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The Association Between Depressive Symptoms, Relationship Satisfaction, and Self- and Partner-Attributions

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THE ASSOCIATION BETWEEN DEPRESSIVE SYMPTOMS, RELATIONSHIP SATISFACTION, AND SELF- AND PARTNER-ATTRIBUTIONS

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ABSTRACT

THE ASSOCIATION BETWEEN DEPRESSIVE SYMPTOMS, RELATIONSHIP SATISFACTION, AND SELF- AND PARTNER-ATTRIBUTIONS

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Attributions of partners have been examined in the depressive symptom-relationship satisfaction literature, while attributions of self have not been adequately addressed. In the present study, attributions of self and partner were investigated as mediators of the association between depressive symptoms and relationship satisfaction. A student and community sample of 270 adults in heterosexual romantic relationships completed an online survey consisting of depressive symptom, relationship satisfaction, and relationship attribution inventories. Pearson's product-moment correlation and multiple regression analyses were utilized to assess meditational pathways. Depressive symptoms were significantly negatively correlated with relationship satisfaction. Self- and partner-attributions were significantly positively correlated with relationship satisfaction. Self- and partner-attributions did not mediate the relationship between depressive symptoms and relationship satisfaction. Rather, results indicated that depressive symptoms and partner-attributions were significant predictors of relationship satisfaction, but self-attributions were not. Partner-attributions were found to partially mediate the depressive symptom-relationship satisfaction link for the student subsample. Clinical implications, limitations of the present study and considerations for future research are also discussed.

This dissertation is dedicated to my parents and my husband for their continued support, patience, and encouragement throughout the long road.

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CHAPTER I

INTRODUCTION

Overview

Depression and marital difficulties are among the most frequent problems for which adults seek mental health services (Beach & O'Leary, 1992). The association between these two problems has been examined, as it has been theorized that depressive symptoms may negatively impact a depressed individual's romantic relationship, and that problems in an individual's romantic relationship may lead to depressive symptoms. Understanding the association between depressive symptoms and relationship problems is particularly important due to the high prevalence of depressive symptoms and relationship dysfunction in the U.S. and the considerable negative outcomes of such problems.

Depression is a prevalent mental illness with debilitating personal and professional consequences. Major Depressive Disorder affects approximately 14.8 million American adults, or about 6.7% of the U.S. population age 18 and older in a given year (Kessler, Chiu, Demler, & Walters, 2005). Dysthymic disorder affects approximately 1.5% of U.S. population age 18 and older in a given year, affecting 3.3 million American adults (Kessler et al., 2005). There are significant health related as well as financial costs associated with depression, including disability, ischaemic heart disease, self harm and depression related suicide. Major Depressive Disorder is the leading cause of disability in the U.S. for individuals aged 14 - 44 (World Health Organization, 2004). Interpersonally, a substantial base of empirical research has

documented the pervasive relationship difficulties of depressed individuals as well (Joiner, 2002).

There appears to be an increasing recognition that persons with subsyndromal depression also have a degree of functional disability, with associated negative outcomes (Judd et al., 1996; Lyness, King, Cox, Yoediono, & Caine, 1999; Chen et al., 2000; Beekman et al., 2002), which may respond to treatment (Rollman and Reynolds 1999; Copeland et al. 1999; Judd et al. 2002), and therefore warrant further investigation. Research has examined individuals with depressive symptoms who do not meet the diagnostic criteria for Major Depressive Disorder (Copeland, Chen, Dewey, McCracken, Gilmore, & Larkin, 1999; Goldney et al. 2004; Judd et al. 1996, 2002; Pincus et al. 1999; Sherbourne, Wells, Hays, Rogers, Burnam, & Judd, 1994). Such studies have grouped and labeled depressive symptoms as subsyndromal, subthreshold, sub-case, and minor depression. Research studies have demonstrated that individuals with depressive symptoms, who do not meet the criteria for Major Depressive Disorder, may experience a significant degree of clinical and functional impairment (Sherbourne et al. 1994; Judd et al. 1996, 2002). Goldney et al. (2004) identified elevated depressive symptoms in 12.9% of their community sample of 3,010 rural and urban community participants. In the current study, depressive symptoms, as opposed to clinical diagnosis, were measured to facilitate the dimensional investigation of depression phenomenology.

The high prevalence of depression and depressive symptoms actually appears small when compared to the frequency of divorce. In the U.S., divorce rates are estimated between 50% and 67% for first marriages (Bramlett & Mosher, 2001), and even couples who choose to stay together are often not satisfied in their relationships

(Fraenkel, Markman, & Stanley, 1997). According to a report by the National Center for Health Statistics, the data show that a great many marriages also end in legal separation but not in divorce (Bramlett & Mosher, 2001).

The negative ramifications of martial discord and divorce are evident in multiple levels including, family functioning, individual mental and physical health, and economic stability (Amato, 2000). For example, marital discord has been shown to be associated with physiological reactivity (Leverson, Cartensen, & Gottman, 1994) and to lead to suppressed immune system functioning (Kiecolt-Glaser, Malarkey, & Chee, 1993). Marital dissatisfaction has also been linked to emotional problems, such as sadness, irritability, and diminished interest in sex, as well as other depressive symptoms (Beach, Katz, Kim, & Brody, 2003). Moreover, some research suggests that marital dissatisfaction appears to be intertwined with diagnosable episodes of major depression as well as with sub-clinical changes in depressive symptomatology (Beach, 2001).

A great deal of research has attempted to better understand the association between depressive symptoms and relationship dissatisfaction (for review, see Whisman, 2001). Cognitive attribution is one potential mechanism, which has been proposed as a means of understanding the strong association documented between depressive symptoms and relationship dissatisfaction. Attribution is the set of thought processes used to assign causes to our own behavior and to the behavior of others. Studies report that maladaptive attributions have been found to be characteristic of depressed individuals and distressed couples (Heene et al., 2005). It may be theorized that individuals experiencing depressive symptoms are likely to make maladaptive attributions regarding their partners, contributing to relationship dissatisfaction. It is also

possible that dissatisfied partners may be likely to make maladaptive self-attributions which may contribute to depressive symptomatology.

Up to this point, however, research on attributions in intimate relationships has focused predominantly on judgments about a partner's role in or responsibility for negative events or difficulties in a relationship. Attributions regarding the self in the relationship have largely been ignored. The present study contends that the investigation of both self- and partner-attributions in association with relationship satisfaction and depression will advance our current understanding of the links among attributions, relationship satisfaction and depressive symptoms. In order to better comprehend the interplay among depressive symptoms, relationship satisfaction, and attributions, it is necessary to first review existing psychological research on these broad topics from their theoretical foundation to studies of their associations.

The Association between Depressive Symptoms and Relationship Satisfaction

The importance of primary relationships and the connection between significant relationships and well-being have been recognized for some time (Caplan, 1974). Specifically, some research suggests that supportive and confiding relationships can serve as a protective factor for the development of depression (Brown & Harris, 1978). In contrast, it has also been documented that stress in primary relationships may serve as a risk factor for depressive symptomatology (Ilfeld, 1977).

Indeed, it has been found that approximately 50% of maritally discordant women are depressed (Beach, Jouriles, & O'Leary, 1985, Weissman, 1987) and approximately 50% of depressed women experience marital discord (Rounsaville, Weissman, Prusoff, & Herceg-Baron, 1979a, 1979b). Not all people who develop depression experience

significant relationship problems, as individuals develop depression for various reasons. However, Beach, Sandeen, and O'Leary (1990) contended that relationship dissatisfaction, specifically in married relationships, can be part of a causal mechanism leading to depression.

The marital relationship holds, at a minimum, considerable influence over feelings of well-being (Diener, 1984) and may often play a central role in the etiology and maintenance of depressive episodes (Beach & Nelson, 1990). The marital relationship, as a confiding and intimate relationship, has the potential to provide social support and enhanced coping with stressful life events. Alternatively, marital relationships are capable of stress-enhancement. Marital discord is shown to decrease available support from the partner and increase levels of major stressors in the marital relationship. Both decreases in relational support and increases in stress have shown evidence of being related to depressive symptomatology (Beach et al., 1990). Taken together, the decreases in marital support and increases in marital stress may mediate the association between marital discord and depression (Beach et al., 1990).

There have been several theoretical perspectives proposed to account for the association between depression and marital dissatisfaction. In general, these perspectives can be divided into (a) those that suggest that marital dissatisfaction leads to depression, (b) those that suggest that depression leads to marital dissatisfaction, and (c) those that suggest that a third variable contributes to both depression and marital dissatisfaction.

The relationship between marital discord and depressive symptoms can be bidirectional. Common depressive symptoms include avoidance of others, difficulty

concentrating on a topic, and loss of interest in previously gratifying behavior. These symptoms of depression may be expected to strain a relationship, leading to relationship difficulties, and limiting the capacity of a couple to make progress in resolving preexisting relationship distress. In addition, as the depressed individual becomes more focused on him/herself and his/her own flaws (Pyszcynski & Greenberg, 1987), decreased attention to the relationship would be expected and could be detrimental to the relationship (Pearlin & Schooler, 1978). Therefore, it seems likely that as the relationship between marital discord and depression unfolds, an increasingly vicious cycle is established.

The associations between depression and romantic dysfunction, and specifically marital dysfunction, have been studied for more than three decades, resulting in a large body of literature. Conclusions from this research can be described broadly as follows: (a) negative marital events such as conflicts, chronically stressful and unsupportive circumstances, and divorce can lead to depressive symptoms and depression; (b) depressive symptoms and depression can lead to negative marital events such as dissatisfaction and chronically stressful circumstances; and (c) dysphoric and depressed spouses and their partners behave in a negative fashion toward one another.

There is a body of research which indicates that marital dissatisfaction leads to depressive symptoms and/or depression (Beach et al., 2003; Beach & O'Leary, 1993a; Whisman, 2001; Whisman & Bruce, 1999). In a longitudinal study, Beach and O'Leary (1993a) found that pre-marital relationship satisfaction predicted subsequent depressive symptoms over 18 months among newlyweds. They concluded that nearly 20% of the variance in depressive symptoms at 18 months of marriage could be attributed to change

in marital satisfaction over time. Similarly, Whisman and Bruce (1999) found that the presence of marital dissatisfaction doubled the risk for major depression one year later. Also, in a randomly drawn sample of established marriages, level of marital satisfaction predicted change in self-reported symptoms of depression one year later (Beach et al., 2003). Beach et al. (2003) also concluded that for men and women, satisfaction predicted shifts in depression beyond the effect of prior depressive symptoms.

Marital dissatisfaction has also been found to predict increases in depressive symptoms over time (Beach & O'Leary, 1993a, 1993b; Fincham, Beach, Harold, & Osbourne, 1997), and to co-vary with changes in depressive symptoms (Karney, 2001; Kurdek, 1998). Examining the effect of experiencing distressing marital events relative to no such events, Cano and O'Leary (2000) found that marital events resulted in a six-fold increase in the risk of clinical depression; and this increased risk remained after controlling for family and personal history of depression. In a sample of Latina women, Hollist, Miller, Falceto, and Fernandes (2007) found that marital satisfaction was a strong predictor of depression two years later and that marital satisfaction related to co-occurring depression as well.

There is also a body of research which suggests that depression or depressive symptoms precede marital dissatisfaction and/or causes dysfunctional marital interaction (Basco, Prager, Pita, Tamir, & Stephens, 1992; Davila, Bradbury, Cohan, & Tochluk, 1997; Davila, Karney, Hall, & Bradbury; 2003; Fincham et al., 1997; Gotlib & Whiffen, 1989; Kurdek, 2003; Schmaling & Jacobson, 1990; Uebelacker, Courtnage and Whisman, 2003). Gotlib and Whiffen (1989) noted that depression affected marital functioning of the depressed individual and the spouse as well. Kurdek (2003) found that

marital distress could be accounted for by negative concepts of self (a possible indicator of depressive symptoms) and negative concepts of partner. Having major depressive disorder during adolescence has been found to predict later marital dissatisfaction (Gotlib, Lewinsohn, & Seeley, 1998). Ulrich-Jakubowski, Russell, and O'Hara (1988) reported that depressive symptomatology predicted the subsequent level of marital dissatisfaction among retired men in the community.

As can be seen by the preceding studies, there has been a great deal of research investigating the association between depression and relationship problems. Whisman's (2001) meta-analysis of 26 studies in this area, involving more than 3,700 women and 2,700 men, provides a valuable summary of findings. Whisman (2001) found a medium to large effect size for the association between depressive symptoms and relationship dissatisfaction. Relationship dissatisfaction was shown to account for approximately 18% (r = -.42) of the variance in the depressive symptoms of women and 14% (r = -.37) of the variance in depressive symptoms in men (Whisman, 2001). An even stronger negative association (r = -.66) between marital satisfaction and depression was found across 10 studies using clinical populations of patients with diagnoses of depression. Whisman's review and the work of others demonstrate that research involving diverse methods and samples repeatedly concludes that depressive symptoms covary reliably with marital dysfunction and that longitudinal links between these variables exist in both directions (e.g., Beach et al., 1990; Burns, Sayers, & Moras, 1994; Davila et al., 1997; Karney, 2001; for reviews, see Gotlib & Beach, 1995, Whisman, 2001).

According to Davila's (2001) review of marital satisfaction and depression, there is evidence supporting bi-directional causal effects. A number of studies have attempted

to address the apparently bi-directional relationship between depressive symptoms and relationship functioning. Controlling for the change in each variable, Kurdek (1998) found that spouses who experience increases in depressive symptoms tend to experience steeper declines in their marital satisfaction than they would have otherwise given their overall rate of change in satisfaction. In a similar study, Karney (2001) examined within-subject associations between depressive symptoms and marital satisfaction and found bi-directional associations as well. Davila et al. (2003) also found within-subjects bi-directional associations between depressive symptoms and marital satisfaction. Depressive symptoms were found to be as likely to predict changes in marital satisfaction as marital satisfaction was to predict changes in depressive symptoms. Associations between depressive symptoms and marital satisfaction were found to be robust across levels of symptom severity and aspects of marital functioning (Davila et al. 2003).

Therefore, the available research has established that marital dysfunction predicts subsequent depression as well as the other way around. Depression and marital distress influence each other, and the association appears to be best described as bi-directional. Davila (2001) called for a move beyond efforts aimed at determining whether marital dysfunction is a better predictor of depression or vice versa to a likely more fruitful and clinically relevant focus of study on the mechanisms of association between marital dysfunction and depression. Understanding the processes and factors that contribute to the course of depressive symptoms, rather than searching for causality, may be more helpful for guiding intervention due to the multivariate nature of depression and relationship functioning.

