

ABSTRACT

Title of Thesis: THE ASSOCIATIONS OF DEPRESSION SYMPTOMS, WITHDRAWAL BEHAVIORS, AND WITHDRAWAL COGNITIONS WITH INTIMATE BEHAVIOR AND PLEASURE FROM A PARTNER'S INTIMATE BEHAVIOR AMONG CLINICAL COUPLES

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This study examined the association between withdrawing behaviors, withdrawal cognitions, and depression symptoms and both the degree of the individual's own intimate behavior and his/her pleasure from receiving intimate behavior from a partner. Results indicated that thoughts or cognitions involving the desire to distance oneself from an interaction were significantly related to lower levels of intimate behavior and lower levels of pleasure experienced from a partner's intimate behavior. Further, there was a trend toward support for the notion that individuals with higher levels of depression symptoms engage in lower levels of intimate behavior. For females, the presence of depression symptoms was associated with less pleasure experienced from a partner's intimate behavior. In contrast, avoidant behavior during conflict was not found to be associated with the initiation of intimate relationship behavior and was only associated with the amount of pleasure that females experienced from intimate behavior.

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CLINICAL COUPLES

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Thesis submitted to the Faculty of the Graduate School of the
University of Maryland, College Park, in partial fulfillment
of the requirements for the degree of
Master of Science
2008

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2008

ACKNOWLEDGEMENTS

It is with great pleasure that I recognize the following people for their support, encouragement, and insight throughout the process of writing this thesis.

Norm- For your unconditional patience, flexibility, insight, and kindness- I truly could not have completed this project without your guidance and support. Thank you!

Sally and Carol- For your continued support and encouragement throughout this process- Your input enabled this project to be stronger than I ever could have imagined. Thank you!

The Marriage and Family Therapy class of 2006- Amanda, Annie, Hannah, Joanna, Jocelyn, Kate, Katie, Kirk, and Reena - I have learned and grown from my relationships with each of you. Thank you for believing in me, and in turn, allowing me to believe in myself.

To my family- my Mom, my Dad, my brother Matt, Mommom, and Pop- I went into this field because of you- I can only hope that in my future endeavors, I will be able to help others cultivate a family environment similar to the one that I have been so privileged to experience - an environment characterized by unconditional love, nurturance, and encouragement. Know that your love and support has provided the foundation for all that I have accomplished. With your guidance, I have learned how to recognize and access my strengths, how to chase down my dreams, and how to truly love and support another person. Through you, I have learned the value and meaning of “family”- Thank you.

To Allen- For bringing light, laughter, and love to my life and for teaching me how to carry those pieces through to all of my endeavors- Thank you.

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CHAPTER 1

Introduction

Statement of the Problem

Intimacy, or a sense of closeness or connectedness with others, has consistently been identified as a central and fundamental component of individual and relational well-being (Berscheid & Reis, 1998; Epstein & Baucom, 2002; Prager, 1995). Prager's (1995) review of intimacy research concluded that intimacy within a couple's relationship is associated with higher reported levels of overall relationship quality, relationship satisfaction, and individual functioning. As a result, many research studies have attempted to identify variables or factors that either facilitate or inhibit the experience of intimacy within the couple relationship.

Researchers have consistently highlighted the importance of open and engaged communication patterns (Laurenceau, Rovine, & Barrett, 2005) and positive dyadic involvement (Prager & Roberts, 2004) in the facilitation of relationship intimacy. Furthermore, a lack of such positive behaviors and attitudes has been associated with poorer relational harmony and lower overall levels of perceived intimacy (Roberts & Greenberg, 2002).

Because partners' positive behavior toward each other is an important component of perceived relationship intimacy, and intimacy has been found to be highly correlated with relationship well-being and satisfaction, it is important to explore potential obstacles or inhibitors to the experience of relationship intimacy. Depression has been identified as one such obstacle in that it has been associated with lower perceived levels of marital intimacy, especially self-disclosure based intimacy (Culp & Beach, 1998). However,

although depression symptoms have also been found to be associated with higher levels of negative communication styles including the demand-withdrawal pattern and lower levels of partner comprehension and understanding during communication (Sher & Baucom, 1993), little research has been conducted on the relation between symptoms of depression and intimate behavior.

Research on marital couple relationships has also found that withdrawal behaviors by either husbands or wives are associated with marital distress, increased negativity, and less positive connection in relationships (Stanley, Markman, & Whitton, 2002).

However, no direct link between withdrawal behaviors and perceptions of intimate relationship behaviors has been established. The present study examined that possible link. Furthermore, research on couple communication patterns and their impacts on relationship quality traditionally has failed to measure the thoughts or cognitions individuals experience that are associated with their withdrawal behavior, as well as associated with less intimate behavior. Consequently, it is important to investigate the degree to which withdrawal cognitions such as “I need to get out of here” or “I should avoid the issue” are associated with individuals withdrawing more, exhibiting fewer positive intimate behaviors toward their partner, and experiencing lower pleasure when their partners approach them with intimate relationship behaviors.

As mentioned above, intimacy is a fundamental human motivation and value (Epstein & Baucom, 2002). Individuals establish close connections with family members, friends, and significant others throughout the life course in order to fulfill and satisfy the basic human needs for support, love, and understanding. Additionally, although individuals report intimate experiences in a variety of relationships, many view

marriage as the relationship that serves as their primary source of affection and support and therefore the most intimate adult relationship they experience (Levinger & Huston, 1990). Furthermore, difficulties with intimacy are frequently implicated in decisions to seek therapy for marital or relationship problems, and increasing or enhancing intimacy is often one of the primary goals of couple therapy. Therefore, comprehensive research on factors that influence individuals' experiences of relational intimacy is necessary in order to design clinical interventions that would be most effective in facilitating couples' intimacy.

Purpose

This study explored the association between potential obstacles to intimacy (withdrawing behaviors, withdrawal cognitions, and depression symptoms) and both the degree of the individual's own intimate behavior and his or her pleasure from receiving intimate behavior from a partner. Specifically, the study examined the degrees to which an individual's depression symptoms, withdrawal behaviors, and withdrawal cognitions are associated with (a) his/her partner's perception of the person's intimate relationship behaviors, as well as with (b) the individual's own degree of pleasure experienced when his/her partner exhibits specific types of intimate relationship behavior.

The present study used a clinical sample of heterosexual couples to examine the relationships between the potential obstacles to intimacy and levels of intimate behavior and experienced pleasure. Furthermore, a specific subset of this clinical sample, couples who have experienced mild to moderate levels of physical and/or psychological abuse, were utilized in the present study. Therefore, the findings will have direct implications for barriers to intimacy within this specific population. Future research should examine

intimate behavior and barriers to intimacy among community samples to determine the generalizability of the present results.

Overall, it is important to conduct research on the relationships that depression symptoms, withdrawal behaviors, and cognitions have with intimacy for a number of reasons. First, because intimacy has been found to be highly correlated with individual well-being and relationship satisfaction, it is important to explore potential obstacles or inhibitors in the experience of relationship intimacy. Second, a deeper and more comprehensive understanding of the individual factors that contribute to some couples being intimate and others being disconnected will enable clinicians to develop and utilize interventions specifically targeted toward the enhancement of more specific intimate relationship experiences.

Review of Literature

Conceptualizing and Measuring Intimacy

In the current literature, intimacy is most often measured using self-report instruments and/or qualitative interviews. However, some studies have also utilized daily diary reports to measure the experience of relationship intimacy. For example, in a study examining intimacy as an interpersonal process, Laurenceau, Rovine, and Barrett (2005) asked relationship partners to keep a daily diary of intimate couple interactions as a way to obtain detailed, accurate, and focused accounts of intimate relationship activity. The researchers anticipated that daily, comprehensive records would better capture the dynamic nature of the intimacy process that often “appears static with the use of more conventional, cross-sectional designs” (Laurenceau et al., 2005, p.316). Despite this perspective, however, most researchers consistently utilize more global self-report

instruments and participant interviews to assess the meaning and experience of relationship intimacy.

Although the types of instruments and techniques utilized in the measurement of relationship intimacy are relatively consistent across studies, definitions and conceptualizations of intimacy vary. In a review of the literature on intimacy, Berscheid and Reis (1998) found that the term “intimacy” has been used varyingly to refer to feelings of closeness and affection between partners; the state of having revealed one's innermost thoughts and feelings to another person; relatively intense forms of nonverbal engagement (notably, touch, eye contact, and close physical proximity); particular types of relationships (especially marriage); sexual activity; and stages of psychological maturation.

Furthermore, intimacy has also often been conceptualized as companionship, as a process that changes with maturational transitions in relationships (White, Speisman, Jackson, Bartos, & Costos, 1986), and as a dynamic process that includes emotional, intellectual, social, and cultural dimensions (Schaefer & Olson, 1981). Additionally, intimacy has been associated with emotional bonding and attachment in adult romantic relationships (Johnson, 2004).

Most frequently, however, intimacy has been identified as an interpersonal process characterized by the self-disclosure to another person of thoughts and feelings that are not usually apparent in the social roles and behaviors of everyday life. This framework identifies intimate relationships as providing the foundation for the open and honest disclosure of levels of the self that most often remain hidden from others in daily life. Furthermore, in the literature on intimacy, such self-disclosing behavior by one

partner is often unequivocally accompanied by the other partner's responsiveness, or active attention, interest, understanding, and empathy for the disclosing partner's perspective (Laurenceau et al., 2005). In this sense, intimacy is synonymous with revealing the most hidden and personal aspects of oneself to one's partner and subsequently feeling and believing that the partner both attends to and reacts supportively to central, core defining principles of the self (Reis, Clark, & Holmes, 2004).

As demonstrated in the above definitions, the conceptualization of intimacy has often been intertwined with relationship concepts such as love, attachment, passion, support, and commitment that also have been found to promote relationship well-being and satisfaction. Therefore, the growing trend in intimacy research has been to distinguish intimacy from other related concepts by devising a consistent and comprehensive empirical definition that takes into account the various theoretical perspectives, lay definitions, and subjective experiences of intimacy that currently exist (Prager, 1995).

The most widely referenced conceptualization of intimacy to date (Prager, 1995) attempts to consolidate the varying theoretical descriptions into one comprehensive, guiding definition of relational intimacy. Prager (1995) identifies intimacy in terms of two basic concepts: intimate interactions and intimate relationships. *Intimate interactions* are comprised of 1) both verbal and nonverbal behaviors by partners that involve sharing between them (e.g., self-disclosure, emotional expressiveness) and 2) intimate experiences, or feelings and perceptions that people have during and because of their intimate interactions (e.g., warmth, pleasure, affection). In this framework, *intimate relationships* are conceptualized as being composed of multiple intimate interactions and

their subjective experiential byproducts. Intimate relationships are distinguished from other personal relationships by the frequency of intimate interactions between partners. This conceptualization of intimacy, which identifies it as the driving force or process behind feelings of passion, love, commitment, support, etc., has been supported by many of the existing empirical studies on interpersonal relationships.

For example, in a study of the characteristics of long-lasting relationships, Mackey, O'Brien, and Mackey (1997) conducted comprehensive interviews with 72 partners from 36 relationships that had lasted at least 15 years. The researchers found that intimacy emerged as a significant predictor of relationship satisfaction. Furthermore, participants described intimacy as the verbal sharing of inner thoughts and feelings between partners along with the mutual acceptance of those thoughts and feelings.

