Psychology**

**Western Michigan University  
Kalamazoo, Michigan  
June 2002**

## **FACTORS PREDICTING DISTRESS AT MARITAL THERAPY ONSET**

**Joseph J. H. Horak, Ph.D.**

**Western Michigan University, 2002**

**Higher levels of distress at marital therapy onset predict poorer treatment outcomes in several studies. This study selected nine variables to determine their ability to predict distress at marital therapy onset. The first two predictor variables, shame (measured by the Internalized Shame Scale; Cook, 2000) and expressive atmosphere in the family of origin (measured by the Family of Origin Expressive Atmosphere Scale; Yelsma, Hovestadt, Anderson, & Nilsson, 2000), were chosen from the literature and studies that considered these variables to be related to marital distress. The remaining seven sociodemographic predictor variables—(1) parental divorce as a child, (2) pregnancy before marriage, (3) number of children, (4) combined gross income, (5) premarital cohabitation, (6) length of courtship, and (7) length of marriage—were selected from studies that identified their ability to predict divorce. The dependent variable was marital distress (measured by levels of dyadic adjustment on the Dyadic Adjustment Scale; Spanier, 1989).**

**The sample consisted of 38 subjects, 18 males and 20 females, that were beginning marital therapy. A multiple regression analysis utilizing a stepwise forward decision model was conducted, which resulted in four variables in the final prediction**

**model. The four variables that significantly predicted distress at marital therapy onset were lower levels of combined gross income, longer length of marriage, parental divorce as a child, and higher levels of shame. The post hoc analysis revealed that expressive atmosphere in the family of origin was significantly correlated with shame.**

**Implications and recommendations for the treatment of highly distressed couples include: (a) exploring the impact of parental divorce and lower levels of combined gross income on current marital functioning; (b) addressing affect in marital therapy with a particular emphasis on tolerating and mastering shame; (c) addressing the role that family of origin may play in the creation of shame; and (d) encouraging couples experiencing higher levels of distress to seek marital therapy early, because over time distressed couples may not self-correct and the degree of distress appears to accumulate.**

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## **Acknowledgments—Continued**

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**Joseph J. H. Horak**

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## **CHAPTER I**

### **INTRODUCTION**

#### **Background of the Problem**

**In the early and mid-20th century, the profession and practice of marriage and family therapy emerged from concern with three different types of problems that traditional approaches to psychotherapy were ineffective in treating. Family therapy emerged from approaches developed in treating schizophrenia and child behavior problems, while marital therapy emerged from requests of couples having marital difficulties (Gurman & Kniskern, 1991; Nichols & Everett, 1986).**

**Marital therapy can trace its origin back to the 1920s, in the period called the Sexual-Reform Movement. During this period, clinics emerged that provided guidance and advice (often providing instruction regarding premarital education, sexual issues, and birth control) in the United States, Austria, Germany, and the former Soviet Union (Gurman & Kniskern, 1991). However, couples requested more direct help with their marital problems, and the profession of marriage therapy continued to expand its focus. Marital counseling and later marital therapy resulted from the public demand for assistance (Nichols & Everett, 1986). In many ways, the marital therapy profession has been trying to catch up theoretically as it attempts to respond to the ever-increasing demands of couples.**

**In traditional psychoanalysis, which was the prevailing paradigm of the early 20th century, an analyst would only treat one spouse of a marital couple. However, during the mid-20th century, some analysts began to break with this tradition and began to treat individual spouses concurrently, which meant treating each spouse in individual therapy. Thus, each spouse had little knowledge of the other's therapy. After the practice of concurrent marital therapy began, marital counseling began to treat couples conjointly, where both spouses were present in the same session. Treating couples conjointly was a bold move and in direct opposition to the prevailing psychoanalytic approach, which contended that treating both spouses conjointly would negatively impact transference, the central element in psychoanalysis (which holds that a patient recreate and rework dynamics from childhood parental relationships in the therapy relationship) (Freud, 1957). However, when marital therapists were able to demonstrate significant therapeutic gains with both spouses present, this contributed markedly to decreasing the dominance that psychoanalysis exerted on the field of psychotherapy (Nichols & Everett, 1986).**

**An early debate in marital therapy centered on the question as to whether marital therapy was counseling (meaning conscious level interaction with a focus on the present) or psychotherapy (meaning addressing intra-psychic and unconscious factors in a conscious manner) (Nichols & Everett, 1986). On one side of this debate was Emily Mudd, who in 1932 founded the Marriage Council of Philadelphia. Mudd (1951) contended that a marriage counselor was not a psychotherapist and believed**



that marriage and family therapy belonged under the supervision of psychiatry. Those on the other side of this debate (Harper, 1953; Stokes, 1951) considered marriage counseling to be an independent profession and a specially adapted form of psychotherapy. Eventually, the term *marriage counseling* was replaced by *marriage therapy* or *marital therapy*, which signifies that those who considered marital therapy a form of psychotherapy eventually prevailed. One of the pioneers of family of origin therapy, James Framo (1973), defined contemporary marital therapy as a form of depth treatment that deals with the psychodynamics of each spouse but also examines the interlocking nature of the marital bond.

By the 1970s, the profession of marital therapy had become recognized as a separate profession. In 1978, marital therapy officially merged with the more dynamic field of family therapy as the American Association for Marriage Counselors (AAMC) became the American Association for Marriage and Family Therapy (AAMFT) (Gurman & Kniskern, 1991). Today the profession and practice of marriage and family therapy has become an established mental health profession. Yet because of its somewhat anti-establishment history, shaped by challenging traditional paradigms, the profession and practice of marriage and family therapy exhibits some ambivalence as it enters into the mental health mainstream (Horak, 1999).

In spite of its consumer driven history, marital therapy has held up to the scrutiny required by managed health care, which demanded outcome studies to demonstrate the efficacy of mental health treatments. There is a consensus among

reviewers of the marital therapy outcome literature as to the efficacy of marital therapy. The research shows that marital therapy reduces conflict and increases marital satisfaction of participant spouses when compared to no-treatment control groups (Baucom & Hoffman, 1986; Bradbury & Fincham, 1990; Dunn & Schwebel, 1995; Jacobson & Addis, 1993; O'Leary & Smith, 1991; Shadish et al., 1993; Pinsof & Wyne, 1996).

The majority of these studies have been efficacy studies, performed in university settings under controlled circumstances. There have been few effectiveness studies, taking place in "real world" natural settings, which could address the problem of external validity. Therefore, how well the efficacy studies generalize to situations similar to how most marital therapy is practiced remains unknown. Also, few long-term studies have been conducted which could demonstrate if the gains that marital therapy provide are sustained over time.

In addition, there is some debate as to the degree of effectiveness of marital therapy. Because of the fact that no-treatment control groups consistently show little improvement or decreases in marital satisfaction, small changes on scales measuring marital satisfaction in treatment groups can result in statistical significance. Subsequently, some couples improve in response to treatment but still are in distressed relationships. This has resulted in more conservative analyses of data to ensure couples are no longer distressed, as opposed to simply improved (Jacobson & Truax, 1991). However, some researchers argue the more conservative analysis holds marital therapy to higher standards than other types of treatment. To

avoid the problems raised by this debate, many researchers analyze data using both traditional as well as Jacobson and Truax's (1991) more conservative analysis, the Reliable Change Index (RCI).

The RCI attempts to determine if the measure of marital satisfaction has improved to a level that is considered within a relationally nondistressed distribution as opposed to an increase that is simply statistically significant while still remaining within a distressed distribution. Jacobson and Truax (1991) contend that when the magnitude of change for a given couple exceeds +1.96 standard errors on a dependent variable measure, then the change is statistically unlikely to occur due to measurement error and, therefore, a statistically reliable change has occurred. More specifically, the RCI is calculated by subtracting the pretreatment score on dependent variable from posttreatment score on the dependent variable and dividing by the standard error of difference between the two test scores. The standard error of the difference is calculated by taking the square root of the sum that is obtained by squaring the standard error of measurement and multiplying by 2. Obtaining an RCI score larger than 1.96 has a probability of .05.

When using traditional analyses, marital therapy success rates are reported as high as 70 to 80% (O'Leary & Smith, 1991; Shadish et al., 1993). If the RCI analysis is used, success rates drop to between 40 to 50% (Wesley & Waring, 1996; Shadish et al., 1993). Regardless of which analysis is used, a significant proportion of couples are not helped by marital therapy.

### **Statement of the Problem**

**A significant percentage of couples have poor responses to marital therapy, and several studies have attempted to determine which factors will predict a poor outcome in marital therapy. One finding that has been consistent across many studies is that a higher degree of distress reported by couples prior to marital therapy predicts less favorable treatment outcomes (Crane, Soderquist, & Frank, 1995; Hampson, Prince, & Beavers, 1999; Jacobson & Addis, 1993; Snyder, Mangrum, & Wills, 1993; Wesley and Waring, 1996). Identifying factors that predict higher levels of distress at marital therapy intake may assist in developing theoretical models and interventions that could increase the treatment success rate for those couples currently not responding well to marital therapy.**

**This study will attempt to identify several factors that may predict levels of marital distress at marital therapy onset. Understanding these factors may assist in developing new approaches, which may more effectively treat couples that are more at risk for an unfavorable outcome in marital therapy. It is hoped that the knowledge gained from this study will enhance the development of more effective treatment approaches for couples in marital therapy.**

### **Purpose and Importance of Study**

**Today separation and divorce are common occurrences. Current estimates put the divorce rate somewhere between 50% (Cherlin, 1981) and 67% (Martin & Bumpass, 1989). The divorce rates for second marriages tend to be about 10%**

higher than for first marriages (Glick & Lin, 1986). However, divorce and marital conflict are not always viewed as negative (Gottman, 1994), and at times it is a necessary outcome to violent and abusive marriages. Yet, many couples (even those with chronic conflicts) desire to make their marriages healthy and able to endure “till death do us part.”

The negative impact of divorce is considerable. Divorce can have a major impact on the health and well-being of all family members (Bray & Hetherington, 1993; Waite & Gallagher, 2000). Separation and divorce have strong negative consequences for the mental and physical health of both spouses. These negative consequences for men include an increased risk of psychopathology, increased incidence of physical illness, suicide, violence, homicide, and mortality from diseases (Bloom, Asher, & White, 1978). The results of a 9-year epidemiological prospective study on predictors of dying have demonstrated that the stability of marriage is the best predictor of staying alive, even when controlling for such factors as initial health and health habits (Berkman & Breslow, 1983; Berkman & Syme, 1979). While previous research seemed to suggest that men received the majority of health buffering effects of marriage, more recent studies suggest that the health of woman is equally positively affected (Gottman & Levenson, 1992; Kiecolt-Glaser, Fisher, et al., 1987; Kiecolt-Glaser, Kennedy, et al., 1988).

Studies addressing the impact of divorce on children demonstrate an increase in a wide range of potential problems including depression, withdrawal, poor social competence, health problems, poor academic performance, and many conduct

related problems (Cowan & Cowan, 1992; Emery, 1982, 1988; Emery & O'Leary, 1982; Forehand, Brody, Long, Slotikin, & Fauber, 1986; Gottman & Katz, 1989; Hetherington, 1988; Hetherington & Clingempeel, 1992; Hetherington, Cox, & Cox, 1982; Katz & Gottman, 1991a, 1991b; Peterson & Zill, 1986; Porter & O'Leary, 1980; Shaw & Emory, 1987).

The evidence is convincing that separation and divorce are serious problems in society and may have a negative impact on each family member. Understanding more about how to improve the potential for positive outcome in marital therapy is important to assist in minimizing the potential negative consequences of divorce. Because previous studies have demonstrated that higher levels of distress predict poorer outcomes in marital therapy, this study hopes to identify factors that predict higher levels of distress at the beginning of marital therapy. Hopefully, understanding more about couples that experience greater levels of pretreatment distress will result in theoretical approaches that may increase the chances of successful outcome in marital therapy.

### **Rationale and Theoretical Framework**

Based upon a review of the literature, nine factors were identified to be worthy of exploration because of their potential in contributing to pretreatment marital distress: (1) shame, (2) emotional expressive atmosphere in the family of origin, (3) pregnancy before marriage, (4) parental divorce as a child, (5) number of

children, (6) socioeconomic status, (7) premarital cohabitation, (8) length of courtship, and (9) length of marriage.

