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Pepperdine University
Graduate School of Education and Psychology

UNDERLYING EMOTIONS OF DEMANDING BEHAVIOR IN COUPLE INTERACTIONS

A clinical dissertation submitted in partial satisfaction
of the requirement for the degree of
Doctor of Psychology

by

Emily Caroline Edwards

March, 2018

Kathleen Eldridge, Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

Emily Caroline Edwards

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

Kathleen Eldridge, Ph.D., Chairperson

Carrie Castañeda-Sound, Ph.D.

Aaron Aviera, Ph.D.

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VITA

EMILY CAROLINE EDWARDS, M.A.**EDUCATION**

Pepperdine University, Graduate School of Education and Psychology, Los Angeles, CA
Doctor of Psychology in Clinical Psychology, Psy.D. May 2018

Pepperdine University, Graduate School of Education and Psychology, Malibu CA
Masters of Arts in Clinical Psychology May 2014
 Emphasis in Marriage and Family Therapy

American University, Washington, DC
Bachelor of Arts in Psychology, Minor in Health Promotion December 2011
 Cum Laude

University College London, London, UK
Semester Abroad December 2010

CLINICAL EXPERIENCE

Nebraska Internship Consortium in Professional Psychology Omaha, NE
Site: University of Nebraska Medical Center: Munroe-Meyer Institute
Predoctoral Psychology Internship, APA accredited, 2000 hours
 July 2017 - Present

Pediatric Feeding Disorders Program

Supervisors: Dr. Cathleen Piazza, Ph.D. & Dr. Suzanne Milnes, Ph.D.

- Directly implement individualized and data-based assessment and treatment protocols (e.g., home baselines, standard outcome baselines, functional analyses, escape extinction, attention extinction, stimulus fading, paired stimulus preference assessment, and chewing protocols) with children with severe feeding difficulties and co-occurring complex medical (e.g., tube dependence, severe food allergies) and developmental needs (e.g., intellectual disability and chromosomal abnormalities) in the intensive day and outpatient treatment programs. Client population included children ages 4-15 and their families. .
- Work directly with patient and caregivers to implement behavioral strategies to manage interfering behaviors relating to co-occurring mental health concerns (e.g., Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, and Autism).
- Evaluate every treatment component using single-case experimental designs to determine efficacy of protocols and participate in applied clinical research.
- Supervise and coordinate team members' activities.
- Worked directly with a Spanish translator for two months during a Spanish-speaking patient's admission. Collaborated with the translator to learn several Spanish phrases in order to communicate with patient and caregiver.
- Collaborate and consult with parents, physicians, gastroenterologists, social workers, and teachers to provide continuity of care. Provide feeding training to parents, extended family members, school personnel, and other members of a child's team as appropriate.
- Collect data during feeding sessions, graph data and present to Dr. Piazza and Dr. Milnes to inform treatment decisions.
- Present case information once a week to all members of the Pediatric Feeding Disorders

team, including behavior analysts, licensed psychologists and behavior technicians.

- Participate in interdisciplinary evaluation clinic evaluating the necessity for intensive pediatric feeding service

Autism Diagnostic Clinic

Supervisors: Dr. Amanda Zangrillo, Psy.D. & Andrea Clements, M.A., BCBA

August 2017 - present

- Administer and score the Autism Diagnostic Observation Scale 2 (ADOS-2) with children ages five to nineteen.
- Participate in interdisciplinary team meetings to determine diagnosis.

The Saban Research Institute Children's Hospital Los Angeles, Los Angeles, CA

Pediatric Neuropsychology Extern

July 2016 – June 2017

Supervisor: Sharon O'Neil, Ph.D., M.H.A.

- Completed both clinical and psychodiagnostic neurodevelopmental and neuropsychological evaluations with a diverse population of infants, children, adolescents, and adults (ages 3-months to 18-years-old), who primarily present with the following diagnosis: brain tumors, leukemia, epilepsy, sickle cell disease, preterm birth, congenital heart disease and various medical and psychological sequelae.
- Participated in all stages of the assessment process, starting with case consultation, clinical interview and development of a comprehensive test battery based on the referral and unique needs of the patients, diverse in language and cognitive abilities.
- Completed structured and semi-structured clinical interviews, test administration, interpretation and integrative reports to summarize results, provide individualized, developmentally appropriate recommendations, identify resources and avenues of support to impart academic and clinical interventions (e.g., IEP Plan, therapy services, psychopharmacological treatment, etc.), and to promote improved functioning across domains.
- Provided client-centered psychoeducation, assessment results, and recommendations to patients, guardians, school faculty, and treatment team members by co-facilitating feedback sessions while also collaborating with a multidisciplinary team and external sources for continuity of care and multimodal treatment, across settings.
- Participated in weekly neuropsychology didactics, pediatric grand rounds, neurology grand rounds, and brain cuttings led by neuropathologists.
- Collaborated and establish working relationship with professionals across disciplines through consultation and participation in weekly treatment team meetings, colloquia, and training seminars to address patients' needs, promote continuity of care, and further develop working understanding of team processes and group role in services provided.

Plastic & Maxillofacial Surgery at Children's Hospital Los Angeles, Los Angeles, CA

Girl-Talk Support Group Co-Facilitator

September 2016 – June 2017

Supervisor: Alexis Johns, Ph.D.

- Co-facilitated a weekly support group with Dr. Alexis Johns for females with craniofacial diagnoses (ages 6 to 17-years-old) to promote self-esteem, increase affective abilities, learn the importance of expressive thoughts and feelings, and develop and practice interpersonal skills through role-plays and interactive activities.
- Facilitated activities in a group setting including play, art, and games to provide members with opportunities for exploration and enhancement of intra and interpersonal skills, aligned with overarching goals of the group.

- Provided support throughout the group to individual members participating in activities and provide support for social skill development and the enhancement of pro-social behaviors, effective communication and affect regulation through modeling, interactive dialogue, and feedback.
- Administered brief, self-report assessment measures at specified intervals throughout the group cycle to gather baseline information, monitor fluctuations in self-esteem throughout the group, and review the overall effectiveness of the group.

Center for Autism and Related Disorders, Woodland Hills, CA

Psy.D. Trainee

August 2015 – August 2016

Supervisor: Daniel Oakley, Psy.D.

- Conducted developmental and psychodiagnostic assessments and consultations for children, adolescents, and adults (ages 2 to 35-years-old) with developmental and psychological disorders, with the most frequent referrals including Autism Spectrum Disorder; Memory and Language Disorders; Learning Disabilities; and Attention Deficit Disorder.
- Provided feedback to parents, applied behavioral analysis (ABA) therapists, and supervisors after assessments.
- Scored assessments after administration along with writing a comprehensive report.

Pepperdine University West Los Angeles Community Counseling Center, Los Angeles, CA

Psy.D. Trainee

July 2015 – June 2017

Supervisor: Carol Falender, Ph.D.

- Facilitate weekly individual and family psychotherapy sessions with a diverse population of children, adolescents, and adults utilizing consistent monitoring of progress and reevaluation to promote achievement toward treatment goals.
- Impart interventions from cognitive behavioral therapy and behavioral therapy to individualize treatment and provide evidence-based, efficacious treatment for the presenting problems, decrease levels of distress, improve functioning, and work towards achieving collaboratively developed treatment goals.
- Completed training for Comprehensive Behavioral Intervention for Tics, Coping Cat, and Trauma-Focused CBT along with utilizing these treatments in individual therapy.
- Collaborate with external professionals based on the client and diagnosis in order to further coordinate care and provide efficacious treatment.
- Administer, score, and interpret assessment measures including the Outcome Questionnaire (OQ-45), Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI-II), Beck Anxiety Inventory (BAI), and Quality of Life Inventory (QOLI) to contribute to ongoing research evaluating clinical outcomes and progress.
- Conduct comprehensive and diagnostic intake evaluations to obtain clinically relevant information, history of symptoms, and psychosocial background to increase understanding of the individual and their difficulties.

Juan de Anza Elementary School, Del Air, CA

Psy.D. Trainee

September 2014 – July 2015

Supervisor: Keegan Tangeman, Psy.D.

- Conducted a psychotherapy group for children of divorce in a school-based setting for children ages 8 to 10 years old.
- Created a group therapy manual for children of divorce through research on evidence-based practice.
- Imparted interventions including (cognitive-behavioral therapy and trauma-focused cognitive behavioral therapy) to aid in the processing of family disruption due to divorce,

along with sibling issues, disagreements with friends, and problematic behavioral patterns at school.

- Provided individual therapy based on cognitive behavioral therapy, behavioral therapy, or trauma-focused cognitive behavioral therapy to children ages 5-10 years old.
- Worked as a team with the school psychologist, principal, and teachers in order to gain insight and information regarding the child's behavior and difficulties at school.
- Conducted clinical interviews with parents in order to gain information on the child's social, emotional, psychological, and health history.

Social Skills Summer Camp, Los Angeles, CA

Psy.D. Trainee

June 2015 - July 2015

Supervisor: Erika Rich, Ph.D.

- Led children ages 5-12 with diagnoses of autism, ADHD, or generalized disruptive behaviors on various activities, including mindfulness practices and social skills development exercises.
- Taught strategies to apply in various play situations (e.g., cooperative play, sharing of ideas, reciprocity in play, giving compliments, having a two-way conversation).
- Attended a two-day long didactic on managing disruptive behaviors and developed social skills.

The People Who Care Youth Center, Los Angeles, CA

Marriage and Family Therapist Trainee

January 2013 – May 2014

Supervisor: Diane Griggs, LCSW

- Provided individual, family, and couple counseling to individuals on probation, first offenders, and individuals mandated by The Department of Child and Family Services. The hours were variable and ranged from 2-10 hours per week working with an average client load of five.
- Conducted agencies intake evaluations with adults and adolescents mandated to perform community service.

Metropolitan State Hospital, Norwalk, CA

Undergraduate Trainee / Penal Code Intern

June – August 2011

Supervisor: Alexander Bacher, Psy.D.

- Provided art and music therapy to inmates who were deemed not guilty by reason of insanity to help instill positive self-care methods and encourage the use of adaptive coping mechanisms while residing at the facility.
- Worked one on one with inmates as well as in group settings focusing on cognitive and drug rehabilitation therapy to help prepare for a return to court.

Children's National Medical Center, Washington, DC

Undergraduate Trainee / Outpatient Psychiatry Intern

June – August 2010; January – May 2011

Supervisor: Irene Chatoor, M.D.

- Worked in the Outpatient Psychiatry Department with children ages five months to seven years old who have feeding disorders (infantile anorexia, sensory food aversions, and post-traumatic feeding disorder).
- Improved knowledge of talk therapy through observation of therapy sessions.
- Conducted individual play therapy sessions with children to enhance our understanding of their feeding disorder.
- Assisted in the compilation of research and data for Dr. Irene Chatoor's feeding disorders

research book.

ASSISTANTSHIP POSITION

Pepperdine University, Graduate School of Education and Psychology, Los Angeles, CA
Teaching Assistant September 2014 – April 2017

Supervisor: Drew Erhardt, Ph.D.

- Assisted with preparation of materials and administrative duties for the masters-level psychology course, Child and Adolescent Psychology.
- Evaluated students' exams and provide feedback on areas of growth.
- Conducted literature searches and online research for Dr. Erhardt's articles and book submissions.

Pepperdine University, Graduate School of Education and Psychology, Los Angeles, CA
Student Government, Pepperdine University: Steering Committee
 September 2016 – April 2017

- Attended monthly meetings with other student officers to discuss organizational details, plan events, and program wide changes.
- Met with the Graduate School of Education and Psychology Executive Committee to discuss changes within the Psy.D program, evaluate and make modifications to previous plans implemented.
- Assisted with preparation for meeting with the American Psychological Association (APA) to aid in APA accreditation while also voicing program concerns of the student body.
- Acted as the liaison between the students and faculty members to discuss and resolve grievances and identify effective strategies in program or student enhancements.

RESEARCH EXPERIENCE

Feeding Disorder Research Lab at Children's Hospital Orange County, Orange County, CA
Research Assistant October 2016 – June 2017

Supervisor: Cindy Kim, Ph.D.

- Acted as the primary research assistant in a longitudinal study examining the effect of inpatient treatment on the participant and their ability to sustain functioning, after gastrointestinal (GI) feeding tube removal.
- Inquired about the individual's progress, post-discharge and specifically related to weight fluctuations, ability to consume food and sustain intake, manage dietary improvements or modifications, or the resultant need to have GI tube replaced.
- Assisted with the coordination and conduction of quantitative research with a scope and focus on program and resource development, clinical application, outcome studies, and treatment efficacy.
- Developed questionnaires and surveys, call clients' guardians post-discharge, track client progress on various levels (i.e., 30 days, 60 days, 90 days, 360 days and at two years) post-discharge, code and enter data into a statistical database.
- Obtained information that was utilized as primary data in the presentation and publication of research findings to demonstrate and support the efficacy of treatment modalities.
- Completed literature review in anticipation of intention to submit the results for publication and present findings at a convention to promote and support the advancement of efficacious treatment options for individuals with feeding disorders and

related conditions.

Doctoral Dissertation

Chair: Kathleen Eldridge, Ph.D.

Title: *Underlying Emotions of Demanding Behavior in Couple Interactions*

- Aim: To identify what emotion(s) precipitate the behaviors of demand and withdraw within the demand-withdraw pattern of communication. Additionally, to forward the integration of emotion arousal, emotion regulation, and demand-withdraw literature, and provide clinical implications for emotion regulation work with couples experiencing demand-withdraw. Oral examination passed in April 2016. IRB approval granted September 2016. Defended December 2017.

Trichotillomania Research Lab, Washington, DC

Research Assistant

August – December 2011

Supervisor: David Haaga, Ph.D.

- Scored the degree of alopecia evident in adult participants' photos to assess the efficacy of proposed treatment plan.
- Monitored project therapists' therapeutic interventions through watching taped therapy sessions.
- Rated the extent to which the project therapists adhered to the instructions given in each treatment manual to ensure that the study was valid and reliable.

PUBLICATIONS

Eldridge, K.A., Cencirulo, J., & Edwards, E. (2017). Demand-withdraw patterns of communication in couple relationships. In J. Fitzgerald (Ed.), *Foundations for couples' therapy: Research for the real world* (pp. 112-122). New York: Routledge.