Mackey, Diemer, and O'Brien (2000) defined intimacy as the "sense that one could be open and honest in talking with a partner about personal thoughts and feelings not usually expressed in other relationships" (p. 202). The authors conducted 216 in-depth interviews with spouses in 108 heterosexual or same-sex relationships. They found that factors related to high levels of relationship intimacy included minimal levels of interpersonal conflict, conflict resolution or management characterized by face-to-face discussions of differences, feelings of equity and fairness within the relationship, and the expression of physical affection between partners (especially through touching and hugging).

Helgeson, Shaver, and Dyer (1987) asked participants to describe instances in which they had experienced feelings of intimacy with members of the same and opposite sex. Self-disclosure, physical contact, sexual contact, sharing activities, mutual

appreciation of the other, and warmth emerged as the major themes characteristic of intimate relationships. Across genders, intimacy was associated more with appreciation and affection than with self-disclosure. It should be noted, however, that participants' definitions were not specific to either romantic relationships or friendships, so it was difficult to delineate what components of intimacy are characteristic of which types of relationships.

Monsour (1992) examined conceptions of intimacy in same- and opposite-sex relationships among a sample of 164 college students. Self-disclosure was found to be the most significant characteristic of intimacy, followed by emotional expressiveness, unconditional support, shared activities, physical contact, and lastly, sexual activity. It is important to note that this study asked participants to describe intimate characteristics of platonic rather than romantic relationships, which may have influenced the nature of the responses. Additionally, the study solely focused on the short-term relationships of young adults.

Sexual involvement, a specific type of "intimate interaction" (see Prager, 1995), has also been identified as an important component of intimate romantic relationships. In many studies, the phrases "being intimate" and "engaging in intimate behaviors" are often automatically equated or associated with sexual activity (Vohs & Baumeister, 2004). Parks and Floyd (1996), in their study investigating the meanings associated with close and intimate relationships among a sample of 270 college students, found that 50% of the respondents identified sexual interactions between partners as being the defining relationship characteristic that distinguished intimacy from closeness.

Additionally, Hinchliff and Gott (2004) examined the role of sexual activity in long-term marital relationships through in-depth interviews with 69 participants, aged 50-86 years, who had been married for a minimum of 20 years. Participant interviews indicated that sexual activity played an important role in fostering closeness and connectedness within the couple relationship. Specifically, many participants reported that sexual activity allowed them to feel needed and valued by their partner.

In Prager's (1995) abovementioned definition of intimacy, nonverbal sharing is an important component of intimate interactions. Shared meaningful glances, affectionate touches, shared emotional expressions such as tears or laughter, and sexuality involve sharing something deeply personal with another, even though the message may be one that the other is already aware of and even though the message is not verbalized. However, other than sexual involvement, many aspects of Prager's notion of nonverbal meta-communication have not been empirically tested or validated.

Much of the existing literature on intimacy utilizes samples of young adults to determine the extent and experience of intimate relationship behavior. The extensive and almost exclusive use of young adult, college student samples limits the generalization of the findings to other subgroups and populations. Furthermore, many of the studies on intimacy have examined platonic friendships for insight into the meaning of intimate relationships. However, the examination of platonic relationships may generate results that are markedly different from the experience of intimacy in romantic relationships. Consequently, the present study adds to knowledge on intimacy by investigating a sample of adult couples.

Working Definition of Intimacy

Although many different definitions of intimacy have been proposed and explored, all of them have at least one important aspect in common - a feeling of closeness or connectedness that develops through shared, dyadic processes. Therefore, based on the aforementioned conceptualizations of intimacy, particularly Prager's (1995) conceptualization, the definition that guides the present study is as follows: Intimacy is a sense of closeness or connectedness within couple relationships that develops through shared, dyadic processes and interactions. In this study, partner reports of intimate interactions, including expressions of sexuality, open and engaged communication patterns, and positive dyadic involvement, are utilized to assess relational intimacy. These types of behaviors, because of their ability to foster subjective experiences of intimacy and interdependence while simultaneously encouraging relational harmony, are important measures or indicators of overall relationship intimacy.

Intimacy as a Fundamental Human Motivation

Research has consistently identified intimacy as a fundamental human motivation and value (Baumeister & Leary, 1995; Epstein & Baucom, 2002; McAdams, 1984; Prager, 1995). Across time and cultures, people have demonstrated a powerful need to establish strong and stable connections with others. Intimacy has been identified as a defining characteristic of close relationships and, along with affiliation, altruism, and succorance, one of the core communally-oriented motives that drives interpersonal connections (Epstein & Baucom, 2002).

In an extensive review of existing empirical and theoretical literature, Baumeister and Leary (1995) found evidence that people have a basic need to establish and maintain

strong, enduring relationships with others. Specifically, the findings from this review indicated that people have a need for frequent, affectively pleasant or positive interactions with the same individuals and that they need these interactions to occur in a framework of long-term, stable caring and concern. Furthermore, Baumeister and Leary (1995) found that a deficit in intimate interpersonal relationships was associated with problems in psychological well-being.

Research has also indicated that intimacy is a universal, communal need that all people experience to a greater or lesser degree (Epstein & Baucom, 2002; Prager, 1995). An individual's need for intimacy is reflected in the frequency and likelihood of intimate behavior and also significantly influences the individual's cognitive and emotional states. Studies have found that individuals high in intimacy motivation are more likely than their low scoring counterparts to engage in intimate interactions in order to satisfy their needs (McAdams & Constantian, 1983). Furthermore, research examining intimacy in terms of need fulfillment in couple relationships has found that intimacy need fulfillment is associated with greater relationship satisfaction and lower levels of negative attributions regarding partner intentions (Kirby, Baucom, & Peterman, 2005). Therefore, by definition, intimacy needs are motivating.

Overall, the existing empirical and theoretical literature indicates that intimacy meets the criteria for a "fundamental human motivation" (Baumeister & Leary, 1995). Specifically, intimacy has been found to readily produce effects under all but adverse conditions, have affective consequences, direct cognitive processing, lead to ill effects (such as on health or adjustment) if hindered, elicit goal-oriented behavior designed to satisfy it, be universal in the sense of applying to all people, not be derivative of other

motives, affect a broad variety of behaviors, and have implications that go beyond immediate psychological functioning (McAdams, 1984; Prager, 1995). Thus, fulfillment of intimacy needs results in satisfaction and good adjustment, whereas non-fulfillment may result in distress and loneliness (Prager, 1995).

The Role of Intimacy in Individual and Relational Functioning and Well-being

As mentioned, the need to establish and maintain close relationships with others has been identified as a fundamental human motivation and value that is strongly associated with individual and relational well-being (Bersheid & Reis, 1998; Epstein & Baucom, 2002; Mashek & Aron, 2004; Prager, 1995). Strong, intimate relationships contribute to individual well-being through their ability to facilitate and satisfy communal or interpersonal needs for love, support, affection, and understanding, while simultaneously encouraging the individuals to pursue agentic or individually-oriented needs for autonomy, personal achievement, and job satisfaction (Kirby, Baucom, & Peterman, 2005). Thus, intimacy needs and needs for autonomy and achievement are not mutually exclusive, and an intimate base in one's life often serves as a springboard for motivation to pursue one's individual goals. Additionally, Prager's (1995) review of the existing literature on the role of intimacy in the promotion of human well-being indicates that, in the face of stressful life events, individuals who have intimate relationships have fewer stress-related symptoms, faster recoveries from illness, and a lower probability of relapse or recurrence than those who do not have intimate relationships.

Prager's (1995) review also indicates that the absence of intimacy seems to have deleterious effects on individual health and well-being in that individuals who lack intimate relationships have higher mortality rates, more accidents, and are at higher risks

for developing illnesses than those who report having intimate relationships and connections. Furthermore, individuals who report a lack of intimate relationships are also more likely to demonstrate poor self-efficacy, lower self-esteem, psychopathology symptoms (especially depression and anxiety), depressed immunological functioning, and are more vulnerable to feelings of loneliness than their intimately connected counterparts.

As a result of such research regarding the role of intimacy in the promotion of individual health and well-being, interpersonal connections with family, friends, and other significant individuals have been heavily researched within the marriage and family therapy field. Particularly, since many individuals regard marriage as the most intimate relationship they experience and the relationship that serves as their primary source of affection and support (Levinger & Huston, 1990), specific attention has been given to the role of intimacy in marital relationships. Such research indicates that intimacy within the couple relationship has significant implications for relational functioning and well-being. Specifically, high levels of self-reported intimacy are associated with marital satisfaction and stability (Talmadge & Dabbs, 1990). Individuals who engage in such activities as self-disclosure, trust, and interdependence with their partners have been found to experience greater relationship satisfaction and greater relationship longevity while relationships with low levels of intimacy are more likely to end (Simpson, 1987).

Healthy, intimate relationships themselves can contribute to the well-being of each individual member in part by providing an arena in which both partners can satisfy important needs (Epstein & Baucom, 2002). Intimacy can fulfill each partner's need to be understood, attended to, and, ultimately, known deeply by another while still being accepted and valued (Prager, 1995). The satisfaction of such psychological or intimacy

needs is itself associated with increased positivity in the couple relationship, including lower levels of negative attributions regarding partner behaviors, more positive communication patterns, and relationship satisfaction (Kirby et al., 2005).

Thus, there is much literature indicating the important role of intimacy in individual adjustment and well-being. However, more research is needed to determine the extent and importance of intimacy within the couple relationship. Specifically, research should focus on the individual and dyadic characteristics that inhibit the experience of relational intimacy. The identification of potential barriers to intimacy, such as depression symptoms and behavioral and cognitive withdrawal, would encourage clinicians to explore and target these factors in order to facilitate change among couples who feel disconnected and who seek to enhance their level of relational intimacy.

Depression Symptoms and Intimate Relationships

Depression is associated with a variety of cognitive, affective, physiological, and behavioral symptoms, including increased irritability, loss of interest and pleasure, sleep disturbance, appetite or weight disturbance, fatigue or loss of energy, low motivation, poor concentration, and inappropriate guilt or self-reproach (American Psychiatric Association, 1994), that can significantly influence individual adjustment and well-being. However, depression symptoms have also been found to be strongly associated with marital functioning and relationship dynamics.

There have been inconsistent findings from studies regarding the causal pathway or connection between marital quality and depression (assessed either in terms of severity of a set of symptoms or as a clinical diagnosis). Some studies have found that spousal depression leads to marital discord and conflict (Benazon & Coyne, 2000), whereas other

studies indicate that a stressful or discordant marriage precedes or plays a causal role in the development of depression (Brown, Andrews, Adler, & Bridge, 1986). Although there has been inconsistent support for a causal mechanism linking marital quality and depression, studies have consistently identified a strong association.

Specifically, depression has been linked to increased conflict and discord (Sayers, Kohn, Fresco, Bellack & Sarwer, 2001), marital dissatisfaction (McGrath, Keita, Strickland, & Russo, 1990), and negative communication patterns (Sher & Baucom, 1993). Furthermore, some studies have found a direct link between depression and marital intimacy (McGrath et al, 1990; Prager, 1995); specifically, depression symptoms are associated with lower levels of perceived marital intimacy, especially self-disclosure based intimacy (Culp & Beach, 1998). Researchers have identified that a lack of confiding relationships is a predisposing factor for the development of depression (Prager, 1995).

