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THE RELATIONSHIP BETWEEN THE OUTCOME QUESTIONNAIRE AND
THE REVISED DYADIC ADJUSTMENT SCALE
IN MARITAL ASSESSMENT

by

Adam Malan Poll

A thesis submitted in partial fulfillment
of the requirements for the degree

of

MASTER OF SCIENCE

in

Family, Consumer, and Human Development
(Marriage and Family Therapy)

UTAH STATE UNIVERSITY
Logan, Utah

2006

ABSTRACT

The Relationship Between the Outcome Questionnaire and
the Revised Dyadic Adjustment Scale
in Marital Assessment

by

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Utah State University, 2006

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Department: Family, Consumer, and Human Development

This correlational study attempted to determine if the Outcome Questionnaire can be used to collect the same information as the Revised Dyadic Adjustment scale in marital assessment. Both measures are common pretreatment assessments and have relational components. The study used secondary data from the Utah State University Marriage and Family Therapy Clinic. Reliability and correlational tests were performed and the results indicate that the assessments measure different constructs. There also were no statistically significant correlations when comparing the measures by gender, marital distress, and marital satisfaction. Implications are discussed including the formulation of new clinical cut-off scores and the importance of using both measures to perform better assessments.

(67 pages)

ACKNOWLEDGMENTS

I would like to thank all of those people who made it possible for me to complete this project. First, thanks are given to Dr. Scot Allgood for his patience, diligence, and help. Secondly, my thanks to understanding and encouraging committee members, Dr. Thorana Nelson and Dr. Thomas Lee. Also, thanks go to Roxane Pfister for her help with the statistical analyses.

I must give thanks to all of my family members, especially to my mother, Wendy, for her editorial help. Most of all, thank you to my angelic wife and best friend, Amanda. Her patience and support have been unequalled.

Adam M. Poll

CONTENTS

iv

	Page
ABSTRACT.....	ii
ACKNOWLEDGMENTS.....	iii
LIST OF TABLES.....	v
CHAPTER	
I. INTRODUCTION	1
II. REVIEW OF LITERATURE	7
III. METHODOLOGY	24
IV. RESULTS	32
V. DISCUSSION	41
REFERENCES	49
APPENDICES	57
Appendix A. Outcome Questionnaire	58
Appendix B. Revised Dyadic Adjustment Scale	61

LIST OF TABLES

v

Table	Page
1 Demographic Characteristics of the Sample.....	27
2 Previous Treatment History of the Sample	28
3 Pearson Correlation Matrix for RDAS and OQ-45 Subscales and Total Scores	34
4 Gender and the Subscales and Total Means and <i>t</i> Tests	36
5 Pearson Correlation Matrix for RDAS and OQ-45 for Males	37
6 Pearson Correlation Matrix for RDAS and OQ-45 for Females	37
7 Pearson Correlation Matrix for RDAS and OQ-45 for Distressed Clients	38
8 Pearson Correlation Matrix for RDAS and OQ-45 for Nondistressed Clients	39

CHAPTER I

INTRODUCTION

The assessment of couples and families in therapy provides essential information for planning and carrying out interventions and determining outcome, and placing problem definitions within an explainable context (Epstein, 1992). Identifying the couple's or family's particular problem areas early in treatment allows issues to be addressed in a shorter period of time. Early assessment assists in conceptualizing the problem areas and helps promote an individualized and systematic approach to treatment. The manner in which the assessment is conducted also has important implications for developing the therapeutic relationship and how the couple or family makes use of the information (Fowers, 1990).

In the field of marriage and family therapy, clinicians deal with dynamic (changing), not static (unchanging) issues. Humans are complex, dynamic, and unpredictable creatures and attempting to explain their behaviors, thoughts, and feelings is very difficult (Heffer & Snyder, 1998). Generalizations and assumptions regarding humans are therefore dangerous (Fredman & Sherman, 1987). We all are individuals with different motives, ideas, and histories. Each person, couple, and family is unique and understanding differences is key to providing effective services (Cordova, Warren, & Gee, 2001).

"The more pieces of the human puzzle the clinician can access, the more likely it is that the counselor will have a clear image [of the individual, couple, or family]" (Whiston, 1999, p. 3). This clear image allows the clinician to diagnose, determine possible treatment modalities, and create treatment plans. Thus, the need for assessment

in this field is great, even essential. Assessment provides the clinician information, and information provides insight (Whiston).

Along with the complexity of the subject, time is also a factor in assessment. As marriage and family therapists are increasingly pressed to do more brief and efficient therapy, the idea of condensing and using assessment more effectively needs to be addressed. In the past, the assessment phase of therapy often lasted two or more sessions, however, with the advent of managed care, weeks may be all the time the clinician has with the couple or family (Miller, 2002). Clinicians cannot afford the luxury of taking many weeks to do thorough assessments. The influence of managed care and reimbursement issues often limit the therapy to a few sessions and it is not prudent to use most of the sessions on assessment. Brief, but thorough, and focused assessments allow interventions to begin sooner in the treatment process (Cordova et al., 2001).

There are two general types of assessments in marital and family therapy. First, the clinical interview assessment provides the clinician information while building an initial rapport with the clients. These interviews seek to expand the knowledge of the client's reality and relationship dynamics for the clinician (Fredman & Sherman, 1987). Clinical interviews are typically informal and often less threatening to the client than formal assessments. Within the clinical interview, the clinician can use a pre-determined outline to gather information, or a free-flowing process may be used. The effectiveness of the clinical interview often relies on the clinician's experience and ability (Cordova et al., 2001).

The second type of assessment are formal measurements. As early as 1978, there were over 800 formal assessment instruments available to the clinician working within

the realm of marital and family therapy (Straus & Brown, 1978). It also seems to be common knowledge that formal assessment in marital and family therapy increases the effectiveness of the therapy (Fowers, 1990; Snyder, 1981), yet only 39% of marriage and family therapists report using any type of standardized assessment regularly (Boughner, Hayes, Bubenzer, & West, 1994).

The type of information gained by the assessment depends on the type of assessment that is administered. Within the numerous assessments available to the marriage and family therapist, there are two primary types: systemic or relational, and individual assessments (Whiston, 1999). Individual assessments focus on the stress, symptoms, dislikes, tendencies, and thoughts of one person. The systemic assessments look at generational patterns, relationship dynamics, and interactions between two or more individuals (Nichols & Schwartz, 1998). Marriage and family therapists use both individual and systemic assessments in helping people change.

Most assessment instruments introduced to the field of marriage and family therapy were created on a theoretical basis (Heffer & Snyder, 1998). Some theoretical views assess the family or couple as a whole (e.g., Milan, structural, Bowen), while other theorists prefer to take a more individual approach to assessment such as psychoanalytic and experiential (Nichols & Schwartz, 1998). For example, Bowen therapists use a genogram or family map to assess couples and families. Structural family therapists, on the other hand, would use structural mapping to assess the same dynamics. These instruments and numerous others focus on the systemic or relationship dynamics within the couple or family, and are generally administered with the entire family and/or couple present (Bowen, 1978; Minuchin, 1974).

Solution-focused and narrative therapists assess the client's barriers to change, or what is holding them back from their goals (Berg & Miller, 1992). Assessments within these theories are therefore more focused on solutions to overcoming the barriers and less on the presenting problem. In fact, solution-focused therapists tend to shy away from formal assessment altogether, feeling that it fuels problem-focused thought (Nichols & Schwartz, 1998).

The most-used type of assessments in marriage and family therapy are individually based (Boughner et al., 1994). These instruments have been adopted from individual therapy and are used to provide vital information about the mental, emotional, and social status of the individual within the marital or family relationship. The individual-based instruments thus allow the clinician to identify non-relational issues such as psychosis, mood disorders, and personality disorders (Whiston, 1999).

Fredman and Sherman (1987) suggested that marriage assessment presents a "unique problem" because the subject that is measured is neither an individual nor a group; "it is a system and the relationships" (p. 7). Most individual-based assessments fail to acknowledge the system of the couple or family.

Many assessments that are standardized measures have no "fit" with outpatient and managed care. The tests have been too long, too costly, or irrelevant to treatment (Fowers, 1990). The Outcome Questionnaire (OQ-45; Lambert et al., 1996), a simple, brief (20 minutes), economical, and clinically relevant outcome measure, provides normative scores on client level of symptomatic distress, social, and interpersonal functioning (Miller, 2002). The OQ-45 has become a valuable tool for the marriage and family therapist because of its ability to be used before, during, and after the therapy

process. This gives the clinician a constant view of the amount and rate of change, and the brevity of the measure does little to interrupt the treatment process.

Another primary assessments used by marriage and family therapists is the Revised Dyadic Assessment Scale (RDAS; Busby, Crane, Larson, & Christensen, 1995). The OQ-45 has been deemed very effective, efficient, and complete for assessment in couples and family therapy (Miller, 2002). The RDAS is also a quick, simple, and economical measure. The RDAS is known for its ability to determine whether a couple is distressed or nondistressed (Busby et al.; Okiishi, Lambert, Nielson, & Ogles, 2003). Both the OQ-45 and the RDAS have been used for several years at the Utah State University Marriage and Family Therapy Clinic. The data for this study will come from those clients who have sought services and agreed to allow their clinical assessment data to be used in research.

Problem Statement

Although ongoing assessment is important and essential for highly effective marital therapy, it can become redundant. Clinicians are already overwhelmed with massive amounts of paperwork (Miller, 2002). The amount of mandatory paperwork and the redundancy of information may explain the minimal use of standardized measures among marital and family therapy clinicians, particularly when the clinical interview seems to provide sufficient information for treatment. Reducing the time and effort required, while retaining the benefits of formal assessment may encourage more clinicians to use such instruments in their assessment of clients and their problems.