PRESENTATIONS

Healthy Hands Presentation

April 2015

- An oral presentation was given to 192 kindergarten children at Cabrillo Elementary School in the Wiseburn School District.
- The presentation focused on how not to spread germs when one is sneezing and coughing, along with how to stay sanitary after going to the bathroom, playing on the playground, or when one is sick.

American Association for Marriage and Family Therapy Conference

February 2014

- Title: The role of rap music in creating a therapeutic alliance with African American and Latino youth
 - Poster presented to 100 licensed clinicians and students interested in multiculturalism.
-

ABSTRACT

Demand-withdraw is an ineffective communication pattern frequently experienced by distressed couples. Therapists often attempt to address this pattern by helping partners understand and regulate the emotions that underlie these behaviors. To date, there is a lack of research focusing on the emotional experiences underlying the demand-withdraw pattern of interaction in couples. Related lines of research focus on emotional arousal and the expression of hard and soft emotions, but this research does not specifically investigate demand-withdraw interactions. The purpose of this study is to identify what emotions underlie demanding behavior in both men and women during marital demand-withdraw conflict interactions. Six couples were chosen from a five-year longitudinal randomized clinical trial that compared Integrative Behavioral Couple Therapy (IBCT) and Traditional Behavioral Couple Therapy (TBCT). Researchers viewed 10-minute pre-treatment problem-solving interactions to observe the demand-withdraw pattern in vivo among couples seeking therapy. The Behavioral Affective Rating Scale (BARS) was used to code the emotions observed during the interactions. The results indicated that the types of emotions varied not only depending on who initiated the problem-solving interaction (e.g., wife topic-husband topic) but also between the different couples, and when comparing gender. Anxiety (#2) and aggression (#4) were in the top four most commonly observed emotions for husbands, while they were two of the least observed emotions for wives. Moreover, frustration and hurt were the two most observed emotions for wives, while they were the least observed emotions for husbands.

Introduction

Background Literature and Current Status of Theory and Research

Marriage data collection began to appear after 1850 through the use of church records that documented the age of marriage (McHale, King, Hook, & Booth, 2016). Since then, our knowledge of marriage has increased substantially. Current statistics state that about 90% of people marry by the age of 50 with divorce rates in the 40th and 50th percentile (Glick, Rait, Heru, & Ascher, 2015). Adjusting for age, the current divorce rate is 40% higher than it was in 1980 and three times as high as it was in 1960 (McHale et al., 2016). With a significant percentage of the population marrying and about half divorcing, it is interesting to look at the positive and negative effects of marriage.

Marriage, Conflict, and Health. Compared to the unmarried, married couples report better health, lower rates of chronic illness, and are more likely to live longer and survive heart attacks (Kiecolt-Glaser & Newton, 2001; McHale et al., 2016). A study done in 1990 reported that unmarried men had a 250% greater risk of mortality compared to married men, and unmarried women had a 50% increased risk compared to married women (McHale et al., 2016; Ross, Mirowsky, & Goldsteen, 1990). Based on this study along with others, it seems that the health benefits associated with marriage are greater for men than they are for women (Kiecolt-Glaser & Newton, 2001; McHale et al., 2016). Additionally, research has shown that marital status is more important to the health of a man, while marital quality has more impact on a woman's health (McHale et al., 2016). Although this may be true, research suggests that a dissatisfied marriage is worse than no marriage at all when it comes to health (McHale et al., 2016).

Strained interactions seem to cause more damage to an individual's health than positive interactions do to protect health. Additionally, this relationship strain appears to have a more substantial impact on women compared to men (Kiecolt-Glaser & Newton, 2001; Proulx, Helms, & Buehler, 2007). Kiecolt-Glaser and Newton (2001) found that wives had larger blood pressure

changes than husbands during marital conflict. In addition, during specific forms of conflict, such as wife demand-husband withdraw interactions, there were higher levels of norepinephrine and cortisol detected in wives' bodies compared to husbands. Moreover, these physiological changes that occur during marital conflict persist after the conflict is over more often for wives than husbands (Kiecolt-Glaser & Newton, 2001). For both husbands and wives, marital discord has been shown to increase depression and depressive symptoms ten-fold (Kiecolt-Glaser & Newton, 2001; Proulx et al., 2007). Conflict interactions can also alter both spouses' physiological functioning (e.g., endocrine and immune functions). Additionally, during problem-solving interactions, researchers saw increased blood pressure and heart rates (Kiecolt-Glaser & Newton, 2001).

Gender and the Demand-Withdraw Pattern of Communication. Conflict within marriage can manifest in many ways; one particularly common way is referred to as the demand-withdraw pattern. The demander is the partner who pursues discussion or changes in the relationship, and the withdrawer is the partner who avoids discussing the problematic issue by withdrawing physically or disengaging from the conversation (Vogel, Murphy, Werner-Wilson, Cutrona, & Seeman, 2007). This pattern is one of the most "destructive and least effective interaction patterns" (Papp, Kouros, & Cummings, 2009, p. 285). Additionally, multiple studies have confirmed that high levels of demand-withdraw interactions are associated with lower levels of relationship satisfaction (Baucom, Atkins, Eldridge, McFarland, Sevier, & Christensen, 2011; Eldridge, Sevier, Jones, & Atkins, 2007; Heavey, Layne, & Christensen, 1993; Papp et al., 2009). Wife demand-husband withdraw was found to be particularly damaging to long-term relationship well-being, leading to current relationship dissatisfaction along with longitudinal decreases in wives' satisfaction (Heavey et al., 1993).

Currently, there is a debate regarding whether or not gender plays a role in a partner assuming the role as the demander or withdrawer. Some studies have shown that women tend to be the demander and men the withdrawer; however, other studies have shown that gender

plays less of a role and that the demander is more often the person who is desiring change (Papp et al., 2009; Verhofstadt, Buysse, de Clercq, & Goodwin, 2005; Vogel et al., 2007).

Research that demonstrated gender differences concluded that demand-withdraw behaviors are not due to fundamental differences in men and women but to inequalities in power and resources (Kluwer, Heesink, & Van De Vilert, 2000; Sagrestano, Heavey, & Christensen, 1998; Vogel et al., 2007). This imbalance of power leads the wife to exhibit demands due to sex-based inequalities in marriage (e.g., the husband is the breadwinner controlling the family income and wife is in charge of taking care of the house and children; Christensen & Heavey, 1990; Vogel et al., 2007). The wife seeks collaboration for resolution of the conflict, while the husband is content without collaborating. The wife who needs collaboration is likely to use demanding behaviors to elicit change, while the husband is likely to withdraw to maintain power/control by not collaborating and making changes (Christensen & Heavey, 1990; Heavey et al., 1993; Vogel et al., 2007).

As sex-based inequalities within marriage have declined, research has begun to show that gender plays less of a role. In 1990, Christensen and colleagues conducted a study where they had husbands and wives discuss problems, one chosen by the husband and the other by the wife. They found that during the wife's problem discussion she expressed more demands than she did in the husband's problem discussion (Christensen & Heavey, 1990; Vogel et al., 2007). Vogel et al. (2007) found no relationship between differences in spouse's SES status or self-reported ability to make decisions in the relationship and who demanded or withdrew the most. Additionally, a study on couple's patterns of behavior in the home found equal occurrences of husband demand-wife withdraw and wife demand-husband withdraw (Papp et al., 2009). Due to the structure of marriage and intimate relationships changing, continued research is needed on the relationship between gender and demand-withdraw interactions.

Emotional Expression, Arousal, and Communication Within Couples. Effective emotional communication can lead to stronger bonds; however, couples who struggle with

communication (i.e., demand-withdraw interactions) and regulating their emotional arousal can have difficulty recalling, retaining, and learning new coping skills (Baucom, Weusthoff, Atkins, & Hahlweg, 2012; Gross, 2002). These skills are not only important for learning and memory, but they also impact individual and couples' well-being. Relationship satisfaction is maintained or increased when partners can access their own emotions and be aware of their partners' emotions (Croyle & Waltz, 2002).

When couples do express emotion, unhappy couples tend to express more overt anger, disgust, and criticism than happy couples (Croyle & Waltz, 2002). Expression of those hard emotions (anger and resentment) that are associated with asserting power and control lead to significantly higher levels of negative communication and decreased conflict resolution. Whereas, expression of soft emotions (sadness and fear), which convey vulnerability is correlated with positive communication and increased resolution of conflict (Croyle & Waltz, 2002; Sanford, 2007a, 2007b). Due to the positive correlates of expressing soft emotions, couples in therapy are often encouraged to identify and express soft emotions instead of hard. Two therapies that focus on the expression of soft emotion are Integrative Behavioral Couples Therapy (IBCT) and Emotion-Focused Couples Therapy (EFCT). IBCT uses empathic joining as a way to encourage the individual to express soft emotions without blaming ones' partner (Cordova, Jacobson, & Christensen, 1998), while EFCT utilizes a nine-step process that focuses on emotional communication between couples (Johnson, 2004). EFCT addresses the couples' secondary and maladaptive emotions (e.g., anger and contempt) and then explains that primary emotions (e.g., sadness and fear) underlie those secondary emotions and redirects the couple to focus on those primary emotions (Snyder, Simpson, & Hughes, 2006; Dalgleish, Johnson, Burgess, Wiebe, & Tasca, 2015).

In therapy, couples come in with varying levels of emotional awareness, which leads to differing levels of ability in communicating those feelings. This can especially become an issue when one partner is more verbal than the other (Croyle & Waltz, 2002), such as in the demand-

withdraw pattern. Not surprisingly, demand-withdraw patterns are associated with higher levels of negative emotions (e.g., sadness, anger, and fear) and lower levels of positive interaction (e.g., affection, problem-solving, support, and compromise) (Papp et al., 2009). Moreover, hard emotion has been associated with demanding behavior while flat emotion (boredom, apathy, and disinterest) is associated with withdrawal (Sanford, 2007a).

Research has also studied demand-withdraw behavior and emotional arousal. Emotional arousal was defined by Schachter and Singer (1963) as both a physiological response combined with cognitive thoughts. Those cognitions interpret the situation based on an individual's past experiences and provide context for them to understand and label their feelings. It is the cognitive thoughts that determine how the physiological arousal will be labeled (e.g., fear, anger, joy) (Schachter & Singer, 1963). Emotional arousal can be measured by asking participants to describe their emotions or complete questionnaires, observation of physiological arousal, and analyzing the pitch of couples' speech. Studies have shown that demanding behavior is related to vocally-encoded emotional arousal and that the more an individual demands, the greater their arousal. Conversely, withdrawers were less aroused than demanders (Baucom et al., 2011). In Christensen and Heavey's study (1993) they found that both husbands and wives reported feeling more anxiety when discussing the husbands' problem-issue compared to the wives' (Heavey et al., 1993).

Current Study

Critique and Need for Further Study. According to the literature summarized above, emotion regulation can increase relationship satisfaction, and high levels of emotional arousal can lead to negative patterns of interaction. Additionally, hard emotions tend to be associated with demand-withdraw interactions, and expression of hard and soft emotions impact both the individual and the couple differently. Moreover, a large component of IBCT and EFCT is accessing vulnerable emotions underlying the demand-withdraw pattern to start learning a more productive way of communicating. The current demand-withdraw literature has focused on

physiological arousal and negative affect but has not qualitatively examined the exact emotions (e.g., happiness, anger, frustration, contempt, etc.) that underlie both demand and withdraw behavior, on either an intrapersonal or interpersonal level, leaving a central gap in the literature.

Focus and Scope of the Current Study. Given that high levels of emotional arousal lead to negative health consequences and interpersonal consequences, such as an increase in demand-withdraw, it is critical to begin to understand specific emotions that partners are experiencing when they are engaging in demanding and withdrawing behavior to implement successful interventions (Christensen & Heavey, 1990; Sanford, 2007b). Currently, there are very few studies examining the underlying emotions of the demander or withdrawer. Therefore, there is a need for additional research to test hypotheses on the type and nature of emotions associated with demand-withdraw. The aim of this study then is to identify what emotions underlie the behaviors of demand within the demand-withdraw pattern of communication. By doing so, the author hopes that this study contributes to the integration of the emotional arousal, emotion regulation, and demand-withdraw literature, and provides clinical implications for emotion regulation work with couples experiencing demand-withdraw.

Due to the limited existing research on this phenomenon, and the complex and idiosyncratic nature of human emotion, a qualitative research study was best suited for the topic. Qualitative research allows for close observations and rich descriptions of a topic, which provides a vast amount of information and a foundation for generating additional hypotheses. Six married couples who were distressed and seeking therapy were chosen as it is appropriate to choose between 4-6 couples when using a qualitative design (Yin, 2014). Researchers used 10-minute video recorded problem-solving interactions between husbands and wives to observe emotional arousal during demand-withdraw interactions. These 10-minute problem-solving interactions provided more opportunities to observe demand-withdraw interactions than therapy sessions because a therapist was not present to prevent or redirect conflict. Although the researchers attempted to observe demand-withdraw in the context of couple therapy sessions,

examples of the pattern were very brief since the therapist would stop the cycle before researchers could code observed emotions.

The current study examines the following research questions:

- Research Question 1: What are the emotional underpinnings for the person that demands during demand-withdraw couple interactions?
- Research Question 2: What unique patterns exist in the emotions underlying demand behavior when considering gender?
- Research Question 3: What unique patterns exist in the emotions underlying demand behavior when considering whether husband or wife chose the problem topic to discuss?

Methods

General Project Design

The researchers used a multiple case study approach because case studies have been shown to be useful when one is asking “how” and “why” questions (Yin, 2014). This fits with the current research question, why partners demand, with a focus on the emotional correlates of these behaviors. Multiple cases were evaluated instead of a single case because it not only allows for more rich descriptions of cases but also the ability to compare and contrast across cases (Baxter & Jack, 2008). In addition, multiple case studies are more robust and transferable than a single case study (Chmiliar, 2010).