Although little research exists on the topic, it can be posited that some particular symptoms of depression are likely to affect partners' experiences of relational intimacy negatively. Specifically, the tendency to withdraw from interpersonal and social interactions may compound feelings of loneliness and isolation and lead to lower perceived levels of connectedness and intimacy. Additionally, the higher levels of irritability characteristic of depressed individuals may limit intimate communication between partners, particularly the self-disclosure and partner responsiveness components mentioned above. Finally, loss of interest and lack of engagement in pleasurable activities can influence one's desire and ability to engage in behaviors such as sexual

interactions or demonstrations of affection that foster and maintain intimate connections with partners.

The Role of Avoidant Behaviors and Cognitions in Couple Relationships

Withdrawal behaviors and cognitions are actions and thoughts that result in the physical or emotional distancing or retreating of one partner from an interaction with the other partner, such as an argument or discussion. They are also referred to as behavioral and cognitive avoidance in the recent literature on coping, and these patterns have begun to receive increasing empirical attention. In particular, a number of research studies have found that avoidant coping processes are negatively associated with individual health and well-being. Specifically, a recent review of existing findings (Tiet et al., 2006) indicates that avoidance coping was associated with greater posttraumatic stress disorder (PTSD) severity, personality disorders, violence risk, hostility, suicide, and co-morbid psychopathology among substance use patients. Furthermore, Tiet et al. (2006) found in their own study that avoidance coping is associated with lower levels of family functioning, lower levels of social functioning, and higher levels of PTSD symptoms.

A recent study examining the relationships among anger, stress, coping, social support, and health (Diong et al., 2005) found an association between anger expression and avoidance coping. Individuals who reported higher levels of anger expression were more likely to experience stress, to deal with that stress using avoidant coping strategies, and to experience subsequent psychological distress and physical illness.

The results of these studies seem to indicate that although avoidant coping strategies function to reduce immediate distress, they also serve to increase the risk for later individual psychological and physical distress. Furthermore, withdrawal from

conflict or other environmental stressors or demands influences an individual in ways that are likely to negatively affect the quality and functioning of his or her intimate relationships. In particular, avoidant behaviors and cognitions are likely to contribute to alienation and emotional distance from others.

Regardless of this outcome for individuals, however, little empirical attention has been given to the role of avoidant coping in the couple relationship. Some research has indicated that withdrawal behaviors in either husbands or wives are associated with marital distress, increased negativity, and less positive connection between partners (Stanley, Markman, & Whitton, 2002); however, no direct link between withdrawal behaviors and perceptions of intimate relationship behaviors has been established. Furthermore, research on couple communication patterns has traditionally neglected to measure how avoidant thoughts such as “I need to get out of here” are associated with withdrawal behaviors and with partners’ perceptions of intimate relationship behaviors.

The Relation between Depression and Couple Communication Patterns

As mentioned above, studies have found that depression is significantly related to marital distress. Furthermore, marital distress has been found to be associated with particular communication patterns in romantic relationships. Specifically, distressed couples have been found to communicate differently from their non-distressed counterparts along several dimensions: distressed couples generally display increased levels of negativity and decreased levels of positivity in their everyday interactions as well as in problem solving attempts. Furthermore, they often interact with one another using the demand/withdrawal pattern wherein one spouse makes a complaint or request

for change and the other spouse avoids or withdraws from the discussion in an attempt to avoid confrontation or discord (Baucom et al., 2007).

Some studies have also found a direct link between depression and communication patterns, particularly behavioral and cognitive avoidance strategies (Moulds, Kandris, Starr, & Wong, 2007). For example, Marchand and Hock (2000) found that husbands' conflict avoidance strategies were associated with both their depression and their marital satisfaction and that wives' conflict avoidance was related significantly to their depression. Additionally, a study examining the relationship between marital cognitions and depression in the context of marital discord found that depressed spouses, particularly wives, exhibited more self-blame and hopeless thoughts than their non-depressed counterparts (Sayers, Kohn, Fresco, Bellack, & Sarwer, 2001). Self- and partner-blame, in particular, were found to be associated with more withdrawal from interactions and less effective problem solving or interpersonal warmth.

In conclusion, researchers have found that, in couples in which one spouse is depressed, there are more negative communication styles (blaming, criticism, withdrawing, etc.) than in couples where there is no depression (Sher & Baucom, 1993). It should be noted that, in these studies, depression was assessed in terms of severity of depression symptoms and was based on overall scores from the *Beck Depression Inventory* (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and other self-report questionnaires. Therefore, a link between depression symptoms and withdrawal cognitions and behaviors has been established in existing research, and it formed the basis for the inclusion of these factors in the present study.

Summary

The literature reviewed suggests that there is a correlation between intimacy and individual and relational well-being. Furthermore, although some research has been conducted investigating the impact of depression symptoms and cognitive and behavioral avoidance on perceptions of intimacy, little research has investigated the relations among depression symptoms, withdrawal cognitions and behaviors, and intimate relationship behaviors. The present study investigated how depression symptoms and avoidant behaviors and cognitions are related to intimacy, measured in terms of intimate relationship behaviors and the pleasure that partners experience from receiving these behaviors.

Theoretical Base for the Study

Based on social exchange theory, this study focused on the transactional nature of intimate relationship behaviors through the examination of factors (i.e., depression symptoms, withdrawal behaviors, and withdrawal cognitions) that influence the occurrence and experience of relational intimacy. A social exchange theoretical framework, very broadly, focuses on the exchange of resources (material or symbolic) between or among people and involves concepts including rewards, costs, and reciprocity (Sprecher, 1998). Rewards are exchanged resources that are pleasurable and gratifying to the involved parties, whereas costs are defined as exchanged resources that result in a loss or punishment (White & Klein, 2002). Finally, reciprocity is comprised of in-kind positive or negative responses of individuals toward the behaviors of others.

In terms of intimate relationships, the basic principle of social exchange theory is that individuals act to maximize their rewards and minimize their costs. According to the

theory, a person is most satisfied when the relationship is perceived as providing a favorable ratio of rewarding experiences to costs and also is equitable in that the contributions/inputs made to the relationship by oneself and the partner are perceived to be equal or reasonable/fair (Larson, 1998).

Social exchange theory posits that individuals' perceptions of equity in their relationship depend on their perceptions of deserved outcomes in the relationship. Individuals come to relationships with an awareness of societal norms for relationships and their own backlog of experiences. As a result, they engage in relationships with clear expectations of (a) what is deserved and realistically obtainable within relationships, and (b) what they consider to be important for them to experience within a relationship. An individual compares outcomes that he or she receives from a partner to those that he or she considers to be deserved, and this balance is considered in relation to the inputs that the individual has made to the relationship (Larson, 1998). If the balance equals zero, the relationship is termed equitable. Social exchange theory posits that individuals constantly weigh the costs and benefits of their relationship to determine whether, in comparison to other options, their relationship is the most equitable and satisfying alternative.

The occurrence and positive experience of intimate relationship behaviors has a significant influence on individual and dyadic well-being, including more positive outcomes, higher overall adjustment, and greater relationship satisfaction (Prager, 1995). Individuals engage in and accept intimate behaviors from their partners as a way to fulfill the fundamental need to establish close interpersonal attachments. Intimate relationship behaviors, including active communication and responsiveness, sexual activity, self-

disclosure, and positive dyadic involvement, are a rewarding component of close relationships and are positively associated with an individual's personal adjustment.

Thus, exchanges of intimate behaviors and a partners' experience of pleasure from such acts are important components of satisfying couple relationships, and social exchange theory suggests that any factors that detract from exchanges of intimacy will reduce relationship quality. Therefore, social exchange theory would posit that individuals' tendencies toward depression, behavioral withdrawal, and cognitive avoidance all will reduce the intimate exchanges that are important components of a rewarding relationship.

One of the primary symptoms of depression is a lowered motivation to initiate behavior (American Psychiatric Association, 1994; Beck, Rush, Shaw, & Emery, 1979). Depressed individuals commonly are unlikely to engage in or initiate a variety of behaviors, including routine and other instrumental behaviors. Therefore, the lowered motivation characteristic of depression seems likely to reduce individuals' intimate behaviors toward their partners. Another characteristic symptom of depression is a lack of interest or pleasure in various life activities (American Psychiatric Association, 1994; Beck et al., 1979). Depression often results in a reduction in the amount of pleasure an individual experiences from behaviors that are generally regarded as pleasurable and enjoyable. Therefore, a general decrease in pleasure would also seem likely to reduce the pleasure that individuals' experience from their partners' intimate acts. Similarly, an individual's tendency to withdraw behaviorally or cognitively during conflict appears to pose risks for decreased intimate behavior toward a partner and for the person experiencing less pleasure than when the partner behaves in intimate ways. It is likely

that individuals who withdraw from interpersonal exchanges would not be interested in either initiating or enjoying intimate behavior with their partner.

The present study conceptualized intimate relationship behaviors and barriers to relational intimacy in terms of social exchange theory. Specifically, exchanges of intimate behavior between partners are an important component of a satisfying relationship, but factors such as depression symptoms and tendencies toward behavioral and cognitive withdrawal may interfere with the reciprocal exchange and pleasurable experience of intimate relationship behaviors.

Definitions of Variables

As noted above, the purpose of the present study was to explore the association between potential obstacles to intimacy (withdrawing behaviors, withdrawal cognitions, and depression symptoms) and both the degree of the individual's own intimate behavior and his or her pleasure from receiving intimate behavior from a partner. The following are the definitions of the variables used in the present study.

Independent Variables

Depression symptoms. Common symptoms of depression include cognitive, behavioral, and affective disturbances, including loss of interest in activities that were once pleasurable and enjoyable (including sexual activity), lack of emotional expression, a persistently sad, anxious, or empty mood, a pessimistic sense of inadequacy, social withdrawal, lowered motivation, and extreme irritability (American Psychiatric Association, 1994; Beck et al., 1979).

Withdrawal behaviors. Any behaviors that result in the physical distancing or retreating of an individual from interaction with a partner, such as during an argument or discussion (Christensen & Sullaway, 1984).

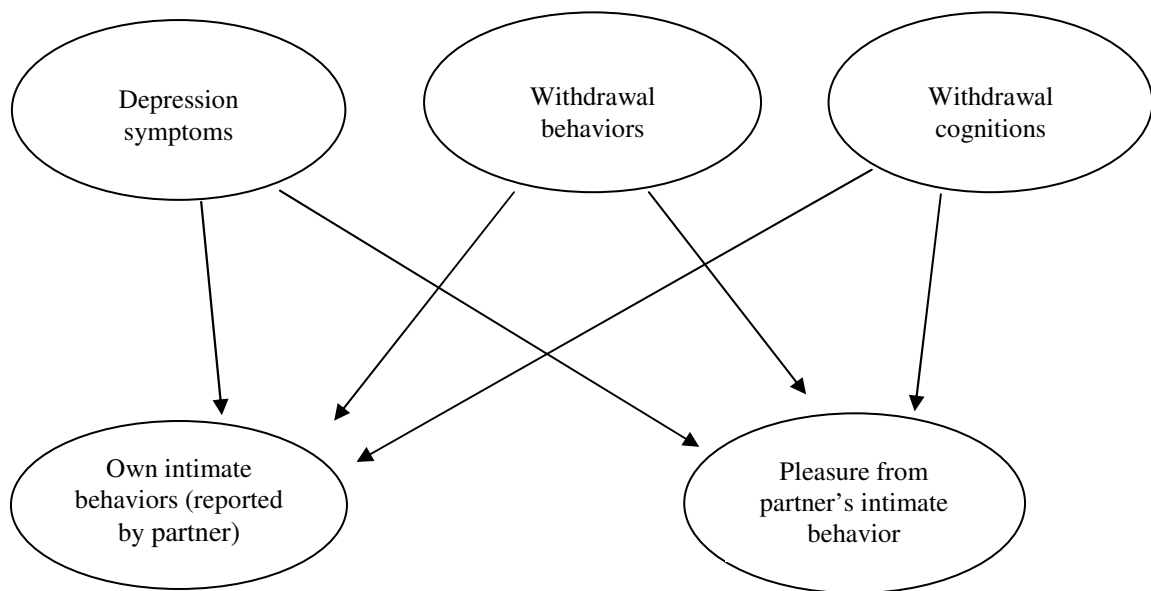
Withdrawal cognitions. An individual's thoughts involving the desire and/or intent to retreat or distance oneself behaviorally or cognitively from a particular interaction (e.g., "I want out" or "I want to ignore this") (Metz, 1993).