Attribution Theory

Attribution is the set of thought processes used to assign causes to our own behavior and to the behavior of others. When an individual is not sure what is causing the behavior of someone he/she is observing, he/she attributes causes that seem appropriate. People often try to decide whether someone's behavior is the result of *internal* or *external* causes (Heider, 1958). Internal attributions are explanations based on someone's personal characteristics, such as attitudes, traits, abilities, or moods. External attributions are explanations based on the situation, such as stimuli in the environment, the events of the day, and the rewards and penalties associated with certain acts. Internal attributions are known as *dispositional*; external attributions are known as *situational.*

Kelley (1967) proposed the theory that individuals rely on three types of information when deciding whether to make an internal or an external attribution for someone's behavior: consensus information, consistency information, and distinctiveness. *Consensus* information refers to how a person's behavior compares with other people's behavior. If an individual behaves the same way that other people do in a situation, then an external attribution is likely to be made. If an individual behaves in an unusual way, an internal attribution is often made, seeing the cause as pertaining to something about that person instead of something about the situation. *Consistency* information refers to how a person's behavior varies from one time to the next. For example, if someone almost always seems friendly, you would make an internal attribution ("this is a friendly person"). If someone seems friendly at times and less friendly at other times, you may look for external attributions ("something just happened to cause this person to be friendly today"). *Distinctiveness* refers to how a person's

behavior varies from one object or social partner to another. For example, if someone is friendly to most people, but unfriendly to one particular person, you are likely to make an external attribution for the unfriendly behavior ("this is a friendly person who does not like person x").

In most cases, individuals accurately judge available evidence and make appropriate internal or external attributions for people's behavior. However, one error individuals are especially likely to make is assigning internal attributions to other people's behavior, even when they see evidence for an external influence on behavior. This tendency is referred to as the *fundamental attribution error* (Ross, 1977). Moreover, people are more likely to make internal attributions for other people's behavior than they are for their own (Jones & Nisbett, 1972). This tendency is called the *actor-observer effect*.

Weiner, Frieze, Kukla, Reed, Rest, and Rosenbaum (1971) were the first to note that in addition to judgments of internality/externality, causes may also vary in their perceived stability over time. Weiner et al.'s (1971) work added the classification of *stability* (stable-unstable) to existing classification of *locus* (internal-external). A third dimension of *globality* later developed out of Abramson, Seligman, and Teasdale's (1978) reformulated model of learned helplessness. Globality was identified to distinguish causal factors that apply generally across situations from those *specific* to certain situations. Abramson et al.'s (1978) theory applied attribution theory to depression, concluding that helpless and depressed persons make attributions about negative events that are internal, stable, and global.

Further understanding of causality leads to the distinction of *intentional-unintentional* behavior. Attributions of intentionality also affect how behavior is perceived. Work based on Heider's (1958) levels of responsibility for actions has shown that a person is praised more for positive outcomes when these are perceived to be intentional rather than unintentional, and negative outcomes elicit more blame when they are perceived to have been produced intentionally (e.g., Shaw & Sulzer, 1964).

As attributions affect how one perceives behavior, it may be considered that attributions are important in many domains. Of key significance to the proposed study, attributions have been demonstrated to be particularly relevant to relationship satisfaction and depression. The association between attributions and both relationship satisfaction and depression will be reviewed, leading to the examination of the contribution which attributions make to further understanding the association between relationship satisfaction and depressive symptoms.

Depressive Symptoms and Attributions

The Learned Helplessness theory of depression (Abramson et al., 1978) was one of the first attributional models of depression. It predicts that depressed individuals attribute negative events to the self. The association between attributions and depression has been exhibited in many studies (for reviews, see Peterson, Meier, & Seligman, 1993; Sweeney, Anderson, & Bailey, 1986).

The Learned Helplessness theory of depression is largely based on the concept that the degree to which one learns that he/she can escape or control important negative events in life, has a significant effect on one's subsequent attempts to exert control over

those events or to cope with them in the future. According to the original formulation of the Learned Helplessness model, when an organism is exposed to uncontrollable events it will often show a subsequent disruption of the ability to learn adaptive behavior in situations that are similar to the original events (Abramson et al., 1978).

For example, when dogs were initially exposed to inescapable shock and later placed in a shuttle box where they could avoid the shock by jumping over a barrier, they exhibited marked deficits in the acquisition of the avoidance response. It was inferred from these results that the dogs in the initial helpless condition perceived a noncontingency between their response and the environmental outcome. The dogs' perception of helplessness in terminating the aversive stimulus during the first stage of the experiment appears to have generalized to their behavior in subsequent phases of the experiment. It was hypothesized that the dogs learned to expect the same noncontingency in the future. In addition to decreased coping behavior, perceived lack of control was observed to be associated with a negative effect on mood, leading to depression (Abramson et al., 1978). The expectation of lack of control in the future is thought to be necessary for Learned Helplessness to occur, i.e., one must expect future noncontingency between his or her behavior and punishment in order to become passive and nonresponsive in the face of adversity. Exposure to uncontrollable events has been shown to produce the same type of debilitating effects in humans (Hiroto, 1974).

The original formulation of the Learned Helplessness hypothesis was later considered insufficient to explain some of the components of depression when it occurs in humans. For example, the Learned Helplessness model as originally proposed did not directly address the issue of self-esteem, which is sometimes found to be low in

depressed individuals (Abramson et al., 1978). The reformulated model of Learned Helplessness specifies that when someone perceives an outcome to be uncontrollable, he or she asks themselves "why?" The person's reasons for explaining the uncontrollable situation are causal attributions. As discussed above, these causal attributions have been shown to vary along at least three bipolar dimensions. The dimensions are internal-external, stable-unstable, and global-specific.

It is theorized that individuals make internal attributions when they believe that events are caused by some aspect of themselves (i.e., internal to themselves); they make external attributions when they believe that the events are caused by something outside themselves, i.e., by the situation or another agent (Peterson, Semmel, von Baeyer, Abramson, Metalsky, & Seligman, 1982). When the cause of an event is expected to be lasting, people are said to make stable attributions; when it is assumed to be temporary, the attributions are called unstable. Finally, when an event is attributed to a cause that involves a wide variety of situations, global attributions are being made; in contrast, when circumscribed, specific factors are seen to be the cause of an event, specific attributions are made.

It has been shown that an internal, stable, and global attributional pattern or style in response to unpleasant events is highly correlated with the presence of depression (Seligman, Abramson, Semmel, & von Baeyer, 1979). For example, a student who fails a test can generate many different causal scenarios to explain his failure. He may believe "I failed this test because I am not intelligent [internal], I am terrible in all subjects [global] and I will always be unintelligent and terrible at everything [stable]." An alternative causal explanation for failing a test may be: "I failed because the teacher was

in a bad mood and gave an unfair test." This explanation falls on the external, unstable, and specific side of the bipolar causal dimensions. Peterson et al. (1982), using the Attribution Style Questionnaire, found that depressed college students reported more internal, stable, and global attributions for bad events than a group of nondepressed college students. Also, through the use of a longitudinal design, it was shown that the presence of this depressive attribution style helped predict the onset of depression when unpleasant events occurred (Peterson & Seligman, 1984). Furthermore, in a meta-analytic review of the association between attribution styles and depression across 104 studies (Sweeney et al., 1986), attributions for negative events to stable ("It's going to last forever."), global ("It's going to affect everything I do"), and internal ("It's all my fault") causes were consistently positively correlated with depression scores. For positive events, attributions to unstable, specific, and external causes were associated with depression.

Relationship Satisfaction and Attributions

While attribution theory and research have increased understanding and informed the treatment of depression, therapists and researchers recognize the importance of attributions in relational difficulties as well. In a review of this literature, Bradbury and Fincham (1990) determined that studies have repeatedly found an association between relationship satisfaction and attributions for relationship events. Specifically, relationship-enhancing attributions occur most often in satisfied couples. While, dissatisfied/distressed couples, most often make distress-maintaining interpretations.

Within the relationship literature, specific types of attributions have been identified that may be specifically relevant to the study of romantic relationships, causal attributions, detailed above, and responsibility attributions. Responsibility attributions are considered to be judgments that presuppose a causal attribution, concern an individual's accountability or answerability for some event, and determine liability and sanctions (Fincham & Bradbury, 1988; Fincham & Bradbury, 1993). Responsibility attributions are thought to be distinct from causality, which includes dimensions of locus (internal-external), stability, and globality, which pertain to who or what produced an outcome or event (Bradbury & Fincham,1993). As Heider (1958) delineated, responsibility rests on a number of criteria, particularly judgments of intentionality and forseeability of outcomes.

Bradbury and Fincham's (1990) review indicated that research on responsibility attributions has found distressed partners tend to view their partner as selfishly motivated and behaving with negative intent. A study conducted by Fincham, Beach, Bradbury (1989) with women who were not receiving any form of therapy, found that marital satisfaction was associated with seeing the causes of positive behaviors as intentional, unselfishly motivated, and praiseworthy, and related inversely with identifying the causes of negative behavior as intentional, selfishly motivated, and blameworthy.

Townsley, Beach, Fincham, and O'Leary (1991) examined two types of marital cognitions (1) dysfunctional beliefs about relationships (e.g., "it is destructive for spouses to disagree," or "spouses cannot change," Epstein & Eidelson, 1981); and (2) attributions of blame and responsibility toward one's spouse for his or her behavior (judgments of intentionality, blameworthiness, and selfishness as measured by a shortened version of

the Marital Attributional Style Questionnaire (MASQ; Fincham et al., 1989). Among 50 Caucasian women, attributions of blame and responsibility contributed significantly to the prediction of marital adjustment. Regression analyses performed in this study indicated that attribution of blame was most consequential for marital discord. As responsibility attributions for a spouse's negative behavior became more benign, marital adjustment significantly increased (Townsley et al., 1991). Bradbury and Fincham's (1990) review also concluded that responsibility attributions appear to be more salient in marriage than causal attributions. However, evidence has shown that the more likely relationship partners were to assign blame to their partners and attribute their marital conflicts to global or stable causes, the more likely they are to report marital dissatisfaction scores (Sabourin, Lussier, & Wright, 1991). It has been repeatedly demonstrated that both causal (internal, stable, and global causes of partner behavior) and responsibility attributions have a role in both causing and maintaining marital distress (Fincham & Bradbury, 1993; Johnson, Karney, Rogge, & Bradbury, 2001; Karney & Bradbury, 2000). Therefore, the inclusion of both responsibility and causal attributions is likely important to provide further understanding of attributions in relationship satisfaction.

Previous study of relationship satisfaction and attributions has found that satisfied partners tend to attribute negative events to external, unstable and specific causes (Jacobsen, McDonald, Folette, & Berley, 1985). Satisfied couples also tend to view negative events as less controllable and unintentional, and attribute less responsibility to the partner. Furthermore, relationally satisfied couples are more likely to see positive events as global, or as a typical behavior of the partner (Karney, Bradbury, Fincham, &

Sullivan, 1994). In contrast, dissatisfied couples, most often make distress-maintaining (maladaptive) interpretations. They view negative events as caused by internal and stable characteristics of the partner and as global or typical for the partner. Further, when one partner behaves in a negative way, individuals in dissatisfied couples view the partner as being in control and responsible for the act (Baucom, 1987; Fincham, 1985; Fincham, Beach, & Baucom, 1987; Holtzworth-Munroe & Jacobsen, 1985; Schaefer-Porter & Hendrick, 2000).

The link between attributions and satisfaction is supported through longitudinal research. Fletcher, Fincham, Cramer, and Heron (1987) discovered that when measuring attributions for relational events and relational satisfaction in two-month intervals, there was a significant longitudinal association between attributions at time 1 and relationship satisfaction at time 2. Similarly, Fincham and Bradbury (1987) found that when measuring attributions and satisfaction over a 12-month period, time 1 attribution scores predicted time 2 satisfaction scores, even when controlling for time 1 satisfaction. These studies highlight the well-supported link between attributions and satisfaction. Based on such research, it may be predicted that individuals who make more positive attributions for partner behavior will also report greater relational satisfaction.

Evidence for the association between attributions and relationship satisfaction has been shown across cultures and methods (cross-sectional, longitudinal, standardized/hypothetical stimuli vs. real marital conflicts) (Fincham & Beach, 1988; Fincham & Bradbury, 1993; Madden & Janof-Bulman, 1981; Sabourin, et al., 1991). Research in the 1980s demonstrated that attributions play an important role in marital satisfaction (Bradbury & Fincham, 1990 for a review). This research continued into the

1990s. Initially, researchers posited a particular direction for the link between negative attributions and relationship satisfaction, specifically, that negative attributions lead to decreased satisfaction (Fincham & Bradbury, 1987). As the literature continued to grow and evolve, investigators have developed more complex models that hypothesize reciprocal influences between relationship satisfaction and attributions (Fincham, Harold, & Gano-Phillips, 2000; Johnson et al., 2001; Karney & Bradbury, 2000).

Attributions for Self and Partner and Relationship Satisfaction

Early studies, which limited attribution ratings to the dimension of causal locus, reported that nondistressed spouses tended to make similar attributions for self and partner behaviors, whereas distressed spouses tended to make attributions that cast their own behavior in a positive light (Fichten, 1984; Kyle & Falbo, 1985; Fincham, 1985). Fincham et al. (1987) furthered this research by examining self- and partner-attributions across several attributional dimensions. Attributions of spouses seeking therapy were compared to happily married persons in the community. Their results also revealed that self-other attribution differences varied as a function of marital distress. Relationally nondistressed spouses showed a positive attribution bias by making more benign attributions for partner behavior as opposed to self-behavior, whereas distressed spouses showed a negative attribution bias by making less benign attributions for partner behavior than for self-behavior. Distressed subjects, relative to nondistressed participants, made more destructive attributions for their partner's behavior (they saw causes as more global, inferred less positive intent and more selfish motivation, and considered the behavior less praiseworthy).

These studies point to the conclusion that maritally satisfied spouses may make similar attributions for self and partner behavior, exhibiting a tendency toward partner- and self-enhancing attributions, while maritally dissatisfied spouses may exhibit a tendency toward unfavorable partner-attributions and favorable self-attributions (Bradbury & Fincham, 1990). Consequently, the complexity of the association between relationship satisfaction and attributions may be further delineated by examination of both self- and partner-attributions. Bradbury and Fincham (1990) noted the importance of further examining these preliminary conclusions, stating that continued research in the area of self-attributions may extend our understanding of the many studies that have examined attributions of partner only.