According to Yin (2014), there are several steps to take after choosing to conduct a multiple case study. First, one must consider whether to use an embedded or holistic design. An embedded case study analyzes more than one sub-unit, which refers to anything that is being studied (e.g., different funded projects within one organization), while a holistic design focuses on one global question (Yin, 2014). The researchers in this study conducted a holistic design because the focus was on one phenomenon (e.g., emotions underlying demand). The next step, according to Yin (2014), is to decide whether to create a literal or theoretical replication. A literal replication occurs when the cases selected are similar, and the predicted results are similar as well, whereas a theoretical replication occurs when the cases are selected based on the thought that they will produce opposing results. The researchers chose a literal replication in this case because they predicted that the case studies would yield similar results. The last step before conducting a multiple case study design is determining whether cases are instrumental, intrinsic, or collective. In an instrumental case study, the case is not the main focus but rather a tool to understand a phenomenon; in intrinsic case studies, the case itself is the main focus of exploration, and the goal is to understand the uniqueness of the case rather than to build theory or compare it to other cases. Conversely, a collective case study explores multiple instrumental case studies. Due to the focus on gaining an understanding of a particular phenomenon in

multiple cases (e.g., emotions underlying demand), a collective design was utilized in this study (Grandy, 2010; Yin, 2014).

The researchers conducted a theoretical thematic analysis of the data. Thematic analysis involves examining and documenting patterns within a data set. A theoretical approach to thematic analysis was chosen due to the researchers' decision to focus on a particular area of interest (i.e., emotions underlying demand) before initiating coding. If the researchers had coded without a specific research question and then evolved an area of interest through the coding process, then an inductive approach would have been chosen. Thematic analysis is broken down into six phases of data collection (e.g., familiarization, coding, searching for themes, reviewing the themes, and defining and naming themes) (Braun & Clarke, 2006). These six processes were followed to identify and describe patterns of emotion underlying demand behavior. Themes are represented in the results section as identified patterns between couples, individuals, and genders. During the coding phase, the Behavioral Affective Rating Scale (Johnson, Johns, Kitahara, & Ono, 1998; see Appendix C) was used to guide researchers in identifying emotions. The BARS and thematic analysis are described further below.

Participants

Original Sample. Participants in this study were taken from a five-year longitudinal randomized clinical trial that compared Integrative Behavioral Couple Therapy (IBCT) and Traditional Behavioral Couple Therapy (TBCT). This study examines the archival data (e.g., self-report data, 10-minute pre-treatment problem-solving interactions, and couples therapy sessions) of six couples selected from the original sample of one hundred thirty-four seriously and chronically distressed heterosexual married couples (Christensen et al., 2004). To be included in the original study, the couples had to be legally married, cohabitating, requesting couples therapy, and experiencing serious and consistent marital distress. Marital distress was measured at three different points through a phone interview, mailed questionnaires, and in-person assessment before couples attended therapy. Other inclusion criteria mandated that

both partners had to be fluent in English, completed a high school education or its equivalent, and be between the ages of 18-65 years old (Christensen et al., 2004).

The exclusion criterion for the original study was determined by a diagnostic interview. If one partner met criteria for a diagnosis that would hinder treatment, they were excluded from the study. The specific disorders that were excluded were current diagnoses of bipolar disorder, schizophrenia, substance abuse, antisocial, borderline, or schizotypal personality disorder. Another exclusion criterion was domestic violence as reported by the dyad's wife. Due to confounding therapy results when multiple treatments are used, individuals were not eligible if they were currently in any form of psychotherapy. Partners could be selected for the study if they were using psychotropic medication, as long as they had been taking the medication for at least 12 weeks, were on a stable dose for at least 6 weeks before marital treatment, and if their doctor did not expect to change the dosage or medication (Christensen et al., 2004).

Couples in the original sample ranged in age from 22 to 72 years old, with a mean age of 41.62 for wives and a mean age of 43.49 for husbands. Couples on average were married for ten years and had an average of 1.10 children. The mean education level for husbands was 17.03 years and 16.97 years for wives. The sample was predominantly Caucasian (husbands: 79.1%, wives: 76.1%), African American (husbands: 6.7%, wives: 8.2%), Asian or Pacific Islander (husbands: 6.0%, wives: 4.5%), Latino/Latina (husbands: 5.2%, wives: 5.2%), and Native American or Alaskan Native (husbands: 0.7%) (Christensen et al., 2004).

All couples in the study consented to the use of their data for research purposes, including self-report and video data. The original study and use of archival data were approved through the Institutional Review Boards of the involved universities.

Current Study Sample. To establish a higher degree of certainty in comparing results, and due to sparsely available research on the proposed topic, the researchers chose six cases for the study, well within the range of Yin's (2014) recommendations of 4-6 replications for studies. The inclusion criteria for selecting the six participants were: (a), The couple must be

experiencing the demand-withdraw pattern of interaction, (b), Three of the chosen couples must predominantly exhibit the pattern of female demand-male withdraw while the other three couples must predominantly exhibit the male demand-female withdraw pattern, and (c), The couple must have consented to the use of transcriptions of their sessions for scientific articles and books.

Of the six couples chosen, the average age of wives was 40 years old and 44 years old for husbands. Years married ranged from 1.5 to 19 years, with an average of 8 years. Eighty-three percent of the participants were Caucasian; one participant self-identified as African American and one as Indonesian. All couples completed high school with 66% completing 15 or more years of school. Both husbands and wives reported high levels of marital distress; husbands reported on average a T-score of 68 (see Table 1) on the Marital Satisfaction Inventory-Revised (MSI-R) indicating a high level of distress, and wives reported a T-score of 66 (see Table 1) also suggesting a high level of distress.

Table 1

Marital Satisfaction Inventory-Revised, Global Distress Scale T scores

Husband report of global distress
Couple 1: 74
Couple 2: 72
Couple 3: 70
Couple 4: 57
Couple 5: 71
Couple 6: 69
Wife report of global distress
Couple 1: 67
Couple 2: 66
Couple 3: 66
Couple 4: 60
Couple 5: 67
Couple 6: 73

Note. Mean of 50 and standard deviation of 10; Low <50, Moderate 50-60, High >60.

When rating the level of male demand-female withdraw on the Communication Patterns Questionnaire (CPQ), those three couples reported an average score of 23 out of 27 (see Table 2), indicating high levels of male demand-female withdraw.

Table 2

Communication Patterns Questionnaire - Husbands

Husband report of husband demand-wife withdraw (Out of 27)
Couple 1: 8
Couple 2: 3
Couple 3: 6
Couple 4: 21
Couple 5: 23
Couple 6: 24
Husband report of wife demand-husband withdraw (Out of 27)
Couple 1: 20
Couple 2: 27
Couple 3: 25
Couple 4: 10
Couple 5: 13
Couple 6: 13
Husband report of demand-withdraw amount (Out of 54)
Couple 1: 28
Couple 2: 30
Couple 3: 31
Couple 4: 31
Couple 5: 36
Couple 6: 37

When rating the level of female demand-male withdraw those three couples reported an average score of 25 out of 27 (see Table 3), indicating high levels of female demand-male withdraw.

Table 3

Communication Patterns Questionnaire- Wives

Wife report of husband demand-wife withdraw (out of 27)
Couple 1: 4 Couple 2: 9 Couple 3: 5 Couple 4: 24 Couple 5: 27 Couple 6: 20
Wife report of wife demand-husband withdraw (Out of 27)
Couple 1: 26 Couple 2: 23 Couple 3: 26 Couple 4: 6 Couple 5: 5 Couple 6: 10
Wife report of demand-withdraw amount (Out of 54)
Couple 1: 30 Couple 2: 32 Couple 3: 31 Couple 4: 30 Couple 5: 32 Couple 6: 30

Measures

In the original study, couples completed multiple assessments before, during, and after treatment. These consisted of self-report measures, diagnostic interview, recorded relationship and personal discussions between partners, and recorded therapy sessions. Therapists and supervising consultants also completed measures.

Archived data from some of these assessments were used in the current study to select and describe cases and to examine emotions during demand-withdraw. This section describes those measures.

Measures for Case Selection and Description

Therapist and Consultant Post-Treatment Questionnaire. This measure was used to select couples with predominant demand-withdraw and to help choose the number of female/male demand cases. This measure consists of 7 items relating to major themes in therapy, 5 items relating to major patterns of interaction, 17 items addressing major events in therapy, and 6 miscellaneous questions focusing on long-term gains and how connected the couple was to the therapist. This measure was administered to therapists and consultants at the end of each couple's course of treatment.

Communication Patterns Questionnaire. This measure provided the researchers with information on the couple's demand-withdraw pattern. There are 3 questions that focus on how the partner behaves when a problem arises, 11 questions on how they behave when discussing a problem, and 9 questions on how they behave after the discussion of a problem. The CPQ has demonstrated good reliability and validity across multiple studies (Bodenmann, Kaiser, Hahlweg, & Fehm-Wolfsdorf, 2005). It was administered at intake and week 26.

Demographics. The demographics questionnaire was used to understand and describe the couple's demographics. This questionnaire is a 47-item measure that gathers information regarding cultural identity, languages spoken, education, family history, marriage history, and children. This was administered during the screening process before the treatment started. When used to describe couples in the results section, limited information was provided, and some information was changed to maintain privacy and prevent identification.

Marital Satisfaction. Marital satisfaction was measured to determine if the couple met the distress criteria for the study, along with tracking marital satisfaction scores to measure change throughout treatment. The Marital Satisfaction Inventory-Revised (MSI-R; Snyder, 1997) has 2 validity scales, 1 scale of global distress, and 10 scales looking at specific domains of marriage. The MSI-R is well normed and was administered before the intake during the screening process. The Global Distress Scale (GDS) of the MSI-R measures overall

dissatisfaction in marriage. It consists of 22 true-false items about the couple's relationship. The GDS was one of the primary methods of assessing change in relationship satisfaction. It was administered at intake, week 13, week 26, and at the final session.

Individual Functioning. The Compass Outpatient Treatment Assessment System (COTAS) (Sperry, Brill, Howard, & Grissom, 1996) has 3 self-report scales that assess patient functioning: subjective well-being, current symptoms, and current life functioning (Christensen et al., 2004). The Compass has demonstrated good reliability and validity and was administered before treatment started, week 13, and week 26. The Compass was administered to determine if individual functioning improves in the context of couple treatment.

Recorded Therapy Sessions and Pre-treatment Recorded Interactions. Along with using the aforementioned measures, the research team watched the first ten sessions for each of the six couples chosen, to conceptualize and describe the couple's reason for seeking treatment and their demand-withdraw pattern of interaction.

Before therapy, couples were instructed to participate in two pre-treatment 10-minute uninterrupted problem-solving interactions, one focused on a topic chosen by the wife, and one focused on a topic chosen by the husband. The couple was instructed to discuss the issue for 10 minutes, trying to resolve it as best as possible. The research team utilized both the husband and wife pre-treatment 10-minute problem-solving discussions to observe underlying emotions during demand-withdraw interactions. To observe emotions underlying demand behavior, coding involved rating the 3 wives in the wife-demand/husband-withdraw couples and the 3 husbands in the husband-demand/wife-withdraw couples. Each couple completed two interactions (wife topic and husband topic), so two 10-minute interactions were observed for each of the 3 wives and 3 husbands, for a total of 12 interactions observed (6 for wives in the wife-demand/husband-withdraw couples, 6 for husbands in the husband-demand/wife-withdraw couples).

Measures for Examining Emotion

The Behavioral Affective Rating Scale. The BARS (Johnson et al., 1998) was used as a way for researchers to learn how to infer emotions from patterns of behavior. The BARS rating scale was used while viewing the pre-treatment 10-minute problem-solving interactions to rate the emotions underlying demand. The BARS requires that coders rate the affect in a couples' interactions on a scale from 0 to 4 based on the individual's body language, facial expressions, and tone of voice. Although the BARS is designed to focus on non-verbal behavior and not verbal content, this study looks at content in addition to non-verbal behavior to capture verbalized emotions (e.g., "I'm frustrated."). 0 = *absence of the affect*, 1 = *mild*, 2 = *medium*, 3 = *strong*, and 4 = *extreme*. The BARS manual contains a list of examples of the 0-4 rating system for each affect. The BARS assesses affection, humor, anxiety, engaging, disengaging, defensiveness, aggressiveness, scorn, frustration, and hurt. The researchers chose this measure because the manual is brief, easy to understand, free, and it requires no professional training to be used. A similar coding system, the Specific Affect Coding System (SPAFF) requires a coder to complete eighty hours of training along with purchasing the manual and coding system. Fortunately, the BARS was developed as an alternative measure to the SPAFF and has been studied in comparison to the SPAFF. Comparison results found that convergent validity for the BARS was established because there was a significant and positive correlation between the BARS and SPAFF, due to categorical similarities in the assessment of dyadic affect. Discriminant validity was established because the correlations of different affects that were measured by the SPAFF and BARS were not significant (Johnson, 2002).

Procedures

Original Study Procedures

In the original study, couples went through a three-stage screening process, which included a phone interview to evaluate demographic eligibility and marital satisfaction, a mailed questionnaire packet to assess marital satisfaction and domestic violence, and an in-person intake interview to evaluate marital satisfaction and psychiatric eligibility. At this pre-treatment assessment, partners were also asked to complete four 10-minute recorded conversations with each other about a relationship and personal problems to assess their problem-solving and social support behaviors. Only the two interactions about relationship problems were used in this study, not the personal problem discussions. After completing the three-stage screening process, the couples were notified if they were accepted into the study. If accepted, the couples were given the name of a therapist and instructed to schedule an appointment. After scheduling their first appointment, the couples were randomly assigned to either TBCT or IBCT. The couples could receive a maximum of 26 sessions; however, they could end earlier if they felt that their problems had significantly resolved (or if they chose to end treatment for any reason). Outcome measures (DAS, GDS, MSI, MSI-R, and COMPASS) were administered at intake, after 13 weeks, 26 weeks, and at the final session. At the end of treatment, the Short Therapeutic Bond Scale and the Client Evaluation of Services Questionnaire were administered. Therapists and consultants completed the Therapist and Consultant Post-Treatment Questionnaire. The couples were followed at 6, 12, 18, and 24 months post-treatment to assess whether or not their gains in treatment had increased, plateaued, or decreased and whether or not these changes were significant based on treatment group (IBCT versus TBCT) (Christensen et al., 2004).