Dependent Variables

Intimate relationship behaviors. An individual's behaviors that foster closeness or connectedness indicative of overall relationship intimacy, as perceived by the individual's partner who is the recipient of those behaviors (Prager, 1995).

Pleasure from partner-initiated intimate behavior. The degree to which the recipient of intimate behavior experiences the behavior as pleasurable.

Figure 1.1: Diagram of Proposed Study



Hypotheses

Based on the literature on intimacy, depression, avoidant behaviors, and cognitions, the following hypotheses, which are illustrated in Figure 1.1, were tested in this study:

Hypothesis 1

Individuals with higher levels of depression symptoms will exhibit lower levels of intimate behavior toward their partners, as reported by the partners. This association was tested separately for both male and female partners in the relationship.

Hypothesis 2

Individuals who demonstrate higher levels of withdrawal behaviors in their couple relationship will exhibit less intimate behavior toward their partners, as reported by the partners. This association was tested separately for both male and female partners in the relationship.

Hypothesis 3

Individuals who experience higher levels of withdrawal cognitions during conflicts with their partners will exhibit less intimate behavior toward their partners, as reported by the partners. This association was tested separately for both male and female partners in the relationship.

Hypothesis 4

Individuals with higher levels of depression symptoms will report lower levels of pleasure from their partner's intimate relationship behavior. This association was tested separately for both male and female partners in the relationship.

Hypothesis 5

Individuals who exhibit higher levels of withdrawal behavior in couple interactions will report lower levels of pleasure from their partner's intimate relationship behaviors. This association was tested separately for both male and female partners in the relationship.

Hypothesis 6

Individuals who exhibit higher levels of withdrawal cognitions will report lower levels of pleasure from their partner's intimate relationship behaviors. This association was tested separately for both male and female partners in the relationship.

Research Questions

In addition to the above hypotheses, this study addressed three research questions:

1. What are the relative associations of the three potential obstacles (depression symptoms, withdrawal behaviors, and withdrawal cognitions) with individuals' intimate behavior toward their partners?
2. What are the relative associations of the three potential obstacles (depression symptoms, withdrawal behaviors, and withdrawal cognitions) with the amount of pleasure that individuals experience from receiving intimate behavior from a partner?
3. Are there gender differences in the relations of depression symptoms, withdrawal cognitions, and withdrawal behavior with intimate behavior and pleasure derived from a partner's intimate behavior, namely:
 - a. in the relation between depression symptoms and degree of intimate behavior toward their partner;

- b. in the relation between withdrawal behaviors and degree of intimate behavior toward their partner;
- c. in the relation between withdrawal cognitions and degree of intimate behavior toward their partner;
- d. in the relation between depression symptoms and levels of pleasure from their partner's intimate behavior;
- e. in the relation between withdrawal behaviors and levels of pleasure from their partner's intimate behavior;
- f. in the relation between withdrawal cognitions and levels of pleasure from their partner's intimate behavior?

CHAPTER 2

Method

Sample

The present study was a secondary analysis of data collected from a sample comprised of 87 heterosexual couples who sought therapeutic services at a university-based clinic, the Center for Healthy Families at the University of Maryland, College Park, between 2000 and 2007. Each of the couples utilized in the sample voluntarily consented to participation in a treatment outcome study that compares various couple therapy models in treating psychological and/or physical abuse.

All couples qualified to participate in the original study based on the following criteria: 1) both partners are 18 or older, 2) both partners report commitment to the relationship, 3) one or both partners report mild to moderate levels of psychological and/or physical abuse, but no severe forms of abuse, 4) both partners feel safe living and participating in conjoint couple therapy with each other, and 5) neither partner has an untreated alcohol or substance abuse problem.

It should be noted that the couples in the original study were specifically selected on the basis of their reports of mild to moderate levels of physical and/or psychological abuse in their relationships. The present study, which uses data from the original outcome study, necessarily was conducted with the same clinical sample. The use of such a select sample that has experienced some abusive behavior in their relationships should be taken into account when interpreting the results of the study; for example, abusive behavior may generally reduce intimate behavior in these couple relationships.

Table 2.1 summarizes the demographic characteristics of the sample.

Table 2.1
Demographic Characteristics of the Sample

Variables	Males <i>n</i> =87	Females <i>n</i> =87
Mean age of partner (<i>SD</i>)	32.8 (9.5)	30.9 (9.1)
Average length of relationship (<i>SD</i>)	7 years (7.3)	7 years (7.4)
Average personal yearly gross income	\$38,606	\$ 23,486
Relationship status	<i>n</i> / %	<i>n</i> / %
Married, living together	46 / 48.4%	48 / 50.5%
Married, separated	5 / 5.3%	5 / 5.3%
Living together, not married	20 / 21.1%	18 / 18.9%
Separated	2 / 2.1%	1 / 1.1%
Dating, not living together	14 / 14.7%	16 / 16.8%
Race	<i>n</i> / %	<i>n</i> / %
Native American	3 / 3.2%	0 / 0.0%
African American	28 / 29.5%	35 / 36.8%
Asian/Pacific Islander	2 / 2.1%	2 / 2.1%
Hispanic	8 / 8.4%	9 / 9.5%
White	43 / 45.3%	38 / 40.0%
Other	3 / 3.2%	3 / 3.2%

Instruments and Procedures

The data that were used for this study were gathered from questionnaires given to all couples who present for treatment at the university-based clinic. Each member of the couple is given a battery of assessment forms on Day 1 when they present for treatment regardless of whether they are eligible for participation in the larger research study on couple therapies for abusive behavior. Measures included in this Day 1 assessment that were utilized in the present study are the *Beck Depression Inventory* (BDI) and the *Communication Patterns Questionnaire* (CPQ). After the Day 1 assessment is completed, those couples who meet all of the eligibility criteria for participation in the treatment outcome study are invited to take part in it. Those couples who voluntarily agree to participation in the study are asked to complete a Day 2 assessment upon their

next visit to the clinic. In the present study, the measures that were utilized from this Day 2 assessment are the *Styles of Conflict Inventory* (SCI) and the *Positive Partner Behavior* scale (PPB). The following are descriptions of the measures that were utilized in this study. Table 2.2 provides a summary of how the dependent and independent variables were operationalized in this study.

Depression symptoms were measured using the *Beck Depression Inventory* (BDI; Beck et al., 1961). The BDI (see Appendix A for a copy) is a 21-item self-report rating inventory measuring characteristic symptoms of depression, such as suicidal ideation, mood, self-dissatisfaction, body image, somatic symptoms, social withdrawal, and guilt (Beck et al., 1961). Each partner is asked to rate the severity of his or her own symptoms by using a four-point scale ranging from zero to three. The overall BDI score, which is calculated by adding together the response scores from the 21 items, can range from 0 to 63. In terms of gauging the sample's overall level of depression, total BDI scores of 9 or less are considered as indicating minimal depression, scores of 10-18 indicate mild to moderate levels of depression, scores of 17-29 indicate moderate to severe depression, and scores of 30 and above are indicative of severe depression (Beck, Steer, & Garbin, 1988). As is typically the case in research and clinical practice with the BDI, the individual's total score was used as the index of depression, and BDI scores of the sample were treated as a continuous variable.

Evidence for the validity and reliability of the BDI are strong (Beck, Steer, & Garbin, 1988). The internal consistency reliability ranges from .73 to .92, with a mean coefficient alpha of .87. Test-retest reliability coefficients are greater than .60. The convergent validity for the BDI is strong. For example, correlations with other measures

of the same types of symptoms are consistent. Research also indicates that the BDI has the ability to discriminate subtypes of depression and to differentiate depression from anxiety (Beck, Steer, & Garbin, 1988).

Withdrawal behaviors were measured using the *Communication Patterns Questionnaire* (CPQ; Christensen & Sullaway, 1984). The CPQ is a self-report instrument that assesses marital communication patterns in three phases of couple conflict - when a relationship problem initially arises, during a discussion of a relationship problem, and after the discussion of a relationship problem. The CPQ assesses three types of dyadic communication patterns - mutual constructive communication, mutual avoidance, and demand/withdraw. Each member of the couple is asked to rate the likelihood of particular communication patterns occurring during conflict with his/her partner using a 9-point Likert scale, ranging from 1 = very unlikely to 9 = very likely. Items on the demand/withdraw subscale that are associated with withdrawal behaviors were utilized to measure the presence of withdrawing behaviors in each partner (see Appendix B for subscale item content).

Following procedures that are commonly used when both members of couples report on the same aspects of couple interactions, in the present study composite scores on the CPQ were obtained by averaging the two partners' reports about how much each member of the couple engages in withdrawal behavior. Specifically, both partners' average item scores for the three items on the male demand/female withdraw subscale (items 3a (in section A), 5a (in section B), and 6a (in section B)) were averaged to obtain an overall index of the female partner's withdrawal behavior. Similarly, both partners' average item scores for the three items on the female demand/male withdraw subscale

(items 3b (in section A), 5b (in section B), and 6b (in section B)) were averaged to obtain an overall index of the male partner's withdrawal behavior. Each partner's overall score on this measure could range from 1-9.

Internal consistency reliabilities for the CPQ are acceptable, ranging from .62 to .84, with a mean of .71 (Christensen & Shenk, 1991). The subscales reliably distinguish between distressed and non-distressed couples and are significantly related to marital adjustment in the expected direction ($r = -.55$ for the demand/withdraw subscale) (Christensen & Heavey, 1990; Noller & White, 1990). Finally, there appears to be a reliable concordance between spouses in responding to the subscale ($r = .73$ for inter-partner agreement on the demand/withdraw subscale) (Christensen & Shenk, 1991; Noller & White, 1990).