The purpose of this study was to determine whether the OQ-45 sufficiently measures marital distress so that clinicians could use it alone and not use the RDAS. This could potentially reduce therapist resistance to the use of formal assessments and increase the likelihood that therapists would use such instruments frequently to help guide their decisions about interventions. The data for this study were collected, as part of a clinical research assessment package at the Utah State University Marriage and Family Therapy Clinic. All subjects completed an informed consent, which indicated the data could be used for research.

CHAPTER II

REVIEW OF LITERATURE

Assessment means the systematic gathering of information (Heffer & Snyder, 1998). There are some indications that assessment has been available for 2,500 years, utilized by the Greeks and Chinese. The often-criticized IQ testing began in 1895. In the field of marriage and family therapy, assessment is generally related to the theoretical framework used by the therapist (Whiston, 1999). Couple and family assessments tend to be systemic in nature, meaning clinicians are more concerned with interactions and relationships among people than individual dynamics (Fredman & Sherman, 1987).

This review of literature focuses on the necessity of assessment in the field of marriage and family therapy. The need and effectiveness of assessment in marriage and family therapy are also reviewed within both general assessments and self-report measures. Two assessments, the OQ-45 and RDAS, are evaluated as well as the Dyadic Assessment Scale (DAS), the forbearer of the RDAS.

Types and Need of Assessment in Marriage and Family Therapy

Assessments designed for marriage and family therapy have very short histories compared to personality and intelligence testing. Thus, instruments in this area are not as well researched, yet later assessments have more research (Whiston, 1999). This being said, research seems to indicate that self-report assessments are effective in marriage and family therapy because hours of interviewing can be condensed by an effective assessment. It also appears the effectiveness of the chosen assessment depends greatly on

the individual clinician (Fredman & Sherman, 1987). Assessment feedback in this section refers to mere information regarding the couple and their relationship being addressed with them, not to be confused with cybernetic feedback. Cybernetic feedback refers to any stimulus that either perpetuates or alters the system, where as informational feedback is simply a pronounced view of a given issue (Becvar & Becvar, 1982).

Frequent assessment can act as ongoing feedback for the clinician. This feedback comes in the way of evidence of progress or lack of progress toward healthy thinking, acting, and feeling of the client. Through assessment, the clinician can measure outcome, progress, and engagement in the therapy process (Miller, 2002). The clinician can then tailor a treatment plan and assign an effective modality from the data obtained from the given assessment. Assessment informs the clinician of the level of success of therapy through the feedback and information provided (Lebow, 2000).

Assessment has now become a director of treatment, intervention, and outcome among some clinicians. Miller (2002) stated:

Assessment, in other words, should no longer precede and dictate intervention, but rather weave in and out of therapeutic process as a pivotal component of treatment itself. Clearly, clients who are informed, and who inform, feel connected to their therapist and therapy; their participation--one of the most potent contributors to positive outcome--is thereby courted and secured. At the same time, day-to-day clinical work becomes guided by reliable and valid feedback about the factors that account for how people change in treatment. (p. 8)

Filsinger (1983) outlined an approach to integrating assessment and therapy through using assessment tools to evaluate the ongoing process of therapy. He stated:

[A]ssessment could be used to monitor the progress the couple is making. Improvement in one area of family functioning can be a cue to move on to other issues. In addition, information obtained from assessment of the therapy process could be used to select the next appropriate intervention. (p. 16)

Thus, assessments can guide therapeutic planning throughout the course of treatment.

Couples seeking therapy are often demoralized and seeking for better ways to understand and deal with their problems. The assessment process can help orient the couple to the kinds of issues that are relevant to their difficulties and assist them in viewing their relationship in new ways (Filsinger, 1983). Completing an inventory can highlight areas of agreement and strength and counteract the tendency to become overwhelmed by difficulties. This promotes hope and a renewed appreciation for the positive aspects of the relationship. Presenting the couple's difficulties in an organized and comprehensive manner can also induce a sense of relief and hope through showing that areas for improvement are circumscribed rather than all-encompassing (Snyder, 1981).

There are several issues of marital therapy that assessment can and should expound upon and explain for the clinician and client. Lebow (2000) indicated that the clinician must take into account and assess areas that involve both individual and relational components of the client system. These components include the individual stages of development; the amount of positive and negative communication within the relationship; the individual abilities and levels of attachment; and any psychopathology particularly depression, conduct disorder, and substance abuse. Assessment then indicates and elaborates on these individual and relationship factors.

Magnavita (2000b) stated that there are four theoretical and empirical factors that pertain to assessment within marital therapy. First, he described the intersubjectivity of the dyadic relationship. Because clients maintain their own realities while therapists maintain their own. By performing assessments, the therapist demonstrates they are

actively working to understand the client situation and thus working to understand their reality.

Secondly, the triadic theory attempts to explain the context of the individual or couple's problem and treatment. This is accomplished by drawing in another individual (therapist) to help diffuse stress and anxiety. This helps make possible for relationship symptoms and psychopathology to be explained within the family system, rather than an individual problem. Assessment can further than explain the influence of relational symptoms on the family system (Magnavita, 2000b).

Third, therapeutic alliance or the relationship between therapist and client plays an important role in the level of success of therapy. Most clinicians understand that if the alliance is not strong, treatment outcomes may be in jeopardy. Magnavita (2000b) noted the two most important factors to the therapeutic alliance are active collaboration and interpersonal readiness. Assessment therefore can demonstrate to the client the therapist's desire for collaboration, in turn building a stronger therapeutic alliance.

Fourth, Magnavita (2000b) concluded that marital therapy has helped establish a movement toward relational diagnosis. It has taken some time for relational diagnosis to evolve and it is still in its infant stage. Relational diagnosis assumes that psychopathology is directly caused or influenced by a relationship. Kaslow (1996) explained why the system is so important to diagnosis:

On a clinical level, a widely accepted relational diagnosis schema would permit us to clearly and accurately convey to other mental health professionals our assessment of our clients' problems and the rationale behind treatment plan and intervention used. In addition, such a taxonomy would simplify the task of researchers seeking to mount or replicate a study involving relational dynamics and patterns. (p. xii)

In assessing both the individual and the relationship, the clinician assumes a high amount of complexity. Both individual and relational issues can be complicated in the manifestation of the problem (Magnavita, 2000a). Multi-generational and other relational-based personality disorders need to be addressed in relational diagnosis. Thus, assessments that measure relational diagnosis help bring more credibility and promote research in the field of marriage and family therapy. Rigazio-DiGilio (2000) also called for an increase of relational diagnosis. She suggested that “the constructs of worldview, information processing styles, power differentials, and interpersonal connectiveness are the conceptual tools to guide relational diagnosis” (p. 1017).

Filsinger (1983) stated the following ways in which standardized assessment procedures can assist the clinician:

. . . by promoting hope for a positive outcome, (b) developing a relationship (rather than blaming) focus, (c) identifying problem areas in their relationship utilizing specific assessment data, (d) promoting focused and productive discussion of relevant issues, (e) confronting couple myths, (f) assisting in appropriately matching clients to services, (g) evaluating the ongoing progress of the therapy or enrichment, (h) evaluating outcome and termination planning, and (i) facilitating enrichment and prevention. (p.18)

There has been little research on the influence of the assessment phase of therapy on the therapeutic alliance (Ackerman, Hilsenroth, Baity, & Blagys, 2000). The assessment process may impact the client’s experience of assessment feedback and aid in the development of a therapeutic alliance. In addition, initial feedback from assessments does not have to be positive to provoke change if the feedback validates client’s views of the self (Ackerman et al.). Swann (1997) stated:

[B]eing understood by a therapist may reduce feelings of alienation, for it tells patients that someone thought enough of them to learn who they are. For these

and related reasons, when provided in a supportive context, self-verifying feedback may have beneficial effects, even when it is negative. (p. 179)

Assessment feedback may be used to help clients accept themselves as experts of their own lives and experiences (Ackerman et al., 2000). "By treating clients as experts of themselves, and engaging them as collaborators in each stage of the assessment, we demonstrate that we view them as valuable, capable individuals" (Finn & Tonsager, 1997, p. 381).

Allen, Montgomery, Tubman, Frazier, and Escover (2003) described assessment feedback as "... an intervention that enhances self-related processes such as self-understanding, self-verification, positive regard, and self-awareness" (p. 167). They also stated that many clinicians feel early enhancement of these self-related concepts helps create a collaborative identification to treatment and motivation to change. In their study, Allen et al. found significantly higher self-related scores among the experimental group ($n = 83$) of subjects that received assessment feedback.

Fletcher (1991) reported that of the 50 subjects in his study regarding assessment feedback, 58% desired feedback after being assessed. Clients have an idea of their problems, and tests help to confirm or disconfirm their hypotheses. Fletcher also determined that clients who receive feedback tend to be more successful in making positive behavioral changes.

Levine (2001) discussed how assessment feedback influences the behavior of the individual. He stated that through receiving feedback, individuals build autonomy earlier in life. Thus, clients who receive feedback are more likely to participate in interventions

and become more invested in therapy because they have a sense of ownership regarding their problems and behavior.

An additional function of marital assessment includes early placement in appropriate services. Matching the intervention to the client's difficulties is essential, whether services are available within a given setting or through a referral (Fowers, 1990). Placement decisions can go seriously wrong without information regarding the level, type, and pervasiveness of distress in the client. In marital therapy, initial data regarding these issues may be obtained from marital satisfaction and stability measures.