Current Study Procedures and Data Analysis

After receiving Institutional Review Board (IRB) approval, the researchers selected six cases based on the inclusion criteria outlined above. The researchers then examined the self-

report measures and viewed the first four sessions, (considered the assessment phase of treatment), along with an additional six sessions (10 sessions total) of each couple to summarize and conceptualize each couple's reason for distress, and become familiar with the nature of their emotions. The researchers then focused on the pre-treatment 10-minute problem-solving interactions to view the demand-withdraw pattern.

After selecting and describing the six couples, the researchers followed the steps of thematic analysis. The first step was to familiarize oneself with the data. This step involved the researchers viewing and reviewing the 10 minute-pre-treatment problem-solving videos to have a comprehensive understanding of their content. The next phase was coding. This phase involved the researchers developing labels (codes) that identified the different emotions underlying demand-withdraw patterns of interaction (Braun & Clarke, 2006). Emotions were documented and coded when the individual used words describing their emotion, when the therapist or partner used words to describe the individual's emotions and the individual indicated it was accurate, and according to the instructions in the BARS. The third step involved searching for themes. After the researchers collected and coded the data, they then identified patterns of underlying emotion for individuals who demand (Braun & Clarke, 2006). The next phase involved reviewing the themes. The researchers investigated each pattern against the data to determine if refinement was needed by reviewing the coded emotions, the couple's background history, and similarities and differences between the couples. The last phase was defining and naming themes, which involved the researchers carefully describing each pattern of emotion in rich detail (Braun & Clarke, 2006).

To become trained in the BARS, the researchers read the BARS manual and attached study. Next, excerpts of training tapes in which demand-withdraw was displayed (e.g., examples of other couples from the original study that were not selected as participants for the current study) were selected for each coder to rate, and BARS ratings between coders were compared to see if they were similar or different. Overall there was a high level of agreement between

coders and when differences did occur the coders re-watched the excerpt, discussed, and then subsequently came to an agreement. The coders met and watched all 12 pre-treatment 10-minute problem-solving interactions along with multiple therapy sessions. To increase trustworthiness, an external auditor was used when the coders could not come to an agreement or needed an additional opinion on the emotion being observed. The external auditor watched the video clip with the coders and discussed their thoughts and recommendations on how to proceed.

The researchers then reviewed DVD footage from the interactions using the BARS to code emotions underlying the demand-withdraw pattern. First, the researchers watched each 10-minute interaction continuously without rating to obtain an overview of the interaction. The clip was then watched again, this time with the researcher concentrating on either the demander or the withdrawer. The researcher stopped the recording after every 30 seconds to rate the clip for the ten behavioral affects. Lastly, the researchers repeated the previous step, focusing instead on the behavioral affects of the opposite partner (Johnson et al., 1998).

Qualitative analysis is not without its limitations. To increase trustworthiness, there are several recommended processes (Hays & Singh, 2012). The researchers selected an adequate sample, conducted a thorough literature search, took notes on researcher bias after watching videos, and provided a comprehensive description of the cases, all to increase credibility. To manage researcher bias, the researchers completed self-reflective journaling after each coding session and participated in weekly discussions about their potential bias with the research team (Hays & Singh, 2012). The researchers used multiple coders, consistent checking of coders' BARS ratings, and an external auditor to increase dependability. Additionally, a description of each coder is provided to display transparency of any biases.

Two researchers participated in coding all twelve 10-minute problem-solving discussions. Descriptions of the researchers are as follows: Emily Edwards is a 27-year-old single heterosexual Caucasian female. She graduated with her masters in marriage and family

therapy and is currently pursuing her doctorate in clinical psychology. Her past clinical experiences include providing family therapy and individual therapy to adults and children as young as five years old. Although Emily has experience working with parents of children she does not have any specific experience conducting couples therapy. Additionally, she co-authored a published chapter on demand-withdraw. Biases and assumptions made were:

- Due to similarities in gender and sexual orientation, there was an assumption that the researcher would have a stronger connection to the wives compared to the husbands.
- There was an assumption that the sample would be more diverse in ethnicity and level of education.
- There was an assumption that demand-withdraw behavior would be viewed during couple's therapy sessions.
- There may have been a negative bias towards couples that the researcher disliked which could have impacted how the researcher viewed and rated observed emotions.
- There may have been a positive bias toward couples that the researcher liked which could have impacted how the researcher viewed and rated observed emotions.

Jason Cencirulo is a 35-year-old gay male. He graduated with his master's in psychology and is currently pursuing his doctorate in clinical psychology. His past clinical experiences involve providing individual psychotherapy for children, adolescents, and adults. He has worked with diagnostically and demographically diverse civilian populations in addition to Veterans and their families. He has also contributed to a published chapter and an encyclopedia entry on issues concerning couples, including the demand-withdraw pattern of communication. Biases and assumptions were made, and included:

- That the demand-withdraw patterns of communication would be viewable during couples' therapy sessions and that couples would demonstrate observable signs of relational distress.

- That countertransferential negative feelings toward aggressive and/or hostile participants might impact rated observed emotions.
- That countertransferential positive feelings toward the use of humor or displays of affection might impact rated observed emotions.
- That the cultural context of the clients, including demographic realities, salient identities, and the time and location in which the data was collected would influence the presentation of client distress and therapeutic intervention.

Results

Results begin by presenting pertinent descriptive data on the selected sample of six couples. Included in the tables below are the Global Distress Scale (GDS) T-scores of the MSI-R that indicate levels of marital distress, CPQ scores of demand-withdraw communication patterns, and COMPASS scores of individual functioning.

Table 4

COMPASS- Husband T-Scores

Symptoms
Couple 1: 39.048
Couple 2: 50.857
Couple 3: 37.905
Couple 4: 31.810
Couple 5: 39.810
Couple 6: 37.143
Functioning
Couple 1: 55.516
Couple 2: 57.688
Couple 3: 57.688
Couple 4: 50.784
Couple 5: 49.722
Couple 6: 65.655
Well-being
Couple 1: 61.811
Couple 2: 48.875
Couple 3: 58.577
Couple 4: 71.514
Couple 5: 65.045
Couple 6: 58.577
Mental Health
Couple 1: 61.451
Couple 2: 52.308
Couple 3: 61.484
Couple 4: 66.396
Couple 5: 60.106
Couple 6: 65.019

Note. Mean of 50, standard deviation of 10; a score of 50 is representative of individuals seeking therapeutic treatment, a score above 60 has been shown to be representative of a normal population, while a score of 30 indicates high levels of distress (Sperry et al., 1996).

Table 5

COMPASS- Wife T-scores

Symptoms
Couple 1: 33.714
Coupe 2: 45.238
Couple 3: 39.429
Couple 4: 40.571
Couple 5: 33.333
Couple 6: 36.381
Functioning
Couple 1: 62.034
Couple 2: 45.377
Couple 3: 54.791
Couple 4: 62.758
Couple 5: 63.482
Couple 6: 58.413
Well-being
Couple 1: 61.811
Couple 2: 48.875
Couple 3: 58.577
Couple 4: 55.343
Couple 5: 65.045
Couple 6: 55.343
Mental Health
Couple 1: 66.251
Couple 2: 49.598
Couple 3: 59.694
Couple 4: 61.148
Couple 5: 68.302
Couple 6: 61.085

Note. Mean of 50, standard deviation of 10; a score of 50 is representative of individuals seeking therapeutic treatment, a score above 60 has been shown to be representative of a normal population, while a score of 30 indicates high levels of distress (Sperry et al., 1996).

The GDS T-scores have a mean of 50; T-scores below 50 indicate low marital distress, 50-60 indicates moderate levels of marital distress, and above 60 indicates high levels of marital distress. The CPQ had both husband and wife rate the amount of female demand-male withdraw and male demand-female withdraw. The results below are out of 27; therefore, a number 20 and above indicated high levels of the pattern. Lastly, the COMPASS to date has

one research study comparing T-scores (Sperry, Brill, Howard, & Grissom, 1996). That study reports a mean of 50 indicates a level of distress that is normative for those seeking therapeutic treatment, while a T-score of 30 indicates a high level of distress and a T score above 60 is indicative of a normal population (e.g., those not seeking treatment).

CPQ scores reveal a carefully selected sample with demand-withdraw communication patterns clearly represented. Baucom et al. (2011) found that demand-withdraw interactions are associated with lower levels of relationship satisfaction. On average husband demand-wife withdraw was rated 23/27 indicating high levels of the pattern and wife demand-husband withdraw was rated 25/27 indicating high levels of the pattern. As expected, marital distress was rated by all couples in the moderate to high range. COMPASS scores revealed that the majority of wives and husbands were experiencing high levels of symptoms (e.g., having repetitive thoughts, problems at work, feeling sad most of the time, feeling guilty, etc.). Moreover, on the functioning scale (e.g., the degree to which emotional and psychological problems interfere with family, intimacy, socialization, health, work, and self-management), 83% of husbands and 50% of wives scored similarly to those seeking psychological treatment. Well-being (e.g., levels of distress and energy; health; emotional and psychological adjustment and current life satisfaction) scores suggested that around half of both husbands and wives reported happiness levels similar to others seeking therapeutic treatment. Lastly, the average score for husbands and wives on the mental health index was 61; the mental health index T-score is a combined score of symptoms, current life functioning, and subjective well-being. A score of 61 indicates that both husbands and wives were experiencing similar distress to people in the normal population (e.g., those not seeking treatment).

Summary of Coding Data. Before presenting more couple-specific and emotion-specific descriptions, summaries of the emotion data from the BARS coding are provided next, in visual and text formats. Visual summaries of the BARS coding data include a figure of the emotions during demand behavior for both husbands and wives combined, a figure showing

similarities and differences between the sexes, and a figure showing similarities and differences between husband topic (HT) versus wife topic (WT). Written descriptions of the results and a comparison of husbands and wives are also provided.

To assess emotion experienced during the videotaped problem-solving interactions the BARS rating scale was used while observing the 12 recorded interactions (wife topic and husband topic for each couple). The results below reflect the emotions expressed based on the 0-4 BARS rating scale for each emotion (affection, humor, anxiety, engaging, disengaging, defensive, aggressive, scorn, frustration, and hurt). In the figures below, the y-axis represents the total BARS rating for each emotion observed. For example, a rating of 47 for anxiety indicates the sum of all BARS 1's, 2's, 3's, and 4's observed for that emotion.

Emotions During Demand Behavior - Total.

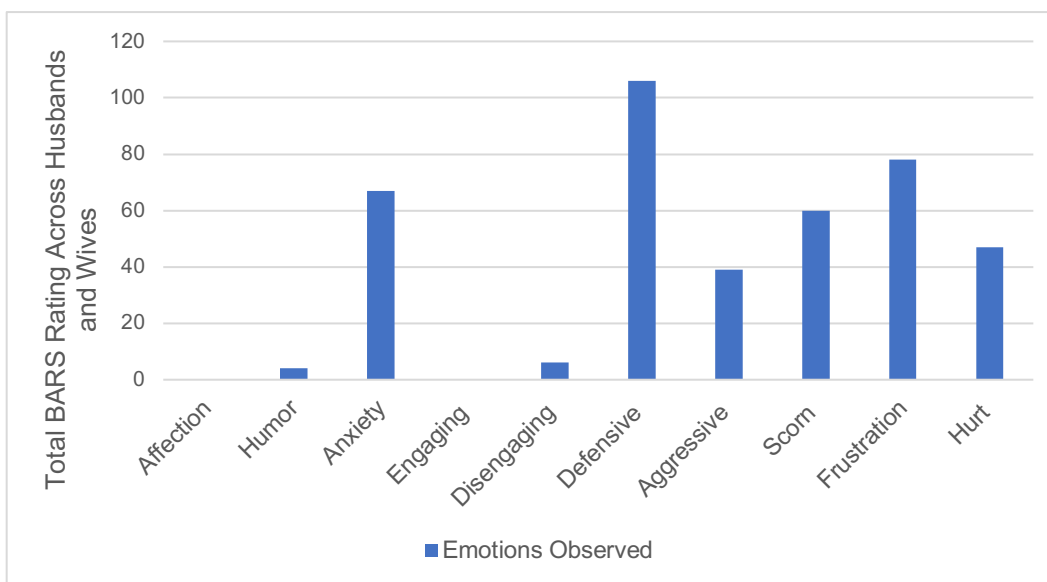


Figure 1. Emotions During Demand Behavior – Total. Emotions during demand behavior. This figure illustrates observed emotions for all demanders (3 males from the male-demand/female-withdraw couples, and 3 females from the female-demand/male-withdraw couples). Each of these participants were observed across the 2 interactions (wife-chosen topic and husband-chosen topic) for their couple, for a total of 12 interactions observed.

When totaling both husbands' and wives' emotions during demanding behaviors, the results indicated that defensiveness (106) was the most common emotion underlying demand behavior. Frustration (78) was the second most observed emotion, and anxiety (67) was third.

Scorn was rated 60 times, hurt 47 times, and aggression 39 times. The emotions that were least frequently rated during demand behavior were disengagement (6) and humor (4). Affection (0) and engaging (0) were not observed during demand behavior. This data indicates that when their partner began to withdraw and/or was actively withdrawn, the majority of individuals experienced defensiveness, frustration, and anxiety in trying to be heard and initiate change.

Wives' and Husbands' Emotions During Demand Behavior.