Withdrawal cognitions were measured using a cognition subscale of the *Styles of Conflict Inventory* (SCI; Metz, 1993). The SCI is a self-report instrument that evaluates the individual's behavioral, affective, and cognitive responses to discord in the dyadic relationship. The 30-item cognition scale of the SCI presents statements that represent automatic thoughts that an individual might experience during periods of conflict with his/her partner. Each member of the couple is asked to rate the frequency with which he or she experiences each type of thought, such as "We'd better not get into this; avoid the subject", "I'll back off so it doesn't get worse", or "I want to go away" during couple conflict using the following values: 1 = never, 2 = rarely, 3 = occasionally, 4 = often, 5 = very often. The SCI cognition scale includes four subscales: (a) aggressive cognitions, (b) constructive cognitions, (c) submissive cognitions, and (d) withdrawal and avoidance cognitions. The original SCI (Metz, 1993) did not include withdrawal/avoidance

cognition items, but such items subsequently were added on an experimental basis (Metz, 2008). For the purposes of the present study, the scores from the subscale assessing withdrawal and avoidance cognitions were used to measure the degree to which each member of a couple experiences withdrawal/avoidance cognitions during couple conflict (see Appendix C for the subscale item content). In this study, each partner's total score on this subscale was computed by summing the individual's response values from the 12 items; thus total withdrawal/avoidance cognition scores could range from 12 to 60.

The internal consistency of the 12-item SCI withdrawal/avoidance cognition subscale was calculated by the present investigator for the total Center for Healthy Families clinic sample of 298 males and 296 females who had completed broad pre-therapy assessments associated with the original study from which the present study's data were derived. The Cronbach alphas were .90 for males and .90 for females. Furthermore, in order to evaluate the validity of the SCI withdrawal/avoidance subscale this investigator computed the Pearson correlations between individuals' scores on the withdrawal/avoidance subscale and their reports of their own withdrawing behavior, as measured by the demand/withdraw subscale of the *Communication Patterns Questionnaire* (CPQ; Christensen, 1987), as well as their reports of the steps that they had taken toward separation or divorce, as measured by Epstein and Werlinich's (2001) revised version of the *Marital Status Inventory* (MSI; Weiss & Cerreto, 1980). For males, SCI withdrawal cognitions and CPQ withdrawal behaviors were significantly correlated ($r = .61, p < .01, 2\text{-tailed}$) as were withdrawal cognitions and MSI steps taken toward separation or divorce ($r = .42, p < .01, 2\text{-tailed}$). For females, SCI withdrawal cognitions were significantly correlated with CPQ self-reported withdrawal behavior ($r =$

.53, $p < .01$) and with MSI reports of steps taken toward separation or divorce ($r = .38$, $p < .01$).

Intimate relationship behavior was measured using the *Positive Partner Behavior* scale (PPB, which is based on the Spouse Observation Checklist; Wills, Weiss, & Patterson, 1974). The PPB is a 54-item self-report instrument that is used to assess both the amount of positive behavior that each member of the couple perceives the other as exhibiting during the past week and the degree of pleasure that the recipient experienced from those acts. This measure asks each member of the couple to indicate whether particular behaviors happened or did not happen in the relationship during the past week. “Not applicable” is also provided as a response choice. Next, the respondent is asked to rate the degree of pleasure derived from the presence or absence of the activity, on a scale ranging from “extremely unpleasant” = 1 to “extremely pleasant” = 9 for each of the 54 items.

For the purpose of the present study, an intimacy subscale was derived from the PPB based on the definition of intimacy utilized in this study. The items selected for this subscale represent expressive and affectionate behaviors that are initiated by one partner and directed toward the other partner. Specifically, the intimacy subscale items reflect behaviors that are characteristic of intimate interpersonal communication, affection, and sexual intimacy, and therefore have the potential to contribute significantly to each partner’s experience of connection or closeness within the couple relationship.

Each item in the subscale made contributions to the scale having high internal consistency. The Cronbach alpha for the 13-item intimacy subscale was .81 for males and .84 for females. Questions 1, 2, 3, 4, 5, 6, 25, 34, 37, 38, 39, 40, 41 (see Appendix D

for the subscale item content) were used to measure intimate relationship behavior, with respondents indicating either 1 = yes it happened, or 0 = no, it did not happen. If the behavior occurred during the past week, the partner also rates the behavior according to the pleasure that it elicited, ranging from 1 = extremely unpleasant to 9 = extremely pleasant. From these ratings, a total pleasure from partner's intimate behavior score was calculated by multiplying the score for whether each behavior happened (1 or 0) by the pleasure rating (1-9), computing the sum of these products, and then dividing the total by the total number of items that indicated an intimate behavior had occurred (0-13).

Table 2.2
Summary of Variables and Instruments Used to Measure Them

Variables	Instruments	Total Score
Depression symptoms	<i>Beck Depression Inventory (BDI)</i>	Σ (response scores (0-3) from 21 items); possible range from 0-63
Withdrawal behaviors	<i>Communication Patterns Questionnaire (CPQ)</i>	Average of both partners' mean item scores for 3 items for each partner's withdrawal (Σ (response scores (1-9) for 3 items)/3); possible range from 1-9
Withdrawal cognitions	<i>Styles of Conflict Inventory (SCI)</i>	Σ (response scores (1-5) of 12 items); possible range from 12-60
Intimate relationship behavior	<i>Positive Partner Behavior Scale (PPB)</i>	Σ (happened (1,0))
Pleasure from partner-initiated intimate behavior	<i>Positive Partner Behavior Scale (PPB)</i>	Σ (happened (1,0) x <u>pleasure rating</u>) # happened

CHAPTER 3

Results

Overview of Analyses

First, in order to obtain an overview of the present sample's levels of depression symptoms, withdrawal behaviors, withdrawal cognitions, intimate behavior, and pleasure from intimate behavior, the means and standard deviations were calculated for their total BDI scores (in order to assess overall levels of depression symptoms), the couple's averaged CPQ withdrawal scores (to assess overall levels of withdrawal behaviors), their total SCI withdrawal and avoidance subscale scores (to assess overall levels of withdrawal cognitions), and their total PPB scores (to assess overall levels of intimate relationship behavior and pleasure experienced from intimate relationship behavior). Furthermore, *t*-tests were conducted to determine whether any gender differences existed on any of these variables.

Next, each hypothesis was tested with individual Pearson's correlations, separately for females and males. The Pearson's correlations determined the degree to which the variables are related. Additionally, Research Questions 1 and 2 were tested with multiple regression analyses, separately for females and males. The multiple regression analyses provided information about the relative contributions of the three independent variables in accounting for variance in each of the dependent variables. In each analysis, the independent variables were the degree of depression symptoms, the degree of withdrawal behaviors, and the degree of withdrawal cognitions.

Each analysis was run twice for each gender, once for the dependent variable of degree of pleasure that the individual reports experiencing from partner-initiated intimate

behavior and once for the partner's report of the degree of intimate relationship behaviors that the individual exhibits. For each multiple regression analysis, the three predictor variables were entered simultaneously, controlling for their statistical redundancy in accounting for variance in the dependent variable. It should be noted that all of the analyses conducted in this study were correlational and determine only the degrees of associations but not the causal directions among the variables. Therefore, the results should be interpreted with caution, and any inferences regarding causality must be speculative and open to alternative explanations.

In addition to the tests of the hypotheses regarding relations between obstacles (depression symptoms, withdrawal cognitions, withdrawal behavior) and intimate behavior, possible gender differences in these relations that were posed in Research Question 3 were explored by computing the test for the difference between two correlation coefficients. This test compared the Pearson correlations of the females and males for each relationship between an independent variable and a dependent variable.

The Sample's Scores on the Measures

Table 3.1 presents the means, standard deviations, and *t*-test results comparing females' and males' means on the measures used in this study. Consistent with prior research (e.g., Kessler, McGonagle, Swartz, Blazer, & Nelson, 1993; Weissman & Klerman, 1977), females scored significantly higher on depression than did males. Also consistent with prior studies (e.g., Christensen & Heavey, 1990; Heavey, Layne, & Christensen, 1993), males scored higher than females on withdrawal behavior. There was a trend toward males scoring higher than females on enacting intimate behaviors.

Table 3.1

Means, Standard Deviations, and t-Test Results for the Samples' Scores on the Measures

<i>BDI</i>	<i>n</i>	<i>Mean</i>	<i>SD</i>	<i>t</i>	<i>Sig. (2-tailed)</i>
Females	87	13.52	8.22	3.17	.002
Males	87	10.10	6.46		
<i>CPQ Withdrawal</i>					
Females	75	4.49	1.75	-3.06	.003
Males	75	5.44	1.73		
<i>SCI Withdrawal</i>					
Females	70	33.70	9.20	1.62	.11
Males	70	31.17	8.88		
<i>PPB Overall Intimate Relationship Behavior</i>					
Females	71	9.06	3.33	-1.79	.077
Males	71	9.65	2.98		
<i>PPB Pleasure from Intimate Relationship Behavior</i>					
Females	67	7.19	1.27	.41	.68
Males	67	7.25	1.55		

Note. BDI= Beck Depression Inventory; CPQ= Communication Patterns Questionnaire; SCI= Styles of Conflict Inventory, PPB= Positive Partner Behavior scale.

Test of Hypotheses

Pearson correlations were used to test the hypotheses of the present study. The results of the analyses for each of the study's hypotheses are presented below, in order by hypothesis. A summary of the correlational results is presented in Table 3.2.

Hypothesis 1:

Individuals with higher levels of depression symptoms will exhibit lower levels of intimate behavior toward their partners, as reported by the partners.

Pearson correlations were used to determine the direction and strength of the association between each partner's depression symptoms and his/her partner's perception of the individual's intimate relationship behavior. For females, there was a non-significant trend consistent with the hypothesis for their depression symptoms to be negatively associated with their initiation of intimate behavior ($r = -.16, p = .09$, 1-tailed). Similarly for males, there was a trend for depression symptoms to be negatively associated with their initiation of intimate relationship behavior ($r = -.17, p = .08$, 1-tailed). Thus, there was a trend toward support for this hypothesis among both females and males.

Hypothesis 2:

Individuals who demonstrate higher levels of withdrawal behaviors in their couple relationship will exhibit less intimate behavior toward their partners, as reported by the partners.

Pearson correlations were used to determine the direction and strength of the association between each partner's withdrawal behaviors and his/her partner's perception of the individual's intimate relationship behavior. This hypothesis was not supported for females in that the correlation between withdrawal behaviors and intimate relationship behavior was $-.14$ ($p = .12$, 1-tailed). This hypothesis also was not supported for males in that the correlation between withdrawal behaviors and intimate relationship behavior was $-.12$ ($p = .16$, 1-tailed). Thus, this hypothesis was not supported for either female or male partners.

Hypothesis 3:

Individuals who experience higher levels of withdrawal cognitions during conflicts with their partners will exhibit less intimate behavior toward their partners, as reported by the partners.

Pearson correlations were used to determine the direction and strength of the association between each partner's withdrawal cognitions and his/her partner's perception of the individual's intimate relationship behavior. As predicted, the higher the females' levels of withdrawal cognitions, the lower their levels of intimate relationship behavior toward their male partners, $r = -.28$ ($p < .01$, 1-tailed). Also, the higher the males' levels of withdrawal cognitions, the lower their levels of intimate relationship behavior toward their female partners, $r = -.22$ ($p = .03$, 1-tailed). Thus, Hypothesis 3 was supported for both genders.

Hypothesis 4:

Individuals with higher levels of depression symptoms will report lower levels of pleasure from their partner's intimate relationship behavior.