### **Factor 1: Shame**

Prior to the late 1980s, very little had been written about shame. However, this construct has received considerable attention since that time. Nathanson (1987) has argued that shame plays a central role in many interactions and is the “master” emotion. Kaufman (1992) described the experience of shame:

To feel shame is to feel seen in a painfully diminished sense. The self feels exposed to itself and to anyone else present. Shame is an impotence-making experience because it feels as though there is no way to relieve the matter . . . The binding affect of shame involves the whole self. (p. 8)

Shame is considered to be a significant emotional component in individual psychopathology (Cook, 1996). Yet, shame has been a largely hidden phenomenon in the treatment of couples (Balcom, Lee, & Tager, 1995). In interpersonal relationships, expressions of shame often take the form of defenses used against the experience of shame. These defenses have been described as: (a) rage, (b) contempt, (c) perfectionism, (d) blame, (e) projection, (f) withdrawal, or (g) denial (Fossum & Mason, 1986; Kaufman, 1989, 1992; Lansky, 1991; Nichols, 1991). When individuals in intimate relationships experience shame and have difficulty tolerating and mastering this emotion, defenses destructive to the relationship are activated.

The most consistent affective predictors of divorce present during the resolution of conflict have been identified as: (a) disgust, (b) contempt, (c) defensiveness, (d) stonewalling, (e) domineering, (f) and belligerence (Gottman,

1994; Gottman, Coan, Carrere, & Swanson, 1998; Gottman & Levenson, 1992; Matthews, Wickrama, & Conger, 1996). These affective predictors of divorce may also stem from an inability to tolerate and master shame. Levenson and Gottman (1985) have also demonstrated that a higher level of physiological arousal prior to marital conflict is also predictive of an eventual divorce. The physiological arousal they studied may be another example of the intense physical manifestation in response to shame, which is seen as a significant threat to the individual. Over time, if such responses and defenses occur in response to shame, the basic bond or connection, which Kaufman (1992) called the “interpersonal bridge,” becomes threatened and eventually broken. From both theoretical considerations as well as from the few studies exploring shame in individual psychopathology, shame warrants consideration as a potential predictor variable in relation to marital distress.

### Factor 2: Expressive Atmosphere in the Family of Origin

Many theories attempting to explain current difficulties in marital functioning assume that previous difficulties in the family of origin are critical contributing factors. Framo (1992) stated: “Of all the forces that impinge on people (culture, society, work, neighborhood, friends, etc.), the family [of origin] by far has the greatest imprinting influence” (p. 122). Many theorists have assumed that family of origin experiences have particular importance on subsequent marital satisfaction (Bowen, 1978; Framo, 1992; Kerr & Bowen, 1988; Schnarch, 1991). Because



families of origin experiences are considered theoretically to be important, this factor warrants consideration.

### **Factors 3, 4, 5, 6, 7, 8 and 9: Sociodemographic Factors**

Research over several decades has demonstrated that not all marriages are equally likely to end in divorce. While earlier marriage and family therapy studies have cited socio-demographic variables as predictors of divorce more recent studies simply focus on factors more intrinsic to the couple's interactions. While demographic factors have not been studied recently, if they are contributing to marital distress, models of treatment will need to include an approach that considers their impact on couples in treatment.

The following 10 sociodemographic variables have been shown to contribute to divorce: (1) parental divorce as a child, (2) premarital sex, (3) premarital pregnancy, (4) age at first marriage, (5) length of courtship, (6) premarital cohabitation, (7) racial status, (8) combined gross income, (9) economic cycles, and (10) length of marriage (Kitson, Babri, & Roach, 1985; Larson, Swyers, & Larson, 2002; Mott & Moore, 1979; South & Spitze, 1986). Premarital sex was excluded from consideration, due to the fact remarried couples were included in this study, making this variable more complicated to measure. Previous studies have shown some racial minority groups experience higher divorce rates than Whites (London, 1991). Cherlin (1981) has suggested that such discrepancies are due to socioeconomic factors more than race. This current study is including combined

gross income; however, because of the potential to misinterpret results in a racially biased manner, race and ethnic background were excluded from this study.

While the data are not conclusive, several studies have demonstrated that economic depressions retard divorce, while prosperity increases it (Cherlin, 1981; Glick & Lin, 1986). Other studies conclude just the opposite (Johnson & Booth, 1990; South, 1985). Regardless of the debate related to this factor, it needs to be studied over a period of several years, which does not fit within the design of the current study.

For the purposes of this study, the following seven sociodemographic variables were included as predictor variables: (1) parental divorce as a child, (2) premarital pregnancy, (3) combined gross income, (4) premarital cohabitation, (5) number of children, (6) length of courtship, and (7) length of marriage. If any of the sociodemographic variables are found to predict higher levels of distress at marital therapy onset, the treatment of distressed couples will need to focus more closely upon how these variables impact upon couples' relationship.

### **Delineation of the Research Problem**

The first step in studying the problem of how to determine factors that contribute to marital distress prior to treatment is to determine how to conceptualize the factors in an empirical design. Levels of marital distress will be the dependent variable. The predictor variables were: (a) levels of shame, (b) levels of emotional expressiveness in the family of origin, (c) the occurrence of parental divorce as a

child, (d) the occurrence of pregnancy before marriage, (e) number of children, (f) combined gross income, (g) cohabitation before marriage, (h) length of courtship, and (i) length of marriage. These variables were examined in a multiple regression analysis to determine the degree to which these variables individually and/or in combination can predict marital distress at marital therapy onset.

### **Statement of Research Hypotheses**

The following hypotheses are proposed:

1. Levels of shame will predict levels of distress at marital therapy onset.
2. Levels of perceived expressive atmosphere in the family of origin will predict levels of distress at marital therapy onset.
3. The occurrence of parental divorce as a child will predict levels of distress at marital therapy onset.
4. The occurrence of pregnancy before marriage will predict levels of distress at marital therapy onset.
5. Number of children will predict levels of distress at marital therapy onset.
6. Levels of combined gross income will predict levels of distress at marital therapy onset.
7. Cohabitation before marriage will predict levels of distress at marital therapy onset.
8. Length of courtship will predict levels of distress at marital therapy onset.
9. Length of marriage will predict levels of distress at marital therapy onset.

It is further hypothesized that various combinations of these variables will be able to predict marital distress at onset of marital therapy.

### Definition of Terms

In this study, a number of terms will be used that are intended to convey specific meanings. These include the following terms, whose definitions are provided.

***Marital Therapy:*** Conjoint marital therapy where both spouses are together in the same session (Everett, 2000).

***Marital Distress:*** Marital distress is defined objectively in this study as a measured by the Dyadic Adjustment Scale (DAS; Spanier, 1989). The DAS has been used in over 1,000 published studies measuring relationship distress. Scores less than 100 on the DAS are considered to identify poor dyadic adjustment and are therefore labeled as relationally distressed. In this study, the term *marital distress* is operationally defined generally as lower scores on the DAS and specifically as scores of 99 or less on the DAS (Spanier, 1989).

***Shame:*** Shame is objectively measured in this study by scores on the Internalized Shame Scale (ISS) (Cook, 1999). Higher scores represent higher levels of shame (Cook, 1999).

***Expressive Atmosphere in the Family of Origin:*** Family atmosphere in the family of origin is objectively defined as the score of each subject on the Family of Origin Expressive Atmosphere Scale (FOEAS). Higher scores represent higher

levels of emotional expressive atmosphere in the family of origin (Yelsma, Hovestadt, Anderson, & Nilsson, 2000).

*Sociodemographic Variables:* Sociodemographic variables are variables that describe a population. For the purpose of this study, seven specific variables, which have been shown to predict divorce, have been chosen: pregnancy before marriage, parental divorce as a child, number of children, combined gross income, cohabitation before marriage, length of courtship, and length of marriage.

*Subjects:* The subjects in this study are legally married adult males and/or females who are presently seeking marital therapy.

#### Scope and Delimitations of Study

One of the major limitations of this study is that all possible factors that may be contributing to marital distress are not known. Also, the sample used in this study was drawn from marital couples seeking services of marital therapists who are primarily Clinical Members of the American Association for Marriage and Family Therapy (AAMFT) in Michigan. How well these results will generalize to other client populations is unknown. It is not known how couples that seek out AAMFT Clinical Members differ from those that seek marital therapy from other allied mental health professionals. In addition, the presence of measurement error should be acknowledged in any study, especially studies that utilize self-report measures. Even though the instruments chosen for this study have satisfactory reliability and validity psychometric properties, a degree of measurement error is unavoidable.

**Regardless of these limitations, this study remains important. Most studies attempting to address factors predicting levels of marital distress, pretreatment, will face similar limitations.**

## **CHAPTER II**

### **REVIEW OF RELATED LITERATURE**

#### **Introduction**

**This chapter will begin with a review of the literature, which addresses variables that predict outcome in marital therapy. Next, the empirical studies on shame and perception of health in the family of origin will be reviewed. Finally, the sociodemographic variables which predict divorce will be addressed. The purpose of this review is to provide an understanding of the previous research in this area, as well as providing a rationale for the choice of predictor variables in the present study.**

#### **Prediction and Marital Therapy**

**The majority of studies conducted that address predictor variables and marital therapy outcome are reported in the behavioral marital therapy literature. How this generalizes to other approaches is unknown. Jacobson and Addis (1993) found that couples who respond better to behavioral marital therapy have the following six characteristics: (1) do not have premature closure in their problem solving, (2) are less distressed at the beginning of marital therapy, (3) are younger, (4) are more emotionally engaged with each other (opposed to becoming**

emotionally disengaged), (5) are less rigid in their gender roles, and (6) are not depressed.

Snyder et al. (1993) found some similar results in their sample of couples treated using either behavioral or insight-oriented marital therapy. Their study found four characteristics predicted poorer outcome to marital therapy: (1) have higher higher levels of global distress, (2) have poor problem-solving skills, (3) demonstrate low psychological resilience, and (4) experience higher levels of depression.

Hampson et al. (1999) also addressed the issue of which couples fare better or worse in marital therapy. This effectiveness study was conducted in a Texas clinic that utilized a sliding fee scale where therapists conducted marital therapy based on their own personal model. The researchers found the following two characteristics predicted a more favorable response to marital therapy: (1) no or few children, and (2) higher levels of couples pretreatment self-rated competency. The other variable in this study, which did not predict marital therapy outcome, was a therapist rating of couples' competency pretreatment. Also, this study did not include a measure of marital distress, pretreatment.

Thus, research exploring predictive factors in response to marital therapy shows that levels of distress at marital therapy intake are an important variable in predicting response to marital therapy. The present study will explore what factors may be related to such high levels of distress at marital therapy intake. The next part of this chapter addresses research related to the variables under study, which may



**predict pretreatment distress. These include shame, expressive atmosphere in the family of origin, parental divorce as a child, number of children, socioeconomic status, cohabitation before marriage, and length of courtship.**

### **Predictor Variables**

#### **Shame**

**One of the first researchers to study shame was Tomkins (1987), who postulated the existence of nine innate affects (one of which is shame) that are biologically based and programmed to produce a characteristic set of expressions on the face and create other physiological reactions (i.e., blushing, increased pulse rate, perspiration, etc.). Tomkins developed his model as a young father when he observed his newborn infant and determined the existence of each innate affect by the presence of a corresponding facial expression. In the case of shame, characteristics exhibited on the face are the eyes and head cast downward with the gaze averted, with an overall slumping of the body posture.**

**Tomkins (1987) and Nathanson (1987) contend that these innate affects are “hard wired” and universal to all humans. Eventually, these internal physiological states become entwined with cognitions as a child begins to understand and explain his or her internal states. Cook (1999) contends that as the person develops the capacity for language and cognitions, the innate shame response becomes co-assembled with other cognitions and behaviors into the complex emotion of shame. Cook considers shame to be a ubiquitous emotion that is necessary in varying**

degrees to shape behavior. Shame is used by society and religions to shape behavior congruent with its norms and in order to transmit to the next generation a set of behaviors, attitudes, and ways of being “appropriate” for various cultures (Cook, 1999). Without the use of shame to shape culturally acceptable behaviors, it is unlikely that civilization could have progressed in any meaningful manner.

However, shame can also become toxic and have strong negative effects upon development. Nathanson contends that shame’s capacity to damage one’s sense of self increases with the frequency, as well as how early in one’s life shame is experienced. Nathanson states that “very little in the life experience of the child calls attention to the nature of the self as powerfully as does [the] shame affect . . . [He suspects] that shame produces a *sense of an incompetent self (sic)*” (Nathanson, 1987, p. 210).

Tomkins (1987) describes the process of how shame becomes internalized (or intertwined with one’s sense of self). He contends that shame experiences are magnified as they become embedded in one’s memory bank of associations to various scenes in which shame was originally triggered. Subsequently, children, when they may be experiencing a similar emotion, will remember the original scene and the intense feelings of shame and alter their behavior to avoid the possibility of further shame. If shame becomes internalized, the person shames himself or herself without needing any input from the external world.