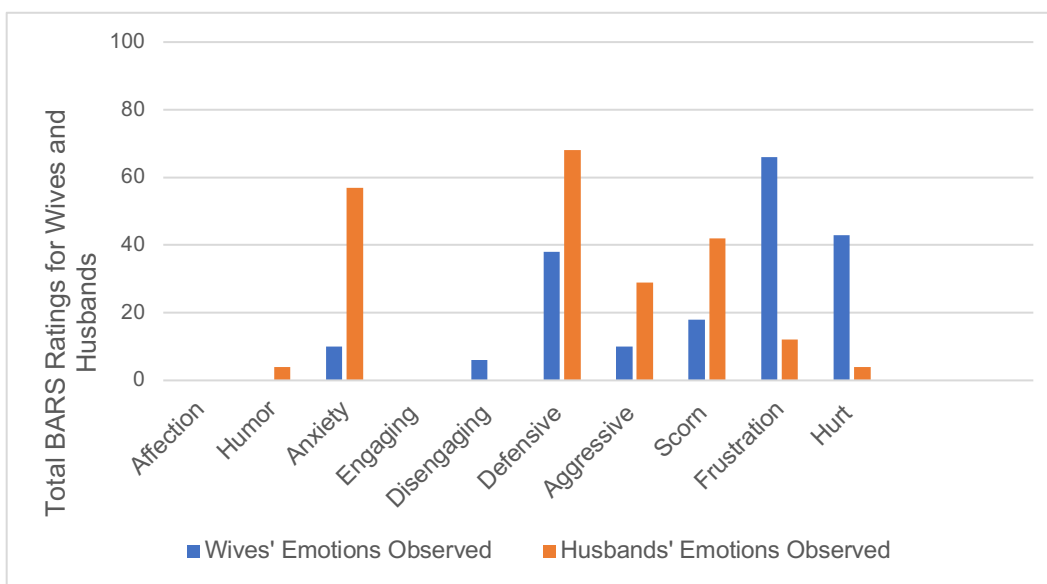


Figure 2. Wives' and Husbands' Emotions During Demand Behavior. Wives' (n = 3) and husbands' (n = 3) observed emotions during demand behavior. This figure illustrates the differences and similarities in observed emotions between wife and husband demanders (6 total observed interactions for wife demanders and 6 total for husband demanders).

Wives' Emotions During Demand Behavior. When taking into account only wives' emotions when demanding during the 6 interactions observed for the 3 wife-demand/husband-withdraw couples, the results indicated that frustration (66) was the most common emotion underlying demand behavior. Hurt (43) was the second most observed emotion, defensive (38) was third, and scorn (18) was fourth. The emotions that were rated the least were aggression (10), anxiety (10), and disengaging (6). Affection, humor, and engaging were not observed during the recorded pre-treatment problem-solving interactions.

Husbands' Emotions During Demand Behavior. When taking into account only husbands' emotions when demanding during the 6 interactions observed for the 3 husband-

demand/wife-withdraw couples, the results indicated that defensiveness (68) was the most common emotion underlying demand behavior. Anxiety (57) was the second most observed emotion, scorn (42) was third, and aggression (29) was fourth. The emotions that were rated the least were frustration (12), hurt (4), and humor (4). The emotions that were not observed were affection, engaging, and disengaging.

Comparison. When comparing husbands to total demand (e.g., wife and husband totals combined) both defensiveness and anxiety were two of most common emotions observed. When comparing wives' and husbands' emotional arousal, frustration and hurt were two of the least observed husband emotions and the two most observed wife emotions. Additionally, anxiety and aggression were two of the least observed emotions for wives and in the top four most observed emotions for husbands. Moreover, husbands and wives both appear to experience and express defensiveness while trying to be heard and initiate change; however, husbands demonstrate it somewhat more frequently. Overall, there were clear differences between the amount of observed emotion for wives and husbands across all emotions.

Wife Topic Versus Husband Topic. The results are also broken down into wife topic versus husband topic. Wife topic indicates that the wife chose the problem topic she wanted to discuss whereas husband topic indicates the husband chose the problem topic of discussion. Each couple had two discussions, one focused on the wife's chosen topic and one on the husband's chosen topic. During each pre-treatment 10 minute problem-solving discussion, the couple was asked to focus on the topic that the individual had chosen for the entire 10-minutes.

Wives' and Husbands' Emotions During Wife Topic.

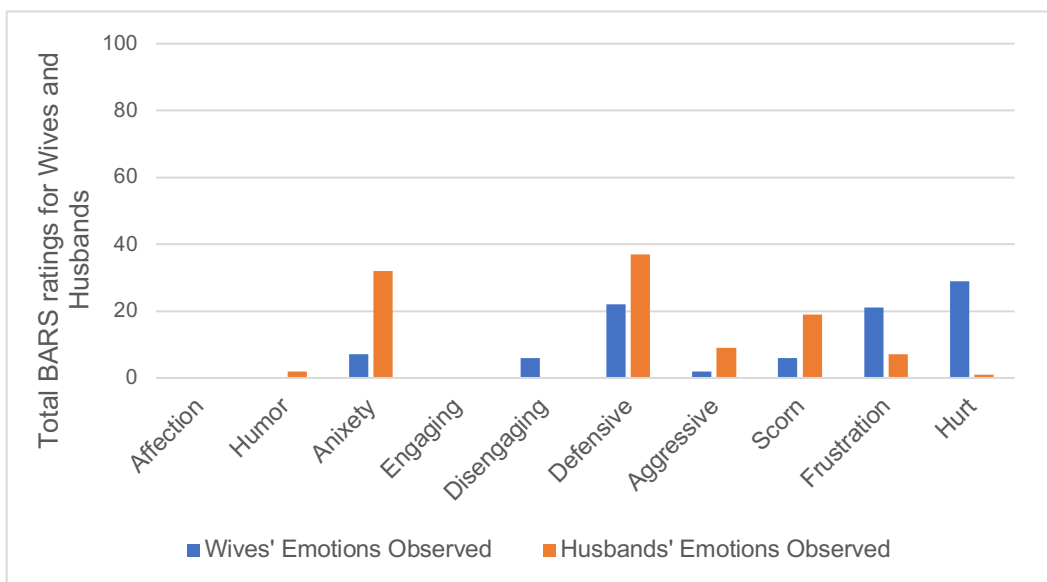


Figure 3. Wives' and Husbands' Emotions During Wife Topic. Wives' ($n = 3$) and husbands' ($n = 3$) emotions during wife topic. This figure illustrates a comparison between husbands' and wives' observed emotions during the 3 wife chosen topics for husbands (husband-demand/wife withdraw couples) and the 3 wife chosen topics for wives (wife-demand/husband withdraw couples).

Wives' Emotions During Wife Topic. When talking into account only wives' emotions during the 3 wife-topic interactions for the 3 wife-demand/husband-withdraw couples, the results indicated that hurt (29) was the most common emotion underlying demanding behavior. Defensiveness (22) was the second most observed emotion, frustration (21) was third, and anxiety (7) was fourth. The emotions that were rated the least were scorn (6), disengaging (6), and aggressive (2). The emotions that were not observed were affection, humor, and engaging.

Husbands' Emotions During Wife Topic. When taking into account only husbands' emotions during the 3 wife-topic interactions for the 3 husband-demand/wife-withdraw couples, the results indicated that defensiveness (37) was the most common emotion underlying demand behavior. Anxiety (32) was the second most observed emotion, scorn (19) was third, and aggression (9) was fourth. The emotions that were rated the least were frustration (7), humor (2), hurt (1). The emotions that were not observed were affection, engaging, and disengaging.

Comparison. When comparing husbands and wives during wife-topic, defensiveness was one of the most common observed emotions for both husbands and wives. Differences were that hurt and frustration were two of the most common emotions observed in wives whereas they were two of the least in husbands. Additionally, husbands were rated high in anxiety, while wives were rated low in anxiety.

Wives' and Husbands' Emotions During Husband Topic.

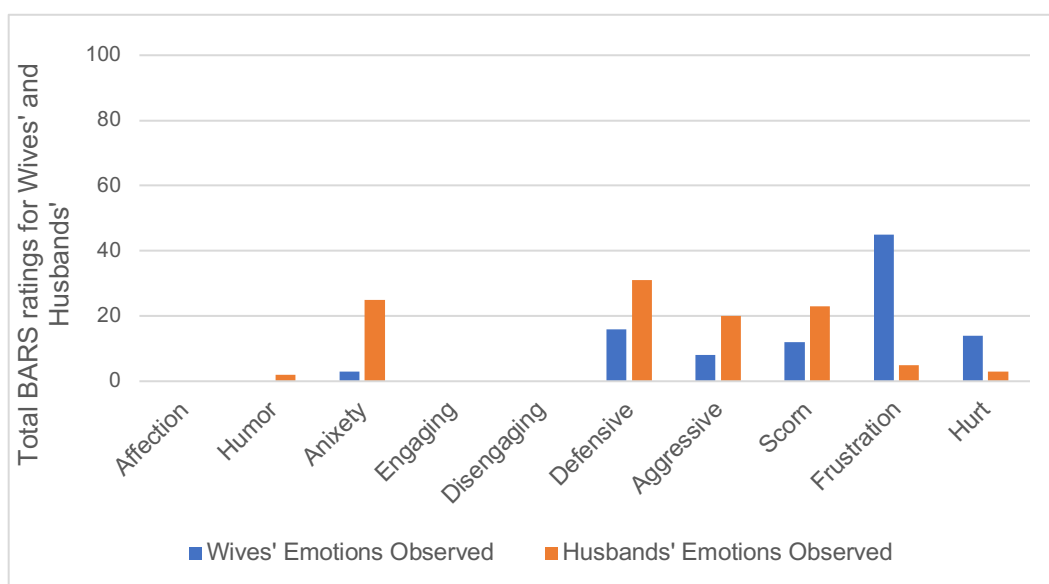


Figure 4. Wives' and Husbands' Emotions During Husband Topic. Wives' ($n = 3$) and husbands' ($n = 3$) emotions during husband topic. This figure illustrates a comparison between husbands' and wives' observed emotions during the 3 husband chosen topics for wives (wife-demand/husband withdraw couples) and the 3 husband chosen topics for husbands (husband-demand/wife withdraw couples).

Wives' Emotions During Husband Topic. When taking into account only wives' emotions during the 3 husband-topic interactions for the 3 wife-demand/husband withdraw couples, the results indicated that frustration (45) was the most common emotion underlying demanding behavior. Defensiveness (16) was the second most observed emotion, hurt (14) was third, and scorn (12) was fourth, and aggression (8) was fifth. The emotion that was rated the least was anxiety (3). The emotions that were not observed were affection, humor, engaging, and disengaging.

Husbands' Emotions During Husband Topic. When taking into account only husbands' emotions during the 3 husband-topic interactions for the 3 husband-demand/wife withdraw couples, the results indicated that defensiveness (31) was the most common emotion underlying demanding behavior. Anxiety (25) was the second most observed emotion, scorn (23) was third, and aggression (20) was fourth. The emotions rated the least were frustration (5), hurt (3), and humor (2). The emotions that were not observed were affection, engaging, and disengaging.

Comparison. When comparing wives to husbands during husband-topic, defensiveness was one of the most common observed emotions for both husbands and wives. Additionally, scorn was also rated high for both husbands and wives. Differences were frustration and hurt were two of the most observed emotions in wives whereas they were two of the least in husbands. Moreover, husbands were rated high in anxiety, while wives were rated low in anxiety.

When comparing topics, there were many similarities. Defensiveness was one of the most common emotions observed for both husbands and wives across wife and husband chosen topic. Differences also remained the same across topic. Frustration and hurt were two of the most observed emotions in wives and two of the least in husbands. Additionally, husbands rated high in anxiety across both topics while wives were rated low in anxiety.

Couple-Specific Descriptions and Individual Results

Written descriptions of each couple and individual are provided next. Descriptions include demographics, pertinent self-report data, number of sessions attended, and presenting problems from therapist, consultant, and client perspectives. Information that would make couples identifiable to others was removed, revised to be less specific, or changed altogether (if not pertinent to demand-withdraw). Additionally, graphs, tables, and text descriptions of individual's emotion data are provided, multiple comparisons are made, and notable patterns/themes are described.

Couples with Predominant Wife Demand-Husband Withdraw Patterns

Couple 1. Couple 1 attended 25 therapy sessions. Husband is in his early forties, Caucasian, completed 18 years of education and is employed in education. Wife is 40 years old, African American, completed 18 years of education and is employed as a manager. They have been married for eight years, and both have a child from a previous marriage and three children from their marriage.

Before couple's therapy, both Husband and Wife completed the MSI-R and rated their level of global distress in the high range (Husband: 74; Wife: 67). On the COMPASS rating scale, Husband and Wife reported that they were experiencing symptoms (e.g., having repetitive thoughts, problems at work, feeling sad most of the time, feeling guilty, etc.) that caused distress. Additionally, for well-being (e.g., level of distress, feeling energetic and healthy, satisfaction with life) both husband and wife reported a rating similar to those in the normal population (e.g., those not seeking treatment). On the ability to function in daily life (e.g., the degree to which emotional and psychological problems interfere with family, intimacy, socialization, health, work, and self-management), Husband reported a rating similar to others seeking psychological treatment, while Wife had a rating similar to the normal population. On the mental health symptoms index, both Husband and Wife indicated that they were experiencing distress, similar to others in the normal population.

Lastly, couple 1 completed the CPQ where both Husband and Wife described high levels of wife demand-husband withdraw (Wife's rating: 26; Husband's rating: 20), and lower levels of husband demand-wife withdraw. As reported by the wife during couple's therapy videos, her presenting concerns included that her husband is "dishonest" along with a lack of verbal affection and support in child rearing/managing their company. As reported by Husband during therapy, his presenting concerns included a lack of sexual intimacy at a level that he desires along with consistent arguments regarding child rearing.

Couple 2. Couple 2 attended 26 therapy sessions. Both spouses are in their late 40's and Caucasian. Husband completed 21 years of education and is employed as a consultant. Wife completed 15 years of education and is employed as a buyer. Couple 2 has been married 19 years. Wife was previously married and has three children from that marriage. Wife and Husband have one child of their own.

Before couples' therapy, both Husband and Wife completed the MSI-R and rated their level of global distress in the high range (Husband: 72; Wife: 66). On the COMPASS rating scale, both Husband and Wife reported a level of symptoms (e.g., having repetitive thoughts, problems at work, feeling sad most of the time, feeling guilty, etc.) similar to others seeking treatment. Their ability to function in daily life (e.g., the degree to which emotional and psychological problems interfere with family, intimacy, socialization, health, work, and self-management), well-being (e.g., level of distress, feeling energetic and healthy, satisfaction with life) and mental health were again rated similar to individuals seeking psychological treatment.

Lastly, they completed the CPQ where both Husband and Wife described high levels of wife demand-husband withdraw (Wife's rating: 23; Husband's rating 27), and low levels of husband demand-wife withdraw. Major themes in therapy were related to control and responsibility regarding money, frustration due to Husband withdrawing, lack of emotional expression and support. In the 10-minute pre-treatment problem-solving videos, Wife stated, "you remove yourself (husband) from us." As reported by the husband during couple's therapy videos, Husband perceives his wife as too critical, and at times he feels "picked on." Whereas, Wife feels "unsupported" and "frustrated" due to Husband's job insecurity which causes financial instability. Husband stated, "It's been a tough ten years...there's been a lot of emotional duress and financial duress."