With further consideration of self- and partner-attributions, it may be hypothesized that the impact of one's partner-attribution ("He doesn't do work around the house because he is lazy") may be a function of the attribution one makes for one's own behavior. A similar attribution for one's own behavior may minimize the impact of the partner's behavior ("I tend to be lazy too"), whereas a self-enhancing attribution may maximize the impact of the partner's behavior ("When I don't do my chores it's because I am too busy with work"). Bradbury and Fincham (1990) contended that consideration of attributions for partner behavior in relation to those made for one's own behavior appears to be extremely important to a comprehensive understanding of attributions in romantic relationships.

However, much of the relationship satisfaction literature has focused on the partner. Rationale for the exclusion of the self has been that partner attributions are likely to have the most important implications for marital satisfaction and for subsequent

behavior (Fincham & Bradbury, 1992). It should be noted, however, that conceptual analyses of the locus dimension in close relationships (e.g., Fincham, 1985; Newman, 1981) showed that causal locus could be analyzed in terms of several components (e.g., partner, self, outside circumstances, partner in relation to self, and the relationship). Although correlated, the correlations between these components are quite modest (Fincham, 1985). Based on these findings, Fincham and Bradbury (1992) concluded that it should not be assumed that assessment of partner as the locus of the cause captures all possible information about the locus dimension. Fincham and Bradbury (1992) specifically noted that there are likely to be circumstances (e.g., investigation of depression in marriage) under which other components of this dimension (e.g., self as locus) may be of equal interest.

Despite these previous calls for attention, there has been a lack of further research on self-attributions in the relationship literature to clarify their impact, although differences between self and other attribution have been widely investigated in social psychological research (Jones & Nisbett, 1972). Jones and Nisbett (1972, p. 80) postulated a "pervasive tendency" for people to attribute their own actions to situational factors (external locus) while attributing the actions of others to stable, personal dispositions (internal locus). This tendency is referred to at the actor-observer bias. However, few studies provide data relevant to self-partner attributional differences in close relationships.

One pertinent study, Orvis, Kelley, and Butler (1976), found that when explicit disagreements occurred between cohabitating couples regarding the cause of a behavior, participants tended to see the causes of partner behavior as due to partner characteristics

or attitudes, while their own behavior was perceived as due to environmental factors, temporary internal states, the intrinsic quality of the activity, concern for partner welfare, or beliefs about what is preferable. These findings generally coincide with the actor-observer differences posited by Jones and Nisbett (1972). Further, Thompson and Kelley (1981) examining self-partner attributions in romantic relationships, found that the more successful a romantic relationship is rated by its participants (including dating and marriage), the more likely they are to see the partner, rather than themselves, as being the cause of positive relationship events and to assume responsibility themselves for at least some negative events. As most subjects rated their relationship as highly successful, such findings suggest a potential positive bias regarding attributions for partner behavior as compared with self-attributions in nondistressed couples, which coincide with Fincham et al.'s (1987) findings. However, Fincham et al. (1987) found no evidence for the actor-observer attribution differences noted in prior attribution research (Jones & Nisbett, 1972) or for the simple positivity effect (good behaviors are attributed to persons, whereas bad behaviors are attributed to situational circumstances) found in research involving close relationships (Taylor & Koivumaki, 1976).

Elaborating on the positivity effect, Taylor and Koivumaki (1976) found that participants explained events that happened to friends and spouse, but not to strangers, similarly to how they explained events that happened to themselves. Participants attributed causality in a more actor-supportive fashion for themselves, a friend, and their spouse, as compared to an acquaintance. Taylor and Koivumaki (1976) found little support for differences in self-other attributions when subjects ascribed traits to a person (acquaintance, friend, spouse, self) or rated the causes of their behaviors on a

dispositional-situational bipolar scale. Instead, a positivity effect emerged as persons were seen to cause good behaviors, whereas situational factors were considered to be the cause of bad behaviors, an effect that became more pronounced as a function of increasing familiarity with the target person. However, Taylor and Koivumaki's participants were couples within the community and no measures of relationship quality were obtained. The conditions under which there is a pervasive tendency to attribute another's actions to stable personal dispositions while attributing one's own similar actions to situational requirements, therefore, appears to be more complicated than Jones and Nisbett (1972) suggested. Minimally, the relationship quality between then observer and actor needs to be taken into account.

As described above, attributions have informed the understanding of both depression and relationship satisfaction. Specific causal attributional patterns are often associated with increasing levels of depressive symptoms, and particular causal and responsibility attributional patterns are repeatedly associated with increasing levels of relationship dissatisfaction. Attributions made about one's self have been examined in association with depressive symptoms, while attributions made about one's partner have been investigated in association with relationship satisfaction. In an attempt to examine the link between depression and relationship satisfaction, attributions will likely play an important role. Examination of both self- and partner-attributions will provide an opportunity for further knowledge in this area.

Attributions and the Relationship Satisfaction-Depressive Symptoms Link

Although the link between relationship satisfaction and depressive symptoms has been established by over three decades of research, questions remain about why

depressive symptoms and relationship dissatisfaction co-occur. One question involves the mechanisms that govern the link between depressive symptoms and relationship satisfaction. To increase understanding of the association between depressive symptoms and relationship satisfaction, it is important to examine the constructs through which the association may be mediated (Davila, 2001; Whisman, 2001). In attempt to clarify the nature of the association between relationship satisfaction and depressive symptoms, it is also particularly important to examine specific groups for whom relationship dissatisfaction is most closely linked with depressive symptoms by investigating moderators of depressive symptoms and relationship satisfaction. Specification of moderating and mediating variables may increase understanding of the mechanisms through which depressive symptoms and relationship satisfaction affect one another and under which conditions, thereby highlighting avenues of clinical intervention for the improvement of marital quality and/or the reduction of depressive symptoms.

As we have seen, attributions have been found to be associated with both relationship satisfaction and depression. While depressed individuals tend to attribute negative events (personal failures) to causes internal to self, stable, and global (Abramson et al., 1978), stable and global attributions for one's partner's negative behaviors have been found to predict increased relationship distress (Fincham & Bradbury, 1993). However, few studies have examined how views of both self and partner relate to relationship satisfaction and depressive symptoms.

Some studies have examined the interplay between partner-attributions, relationship satisfaction and depression, but not self-attributions. Gordon, Friedman, Miller, and Gaertner (2005) examined the association between depression, relationship

dissatisfaction, and partner-attributions. This study tested three models involving marital attributions of partners' negative behavior, marital discord, and depression. The first model tested relationship attributions as mediating the link between marital distress and depression, examining whether marital distress would continue to significantly predict depression when the effect of the attributions was statistically removed. Gordon et al. (2005) did not find evidence for the mediation model for partner-responsibility or partner-causal (locus, stability, globality) attributions, which was consistent with previous findings (Fincham & Bradbury, 1993; Heim & Snyder, 1991). In other words, Gordon et al. (2005) failed to find evidence that partner- responsibility or partner-causality attributions account for the association between marital distress and depression.

The second model tested by Gordon et al. (2005) was relationship distress as a mediating variable for the association between attributions of partner responsibility and depression and attributions of partner causality and depression. Gordon et al. (2005) found this association to be supported for responsibility and causal attributions. Specifically, Gordon et al. (2005) found that marital distress accounted for the association between responsibility attributions and depression, and marital distress accounted for the association between causal attributions and depression. The third model tested by Gordon et al. (2005) was attributions of partner responsibility as a moderating variable in the association between depression and marital distress. The hypothesis for moderation was supported. It was found that the link between marital satisfaction and depression varied as a function of the degree to which participants made responsibility attributions. Specifically, marital adjustment and depression were more strongly associated for individuals who made more responsibility attributions for their partner's behaviors.

While for individuals who made fewer responsibility attributions for their partners' negative behaviors, the association between marital adjustment and depression was greatly reduced.

In both nonclinical (Heene et al., 2005) and clinical samples (Heene, Buysee, & Van Oost, 2007), depressed participants were more likely to attribute negative partner behavior to internal (the cause of partner behavior within the spouse), global (the cause of partner affects many areas in the relationship), and stable (the cause of partner behavior persists over time) causes. Also as depression increased, marital adjustment decreased. Further statistical analysis using hierarchical multiple regression demonstrated, unlike Gordon et al. (2005), that causal attributions (internal, global, and stable causes of partner behavior) mediated the association between depressive symptoms and marital adjustment for depressed partners. In other words, the relationship between depressive symptoms and marital adjustment was found to be accounted for by causal attributions. Heene et al. (2005; 2007) concluded that this mediation relationship may indicate that depressed individuals tend to see others as the cause of negative relationship events, which may lead to relationship dissatisfaction, or this mediation relationship may instead suggest that individuals who are distressed in their relationship tend to blame their partner for causing this distress, which may lead to depression.

However, in Heene et al.'s (2007) study, depressive symptoms were found to be a significant correlate of marital adjustment for participants who saw the cause of relationship events less due to their partner, but depressive symptoms were not found to be a significant correlate of marital adjustment for participants who attributed causality more to their partner. These findings could suggest that depressed individuals see

themselves more, and their partners less, as the cause of negative events. Similarly, Försterling, Schuster, Morgenstern (2005) found that dysphoric persons made more antidepressogenic attributions - more external (cause resides outside of partner), unstable (will not have importance for my partner in the future), and specific (concerns only one area of life of my partner), causes for partner's failures than did non-dysphoric individuals. These results may suggest that depressed participants make fewer partner attributions for negative relationship events. A limitation of Försterling et al. (2005), however, was that the vignettes used to assess attributions about the partner were not relationship events, which would likely be more relevant to understanding how depressives' negative attributions affect their interpretation of their romantic relationship.

Uebelacker and Whisman (2005) studied depressed women and found that they had more dysfunctional relationship attributions than non depressed women. However, hierarchical logistical regression showed that attributional styles did not predict significant unique variance in depression status beyond that predicted by participants' relationship satisfaction. Participants' depression status was not associated with the endorsement of relationship attributions or with reports of positive or aversive partner behaviors after controlling for participants' marital satisfaction. Similarly, Bradbury, Beach, Fincham, and Nelson (1996) found that wives that were both clinically depressed and maritally distressed did not differ in marital attributions from wives that were nondepressed and maritally distressed. It may be interpreted based on these findings that relationship satisfaction, rather than depression, may be more closely associated with differences in attributions regarding one's relationship. However, it is possible that important differences do exist in relationship attributions for self-attributions for varying

levels of depressive symptoms. Individuals with higher levels of depressive symptoms may be more likely than those with lower levels of depressive symptoms to blame themselves, rather than their partners, for negative relationship events. Examination of self-attributions is crucial in further understanding the role attributions play in the association between depression-relationship satisfaction. Failure to examine self-attributions may help to explain conflicting findings (Heene et al., 2005, 2007 and Gordon et al., 2005) regarding attributions as mediators of the depression-relationship satisfaction link.

As shown by the above outlined findings, the study of attributions related to the depressive symptoms-relationship satisfaction association has yielded a variety of findings. Both attributions about the partner and the self, as a link in the depressive symptom-relationship satisfaction association, warrants further study to provide further clarity to the existing literature. The study of self-attributions is an important contribution that will provide additional information to increase the understanding of the role of attributions in the depressive symptoms-relationship satisfaction association.

Proposed Model

This study proposed a mediation model wherein the association between depressive symptoms and relationship satisfaction is mediated by self- and partner-attributions (see Figure 1 below). As depressive symptoms increase, it was hypothesized that negative self-attributions and negative partner-attributions increase. As negative self-attributions and negative partner attributions increase, relationship satisfaction

decreases. As depressive symptoms increase, relationship satisfaction will decrease via the association of both variables with self-and partner-attributions.

Purpose

The purpose of the present study was to examine self- and partner-attributions in association with relationship satisfaction and depressive symptoms in an attempt to clarify the link between relationship satisfaction and depressive symptoms and further understand variables that may mediate this link. Greater understanding of these associations will benefit those who suffer from these highly prevalent problems by informing treatment through increased specificity of intervention. In an attempt to achieve this goal, the following hypotheses were examined.

Hypotheses

1. Depressive symptoms will be negatively associated with relationship satisfaction.
2. Depressive symptoms will be positively associated with self-attributions for relationship problems.
3. Self-attributions for relationship problems will be negatively associated with relationship satisfaction.
4. Depressive symptoms will be positively associated with partner-attributions for relationship problems.
5. Partner-attributions for relationship problems will be negatively associated with relationship satisfaction

6. The association between depressive symptoms and relationship satisfaction will be mediated by self-attributions and partner-attributions for negative relationship behaviors (see Figure 1).

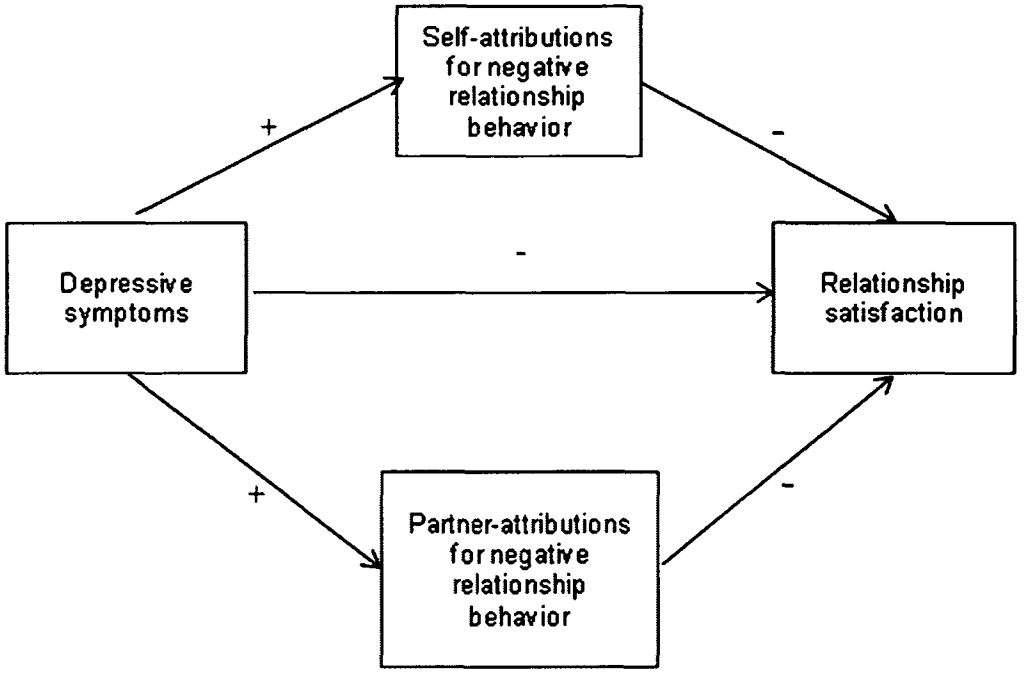

Figure 1. Self- and partner-attributions as mediators of the association between depressive symptoms and relationship satisfaction.