Nathanson states:

that the innate affect shame—humiliation at all ages and in all stages of human development, is a powerful mechanism for the elaboration of the

**sense of self. Shame produces a painful self-awareness at every stage in human development simply because of the ability of this affect script to interfere with every pleasant way we know ourselves. Through shame we are forced to know and remember our failures. While it is clear that shame affect is triggered by experiences that have nothing at all to do with competence, shame produces awareness of an incompetent self. (Nathanson, 1987, p. 211)**

**According to Kaufman (1989), once shame becomes internalized, it forms a major aspect of one's identity, and the shame affect becomes essentially autonomous and can be triggered without reference to any interpersonal event. He describes shame as:**

**the affect of inferiority. No other affect is more central to the development of identity. None is closer to the experienced self, nor more disturbing. Shame is felt as an inner torment. . . . Shame is a wound made from the inside, dividing us from both ourselves and others. (Kaufman, 1989, p. 17)**

**While not cited in the shame literature, the developmental theorist, Harry Stack Sullivan (1953), actually came very close to understanding shame and its relation to development and psychopathology. Central to Sullivan's model is the affect he labeled *anxiety*. However, his definition of this term is actually much closer to what Nathanson, Kaufman, and Tomkins would later label *shame*. Sullivan used the term *anxiety* to refer to the wide range of negative feelings that would include anxiousness, shame, dread, loathing, and feelings of personal worthlessness (Chapman, 1976). Sullivan also understood the central role of shame (*anxiety*) that cultures use to "train people in becoming people" (Sullivan, 1953, p. 8).**

**Sullivan understood *anxiety* to be always interpersonal in nature, resulting from "things going wrong" in one's relationships with others. However, when one experiences a significant amount of these strong emotional reactions, psychological**

problems occur and a person's ability to improve his or her interpersonal relationships becomes hindered. Sullivan, the founder of the Relational School of Therapy, contended anxiety (shame) had a tendency to bind a person in whatever unhealthy relationship patterns one has previously experienced (Chapman, 1976; Sullivan, 1953). Subsequently, Sullivan developed an approach that understands the importance of current relationships (including the therapeutic relationship) in healing and resolving these difficult relational patterns and the underlying shame.

Cook (Internalized Shame Scale–ISS, 1999) asserts that all forms of psychopathology are basically emotional disorders with shame as a common component in each. He studied the relation between shame (as measured by the ISS) and various psychological symptoms, as measured by the Brief Symptom Check List (a 50-item version of the SCL-90) (Cook, 1999). Table 1 shows these results. A few studies have addressed the role of shame in relation to marriage or other couple relationships. Blaisdell (1995) found internalized shame negatively associated with intimacy and marital adjustment. Owens (1995) found high levels of internalized shame to be predictive of lower levels of perceived and expected intimacy. Ruch (1996) found a relationship between internalized shame and what are considered to be problematic attachment styles.

While studies reporting research on shame are relatively recent and few, it appears that internalized shame may be correlated with individual psychopathology symptoms. Internalized shame also appears to be related to various dysfunctional relationship aspects and also appears to be related to a decrease in intimacy as well

**Table 1**  
**Comparative Correlations of Shame With SCL-50 Scales**

SCL-90	Correlation With ISS
Interpersonal Sensitivity	.74
Psychoticism	.72
Depression	.71
Anxiety	.62
Obsessive-Compulsive	.61
Paranoid Ideation	.61
Phobic Anxiety	.55
Hostility	.51
Somatic	.45

*Note.* All correlations are statistically significant at the  $p < .01$  level.  
 As cited in Cook, 1999. p. 21. ( $N = 336$  adult outpatient clients).

as an increase in marital dissatisfaction. Subsequently, the inclusion of internalized shame in the present study as a predictor variable appears to be warranted.

#### Expressive Atmosphere in the Family of Origin

Studies have demonstrated that members of healthy families tend to share more emotional information with each other (Hauser, Powers, & Noam, 1991), while members of dysfunctional families tend to withhold or not share their feelings, wants, likes, and dislikes with each other (Ferreira & Winter, 1968). The family of origin is the place where the capacity for intimacy and relational ability is formed.

**Bornstein, Fitzgerald, Briones, Pieniadz, and D'Ari (1993) found that children's affective expressions were associated with the quality of relationships between family members as well as the amount of information and types of emotions shared in the family. Children from highly expressive families have shown higher levels of unrestricted expressiveness, express more negative affect, and communicate better nonverbally than children from lower expressive families (Halberstadt, 1986, 1991; Halberstadt, Fox, & Jones, 1993). Also, children who felt others were responsive to their emotional needs appeared to feel worthy of being loved or included; however, children who felt others were unresponsive or neglectful of their emotional needs appeared to feel uncertain as to their self-worth (Cassidy, 1988).**

**Childhood experiences appear to have considerable influence on later adult relationships. Emotional expressiveness learned in the family of origin influences later adult relationships (Bochner, 1976; Booth-Butterfield & Booth-Butterfield, 1990). This research is consistent with the concept of differentiation (Bowen, 1978). The differentiated person is able to choose between operating on an intellectual and emotional basis, as opposed to being more emotionally reactive. The level (or degree) of differentiation in the family of origin is believed to have strong intergenerational influence (Bowen, 1978) and also to significantly affect marital satisfaction (Schnarch, 1991).**

**The studies examining the expressive emotional environment in the family of origin initially utilized the Family of Origin Scale (Hovestadt, Anderson, Piercy,**

Cochran, & Fine, 1985). The empirical studies examining perception of health in family of origin as measured by the Family of Origin Scale (FOS) are few and the results are somewhat contradictory. Wilcoxon and Hovestadt (1983) found no correlation between the perceptions of health in family of origin as measured by the Family of Origin Scale (FOS) and marital satisfaction as measured by the Dyadic Adjustment Scale (DAS). However, the greater the discrepancies between the scores of a couple did correlate with lower levels of marital satisfaction ( $r = -.59$ ,  $p < .05$ ,  $n = 75$  couples). Fine and Hovestadt (1984) found a correlation between FOS scores and single persons' perceptions of marriage. Yet the perception of future marital satisfaction and actual marital satisfaction are two very different entities.

In contrast to the Wilcoxon and Hovestadt (1983) study, Campbell, Masters, and Johnson (1998) found a negative correlation between marital satisfaction (as measured by the DAS) and the FOS ( $r = -.41$ ,  $p < .001$ ,  $n = 79$ ). This study used a clinical population. Canfield, Hovestadt, and Fenell (1992) found perceived levels of health in the family of origin (as well as number of children and socioeconomic status) to predict current levels of healthy family functioning. The studies exploring perception of health in family of origin suggest it is an important variable to study for its predictive ability in marital distress.

### **Demographic Predictors of Divorce**

**Historically, demographic factors were the first variables studied in attempting to predict marital instability and divorce. Subsequently, research shifted to focus on personality variables and eventually upon dynamics in the couple interaction (Larson & Holman, 1994). The majority of studies that have attempted to identify sociodemographic variables that predict divorce have been longitudinal studies. While very helpful, the weaknesses of such studies include that they are retrospective. Two inherent potential weaknesses exist in studies utilizing longitudinal methodology. First, factors that were present 30 years ago which predict an outcome today may not predict the same outcome 30 years in the future. Second, social mores and values change and evolve over time. Subsequently, certain factors (i.e., cohabitation before marriage, which did not occur with as much frequency in the past) may have meant something very different 30 years ago and may not continue to have the same meaning and, therefore, may lose its predictive ability.**

**It is also not known if variables that predict divorce will also predict marital distress. A significant body of research exists that has studied variables predicting divorce, which is an easier variable to measure in longitudinal studies compared to marital distress or marital satisfaction. The results of this study may help determine if these same variables predict marital distress or, on the contrary, if significant differences exist between those who divorce and those who are married and distressed who may or may not divorce.**



In the present study, the researcher chose the following sociodemographic variables: (a) the occurrence of parental divorce as a child, (b) the occurrence of pregnancy before marriage, (c) number of children, (d) combined gross income, (e) cohabitation before marriage, (f) length of courtship, and (g) length of marriage.

### Parental Divorce as a Child

The research shows that children of divorced parents are more likely to foresee a divorce in their future than children from intact families (Bumpass & Sweet, 1972; Kobrin & Waite, 1984; Masur, 1993; Pope & Mueller, 1979). Also, children of divorced parents are less optimistic about future marriages and consider divorce more acceptable (Amato, 1988). Feng, Giarrusso, Bengtson, and Frye (1999), using a longitudinal questionnaire, gathered data from parents and children from 1971–1997 ( $N = 1,331$  and  $2,044$ , respectively) to investigate the intergenerational transmission of marital quality and instability and the effects of parental divorce on children's marital quality. This study found that females who experienced parental divorce increased the likelihood of divorce. These studies suggest that children exposed to divorce in their families appear to have a greater chance of experiencing a divorce when they are adults.

### Pregnancy Before Marriage

It would seem that a couple beginning the difficult process of establishing a marriage would experience more difficulty if they have to adjust to the demands of

parenting simultaneously. Also, when a premarital pregnancy occurs, it may suggest that the decision to marry may be complicated and possibly made hastily. Furstenberg's (1976) study found that if a female is pregnant before marriage, the couple is twice as likely to divorce as the general population. He collected information on the marital careers of 103 young women who had premarital pregnancies in their early teens (most of whom eventually married) and 90 of their classmates that did not have premarital pregnancies. The marital histories of the two samples show that disruption in the courtship process and limited economic resources are the most important factors contributing to marital dissolution when a premarital pregnancy occurs. Christensen and Rubinstein (1956) found that premarital pregnancy seems to intensify the conflict which a couple may already be in, and thereby increase the chances for a divorce. Heaton's (2002) study, which used the 1995 National Survey of Family Growth ( $N = 10,847$  women, aged 14–45 years), also found that premarital pregnancy continues to predict divorce.

### Number of Children

Having children has been shown to increase marital conflict and predict future divorce. Kurdek (1993) found that marital quality declined following the birth of a first child, compared to a control group of couples that did not have a child. As cited earlier, Hampson et al. (1999) found that couples with fewer children responded better to marital therapy. The addition of a child to a marriage can be quite challenging, and afterward a couple is required to address many issues they

otherwise may never encounter. Couples with children will address many issues including discipline options, childcare versus staying home with children, the financial demands of raising children, and the numerous time-consuming ways that children require care, which takes away from couple time.

### Combined Gross Income

Divorces are somewhat more likely to occur among individuals with lower levels of education, lower income, and lower status occupations (Kitson & Rashke, 1981; Martin & Bumpass, 1989). An unstable and unpredictable income has been shown to increase the likelihood of divorce (Cherlin, 1981). Weiss and Willis (1997) showed that increases in either spouse's income reduce the incidence of divorce, and Yeung and Hofferth (1998) showed that income loss, and especially loss of work hours, increase the incidence of divorce. The strain of economic difficulties appears to have a negative impact upon marriage.

### Premarital Cohabitation

Several studies have shown that premarital cohabitation predicts higher levels of divorce (Bennet, Blanc, & Bloom, 1988; Booth & Johnson, 1988; DeMaris & Leslie, 1984). Couples who choose cohabitation before marriage are 50% more likely to divorce than couples that do not choose cohabitation. In addition, marriages in which no prior cohabitation occurred are more stable than those in which the partners previously cohabited (Clarksberg, Stolzenberg, & Waite, 1995;

Cunningham & Antill, 1994; Liefbroer & de Jong Gierveld, 1993; U.S. Bureau of the Census, 1996). It is speculated that cohabitation prior to marriage may be indicative of a lower level of commitment to the relationship. However, it is unknown as this trend increases if it will continue to predict divorce.

### Length of Courtship

Courtship provides an opportunity for couples to get to know each other and determine their degree of compatibility. It also allows couples to wait until the “falling in love phase” of the relationship has subsided, so the decision to marry can be made during a time of less over-idealization and emotional intensity. Courtships lasting less than a year are associated with a higher risk of divorce. Thornes and Collard (1979) found that 20% of divorced couples, compared to only 8% of continuously married couples, reported knowing their spouse for less than one year before marriage. This figure rose to 25% for divorced women who were pregnant before marriage. Furstenburg (1976) found that women with longer courtships before marriage and higher frequencies of interactions with their fiancés were half as likely to separate after marriage as those who had shorter courtships and less interaction during the engagement period.