Multidimensional satisfaction measures can assist couples and professionals in clarifying primary areas of concern such as communication, conflict resolution, sexual difficulty, and child-rearing. This information helps to match clients to individual couple therapy, couples' group therapy, sex therapy, skills training, enrichment services, or other treatment modalities. Marital stability measures can also assist in identifying couples that may benefit from couples' groups or skills training approaches (Fowers, 1990).

Another use of assessment devices is in evaluating the effectiveness of interventions. Ongoing outcome assessment can improve therapeutic and educational services through program evaluation, the evaluation of practitioners, and/or innovative approaches (Pinsof & Wynne, 1995). Outcome measures can also assist in termination planning with clients through demonstrating specific areas of progress, highlighting areas for continued attention, and examining the appropriateness of termination (Fowers, 1990). Giving the clients a visual indicator of progress and how it has occurred seems to increase their hope for continued change and hope for future success (Fredman & Sherman, 1987).

There are numerous uses for assessment in marriage and family therapy.

Treatment can be adapted, contoured, and created in conjunction with the feedback received from assessments. Modalities, interventions, and additional assessments can be better chosen as the clinician gathers more information regarding the clients. Standardized instruments provide effective and interpretable feedback helpful for both client and clinician (Kobak et al., 1997).

Self-report Assessments

In 1994, Boughner et al. reported that the instruments most frequently used by marriage and family therapists were adopted from individual therapy. These individual self-report tests seem to allow the clinician to identify differences in personality, expectations, and preferences within the couple or family. The researchers indicated the 598 clinicians that responded to their survey were not asked why they used the assessments they did, only which assessments were used. No single instrument was used by more than 8% of the clinicians.

In his review of marriage and family assessment, Filsinger (1983) wrote, "self-report measures offer several important advantages. They are easy to administer and to score; they represent the most commonly employed techniques in research and practice" (p. 153). He further suggested such instruments would continue to be widely used due to their inexpensive nature as well. Some drawbacks to self-report assessments include lack of honesty and placating (answering how you think you should rather than being completely truthful). Clients may answer in the way they feel the clinician would wish them to, or blatantly lie (Filsinger).

Some self-report measures have been developed to assess the quality of the marital relationship. Well-known standardized assessments used to measure this dimension include the Dyadic Adjustment Scale (DAS; Spanier, 1976), the Marital Adjustment Test (MAT; Locke & Wallace, 1959), the Revised Marital Adjustment Test (RMAT; Kimmel & Van Der Veen, 1974), and the Kansas Marital Satisfaction Scale (KMSS; Schumm, Nichols, Schectman, & Grisby, 1983). More recently, the RDAS (Busby et al., 1995) was introduced as an additional and improved measure of marital quality. Although these instruments each measure specific aspects of the marital relationship, they are all similar in their assessment of a marriage rather than an individual or non-marital relationship.

It appears that assessment, and primarily self-reporting assessment can be vital in marriage and family therapy. There are many valuable, statistically valid measures to aid in the effectiveness of treatment (Fredman & Sherman, 1997). Their value also appears to be within the training, desire, and intuitiveness of the individual clinician and the honesty of the client (Filsinger, 1983).

The Outcome Questionnaire

The Outcome Questionnaire (OQ-45; Lambert et al., 1996) is designed to measure an individual's difficulties and progress in therapy and is meant to be used more than once throughout the course of therapy. The measurement of progress is based on Lambert's (1983) suggestions of three aspects of an individual's life that should be evaluated. The three aspects include individual subjective discomfort, their interpersonal relationships, and their social role performance. It has been made clear that the OQ-45

was not designed to diagnose disorders, but to simply assess for symptoms (Lambert et al.).

The creators of the OQ-45 claim the measure to be unique in its ability to provide high levels of reliability and validity and to be sensitive to change over time while being available at a very low cost. It is designed to measure and detect common symptoms within a very wide range of adult mental disorders, including stress-related concerns (Lambert et al., 1996). The OQ-45 is regarded generally as a well-established and tested assessment. It has also been shown to remain constant over time that people are not in treatment (Okiishi et al., 2003). Although the instrument contains three useful subscales, a combined score allows for a global assessment of functioning.

The first subscale of the OQ-45 is Symptom Distress (SD) and consists of 25 items. This scale is created from a 1988 NIMH study that identified the most common types of mental disorders and a 1992 Human Affairs International review of the most prevalently used DSM-III-R codes (Regier et al., 1998). The most frequently reported symptoms were depression and anxiety. The creators of the OQ-45 heavily loaded the assessment on depression and anxiety indicators with no attempt to provide separate scales for the two disorders, believing the two were so closely related that it was too difficult to distinguish them. Substance abuse is also measured in this subscale, but only to the extent of identification, not severity (Lambert et al., 1996).

Interpersonal Relations (IR) is the second subscale of the OQ-45 and consists of eleven items. This subscale measures both satisfaction and problems in an individual's interpersonal relationships. Items that deal with family, spouses, and friends are

included. These items were derived from the marital and family therapy literature (Lambert et al., 1996).

The final subscale, Social Role (SR), looks at the general level of the individual's level of dissatisfaction, conflict, and distress in conjunction with career, family life, and other roles. The nine items in the subscale measure the individual's performance within societal tasks. The creators thought that once symptoms of distress occur in an individual, problems and dissatisfaction are manifested in all life areas (Lambert et al., 1996).

The OQ-45 uses a five point Likert-style scale to gather the responses. This scale allows for equal interval data to be collected. The scale ranges from "never" to "almost always." The correlating numeric values of each response depend on the coding of each question. All numeric values are assigned on the instrument itself and allow for easy scoring for the administrator (see Appendix A). There are a total of forty-five questions with twenty-five questions for the SD subscale, eleven for the IR subscale, and nine for the SR subscale (Lambert et al., 1996).

The OQ-45 seems to be an effective instrument for marriage and family therapists for more than one reason. First, the OQ-45 is used in initial sessions to help determine treatment plans and assess for serious problems such as suicidal ideation. Second, it is able to measure change throughout the therapy process. Third, this assessment can be used to determine both quality of therapy and effectiveness of treatment. Fourth, the low cost of the instrument lends to a broader spectrum of use. Finally, the OQ-45 is short and easily scored. This provides the clinician with almost instant feedback, allowing more time for treatment.

The Dyadic Assessment Scale

The DAS was first reported by Spanier in 1976. It quickly demonstrated value to both clinicians and researchers due to its ease of administration, simplicity, and reliability. It is a paper and pencil instrument and its combined qualities of being both small (only 32 items) and complex (four separate subscales) proved to be effective in measuring adjustments in relationships. Content validity of the DAS was established through examination by a panel of three judges. Construct validity has been established through its use in more than 1,000 studies, and concurrent validity has been established by its correlation ($r = .86$) with the Locke-Wallace Marital Adjustment Scale (Fowers, 1990).

Criterion-related validity was established through multiple studies that demonstrated that scores on the DAS distinguish between married and divorced individuals, married and cohabiting couples, heterosexual and homosexual couples, and open and closed relationships, as well as sex role and gender differences and differences between childless and parenting couples (Spanier, 1976).

The DAS consists of four dimensions: consensus on matters of importance to marital functioning, dyadic satisfaction, dyadic cohesion, and affectional expression (Busby et al., 1995). Spanier (1976) claimed the measure could be used as a composite, determining overall marital adjustment. The measure could also be divided into four separate subscales without losing its validity or reliability. Due to the versatility and value of the measure, the DAS was widely used among clinicians and researchers (Fredman & Sherman, 1987).

Confusion arose concerning the breadth of the measure and Spanier and Thompson (1982) evaluated the DAS as a multidimensional instrument versus a one-dimensional measure. Several researchers between the years of 1982 and 1990 cited errors in the DAS. Finally, Thompson (1988) suggested a revision of the DAS. Gottman (1999) suggested that the DAS is merely a copy of the 1959 Locke-Wallace measure, replacing "relationship" with "marriage."

The DAS was later revised by Busby et al. in 1995. The primary purpose of the revision was to introduce an instrument to better measure and determine the difference between distressed and nondistressed couples. The primary problem found by previous researchers using the DAS was an issue of construct hierarchy (the statistical weight of each question). The goal of the revision was to adjust the subscales of the DAS while following standard construct hierarchy.

Initially, the creators of the DAS made bold claims of the global ability of the measure. There is little doubt of the intuitiveness of the measure and the value of the subscales. However, Busby et al., (1995) determined that the DAS was unable to differentiate between a distressed and nondistressed couple. Because of this, a revision was deemed appropriate.

The Revised Dyadic Adjustment Scale

The RDAS (Busby et al., 1995) is described as "an improved version of the DAS that can be used to evaluate dyadic adjustment in distressed and nondistressed relationships" (p. 290). The RDAS consists of three subscales: the dyadic consensus subscale, the dyadic satisfaction subscale, and the dyadic cohesion subscale. Busby et al.

listed its advantages over the DAS as (a) brevity—it consists of 14 items, 18 fewer items than the DAS; (b) acceptable levels of construct validity; and (c) adequate internal consistency. It also maintains the original scale's goals to accomplish (a) multidimensionality, (b) show a strong correlation to the MAT, and (c) demonstrate the ability to distinguish between distressed and nondistressed individuals and relationships (Crane, Middleton, & Bean, 2000).