CHAPTER II

METHOD

Participants

Participants were recruited through two convenience sampling methods. One method was to recruit students encouraged by extra credit in psychology classes at a medium sized university. The second method recruited participants through online professional and social networking to increase the age range and length of relationship of the sample. Eligible participants must have been currently involved in a heterosexual romantic relationship for at least six months or longer. The number of participants needed was determined based on a power analysis for multiple regression. For three predictors, with a medium effect sized, the *n* needed is 108. To account for missing data, the recruitment goal was 125 for both sampling groups, yielding at least 250 participants.

Data were collected from 348 participants. Data were discarded from 47 respondents due to greater than 10% missing data. Of the remaining participants, data were discarded from 31 respondents due to ineligibility (not in a monogamous, opposite sex relationship for at least six months). The final data included responses from 270 participants (148 students and 122 non-students). The majority of the sample was female and Caucasian, 62.7% female and 79% Caucasian. The sample was also youthful, 78.2% of the participants were 35 years old or younger, with 30.6% between 18-20 years old. Demographic information on the participants is reported in Table 1.

Table 1

Demographic Characteristics of Student and Non-Student Participants

Demographic	Student	Non-Student	Total
Female	59.9%	67.2%	62.7%
Age			
20 or under	55.4%	.8%	30.6%
21 to 25	26.4%	9.9%	18.8%
26 to 30	6.1%	32.2%	18.5%
31 to 35	4.1%	18.2%	10.3%
36 to 40	2.0%	13.2%	7.0%
41 to 50	5.4%	9.9%	7.4%
51 or over	.7%	15.7%	7.4%
Ethnicity			
African-American	20.5%	3.4%	12.7%
Asian, Pacific Islanders	6.2%	1.7%	4.1%
Caucasian	67.8%	92.4%	79.0%
Hispanic	1.4%	1.7%	1.5%
Other	4.1%	.8%	2.6%

The majority of participants were living with their partner (59.4% cohabitating); 43% were married. Relationship characteristics for participants are reported in Table 2. A comparison of student and non-student relationship characteristics is reported in the Results section (Table 3).

Table 2

Participant Relationship Characteristics

Variable	Percentage
Length of Relationship	
6 months – 1 year	21.7%
2 – 4 years	33.8%
5 – 7 years	12.5%
Longer than 7 years	32.0%
Cohabitating	59.4%
Married	43.0%

Procedure

The study was conducted in accordance with the code of ethics of the American Psychological Association and was approved by the College Human Subjects Committee at the participating university. Data were collected via a one time, self-report on-line survey, approximately 25 minutes in length. Respondents read a detailed description of the study before beginning the survey (see Appendix A). Participation was voluntary and anonymous.

Survey

The online survey consisted of a battery of self-report questionnaires designed to assess the following variables: relationship status, depressive symptoms, self- and partner-attributions, and relationship satisfaction.

In addition to demographic information of gender, age and ethnicity, participants were asked a series of questions regarding relationship status. Participants were asked if they were currently in a relationship (yes/no) and if their partner was "same sex" or "opposite sex." Participants were asked to identify the length of their romantic relationship (1-5 months, 6 months to 1 year, 2 – 4 years, 5 – 7 years, greater than 7 years), cohabitating (yes/no), married (yes/no). Participants were also asked: "Are you currently in therapy for this relationship, or do you plan to seek therapy for this relationship?" "How important is your relationship to you?" (1 (not at all) to 7 (very much)) (Forsterling et al., 2005), and "Do you see yourself in this relationship in 5 years?"

Measures

Center for Epidemiologic Studies – Depression Scales (CES-D; Radloff, 1977; Appendix B*)*. The CES-D is a 20-item measure developed to assess depressive symptoms in a community sample (Radloff, 1977). The CES-D uses items that are rated on a 4- point Likert-type scale indicating how often in the past week the respondent experienced various depressive symptoms (e.g., "How often did you feel like not eating; had a poor appetite?" "How often did you feel like everything you did was an effort."). Responses are summed across items. Total scores range from 0 to 60, with higher scores indicating more depressive symptoms. Scores of 16 or higher indicate possible clinical depression (Radloff, 1977). Studies show that clinically depressed individuals score higher on the CES-D than do nondepressed individuals (Weissman et al., 1996). The CES-D was chosen due to its validity and reliability in the assessment of depressive symptoms within a community sample. In the present study, Cronbach's α for the CES-D was .80.

Dyadic Adjustment Scale (DAS; Spanier, 1976; Appendix C). The DAS is a 32-item self-report measure used to assess relationship quality. The DAS is a widely used self-report measure, which discriminates reliably between distressed and nondistressed partners (Christensen & Heavey, 1999; Gupta, Coyne, & Beach, 2003). The Dyadic Adjustment Scale yields a total score and four subscores reflecting Satisfaction (10 items; e.g., "In general, how often do you think that things between you and your partner are going well?"); Cohesion (5 items; e.g., "Do you and your mate engage in outside interests together?"); Consensus (13 items; e.g., "[To what extent do you agree versus disagree on] handling family finances?"); and Affectional Expression (4 items: e.g.. "[To what extent

do you agree versus disagree on] demonstrations of affection?"). Continuous scales with scores ranging from 0 to 4, 0 to 5, or 0 to 6, as well as categorical items are used. Possible scores on the DAS range from 0 to151, and higher scores indicate greater relationship adjustment. Individuals scoring <100 are commonly categorized as relationally distressed (Knoblock, 2010). In the present study, the participant's total score on the DAS was used as the index of relationship satisfaction. Psychometrical analyses support the reliability and validity of this instrument (Carey, Spector, Lantinga, & Krauss, 1993; Christensen & Heavey, 1999; Eddy, Heyman, & Weiss, 1991; Fisher & Corcoran, 1994; Wampler, Shi, Nelson, & Kimball, 2003). Internal consistency for the DAS was high in the present study with a Cronbach's α of .90.

Relationship Attribution Measure (RAM; Fincham & Bradbury, 1992; Appendix D). The RAM was developed to assess self-reported attributions for partner's behavior, especially for negative relationship events. Stimulus events on the RAM consist of four hypothetical negative partner behaviors (e.g., "your spouse criticizes something you say"). The use of hypothetical behaviors is beneficial due to the standardization of stimuli across participants. Also, the pattern of responses to such behaviors is similar to that found for attributions for real marital difficulties (Fincham & Beach, 1988; Fincham & Bradbury, 1992). Attributions for negative events are used because attributions of negative events appear to be related more consistently and more strongly to marital satisfaction than are attributions for positive events (e.g., Baucom, Epstein, Sayers, & Sher, 1989; Fincham et al., 1987) and are most relevant in the clinical context.

On the RAM, after imagining the occurrence of each of four hypothetical negative relationship events (i.e., criticizing, spending less time, not paying attention, and being

cool and distant), participants are asked to make judgments reflecting three dimensions of causal attribution and three dimension of responsibility attribution. The causal attributions reflect locus, the cause of the behavior within the partner, e.g., the "behavior was due to something about him/her"; stability, the cause persists over time, e.g., ""The reason my partner [behaves in a negative way] is not likely to change"; and globality, the cause affects many areas in the relationship, e.g., "The reason that my partner [behaves in a negative way] affects other areas of our relationship." The three dimensions of responsibility attribution are intentionality, e.g., "My partner [behaves in a negative way] on purpose rather than unintentionally"; selfish intent, e.g., "My partner's behavior was motivated by selfish rather than unselfish concerns"; and blame, e.g., "My partner deserves to be blamed for [negative behavior]." Higher scores in the RAM reflect a tendency to judge the partner's actions critically and to hold the partner responsible for those actions. The higher individuals score on this instrument, the more likely they are to engage in behaviors that hinder the resolution of relationship difficulties (Fincham & Bradbury, 1992). Internal consistency for the RAM in the present study was high; Cronbach's α was .92.

Self-attributions were measured using a modified version of the RAM created to assess judgments of one's own behavior in negative relationship behaviors (Appendix E). Using the modified RAM, participants were asked to rate their own behavior on the same four negative relationship events on which they rated their partners' behavior. Participants then made judgments of their own behavior, again rating each behavior on the three dimensions of causality (locus, stability, and globality) and the three dimensions

of responsibility (intentionality, selfishness, blameworthiness). Cronbach's α for the Self-RAM was .89.

The presentation of the questions regarding self-attributions and partner-attributions was randomly counterbalanced. Half of the participants completed the partner-attribution measure prior to completing the self-attribution measure. Half of the participants completed self-attributions questions prior to completing the partner-attribution questions. No significant difference was found for presentation style.

Statistical Analyses

The Pearson product-moment correlation was used to test H1 - H5 and prior to performing multiple regression for meditational analyses (H6). Pearson's (r) determined whether there was a significant relationship between the two variables examined in each correlation. Bon Ferroni correction was used to account for multiple comparisons. An acceptable p value of .05 was divided by the number of comparisons (5), resulting in a new p value of .01.

To test for mediational pathways as described in hypotheses H6, it was necessary for four conditions to be fulfilled (Baron & Kenny, 1986; Holmbeck, 1997, 2002). Depressive symptoms were entered in to the equation first. Depressive symptoms had to be significantly associated with the hypothesized mediators (self- and partner-attributions). Second, depressive symptoms had to be significantly associated with relationship satisfaction. Third, self- and partner-attributions had to be significantly associated with relationship satisfaction. In a fourth step, the impact of depressive symptoms on relationship satisfaction had to be less after controlling for self- and

partner-attributions. These conditions would be assessed with multiple regression analyses (see Holmbeck, 1997, 2002). To determine whether the total effect of depressive symptoms on relationship satisfaction was reduced significantly upon introduction of self- and partner-attributions, Sobel's (1982, 1988) significance test would be used. The percentage of the total effect mediated would also be computed (Holmbeck, 2002).

There are several issues and assumptions that were accounted for prior to the use of multiple regression: (1) Outliers can greatly impact the regression equation and affect the precision of the estimation of regression weights (Tabachnick & Fidell, 2001). Outliers were deleted or Winsorized before performing a multiple regression. Winsorized refers to replacing the highest and lowest scores with adjacent values from the remaining data (Barnett & Lewis, 1994); (2) An assumption of multiple regression is the absence of multicollinearity and singularity. Prior to performing multiple regression, variables were checked for multicollinearity and singularity. No variables were found to have correlations > /.9/, and therefore, no variables were deleted or collapsed; (3) There is no assumption that variables must be normal to perform a multiple regression, but the prediction equation is enhanced if the IVs are normally distributed. The residual statistics in SPSS were examined to assess for normality prior to performing the multiple regression. (4) There should be linearity between variables. Scatterplots were examined to assess for linearity. (5) Heteroscedasticity can occur if variables are skewed. No variables were found to be skewed and, therefore, were not transformed or eliminated. Regarding causation in the present study, as this study was cross-sectional and utilized correlational data, quantitative information regarding the strength of the association

between relationship satisfaction, depressive symptoms and attributions was gained, but the results of the present study are not sufficient to ascertain the existence of a causal relationship between the variables studied.

CHAPTER III

RESULTS

Preliminary Analyses

Prior to conducting the primary analyses, the data were checked for missing values. Of the respondents, 13.5% had missing data for more than 10% of the responses. Data for the respondents with more than 10% missing data were not included in any analysis. Of the 270 remaining eligible participants, some respondents did not answer questions on one or more of the measures leading to approximately 1% missing data points. Individual missing data points were replaced with the series mean for each of the subscales, respectively.

Scores were then tested for linearity, skewness, and kurtosis. None of the measures were found to be skewed or kurtotic (>/2/). Eight outliers (4 CES-D scores, 2 DAS scores, 1 RAM, 1 Self-RAM) over three standard deviations from the mean were replaced with adjacent values from the remaining data (Barnett & Lewis, 1994). The eight outliers were scores from eight different participants. Internal consistency was calculated for all measures and, as reported in the Method section, all alphas were found to be acceptable.

Participants were solicited from two different sampling methods to increase diversity in demographic and relationship variables and so that comparisons could be made between the two groups. Student and non-student sampling groups were compared on relationship variables and on each of the measures. For students, 10.17% had been in their relationship for 7 years or longer, while 59% of non-students had been

in their relationship for 7 years or longer. The length of the non-student relationships was significantly longer than student relationships, χ^2 (3) = 90.59, $p < .001$. Non-students were also significantly more likely to be married, χ^2 (1) = 91.34, $p < .001$. 16.9% of students were married and 75% of non-students were married. Of the student group, 90% saw themselves in the relationship in 5 years, and 99.2% of the non-student group saw themselves in the relationship in 5 years. Comparing the student and non-student subsamples, significantly more non-students saw themselves in the relationship in 5 years than students, χ^2 (1) = 10.41, $p < .01$. Student and non-student groups were also compared on the question "How important is your relationship to you?" The student mean on this question was 6.4; non-student mean was 6.9. Comparing the student and non-student means shows that non-students report that their relationship is significantly more important to them than students, $t(266) = -5.85$, $p < .001$.

Table 3

Relationship Characteristics of Student and Non-Student Participants

Variable	Student	Non-Student
Length of Relationship		
6 months – 1 year	36.5%	4.1%
2 – 4 years	43.2%	23.0%
5 – 7 years	10.1%	13.9%
Longer than 7 years	10.1%	59.0%
Cohabitating	31.3%	92.6%
Married	16.9%	75.0%

Students reported significantly more depressive symptoms than non-students, $t(268) = 3.08, p < .01$. Non-students reported significantly more negative self-attributions than students, $t(268) = -2.09, p < .05$. Non-students' self-attribution scores were more negative than non-student partner-attributions, while students' self- and partner-attributions were similar, although student partner-attributions are slightly more negative than student self-attributions. Comparisons for student and non-student groups on each of the measures are presented in Table 4.

Table 4

Between Group Comparisons for Students and Non-Students

Measure	Sample Group Mean		*T*	*P*
	Student	Non-Student		
CES-D	19.14	16.76	3.08	.002**
Self-RAM	73.43	77.20	-2.09	.04*
RAM	74.66	72.14	1.18	.24
DAS	115.19	116.79	-.97	.33

* $p < .05$
** $p < .01$

Pearson Correlations for All Participants

Hypothesis 1 stated that depressive symptoms would be negatively associated with relationship satisfaction. To examine this hypothesis, a Pearson correlation was computed for CES-D total score and DAS total score. Support was found for this hypothesis. Depressive symptoms, as measured by the CES-D were significantly and negatively associated with relationship satisfaction, as measured by DAS score, $r(270) = -.30, p < .01$.