### Length of Marriage

The 1979 U.S. Department of Health, Education, and Welfare Report of Vital Statistics found that 40% of all divorces occur within the first 5 years of

**marriage (U.S. Department of Health, Education, and Welfare, 1979). Mott and Moore (1979) also found that as marriages enter the fifth and sixth years, the probability of dissolution declines. South and Spitze (1986) utilized data from the National Longitudinal Surveys of Young and Mature Women ( $N = 18,585$  females) and found an inverse relationship between marital duration and the probability of divorce. Thus, as the duration of a marriage increases, the probability of divorce decreases.**

### **Conclusion**

**This researcher chose to study shame and the emotional expressive atmosphere in the family of origin as predictor variables in relation to marital distress pretreatment. In addition, sociodemographic factors that have not been studied recently in the marital therapy literature have also been included in this study. Previous research has demonstrated their relation to divorce. No previous research has explored if these demographic factors predict marital distress at marital therapy onset. The present study will be able to determine if shame and expressive atmosphere in the family of origin and demographic variables are able to predict marital distress, at marital therapy onset.**

## **CHAPTER III**

### **METHODOLOGY AND DESIGN**

**This analytical variable study utilized correlational and multiple regression analyses. The dependent variable was marital distress as measured by the Dyadic Adjustment Scale (DAS; Spanier, 1989). The nine predictor variables were:**

- (1) shame (as measured by the Internalized Shame Scale (ISS, Cook, 1999);**
- (2) emotional expressive atmosphere in the family of origin (as measured by the Family of Origin Expressive Atmosphere Scale (FOEAS, Yelsma et al., 2000);**
- (3) the occurrence of pregnancy before marriage; (4) the occurrence of parental divorce as a child; (5) number of children; (6) combined gross income;**
- (7) premarital cohabitation; (8) length of courtship, and (9) length of marriage. The variables and measurement instruments are listed in Table 2.**

#### **Sample**

**Initially the research sample was obtained by inviting 200 of the 435 marital therapists randomly selected from the Michigan Register of Marriage and Family Therapy Providers, which is published by the Michigan Association for Marriage and Family Therapy (MAMFT). MAMFT is a division of the American Association for Marriage and Family Therapy (AAMFT). Individuals listed in this Register are Clinical Members of AAMFT. Clinical members have met the educational and**

**Table 2**  
**Variables and Measurement Instruments**

Variables	Measure
<b>Dependent Variable:</b>	
<b>Marital Adjustment</b>	<b>Dyadic Adjustment Scale (Total DAS Score)</b>
<b>Predictor Variables:</b>	
1. Shame	Internalized Shame Scale
2. Emotional expressiveness in family of origin	Family of Origin Expressive Atmosphere Scale
3. Pregnancy before marriage	Sociodemographic Form
4. Parental divorce as a child	Sociodemographic Form
5. Number of children	Sociodemographic Form
6. Combined gross income	Sociodemographic Form
7. Cohabitation before marriage	Sociodemographic Form
8. Length of courtship	Sociodemographic Form
9. Length of marriage	Sociodemographic Form

training standards defined by the AAMFT as being necessary for the clinical practice of marital and family therapy. Thirty-four Clinical Members agreed to participate in this study.

Because of the low response rate, all AAMFT Clinical Members in the Michigan division with email addresses were invited to participate in the study. An additional 19 Clinical Members accepted the invitation. A search and referral method was employed to recruit an additional 5 marital therapists, who were not AAMFT Clinical Members, but were in the same geographic area as the researcher.

Two of the 4 additional therapists were licensed marriage and family therapists, and the other 3 had received supervision from a licensed marriage and family therapist. The total number of therapists participating in this study was 48.

The collaborating marital therapists agreed to invite up to 4 legally married couples to participate sometime during the first 4 sessions of marital therapy. Therapists were limited to recruiting no more than 4 couples. The final sample consisted of 38 subjects including 13 couples. Inclusion in the study required that subjects be legally married adults who are presently seeking marital therapy. Legal marital status was a requirement for subject participation in this study because predictor variables 7 (cohabitation before marriage) and 9 (length of marriage) were predicated on the assumption that a legal marriage has occurred. Gay and lesbian couples that are not able to legally marry in Michigan, as well as cohabitating heterosexual couples, were excluded from this study.

#### Descriptive Statistics of the Sample

The 38 subjects included 18 males and 20 females. The number of years the subjects had been married ranged from 2 to 43, with a mean of 15.5 ( $s = 12.7$ ). The education attainment level of subjects ranged from a completion of high school to completion of a doctoral degree. The mean educational attainment level was category three, which indicated attainment of a bachelors' degree. The subjects reported a range of 0 to 4 children living with them, with a mean of 1.1 children per subject or subject couple. In this study, children living with a subject included



biological, adopted, stepchildren, or biological children from a previous relationship. The number of previous marriages per subject ranged from 0 to 2 with a mean of .3. Eight subjects had been pregnant before marriage (excluding pregnancies from previous marriages). Ten of the subjects had experienced parental divorce as a child, and 21 of the 38 cohabitated before marriage. The length of courtship ranged from 9 to 120 months, with a mean of 34.8. Twelve income categories were included in the study and the actual income range reported by subjects was from \$25,001–\$35,000 to \$125,001+, with the mean falling in the eighth category which was the \$75,001 to \$85,000 category. Of the seven ethnic/racial categories included in this study, 36 of the subjects self-reported as White/Caucasian, while two subjects self-reported as Other.

### Procedures

Initially an advertisement (Appendix B) was placed in the *Michigan Mentor*, the MAMFT Newsletter. This advertisement announced and explained the study as well as encouraged therapists to participate. Utilizing the 2001 Michigan Register of Marriage and Family Therapy Providers, 200 marital therapists were randomly chosen and mailed an invitation to participate in the study. Therapists that agreed to participate returned a postcard indicating their agreement to participate in the study and were then mailed a packet of information which included: (a) the Therapist Consent Form (Appendix C), (b) client packets (described below), and (c) instructions for the therapist (Appendix D). Phone calls were made to the therapists

**for the purpose of thanking them for their participation and to answer any questions.**

**Phone contacts were also made to therapists who had not returned the postcard in order to answer any questions and determine if they desired to participate.**

**Therapists continued to invite couples to participate in this study for up to 12 months from the beginning of the study or until four couples had agreed to participate.**

**During one of the first four marital therapy sessions, spouses were invited to participate in this research study (see directions, Appendix D). The couple was informed that it was acceptable if only one spouse participated. For subjects who elected to participate, the therapists provided each spouse with a packet that contained the following: (a) the Dyadic Adjustment Scale (DAS); (b) the Internalized Shame Scale (ISS); (c) the Family of Origin Expressive Atmosphere Scale (FOEAS); (d) the Sociodemographic Form (Appendix A); (e) instructions (Appendix E); (f) Client Consent Form (Appendix F); and (g) a form requesting each spouse to answer the testing materials alone, not in consultation with their spouse (Appendix G). Each member of the couple was requested to mail back the completed packet of materials to the researcher separately in the addressed, stamped envelope provided. During the session after the couple agreed to participate in this study, the marital therapist asked the spouse(s) that agreed to participate if they had any questions. If the clients had any questions, they were provided with the researchers' telephone numbers.**

Upon receiving the materials from couples, the researcher immediately separated and then separately stored the Client Consent Forms (Appendix F) and the form requesting spouses to fill out the testing materials separately (Appendix G), which contained the clients' names. The score on these scales (DAS, FOEAS, ISS) and answers on the Sociodemographic Form were stored separately without any identifying information. There was no need to keep a record of client names or identification numbers on the instruments. The original results will be kept in a locked file in the primary researcher's office for a minimum of 3 years.

### Instrumentation

#### Dyadic Adjustment Scale

Spanier (1989) developed the Dyadic Adjustment Scale (DAS). The scale was developed by using items from the Marital Adjustment Test (Locke & Wallace, 1959) with the addition of other items which were thought to be of potential benefit in determining marital adjustment. Marital adjustment was operationally defined as any item that was rationally related to marriage, was normally distributed, and discriminated married from nonmarried spouses (Spanier, 1989). Through item analysis, the instrument was shortened to 32 items.

The total score on the DAS ranges from 0 to 150. Of the 32 items, 27 are 6-point Likert-type scales, one is a 7-point Likert-type scale, and the two remaining items call for yes/no responses. Individuals scoring less than 100 are considered to indicate poor dyadic adjustment and are classified by as Relationally Distressed

(Spanier, 1989). Mean total scores for Spanier's (1976) original divorced and married samples were 70.7 and 114.8, respectively. Spanier (1976) derived the following four subscales from factor analysis: (1) Dyadic Satisfaction, (2) Dyadic Consensus, (3) Dyadic Cohesion, and (4) Dyadic Affectional Expression.

### Reliability

Internal consistency reliability research using Cronbach's coefficient alpha has been conducted in several studies. A summary of these results for the DAS total score (excluding the results for subscales scores) is listed in Table 3.

Table 3

#### Alpha Reliability Coefficients for the Dyadic Adjustment Scale

Source	Alpha for DAS Total Score
Spanier (1976)	.96
Sharpley & Cross (1982)	.96
Filsinger & Wilson (1983)	
Males	.94
Females	.93
Antill & Cotton (1982)	
Males	.90
Females	.92
Johnson & Greenberg (1985)	.84

### Validity

Spanier (1976) administered the scale to married ( $N = 218$ ) and divorced ( $N = 94$ ) individuals. For each item in the DAS,  $t$  tests revealed significant mean

differences (44.1,  $p < .001$ ) between the responses of the divorced and married samples. Several studies have supported the criterion-related validity of the DAS. Jacobson, Follette, and McDonald (1982) studied distressed and nondistressed couples responses to daily events. They found that the DAS was correlated with more reactive responses for the distressed than nondistressed couples. Smolen, Spiegel, and Martin (1986) found that low DAS scores indicated poor marital functioning and were related to depression and ineffectual communication.

Some have questioned whether the DAS measures marital "satisfaction" as opposed to "adjustment." These critics have pointed out that the criteria utilized for inclusion of items were atheoretical, yet psychometrically valid. Heyman, Sayers and Bellack (1994) compared brief measures of marital satisfaction (a measure of content validity) with the DAS. DAS scores were highly correlated with the Quality of Marriage Index (Norton, 1983) and Relationship Satisfaction Questionnaire (Burns & Sayers, 1992).

Probably the most important debate surrounding the DAS has been whether it is a unidimensional scale, which measures only global couple adjustment, or is a multidimensional scale that measures four subscales. The multidimensional factor structure of the DAS was not replicated by Bourchard, Sabourin, Lussier, Wright, and Boucher (1991). Kazak, Jarmas, and Snitzer (1988) found only weak support for the multidimensionality and recommended that the DAS is best used as a global measure. However Crane, Busby, and Larson (1991) conducted a study which utilized a factor analysis and supported the multidimensionality of the DAS,

especially with distressed couples. Yet they found problems with the first subscale (Dyadic Satisfaction) when it was used alone. More recent studies have strongly supported its multidimensionality (Kurdek, 1992; Sabourin, Lussier, Laplante, & Wright, 1990; Shek, 1995). This researcher decided not to include the subscales of the DAS in this study.

### Internalized Shame Scale

Early attempts to develop psychometric instruments to measure shame focused on shame as a state induced by particular circumstances. By contrast, the Internalized Shame Scale (ISS) (Cook, 1987, 1994) focused upon shame as an internalized state of long standing. Construction of the ISS began with a pool of 90 items drawn from phenomenological descriptions of the experience of shame. Through item analysis, the current version of the ISS has been shortened to 30 items (Cook, 1994). A factor analysis of the ISS has not yielded factors that were sufficiently independent of each other, thus reinforcing the unidimensionality of the instrument as a measure of shame (Chang, 1989; Novak, 1986). While the ISS consists of 30 items, only 24 items comprise the ISS score. The remaining 6 items are positively stated items whose main purpose is to reduce the potential response set. These 6 items were taken from the Rosenberg Self-Esteem Scale (Rosenberg, 1965) and can be used as an independent measure of self-esteem. These 6 items are included in the present study.

A 5-point Likert-type scale ranging from 0 (Never) to 4 (Almost Always) is used in responding to each item on the ISS. Before obtaining the composite score, the 6 items comprising the self-esteem scale (items 4, 9, 14, 18, 21, and 28) are omitted. The raw score for the remaining 24 items is summed for the ISS score. The ISS Manual (Cook, 1999) provides normative data for clinical and nonclinical populations. The mean for normal adult males was 30 ( $N = 382$ ) and for normal females, 33 ( $N = 748$ ) (Cook, 1999). Cook contends that scores of 50 or higher on the ISS are indicative of painful, possibly problematic levels of internalized shame. Scores of 60 or higher may be considered very high or extreme and likely to be associated with more severe symptoms such as depression and/or anxiety. The mean for the clinical group, which includes both genders, was 50 ( $N = 180$ ).