Couple 3. Couple 3 attended 25 sessions. Husband is in his late 30's, Caucasian, completed 14 years of school and is employed as a technician. Wife is in her early 30's, Caucasian, completed 20 years of education and is employed as an assistant. Couple 3 has

been married for 1.5 years and have one adopted child. Wife and Husband were previously married. Husband was diagnosed with depression, which he believed started after high school.

Before couples' therapy, both Husband and Wife completed the MSI-R and rated their level of global distress in the high range (Husband: 70; Wife: 66). Additionally, they were given the COMPASS rating scale. Husband and Wife reported high levels of symptoms (e.g., having repetitive thoughts, problems at work, feeling sad most of the time, feeling guilty, etc.). Their ability to function in daily life (e.g., the degree to which emotional and psychological problems interfere with family, intimacy, socialization, health, work, and self-management) and level of well-being (e.g., level of distress, feeling energetic and healthy, satisfaction with life) scores all fell within the range for individuals seeking therapeutic treatment. On the mental health symptoms index, Husband's scores indicated that he was experiencing distress similar to the normal population (e.g., those not seeking treatment) and Wife's scores indicated more distress, similar to those seeking psychological treatment.

Lastly, they completed the CPQ where both Husband and Wife described high levels of wife demand-husband withdraw (Wife rating: 26; Husband rating: 25), and low levels of husband demand-wife withdraw. The typical pattern of interaction as seen in the 10-minute pre-treatment problem-solving video and as explained during couple's therapy videos, is that Wife tries to discuss problems in their relationship and Husband subsequently becomes highly anxious which leads to internal self-deprecation and then verbal and emotional withdraw. Wife becomes frustrated by his withdraw and pursues more conversation with Husband, and consequently, he becomes more withdrawn. Major themes in therapy were ineffective communication, lack of emotional expression, and sexual intimacy. As mentioned during one of their couple's therapy sessions, Husband feels "snapped at" when talking with his wife, he stated, "it's like I'm being hit, I'd rather be hit...I just hate it." Husband and Wife both reported during couple's therapy videos that sexual intimacy is their biggest complaint. Husband has difficulty achieving orgasm due to anxiety; he worries about losing his erection.

Wife Topic/Wife Demand.

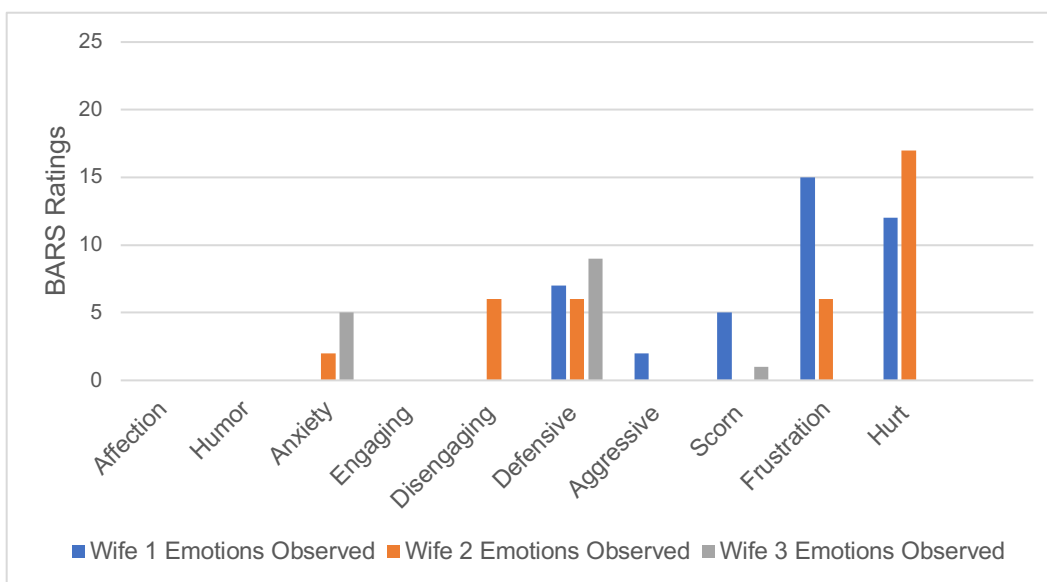


Figure 5. Wife topic/wife demand. This figure illustrates a comparison between all three wives' observed emotions during the 3 wife chosen topics for wife-demand/husband withdraw couples.

Wife 1's Topic (Wife Demand). Frustration (15) was the most common emotion underlying demand behavior. Hurt (12) was the second most observed emotion, defensive (7) was third, scorn (5) fourth, and aggression (2) fifth.

Wife 2's Topic (Wife Demand). Hurt (17) was the most common emotion underlying demand behavior. Frustration (6), defensive (6), and disengaging (6) all tied for second most observed emotion and anxiety (2) was third.

Wife 3's Topic (Wife Demand). Defensive (9) was the most common emotion underlying demand behavior. Anxiety (5) was the second most observed emotion, and scorn (1) was third.

Comparison of Emotions Across Wives During Wife Topics

When comparing Wife 1, 2, and 3 during discussions in which wives chose the topic, there are similarities and differences. One similarity was all three wives had defensiveness as one of the top three emotions observed during wife chosen topic. A difference was that Wife 1 and 2 had more underlying emotions in common compared to Wife 3. Hurt was the first and second most observed emotion for Wife 1 and 2, while hurt was not observed for Wife 3.

Additionally, the emotion observed the most in Wife 1 (frustration) was the second most observed emotion for Wife 2, while it was not observed in Wife 3.

Wife 3 seemed to be an outlier compared to the other two wives, as anxiety was the second most observed emotion for Wife 3, whereas it was the least observed emotion for Wife 2 and was not observed in Wife 1. Another outlier for Wife 3 is scorn, third most observed emotion. Scorn is rated fourth for Wife 1 and is not rated (zero observed scorn emotions) for Wife 2.

Husband Topic/Wife Demand.

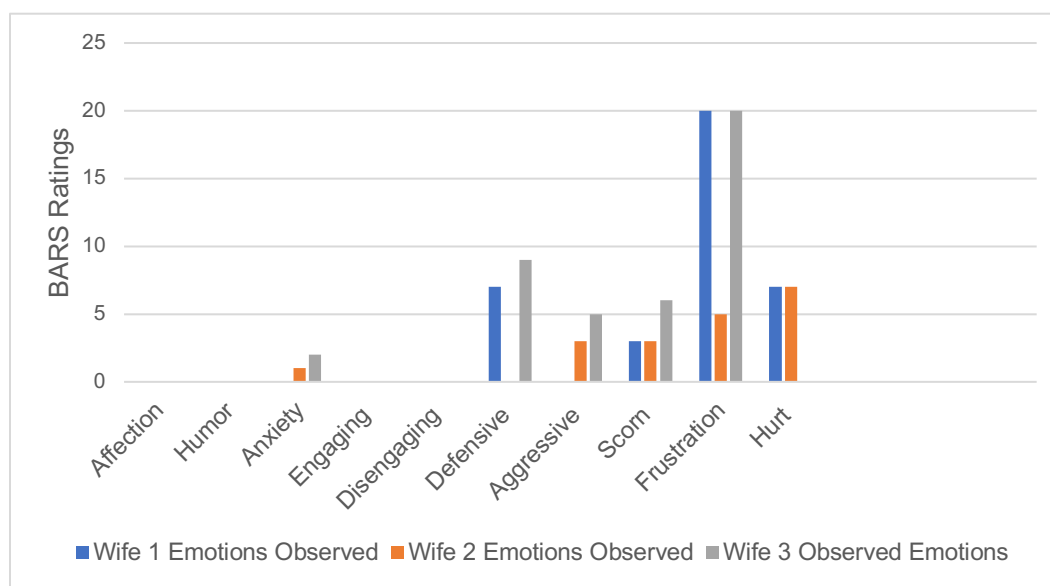


Figure 6. Husband topic/wife demand. This figure illustrates a comparison between all three wives' observed emotions during the 3 husband chosen topics for wife-demand/husband withdraw couples.

Husband 1's Topic (Wife Demand). Frustration (20) was the most common emotion underlying demanding behavior. Hurt (7) and defensive (7) tied for second most observed emotion and scorn (3) was third.

Husband 2's Topic (Wife Demand). Hurt (7) was the most common emotion underlying demand behavior. Frustration (5) was the second most observed emotion while aggression (3) and scorn (3) tied for third most rated emotion. Anxiety (1) was the fourth most observed emotion.

Husband 3's Topic (Wife Demand). Frustration (20) was the most common emotion underlying demand behavior. Defensive (9) was the second most observed emotion, scorn (6) was third, and aggression (5) fourth. The emotion rated the least was anxiety (2).

Comparison of Emotions Across Wives During Husband Topics

When comparing Wife 1, 2, and 3 during discussions in which husbands chose the topic, there are similarities and differences. A similarity across wives is that frustration, the most common emotion underlying demand behavior for Wife 1, was also the most common emotion for Wife 3 and the second most common emotion for Wife 2. Additionally, all three wives had scorn as their third most observed emotion. A difference is that Wives 1 and 3 had more observed emotions in common compared to Wife 2. Defensiveness was Wife 3's second and Wife 1's third most observed emotion, while Wife 2 had no observed defensiveness. Moreover, Wives 1 and 3 not only had frustration as their first most observed emotion but the sum of their frustration was the same (20). Although Wives 1 and 3 seemed to have more in common, Wives 1 and 2 had hurt as the first and second most observed emotion, while Wife 3 had no observed hurt.

Individual Comparisons Within Wives Across Topics

When comparing Wife 1 across the discussions of her chosen issue and Husband's chosen issue, it seems that when Husband picked the topic of discussion Wife's frustration increased, her observed level of hurt decreased, and defensiveness remained stable.

When comparing Wife 2 across the discussions of her chosen issue and Husband's chosen issue, it seems that when Husband picked the topic of discussion Wife's overall observed emotions decreased. Hurt reduced by 10 points, frustration by one point and defensiveness and disengaging decreased from six to zero. The two emotions that increased during the Husband's topic were aggression and scorn which went from zero to three.

When comparing Wife 3 across the discussions of her chosen issue and Husband's chosen issue, the most notable change was the increase in frustration which increased from zero to 20 observations. Additionally, anxiety decreased, and defensiveness stayed constant.

Notable Themes/Patterns in Wife Emotion During Wife Demand Behavior

Defensiveness, scorn, and frustration were observed in all three wives during demanding behavior (see Table 6). Specifically, defensiveness was observed in all three wives during wife's topic. Wives used nonverbal behavior and verbalization to express their defensiveness. They would shake their head back and forth to disagree with what their partner was saying along with putting their hand out as a gesture saying "no" and/or to try and stop their partner from speaking. Defensiveness may have been seen more during wife topic due to their increased desire to defend their problem position. Scorn was observed in all three wives during husbands' topic. Wives used both nonverbal behavior and verbalization to express scorn. They would make comments (e.g., okay, alright, fine) in a sarcastic tone of voice to express scorn. Additionally, they rolled their eyes after their husband commented on their demanding behavior or after they said that they (i.e., husband) have been trying to make the relationship better. Frustration was high for both husband and wife topic. Wives expressed frustration through sighs when their husband would make "excuses" for his behavior. One wife voiced frustration (i.e., sighing) when her husband would discuss why he could not keep a stable job. Another wife expressed frustration (i.e., sighing) when her husband discussed his anxiety during sexual intimacy.

Individual Summaries of Emotion Ratings

Table 6

Combined BARS Ratings Wife Demand

Affection	Humor	Anxiety	Engaging	Disengaging	Defensive	Aggressive	Scorn	Frustration	Hurt
1WT: 0	1WT: 0	1WT: 0	1WT: 0	1WT: 0	1WT: 7	1WT: 2	1WT: 5	1WT: 15	1WT: 12
1HT: 0	1HT: 0	1HT: 0	1HT: 0	1HT: 0	1HT: 7	1HT: 0	1HT: 3	1HT: 20	1HT: 7
2WT: 0	2WT: 0	2WT: 2	2WT: 0	2WT: 6	2WT: 6	2WT: 0	2WT: 0	2WT: 6	2WT: 17
2HT: 0	2HT: 0	2HT: 1	2HT: 0	2HT: 0	2HT: 0	2HT: 3	2HT: 3	2HT: 5	2HT: 7
3WT: 0	3WT: 0	3WT: 5	3WT: 0	3WT: 0	3WT: 9	3WT: 0	3WT: 1	3WT: 0	3WT: 0
3HT: 0	3HT: 0	3HT: 2	3HT: 0	3HT: 0	3HT: 9	3HT: 5	3HT: 6	3HT: 20	3HT: 0

Note. HT: husband topic; WT: wife topic

Couples with Predominant Husband Demand-Wife Withdraw Patterns

Couple 4. Couple 4 attended 23 therapy sessions. Husband is in his mid-40's, Indonesian, completed 15 years of education and is employed as an engineer. Wife is in her late 40's, Caucasian, completed 17 years of education and is employed at a restaurant. Couple 4 has been married for ten years. Wife was married previously and widowed. Husband has no previous marriages. They have one child from their marriage.

Before couples' therapy, both Husband and Wife completed the MSI-R and rated their level of global distress in the moderate range (Husband: 57; Wife: 60). Additionally, they were given the COMPASS rating scale. Husband and Wife reported high levels of symptoms (e.g., having repetitive thoughts, problems at work, feeling sad most of the time, feeling guilty, etc.). Wife stated that she is "terribly depressed," which may have impacted her level of symptoms. Additionally, Wife's ability to function in daily life (e.g., the degree to which emotional and psychological problems interfere with family, intimacy, socialization, health, work, and self-management) was rated similarly to those in the normal population (e.g., not seeking treatment), while Husband's ratings were similar to those seeking treatment. On the well-being section (e.g., level of distress, feeling energetic and healthy, satisfaction with life), Wife's ratings

indicated that she was experiencing distress similar to those seeking treatment, while Husband's scores were more suggestive of those not seeking treatment. Regarding mental health, both Husband and Wife's scores fell within the normative range for individuals not seeking therapeutic treatment.