While the RDAS has the qualities of easy administration and scoring that suggest the likelihood of increased use, an important problem remains that limits its usefulness for researchers and clinicians. Previous studies have indicated that the RDAS is effective in distinguishing distressed from nondistressed clients (White, Stahmann, & Furrow, 1994; Busby et al., 1995), but the cutoff point for separating the two subject groups has not been identified. That is, the polar ends are clear but the middle ranges are not.

Clinicians benefit from using standardized instruments where marital distress/nondistressed cutoff points are known because this allows them to assess their own clients for high levels of marital distress and apply differential treatments accordingly (Crane, 1996). Severely distressed couples are less likely to benefit from therapy (Jacobson & Addis, 1993; Snyder, Mangrum, & Willis, 1993) and for this reason, Crane advised therapists to help highly distressed couples set and achieve small realistic goals while working to help them change the negative perceptions that they have for one another.

The 14-question RDAS is simple to administer and score. The first six questions account for the Consensus subscale. Each item is measured with a Likert-type scale ranging from "Always Agree" to "Always Disagree." The numerical values of the

responses range from 5 to 0. The next four questions are the items of the Satisfaction subscale. This scale ranges from "All of the time" to "Never," and the numerical values range from 0 to 4. The last four items make up the Cohesion subscale and range from "Never" to "More often," with numerical values of 0 to 5 respectively (see Appendix B, Busby et al., 1995).

The revision of the DAS seems to have been appropriate and necessary. The RDAS provides the important distinction between a distressed and nondistressed couple and continues to provide the meaningful feedback from the subscales. The RDAS appears to be an effective measure available to clinicians working with couples, is more easily administrated and used than the DAS because it is shorter.

Gender Differences in Marital Assessment

The question of how gender influences one's marital satisfaction has been debated for some time. Bernard (1972) was the first to convincingly suggest that men tend to report having a higher level of marital satisfaction than women. In response to this Rhyne (1981) concluded that although men are generally more satisfied with their marriages than woman, the same factors or indicators are important in their assessments of determining marital satisfaction. Thus, while men are more satisfied in general, both genders gauge their satisfaction from similar factors.

Schumm, Jurichr, Bollman, and Bugaighis (1985) suggested that women report much lower levels of marital satisfaction than their spouses. Whisman, Weinstock, and Uebelacker (2004) found that there is not a difference in how the two genders responded to a marital satisfaction assessment. The researchers used the MMPI-2 to assess couples'

($n = 774$) level of anxiety and marital satisfaction level. The amount of the individual's anxiety and depression was, however, a strong predictor of marital satisfaction.

Crane, Soderquist, and Frank (1995) reported that wives responses on the MSI and MAT were by far more important in predicting divorce. Female's scores ($n = 235$) on both assessments were highly strong correlated with future divorce, while husbands' scores had no relationship to divorce.

Results of another study (Hattie, Myers, Rosen-Grandon, 2004) suggested that certain relationship interaction processes are less significantly based on one's gender. The researchers used the DAS to identify satisfaction in over 100 couples. Nevertheless, they concluded that the idea that husbands and wives have different preferences in marriage is not a new concept for counselors. However, as counselors attempt to conceptualize the overall nature of a marriage, it is useful to organize that conceptualization into specific characteristics and processes.

Kurdek (2005) studied 526 couples attempting to find any differences between husbands and wives and their marital satisfaction in the first four years of marriage. He found interspousal differences were not significant and he concludes that there is little support for the view of marriage to differ due to gender. The potential difference between males and females in terms of their views of their marriages and how these views are important (or not) to marital therapy are not clear.

Summary of the Literature

Assessment is a vital component of the treatment of couples and families. Although measures of relationships and family systems are relatively new (Whiston, 1999), there seems to be an effort for continued improvement and application of assessment instruments in the field (Lambert et al., 1996). Instruments exist for measuring both individual and marital dynamics, such as the OQ-45 and the RDAS, that are short, easily administered and scored, and provide useful information for therapy. However, because few therapists seem to use standardized instruments, perhaps because of their length and complicated information, it would be useful to have one instrument that measures the constructs of both the OQ-45 and the RDAS. Gender may or may not influence the client's level of marital satisfaction. Therefore, this study examined the differences in mean scores between the genders, attempting to determine a difference or not in its sample. This study investigated the similarities of the OQ-45 and the RDAS and the potential for using the OQ-45 only to gather useful relationship information.

Research Questions

1. What is the relationship between the OQ-45 and/or its subscales with the RDAS?
2. Is there a difference due to the gender of the client in the association between the OQ-45 and/or its subscales with the RDAS?
3. Can the OQ-45 determine the same information as the RDAS regarding distressed and nondistressed couples?

CHAPTER III

METHODOLOGY

The purpose of this research was to determine the potential for using the OQ-45 to measure marital distress. The study used a secondary analysis design to answer the three research questions. The assessment data was collected from 1999 to the present at the Utah State University Marriage and Family Therapy Clinic.

The Utah State University Marriage and Family Therapy Clinic

The Department of Family, Consumer, and Human Development in the College of Education and Human Services sponsors the Marriage and Family Therapy Clinic (MFTC). The MFTC, housed in the Family Life Center, is located near the Utah State University campus.

The MFTC's dual mission is to provide high quality, low cost marital and family therapy services to the public and to provide a training environment for Master's degree students majoring in marriage and family therapy (USU Marriage and Family Therapy Program, 1999). Because the MFTC is a training facility, graduate students in marriage and family therapy conduct the therapy sessions. While conducting therapy, the therapists-in-training are under the direct supervision of clinical faculty who are all licensed Marriage and Family Therapists. The MFTC's facility allows for observation of sessions by clinical supervisors and the video recording of sessions (USU).

The MFTC advertises that family therapy helps strengthen relationships and resolve relationship problems for couples, families, or other nonrelated people. These problems include conflict, communication, general unhappiness, life transition problems, or specifically identified difficulties. The MFTC literature that indicates family therapy can also be used as an adjunct therapy to help people adjust to and manage such difficulties as chronic illness, mental illness, attention deficit disorder, drug/alcohol abuse related problems, eating disorders, and domestic violence (USU, 1999).

The MFTC is open to any individual, couple, or family that desires help with couple concerns, individual concerns, parent-child relationships, or other family issues. Fees are determined on a sliding scale based on income and family size and are paid at the time of each appointment. No one is denied services because of inability to pay. All services at the MFTC are confidential and private. The clinic follows all state and federal laws regarding keeping client information private and secure. Exceptions include situations where abuse is suspected or where someone may be a threat to themselves or others (USU, 1999). Research data have been kept separate from the clinical files of the client. This allows the research data to be analyzed without the identifying information of the individual clients being used or known by the researcher.

Design

The methodology designed to answer the research questions is a quantitative design using a correlational method. Correlational methods are used to study variables that are not manipulated or changed (Dooley, 1995). Correlation is a description of the relationship or association between or among variables. Correlations do not indicate a

causal relationship between variables, but they can suggest a causal relationship (Udinsky, Osterlind, & Lynch, 1982). Because the data have been collected, the study used a secondary analysis method. This fits the criteria of a correlational method because the data have been collected and variables will not be manipulated in any way. A secondary analysis is conducted when data are analyzed in ways that were not intended upon gathering the data initially (Miller, 1986).

Sample

The sample consisted of couples that had participated in marital therapy at the MFTC between the years of 1999 to 2005. A total of 107 of 127 couples, (214 of 244 individuals) met the criteria of taking both the RDAS and OQ-45, and had consented to let their assessment data be used in research. There were twelve couples where one or the other spouse had not completed one of the two assessments. Three files (6 individuals) were impossible to determine which of the two spouses had completed the assessment. Finally, there were five couples who refused to allow their assessment data be used in research. The response rate of the study was 84.3%.

Demographic Statistics

Depending on the year of collection and the clinician that conducted the assessments, some of the demographic information was incomplete or was not asked for in the intake form. The variable of previous treatment was the most incomplete. All of the analyzed cases include gender and complete RDAS and OQ-45 information.

The demographic information for the sample is shown in Table 1. The data show the majority of the couples had not been married long and most were in their twenties. Education is coded in years. For example, completing high school is twelve years of education. The mean is almost fourteen years, suggesting the average client had almost two complete years of college education.

As noted in Table 2, previous treatment was the most incomplete of the demographic variables. Of those who had received previous treatment, most had participated in individual therapy, with fewer participating in couples or marital therapy. It was not possible to gather data regarding the presenting problems for the clients in current and past treatment due to the incompleteness and variation of the intake forms.

Table 1

Demographic Characteristics of the Sample

Variables	<i>n</i>	Males		Females	
		<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Age	212	29.28	8.34	27.42	7.50
Education	209	13.88	1.83	13.79	1.79
Number of Children	212	1.11	1.28	1.05	1.27
Length of Marriage	204	3.79	4.30	3.80	4.30

Table 2

Previous Treatment History of the Sample

Type of treatment	Males		Females	
	<i>N</i>	%	<i>n</i>	%
None	38	79.2	27	56.3
Individual	6	12.5	17	35.4
Couple	2	4.2	3	6.3
Family	1	2.1	0	0

Instruments

Data from couples who completed both assessments (the OQ-45 and the RDAS) were used in the study. Once all the data were entered, SPSS reliability tests were administered to determine the reliability (Cronbach's alpha scores) of the subscales and totals of both the OQ-45 and the RDAS. Following the reliability testing, a multi-variant analysis was conducted to determine the correlation between the sub-scale scores of the instruments.

Both instruments have clinical cut-off scores. These cut-offs are indicators to potential clinical problems and help in making a complete DSM-IV diagnosis. There are cut-off scores for each subscale which have been determined by the creators of the respective instruments.