### Reliability

The 24 items comprising the ISS have an alpha reliability of .95 for nonclinical groups and .96 for clinical groups (Cook, 1994). Rybak (1991) reported a reliability coefficient of .97 for a mixed clinical and nonclinical sample ( $N = 159$ ). McFarland (1992) reported a reliability coefficient of .94 for a nonclinical college age sample ( $N = 173$ ). Goss, Gilbert, and Allen (1994) obtained an alpha coefficient of .94 and a test retest coefficient of .94 ( $N = 156$ ) after 5 weeks.

### Validity

Content validity has been demonstrated by comparing the ISS negative correlations with measures of self-esteem (which measures positive feels toward self). Cook (1999) reports the results of five studies utilizing different self-esteem measures. The ISS correlated negatively with the Coopersmith Scale ( $r = -.52$ ,  $p < .001$ ,  $N = 92$ ), the Janis-Field Feelings of Inadequacy Scale ( $r = -.77$ ,  $p < .001$ ,  $N = 186$ ), and the Rosenberg Self-Esteem Scale ( $r = -.74$ ,  $p < .001$ ,  $N = 85$ ) (Cook, 1999). Chang's study reported a correlation of  $r = -.90$  between the ISS and the Rosenberg Self-Esteem Scale, and a correlation of  $r = -.90$  between the ISS and the Cheek and Buss Self -Esteem Scale. Chang also examined the correlations of the ISS and these two shame scales with a large number of other variables, including depression, anxiety, and anger. He found that the patterns of correlation were nearly identical for the shame and self-esteem measures and concluded that shame and self-esteem were unidimensional (i.e., lower levels of shame are correlated with higher levels of self-esteem).

The ISS has also been studied in relation to depression as measured by the Beck Depression Inventory (BDI). Table 4 presents the ANOVA results comparing the ISS to the four categories of the BDI. These categories are recommended by Beck and Steer (1987).



**Table 4**  
**ANOVA Results Comparing the BDI and the ISS**

<b>Group/BDI Category</b>	<b><i>N</i></b>	<b>Mean</b>	<b><i>SD</i></b>	<b><i>F</i></b>	<b>Probability</b>
1. Asymptomatic	40	29.1	13.2	65.54	.00001
2. Mild Depression	46	41.6	15.1		
3. Moderate Severe	57	61.1	14.8		
4. Extreme	42	68.9	15.9		

Post hoc test (Newman-Keuls)  $p < .05$

Group 2 > Group 1; Group 3 > Groups 1 and 2; Groups 4 > Groups 1, 2, and 3

Cook, 1996, p. 158.

#### Family of Origin Expressive Atmosphere Scale

The precursor of the Family of Origin Expressive Atmosphere Scale (FOEAS) was the Family of Origin Scale (FOS) (Hovestadt et al., 1985). The FOS was designed to measure self-perceived levels of overall health in a family of origin. It was comprised of 40 items to which participants respond on a 5-point Likert scale. Guided by the Timberlawn study of healthy families (cited in Lewis, Beavers, Gossett, & Phillips, 1976), the authors of the FOS developed a multidimensional instrument to measure the general concepts of autonomy and intimacy as well as 10 subscales: (1) Clarity of Expression, (2) Responsibility, (3) Respect for Others, (4) Openness to Others, (5) Acceptance of Separation and Loss, (6) Range of

Feelings, (7) Mood and Tone, (8) Conflict Resolution, (9) Empathy, and (10) Trust. The FOS overall score has a test–retest reliability of  $r = .97$  and coefficient alpha of  $.97$  ( $N = 41$ ), which strongly support the test’s reliability (Hovestadt et al., 1985).

The construct validity of the original FOS has been questioned (Yelsma et al., 2000). In addition, a debate surfaced regarding whether the FOS was a unidimensional or multidimensional measure. Five separate studies identified one major construct as a primary or secondary factor (Gavin & Wamboldt, 1992; Kline & Newman, 1994; Lee, Gordon, & O’Dell, 1989; Mazer, Mangrum, Hovestadt, & Brashear, 1990; Saunders et al., 1994). It has been concluded that the FOS measures perceived “communicative atmosphere or climate within [the] family of origin” (Yelsma et al., 2000, p. 356) and should be used as a global measure of the quality of communication in the family of origin (Saunders et al., 1994).

### Reliability

The unidimensional Family of Origin Expressive Atmosphere Scale (FOEAS) (Yelsma et al., 2000) was developed from the FOS as a measure of perceived level of global expressive atmosphere in the family of origin. It is a 22-item instrument with a Cronbach alpha of  $r = .97$  and a Guttman split half alpha of  $r = .94$  ( $N = 416$ ). These results are similar to the reliability data cited earlier for the FOS. The FOEAS uses a 5-point Likert scale that ranges from 1 = Strongly Agree to 5 = Strongly Disagree. Total scores for the 22 items range from 22 (low) to 110 (high).

### Validity

Because the FOEAS is a new scale, only one study has been conducted exploring the instrument's validity. Yelsma et al. (2000) found that the FOEAS had statistically significant negative correlations with alexithymia in adults ( $r = -.42$ ,  $p < .001$ ,  $n = 295$ ). Alexithymia is (a multidimensional personality trait defined as an affective and cognitive difficulty experiencing and expressing emotion.. This study also reported that lower levels of expressive atmosphere in the family of origin (as measured by the FOEAS) was inversely correlated, with adults experiencing: (a) impaired ability to identify feelings ( $r = -.37$ ,  $p < .0001$ ); (b) impaired ability to describe feelings ( $r = -.42$ ,  $p < .0001$ ); and (c) externally oriented thinking ( $r = -.21$ ,  $p < .05$ ) (Yelsma et al., 2000).

### Sociodemographic Form

The sociodemographic form, developed by this researcher, is presented in Appendix A. This form included questions pertaining to the demographic predictor variables. In addition, other demographic information was collected to assist in determining the of representativeness of the sample

### Hypotheses and Statistical Analysis

The data obtained in this study were analyzed using correlational and multiple regression analyses. Scores on the DAS were the dependent variable. The predictor variables included scores on the ISS and the FOEAS. The

sociodemographic form provided seven additional predictor variables: (a) the occurrence of parental divorce as a child, (b) the occurrence of pregnancy before marriage, (c) number of children, (d) combined gross income, (e) cohabitation before marriage, (f) length of courtship, and (g) length of marriage. Because of the small sample size, no unit analysis was conducted regarding couples scores. Instead, only subject scores were used in this study (and no significant differences existed between the wife and husband scores). Table 5 lists the variables in this study.

**Table 5**

**Variables in the Study**

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<b>Y = Dependent Variable = Dyadic Adjustment Score (Total Score)</b>	
<b>X<sub>1</sub> = ISS</b>	<b>X<sub>2</sub> = FOEAS</b>
<b>X<sub>3</sub> = Pregnant before marriage (Yes/No)</b>	<b>X<sub>4</sub> = Parental Divorce (Yes/No)</b>
<b>X<sub>5</sub> = Number of Children</b>	<b>X<sub>6</sub> = Combined Gross Income</b>
<b>X<sub>7</sub> = Premarital Cohabitation (Yes/No)</b>	<b>X<sub>8</sub> = Length of Courtship</b>
<b>X<sub>9</sub> = Length of Marriage</b>	

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SPSS software (CITE) was used to conduct all statistical analysis in this study. A multiple regression analysis was conducted using the entire prediction equation (including all predictor variables). Then, another regression analysis was conducted utilizing a stepwise forward decision model, which was employed to determine which predictor variables would be the best fit for a prediction model. Correlations of each variable to the other predictor variables and the dependent

variable were conducted. In addition, tests for linearity for each predictor variable and *t* tests between gender groups were conducted. Alpha  $\leq$  .05 for all statistical analysis.

### Null Hypotheses

1. Levels of shame (as measured by the ISS, Cook, 1999) will not predict levels of distress at marital therapy onset (as measured by the DAS, Spanier, 1989).
2. Levels of emotional expressive atmosphere in the family of origin (as measured by the FOEAS, Yelsma et al., 2000) will not significantly predict levels of distress at marital therapy onset (as measured by the DAS, Spanier, 1989).
3. The occurrence of pregnancy before marriage will not significantly predict levels of distress at therapy onset (as measured by the DAS, Spanier, 1989).
4. The occurrence of parental divorce as a child will not significantly predict levels of distress at marital therapy onset (as measured by the DAS, Spanier, 1989).
5. The number of children will not significantly predict levels of distress at marital therapy onset (as measured by the DAS, Spanier, 1989).
6. Levels of combined gross income will not significantly predict levels of distress at marital therapy onset (as measured by the DAS, Spanier, 1989).
7. Premarital cohabitation will not significantly predict levels of distress at marital therapy onset (as measured by the DAS, Spanier, 1989).
8. The length of courtship will not significantly predict levels of distress at marital therapy onset (as measured by Spanier, 1989).

**9. The length of marriage will not significantly predict levels of distress at marital therapy onset (as measured by Spanier, 1989).**

### **Limitations**

**A major limitation of this study is there is no way of knowing whether other predictor variables may have equal or greater impact upon the dependent variable than those predictor variables included in this study. Also, the sample was drawn from couples seeking marital therapy from therapists who were almost exclusively AAMFT Clinical Members in Michigan. It is possible that couples seeking therapy from AAMFT Clinical Members may be more distressed (compared to couples seeking therapy from other mental health providers such as psychologists, social workers, or clergy). How well the results will generalize to couples seeking marital therapy from other mental health providers is not known. The possibility of measurement error needs to be considered in any study, especially studies that use self-report instruments. While each of the research instruments chosen has sufficient reliability and validity psychometric properties, a degree of measurement error is unavoidable. However, any study attempting to explore this subject area will encounter similar problems.**

### **Summary**

**This is an analytical variable study that utilized correlational and multiple regression analyses. After conducting a multiple regression analysis for the entire**

**prediction equation, a stepwise forward addition decision model was conducted to determine which variables would result significantly predict the dependent variable. Follow-up correlations between each predictor variable and all other predictor variables and the dependent variable were conducted. Lower levels of marital satisfaction (as measured by the DAS, Spanier, 1989) is the dependent variable and levels of shame (as measured by the ISS, Cook, 1999), levels of emotional expressive atmosphere (as measured by the FOEAS, Yelsma et al., 2000), the occurrence of pregnancy before marriage, the occurrence of parental divorce as a child, number of children, combined gross income, premarital cohabitation, length of courtship, and length of marriage are the predictor variables.**

## CHAPTER IV

### RESULTS

The present study was designed to identify selected variables that would significantly predict higher levels of distress at marital therapy onset. The dependent variable was levels of marital distress (which were defined as lower dyadic adjustment scores on the DAS; Spanier, 1989). The nine predictor variables were: (1) levels of shame (as measured by the Internalized Shame Scale (ISS) (Cook, 1999); (2) levels of emotional expressive atmosphere in the family of origin (as measured by the Family of Origin Expressive Atmosphere Scale (FOEAS) (Yelsma et al., 2000); (3) the occurrence of pregnancy before marriage; (4) the occurrence of parental divorce; (5) number of children; (6) combined gross income; (7) premarital cohabitation; (8) length of courtship; and (9) length of marriage.

SPSS software (CITE) was used to conduct all statistical analyses in this study. Before conducting the multiple regression analysis, *t* tests were conducted between male and female mean scores on all predictor variables and the dependent variable. There were no significant results on any of the *t* tests and, therefore, male and female subject scores were combined for the multiple regression analysis.

Tests for linearity were determined by conducting a multiple regression analysis using a quadratic model (where the scores for each variable are squared). The *t* test for each beta weight in a quadratic model yields a curvature coefficient. If



the curvature coefficients for each variable were nonsignificant, then it was concluded that the assumption of linearity was met. If the  $t$  tests were significant, it was concluded that the variable might be better explained using a quadratic model (where there is one bend in the regression line) as opposed to a linear model. The results of the quadratic regression yielded nonsignificant  $t$  tests for the beta weight for all of the predictor variables with the exception of combined gross income.

The frequency distribution of combined gross income and the dependent variable was examined. The distribution was normal except for the final two categories. The 11th category (\$115,001–\$125,000) had only 1 subject, while the 12th and final category (125,000+) had 6 subjects. This suggests that a possible ceiling effect may be causing the curve in the regression line as opposed to a true nonlinear distribution. This was probably due to the fact that the subjects in the sample had higher levels of combined gross income than was anticipated. To determine whether to use a linear or quadratic model for levels of combined gross income, the results were calculated first with all variables in the linear model, and secondly with all variables in a linear model with the exception of combined gross income, which was in a quadratic model. The results between these two multiple regression analyses were almost identical. Therefore, the decision was made that the nonlinear distribution between combined gross income and the dependent variable was due to the presence of outlier scores that resulted in a ceiling effect, as opposed to a true nonlinear relationship. Subsequently, the data were analyzed using a multiple regression analysis based upon a linear model for all predictor variables.