Lastly, they completed the CPQ where both Husband and Wife described high levels of husband demand-wife withdraw (Wife: 24; Husband: 21). The typical pattern of interaction as seen in the 10-minute pre-treatment problem-solving video and as explained during couple's therapy videos, is that Husband expresses aggressive and critical remarks regarding his Wife's involvement in his business, Wife withdraws from the conversation, Husband responds critically and increases his demanding/insisting that he help her with his business and Wife continues to resist helping him and withdraws further. Major themes in therapy were related to control and responsibility. As reported by the husband during therapy, he becomes "frustrated" with his wife for not "being supportive of him" by refusing to help him with work. Additionally, Wife reported during couple's therapy videos that her husband is "critical" of her job and her as a wife. The wife stated, "I was doing my best...my best is never enough."

Couple 5. Couple 5 attended 24 therapy sessions. Husband is 40 years old, Caucasian, completed 15 years of education and is employed as a regional director. Wife is in her mid-30's, Caucasian, completed 15 years of education and is employed as an office manager. Couple 5 has been married for six years, and they have two children together. Wife and Husband were both previously married; Husband has one child from his previous marriage.

Before couples' therapy, both Husband and Wife completed the MSI-R and rated their level of global distress in the high range (Husband: 71; Wife: 67). Additionally, they were given the COMPASS rating scale. Husband and Wife reported high levels of symptoms (e.g., having repetitive thoughts, problems at work, feeling sad most of the time, feeling guilty, etc.). Additionally, Wife's ability to function in daily life (e.g., the degree to which emotional and psychological problems interfere with family, intimacy, socialization, health, work, and self-

management) was rated similarly to those not seeking treatment, whereas Husband's scores indicated that he was experiencing stress similar to those seeking treatment. Regarding well-being (e.g., level of distress, feeling energetic and healthy, satisfaction with life) and mental health, both Husband and Wife reported scores all within the normative range for individuals not seeking therapeutic treatment.

Lastly, they completed the CPQ where both Husband and Wife described high levels of husband demand-wife withdraw (Wife: 27; Husband: 23), and lower levels of wife demand-husband withdraw. The typical pattern of interaction as seen in the 10-minute pre-treatment problem-solving video and as explained during couple's therapy videos is that Husband pursues discussion of their emotional and physical relationship, Wife withdraws, Husband makes critical remarks about Wife, and Wife continues to withdraw. A major theme in therapy was a lack of trust due to the relationship starting when Husband was still married. Throughout the couple's therapy videos, Wife was unexpressive, withdrawn, unassertive. This may be due to Wife not feeling safe having conversations with Husband because he "attacks and scolds" her. The wife stated, "I feel put in a place where I don't feel comfortable...I don't have that trust that you're not going to blow up on me." In couple's therapy videos Husband reported that he feels "abandoned" and "disconnected" from his wife. The husband stated, "our sexual relationship has died...I want an affectionate, passionate relationship." Moreover, he expressed anxiety about whether or not his wife was having an extramarital affair; he stated, "I would think you would want the same (affectionate relationship) unless there's some reason I shouldn't be touching you." Later on, in couple's therapy, Wife disclosed a current extramarital affair.

Couple 6. Couple 6 attended 25 therapy sessions. Husband is in his early 50's, Caucasian, completed 17 years of education and is employed as a writer/editor. Wife is in her late 30's, Caucasian, completed 18 years of education and is employed as an administrative assistant. Couple 6 has been married for three years. Wife was married previously and has two children from that marriage. Wife and Husband have one child from their marriage.

Before couples' therapy, both Husband and Wife completed the MSI-R and rated their level of global distress in the high range (Husband: 69; Wife: 73). Additionally, they were given the COMPASS rating scale. Husband and Wife reported high levels of symptoms (e.g., having repetitive thoughts, problems at work, feeling sad most of the time, feeling guilty, etc.). Additionally, Wife's ability to function in daily life (e.g., the degree to which emotional and psychological problems interfere with family, intimacy, socialization, health, work, and self-management) was rated similarly to those seeking treatment, while Husband's scores were similar to those not seeking treatment. On the well-being (e.g., level of distress, feeling energetic and healthy, satisfaction with life) scale, both Husband and Wife reported scores similarly to those seeking treatment; however, on the mental health index, their scores all fell within the normative range for individuals not seeking therapeutic treatment.

Lastly, they completed the CPQ where both Husband and Wife described high levels of husband demand-wife withdraw (Wife: 20; Husband 24), with lower levels of wife demand-husband withdraw. The typical pattern of interaction as seen in the 10-minute pre-treatment problem-solving video and as explained during couple's therapy videos is that Husband has "obsessive" thoughts and starts a long-winded discussion of them, Wife becomes frustrated and withdraws, Husband criticizes Wife's ability to make decisions and engage, and Wife withdraws further. In the 10-minute pre-treatment problem-solving videos the wife stated, "I feel nagged...I feel nagged constantly...I feel alone and unheard, and then I don't do anything." Major themes in therapy were a lack of affection and positive interaction. As reported by Wife and Husband during couple's therapy videos, their financial stressors from medical bills for them and their son lead to anxious and depressive thoughts. Additionally, Wife reported that she is anxious about losing weight, as she has struggled with an eating disorder throughout her life. Husband stated during couple's therapy videos that he "obsesses" and "ruminates" about things, which lead to unhappiness and anxiety.

Wife Topic/Husband Demand.

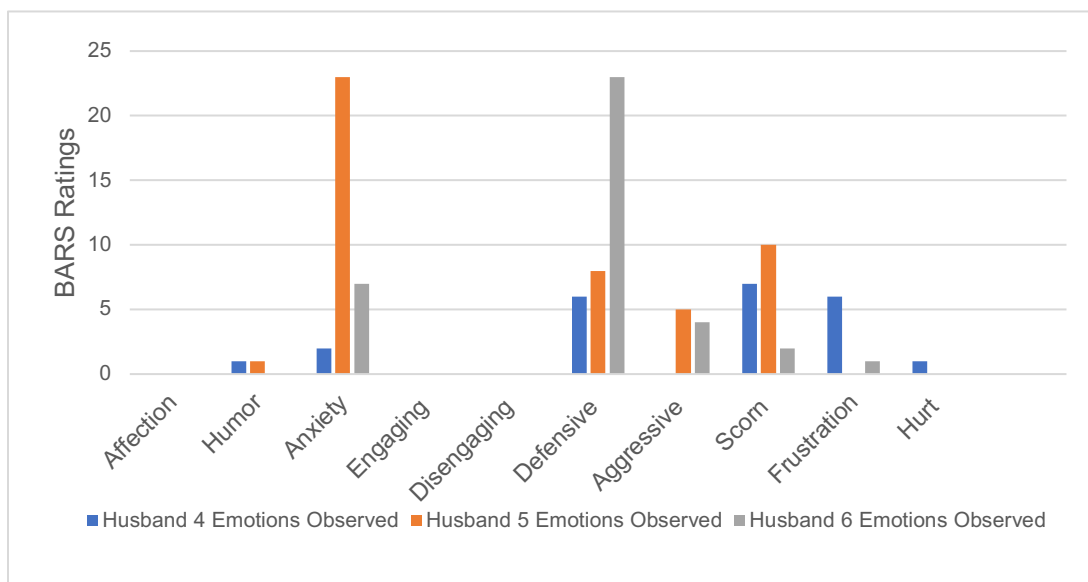


Figure 7. Wife topic/husband demand. This figure illustrates a comparison between all three husbands' observed emotions during the 3 wife chosen topics for husband-demand/wife withdraw couples.

Wife 4's Topic (Husband Demand). Scorn (7) was the most common emotion underlying demand behavior. Frustration (6) and defensive (6) tied for second most observed emotion. Anxiety (2) was the third most rated emotion and humor (1) and hurt (1) tied for fourth.

Wife 5's Topic (Husband Demand). Anxiety (23) was the most common emotion underlying demand behavior. Scorn (10) was the second most observed emotion, defensive (8) third, aggressive (5) fourth, and humor (1) fifth.

Wife 6's Topic (Husband Demand). Defensiveness (23) was the most common emotion underlying demand behavior. Anxiety (7) was the second most observed emotion, aggressive (4) third, scorn (2) fourth, and frustration (1) fifth.

Comparison of Emotions Across Husbands During Wife Topics

When comparing all three husbands, there were similarities and differences. The most significant difference was related to frustration. Frustration was the second most observed emotion for Husband 4, fifth for Husband 6, and was not observed for Husband 5. The similarity between all three husbands was defensiveness, which was in their top three emotions

observed. Additionally, there were instances where observed emotions would rank similarly (e.g., first, second, third) but the amount of observed emotion was significantly different. For example, anxiety was the most common emotion observed for Husband 5, and while it was the second most observed emotion for Husband 6, it did not reach the same levels as Husband 5. Moreover, defensiveness was the first and second most observed emotion for Husband 6 and 4 respectively; however, Husband 6's amount of defensiveness observed was much higher than Husband 4's. Additional similarities were, Husband 5 and 4 had scorn as the first and second most observed emotion and defensiveness as second and third.

Husband Topic/Husband Demand.

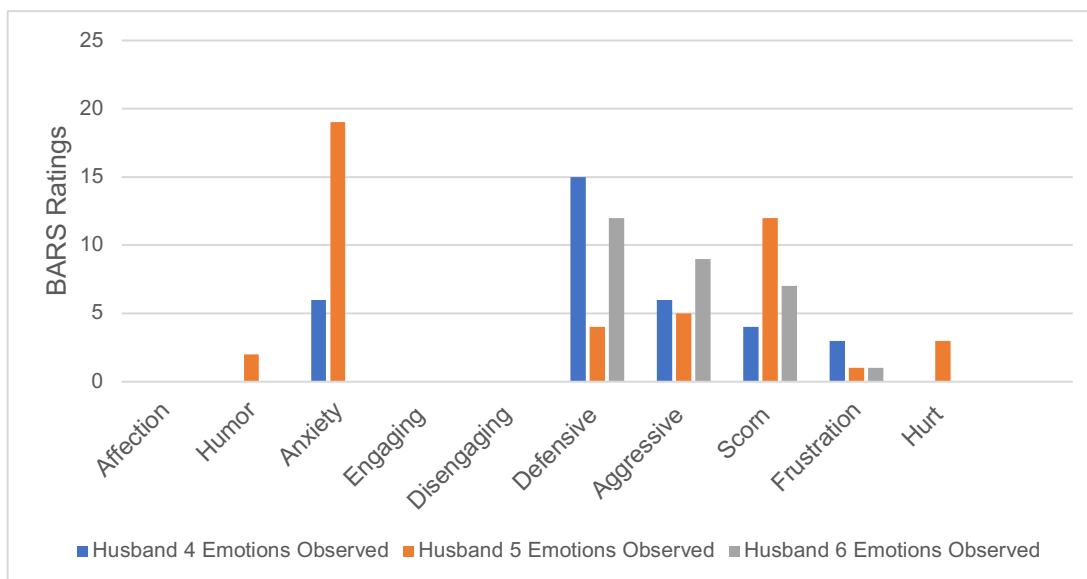


Figure 8. Husband topic/husband demand. This figure illustrates a comparison between all three husbands' observed emotions during the 3 husband chosen topics for husband-demand/wife-withdraw couples.

Husband 4's Topic (Husband Demand). Defensive (15) was the most common emotion underlying demand behavior. Anxiety (6) and aggression (6) tied for second most observed emotion. Scorn (4) was third most rated emotion and frustration (3) fourth.

Husband 5's Topic (Husband Demand). Anxiety (19) was the most common emotion underlying demand behavior. Scorn (12) was the second most observed emotion, aggression

(5) third, defensive (4) fourth, and hurt (3) fifth. Humor (2) and frustration (1) were the emotions rated the least.

Husband 6's Topic (Husband Demand). Defensive (12) was the most common emotion underlying demand behavior. Aggression (9) was the second most observed emotion, scorn (7) third, and frustration (1) fourth.

Comparison of Emotions Across Husbands During Husband Topics

When compared to Husband 5, Husband 4 was most similar to Husband 6, as they had the same top four expressed emotions (defensive, aggression, scorn, and frustration). While scorn was the third most observed emotion and aggression the second for both Husband 4 and 6, it was the second and third most observed emotion for Husband 5. A difference was, although anxiety was rated second for Husband 4 and first for Husband 5, it was substantially lower than the observed amount for Husband 5 (6 versus 19).

Individual Comparison Within Husbands Across Topics

When comparing Husband 4 across the discussions of his chosen issue and Wife's chosen issue, it seems that when he picks the problem topic, scorn and frustration decrease while observed defensiveness and anxiety more than double. Additionally, aggressiveness increased from zero observations to six

When comparing Husband 5 across the discussions of his chosen issue and Wife's chosen issue, it seems that when he picks the problem topic, anxiety and defensiveness decrease, while aggression remained stable compared to Wife's topic.

When comparing Husband 6 across the discussions of his chosen issue and Wife's chosen issue, it seems that when he picks the problem topic, his defensiveness substantially decreases (11 points) and anxiety declines to zero. Additionally, both aggression and scorn more than doubled during husband chosen topic.

Notable Themes/Patterns in Husband Emotion During Husband Demand Behavior

Defensiveness, aggression, scorn, frustration, and anxiety were observed in all three husbands during demanding behavior (see Table 7). Specifically, defensiveness and scorn were observed in all three husbands in both husband and wife topic. Similar to wives, husbands used both nonverbal behavior and verbalization to express their defensiveness. They would say, “I did X, only because you did Y” or “You did X, so I did Y.” One Husband became defensive regarding magazine subscriptions stating that his wife bought books, so he bought magazines, and that if she can spend money so can he. Additionally, husbands would shake their head back and forth to disagree with what their partner was saying. One husband shook his head to disagree with his wife’s comment that he is too focused on their sex life. Moreover, husbands would put their hand out as a gesture saying “no” and/or to try and stop their partner from speaking.