Validity

The construct validity of the OQ-45 was determined by correlation coefficients in

regards to several counterpart studies such as the Symptom Checklist-90-R (Derogatis, 1977); Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961); Zung Self-Rating Depression Scale; Zung Self Rating Anxiety Scale; Taylor Manifest Anxiety Scale; and the State-Trait Anxiety Inventory (Spielberger, 1983). The validity for the other two OQ-45 subscales, were not as strong: Interpersonal Relations (IIP): .47 to .49, and Social Role (SAS): .53 to .73. The total score of the OQ-45 had very strong correlations to its counterparts, showing good validity as an overall measure of distress (Lambert et al., 1996). As well, the OQ-45 has adequate *t*-test scores for each subscale that are statistically significant beyond the .001 level of confidence regarding criterion validity in comparison to the total and subscale mean scores of the KMSS (Lambert et al., 1996).

To determine the RDAS construct validity, factor analyses were conducted with the LISREL program (Joreskog & Sorbom, 1989). The first confirmatory analysis was to evaluate the first-order subscales simultaneously. The LISREL program produced factor scores and *t* values for each item. The *t* values for each of the items of the consensus, satisfaction, and cohesion subscales were statistically large. Each item had *t* values over 10. It was hypothesized that the RDAS would be an improvement over the DAS if the correlation coefficient between the RDAS and the MAT was similar to or higher than the coefficient between the DAS and the MAT. With this sample the correlation coefficient between the RDAS and the MAT was $r = .68$ (Busby et al., 1995). The criterion validity of the RDAS was very high in determining the difference between distressed and nondistressed couples. A discriminant analyses comparing the RDAS and the DAS demonstrated that the RDAS and the DAS were equal in their ability to classify

cases as either distressed or nondistressed. With an 86% accuracy rate for nondistressed and a 74% rate for distressed couples the RDAS shows strong validity again in comparison to the DAS and MAT (Busby et al., 1995).

Reliability

The OQ-45 demonstrated an internal consistency which was considered high, and test-retest values were significant at the .01 level. The correlation coefficient over a 10-week time frame showed continued reliability with scores between .86 and .66 (Lambert et al., 1996).

The RDAS reliability appears to be strong as well. The Spearman-Brown split-half was .95 and Cronbach's alpha was .90. The Guttman split-half reliability coefficient for the RDAS was .94, and for the DAS, was .88 (Busby et al., 1995). These all demonstrate the RDAS has strong internal consistency and reliability.

Procedures

Prior to an initial session at the MFTC, all couples completed the OQ-45 and RDAS assessments as part of the intake paperwork. The assessments were administered by someone other than the primary clinician. The data were taken from the research files and entered into SPSS (statistical software) for analysis. It is important to note that the RDAS is coded opposite to the OQ-45. Because of this the RDAS scores were reversed in the study. This allows the statistics to be more easily examined and explained. This will influence the cut-off scores of the RDAS only, for they will need to be reversed as well in order to clinically determine distress in the client.

Clients who use the services of the MFTC need to provide information in order for the therapist to assess their situation. To use these data for research, the entire process of assessment and information gathering was reviewed and approved by the Internal Review Board. Couples included in the data collection have given signed consent for their assessment scores to be used in research at the university. These scores are anonymous and the researcher cannot link scores to individual clients.

CHAPTER IV

RESULTS

Plan of Analysis

“Data analysis is the process of organizing and arranging the data so that the results of the study can be interpreted” (Miller, 1986). The design of the study was correlational to assess the relationship between two commonly used measures (Dooley, 1995; Udinsky et al., 1982).

Reliability

Prior to any statistical analyses, reliability tests completed on each of the OQ-45 subscales and total scores and the RDAS subscales and total scores. This was accomplished by calculating a reliability (alpha) test for each scale and subscale. The data distributions in the sample created a normal bell-shaped curve, allowing for statistical integrity (Holcomb, 1998).

The reliability coefficients for RDAS are as follows: total ($r = .87$), consensus ($r = .73$), satisfaction ($r = .80$), and cohesion ($r = .73$). For the OQ-45, the reliability coefficients are as follows; total ($r = .93$), symptom distress ($r = .91$), interpersonal relationships ($r = .81$), and social role ($r = .64$). These reliability results indicate that the measures for the present sample are comparable to established norms. In addition, the reliabilities all fall into ranges acceptable for research (Pedhazur & Schelkin, 1991).

Research Question Number One

What is the relationship between the OQ-45 and/or its subscales with the RDAS?

The Pearson's R was used to determine the significance and strength of the relationships between two quantitative variables (Holcomb, 1998). The strength of the correlation of the two variables is determined by how close the score is to 1 or -1. The closer the score is to 1 or -1, the stronger the correlation; the closer the score is to zero the weaker the correlation is. Because the RDAS and the OQ-45 are coded opposite to each other, the RDAS was recoded so that the lower score would indicate a more positive response like the OQ-45.

The subscales of the OQ-45; SD, IR, and SR and the total score were compared to the total score and subscales of the RDAS (consensus, satisfaction, and cohesion) and are reported in Table 3. The results indicate that the strongest relationship was between the OQ-45 IR subscale and the total score on the RDAS, with a moderately strong correlation ($r = .74$, Lambert et al., 1996).

The IR subscale of the OQ-45 has moderate correlational strength with the consensus ($r = .70$), satisfaction ($r = .70$), and cohesion ($r = .48$) subscales of the RDAS. The other two OQ-45 subscales SD and SR show weaker correlations to both the RDAS total score and individual subscale scores, although each has a statistically significant relationship. There is moderate correlation between the OQ-45 total score and the RDAS total score, yet again it is statistically significant relationship ($r = .57$). In sum, while the correlations are statistically significant, the explained variance between these measures is low (*r-squared* range: between 23% - 55%). While there is a relationship between the

Table 3

Pearson Correlation Matrix for RDAS and OQ-45 Subscales and Total Scores

Variable	OQ-45 IR	OQ-45 SR	OQ-45 Total	RDAS Con	RDAS Sat	RDAS Coh	RDAS Total
OQ-45 SD	.68*	.70*	.96*	.44*	.36*	.24*	.42*
OQ-45 IR		.53*	.82*	.70*	.70*	.48*	.74*
OQ-45 SR			.78*	.36*	.27*	.21*	.33*
OQ-45 Tot				.58*	.49*	.37*	.57*
RDAS Con					.66*	.55*	.89*
RDAS Sat						.53*	.86*
RDAS Coh							.80*

* $p < 0.01$ level, ** $p < 0.05$ level, Con = RDAS Consensus, Sat = RDAS Satisfaction, Coh = RDAS Cohesion.

measures, the explained variance would indicate that the measures are assessing different constructs according to Pedhazur and Schelkin (1991).

Research Question Number Two

Is there a difference due to the gender of the client in the association between the OQ-45 and/or its subscales with the RDAS? To obtain an overall perspective of the scores by gender, paired t tests were performed because the husbands and wives data were available. The t test is used in testing for significant differences between groups. A t test can also be used for a single group to test for a significant difference from zero or any other value. The larger the t value, the greater chances of statistical significance between the two groups (Stevens, 1990).

In Table 4, the OQ-45 and RDAS totals and subscale means are compared between males and females. For all eight dependent variables compared, females had a higher mean score than males. The most notable differences are with the OQ-45 SD score and, OQ-45 total score mean. Differences between the genders on these two scales are 7 and 9, respectively. It is important to note that the mean scores for SD and total scores for the OQ-45 are above the clinical cut-off levels for females, with the exception of the SR subscale. The clinical cutoff scores for the OQ-45 (and mean female scores) are as follows: total = 63 (65.49), SD = 36 (36.40), IR = 15 (18.06), and SR = 12 (11.18) (Lambert et al., 1996). The only male mean score on the OQ-45 that is above the clinical cutoff is the IR subscale (15.36).

The mean RDAS scores of both male and female clients were all below the clinical cut-offs. Because the RDAS is scored in an opposite manner than the OQ-45, this indicates the client's mean scores are considered distressed. A total of 148 clients were determined as distressed by scoring lower than the RDAS total cut-off score of 48, which is 69.2% of the sample (Busby et al., 1995). Of the females clients ($n = 106$), 73% were considered distressed, while 66% of the males ($n = 107$) were determined to be distressed. Table 4 shows the t -test results that are associated with the SD subscale.

The two genders were separated and scores correlation tests were run for each group on the OQ-45 total and subscale scores and the RDAS total and subscale scores. A comparison of the correlations between the OQ-45 and RDAS for males shows statistically significant relationships among the measures (see Table 5). The

Table 4

Gender and the Subscales and Total Means and t Tests

Variable	Males		Females		<i>t</i> ***	<i>df</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
OQ-45 SD	29.24	12.55	36.40	19.73	4.06**	206
OQ-45 IR	15.38	6.13	18.06	6.03	3.20**	210
OQ-45 SR	10.13	3.85	11.18	3.82	1.99*	211
OQ-45 Total	54.85	20.35	65.49	12.90	3.82**	205
RDAS Consensus	20.44	3.81	19.58	4.77	1.45	211
RDAS Satisfaction	12.52	3.54	12.08	3.61	.90	212
RDAS Cohesion	10.26	3.17	9.90	3.41	.81	212
RDAS Total	43.22	8.88	41.53	10.10	1.30	211

*** Level of significance is two-tailed.

explained variances, however, are (*r-squared* range: 6.38% - 61.31%) which indicates that for males, the instruments are assessing different constructs (Table 5).