This multiple regression analysis utilized a stepwise forward decision model and resulted in four variables in the final prediction model ( $\alpha \leq .05$ ). The results of the multiple regression analysis are presented in Table 6.

**Table 6**  
**Model Summary**

<b>Model</b>	<b>R</b>	<b>R<sup>2</sup></b>	<b>Adjusted R<sup>2</sup></b>	<b>Std. Error of the Estimate</b>	
	.673	.453	.386	14.3291	
<b>ANOVAR Model</b>	<b>Sum of Squares</b>	<b>df</b>	<b>Mean Square</b>	<b>F</b>	<b>Sig.</b>
Regression	5603.731	4	1400.933	6.823	.000
Residual	6775.637	33	205.322		
Total	12379.368	37			
<b>Predictors: (Constant), Combined Gross Income, Length of Marriage, Parental Divorce as a Child, Shame (as measured by the ISS)</b>					
<b>Dependent Variable: Marital Distress (as measured by the DAS)</b>					
<b>Coefficients Model</b>	<b>Sum of Squares</b>	<b>df</b>	<b>Beta</b>	<b>t</b>	<b>Sig.</b>
(Constant)	46.985	14.931		3.147	.003
Combined Gross Income	3.932	1.042	.504	3.774	.001
Length of Marriage	-.727	.209	-.503	-3.482	.001
Parental Divorce	14.587	5.796	.356	2.517	.017
Shame	-.301	.138	-.284	-2.170	.037

Lower dyadic adjustment scores on the dependent variable are interpreted to mean higher levels of marital distress. The variable with the highest beta weight and therefore the strongest predictive value in the final prediction model was combined gross income ( $t = 3.774, p < .001$ ). Lower levels of combined gross income significantly predicted higher levels of marital distress at marital therapy onset. The variable with the second largest beta weight was length of marriage ( $t = -3.482, p < .001$ ), which means that the longer length of marriage significantly predicted higher levels of distress at marital therapy onset. The variable with the third largest beta weight was parental divorce as a child ( $t = 2.517, p < .017$ ), which means that when a subject experienced parental divorce as a child, it significantly predicted higher levels of distress at marital therapy onset. Finally, the variable with the fourth largest beta weight was shame ( $t = -2.170, p < .037$ ), which means that higher levels of shame as measured by the ISS (Cook, 1999) significantly predicted higher levels of distress at marital therapy onset. The combination of the four predictor variables in the final prediction model (lower levels of combined gross income, parental divorce as a child, longer duration of marriage, and higher levels of shame) significantly predicts distress at marital therapy onset ( $R^2 = .453$ ). The other six predictor variables did not meet criteria for inclusion in the final prediction model.

A post-hoc analysis of correlations between the nine predictor variables and the dependent variable was conducted. There was a significant correlation between lower levels of emotional expressiveness in the family of origin (as measured by the FOEAS (Yelsma et al., 2000) and higher levels of shame (as measured by the ISS,

Cook, 1999) ( $r = -.462, p < .002$ ). Thus, higher levels of shame are significantly correlated with lower levels of emotional expressive atmosphere in the family of origin.

### **Decision Regarding Null Hypotheses**

The following null hypotheses were retained:

1. Levels of emotional expressive atmosphere in the family of origin (as measured by the FOEAS, Yelsma et al., 2000) will not significantly predict levels of distress at marital therapy onset (as measured by the DAS, Spanier, 1989).
2. The occurrence of pregnancy before marriage will not significantly predict levels of distress at marital therapy onset (as measured by the DAS, Spanier, 1989).
3. The number of children will not significantly predict levels of distress at marital therapy onset (as measured by the DAS, Spanier, 1989).
4. Premarital cohabitation will not significantly predict levels of distress at marital therapy onset (as measured by the DAS, Spanier, 1989).
5. The length of courtship will not significantly predict levels of distress at marital therapy onset (as measured by Spanier, 1989).

The following null hypotheses were rejected:

1. Levels of shame (as measured by the ISS, Cook 1999) will not predict levels of distress at marital therapy onset (as measured by the DAS, Spanier, 1989).
2. The occurrence of parental divorce as a child will not significantly predict levels of distress at marital therapy onset (as measured by the DAS, Spanier, 1989).

**3. Levels of combined gross income will not significantly predict levels of distress at marital therapy onset (as measured by the DAS, Spanier, 1989).**

**4. The length of marriage will not significantly predict levels of distress at marital therapy onset (as measured by Spanier, 1989).**

**Four predictor variables (lower combined gross income, parental divorce as a child, length of marriage, and shame) remained in the final prediction model. The combination of these four variables significantly predicts levels of distress at marital therapy onset (as measured by the DAS, Spanier, 1989).**

**Because the dependent variable was level of distress at marital therapy intake, it was important to look at the distribution of the subject scores on the DAS. The mean for the DAS in this study was 83.7 ( $s = 18.29$ ). According to Spanier (1989), raw scores below 100 on the DAS indicate relational distress. Mean total scores for Spanier's (1976) original divorced and married samples were 70.7 and 114.8, respectively. Therefore, it is concluded that subjects in this study were representative of persons experiencing high levels of marital distress.**

### **Summary**

**The data in this study were analyzed by conducting a multiple regression analysis that utilized a stepwise forward decision model. Four variables (levels of combined gross income, length of marriage, parental divorce as a child, and levels of shame) were determined to significantly predict the dependent variable, higher levels of marital distress at marital therapy onset. While emotionally expressive atmosphere**

**in the family of origin did not significantly predict lower levels of marital satisfaction, it did have a significant correlation with shame.**

## **CHAPTER V**

### **SUMMARY AND DISCUSSION**

#### **Summary**

**Marital therapy outcome research has demonstrated one consistent finding across several research studies (Hampson et al., 1999; Jacobson & Addis, 1993; Snyder et al., 1993). Higher levels of distress reported by couples prior to marital therapy predict less favorable treatment outcomes. This study was conducted to determine if certain variables could be identified that predict higher levels of marital distress at marital therapy onset. Identifying these variables may assist in developing more effective theoretical models and therapeutic interventions for maritally distressed couples. Chapter II covered a review of the literature relating to shame, expressive atmosphere in the family of origin, and sociodemographic variables that predict divorce which include: (a) parental divorce as a child, (b) pregnancy before marriage, (c) number of children, (d) combined gross income, (e) premarital cohabitation, (f) length of courtship, and (g) length of marriage.**

**Forty-three Clinical Members of the American Association for Marriage and Family Therapy who belonged to the Michigan division agreed to assist the researcher in recruiting couples for this study. Five additional mental health therapists who conducted marital therapy also collaborated in this study. Two of the four additional therapists were licensed marriage and family therapists, and the other**

three additional therapists had received supervision from licensed marriage and family therapists. The collaborating therapists invited couples entering marital therapy to participate in this study at some point during one of the first four sessions.

Each subject completed the Dyadic Adjustment Scale (DAS; Spanier, 1989), the Internalized Shame Scale (ISS; Cook, 1999), the Family of Origin Emotional Atmosphere Scale (FOEAS; Yelsma et al., 2000) and a sociodemographic questionnaire (Appendix A). The DAS is a self-report questionnaire that was developed to measure dyadic adjustment. Scores of less than 100 are interpreted as indicative of relational distress. The ISS is a self-report questionnaire that measures internalized shame. Higher scores are indicative of higher levels of shame. The FOEAS is a self-report questionnaire that was designed to measure perceived “communicative atmosphere or climate within [the] family of origin” (Yelsma et al., 2000, p. 356) and is considered to be a global measure of the quality of communication in the family of origin (Saunders et al., 1994). Higher scores on the FOEAS are indicative of higher levels of emotional expressiveness in the family of origin.

The researcher developed the Sociodemographic Form. Included on this form were questions regarding the seven sociodemographic predictor variables in this study: (1) the occurrence of parental divorce as a child, (2) the occurrence of pregnancy before marriage, (3) number of children, (4) levels of combined gross income, (5) cohabitation before marriage, (6) length of courtship, and (7) length of



marriage. The sample consisted of 38 subjects including 18 males and 20 females. The number of years the subjects had been married ranged from 2 to 43, with a mean of 15.5 ( $s = 12.7$ ). The education attainment level of subjects ranged from a completion of high school to completion of a doctoral degree. The mean educational attainment level was category three which indicated attainment of a bachelors' degree. The subjects reported a range of 0 to 4 children living with them, with a mean of 1.1 child per subject or subject couple. In this study, children living with a subject included biological, adopted, stepchildren, or biological children from a previous relationship. The number of previous marriages per subject ranged from 0 to 2 with a mean of .3. Eight subjects had been pregnant before marriage (excluding pregnancies from previous marriages). Ten of the subjects had experienced parental divorce as a child, and 21 of the 38 cohabitated before marriage. The length of courtship ranged from 9 to 120 months with a mean of 34.8. Twelve income categories were included in the study. Twelve income categories were included in the study and the actual income range reported by subjects was from \$25,001–\$35,000 to \$125,001+, with the mean falling in the eighth category which was the \$75,001 to \$85,000 category. Of the seven ethnic/racial categories included in this study, 36 of the subjects self-reported as White/Caucasian, while two subjects self-reported as Other.

This analytical variable study utilized correlational and multiple regression analyses. The dependent variable was levels of marital distress as measured by the Dyadic Adjustment Scale (DAS; Spanier, 1989). The nine predictor variables were:

**(1) levels of shame (as measured by the Internalized Shame Scale (ISS; Cook, 1999); (2) levels of emotional expressive atmosphere in the family of origin (as measured by the Family of Origin Expressive Atmosphere Scale (FOEAS) (Yelsma et al., 2000); (3) the occurrence of pregnancy before marriage; (4) the occurrence of parental divorce as a child; (5) number of children; (6) levels of combined gross income; (7) premarital cohabitation; (8) length of courtship; and (9) length of marriage. A multiple regression analysis that utilized a stepwise forward decision model was conducted to determine the predictive ability of the nine predictor variables.**

### **Findings**

**Nine hypotheses were formulated and tested. The multiple regression analysis resulted in four variables that remained in the final prediction model. The variables that significantly predicted the dependent variable (higher levels of marital distress as measured by the DAS; Spanier, 1989) were: (a) lower levels of combined gross income; (b) a longer length of marriage; (c) the occurrence of parental divorce as a child; and (d) higher levels of shame (as measured by the ISS; Cook, 1999) (with  $\alpha \leq .05$ ). The combination of these four variables significantly predicted higher levels of marital distress at marital therapy onset. The proportion of variance on the dependent variable explained by these four predictor variables ( $R^2$ ) was .456. Variables that did not significantly predict the dependent variable were: (a) lower levels of emotional expressive atmosphere in the family of origin (as measured by**

the Family of Origin Expressive Atmosphere Scale (FOEAS) (Yelsma et al., 2000); (b) the occurrence of pregnancy before marriage; (c) larger number of children; (d) the occurrence premarital cohabitation; and (e) shorter length of courtship. A post hoc analysis revealed that lower levels of emotional expressive atmosphere in the family of origin (as measured by the FOEAS; Yelsma et al., 2000) were significantly correlated with higher levels of shame (as measured by the ISS; Cook, 1999).

### Conclusions and Implications

Before discussing any conclusions and implications, several factors should be noted that might limit the generalizability of this study. The sample size was below what was anticipated and relatively small given the number of predictor variables. When compared to the general population, the subject sample had higher levels of combined gross income, had attained higher levels of education, and was lacking in racial and ethnic diversity. However, the subject sample may be representative of couples seeking marital therapy, which is relatively expensive and a type of psychotherapeutic treatment that is rarely reimbursed by health care insurances or managed care organizations. Also, the sample was drawn only from couples in Michigan. How well these results generalize to the population of couples entering marital therapy with other mental health professionals is not known.

Three of the four predictor variables (lower levels of combined gross income, the occurrence of parental divorce as a child, and higher levels of shame)

investigated in this present study were identified in the professional literature as influencing marital distress or divorce. Within previously mentioned studies, shorter length of marriage was determined to predict divorce, while the present study found longer length of marriage predicted higher levels of distress at marital therapy onset. The findings of this study provided no statistically significant empirical validation of the remaining predictor variables: (a) lower levels of emotional expressive atmosphere in the family of origin, (b) occurrence of pregnancy before marriage, (c) larger number of children, (d) occurrence of premarital cohabitation, and (e) shorter length of courtship. The aforementioned variables were found not significant in predicting levels of marital distress at marital therapy onset in comparison to the other four variables in final prediction model. This would suggest that these variables may contribute nominally to marital distress at marital therapy onset, or that their contribution to the dependent variable is better explained by the other variables, which remained in the final prediction equation.