Hypothesis 2 stated that depressive symptoms would be positively associated with self-attributions for relationship problems. To examine this hypothesis, a Pearson correlation was computed for CES-D total score and Self-RAM total score. This hypothesis was not supported, $r(270) = .03$, *ns*. Depressive symptoms and self-attributions for relationship problems were not found to be significantly associated.

Hypotheses 3 stated that self-attributions for relationship problems would be negatively associated with relationship satisfaction. To examine this hypothesis, a Pearson correlation was computed for Self-RAM total score and DAS total score. This hypothesis was supported. Self-attributions were significantly and negatively associated with relationship satisfaction, $r(270) = -.25, p < .01$.

Hypothesis 4 stated that depressive symptoms would be positively associated with partner-attributions for relationship problems. To examine this hypothesis, a Pearson correlation was computed for CES-D total score and RAM total score. This hypothesis

was not supported. Depressive symptoms were not significantly associated with partner-attributions for relationship problems, $r(270) = .10$, *ns*.

Hypothesis 5 stated that partner-attributions for relationship problems would be negatively associated with relationship satisfaction. To examine this hypothesis, a Pearson correlation was computed for RAM total scores and DAS total scores. This hypothesis was supported. Partner-attributions for relationship problems were negatively and significantly associated with relationship satisfaction, $r(270) = -.36$, $p < .01$.

Hypothesis 6 could not be examined because the conditions for mediation were not fulfilled. To test for mediational pathways as described in hypotheses H6, it was necessary for depressive symptoms to be significantly associated with the hypothesized mediators (self- and partner-attributions). However, depressive symptoms were not found to be significantly related to partner-attributions or self-attributions. The intercorrelations for depressive symptoms, self- and partner-attributions, and relationship satisfaction are presented in Table 5.

Table 5

Depressive Symptoms, Self- and Partner-Attributions, and Relationship Satisfaction Correlations

Measure *SD*	1	2	3	4	Mean
1. Depressive Symptoms 6.42	-----				18.1
2. Self-Attributions 14.83	.03	-----			75.1
3. Partner-Attributions 17.47	.10	.56**	-----		73.5
4. Relationship Satisfaction 13.56	-.30**	-.25**	-.36**	-----	115.9

**$p<.01$

Pearson Correlations for Non-Students

Pearson Correlations were also done to examine difference in student and non-student groups for Hypothesis 1-5. A Pearson correlation was computed for CES-D total score and DAS total score for the non-student group. Depressive symptoms, as measured by the CES-D were significantly and negatively associated with relationship satisfaction, as measured by DAS score, $r(122) = -.30, p < .01$.

A Pearson correlation was computed for CES-D total score and Self-RAM total score for the non-student group. Depressive symptoms and self-attributions for relationship problems were not found to be significantly associated for non-students, $r(122) = .16$, *ns*.

A Pearson correlation was computed for Self-RAM total score and DAS total score for non-students. Self-attributions were significantly and negatively associated with relationship satisfaction, $r(122) = -.24, p < .01$.

A Pearson correlation was computed for CES-D total score and RAM total score for non- students. Depressive symptoms were not significantly associated with partner-attributions for relationship problems for non-students, $r(122) = -.01$, *ns*.

A Pearson correlation was computed for RAM total scores and DAS total scores for the non-student group. Partner-attributions for relationship problems were negatively and significantly associated with relationship satisfaction, $r(122) = -.29, p < .01$. The intercorrelations for depressive symptoms, self- and partner-attributions are presented in Table 6.

Table 6

Depressive Symptoms, Self- and Partner-Attributions, and Relationship Satisfaction Correlations for Non-Students

Measure	1	2	3	4	Mean *SD*
1. Depressive Symptoms	-----				16.8 5.50
2. Self-Attributions	.16	-----			77.2 14.30
3. Partner-Attributions	- .01	.58**	-----		72.1 16.71
4. Relationship Satisfaction	-.30**	-.24**	-.29**	-----	116.8 12.68

**$p<.01$

Pearson Correlations for Students

A Pearson correlation was computed for CES-D total score and DAS total score for the student group. Depressive symptoms, as measured by the CES-D were significantly and negatively associated with relationship satisfaction, as measured by DAS score, $r(148) = -.29, p < .01$.

A Pearson correlation was computed for CES-D total score and Self-RAM total score for the student group. Depressive symptoms and self-attributions for relationship problems were not found to be significantly associated for students $r(148) = -.00$, *ns*.

A Pearson correlation was computed for Self-RAM total score and DAS total score for students. Self-attributions were significantly and negatively associated with relationship satisfaction, $r(148) = -.28, p < .01$.

A Pearson correlation was computed for CES-D total score and RAM total score for students. Depressive symptoms were significantly positively associated with partner-attributions for relationship problems, $r(148) = .18, p < .05$. Of note, depressive symptoms and partner-attributions were not significantly associated for the non-student group.

A Pearson correlation was computed for RAM total scores and DAS total scores for the student group. Partner-attributions for relationship problems were negatively and significantly associated with relationship satisfaction, $r(148) = -.41, p < .01$. The intercorrelations for depressive symptoms, self- and partner-attributions, and relationship satisfaction for students are shown in Table 7.

Table 7

Depressive Symptoms, Self- and Partner-Attributions, and Relationship Satisfaction Correlations for Students

Measure	1	2	3	4	Mean *SD*
1. Depressive Symptoms	-----				19.3 7.24
2. Self-Attributions	- .00	-----			73.5 15.28
3. Partner-Attributions	.18*	.62**	-----		74.7 18.26
4. Relationship Satisfaction	-.29**	-.28**	-.41**	-----	115.1 14.65

**$p<.01$, *$p<.05$

Multiple Regression Analyses for Predictors of Relationship Satisfaction

Depressive symptoms, self-attributions and partner-attributions were examined as predictors of relationship satisfaction. The combination of the three predictor variables was significant, $F(3, 266) = 22.44$, $p < .001$, $R = .45$ and Adjusted $R^2 = .19$. When the individual predictors were examined, only depressive symptoms and partner-attributions were found to be significant predictors (depressive symptoms: $t(266) = -4.77$, $p < .001$, $\beta = -.26$; partner-attributions: $t(266) = -4.40$, $p < .001$, $\beta = -.30$). Specifically, higher levels of depressive symptoms and partner-attributions predict lower levels of relationship satisfaction. The summary of the multiple regression analysis for predictors of relationship satisfaction are presented in Table 8.

Table 8

Multiple Regression Summary for Prediction of Relationship Satisfaction

Variable	B	β	*T*	*P*
Depressive Symptoms	-.55	-.26	-4.77	.000
Self-Attributions	-.06	-.01	-1.03	*ns*
Partner Attributions	-.23	-.30	-4.40	.000

Note: R = .45 and Adj. R^2 = .19 (N = 270, $p < .001$).

Hierarchical Multiple Regression for Predictors of Relationship Satisfaction for Students

Performing separate correlations for student and non-student groups revealed that depressive symptoms were significantly correlated with partner-attributions for students. Partner-attributions were also significantly correlated with relationship satisfaction. Therefore, the conditions were met to perform a meditational analysis for partner-attributions in the depressive symptom-relationship satisfaction association for students.

In order to perform the meditation analysis, a hierarchical multiple regression analysis was conducted. Depressive symptoms, as measured by CES-D scores, were entered in the first step. Partner-attribution scores were entered in the second step. The dependent variable was relationship satisfaction. Step 1 was significant, such that depressive symptoms significantly predicted relationship satisfaction, $F(1, 146) = 12.92$, $p < .001$, $R = .29$, $R^2 = .09$. The second step was also significant. That is, partner-attributions predicted relationship satisfaction, $F(2, 145) = 19.59$, $p < .001$, $R = .46$, $R^2 = .21$. When examining the individual predictors separately, both depressive symptoms and partner-attributions significantly predicted relationship satisfaction (depressive symptoms: $t(146) = -2.91$, $p < .005$, $\beta = -.22$; partner-attributions: $t(146) = -4.92$, $p < .001$, $\beta = -.37$). The beta for depressive symptoms decreased somewhat in the second step from -.29 to -.22. Sobel test was used to assess whether partner-attributions carries the influence of depressive symptoms to relationship satisfaction. The Sobel's test statistic = 2.50, standard error = 0.052, $p < .05$. Holmbeck's indirect effect was also significant, $z = -14.19$, $p < .05$. Therefore, significant partial mediation, rather than full mediation, was supported. In other words, the beta of depressive symptoms decreased when partner-attribution was entered into the equation, but the depressive symptoms beta

remained significant in the second step (see Table 9).

Table 9

Hierarchical Multiple Regression Summary for Depressive Symptoms and Partner-Attribution in the Prediction of Relationship Satisfaction for Students

Variable	β	R	R^2	R^2 change	F	*t*
Step 1		.29	.08	-	12.92**	
Depressive Symptoms	-.29					-3.59**
Step 2		.46	.21	.08	19.59**	
Depresssive Symptoms	-.22					-2.91*
Partner Attributions	-.37					-4.92**

N = 147
**$p < .001$
*$p < .005$

CHAPTER IV

DISCUSSION

The present study examined the association between depressive symptoms, self- and partner-attributions, and relationship satisfaction. In addition, the present study aimed to examine whether self- and partner-attributions mediated the association between depressive symptoms and relationship satisfaction. It was expected that depressive symptoms would be negatively associated with relationship satisfaction. It was also expected that depressive symptoms would be positively associated with self- and partner-attributions.

Depressive Symptoms and Relationship Satisfaction

It is widely accepted that depressive symptoms are associated with relationship satisfaction (for review, Whisman, 2001). Therefore, in the present study, it was predicated that depressive symptoms would be negatively associated with relationship satisfaction. This prediction was supported. Depressive symptoms were significantly negatively associated with relationship satisfaction for both subsamples. This finding adds to the current literature demonstrating the link between depressive symptoms and relationship satisfaction in a mixed sample of both dating and married participants. Much of the previous literature has focused exclusively on married participants.

Depressive Symptoms and Self- and Partner-Attributions

The association between self-attributions and depression has been exhibited in many studies (for reviews, see Peterson, Meier, & Seligman, 1993; Sweeney, Anderson,

& Bailey, 1986). Attributional models of depression predict that depressed individuals attribute negative events to internal, stable, and global causes. The present study is the first known study to examine depressive symptoms and self-attributions in the context of relationship events. Self-attributions were measured with a modified version of the RAM. The Self-RAM was found to be highly internally consistent with a Cronbach's α of .89. Self- and partner-attributions were found to be moderately positively correlated (r = .60). Although self- and partner-attributions were moderately correlated, with approximately 40% overlap (r^2 = .36), they can be considered to be distinct constructs because $r < .9$. Nevertheless the tendency to make person-centered, stable, and global causal attributions and intentional, selfish, and blameworthy responsibility attributions appears to be consistent whether the person held attributable is self or partner.

In the current study, partner-attributions were not significantly associated with depressive symptoms for the whole group or the non-student subsample. However, depressive symptoms were found to be significantly positively correlated with partner-attributions for the student group. The failure to find a significant correlation between depressive symptoms and partner-attributions for the whole group is contrary to previous findings. Gordon et al. (2006) and Heene et al. (2005, 2007) found significant positive correlations between depressive symptoms and partner-attributions. It is difficult to assess the reason for the difference between student and non-student groups on the association between depressive symptoms and partner-attributions. One potential reason for this difference may be related to differences in investment or commitment to the relationship. The student group reported their relationships to be significantly less important to them than the non-student group. It possible that because the students are

less committed to their relationships, as depressive symptoms increase, they may be more likely to make negative attributions about partner behavior because they are less invested in shielding their partner from blame, consequently viewing partner's behavior to be due to causes internal to the partner, stable, global, intentional, and blameworthy. While the non-students' higher level of investment in the relationship may serve as a kind of buffer against the impact of depressive symptoms on partner-attributions.

In the current study, depressive symptoms were not found to be significantly associated with self-attributions of relationship events for the total group or either of the subgroups. The lack of significant associations between depressive symptoms and self-attributions is surprising because self-attributions were hypothesized to be associated with depressive symptoms based on attributional models of depression. It is possible that thoughts about one's own behavior in relationship events are not associated with depressive symptoms in the same way that one's thoughts about one's behavior in other circumstances. For example, depressive symptoms have been found to be significantly associated with attributional style, as measured by the Attributional Style Questionnaire (ASQ). However, the ASQ asks about a variety of hypothetical situations, related to one's own behavior, the behavior of others, and chance occurrences. The ASQ contains only one hypothetical event about a long-term romantic relationship (out of 12 events). Furthermore, this event is positive, rather than negative. It is likely then that depressive symptoms may be associated with attributions as measured by the ASQ, but not the Self-RAM because the ASQ and the Self-RAM measure different constructs. The Self-RAM specifically examines attributions for one's own negative relationship behavior, while the ASQ measures an overall attributional style. One's attributions for one's own behaviors

in negative relationship events may not be significantly associated with depressive symptoms. One's self-attributions for one's behaviors in relationship events appear to be associated more with relationship satisfaction than depressive symptoms.

Self- and Partner-Attributions and Relationship Satisfaction

Studies have repeatedly found an association between relationship satisfaction and attributions for relationship events (for review, Bradbury & Fincham, 1990). Relationship-enhancing attributions occur most often in satisfied couples. While, dissatisfied/distressed couples most often make distress-maintaining interpretations. Based on previous research, it was predicted that both self- and partner-attributions would be negatively associated with relationship satisfaction. This prediction was supported. In the present study, increased self- and partner-attributions were associated with decreased relationship satisfaction. The more negative the attributions about self- and partner-behavior, the more relationally dissatisfied the participants were. This finding adds to previous studies of partner-attribution and relationship satisfaction by showing that one's thoughts about one's own behavior are also related to relationship satisfaction. This finding is noteworthy in that not only are those who tend to view their partners' behavior negatively dissatisfied, but so are those who view their own behavior negatively. That is, decreased relationship satisfaction is associated with an increased tendency to view one's own negative relationship behavior as the result of characteristics internal to one's self, that are not likely to change, that effect other areas of the relationship, that were done intentionally, for selfish reason, and deserve blame.