Pearson correlations were used to determine the direction and strength of the association between each partner's depression symptoms and his/her own degree of pleasure experienced when his/her partner exhibits specific types of intimate relationship behavior. As predicted, the higher the females' levels of depression symptoms the lower the levels of pleasure they reported experiencing from their male partners' intimate relationship behavior, $r = -.21$ ($p = .04$, 1-tailed). However, males' depression symptoms were not significantly associated with the degree of pleasure they experienced from their female partners' intimate relationship behavior, $r = -.09$ ($p = .23$, 1-tailed). Thus,

Hypothesis 4 was supported only for female partners' depression symptoms and their own degree of pleasure experienced from a partner's intimate behavior.

Hypothesis 5:

Individuals who exhibit higher levels of withdrawal behavior in couple interactions will report lower levels of pleasure from their partner's intimate relationship behaviors.

Pearson correlations were used to determine the direction and strength of the association between each partner's withdrawal behaviors and his/her own degree of pleasure experienced when his/her partner exhibits specific types of intimate relationship behavior. As predicted, the higher the females' levels of withdrawal behaviors the lower the levels of pleasure experienced from their male partners' intimate relationship behavior, $r = -.30$ ($p < .01$, 1-tailed). However, males' withdrawal behaviors were not significantly associated with the degree of pleasure they experienced from their female partners' intimate relationship behavior, $r = -.06$ ($p = .31$, 1-tailed). Thus, Hypothesis 5 was supported only for female partners' withdrawal behaviors and their own degree of pleasure experienced from intimate behavior.

Hypothesis 6:

Individuals who exhibit higher levels of withdrawal cognitions will report lower levels of pleasure from their partner's intimate relationship behaviors.

Pearson correlations were used to determine the direction and strength of the association between each partner's withdrawal cognitions and his/her own degree of pleasure experienced when his/her partner exhibits specific types of intimate relationship behavior. As predicted, the higher the females' levels of withdrawal cognitions, the

lower the levels of pleasure experienced from their male partners' intimate relationship behavior, $r = -.31$ ($p < .01$, 1-tailed). Also, the higher the males' levels of withdrawal cognitions, the lower the levels of pleasure experienced from their female partners' intimate relationship behavior, $r = -.40$ ($p < .01$, 1-tailed). Thus, Hypothesis 6 was supported for both genders.

Table 3.2
Summary of Correlations Testing the Study's Hypotheses

Hypotheses 1 & 4		Intimate Behavior	Pleasure from Intimate Behavior
<i>BDI Total - Female</i>	Pearson Correlation Sig. (1-tailed)	-.16 .09	-.21 .04
<i>BDI Total - Male</i>	Pearson Correlation Sig. (1-tailed)	-.17 .08	-.09 .23
Hypotheses 2 & 5			
<i>CPQ Withdrawal - Female</i>	Pearson Correlation Sig. (1-tailed)	-.14 .12	-.30 <.01
<i>CPQ Withdrawal - Male</i>	Pearson Correlation Sig. (1-tailed)	-.12 .16	-.06 .31
Hypotheses 3 & 6			
<i>SCI Withdrawal & Avoid - Female</i>	Pearson Correlation Sig. (1-tailed)	-.28 <.01	-.31 <.01
<i>SCI Withdrawal & Avoid - Male</i>	Pearson Correlation Sig. (1-tailed)	-.22 .03	-.40 <.01

Note: BDI= Beck Depression Inventory; CPQ= Communication Patterns Questionnaire; SCI= Styles of Conflict Inventory.

Tests of Research Questions

Research Question 1:

What are the relative associations of the three potential obstacles (depression symptoms, withdrawal behaviors, and withdrawal cognitions) with individuals' intimate behavior toward their partners?

In the multiple regression analysis predicting females' intimate behavior toward their male partners as a function of their depression symptoms, withdrawal behaviors, and withdrawal cognitions, the overall model approached significance; $R = .11$, $R^2 = .07$, $F(3, 66) = 2.64$, $p = .06$. Furthermore, there was a trend within this multivariate analysis for withdrawal cognitions to be a significant statistical predictor of less intimate relationship behavior ($\beta = -.25$, $t = -1.90$, $p = .06$).

In the multiple regression analysis predicting males' intimate behavior toward their female partners as a function of their depression symptoms, withdrawal behaviors, and withdrawal cognitions, the overall model was not significant; $R = .28$, $R^2 = .08$, $F(3, 66) = 1.86$, $p = .15$. None of the individual predictors was significant when they were entered simultaneously in the analysis.

Research Question 2:

What are the relative associations of the three potential obstacles (depression symptoms, withdrawal behaviors, and withdrawal cognitions) with the amount of pleasure that individuals experience from receiving intimate behavior from a partner?

In the multiple regression analysis predicting females' pleasure from their partners' intimate behavior as a function of their own degree of depression symptoms, withdrawal behaviors, and withdrawal cognitions, the overall model was significant; $R = .43$, $R^2 = .19$, $F(3, 65) = 4.93$, $p < .01$. Degree of depression symptoms was a significant predictor of less pleasure experienced ($\beta = -.24$, $t = -2.11$, $p = .04$) in this multivariate analysis. Additionally, there was a trend for withdrawal behaviors to be a significant predictor of the recipient's lower pleasure ($\beta = -.23$, $t = -1.84$, $p = .07$).

In the multiple regression analysis predicting males' pleasure from their partners' intimate behavior as a function of their own degree of depression symptoms, withdrawal behaviors, and withdrawal cognitions, the overall model was significant; $R = .45$, $R^2 = .20$, $F(3, 63) = 5.31$, $p < .003$. Consistent with the hypothesis, withdrawal cognitions were a significant predictor of lower pleasure experienced from intimate behavior ($\beta = -.54$, $t = -3.91$, $p < .001$). However, in this model in which withdrawal cognitions were a strong predictor of pleasure in the hypothesized direction, there also was a trend for withdrawal behaviors to be a significant predictor of the recipient's greater pleasure, in the direction opposite to the hypothesis, $\beta = .24$, $t = 1.69$, $p = .096$. This unexpected finding is addressed in the Discussion.

Research Question 3:

Are there gender differences in the relations of depression symptoms, withdrawal cognitions, and withdrawal behavior with intimate behavior and pleasure derived from a partner's intimate behavior; namely:

- a. in the relation between depression symptoms and degree of intimate behavior toward their partner*

As noted earlier, the Pearson correlations of females' and males' depression symptoms and the degree of intimate behavior toward their partner were $-.16$ and $-.17$, respectively. In the Fisher r -to- z transformation analysis computing the difference between two correlation coefficients, it was found that the females' and males' correlations were not significantly different ($z = .05$, $p = .96$, 2-tailed). Thus, the relationship between depression symptoms and degree of intimate behavior toward a partner did not differ significantly by gender.

b. in the relation between withdrawal behaviors and degree of intimate behavior toward their partner

As noted earlier, the Pearson correlations of females' and males' withdrawal behaviors and the degree of intimate behavior toward their partner were found to be -.14 and -.12, respectively. In the Fisher *r*-to-*z* transformation analysis computing the difference between two correlation coefficients, it was found that the females' and males' correlations were not significantly different ($z = -.14$, $p = .89$, 2-tailed). Thus, the relationship between withdrawal behaviors and degree of intimate behavior toward a partner did not differ significantly by gender.

c. in the relationship between withdrawal cognitions and degree of intimate behavior toward their partner

As noted earlier, the Pearson correlations of females' and males' withdrawal cognitions and the degree of intimate behavior toward their partner were -.28 and -.22, respectively. In the Fisher *r*-to-*z* transformation analysis computing the difference between two correlation coefficients, it was found that the females' and males' correlations were not significantly different ($z = -.38$, $p = .70$, 2-tailed). Thus, the relationship between withdrawal cognitions and degree of intimate behavior toward a partner did not differ significantly by gender.

d. in the relation between depression symptoms and level of pleasure from their partner's intimate behavior

As noted earlier, the Pearson correlations of females' and males' depression symptoms and level of pleasure experienced from their partner's intimate behavior were -.21 and -.09, respectively. In the Fisher *r*-to-*z* transformation

analysis computing the difference between two correlation coefficients, it was found that the females' and males' correlations were not significantly different ($z = -.71, p = .48, 2\text{-tailed}$). Thus, the relationship between depression symptoms and level of pleasure experienced from their partner's intimate behavior did not differ significantly by gender.

e. in the relation between withdrawal behaviors and level of pleasure from their partner's intimate behavior.

As noted earlier, the Pearson correlations of females' and males' withdrawal behaviors and level of pleasure experienced from their partner's intimate behavior were $-.30$ and $-.06$, respectively. In the Fisher r -to- z transformation analysis computing the difference between two correlation coefficients, it was found that the females' and males' correlations were not significantly different ($z = -1.42, p = .16, 2\text{-tailed}$). Thus, the relationship between withdrawal behaviors and level of pleasure experienced from their partner's intimate behavior did not differ significantly by gender.

f. in the relation between withdrawal cognitions and level of pleasure experienced from their partner's intimate behavior.

As noted earlier, the Pearson correlations of females' and males' withdrawal cognitions and level of pleasure experienced from their partner's intimate behavior were $-.31$ and $-.40$, respectively. In the Fisher r -to- z transformation analysis computing the difference between two correlation coefficients, it was found that the females' and males' correlations were not significantly different ($z = .59, p = .56, 2\text{-tailed}$). Thus, the relationship between withdrawal cognitions

and level of pleasure experienced from their partner’s intimate behavior did not differ significantly by gender.

Summary of Results

Table 3.3 delineates the measures used to test the study’s hypotheses and summarizes the results.

Table 3.3
Hypotheses, Measures, and Results

Hypothesis 1: Individuals with higher levels of depression symptoms will exhibit lower levels of intimate behavior toward their partners, as reported by the partners.

Measures	Findings
BDI, PPB	A trend toward support for a negative association between depression symptoms and intimate behavior among both female and male partners.

Hypothesis 2: Individuals who demonstrate higher levels of withdrawal behaviors in their couple relationship will exhibit less intimate behavior toward their partners, as reported by the partners.

Measures	Findings
CPQ, PPB	Not supported for either females or males.

Hypothesis 3: Individuals who experience higher levels of withdrawal cognitions during conflicts with their partners will exhibit less intimate behavior toward their partners, as reported by the partners.

Measures	Findings
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SCI, PPB	Supported for both females and males.
Hypothesis 4: Individuals with higher levels of depression symptoms will report lower levels of pleasure from their partner's intimate relationship behavior.	
Measures	Findings
BDI, PPB	Supported for females but not for males.
Hypothesis 5: Individuals who exhibit higher levels of withdrawal behavior in couple interactions will report lower levels of pleasure from their partner's intimate relationship behaviors.	
Measures	Findings
CPQ, PPB	Supported for females but not for males.
Hypothesis 6: Individuals who exhibit higher levels of withdrawal cognitions will report lower levels of pleasure from their partner's intimate relationship behaviors.	
Measures	Findings
SCI, PPB	Supported for both females and males.
Research Question 1: What are the relative associations of the three potential obstacles (depression symptoms, withdrawal behaviors, and withdrawal cognitions) with individuals' intimate behavior toward their partners?	
Measures	Findings
BDI, CPQ, SCI, PPB	The set of predictors significantly predicted degree of engaging in intimate relationship behavior for females. Furthermore, there was a non-significant

trend for withdrawal cognitions to be a predictor of engaging in less intimate behavior among female partners. The set of predictors was not significant for males.