Although the predictive value of four variables—(1) lower combined gross income, (2) longer length of marriage, (3) occurrence of parental divorce as a child, and (4) higher levels of shame—were found to be statistically significant, it would be inappropriate to conclude that a direct cause and effect relationship exists between these variables and distress at marital therapy onset. However, the identification of a relationship between these four variables and marital distress at marital therapy onset can be viewed as being supportive of the theoretical view that these three sociodemographic variables and higher levels of shame may influence marital

**distress. The exact nature of the relationship between these variables awaits further theoretical development and extensive research.**

**While previous studies have found shorter length of marriage to predict divorce, this study found longer length of marriage to predict distress at marital therapy onset. This is an interesting finding that warrants further discussion. The aforementioned studies predicting divorce (Mott & Moore, 1979; South & Spitze, 1986; U.S. Department of Health, Education, and Welfare, 1979) were different from the present study in two crucial aspects. First, the studies that predicted divorce selected subjects from the general population. By comparison, the subjects included in this study were maritally distressed persons entering marital therapy. Significant differences may exist between couples divorcing in the general population and couples entering marital therapy with a desire to improve their relationship. Secondly, the investigators conducting the studies were interested in determining which sociodemographic variables predict divorce and not marital distress. While these two dependent variables (divorce and marital distress) may be related, they are not identical.**

**For couples experiencing high levels of distress, longer length of the marriage may result in higher levels of accumulated distress, which would mean that couples experiencing higher levels of distress might not self-correct over time. While the incidence of divorce decreases with length of marriage, for those couples that are experiencing significant distress and choose to stay married, it may be that the level of distress accumulates. This finding would give support for the position that**

different treatment approaches may be needed based upon length of marriage. Couples at early stages of marriage may have less accumulated distress and yet face a greater probability of divorce, while couples at later stages may have a decreased probability of divorce yet have accumulated higher levels of distress. In addition, the presence of the other predictor variables (lower levels of combined gross income, the occurrence of parental divorce as a child, and higher levels of shame) may negatively impact upon a marriage in such a way that time does not ameliorate the level of distress and may only allow it to accumulate. For couples experiencing higher levels of distress, recommending marital therapy (as opposed to waiting) might assist in decreasing the accumulation of distress and thus increase the probability of a more successful treatment outcome.

The purpose of this study was to identify variables that may predict higher levels of distress at marital therapy onset, in order to guide in the development of more effective treatment approaches for couples and especially for couples that are thought to have a lower chance of success in marital therapy. While this is a preliminary and exploratory study, the results suggest that an understanding of the impact of two sociodemographic predictor variables (higher levels of combined gross income and the occurrence of parental divorce as a child) on marital distress might need to be a greater focus in marital therapy. While it is recognized that these sociodemographic variables cannot be altered by marital therapy, it may be beneficial to increase marital therapists' and couples' awareness and understanding of how these sociodemographic variables impact marital distress. An increased

**understanding regarding how these two sociodemographic variables may be contributing to current marital distress may also help guide more effective models of marital therapy and also may assist couples to develop more effective coping strategies that could mitigate the negative influence of these sociodemographic variables.**

**The fourth variable that significantly predicted marital distress was shame. While shame is used by societies to shape human behavior (Cook, 1999), excessive amounts of shame can result in the internalization of this affect, which results in strong feelings of self-negativity. Unlike the other emotions, when shame is activated, it is not experienced as a reaction the person is having, but rather as an existential fact about the nature of oneself (as worthless, bad, or inadequate) (Nathanson, 1987). For individuals with higher levels of internalized shame, relationships become difficult.**

**Nathanson's (1987) compass of shame explains the four basic relational responses when shame is activated: (1) withdrawal, (2) avoidance, (3) attack self, and (4) attack other. When the powerful affect of shame is activated, it is a very difficult emotion to master and tolerate and, subsequently, these defenses (which are harmful to a relationship) are activated. Kaufman (1989) observed that over time, if such defenses occur in response to shame, the basic relational bond or connection (the "interpersonal bridge") becomes threatened and eventually broken.**

**One of the more significant findings in marital therapy research has been the identification of affective predictors of divorce, which have been identified as:**

(a) disgust, (b) contempt, (c) defensiveness, (d) stonewalling, (e) domineering, (f) and belligerence (Gottman, 1994; Gottman et al., 1998; Gottman & Levenson, 1992; Matthews et al., 1996). The variables that predict divorce, while not identical, are remarkably similar to what have been identified as defenses against shame: (a) rage, (b) contempt, (c) perfectionism, (d) blame, (e) projection, (f) withdrawal, and (g) denial (Fossum & Mason, 1986; Kaufman, 1989, 1992; Lansky, 1991; Nichols, 1991). An understanding of shame and the defenses against shame may add another dimension to the understanding of the affective predictors of divorce.

Balcom et al. (1995) have observed that shame is a largely hidden phenomenon in the treatment of couples. However, shame may warrant a more central role in marital therapy. Approaches that focus upon affect in general (such as Emotionally Focused Marital Therapy; Johnson, 1996; Greenberg & Johnson, 1988) and specifically focus upon increasing the ability to tolerate and master shame (such as Bowenian Family Therapy; Kerr & Bowen, 1988; Schnarch, 1991) would probably result in more effective treatments for healing shame in a relationship.

Emotional expressive atmosphere in the family of origin was significantly correlated with shame. It would be inappropriate to conclude a causal relationship between these two variables, but this result does lend some support to the theoretical position that family of origin experiences may contribute to relational difficulties later in life (Framo, 1981; Kerr & Bowen, 1988; Schnarch, 1991). This finding also would support the theoretical position that treatment approaches addressing shame may need to have some degree of focus on the family of origin.



**Tomkins (1987), Nathanson (1987), and Kaufman (1989) all consider excessive and early shaming experiences in the family of origin to play a significant role in the formation of internalized shame in adulthood.**

**The combination of all four predictor variables was the strongest predictor of marital distress at marital therapy onset ( $R^2 = .453$ ). It could be possible that some degree of systemic interaction exists between these four variables. The influence that these predictor variables (lower levels of combined gross income, longer length of marriage, occurrence of parental divorce as a child, and higher levels of shame) have upon each other warrants further investigation.**

**Implications and recommendations for the treatment of highly distressed couples include: (a) exploring the impact of parental divorce and lower levels of combined gross income on current marital functioning; (b) addressing affect in marital therapy with a particular emphasis on tolerating and mastering shame; (c) addressing the role that family of origin may play in the creation of shame; and (d) encouraging couples experiencing higher levels of distress to seek marital therapy early, because over time distressed couples may not self-correct and the degree of distress appears to accumulate.**

### **Recommendations for Future Research**

**The following are recommendations regarding future research:**

- 1. Future researchers should consider a replication of the present study or a version of the present study that utilizes a larger sample size and a more**

**representative sample population, especially in regard to racial and ethnic diversity, income level, and educational level. It would be important to include length of marriage to determine if this variable continues to predict marital distress.**

**2. Future researchers should consider a replication of this study that would include other variables examined in the professional literature. This was an exploratory study and other variables may exist which can predict marital distress at the onset of marital therapy.**

**3. Future researchers should consider a more in-depth investigation into the relationship between shame and marital distress. A more thorough understanding of the relationship between shame and marital distress could assist in developing more effective treatment models and interventions for couples.**

**4. While much of the current research in marital therapy is focused upon client interaction, future researchers should consider the inclusion of sociodemographic variables. Understanding of how sociodemographic variables may impact upon current marital functioning may assist in developing more effective treatment for couples.**

**5. A follow-up qualitative study consisting of interviewing several highly distressed couples would be beneficial. A deeper and richer understanding of the themes that these couples identify would be useful and also may assist in guiding the direction of future quantitative research.**

**Appendix A**  
**Sociodemographic Form**

**Western Michigan University**  
**Department of Counselor Education and Counseling Psychology**  
**Principal Investigator: Alan J. Hovestadt, Ed.D.**  
**Research Associate: Joseph Horak, M.S.W.**

Code #:00

**PLEASE DO NOT WRITE YOUR NAME ON THIS FORM**

**Sociodemographic Form**

Age: \_\_\_\_\_

Highest Education Level: \_\_\_\_\_ less than 12 years \_\_\_\_\_ High School graduate  
 \_\_\_\_\_ 2 years of college \_\_\_\_\_ Bachelor's Degree  
 \_\_\_\_\_ Master's Degree \_\_\_\_\_ Doctoral (Ph.D., M.D., J.D., Ed.D.)

Ethnic/Racial Background: \_\_\_\_\_ African American \_\_\_\_\_ Latino/Hispanic  
 \_\_\_\_\_ Asian/Pacific \_\_\_\_\_ Native American \_\_\_\_\_ White/Caucasian  
 \_\_\_\_\_ Other: Please specify: \_\_\_\_\_

Length of Current Marriage: \_\_\_\_\_

Please write the ages for any biological or adopted children from your current marriage. Place a circle around the age number of those currently living with you:

\_\_\_\_\_

\_\_\_\_\_

Please write the ages for any other biological children you have.  
 Place a circle around the age number of those currently living with you:

\_\_\_\_\_

\_\_\_\_\_

Please write the ages for any step children your spouse has from other relationships.  
 Place a circle around the age number of those currently living with you:

\_\_\_\_\_

\_\_\_\_\_

Please write the ages for any step children you have from other relationships.  
 Place a circle around the age number of those currently living with you:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Western Michigan University**  
**Department of Counselor Education and Counseling Psychology**  
**Principal Investigator: Alan J. Hovestadt, Ed.D.**  
**Research Associate: Joseph Horak, M.S.W.**

**PLEASE DO NOT WRITE YOUR NAME ON THIS FORM**

Code #: 00

**Sociodemographic Form—Continued**

Number of previous marriages \_\_\_\_\_

Please answer the following questions in regard to your current marriage.

2. Disregarding pregnancies from previous marriages or relationships, were you (or your spouse) pregnant before your marriage? Yes No
  3. Did your parents divorce when you were 18 or younger? Yes No
  4. Did you and your current spouse live together before your marriage? Yes No
  5. How long was your courtship (dating period and time living together) before your marriage? \_\_\_\_\_ (in months)
  6. What is your combined gross income range (include both spouses income)?
 

_____ \$0 – \$17,000	_____ \$17,001 – \$25,000
_____ \$25,001 – \$35,000	_____ \$35,001 – \$45,000
_____ \$45,001 – \$55,000	_____ \$55,001 – \$65,000
_____ \$65,001 – \$75,000	_____ \$75,001 – \$85,000
_____ \$85,000 - \$95,000	_____ \$95,001 – \$115,000
_____ \$115,001 - \$125,000	_____ \$125,001 +
-

**Appendix B**

***Advertisement in Michigan Monitor***

### **An Opportunity to Help the Profession**

**Previous research has shown that couples who are more distressed at intake are more likely to have a poor marital therapy outcome. This study is an attempt to determine which variables may contribute to higher levels of distress at intake. The knowledge gained in this study may assist in the development of more effective treatments for couples.**

**This study will be exploring the following variables and their relation to level of distress pre-treatment: (a) shame (which is highly correlated to individual symptoms and some relational problems); (b) emotional expressive atmosphere in one's family of origin (which theoretically has been thought to contribute to relational problems by Bowen, Framo, and Schnarch) and (c) demographic factors which can predict divorce.**

**Soon some of you will be receiving a letter inviting you to participate in this research project. The demands on therapist's time will be very minimal. It will require inviting couples during the marital therapy intake session, to participate in the study. For each spouse that agrees, you will give them a sealed envelope containing the necessary materials for this research. At home, after the session, the couple will answer the questions on the instruments (which should take the couple about 30 to 60 minutes) and the couple will then mail the packet to the researcher. After four couples agree to participate or three months has passed, nothing further is required of you. A summary of the research findings will be mailed to you.**

**Alan Hovestadt, Ed.D., Principal Investigator and Academic Advisor  
Joe Horak, M.S.W., Research Associate and Doctoral Student**

**Department of Counselor Education and Counseling Psychology, Western Michigan University**

**This advertisement has been approved by the Human Subjects Review Board of Western Michigan University**

**Appendix C**

**Therapist Consent Form to Participate  
in Research Study**



WESTERN MICHIGAN UNIVERSITY  
 H. S. I. R. B.  
 Approved for use for one year from this date:

FEB 0 8 2001

x Michael J. Pritchard  
 HSIRB Chair -

Western Michigan University  
 Department of Counselor Education and Counseling Psychology  
 Principal Investigator: Alan J. Hovestadt, Ed.D.  
 Research Associate: Joseph Horak, M.S.W.