Attributions and the Relationship Satisfaction-Depressive Symptoms Link

Attributions have been found to be associated with both relationship satisfaction and depression. While depressed individuals tend to attribute negative events (personal failures) to causes internal to self, stable, and global (Abramson et al., 1978), stable and global attributions for one's partner's negative behaviors have been found to predict increased relationship distress (Fincham & Bradbury, 1993). The results of Heene et al. (2005, 2007) demonstrated that the relationship between depressive symptoms and marital adjustment was accounted for by causal attributions. Although, others (e.g., Gordon et al.; 2005) did not find support for such mediation. Furthermore, no studies have examined how attributions of both self and partner relate to relationship satisfaction and depressive symptoms.

Based on limited previous research on this topic, it was hypothesized that self- and partner-attributions would mediate the relationship between depressive symptoms and relationship satisfaction, such that depressive symptoms would not predict relationship satisfaction above the contribution of self- and partner attributions. This hypothesis could not be examined as the conditions for this mediation relationship were not supported; depressive symptoms were not significantly associated with the proposed mediators, self- and partner-attributions. When the results of the multiple regression were examined, depressive symptoms and partner-attribution were significant predictors of relationship satisfaction, but self-attribution was not.

For the entire sample as a whole, depressive symptoms were not significantly associated with self- or partner-attributions. This was also true for the subsample of non-students, but this was only partially true for the subsample of students. For students,

partner-attributions were significantly associated with both depressive symptoms and relationship satisfaction. Therefore, the conditions of partner-attribution as a potential mediator of depressive symptom-relationship satisfaction association were met and assessed. Partner attributions were found to significantly partially mediate the depressive symptom-relationship satisfaction association. That is, the contribution of depressive symptoms to relationship satisfaction decreased after the contribution of partner-attribution was taken into account. However, depressive symptoms were still a significant predictor of relationship satisfaction even when partner-attributions were taken into account. This finding is consistent with those of Heene et al. (2005; 2007), which demonstrated that the relationship between depressive symptoms and marital adjustment was accounted for by causal partner-attributions.

Clinical Implications

In the current study, depressive symptoms were not associated with how one views oneself in negative relationship events, although one's attributions about one's partner's behavior were associated with depressive symptoms for a student sample. The current results demonstrate that increased benign or positive attributions for partner relationship behaviors are associated with decreased depressive symptoms. It may, therefore, be helpful for treatment providers to draw attention to cognitive processes related to how depressive individuals view their partners' behaviors.

Attributions of both self and partner were significantly associated with relationship satisfaction, suggesting that cognitive interventions for relationship difficulties in couples counseling may be helpful. This study uniquely contributes

knowledge of a significant association between self-attributions and relationship satisfaction, which has previously received little attention. The current results show that increasing benign or positive attributions for both self- and partner relationship behavior may be related to increased relationship satisfaction.

The current study replicated numerous previous studies which have found depressive symptoms and relationship satisfaction to be significantly negatively correlated. This finding reinforces the potential benefits of the treatment of both depressive symptoms and relationship dissatisfaction, as changes in depressive symptoms are associated with changes in relationship satisfaction and changes in relationship satisfaction are associated with changes in depressive symptoms.

Study Limitations and Future Directions

There are some noteworthy limitations in the present study. First, the present study used self-report, which may not be an accurate representation of attributions. The biases of self-report, such as portraying oneself in an overly positive fashion, should not be ignored.

Second, self-attributions were assessed using a modified version of the RAM. Although the RAM has shown to be a valid and reliable measure of partner-attributions, the validity of the Self-RAM, created for this study, are unknown. Although there was high internal consistency for the Self-RAM in the present study, it is possible that an individual's thinking about him/herself may not be validly captured through the Self-RAM. Previously studied self-attribution measures, such as the Attribution Style Questionnaire (ASQ; Peterson et al., 1982) may more accurately capture an individual's thinking about one's self. Although this measure does not exclusively ask about one's

thoughts about one's behavior in relationship activities, it may be beneficial for future research to compare the Self-RAM to a stronger measure of one's thoughts about the self in general.

CHAPTER V

SUMMARY AND CONCLUSION

The present anonymous survey research collected data from a student and community sample. Correlations between depressive symptoms, relationship satisfaction and self- and partner-attributions were examined. Depressive symptoms and self- and partner-attributions as predictors of relationship satisfaction were also examined. Depressive symptoms were significantly negatively correlated with relationship satisfaction and self- and partner-attributions were significantly negatively correlated with relationship satisfaction. The results of multiple regression analyses indicated that partner-attributions accounted for the most unique variance in relationship satisfaction. Depressive symptoms were also found to account for a significant amount of unique variance in relationship satisfaction.

Future research may seek to validate the Self-RAM by comparing Self-RAM and a validated self-attribution measure, such as the Attribution Style Questionnaire (ASQ; Peterson et al., 1982). The current study does not provide evidence that one's attributions of one's own behavior in relationship events are significantly associated with depressive symptoms. However, it is difficult to determine whether the lack of significant findings is due to a true lack of association or potential flaws of the Self-RAM. Further validity testing of the Self-RAM may provide more information regarding the current study. Comparing the Self-RAM with a reliable and valid measure such as the ASQ may increase understanding of how one's view of one's role in a romantic relationship is potentially associated with depressive symptoms.

The present study has practical applications for individuals experiencing depressive symptoms and relationship dissatisfaction. Clinicians working with dissatisfied partners should screen for depressive symptoms. Targeted interventions aimed at reducing depressive symptoms may serve to increase relationship satisfaction. Furthermore, exploration of cognitions related to self- and partner-behavior is important to expose potentially negative attributions of ambiguous situations which may be replaced through cognitive interventions with positive attributions. Decreasing negative self-and partner-attributions may predict increased relationship satisfaction.

REFERENCES

Abramson, L. Y., Seligman, M. E., & Teasdale, J. D. (1978). Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology, 87*, 49-74.

Amato, P. R., Booth, A. (2000). A generation at risk: Growing up in an era of family upheaval. Cambridge, MA: Harvard University Press.

Barnett, V. & Lewis, T. (1994). *Outliers in statistical data* (3rd ed.). New York: Wiley.

Baron, R. M. & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality & Social Psychology, 51*, 1173-1182.

Basco, M. R., Prager, K. J., Pita, J. M., Tamir, L. M., & Stephens, J. J. (1992). Communication and intimacy in the marriages of depressed patients. *Journal of Family Psychology, 6*, 184-194.

Baucom, D. H. (1987). Attributions in distressed relations: How can we explain them? In S. Duck & D. Perlman (Eds.), *Intimate relationships: Development, dynamics, and deterioration* (pp. 177-206). London: Sage.

Baucom, D. H., Epstein, N., Sayers, S. L., & Sher, T. G. (1989). The role of cognitions in marital relationships: Definitional, methodological, and conceptual issues. *Journal of Consulting & Clinical Psychology, 57*, 31-38.

Beach, S. R. (2001). Marital therapy for co-occurring marital discord and depression. In: S.R. Beach (Ed.), *Marital and family processes in depression: A scientific*

foundation for clinical practice. (pp. 205-224). Washington, DC: American Psychological Association.

Beach, S. R., Jouriles, E. N., & O'Leary, K. D. (1985). Extramarital sex: Impact on depression and commitment in couples seeking marital therapy. *Journal of Sex and Marital Therapy, 11*, 99-108.

Beach, S. R., Katz, J., Kim, S, & Brody, G. H. (2003). Prospective effects of marital satisfaction on depressive symptoms in established marriages: A dyadic model. *Journal of Social and Personal Relationships, 20*, 355-371.

Beach, S. R. & Nelson, G. M. (1990). Pursuing research on major psychopathology from a contextual perspective: The example of depression and marital discord. In G. H. Brody, & I. E. Sigel (Eds.), *Methods of family research: Biographies of research projects: Vol. 2. Clinical populations* (pp. 227-259). Hillsdale, NJ, England: Lawrence Erlbaum Associates, Inc.

Beach, S. R. & O'Leary, K. D. (1992). Treating depression in the context of marital discord: Outcome and predictors of response of marital therapy versus cognitive therapy. *Behavior Therapy, 23*, 507-528.

Beach, S. R., & O'Leary, K. D. (1993a). Marital discord and dysphoria: For whom does the marital relationship predict depressive symptomatology? *Journal of Social and Personal Relationships, 10*, 405-420.

Beach, S. R., & O'Leary, K. D. (1993b). Dysphoria and marital discord: Are dysphoric individuals at risk for marital maladjustment? *Journal of Marital and Family Therapy, 19*, 355-368.

Beach, S. R., Sandeen, E. E., & O'Leary, K. D. (1990). *Depression in marriage: A model for etiology and treatment.* New York: Guilford Press.

Beekman, A. T., Geerlings, S. W.; Deeg, D. J., Smit, J. H., Schoevers, R. S., de Beurs, E., et al. (2002). The natural history of late-life depression: A 6-year prospective study in the community. *Archives of General Psychiatry, 59*, 605-611.

Bradbury, T., Beach, S., Fincham, F., & Nelson, G. (1996). Attributions and behavior in functional and dysfunctional marriages. *Journal of Consulting and Clinical Psychology, 64*, 569-576.

Bradbury, T. N., & Fincham, F. D. (1990). Attributions in marriage: Review and critique. *Psychological Bulletin, 107*, 3-33.

Bradbury, T. N. & Fincham, F. D. (1993). Assessing dysfunctional cognition in marriage: A reconsideration of the Relationship Belief Inventory. *Psychological Assessment, 5*, 92-101.

Bramlett, M. D. & Mosher, W. D. (2001). First marriage dissolution, divorce, and remarriage: United States. *Advanced data from vital and health statistics: no. 323.* Hyattsville, MD: National Center for Health Statistics.

Brown, G. W. & Harris, T. (1978). *Social Origins of Depression.* London: Tavistock Publications Ltd.

Burns, D. D., Sayers, S. L., & Moras, K. (1994). Intimiate relationships and depression: Is there a causal connection? *Journal of Consulting and 1Clinical Psychology, 62*, 1033-1043.

Cano, A., & O'Leary, K. D. (2000). Infidelity and separations precipitate major depressive episodes and symptoms of nonspecific depression and anxiety. *Journal of Consulting and Clinical Psychology, 68*, 774-781.

Caplan, G. (1974). Support systems and community mental health: Lectures on concept development. Pasadena, CA: Behavioral Publications.

Carey, M. P., Spector, I., P., Lantinga, L. J., & Krauss, D. J. (1993). Reliability of the Dyadic Adjustment Scale. *Psychological Assessment, 5*, 238-240.

Chen, L. S., Eaton, W. W., Gallo, J. J., Nestadt, G., & Crum, R. M. (2000). Empirical examination of current depression categories in a population-based study: Symptoms, course, and risk factors. *The American Journal of Psychiatry, 157*, 573-580.

Christensen, A. & Heavey, C. L. (1999). Interventions for couples. *Annual Review of Psychology, 50*, 165-190.

Copeland, J. R., Chen, R., Dewey, M. E., McCracken, C. F., Gilmore, C., & Larkin, B. (1999). Community-based-case-control study of depression in older people: Cases and sub-cases from the MRC-ALPHA study. *British Journal of Psychiatry, 175*, 340-347.

Davila, J. (2001). Paths to Unhappiness: The overlapping courses of depression and relationship dysfunction. In S. R. Beach (Ed.), *Marital and family processes in depression: A scientific foundation for clinical practice* (pp. 71-88). Washington, DC: American Psychological Association.

Davila, J., Bradbury, T. N. Cohan, C., & Tochluk, S. (1997). Marital functioning and depressive symptoms: Evidence for a stress generation model. *Journal of Personality and Social Psychology, 73*, 849-861.

Davila, J., Karney, B. R., Hall, T. W., & Bradbury, T. N. (2003). Depressive symptoms and marital satisfaction: Within-subject associations and the moderating effects of gender and neuroticism, *Journal of Family Psychology, 17*, 557-570.

Diener, E. (1984). Subjective well-being. *Psychological Bulletin, 95*, 542-575.

Eddy, J. M., Heyman, R. E., & Weiss, R. L. (1991). An empirical evaluation of the dyadic adjustment scale: Exploring the differences between marital 'satisfaction' and 'adjustment.' *Behavioral Assessment, 13*, 199-220.

Epstein, N. & Eidelson, R. J. (1981). Unrealistic beliefs of clinical couples: Their relationship to expectations, goals and satisfaction. *American Journal of Family Therapy, 9*, 13-22.

Fichten, C. S. (1984). See it from my point of view: Videotape and attributions in happy and distressed couples. *Journal of Social & Clinical Psychology, 2*, 125-142.

Fincham, F. D. (1985). Attribution processes in distressed and nondistressed couples: 2. Responsibility for marital problems. *Journal of Abnormal Psychology, 94*, 183-190.

Fincham, F. D., & Beach, S. R. (1988). Attribution processes in distressed and nondistressed couples: V. Real versus hypothetical events. *Cognitive Therapy and Research, 5*, 505-514.

Fincham, F. D., Beach, S. R., & Baucom, D. H. (1987). Attribution processes in distressed and nondistressed couples: IV. Self-partner attribution differences. *Journal of Personality & Social Psychology, 52,* 739-748.

Fincham, F. D., Beach, S. R., & Bradbury, T. N. (1989). Marital distress, depression, and attributions: Is the marital distress-attribution association an artifact of depression? *Journal of Consulting and Clinical Psychology, 57*, 768-771.

Fincham, F. D., Beach, S. R., Harold, G. T., & Osborne, L. N. (1997). Marital satisfaction and depression: Different causal relationships for men and women? *Psychological Science, 8*, 351-357.

Fincham, F. D. & Bradbury, T. N. (1987). The impact of attributions in marriage: A longitudinal analysis. *Journal of Personality & Social Psychology, 53*, 510-517.

Fincham, F. D. & Bradbury, T. N. (1988). The impact of attributions in marriage: Empirical and conceptual foundations. *British Journal of Clinical Psychology, 27*, 77-90.

Fincham, F. D. & Bradbury, T. N. (1992). Assessing attribution in marriage: The Relationship Attribution Measure. *Journal of Personality and Social Psychology, 62*, 457-468.

Fincham, F. D., & Bradbury, T. N. (1993). Marital satisfaction, depression, and attributions: A longitudinal analysis. *Journal of Personality and Social Psychology, 64*, 442-452.

Fincham, F. D., Harold, G. T., & Gano-Phillips, S. (2000). The longitudinal association between attributions and marital satisfaction: Direction of effects and role of efficacy expectations. *Journal of Family Psychology, 14*, 267-285.