Research Question 2: What are the relative associations of the three potential obstacles (depression symptoms, withdrawal behaviors, and withdrawal cognitions) with the amount of pleasure that individuals experience from receiving intimate behavior from a partner?

Measures	Findings
BDI, CPQ, SCI, PPB	The set of predictors (particularly depression symptoms) significantly predicted pleasure from intimate behavior for females. Furthermore, there was a trend for withdrawal behaviors to be a significant predictor of the recipient's lower pleasure among female partners. The set of predictors (particularly withdrawal cognitions) significantly predicted pleasure from intimate behavior for males. However, among males when withdrawal cognitions were a strong predictor of pleasure in the direction hypothesized, there was a trend for withdrawal behaviors to be a significant predictor of the

recipient's pleasure in the direction opposite to that hypothesized.

Research Question 3: Are there gender differences in the relations of depression symptoms, withdrawal cognitions, and withdrawal behavior with intimate behavior and pleasure derived from a partner's intimate behavior?

Measures	Findings
BDI, CPQ, SCI, PPB	No gender differences were found.

Note. BDI= Beck Depression Inventory; CPQ= Communication Patterns Questionnaire; SCI= Styles of Conflict Inventory, PPB= Positive Partner Behavior scale.

CHAPTER 4

Discussion

Findings

The purpose of the present study was to examine the degrees to which an individual's depression symptoms, withdrawal behaviors, and withdrawal cognitions are associated with (a) his/her partner's perception of the person's intimate relationship behaviors, as well as with (b) the individual's own degree of pleasure experienced when his/her partner exhibits specific types of intimate relationship behavior. The results of this study indicate that individual-level factors are significantly associated with the behavioral and affective components of relational intimacy. Specifically, thoughts or cognitions involving the desire and/or intent to distance oneself from a behavioral interaction were found to be strongly related to lower levels of intimate behavior and lower levels of pleasure experienced from a partner's intimate behavior. Further, there was a trend toward support for the notion that individuals with higher levels of depression symptoms engage in lower levels of intimate behavior. Among females, higher levels of depression symptoms were associated with less pleasure from a partner's intimate behavior. In contrast, partners' tendencies to engage in avoidant behavior during couple conflict was not found to be associated with the initiation of intimate relationship behavior and was only associated with the amount of pleasure that females experienced from intimate behavior. Knowledge about the associations between potential obstacles to intimate behavior and partners' experiences of relational intimacy can be helpful in the implementation of clinical treatments for distressed and disconnected couples.

Consistency of the Findings with the Hypotheses and Research Literature

There was a statistical trend toward support for the hypothesis that the higher the degree of an individual's depression symptoms the lower their levels of intimate relationship behavior among both female and male partners. This trend is consistent with much of the literature that states that individuals with higher levels of depression symptoms are likely to experience higher levels of relationship distress and lower levels of marital adjustment and intimacy (McGrath et al., 1990; Prager, 1995; Sayers et al., 2001). However, the limited support for the association between depression symptoms and lower intimate relationship behavior identified in this study may be due to the limited range of depression scores reported by the sample (refer to Table 3.1 for means and standard deviations). The mean depression scores of the partners in the current sample do not fall in the clinical range for depression, but rather are indicative of mild levels of depression symptoms. The presence of untreated major mental illness is a criterion for screening out couples and families from treatment at this university-based clinic because the clinic staff is not prepared to provide services, including medication, for severe psychopathology. In addition, untreated mental illness was an exclusion criterion for couples' participation in the research study that served as the source of data for the present study. Furthermore, the clinic is known in the community for its treatment of relationship problems much more than for therapy for depression and other forms of psychopathology, so potential clients who are experiencing high levels of depression are likely to seek assistance elsewhere. These restrictions may have resulted in a sample with a limited range of depression symptoms compared to other clinical or psychiatric samples. Use of a clinical sample without such restrictions may have resulted in a wider

range of depression symptoms which might therefore increase the likelihood of obtaining stronger or more significant results and may provide a clearer understanding of the association between depression symptoms and intimate relationship behavior.

The hypothesis that the higher the degree of an individual's depression symptoms the lower their levels of pleasure experienced from their partner's intimate behavior was supported only in relation to female partners' depression symptoms and levels of pleasure experienced. This finding is inconsistent with much of the literature on depression that has identified a loss of interest or pleasure in daily activities as a common, gender-neutral characteristic of depression (American Psychiatric Association, 1994). A possible explanation for this finding is the presence of an actual gender difference in the clinical features of depression. As noted above, many studies have found that women experience depression more often than men, whether depression is indexed by levels of depression symptoms or by diagnosed unipolar depressive disorders (Kessler, McGonagle, Swartz, Blazer, & Nelson, 1993; Weissman & Klerman, 1977). Additionally, other research has found gender differences in the clinical features and symptom profile of depression (Kornstein et al., 2000). Kornstein et al. (2000) found that women are more seriously affected by depression, as manifested by greater symptom reporting, greater functional impairment in marital adjustment, and poorer quality of life. In the study, a clinical sample of women was more likely than their male counterparts to report a loss of interest or pleasure in daily activities. Given this, it is possible that females' levels of pleasure from partners' intimate behaviors are more likely to be affected by their level of depression. Due to the manner in which depression manifests in males, their levels of

pleasure in relation to intimate relationship behavior may not be one of the more prominent symptoms.

Regarding the lack of an association between depression and intimacy among the males, the males in the current study tended to report lower levels and a more limited range of depression symptoms than did the females, which is consistent with the literature on gender differences in depression (Kessler, McGonagle, Swartz, Blazer, & Nelson, 1993; Weissman & Klerman, 1977). Their more limited variance in depression scores reduced the likelihood of obtaining a significant correlation between depression symptoms and levels of pleasure experienced from intimate behavior. It would be important for future research to use a larger clinical sample with more diversity in psychopathology symptoms, so as to allow a more sensitive test of the hypothesis.

The hypothesis that the higher one partner's levels of withdrawal behaviors the lower his/her levels of intimate relationship behavior would be was not supported for either females or males. This finding is inconsistent with the literature that has found withdrawal behaviors to be associated with increased negativity, marital distress, and less positive connection between partners (Stanley, Markman, & Whitton, 2002). A possible explanation for this finding is the nature of the instrument utilized to assess withdrawing behaviors. The CPQ assesses one partner's withdrawal in response to the other partner's demanding or attacking behavior. Therefore, the measure does not provide a comprehensive understanding of an individual's overall tendency toward behavioral withdrawal. Because the variable of interest in this study was overall withdrawing behavior, and not the demand/withdraw interaction cycle, it would be important for future

research to utilize a more specialized instrument that would isolate partners' overall withdrawal behavior.

The hypothesis that the higher one partner's levels of withdrawal behavior the lower their levels of pleasure experienced from intimate behavior was supported only in relation to female partners' withdrawal behavior and levels of pleasure experienced. These results are somewhat surprising in that it is believed that females and males' withdrawing behavior is associated with a desire to be alone and to distance oneself from a partner. Therefore, it would seem that attempts at connection and closeness would not be perceived as pleasurable by the partner who is attempting to retreat from dyadic interactions. Although this notion was supported for female partners in the relationship, the findings indicate that for males, positive attention from their female partner is enjoyed even during times of tension.

It also is possible that individuals who withdraw during relationship conflicts do not necessarily also withdraw from intimate interactions with their partners; in other words, withdrawal from negative interactions and withdrawal from positive interactions may not be equivalent. Thus this study's assumption that the CPQ assesses a form of withdrawal that will generalize to withdrawal from positive partner behavior might not be appropriate, and future research may benefit from use of a different measure of withdrawal behavior.

The hypothesis that the higher the levels of an individual's withdrawal or avoidance cognitions the lower their levels of intimate relationship behavior was supported for both female and male partners. Furthermore, the hypothesis that the higher the levels of an individual's withdrawal cognitions the lower the levels of pleasure

experienced from intimate behavior was also supported for both female and male partners. These findings are consistent with the literature indicating that avoidance coping is negatively related to individual health, individual well-being, and family and social functioning (Tiet et al., 2006). However, these findings also add to the existing literature in that a strong association was identified between withdrawal cognitions and relational intimacy. The findings clearly demonstrated a strong correlation between the negative cognitions of partners, their lowered motivation to initiate intimate relationship behavior, and their lower degree of pleasure experienced as a result of intimate behavior. It is important to note that this finding may be especially true due to the particular sample utilized in the current study. It is likely that a sample of couples who have experienced abusive behavior in their relationships may be cautious about letting down their guard when a partner behaves positively and quick to think about retreating or withdrawing from dyadic interactions. Regardless, this finding has a direct implication for therapeutic interventions with couples. It is apparent that a significant portion of therapy could be focused on the cognitions of partners presenting to therapy with concerns over lowered and undesirable levels of intimacy. Therapeutic interventions based on the present findings could help address the source of disconnection between partners.

One of the more unexpected findings of this study was that when withdrawal cognitions were a strong predictor of lower pleasure from a partner's intimate behavior (in the hypothesized direction), there simultaneously was a trend for withdrawal behaviors to be a significant predictor of the recipient's *greater* pleasure (in the direction opposite to the hypothesis). It is puzzling that this association was found to be counter to the hypothesized direction only in the multiple regression analysis, whereas the Pearson

correlational analyses did not result in a similar association. One possible explanation is that among males whose lack of pleasure from a partner's intimate behavior is tied to a desire to avoid intimacy, the more that this person truly engages in withdrawal the more he can enjoy the partner's intimacy, because he experiences some control over exposure to the partner's actions. Essentially, when the male partner withdraws, he may feel less vulnerable and may be more likely to enjoy the intimate behavior demonstrated by his partner. The actual reason for the unexpected finding is unknown, and when a number of predictor variables are entered into a multiple regression analysis the effects that their overlapping variance have on each variable's relation with the criterion variable can be complex.

Limitations of the Study

This study was limited in that it utilized data gathered from a clinical sample, and thus the results can only be applied to couples who present to therapy. Additionally, all of the participants in this study reported mild to moderate levels of physical and/or psychological abuse in their couple relationships. Given that the sample consists of individuals who sought therapeutic services and who are involved in at least mildly abusive relationships, their levels of depression symptoms and behavioral and cognitive avoidance may differ from those who have not sought therapy and/or who are not in abusive relationships. Furthermore, difficulties with intimacy are frequently implicated in decisions to seek therapy for marital or relationship problems, and increasing or enhancing intimacy is often one of the primary goals of couple therapy. Therefore, the clinical sample's experience of intimate relationship behaviors and the pleasure

experienced from those behaviors may also be different from the experiences of those who have not sought therapy and/or who are not in abusive relationships.

Another disadvantage of using this particular sample is the number of couples available for inclusion in the study. The relatively small sample size - only 87 couples - can influence the external validity of the results in that they are most directly applicable to couples with the range of personal and demographic characteristics found in the current sample and are not as generalizable to the broader clinical or community population. The relatively small sample size and associated level of statistical power also may have limited the ability to detect relations among some variables in this study.

Although the clinical sample utilized in the current study poses some limitations, it is important to highlight the unique and positive aspects of using this type of sample. Unlike clinical samples used in many prior studies, the couples included in the present sample are culturally diverse. Furthermore, the current sample was not recruited to participate in the study and thus is more representative of couples who seek professional assistance for a variety of relationship problems than are samples in prior studies that were recruited specifically on the basis of their abusive behavior or another specific presenting problem. Additionally, this sample consisted of adult romantic partners, which differs markedly from the young adult platonic samples utilized in existing empirical literature on intimacy in couples. Therefore, the use of the present sample adds to the existing literature by addressing experiences of intimacy within a diverse, clinical adult population that was not recruited for participation.