The same comparison of the correlations between the OQ-45 and RDAS for females shows statically significant relationships among the measures (see Table 6). As with males, the explained variances are low (range 4.25% to 55.35%), which indicates that for females, the instruments are assessing different constructs (Table 6). The conclusion is that although the measures are statistically significantly related, the measures are still assessing enough different constructs that both measures are needed.

Table 5

Pearson Correlation Matrix for RDAS and OQ-45 for Males

Variable	OQ-45 IR	OQ-45 SR	OQ-45 Total	RDAS Con	RDAS Sat	RDASC oh	RDAS Total
OQ-45 SD	.69*	.71*	.96*	.42*	.36*	.34*	.44*
OQ-45 IR		.57*	.84*	.74*	.69*	.54*	.78*
OQ-45 SR			.80*	.40*	.27*	.25*	.37*
OQ-45 Tot				.57*	.49*	.43*	.59*
RDAS Con					.63*	.56*	.87*
RDAS Sat						.55*	.86*
RDAS Coh							.81*

Note. $n = 107$

Table 6

Pearson Correlation Matrix for RDAS and OQ-45 for Females

Variable	OQ-45 IR	OQ-45 SR	OQ-45 Total	RDAS Con	RDAS Sat	RDASC oh	RDAS Total
OQ-45 SD	.68*	.70*	.96*	.44*	.36*	.24*	.42*
OQ-45 IR		.53*	.82*	.70*	.70*	.48*	.74*
OQ-45 SR			.78*	.36*	.27*	.21*	.33*
OQ-45 Tot				.58*	.49*	.37*	.57*
RDAS Con					.66*	.55*	.89*
RDAS Sat						.53*	.86*
RDAS Coh							.80*

Note. $n = 107$

Research Question Number Three

Can the OQ-45 determine the same information as the RDAS regarding distressed and nondistressed couples? The distressed or nondistressed case was determined by their individual RDAS results. By using the RDAS clinical cut-off scores, the distinction was made that the case was distressed if the responses suggested clinical high distress levels in the client.

According to the assessment data, 148 (70%) individuals had RDAS cut-off scores suggesting they were distressed. Based on the explained variances, the results indicate that the instruments for the clients below the distressed cut-offs provide different types of information.

In Table 7, the Pearson's r correlations are shown for the distressed cases with the

Table 7

Pearson Correlation Matrix for RDAS and OQ-45 for Distressed Clients

Variable	OQ-45 IR	OQ-45 SR	OQ Total	RDAS Con	RDAS Sat	RDAS Coh	RDAS Total
OQ-45 SD	.64**	.66**	.97**	.35**	.22**	.15	.33**
OQ-45 IR		.43**	.77**	.52**	.52**	.28**	.60**
OQ-45 SR			.75**	.23**	.12	.05	.18*
OQ-45 Total				.43**	.31**	.21*	.43**
RDAS Con					.39**	.31**	.78**
RDAS Sat						.33**	.77**
RDAS Coh							.70**

Note. $n = 148$

OQ-45 subscale and total scores and RDAS subscale and total scores. The OQ-45 IR subscale had a weak correlation with the RDAS consensus ($r = .54$), satisfaction ($r = .59$), and total score ($r = .54$).

The remainder of the correlations were very weak and statistically not significant. While statistically significant, the explained variances are relatively low. This indicates that the OQ-45 and the RDAS provide different information for distressed clients.

The correlations in Table 8 represent individuals who had RDAS scores that indicate that they were not distressed. Again, similar to previous results, the strength of correlations for nondistressed individuals on the eight assessment variables shows a number of statistically significant relationships.

Table 8

Pearson Correlation Matrix for RDAS and OQ-45 for Nondistressed Clients

Variable	OQ-45 IR	OQ-45 SR	OQ Total	RDAS Con	RDAS Sat	RDAS Coh	RDAS Total
OQ-45 SD	.59**	.60**	.96**	.29*	.20	-.06	.23
OQ-45 IR		.54**	.78**	.47**	.58**	-.01	.54**
OQ-45 SR			.74**	.24	.11	-.01	.19
OQ-45 Total				.37**	.31*	-.05	.34**
RDAS Con					.43**	-.11	.73**
RDAS Sat						-.09	.68**
RDAS Coh							.45**

Note. $n = 65$

The strongest correlations are with the OQ-45 IR subscale and the RDAS consensus ($r = .54$), satisfaction ($r = .55$), and total score ($r = .62$). Although the correlations are slightly higher for nondistressed clients than for the distressed clients, the explained variances are not very high.

CHAPTER V

DISCUSSION

General Observations

Outcome Questionnaire Cut-Off Scores

Cut-off scores are used in clinical practice as an indicator (red flag) of distress in the specific area being assessed. These scores allow the clinician to take further notice in the clinical interview and help make judgments on diagnosis. Clinicians need to look at individual items on the assessment that may have influenced the score. Cut-off scores then should be used with good judgment and prudence by clinicians to be used correctly and effectively.

It is important to note that mean scores for females on each subscale and total is above the clinical cut-off scores. This indicates that the average female client at the MFTC is presenting a high level of clinical distress. In contrast, the male clients' mean scores were above the cut-off score only on the OQ-45 IR subscale. In addition, both genders mean scores are below each cut-off score of the RDAS. All the female mean scores are lower than male scores suggesting a elevated level of reported distress in female clients.

The creators of the OQ-45 indicated that cut-off scores are highly related to the population (Lambert et al., 1996). By using standard deviation and mean scores of each subscale and total scores, the creators suggested formulating cut-off scores to fit a given population. The formula is:

$$c = \frac{(SD1)(M2) + (SD2)(M1)}{SD1 + SD2}$$

Therefore, new cut-off scores were created for this sample to better explain the instrument scores. The new cut-off scores are as follows: SD = 37, IR = 13, SR = 12 (same as general population), and total is 68. Therefore, the scores of the population of this study indicate that only the female IR mean score is above the clinical cut-off for the OQ-45.

The change in clinical cut-off scores can be misleading. If the scores are determined by a clinical population and not a general one, the scores will then move higher. In doing so, future clients may be distressed in terms of the general population, but not the clinical population that the cut-off scores were derived from. Therefore, it is important to use cut-off scores that are derived from the general population from which the clinical population is a part of.

Reliability

Using the Coefficient alpha scores for the present sample, the reported reliabilities of the OQ-45 are comparable to those reported by Lambert et al. (1996). In contrast, the RDAS reliabilities are slightly lower than those reported by Busby et al. (1995). While slightly lower (range of difference: 0.01 – 0.07) than the Busby et al. study, the RDAS reliabilities are still in the acceptable range (Pedhazur & Schmelkin, 1991). Thus, all reliability scores were at or near the published reliability scores of the instrument creators. This provides some evidence for the external validity for this sample and study.

Research Questions

Research Question Number One

What is the relationship between the OQ-45 and/or its subscales with the RDAS?

The IR subscale of the OQ-45 has, by far, the strongest correlation to the RDAS total ($r = .74$; r -squared = .55). This moderately strong correlation suggests that the general information measured by 55% of the RDAS total can be determined with the IR subscale of the OQ-45 (Holcomb, 1998). Thus, only half of the variance can be explained, suggesting that the OQ-45 and RDAS seem to be measuring different constructs. The RDAS Consensus and Satisfaction subscales also show moderate correlations with the IR. This, too, suggests that results be obtained from administering the IR on these two RDAS subscales. The RDAS cohesion subscale has a weak correlation with the IR. The two instruments seem to measure separate constructs.

Clinicians will need to use both the RDAS and OQ-45 to gather information on whether or not the couple is experiencing distress and individual psychopathology. "Positive feedback in systems terms is a message that change has taken place" (Becvar & Becvar, 1982). Therefore, for the clinician to assess for positive feedback in reference to distress and psychopathology, both measures should be used.

Research Question Number Two

Is there a difference due to the gender of the client in the association between the OQ-45 and/or its subscales with the RDAS? The question was derived from the review of the literature, which suggested that female clients are more likely to be a determining factor in the prediction of divorce and overall marital satisfaction. Yet within this study,

although the female clients have higher mean scores on all subscales and totals, there seems to be no significant correlation to gender to the assessment scores. As mentioned in the results the male correlation between the OQ-45 IR subscale and the RDAS total is slightly higher than the female correlation strength. This suggests the OQ-45 IR subscale is a stronger indicator of distress among males than females.

There seems to be no difference between the genders and their relationship between the two measures. Therefore, the feedback loops and feedback itself should not be altered due to the client's gender. As the therapeutic system provides input to the system of the couple, the gender of the client does not change the output. In other words, the gender of the client does not determine whether or not feedback will be positive or negative (Becvar & Becvar, 1982).

Research Question Number Three

Can the OQ-45 determine the same information as the RDAS regarding distressed and nondistressed couples? There seems to be no correlational strength between distressed/nondistressed couples and the eight subscale and total scores. Even the IR subscale's correlation with the RDAS total was lower when the two subject groups were divided. Thus, the IR has no stronger of a relationship with the RDAS with distressed or nondistressed couples. Therefore, it seems the IR of the OQ-45 may not be appropriate to determine whether or not a couple is distressed.

Therefore, whether a client is distressed or not distressed does not change the correlational strength between the two measures. This suggests both measures are needed to gather proper information and provide appropriate feedback to the client about

marriages. Whether the feedback is negative or positive is determined by the client (Becvar & Becvar, 1982). However, the more informed the clinician can be regarding the status of the client's relationship, the more likely feedback will be helpful.