Fisher, M. B. & Corcoran, K. (1994). *Measurement for clinical practice: Vol. 1 Couples, families and children* (2nd ed.). New York: Free Press.

Fletcher, G. J., Fincham, F. D., Cramer, L., & Heron, N. (1987). The role of attributions in the development of dating relationships. *Journal of Personality & Social Psychology, 53*, 481-489.

Försterling, F., Schuster, B., & Morgenstern, M. (2005). Perspectives of causal attributions: A study of couples and depression. *Journal of Social & Clinical Psychology, 24*, 793-810.

Goldney, R. D., Fisher, L. J., Dal Grande, E. T., & Taylor, A. W. (2004). Subsyndromal depression: Prevalence, use of health services and quality of life in an Australian population. *Social Psychiatry and Psychiatric Epidemiology, 39*, 293-298.

Gordon, K. C., Friedman, M. A., Miller, I. W., & Gaertner, L. (2005). Marital Attributions as moderators of the marital discord-depression link. *Journal of Social and Clinical Psychology, 24*, 876-893.

Gotlib, I. H., & Beach, S. R. (1995). A marital/family discord model of depression: Implication for therapeutic intervention. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of couple therapy* (pp. 411-436). New York: Guilford Press.

Gotlib, I. H., Lewinsohn, P. M., & Seeley, J. R. (1998). Consequences of depression during adolescence: Marital status and marital functioning in early adulthood. *Journal of Abnormal Psychology, 107*, 686-690.

Gotlib, I. H. & Whiffen, V. E. (1989). Depression and marital functioning: An examination of specificity and gender differences. *Journal of Abnormal Psychology, 98*, 23-30.

Gupta, M., Coyne, J. C., & Beach, S. R. (2003). Couples treatment for major depression: Critique of the literature and suggestions for some different directions. *Journal of Family Therapy, 25*, 317-346.

Heene, E. L., Buysse, A., & Van Oost, P. (2005). Indirect pathways between depressive symptoms and marital distress: The role of conflict communication, attributions, and attachment style. *Family Process, 44*, 413-440.

Heene, E. L. D., Buysse, A., & Van Oost, P. (2007). An interpersonal perspective on depression: The role of marital adjustment, conflict communication, attributions, and attachment within a clinical sample. *Family Process, 46*, 499-514.

Heider, F. (1958). *The psychology of interpersonal relations.* Hoboken, NJ: John Wiley & Sons Inc.

Heim, S. C., & Snyder, D. K. (1991). Predicting depression from marital distress and attributional processes. *Journal of Marital and Family Therapy, 17*, 67-72.

Hiroto, D. S. (1974). Locus of control and learned helplessness. *Journal of Experimental Psychology, 102*, 187-193.

Hollist, C. S., Miller, R. B., Falceto, O. G., & Fernandes, C. L. (2007). Marital satisfaction and depression: A replication of the marital discord model in a Latino sample. *Family Process, 46*, 485-498.

Holmbeck, G.N. (1997). Toward terminological, conceptual, and statistical clarity in the study of mediators and moderators: Examples from the child-clinical and pediatric psychology literatures. *Journal of Consulting & Clinical Psychology, 65*, 599-610.

Holmbeck, G.N. (2002). Post-hoc probing of significant moderational and meditational effects in studies of pediatric populations. *Journal of Pediatric Psychology, 27, 87-96.*

Holtzworth-Munroe, A. & Jacobsen, N. S. (1985). Causal attributions of married couples: When do they search for causes? What do they conclude when they do? *Journal of Personality & Social Psychology, 48*, 1398-1412.

Ilfeld, F. W. (1977). Current social stressors and symptoms of depression. *The American Journal of Psychiatry, 134*, 161-166.

Jacobsen, N. S., McDonald, D. W., Follette, W. C., & Berley, R. A. (1985). Attributional processes in distressed and nondistressed married couples. *Cognitive Therapy & Research, 9*, 35-50.

Johnson, M. D., Karney, B. R., Rogge, R., & Bradbury, T. N. (2001). The role of marital behavior in the longitudinal association between attributions and marital quality. In V. Manusov & J. H. Harvey (Eds.), *Attribution, communication behavior, and close relationships* (pp. 173-192). New York: Cambridge University Press.

Jones, E. E. & Nisbett, R. E. (1972). The actor and the observer: Divergent perceptions of the causes of behavior. In: E.E. Jones, D.E. Kanouse, H.H. Kelley, R.E. Nisbett, S. Valins, & B. Weiner (Eds.), *Attribution: Perceiving the causes of behavior.* (pp. 79-94). Morristown, NJ: General Learning Press.

Joiner, T. E., Jr. (2002). Depression in its interpersonal context. In I. H. Gotlib & C. L. Hammen (Eds.), *Handbook of depression*. New York, NY: Guilford Press. 295-313.

Judd, L. L., Paulus, M. P., Wells, K. B., & Rapaport, M. H. (1996). Socioeconomic burden of subsyndromal depressive symptoms and major depression in a sample of the general population. *The American Journal of Psychiatry, 153*, 1411-1417.

Judd, L. L., Schettler, P. J., & Akiskal, H. S. (2002). The prevalence, clinical relevance, and public health significant of subthreshold depressions. *Psychiatric Clinics of North America, 25*, 685-698.

Karney, B. R. (2001). Depressive symptoms and marital satisfaction in the early years of marriage: The implications of a growth curve analysis. In S. R. Beach (Ed.), *Marital and family processes in depression* (pp. 45-68). Washington, DC: American Psychological Association.

Karney, B. R. & Bradbury, T. N. (2000). Attributions in marriage: State or trait? A growth curve analysis. *Journal of Personality and Social Psychology, 78*, 295-309.

Karney, B. R., Bradbury, T. N., Fincham, F. D., & Sullivan, K. T. (1994). The role of negative affectivity in the association between attributions and marital satisfaction. *Journal of Personality & Social Psychology, 66*, 413-424.

Kelley, H. H. (1967). Attribution theory in social psychology. *Nebraska Symposium on Motivation, 15*, 192-238.

Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity survey replication. *General Psychiatry, 62*, 617-627.

Kiecolt-Glaser, J. K., Malarkey, W. B., & Chee, M. (1993). Negative behavior during marital conflict is associated with immunological down-regulation. *Psychosomatic Medicine, 55*, 395-409.

Knobloch, L. K. & Knobloch-Fedders, L. M. (2010). The role of relational uncertainty in depressive symptoms and relationship quality: An actor partner interdependence model. *Journal of Social and Personal Relationships, 27*, 137-159.

Kurdek, L. A. (1998). The nature and predictors of the trajectory of change in marital quality over the first 4 years of marriage for first-married husbands and wives. *Journal of Family Psychology, 12*, 494-510.

Kurdek, L. A. (2003). Negative representations of the self/spouse and marital distress. *Personal Relationships, 10*, 511-534.

Kyle, S. & Falbo, T. (1985). Relationships between marital stress and attributional preferences for own and spouse behavior. *Journal of Social & Clinical Psychology, 3*, 339-351.

Levenson, R. W., Carstensen, L. L., & Gottman, J. M. (1994). Influences of age and gender on affect, physiology, and their interrelations: A study of long-term marriages. *Journal of Personality and Social Psychology, 67*, 56-68.

Lyness, J. M., King, D. A., Cox, C., Yoediono, Z., & Caine, E. D. (1999). The importance of subsyndromal depression in older primary care patients: Prevalence and associated functional disability. *Journal of American Geriatrics Society, 47*, 647-652.

Madden, M. E., & Janoff-Bulman, R. (1981). Blame, control, and marital satisfaction: Wives' attributions for conflict in marriage. *Journal of Marriage and the Family, 43*, 663-674.

Newman, H. (1981). Communication within ongoing intimate relationships: An attributional perspective. *Personality & Social Psychology Bulletin, 7*, 59-70.

Orvis, B. R., Kelley, H. H., & Butler, D. (1976). Attributional conflict in young couples. In J. H. Harvey, W. J. Ickes, & R. F. Kidd (Eds.), *New Directions in Attribution Research, Vol. 1*. Lawrence Erlbaum Associates: Hillsdale, NY, pp. 353-386.

Pearlin, L. I. & Schooler, C. (1978). The structure of coping. *Journal of Health and Social Behavior, 19*, 2-21.

Peterson, C., Meier, S.F., & Seligman, M. E. (1993). *Learned helplessness: A theory for the age of personal control.* Cambridge, England: Cambridge University Press.

Peterson, C. & Seligman, M. E. (1984). Causal explanations as a risk factor for depression: Theory and evidence. *Psychological Review, 91*, 347-374.

Peterson, C., Semmel, A., von Baeyer, C., Abramson, L. Y., Metalsky, G. I., & Seligman, M. E. (1982). The Attributional Style Questionnaire. *Cognitive Therapy & Research, 6*, 287-299.

Pincus, H. A., Davis, W. W., & McQueen, L. E. (1999). 'Subthreshold' mental disorders: A review and synthesis of studies on minor depression and other 'brand names.' *British Journal of Psychiatry, 174*, 288-296.

Pyszcynski, T. & Greenberg, J. (1987). Self-regulatory perseveration and the depressive self-focusing style: A self-awareness theory of reactive depression. *Psychological Bulletin, 102*, 122-138.

Radloff, L. S. (1977). The CES-D Scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement, 1*, 385-401.

Rollman, B. L. & Reynolds, C. F. (1999). Minor and subsyndromal depression: Functional disability worth treating. *Journal of the American Geriatrics Society, 47*, 757-758.

Ross, L. (1977). The intuitive psychologist and his shortcomings. In: L. Berkowitz (Ed.) *Advances in experimental social psychology: Vol. 10* (pp. 174-221). New York: Academic Press.

Rounsaville, B. J., Weissman, M. M., Prusoff, B. A., & Herceg-Baron, R. L. (1979a). Marital disputes and treatment outcome in depressed women. *Comprehensive Psychiatry, 20*, 483-490.

Rounsaville, B. J., Weissman, M. M., Prusoff, B. A., & Herceg-Baron, R. (1979b). Process of psychotherapy among depressed women with marital disputes. *American Journal of Orthopsychiatry, 49*, 505-510.

Sabourin, S., Lussier, Y. & Wright, J. (1991). The effects of measurement strategy on attributions for marital problems and behaviors. *Journal of Applied Social Psychology, 21*, 734-746.

Schaefer-Porter, R. L. & Hendrick, S. S. (2000). Attributions, behavioral reactions and relationship satisfaction, *Family Therapy, 27*, 1-18.

Schmaling, K. B., & Jacobson, N. S. (1990). Marital interaction and depression. *Journal of Abnormal Psychology, 99*, 229-236.

Seligman, M. E., Abramson, L. Y., Semmel, A., & von Baeyer, C. (1979). Depressive attribution style. *Journal of Abnormal Psychology, 88*, 242-247.

Shaw, M. E. & Sulzer, J. L. (1964). An empirical test of Heider's levels in attribution of responsibility. *The Journal of Abnormal and Social Psychology, 69*, 39-46.

Sherbourne, C. D., Wells, K. B., Hays, R. D., Rogers, W., Burnam, M. A., & Judd, L. L. (1994). Subthreshold depression and depressive disorder: Clinical characteristics of general medical and mental health specialty outpatients. *The American Journal of Psychiatry, 151*, 1777-1784.

Sobel, M.E. (1982). Asymptotic confidence intervals for indirect effects in structural equation models. In S. Leinhardt (Ed.), *Socialogical methodology* (pp. 290-312). Washington DC: American Sociological Association.

Sobel, M. E. (1988). Direct and indirect effect in linear structural equation models. In J. S. Long (Ed.), *Common problems/proper solutions: Avoiding error in quantitative research* (pp. 46-64). Beverly Hills, CA: Sage.

Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage & the Family, 38*, 15-28.

Sweeney, P. D., Anderson, K., & Bailey, S. (1986). Attributional style in depression: A meta-analytic review. *Journal of Personality and Social Psychology, 50*, 947-991.

Tabachnick, B. G. & Fidell, L.S. (2001). *Using multivariate statistics* (4th ed.). Needham Heights, MA: Allyn & Bacon.

Taylor, S. E. & Koivumaki, J. H. (1976). The perception of self and others: Acquaintanceship, affect, and actor-observer differences. *Journal of Personality & Social Psychology, 33*, 403-408.

Thompson, S. & Kelley, H. (1981). Judgments of responsibility for activities in close relationships. *Journal of Personality and Social Psychology, 41,* 469-477.

Townsley, R. M., Beach, S. R., Fincham, F. D. & O'Leary, K. D. (1991). Cognitive specificity for marital discord and depression: What types of cognition influence discord? *Behavior Therapy, 22*, 519-530.

Uebelacker, L. A., Courtnage, E. S., & Whisman, M. A. (2003). Correlates of depression and marital dissatisfaction: Perceptions of marital communication style. *Journal of Social & Personal Relationships, 20*, 757-769.

Uebelacker, L. A. & Whisman, M. A. (2005). Relationship beliefs, attributions, and partner behaviors among depressed married women. *Cognitive Therapy & Research, 29*, 143-154.

Ulrich-Jakubowski, D., Russell, D. & O'Hara, M. W. (1988). Marital adjustment difficulties: Cause or consequence of depressive symptomatology? *Journal of Social & Clinical Psychology, 7*, 312-318.

Wampler, K. S., Shi, L., Nelson, B. S., & Kimball, T. G. (2003). The Adult Attachment Interview and observed couple interaction: Implications for an intergenerational perspective on couple therapy. *Family Process, 42*, 497-515.

Weiner, B., Frieze, I, Kukla, A. A., Reed, L., Rest, S., & Rosenbaum, R. M. (1971). Perceiving the causes of success and failure. New York: General Learning Press.

Weissman, M. M. (1987). Epidemiology overview. In R. E. Hales & A. J. Frances (Eds.), *American Psychiatric Association annual review, Vol. 6.* (pp. 574-588). Washington, DC: American Psychological Association.

Weissman, M. M., Bland, R. C., Canino, G. J., Faravelli, C., Greenwald, M. A., Hwu, H. G., et al. (1996). Cross-national epidemiology of major depression and bipolar disorder. *Journal of the American Medical Association, 276*, 293-299.

WHO World Mental Health Survey Consortium (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization world mental health surveys. *Journal of the American Medical Association, 291*, 2581-2490.

Whisman, M. A. (2001). The association between depression and marital dissatisfaction. In S. R. Beach (Ed.), *Marital and family processes in depression: A scientific foundation for clinical practice* (pp. 3-24). Washington, DC: American Psychological Association.