### **Therapist Consent to Participate in Research Study**

I have been invited to participate in a research project entitled "Factors Predicting Distress at Marital Therapy Intake." The goal of this research is to gain a better understanding of what factors contribute to higher levels of distress in couples before they begin treatment. Previous research has shown that higher levels of distress at marital therapy intake, predicts a poorer response to marital therapy. The increase in knowledge, from this study, may assist in development of more effective marital therapy interventions.

I will be mailed packets of materials to give to four couples. I will be asked to invite married couples seeking my services for marital therapy to participate in this research project. After four couples agree to participate, or after three months my participation in this study will end. I will read the instructions provided to the couples sometime during the first marital therapy session. It is acceptable for only one spouse to agree to participate. I will provide each spouse that agrees to participate a packet containing the research materials. Each spouse will answer the questions on the measures after the session at their home or office and mail them directly to the researchers. Sometime during the second session, I will ask the spouse(s) that participated if they have any questions about the research and provide them with the researchers names and numbers if the answer is yes.

As in all research, there may be unforeseen risks to those participating. I understand that clients participating in this study, may potentially experience some discomfort, when they complete the scales and demographic questionnaire. I agree to be available to discuss any discomfort if this occurs with my clients. The researchers Alan Hovestadt, Ed.D. (616.387.5117), and Joseph Horak, M.S.W. (616.458.9472) will be available for any short term crisis consultation, if it is necessary. In addition, the researchers will be available for any consultation I may request if any client difficulties arise. If the client desires therapy resulting from any discomfort from their participation in this study, in addition to the marital therapy services I am providing, the researchers will refer for this service. The client will be responsible for the cost of these services if needed.

WESTERN MICHIGAN UNIVERSITY  
H. S. I. R. B.  
 Approved for use for one year from this date:

FEB 08 2001

x *Michael J. Fitch*  
 HSIRB Chair

Western Michigan University  
 Department of Counselor Education and Counseling Psychology  
 Principal Investigator: Alan J. Hovestadt, Ed.D.  
 Research Associate: Joseph Horak, M.S.W.

### Therapist Consent to Participate in Research Study- Continued

The knowledge gained from this research may benefit the profession, by assisting in developing more effective treatments for more distressed couples entering treatment. I will be sent a summary of the research findings when they are completed.

My participation in this research will be kept confidential. I may refuse to participate or quit at any time during the study without prejudice or penalty. If I have any questions or concerns about this study, I may contact either Alan Hovestadt, Ed.D. at 616.387.5117 or Joseph Horak, M.S.W. at 616.458.9472. I may also contact the chair of the Human Subjects Institutional Review Board at 616.387.8293 or the vice president for research at Western Michigan University at 616.387.8298 with any concerns I may have.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. Subjects should not sign this document if the corner does not have a stamped date and signature.

My signature below indicates that I have read and/or had explained to me the purpose and requirements of the study and that I agree to participate.

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

Consent obtained by: \_\_\_\_\_  
 initials of researcher

\_\_\_\_\_  
 Date

## **Appendix D**

### **Instructions for Participating Therapists and Staff**

Western Michigan University  
Department of Counselor Education and Counseling Psychology  
Principal Investigator: Alan J. Hovestadt, Ed.D.  
Research Associate: Joseph Horak, M.S.W.

### **Instructions for Therapists**

Thanks for considering to participate in this study.

**Step one:** Please read the **CONSENT FORM FOR THERAPISTS**. You need to sign and return this form in the addressed stamped envelope that is provided.

After you have signed and mailed this form back to the researchers continue to step two.

**Step two:** Please read the instructions (on the RED paper) to couples during the first marital therapy session. It is acceptable if only one spouse desires to participate in the research study. You will provide each spouse that desires to participate with the packet of testing materials. (Four packets have been mailed to you.) They will answer the questions on the research materials at home or in their office and mail them directly to the researchers. In the second session, you will read the second set of instructions inquiring if they have any questions for the researchers. Once two couples have agreed to participate and they are mailed the packets, nothing further is required from you.

After the research is completed I will be mailing you a summary of the findings. Thanks for your assistance with this research project.

If you have any questions whatsoever, please contact the principal investigator, Alan Hovestadt, Ed.D. at 616.387.5117 or the research associate, Joseph Horak, M.S.W. at 616.458.9472 any time.

**Western Michigan University  
Department of Counselor Education and Counseling Psychology  
Principal Investigator: Alan J. Hovestadt, Ed.D.  
Research Associate: Joseph Horak, M.S.W.**

### **VERBAL INSTRUCTIONS**

**Please read the following instructions sometime during the initial marital therapy session.**

#### **Therapist Scheduling appointment:**

**I am participating in a research project that is studying some aspects related to couples beginning marital therapy. If you are interested you can participate in this study. Are you interested in hearing a little more information?**

**If the answer is yes: This study is trying to determine what may cause couples to be distressed before they enter marital therapy. This type of study may help us develop more effective approaches for couples seeking marital therapy. If you agree to participate, it would require that you answer 97 brief questions. It will probably take between thirty and sixty minutes. Because the measurement instruments are only accurate if they are filled out by one spouse, you will be asked to answer these questions by yourself and to not discuss them with your spouse.**

**Your participation is completely voluntary and you can quit at anytime. If you decide not to participate it will not effect your marital therapy in any way. All information you provide in this research study will be kept confidential. The answers will only be seen by the researchers, and any publications will not contain only reports of group scores without any identifying information.**

**It is acceptable if only one spouse wishes to participate in this study.**

**Are you interested in participating?**

Western Michigan University  
Department of Counselor Education and Counseling Psychology  
Principal Investigator: Alan J. Hovestadt, Ed.D.  
Research Associate: Joseph Horak, M.S.W.

### **VERBAL INSTRUCTIONS - CONTINUED**

**If the answer is yes:** Here is a packet of materials. The phone numbers for the researchers are included if you have any questions. When you have finished participating in this study, there is an included stamped envelope to mail the materials back to the researchers.

**If the answer is no:** Thank you for considering to participate in this study. Your decision to not participate will not have any negative impact on your therapy.

### **SECOND SESSION INSRUCTIONS**

Sometime during the second session read the following question:

Do you have any questions about the research project?

**If yes:** Here is a card with the researchers names and numbers. Please call them.

**If no:** Thank you for considering to participate in this study.

**Appendix E**  
**Client Instructions**

Western Michigan University  
 Department of Counselor Education and Counseling Psychology  
 Principal Investigator: Alan J. Hovestadt, Ed.D.  
 Research Associate: Joseph Horak, M.S.W.

## INSTRUCTIONS

### PLEASE READ BEFORE OPENING SEALED ENVELOPES

Thank you for taking the time to consider participating in this research project. This type of research increases our knowledge base and may help in developing more effective treatments for couples seeking marital therapy. Your participation is completely voluntary and you may quit at any time. Also, it is acceptable if one spouse desires to participate and the other does not.

**STEP ONE:** First, please read and if you decide to participate in this research study, sign the **CLIENT CONSENT TO PARTICIPATE IN RESEARCH FORM**. Please read and sign this form before proceeding to step two.

**STEP TWO:** Please read and sign the **PARTICIPANTS AGREE TO SEPARATELY ANSWER INSTRUMENTS FORM**. The instruments are more accurate if they are completed without discussing them with your spouse.

**STEP THREE:** Open the sealed packet. Please read the instructions carefully before answering the questions on each form. Your packet includes the Dyadic Adjustment Scale, the Family of Origin Expressiveness Scale, the Internalized Shame Scale and a Sociodemographic Form. Then place all of these materials into the provided stamped and addressed **WHITE** envelope and mail it back to the researchers.

If you have any questions please contact the researchers, the Human Subjects Institutional Review Board, or the Vice President for Research at Western Michigan University at the phone numbers below.

Thank you for taking the time to consider being a part of this study.

#### RESEARCHERS:

Alan Hovestadt, Ed.D. Principal Investigator	616.387.5117
Joseph Horak, M.S.W. Research Associate	616.458.9472
Human Subjects Institutional Review Board	616.387.8293
Vice President for Research	616.387.8298



**Appendix F**  
**Client Consent to Participate**  
**in Research Study**

WESTERN MICHIGAN UNIVERSITY  
H. S. I. R. B.  
Approved for use for one year from this date:

FEB 08 2001

x Michael A. Hovestadt  
HSIRB Chair

Western Michigan University  
Department of Counselor Education and Counseling Psychology  
Principal Investigator: Alan J. Hovestadt, Ed.D.  
Research Associate: Joseph Horak, M.S.W.

### **Consent to Participate in a Research Project**

I have been invited to participate in a research project entitled "Factors Predicting Distress at Marital Therapy Intake." The goal of this research is to gain a better understanding of what factors may contribute to higher levels of distress in couples before they begin marital therapy. The knowledge gained from this study may increase our knowledge and assist in development of more effective marital therapies.

If I choose to participate, I will read and answer the following three instruments: the Family of Origin Expressive Atmosphere Scale, the Dyadic Adjustment Scale and the Internalized Shame Scale. I will also be asked to complete a brief Socio-demographic Form, which will ask some background information. It will probably take between 30 to 60 minutes to participate. I will be asked to fill out these instruments separate from my spouse and to mail the results to the researchers in the enclosed WHITE envelope. There are no further requirements. This study hopes to have 35 couples participate.

As in all research, there may be unforeseen risks to the participant. One potential risk of my participation is that I may experience some discomfort by the content of the questions I am answering. If this happens to occur, I can discuss such discomfort with my marital therapist. In addition, the researchers, Alan Hovestadt, Ed.D. and Joseph Horak, M.S.W. are prepared to provide short-term crisis counseling. If I should become significantly upset and desire a referral to a separate therapist for counseling, a referral will be made by the researchers. I will be responsible for the cost of any additional therapy if I choose to pursue it.

I also understand there are no direct benefits for my participating in this research study. The knowledge gained from this study may assist in the development of more effective ways to help future couples seeking marital therapy.

WESTERN MICHIGAN UNIVERSITY  
 H. S. I. R. B.  
 Approved for use for one year from this date:

FEB 08 2001

x *Michael A. Pritchard*

HSIRB Chair

Western Michigan University  
 Department of Counselor Education and Counseling Psychology  
 Principal Investigator: Alan J. Hovestadt, Ed.D.  
 Research Associate: Joseph Horak, M.S.W.

### Consent to Participate in a Research Project- Continued

All of the information collected will be confidential. That means that my name will not appear on any papers except this consent form and the agreement to complete the instruments separately form. The answers sheets I complete will not contain my name, but only have a number. The researcher will store the forms with my name separate from the answer sheets. No list will be made to show which answers belong to which clients. All records will be kept in a locked file in the principal investigators office for a minimum of three years.

**My participation will not affect my status with my therapist and my individual responses will not be shared with my therapist.** I may refuse to participate or quit at any time during the study without prejudice or penalty. If I have any questions or concerns about this study, I may contact either Alan Hovestadt, Ed.D. at 616.387.5117 or Joseph Horak, M.S.W. at 616.458.9472. I may also contact the chair of the Human Subjects Institutional Review Board at 616.387.8293 or the vice president for research at Western Michigan University at 616.387.8298 with any concerns that I have.

The consent documentation has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. Subjects should not sign this document if the corner does not have a stamped date and signature. My signature below indicates that I have read and/or had explained to me the purpose and requirements of the study and that I agree to participate.

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

Consent obtained by: \_\_\_\_\_

initials of researcher

\_\_\_\_\_  
 Date

## **Appendix G**

### **Participants' Agreement to Complete Testing Instruments Separately**

WESTERN MICHIGAN UNIVERSITY  
H. S. I. R. B.  
Approved for use for one year from this date:

FEB 08 2001

x Michael J. Pitelak  
HSIRB Chair

Western Michigan University  
Department of Counselor Education and Counseling Psychology  
Principal Investigator: Alan J. Hovestadt, Ed.D.  
Research Associate: Joseph Horak, M.S.W.

**Agreement to Answer Testing Material Separately**

The results of the testing material are more accurate if it is completed without consulting with your spouse. If you or your spouse do not agree to complete the forms separately do not sign this form.

Please read and if you agree, sign your name below.

**I agree to complete all of the testing materials (Socio-demographic Form, the Family of Origin Expressive Atmosphere Scale (FOEAS), the Dyadic Adjustment Scale (DAS) and the Internalized Shame Scale (ISS) alone, without any discussion with my spouse.**

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Researchers Initials

**I am free to discuss this form and the consent forms with my spouse.**

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