Implications for Clinicians

Couples/Marital Assessment

The OQ-45 is a more complex assessment than the RDAS, in that it attempts to describe both individual and systemic characteristics (Lambert et al., 1996). The advantages of the OQ-45 include indicators for suicidal ideation and an individual assessment through SD and IR. The results of this study indicate that a clinician may obtain the information necessary to determine whether a couple is distressed or not by using the IR subscale of the OQ-45, thus acquiring the same information as the RDAS total. However, the IR subscale and the remainder of the OQ-45 fail to gather the same information as the RDAS, which is to determine if there is distress in a marital relationship.

The OQ-45 seems to be adequate for explaining interpersonal relationship issues, but not the marital relationship specifically. There needs to be some type of assessment instrument that integrates both individual symptoms and marital relationship distress levels. The IR subscale only provide 55% of the same information RDAS. Therefore, both instruments may need to be used together appropriately. This discrepancy may be explained in the fact that the RDAS is measuring the marital relationship specifically, while the OQ-45 IR is measuring all interpersonal relationships (marital, parental, and other familial and intimate).

In order, then, to minimize paperwork and assessment time, an instrument needs to be developed that can assess both individual and relational distress. Both the RDAS and OQ-45 are sound instruments with clear time and ease advantages, yet a combined instrument would be a benefit for clinicians and clients. Most marital therapy clients are seeking positive feedback (feedback that initiates change to the system; Becvar & Becvar, 1982). When assessment measures can completely and quickly determine both relational and individual distress clinicians can more effectively introduce feedback into the system.

Implications for Research

This study indicates that there continues to be a need for short psychometrically sound measures from a systemic theoretical framework that ethically assesses psychopathology and relational functioning. While the OQ-45 seems to practically and precisely determine individual symptoms it seems to fall short of explaining distress in marriage as the RDAS does. Again, this may be do the fact that the OQ-45 IR measures all close relationships and not specify marital.

Study Limitations

The sample of the study was non-representative of the general population. The sample was considerably young, more educated, and more recently married than the Utah average. The data indicate the mean age of first marriage for males (23.9) is about a year and a half higher than that of females (22.2). The average age of first marriage in Utah is 23 for males and 21 for females, thus this sample is slightly older than the state's average

(Schramm et al., 2003). Age at marriage is probably the most consistent predictor of marital stability identified in marital research (Bumpass, Castro Martin, & Sweet, 1991; Larson & Holman, 1994; White, 1990).

Age at marriage has increased substantially over the past few decades (Bumpass et al., 1991; Chadwick & Heaton, 1992), implying that marriages should have become more stable. According to the National Center for Health Statistics (2005), those who marry at or under the age of 18 increase their likelihood of divorce by 24% during the first 10 years of marriage. Of Utahns who first married under age 20, 44% are now divorced (Schramm, Marshall, Harris, & George, 2003). The sample had 7 individuals (2 males, 5 females) who were eighteen and younger at the time of their marriage. All of these 7 clients had RDAS scores that suggested they were distressed.

It is also interesting to note that half of all divorces occur during the first seven years of marriage (Gottman, 1999). In the present sample, the mean length of marriage is 3.8 years (range: .5 - 19.5 years). Thus, the average couple at the MFTC were still in the area of relationship development where there is a higher degree of likelihood of divorce.

The mean education level of the sample is high: 13.9 years for males and 13.8 years for females in this study. The National Center for Health Statistics (2005) reported that individuals who are high-school dropouts, versus those with some college, increase their likelihood of divorce by 13%. This sample education mean indicates the average client of the MFTC had nearly two years of college or post-high school education. Thus, participants in this sample are considered less likely to divorce than others.

The range of number of children of the clients ranged from 0 to 5, with a total of 109 clients having at least one child. Of the couples that had only one child ($n = 35$), the average length of marriage is 3 years. The presence of children is associated with differences in marital structure (lower interaction, more dissatisfaction with finances and the division of labor, and more traditionalism of the division of labor) that are, in turn, associated with lower marital happiness (Heaton, 2002).

REFERENCES

- Ackerman, S. J., Hilsenroth, M. J., Baity, M. R., & Blagys, M. D. (2000). Interaction of therapeutic process and alliance during psychological assessment. *Journal of Personality Assessment, 75*(1), 82-109.
- Allen, A., Montgomery, M., Tubman, J., Frazier, L., & Escover, L. (2003). The effects of assessment feedback on rapport-building and self-enhancement processes. *Journal of Mental Health Counseling, 25*(3), 165-181.
- Beck, A. T., Ward C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives for General Psychology, 4*, 53-63.
- Becvar R. J., & Becvar, D. S. (1982). *Systems theory and family therapy*. Lanham, MD: University Press of America.
- Berg, I., & Miller, S. (1992). *Working with the problem drinker: A solution-focused approach*. New York: Norton.
- Bernard, J. (1972). *The future of marriage*. New York: Bantam Books.
- Boughner, S. R., Hayes, S. F., Bubenzer, D. L., & West, J. D. (1994). Use of standardized assessment instruments by marriage and family therapists: A survey. *Journal of Marital and Family Therapy, 20*, 69-75.
- Bowen, M. (1978). *Family therapy in clinical practice*. New York: Jason Aronson.
- Bumpass, L. L., Castro Martin, T., & Sweet, J. A. (1991). The impact of family background and early marital factors on marital disruption. *Journal of Family Issues, 12*(1), 22-42.
- Busby, D. M., Crane, D. R., Larson, J. H., & Christensen, C. (1995). A revision of the Dyadic Adjustment Scale for use with distressed and nondistressed couples:

- Construct hierarchy and multidimensional scales. *Journal of Marital and Family Therapy*, 21(3), 289-308.
- Chadwick, B. A., & Heaton, T. B. (1992). *Statistical handbook on the American family*. Phoenix, AZ: Oryx Press.
- Cordova, J. V., Warren, L. Z., & Gee, C. B. (2001). Motivational interviewing as an intervention for at-risk couples. *Journal of Marital and Family Therapy*, 27, 355-373.
- Crane, D. R. (1996). *Fundamentals of marital therapy*. New York: Brunner/Mazel.
- Crane, D. R., Middleton, K. C., & Bean, R. A. (2000). Establishing criterion scores for the Kansas Marital Satisfaction Scale and the Revised Dyadic Adjustment Scale. *American Journal of Family Therapy*, 28(1), 53.
- Crane, D. R., Soderquist J. N., & Frank R. L. (1995). Predicting divorce at marital therapy intake: A preliminary model. *American Journal of Family Therapy*, 23(3): 227-236.
- Derogatis, L. R. (1977). *The SCL-90 manual: Scoring, administration and procedures for the SCL-90*. Baltimore: Johns Hopkins University School of Medicine, Clinical Psychometrics Unit.
- Dooley, D. (1995). *Social research methods* (3rd ed.). Englewood Cliffs, NJ: Prentice Hall.
- Epstein, L. (1992). *Brief treatment and a new look at the task-centered approach*. New York: Macmillan.
- Filsinger, E. E. (1983). *Marriage and family assessment*. Beverly Hills, CA: Sage.

- Finn, S. E., & Tonsager, M. E. (1997). Information-gathering and therapeutic models of assessment: Complementary paradigms. *Psychological Assessment, 9*, 374-385.
- Fletcher, C. (1991). Assessment feedback counseling and individual differences: An exploratory study. *Counseling Psychology Quarterly, 4*, 23.
- Fowers, B. J. (1990). An interactional approach to standardized marital assessment: A literature review. *Family Relations, 39*(4), 368.
- Fredman, N., & Sherman, R. (1987). *Handbook of measurements for marriage and family therapy*. Durham, NC: Duke University Press.
- Gottman, J. M. (1999). *The marriage clinic: A scientifically-based marital therapy*. New York: Norton.
- Hattie, J. A., Myers, J. E., & Rosen-Grandon, J. R. (2004). The relationship between marital characteristics, marital interaction processes and marital satisfaction. *Journal of Counseling and Development, 82*(1), 58-71.
- Heaton, T. B. (2002). Factors contributing to increasing marital stability in the united states. *Journal of Family Issues, 23*(3), 392-409.
- Heffer, R.W., & Snyder, D.K. (1998). Comprehensive assessment of family functioning. In L. L'Abate(ed.), *Family psychopathology: The relational roots of dysfunctional behavior*. (207-235). New York: Guilford Press.
- Holcomb, Z. C. (1998). *Fundamentals of descriptive statistics*. Los Angeles: Pyczak Publishing.
- Jacobson, N. S., & Addis, M. E. (1993). Research on couples and couple therapy: What do we know? Where are we going? *Journal of Consulting and Clinical Psychology, 61*(1), 85-93.