Whisman, M. A., & Bruce, M. I. (1999). Marital distress and incidence of major depressive episode in a community sample. *Journal of Abnormal Psychology, 108*, 674-678.

APPENDIX A

Participant Notification Form

Project Title: Project Satisfaction

Introduction: The purpose of this form is to give you information that may affect your decision whether to say YES or NO to participation in this research. To protect your anonymity as a participant, you will not be asked to sign a consent form. If your decision is YES to participate, then you will proceed in the completion of an anonymous online questionnaire. If your decision is NO, you will not complete this questionnaire.

Researchers: Barbara Winstead, Ph.D., Old Dominion University, College of Sciences, Department of Psychology. Student Investigator: Amy H. Smith, M.A.

Description of Research: The aim of this study is to learn more about how individuals' thinking about themselves and their partner is related to the quality of their romantic relationship. This study asks you to complete an online survey. Completion of this survey will take about 25 minutes.

Exclusionary Criteria: To participate, you must be at least 18 years old and currently in an exclusive romantic relationship six months in length or longer.

Risks and Benefits:

Risks: Completing this survey may result in increased self-awareness. It is possible that increased self-awareness may cause emotional distress. As with any research, there may be other risks not yet identified. Should your completion of this study raise any concerns about yourself for which you might wish professional help, ODU students may seek confidential assistance at Counseling Services in Webb Center (757-683-4401).

Benefits: Completing this survey contributes to scientific knowledge. You may also find the survey interesting and learn something about yourself in the completion of this study.

Costs and Payments: Your decision to participate in this study is completely voluntary. You will not receive payment for your participation. If you are a student at Old Dominion University, you will receive one-half (.5) of a research credit that you may use in an eligible psychology course. Participation in research is not a requirement for such credit in psychology classes.

Confidentiality: Your identity will never be recorded in connection with your answers to the questionnaires. Your identity will be kept anonymous. If you are an Old Dominion University student, during the completion of the survey, you will asked to provide your five digit SONA ID. Your SONA ID will be forward to the Departmental Research Participation Administrator. Personal information cannot be linked to you anonymous survey responses.

Withdrawal Privilege: You are free to say NO to participation in this study or to withdraw at any time. Withdrawal will not affect your relationship to Old Dominion University, or otherwise cause a loss of benefits to which you are entitled. You are also free to not answer particular questions on the survey if you prefer.

Voluntary Consent: By continuing to answer the survey questions, you are acknowledging that you have read this form, that you are satisfied that you understand this form, the research study, and its risks and benefits. If you have any further questions about the research, please contact Dr. Barbara Winstead (757-683-3137). If at any time you feel pressure to participate, or if you have questions about your rights or this form, call Dr. George Maihafer, the current IRB Chair, at 757-683-4520.

APPENDIX B

Center for Epidemiologic Studies Depression Scale (CES-D)

Instructions: Below is a list of ways you might have felt or behaved. Please indicate how often you may have felt this way during the past week by checking the appropriate space.

During the past week:	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
1. I was bothered by things that usually don't bother me.				
2. I did not feel like eating; my appetite was poor.				
3. I felt that I could not shake off the blues even with help from my family or friends.				
4. I felt I was just as good as other people.				
5. I had trouble keeping my mind on what I was doing.				
6. I felt depressed.				
7. I felt that everything I did was an effort.				
8. I felt hopeful about the future.				
9. I thought my life had been a failure.				
10. I felt fearful.				
11. My sleep was restless.				
12. I was happy.				
13. I talked less than usual.				
14. I felt lonely.				
15. People were unfriendly.				

16. I enjoyed life				
17. I had crying spells.				
18. I felt sad.				
19. I felt that people dislike me.				
20. I could not get "going."				

APPENDIX C

DYADIC ADJUSTMENT SCALE

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list. (Place a checkmark (√) to indicate your answer).

	Always Agree	**Almost Always Agree**	**Occasionally Disagree**	**Frequently Disagree**	**Almost Always Disagree**	**Always Disagree**
1. Handling family finances	_____	_____	_____	_____	_____	_____
2. Matters of recreation	_____	_____	_____	_____	_____	_____
3. Religious matters	_____	_____	_____	_____	_____	_____
4. Demonstrations of Affection	_____	_____	_____	_____	_____	_____
5. Friends	_____	_____	_____	_____	_____	_____
6. Sex relations	_____	_____	_____	_____	_____	_____
7. Conventionality (correct or proper behavior)	_____	_____	_____	_____	_____	_____
8. Philosophy of life	_____	_____	_____	_____	_____	_____
9. Ways of dealing with parents or in-laws	_____	_____	_____	_____	_____	_____
10. Aims, goals, and things believed important	_____	_____	_____	_____	_____	_____

11. Making major Decisions	_____	_____	_____	_____	_____	_____
12. Amount of time spent together	_____	_____	_____	_____	_____	_____
13. Household tasks	_____	_____	_____	_____	_____	_____
14. Leisure time interests and activities	_____	_____	_____	_____	_____	_____
15. Career decisions	_____	_____	_____	_____	_____	_____
16. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	_____	_____	_____	_____	_____	_____
17. How often do you or your mate leave the house after a fight?	_____	_____	_____	_____	_____	_____
18. In general, how often do you think that things between you and your partner are going well?	_____	_____	_____	_____	_____	_____
19. Do you confide in your mate?	_____	_____	_____	_____	_____	_____
20. Do you ever regret that you married (or lived together)?	_____	_____	_____	_____	_____	_____
21. How often do you and your partner quarrel?	_____	_____	_____	_____	_____	_____
22. How often do you and your mate "get						

on each others' nerves?"	_____	_____	_____	_____	_____	_____
	Every day	Almost every day	Occasionally	Rarely	Never	
23. Do you kiss your mate?	_____	_____	_____	_____	_____	
	All of them	Most of them	Some of them	Very few of them	None of them	
24. Do you and your mate engage in outside interests together?	_____	_____	_____	_____	_____	

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

	Never	Less than once a month	Once or twice a month	Once or twice a week	Once a day	More often
25. Have a stimulating exchange of ideas	_____	_____	_____	_____	_____	_____
26. Laugh together	_____	_____	_____	_____	_____	_____
27. Calmly discuss something	_____	_____	_____	_____	_____	_____
28. Work together on a project	_____	_____	_____	_____	_____	_____

There are some things about which couples sometimes agree and sometimes disagree. Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks.

Check yes or no.		
Yes	No	
29. _____	_____	Being too tired for sex.
30._____	_____	Not showing love.

31. The dots on the following line represent different degrees of happiness in your relationship. The middle point, "happy," represents the degree of happiness of most relationships. Please circle the dot which best describes the degree of happiness, all things considered, of your relationship.

Extremely Unhappy	Fairly Unhappy	A Little Unhappy	Happy	Very Happy	Extremely Happy	Perfect

32. Which of the following statements best describes how you feel about the future of your relationship?

_____ **I want desperately for my relationship to succeed, and would go to almost any length to see that it does.**

_____ **I want very much for my relationship to succeed, and will do all I can to see that it does.**

_____ **I want very much for my relationship to succeed, and will do my fair share to see that it does.**

_____ **It would be nice if my relationship succeeded, but I can't do much more than I am doing now to help it succeed.**

_____ **It would be nice if it succeeded, but I refuse to do any more than I am doing now to keep the relationship going.**

_____ **My relationship can never succeed.**

APPENDIX D

Relationship Attribution Measure

This questionnaire describes several things that your relationship partner might do. Imagine your partner performing each behavior and then read the statements that follow it. Please choose the number that indicates how much you agree or disagree with each statement, using the rating scale below:

1	2	3	4	5	6
DISAGREE	Disagree	Disagree	Agree	Agree	AGREE
Strongly		Somewhat	Somewhat		Strongly

YOUR RELATIONSHIP PARTNER CRITICIZES SOMETHING YOU SAY

My partner's behavior was due to something about him/her

(e.g., the type of person he/she is, his/her mood)..... 1 2 3 4 5 6

The reason my partner criticized me is <u>not</u> likely to change 1 2 3 4 5 6

The reason my partner criticized me is something that

affects other areas of our relationship..... 1 2 3 4 5 6

My partner criticized me on purpose rather than

unintentionally..... 1 2 3 4 5 6

My partner's behavior was motivated by selfish rather

than <u>un</u>selfish concerns..... 1 2 3 4 5 6

My partner deserves to be blamed for criticizing me..... 1 2 3 4 5 6

YOUR PARTNER BEGINS TO SPEND LESS TIME WITH YOU

My partner's behavior was due to something about him/her

(e.g., the type of person he/she is, his/her mood)..... 1 2 3 4 5 6

The reason my partner is beginning to spend less time

with me is <u>not</u> likely to change..... 1 2 3 4 5 6

The reason my partner is beginning to spend less time with

me is something that affects other areas of our relationship... 1 2 3 4 5 6

My partner is beginning to spend less time with me

on purpose rather than unintentionally..... 1 2 3 4 5 6

My partner's behavior was motivated by selfish rather

than unselfish concerns..... 1 2 3 4 5 6

My partner deserves to be blamed for beginning to spend

less time with me..... 1 2 3 4 5 6

YOUR PARTNER DOES NOT PAY ATTENTION TO WHAT YOU ARE SAYING

My partner's behavior was due to something about him/her

(e.g., the type of person he/she is, his/her mood)..... 1 2 3 4 5 6

The reason my partner did not pay attention to me is not

likely to change..... 1 2 3 4 5 6

The reason my partner did not pay attention to me is

something that affects other areas of our relationship..... 1 2 3 4 5 6

My partner did not pay attention to me on purpose

rather than unintentionally..... 1 2 3 4 5 6

My partner's behavior was motivated by selfish rather

than unselfish concerns..... 1 2 3 4 5 6

My partner deserves to be blamed for not paying

attention to me..... 1 2 3 4 5 6

YOUR PARTNER IS COOL AND DISTANT

My partner's behavior was due to something about him/her

(e.g., the type of person he/she is, his/her mood)..... 1 2 3 4 5 6

The reason my partner was cool and distant is not

likely to change..... 1 2 3 4 5 6

The reason my partner was cool and distant is

something that affects other areas of our relationship..... 1 2 3 4 5 6

My partner was cool and distant on purpose

rather than unintentionally..... 1 2 3 4 5 6

My partner's behavior was motivated by selfish rather

than unselfish concerns..... 1 2 3 4 5 6

My partner deserves to be blamed for being cool and

distant..... 1 2 3 4 5 6

APPENDIX E

Self - Relationship Attribution Measure

This questionnaire describes several things that you may do in your relationship. Imagine yourself performing each behavior and then read the statements that follow it. Please choose the number that indicates how much you agree or disagree with each statement, using the rating scale below:

1	2	3	4	5	6
DISAGREE	Disagree	Disagree	Agree	Agree	AGREE
Strongly		Somewhat	Somewhat		Strongly

YOU CRITICIZE SOMETHING YOUR RELATIONSHIP PARTNER SAYS

My behavior was due to something about me

(e.g., the type of person I am, my mood)..... 1 2 3 4 5 6

The reason I criticized my partner is <u>not</u> likely to change.... 1 2 3 4 5 6

The reason I criticized my partner is

something that affects other areas of our relationship..... 1 2 3 4 5 6

I criticized my partner on purpose rather than

Unintentionally..... 1 2 3 4 5 6

My behavior was motivated by selfish rather

than unselfish concerns..... 1 2 3 4 5 6

I deserve to be blamed for criticizing my partner..... 1 2 3 4 5 6

YOU BEGIN TO SPEND LESS TIME WITH YOUR PARTNER

My behavior was due to something about me

(e.g., the type of person I am, my mood)..... 1 2 3 4 5 6

The reason I began to spend less time with my partner is

not likely to change..... 1 2 3 4 5 6

The reason I began to spend less time with my partner is

something that affects other areas of our relationship..... 1 2 3 4 5 6

I began to spend less time with my partner

on purpose rather than unintentionally..... 1 2 3 4 5 6

My behavior was motivated by selfish rather

than unselfish concerns..... 1 2 3 4 5 6

I deserve to be blamed for spending less time with

my partner..... 1 2 3 4 5 6

YOU DO NOT PAY ATTENTION TO WHAT YOUR PARTNER IS SAYING

My behavior was due to something about me

(e.g., the type of person I am, my mood)..... 1 2 3 4 5 6

The reason I did not pay attention to my partner

is not likely to change..... 1 2 3 4 5 6

The reason I did not pay attention to my partner is

something that affects other areas of our relationship..... 1 2 3 4 5 6

I did not pay attention to my partner on purpose

rather than unintentionally..... 1 2 3 4 5 6

My behavior was motivated by selfish rather

than unselfish concerns..... 1 2 3 4 5 6

I deserve to be blamed for not paying

attention to my partner..... 1 2 3 4 5 6

YOUR PARTNER IS COOL AND DISTANT

My behavior was due to something about me

(e.g., the type of person I am, my mood)..... 1 2 3 4 5 6

The reason I was cool and distant to my partner

is not likely to change..... 1 2 3 4 5 6

The reason I was cool and distant to my partner is

something that affects other areas of our relationship..... 1 2 3 4 5 6

I was cool and distant to my partner on purpose

rather than unintentionally..... 1 2 3 4 5 6

My behavior was motivated by selfish rather

than unselfish concerns..... 1 2 3 4 5 6

I deserve to be blamed for being cool and distant

to my partner..... 1 2 3 4 5 6

VITA

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EDUCATION

2004-present **Virginia Consortium Program in Clinical Psychology**
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2004-2006 **Norfolk State University**
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RESEARCH EXPERIENCE

2004-2006 **Research Assistant - Old Dominion University**
Supervisor: Barbara Winstead, Ph.D.
Responsibilities: Conducted literature reviews in the area of doctor-patient communication and self-disclosure in intimate relationships. Prepared and coded video tapes of doctor-patient interactions. Coded data collected via survey regarding unwanted relationship pursuit.

2004-2005 **Research Project - Old Dominion University**
Supervisor: Barbara Winstead, Ph.D.
Topic: Examined doctor-patient relationships as a function of doctors' gender, use of jargon and patient perspective.

2003-2004 **Research Assistant - SUNY Geneseo**
Supervisor: Monica Schneider, Ph.D.
Responsibilities: Assisted in research on threat salience and derogation of outgroups. Administered questionnaires to research participants, assisted in data entry, analysis and interpretation. Contributed to writing of proposal and creating a poster presented at the 2004 American Psychological Society Convention entitled "Gender, Self-esteem, and Sexual Threat as Predictors of Attitudes Toward Gays and Lesbians."