Another possible limitation of the current study involves the types and intended purposes of the instruments utilized to measure the variables. The Positive Partner

Behavior scale was not specifically designed to measure intimate behaviors, and the subscale of the PPB utilized to assess intimacy in this study was developed by the current researcher. Consequently, there is no evidence as to whether or not the intimacy subscale is reliable across other populations who have been administered the PPB. Perhaps the greatest limitation of the measures is that they are self-report scales, which means that there are no objective data regarding depression symptoms, withdrawal behaviors, withdrawal cognitions, and intimate relationship behavior. Nevertheless, self-report data are important in assessing pleasure experienced from a partner's intimate relationship behavior.

Implications

Implications for Research

Although this study provides important information regarding how individual level factors that contribute to alienation and distance are negatively related to partner experiences of relational intimacy, there are several ways in which it could be improved. First, a measure that would provide an assessment of individuals' withdrawing behaviors independent of their partner's demanding behavior would be particularly beneficial in that it would reduce the concerns about assessing behavioral withdrawal within a specific dyadic interaction pattern.

Although it would be difficult to obtain an outsider's assessment of partners' withdrawal cognitions, more objective measures of depression (e.g., clinical interviews), avoidant behaviors (behavioral observation in structured couple interaction tasks), and intimate behavior (behavioral observation again) could help reduce reliance on self-perception and self-report. An objective measure of intimate behaviors would be

particularly helpful in that it would reduce the possibility that perceptions about overall relationship functioning influence how intimate behaviors are reported. For instance, someone who perceived high levels of relationship distress may not perceive some behaviors as intimate. An outside rater's judgments of intimate behavior, although they are more difficult to obtain and are not necessarily objective in themselves, could enhance the validity of a study's measurements.

It also would also be interesting to test different subtypes of intimate relationship behavior. In the current study, intimacy was defined more in terms of affective than instrumental behavior. It would be interesting to see whether the results would differ if instrumental intimate behavior (i.e.; cleaning the house, running errands, preparing a meal, etc.) was included in the analyses.

Another approach to the same study would be to explore associations of different types of depression symptoms with individuals' experiences of intimacy in their couple relationships. For example, it would be interesting to test the correlations between individual symptoms of depression (e.g., lower motivation to engage in or initiate behaviors, greater social withdrawal, lack of emotional expression, high irritability, etc.) and the overall perception of relationship intimacy. This would remove any possible confounding among types of depression symptoms and would reveal whether particular aspects of depression are associated with lower intimacy.

Additionally, it would be beneficial to conduct the same study with additional measures assessing relationship satisfaction and overall marital adjustment. This would add an important element to the study in that it would provide an understanding of the role that intimate behavior plays in relationship functioning. In the current study, it is

assumed, based on existing research findings, that intimacy is an important component of marital satisfaction and well-being. It would be important to assess how influential intimate behaviors are in terms of relationship distress and satisfaction, and whether partners' characteristics that are associated with lower intimacy are also associated with lower relationship satisfaction.

Finally, this study should be replicated with a different and larger sample. The sample should include couples with a broader range of depression symptoms and levels of distress. Furthermore, it would be interesting to assess differences in intimate behavior between clinical and community samples in order to provide a more comprehensive understanding of the role that intimacy plays in relationship functioning.

Implications for Clinical Practice

The findings from this study are useful for clinical practice for several reasons. First, the study highlights the importance of working with the cognitions of distressed and disconnected couples. The results demonstrate that a major focus of therapy for couples presenting with lower perceived levels of intimacy should be on the identification and management of partners' negative cognitions. Therefore, the restructuring of avoidance cognitions may be the most effective intervention for increasing intimate interactions among partners. More in-depth assessment of avoidance cognitions could focus on underlying thoughts that are associated with avoidance cognitions such as "I want to get out of here." Tapping the expectancies that an individual has about negative consequences from failing to avoid the partner (e.g., "If I don't get out of here, my partner will expect me to reciprocate his intimate behavior, and I don't want to be

pressured to behave that way.”) would shed further light on the internal process occurring in avoidance responses that reduce intimacy.

Furthermore, when working with couples in which one or both partners demonstrate depression symptoms, a focus of therapy could be on the individual demonstrating the specific symptoms. For example, the study’s results showed that when individuals reported higher levels of depression symptoms, they also had a tendency to report that their partners were demonstrating lower levels of intimate behavior. Therapists could spend time discussing the depressed partners’ perceptions of the relationship in session and help them to take ownership for their symptoms. By helping partners identify the ways in which their depression symptoms may be influencing their thinking about the relationship (increased negative thinking, higher levels of blame, reduced objectivity, etc.), they may be more able to identify instances of intimate behavior and experience more positive sentiment as a result of the newly recognized intimate experiences.

Conclusion

In conclusion, this study supports the current literature that individual-level factors that result in emotional or physical distancing or isolation are associated with lower levels of intimate relationship behavior. However, some factors (e.g., withdrawal cognitions) were found to be more predictive of relational intimacy than others (e.g., withdrawal behaviors). There are potential reasons why this was the case and further study is warranted in this area to further clarify the impact of potential barriers to intimacy on intimate relationship behavior. Future research should also take care to

measure intimate relationship behavior in a more comprehensive fashion and to consider its impact on overall relationship satisfaction and adjustment.

Based on the findings of this study, therapists should not overlook the power of individuals' thinking when assessing and treating couples' intimacy problems, which often are conceptualized as comprised of behavioral patterns and emotional responses. The exploration of each partner's positive and negative cognitions could help to identify barriers to intimacy and to establish a stronger sense of closeness and connectedness between partners.

Appendix A
Beck Depression Inventory (BDI)

Directions: On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the **PAST WEEK, INCLUDING TODAY!** Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. **Be sure to read all the statements in each group before making your choice.**

1. 0 I do not feel sad.
1 I feel sad.
2 I am sad all the time and I can't snap out of it.
3 I am so sad or unhappy that I can't stand it.
2. 0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel that the future is hopeless and that things cannot improve.
3. 0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.
4. 0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.
5. 0 I don't feel particularly guilty.
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all the time.
6. 0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.
7. 0 I don't feel I am worse than anybody else.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.
8. 0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.
9. 0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. 0 I don't cry any more than usual.
 1 I cry more than I used to.
 2 I cry all the time now.
 3 I used to be able to cry, but now I can't cry even though I want to.
11. 0 I am no more irritated now than I have ever been.
 1 I get annoyed or irritated more easily than I used to.
 2 I feel irritated all the time now.
 3 I don't get irritated at all by the things that used to irritate me.
12. 0 I have not lost interest in other people.
 1 I am less interested in other people than I used to be.
 2 I have lost most of my interest in other people.
 3 I have lost all of my interest in other people.
13. 0 I make decisions about as well as I ever could.
 1 I put off making decisions more than I used to.
 2 I have greater difficulty in making decisions than before.
 3 I can't make decisions at all anymore.
14. 0 I don't feel I look any worse than I used to.
 1 I am worried that I am looking old or unattractive.
 2 I feel that there are permanent changes in my appearance that make me look unattractive.
 3 I believe that I look ugly.
15. 0 I can work about as well as before.
 1 It takes an extra effort to get started at doing something.
 2 I have to push myself very hard to do anything.
 3 I can't do any work at all.
16. 0 I can sleep as well as usual.
 1 I don't sleep as well as I used to.
 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
 3 I wake up several hours earlier than I used to and cannot get back to sleep.
17. 0 I don't get more tired than usual.
 1 I get tired more easily than I used to.
 2 I get tired more doing almost anything.
 3 I am too tired to do anything.
18. 0 My appetite is no worse than usual.
 1 My appetite is not as good as it used to be.
 2 My appetite is much worse now.
 3 I have no appetite at all anymore.
19. 0 I haven't lost much weight, if any, lately.
 1 I have lost more than 5 pounds.
 2 I have lost more than 10 pounds.
 3 I have lost more than 15 pounds.
I am purposely trying to lose weight. Yes ___ No ___
20. 0 I am no more worried about my health than usual.
 1 I am worried about physical problems such as aches, pains, an upset stomach or constipation.
 2 I am very worried about physical problems and it's hard to think of much else.
 3 I am so worried about my physical problems that I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

Appendix B
Communication Patterns Questionnaire (CPQ) Subscale Items

Demand/Withdrawal Subscale Items

Directions: We are interested in how you and your partner typically deal with problems in your relationship.

Please rate each item on a scale of 1 (=very unlikely) to 9 (=very likely).

A. WHEN SOME PROBLEM IN THE RELATIONSHIP ARISES:

	Very Unlikely								Very Likely
3a. Man tries to start a discussion while Woman tries to avoid a discussion.	1	2	3	4	5	6	7	8	9
3b. Woman tries to start a discussion while Man tries to avoid a discussion.	1	2	3	4	5	6	7	8	9

B. DURING A DISCUSSION OF A RELATIONSHIP PROBLEM:

	Very Unlikely								Very Likely
5a. Man nags and demands while Woman withdraws, becomes silent, or refuses to discuss the matter further.	1	2	3	4	5	6	7	8	9
5b. Woman nags and demands while Man withdraws, becomes silent, or refuses to discuss the matter further.	1	2	3	4	5	6	7	8	9
6a. Man criticizes while Woman defends herself.	1	2	3	4	5	6	7	8	9
6b. Woman criticizes while Man defends himself.	1	2	3	4	5	6	7	8	9

Appendix C
Styles of Conflict Inventory (SCI) Subscale Items

Withdrawal/Avoidance Subscale Items

Directions: In general, when you experience disagreement or conflict in your relationship, or when you experience events that might lead to a disagreement, how do you typically react?
Please circle the number that indicates how often YOU have the following thoughts:

	Never	Rarely	Occasionally	Often	Very often
2. Go away; leave me alone.....	1	2	3	4	5
4. I'll deal with it later.....	1	2	3	4	5
9. We'd better not get into this; avoid the subject.....	1	2	3	4	5
13. I want out.....	1	2	3	4	5
14. I won't deal with this.....	1	2	3	4	5
17. I want to go away.....	1	2	3	4	5
18. I want to ignore this.....	1	2	3	4	5
20. I wish I weren't here.....	1	2	3	4	5
23. How can I get out of this?.....	1	2	3	4	5
24. I'll withdraw.....	1	2	3	4	5
26. I'll back off so it doesn't get worse.....	1	2	3	4	5
28. I should avoid the issue.....	1	2	3	4	5

Appendix D
Positive Partner Behavior Subscale Items

Intimacy Subscale Items

1. Partner greeted me affectionately.
2. Partner held, hugged, or kissed me.
3. Partner cuddled close to me in bed.
4. Partner held my hand.
5. Partner touched or patted me affectionately.
6. Partner told me he/she loves me.
25. Partner expressed understanding or support of my feelings or mood.
34. Partner comforted me when I was upset.
37. Partner initiated sexual activity.
38. Partner accepted my sexual advances.
39. Partner tried to please me sexually.
40. Partner listened to me talk about my problems or things that were troubling me.
41. Partner talked to me about his/her problems, or important decisions.

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