- Joreskog, K. G., & Sorbom, D. (1989). LISREL 7: A guide to the program and applications. Chicago: SPSS.
- Kaslow, F. W. (Ed.). (1996). *Handbook of relational diagnosis and dysfunctional family patterns*. New York: Wiley.
- Kimmel, D., & Van Der Veen, F. (1974). Factors of marital adjustment in Locke's marital adjustment test. *Journal of Marriage and the Family*, 36, 57-63.
- Kobak, K. A., Taylor, L. H., Dottle, S. L., Greist, J. H., Jefferson, J. W., Burroughs, D. et al. (1997). A computer-administered telephone interview to identify mental disorders. *Journal of the American Medical Association*, 278(11), 905-910.
- Kurdek, L. A. (2005). Gender and marital satisfaction early in marriage: A growth curve approach. *Journal of Marriage & Family*, 67(1), 68-84.
- Lambert, M. J. (1983). Introduction to assessment of psychotherapy outcome: Historical perspective and current issues. In M. J. Lambert, E. R. Christensen, & S. S. DeJulio (Eds.), *The assessment of psychotherapy outcome* (pp. 132-147). New York: Wiley.
- Lambert, M. J., Hansen, N. B., Umpruss, V., Lunnen, K., Okiishi, J., & Burlingame, G. M. (1996). *Administration and scoring manual for the OQ-45.2*. Stevenson, MD: American Professional Credentialing Services.
- Larson, J. H., & Holman, T. B. (1994). Premarital predictors of marital quality and stability. *Family Relations*, 43, 228-237.
- Lebow, J. (2000). What does the research tell us about couple and family therapies? *Journal of Clinical Psychology*, 56(8), 1083-1094.
- Levine, J. E. (2001). Behavior management principles: Incorporating a biopsychosocial

- perspective. *Child and Adolescent Social Work Journal*, 18(4), 253-261.
- Locke, H. J., & Wallace, K. M. (1959). Short multi-adjustment and prediction tests: Their reliability and validity. *Marriage and Family Living*, 21, 329-343.
- Magnavita, J. J. (2000a). Integrative relational therapy of complex clinical syndrome: Ending the multigenerational transmission process. *Journal of Clinical Psychology*, 56(8), 1051-1064.
- Magnavita, J. J. (2000b). Introduction: Growth of relational therapy. *Journal of Clinical Psychology*, 56(8), 999-1004.
- Miller, B. C. (1986). *Family research methods*. Newbury Park, CA: Sage.
- Miller, S. (2002). *Assessment equals change*. Retrieved October 14, 2004 from <http://www.takingcure.com>
- Minuchin, S. (1974). *Families and family therapy*. Cambridge, MA: Harvard University Press.
- National Center for Health Statistics. (2005). Retrieved October 29, 2005 from <http://www.cdc.gov/nchs/hus/htm>
- Nichols, M. P., & Schwartz, R. C. (1998). *Family therapy: Concepts and methods*. (4th ed.). Needham Heights, MA: Allyn & Bacon.
- Okiishi J., Lambert, M. J., Nielson, S. L., & Ogles, B. M. (2003). Waiting for supershrink: An empirical analysis of therapist effects. *Clinical Psychology and Psychotherapy*, 10, 361-373.
- Pedhazur, E. J., & Schelkin, L. P. (1991). *Measurement, design, and analysis: An integrated approach*. Hillsdale, NJ: Erlbaum.
- Pinsof, W. (1995). *Integrative problem centered therapy*. New York: Basic Books.

- Pinsof, W. M. & Wynne, L. (Eds.). (1995). The effectiveness of marital and family therapy. *Journal of Marital and Family Therapy, 21*, 339-610.
- Regier, D.A., Boyd, J. H., Burke, J. D. Jr., Rae, D. S., Myers, J. K., Kramer, M., et al. (1998). One-month prevalence of mental disorders in the United States. *Archives of General Psychiatry, 45*, 977-986.
- Rigazio-DiGilio, S. A. (2000). Relational diagnosis: A coconstructive-developmental perspective on assessment and treatment. *Journal of Clinical Psychology, 56*(8), 1017-1036.
- Rhyne, D. (1981). Bases of marital satisfaction among men and women. *Journal of Marriage and the Family, 43*, 941-954.
- Schramm, D. G., Marshall, J. P., Harris, V. W., & George, A. (2003). *Marriage in Utah: 2003 baseline statewide survey on marriage and divorce*. Salt Lake City, UT: Utah Department of Workforce Services.
- Schumm, W. R., Jurich, A. P., Bollman, S. R., & Bugaighis, M. A. (1985). His and her marriage revisited. *Journal of Family Issues, 6*(2), 221-227.
- Schumm, W. R., Nichols, C. W., Schectman, K. L., & Grigsby, C. C. (1983). Characteristics of responses to the Kansas Marital Satisfaction Scale by a sample of 84 married mothers. *Psychological Reports, 53*, 567-572.
- Snyder D. K. (1981). *Marital satisfaction inventory manual*. Los Angeles: Western Psychological Services.
- Snyder, D. K., Mangrum, L. F., & Willis, R. M. (1993). Predicting couples' response to marital therapy: A comparison of short- and long-term predictors. *Journal of Consulting and Clinical Psychology, 61*(1), 61-69.

- Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family*, 38, 15-28.
- Spanier, G. B., & Thompson, L. (1982). A confirmatory analysis of the dyadic marital adjustment scale. *Journal of Marriage and Family Therapy*, 44, 731-738.
- Spielberger, C. D. (1983). *Manual for the State-Trait anxiety inventory STAI (Form Y)*. Palo Alto, CA: Consulting Psychologists Press.
- Stevens, J. (1990). *Intermediate statistics: A modern approach*. Hillsdale, NJ: Erlbaum.
- Straus, M., & Brown, B. (1978). *Family measurement techniques: Abstracts of published instruments, 1935-1974*. Minneapolis: University of Minnesota Press.
- Swann, W. B. (1997). The trouble with change: Self-verification and allegiance to self. *Psychological Science*, 8, 177-180.
- Thompson, L. (1988). Women, men, and marital quality. *Journal of Family Psychology*, 2, 95-100.
- Udinsky, B. F., Osterlind, S. J., & Lynch, S. W. (1982). *Evaluation resource handbook: Gathering, analyzing, reporting data*. San Diego, CA: EdITS Publishers.
- Utah State University Marriage and Family Therapy Program (1999). Retrieved October 24, 2004, from <http://www.usu.edu/mft/>
- Whisman, M. A., Weinstock, L. M., & Uebelacker, L. A. (2004). Psychopathology and marital satisfaction: The importance of evaluating both partners. *Journal of Consulting & Clinical Psychology*, 72(5), 830-838.
- Whiston, S. C. (1999). *Principles and applications of assessment in counseling*. Belmont, CA: Wadsworth.

White, L. K. (1990). Determinants of divorce: A review of research in the eighties.

Journal of Marriage and the Family, 52, 904-912.

White, M. B., Stahmann, R. F., & Furrow, J.L. (1994). Shorter may be better: A comparison of the Kansas Marital Satisfaction Scale and the Locke-Wallace Marital Adjustment Test. *Family Perspective*, 28(1), 53-66.

APPENDICES

Appendix A
Outcome Questionnaire (OQ-45.2)

Outcome Questionnaire (OQ-45,2)

Instructions: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this section, work is defined as employment, school, housework, childcare, volunteer work, and so forth.

	Never	Rarely	Sometimes	Frequently	Almost Always
1. I get along well with others	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
2. I tire quickly	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
3. I feel no interest in things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
4. I feel stressed at work/school	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
5. I blame myself for things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
6. I feel irritated	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
7. I feel unhappy in my marriage/significant relationship ...	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
8. I have thoughts of ending my life	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
9. I feel weak	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
10. I feel fearful	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
11. After heavy drinking, I need a drink the next morning to get along. (If you do not drink, mark "never")	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
12. I find my work/school satisfying	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
13. I am a happy person	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
14. I work/study too much	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
15. I feel worthless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
16. I am concerned about family troubles	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
17. I have an unfulfilling sex life	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
18. I feel lonely	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
19. I have frequent arguments	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
20. I feel loved and wanted	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
21. I enjoy my spare time	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0

	Never	Rarely	Sometimes	Frequently	Almost Always
22. I have difficulty concentrating	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
23. I feel hopeless about the future	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
24. I like myself	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
25. Disturbing thoughts come into my mind that I cannot get rid of	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
26. I feel annoyed by people who criticize my drinking (or drug use). (If not applicable, mark "never")	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
27. I have an upset stomach	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
28. I am not working/studying as well as I used to	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
29. My heart pounds too much	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
30. I have trouble getting along with friends and close acquaintances	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
31. I am satisfied with my life	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
32. I have trouble at work/school because of drinking or drug use. (If not applicable, mark "never")	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
33. I feel that something bad is going to happen	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
34. I have sore muscles	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
35. I feel afraid or open spaces, or driving, or being on buses, etc.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
36. I feel nervous	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
37. I feel my love relationships are full and complete	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
38. I feel that I am not doing well at work/school	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
39. I have too many disagreements at work/school	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
40. I feel something is wrong with my mind	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
41. I have trouble falling asleep or staying asleep	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
42. I feel blue	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
43. I am satisfied with my relationships with others	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
44. I feel angry enough at work/school to do something I may regret	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
45. I have headaches	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

Appendix B

The Revised Dyadic Adjustment Scale (RDAS)

Revised Dyadic Adjustment Scale (RDAS)

Instructions: Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

	Always agree	Almost always agree	Occasionally disagree	Frequently disagree	Almost always disagree	Always disagree
1. Religious matters	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
2. Demonstrations of affection	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
3. Making major decisions	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
4. Sex relations	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
5. Conventionality (correct of proper behavior)	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
6. Career decisions	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0

	All the time	Most of the time	More often than not	Occasionally	Rarely	Never
7. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
8. How often do you and your partner quarrel?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
9. Do you ever regret that you married (or lived together)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
10. How often do you and your mate "get on each other's nerves"?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

	Every day	Almost every day	Occasionally	Rarely	Never
11. Do you and your mate engage in outside interests together?	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0

How often would you say the following occur between you and your mate:

	Never	Less than once a month	Once or twice a month	Once or twice a week	Once a day	More often
12. Have a stimulating exchange of ideas	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
13. Work together on a project	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
14. Calmly discuss something	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5