Husbands used both nonverbal behavior and verbalization to express scorn. One husband would make insulting comments about his wife’s education insinuating that he was smarter than her. Additionally, rolling eyes was used to express scorn. One husband rolled his eyes when his wife stated that she does make decisions because he believes she does not make timely decisions and that things “never get dealt with.”

Anxiety was observed in all three husbands during wife’s topic. Anxiety was expressed through shifting and fidgeting with hands/fingers. One husband became anxious and was crossing/uncrossing his legs, playing with his fingers, and crossing/uncrossing his arms when discussing sex. The husband reported that sex is related to anxiety because Wife “is put out when I (husband) make advances toward you (wife).” Another husband would shift his legs and move his hands to different positions when discussing decision making because he, “just wants a decision made” and wife avoids decision making; therefore, events or activities are put on hold, which increases Husband’s anxiety.

Aggression and frustration were observed in all three husbands during husband topic. Aggression was expressed through a forceful tone of voice and pointing comments. One husband made pointing comments stating that his wife does not care about his business and him succeeding because she will not quit her job and work for him. Another husband used a forceful tone of voice to express his anger that his wife is not affectionate anymore; he stated, “you’re put out when I make advances toward you...when you walk by and do that (rub his hair) it sparks my nerves, do you blame me.”

Although frustration was rated lower than other emotions it was observed in all three husbands during husband chosen topic. Husbands expressed frustration through sighing. One husband would sigh when his wife would state that she did not want to quit her job and work full time for him.

Individual Summaries of Emotion Ratings

Table 7

Combined BARS Ratings Husband Demand

Affection	Humor	Anxiety	Engaging	Disengaging	Defensive	Aggressive	Scorn	Frustration	Hurt
4WT: 0	4WT: 1	4WT: 2	4WT: 0	4WT: 0	4WT: 6	4WT: 0	4WT: 7	4WT: 6	4WT: 1
4HT: 0	4HT: 0	4HT: 6	4HT: 0	4HT: 0	4HT: 15	4HT: 6	4HT: 4	4HT: 3	4HT: 0
5WT: 0	5WT: 1	5WT: 23	5WT: 0	5WT: 0	5WT: 8	5WT: 5	5WT: 10	5WT: 0	5WT: 0
5HT: 0	5HT: 2	5HT: 19	5HT: 0	5HT: 0	5HT: 4	5HT: 5	5HT: 12	5HT: 1	5HT: 3
6WT: 0	6WT: 0	6WT: 7	6WT: 0	6WT: 0	6WT: 23	6WT: 4	6WT: 2	6WT: 1	6WT: 0
6HT: 0	6HT: 0	6HT: 0	6HT: 0	6HT: 0	6HT: 12	6HT: 9	6HT: 7	6HT: 1	6HT: 0

Note. HT: husband topic; WT: wife topic

Descriptions of Each Emotion

Lastly, this written section provides descriptions of each emotion, summarizing patterns and providing rich descriptions of observations.

Affection. Based on the results, none of the participants expressed support, warmth and tenderness (e.g., genuine smiles, warm laughter, holding hands, hugging, flirting) with their

partner when demanding. This is expected as they reported high levels of marital distress; it is likely that this would mostly be seen in non-distressed couples. Interestingly though, during couple's therapy sessions a few of the couples would hold hands at the beginning of a session or would put their arm around their partner.

Humor. Although humor was expressed by two individuals during demanding behavior, they were all at low levels (combined BARS ratings across all 12 interactions: 3). The humor used was playful teasing with no ill intention as a way to ease the tension in the room. In both instances partners engaged in a genuine, honest smile or laugh in response to the joke. A humorous interaction where both Husband and Wife laughed and smiled occurred when Wife of couple 4 stated, "Unless you believe in reincarnation" and Husband responded, "I'd become a worm." Humor is likely low as there must be no ill intention shared by the couple and it is expected that this would be seen in non-distressed couples. When individuals made sarcastic jokes, there was ill intention behind the joke, and therefore those were rated under the emotion scorn.

Anxiety. Anxiety was observed in five of the couples; however, Husband 5 was an outlier (BARS ratings for wife topic: 23; BARS ratings for husband topic: 19). The majority of anxiety seen was shifting in their seat, crossing/uncrossing legs, and twirling pens. Additionally, there was some extended fidgeting where individuals would play with their hair, tap or twirl their fingers, and touch their face (e.g., play with their eyelashes). At times the individual fidgeted so often that it was distracting and difficult to focus on the conversation.

Engaging. Similar to affection, engaging had zero reported observations. This is due to the couples' lack of maintaining steady, active eye contact and using affirmative vocal cues. Frequently individuals were looking at the floor or past their partner; if they did make eye contact with each other, it was brief.

Disengaging. Only one individual used disengaging (i.e., displaying a total disinterest in the conversation and not listening; extended break of eye contact, over-talk) during demanding

behavior. Wife 2 broke eye contact for a prolonged period due to frustration with her husband stating how he will change his behavior but has yet to follow through. When Wife 2 disengaged, she not only broke eye contact but she stopped responding to her husband as well, and consequently, there was a break in conversation. The withdrawer (i.e., husband) did not fill the silence, and interestingly, when the demander did not engage in her normal behavior (i.e., demanding), the withdrawing partner did not change his behavior and become the demander, he continued to engage in withdrawing behavior.

Defensive. Defensiveness was observed across all couples, with the highest levels observed in Husbands 4 and 6. The majority of defensiveness observed was shaking one's head and use of defensive hand gestures (e.g., holding a hand out to stop the partner from talking). Examples of defensive comments made by individuals were:

- "And I don't take 20, 40, or 60 dollars out of the ATM, but you do"
- "You're always telling me I can't compare relationships, and then you compare"
- "Well have you ever listened to what you say to me, you make everything my fault"
- "That's a two-way street, I'm not the only one here who can raise voices"
- "I work more hours than you, and it doesn't take away me wanting to be affectionate with you"
- "You don't remind me (about tasks) so what can I do"
- "I always hear what you're saying, and sometimes I repeat what you say."

Defensive comments did not lead to expressions of soft emotions or problem-solving, it led to either additional defensive comments or aggressive/scornful comments/nonverbal behaviors.

Aggressive. Similar to defensiveness, aggression was observed in all couples; however, at lower levels compared to defensiveness. Additionally, it was observed more in husband topic (HT) compared to wife topic (WT). Aggression was mostly observed as a use of a forceful tone of voice when communicating and pointing (e.g., attacking/accusing). Individuals

would raise their voice to talk over their partner or when they became upset because their partner was disagreeing or providing excuses for their behavior. Examples of aggressive comments made by individuals were: “Fine,” “Let me talk,” and “You’re learning disabled.” Aggressive comments made by the demander increased the likelihood of the withdrawer withdrawing verbally from the conversation.

Scorn. Similar to defensiveness and aggression, scorn was observed in all couples and across both HT and WT except for Wife 2 where scorn was only rated in HT. Scorn was observed as rolling eyes and sarcastic tone of voice to convey an insult or condescension. Some examples of scornful comments were:

- “I used to think I had trouble making decisions and then I met you”
- “You need to self-study”
- “You don’t try”
- “You don’t need to learn from somebody else you have a brain”
- “Okay I’m wrong you’re right”

Similarly, to defensiveness, scornful comments did not lead to expressions of soft emotion or problem-solving. These comments or nonverbal behaviors led to more scornful remarks or aggressive/defensive comments/nonverbal behaviors.

Frustration. Similar to defensiveness, aggression, and scorn, frustration was observed in all couples. It was rated the most times in Wife 1 (BARS ratings for wife topic:15; BARS ratings for husband topic:20) and Wife 3 (BARS ratings for husband topic: 20). Based on the data, frustration was observed more frequently in wives compared to husbands; the average BARS rating for husbands was two observations, and for wives, the average BARS rating was 11. Frustration was observed as sighing and tense body posture to convey a loss of patience and that they were upset. Some frustrated comments were:

- “I get frustrated”

- “I’m frustrated because we made a decision about how we were going to spend our money and then you reneged”
- “Ugh”
- “Alright, fine”
- “You make it my fault”
- “I feel like this is a one-way street”
- “Why do I always have to realize and change everything”
- “You have to let me know what’s going on in your head.”

Expressions of frustration were frequently followed by defensive comments and at times were followed by another comment that expressed frustration.

Hurt. Hurt was observed in four out of the six couples. Additionally, hurt was rated more times in wives compared to husbands. Out of the three husbands, hurt was observed once based on the BARS rating scale for Husband 4 wife topic (WT) and a three for Husband 5 husband topic (HT), while all other husbands’ data for hurt was rated zero. Out of the three wives, hurt was observed in both Wife1 and 2 in both WT and HT, while Wife3 had no observed hurt. Hurt was observed as passively looking down and a sad look on the face to express emotional pain and sadness. Some comments that expressed hurt were:

- “I don’t feel heard”
- “I feel like you’re working against me”
- “I miss that affectionate side of our relationship”
- “We become shut out of your life”
- “There are times that I feel like I don’t even need to come home because I don’t have a partner there, I won’t have anyone to talk to”
- “You remove yourself from us”
- “You’re so willing to please everyone else, but you won’t please your family”

- “You break promises to the kids”
- “I’m tired”

Hurt may be linked to demanding behavior in women as sadness is more socially acceptable for women to express compared to men (Madden, Barrett, & Pietromonaco, 2000). At times expressions of hurt led to defensive comments; however, it also led to the withdrawer expressing remorse (e.g., “I’m sorry”) and a soft emotion (e.g., sadness).

Discussion

This study aimed to understand and describe the emotions that occur during demanding behavior in couples' discussions for both men and women. A sample of 6 distressed couples who exhibited the demand-withdraw pattern of interaction were selected for analysis of self-report and observational data.

Results indicated that men and women have different underlying emotions related to demanding behavior. Frustration and hurt were the two most observed emotions for wives, while they were two of the least observed emotions for husbands. Hurt may have been observed more frequently in women compared to men because research has found that women in America and many European countries express sadness using both words and behaviors for a longer duration and with more intensity than men do (Brody, 1999). Additionally, women cry more often than men, and young girls use both facial expressions and words to express sadness more than young boys. Six-year-old girls have been found to report more sadness than boys in response to situations that may elicit either sadness, anger, or hurt (Brody, 1984). Moreover, as boys get older, expression of sadness decreases; second-grade boys were found to exhibit less facial sadness than preschool boys (Eisenberg, Fabes, Schaller, & Miller, 1989).

Regarding husbands' emotions, anxiety and aggression were in the top four most observed emotions, while they were two of the least observed emotions for wives. Aggression may have been significantly lower for wives compared to husbands' due to women internalizing aggression, because of societal expectations on what emotions are acceptable for them to express (Thomas, 2005). Moreover, gender differences in aggression begin early in development (i.e., preschool age). A study conducted with 21, 27, and 36-month-old children showed that boys engaged in more aggression than girls at all three ages (Brody, 1999; Fagot & Hagan, 1985). Interestingly, Fagot, Leinbach, and Hagan (1986) found that 2 - 3-year-old girls who labeled themselves as boys were more likely to be aggressive compared to girls who labeled themselves as girls (Brody, 1999). Additionally, research has indicated that young boys

learn to express aggression early on, and this pattern remains stable later in life. These findings support the substantial influence that nurture and environment can have on children's behavior, specifically what emotions are socially acceptable for them to express based on their gender (Brody, 1999; Huesmann, Guerra, Zelli, & Miller, 1992; Eron 1992). Aggression may have been observed more in husbands compared to wives because androgens like testosterone, which activate to develop the male brain for aggression may increase the likelihood of men to aggress, while women largely lack androgens, which may decrease their likelihood to aggress (Taylor et al., 2000).

Anxiety was observed more frequently in husbands compared to wives, which is interesting, as it has been found that western women express more anxiety than western men (Brody & Hall, 1993; Madden, Barrett, & Pietromonaco, 2000). Moreover, girls are socialized to express fear (i.e., anxiety) whereas boys are not (Brody & Hall, 1993). Anxiety may have been observed more in husbands compared to wives in response to thoughts about their inability to persuade their partner to change.

Not only were there differences in observed emotion when looking at gender but also when comparing wife topic versus husband topic. Research indicates that demanding behavior increases during one's own chosen topic compared to partner chosen topic (Christensen & Heavey, 1990). Additionally, demanding behavior is associated with expression of hard emotions, thereby hard emotions should be expressed more frequently and at higher levels during one's own chosen topic (Sanford, 2007a). When looking at the data for wife demand during wife topic versus husband topic, frustration and defensiveness were the two highest rated emotions during husband topic, while for wife topic, hurt and defensiveness were the two most common emotions expressed. Moreover, for husband topic, scorn and frustration were observed in all three wives, and for wife topic, defensiveness was the only emotion observed in all three wives. Interestingly, hard emotions were expressed more frequently and at higher levels during husband topic compared to one's own chosen topic (i.e., wife topic). Additionally,

aggression, scorn, and frustration (hard emotions) were observed at higher levels for husband topic; defensiveness was the only hard emotion observed more frequently during wife topic compared to husband topic. These results were the opposite of what the researcher hypothesized, as it was expected that hard emotions would be expressed at higher levels during one's own chosen topic and soft emotions expressed at lower levels. These results may have occurred due to their high level of distress and how much the individual believes they can change their partner's behavior. If the demanding behavior is exhibited as a way to pursue change, then lower levels of hard emotion may be observed during one's chosen topic if there is a belief that their partner will not change. Future research should look at how beliefs regarding the likelihood of partner change effect hard emotion expressed during wife topic versus husband topic.

When looking at the data for husband demand, wife topic versus husband topic, anxiety and defensiveness were the two highest rated emotions during wife topic; additionally, anxiety, defensiveness, and scorn were observed in all three husbands. When looking at husband's topic, defensiveness and anxiety were the two most observed emotions, and defensiveness, aggression, scorn, and frustration were observed in all three husbands. Based on the data, husbands also do not conform to the expected levels of hard emotion during one's chosen topic. Although defensiveness was expressed during one's own chosen topic, it was at lower levels compared to wife chosen topic. Moreover, the other top observed emotion was anxiety (a soft emotion). It should be noted; however, that anxiety was not expressed by all three husbands during husband topic but was expressed by all husbands during wife topic. Emotions observed in all three husbands during their chosen topic were: aggression, defensiveness, scorn, and frustration, which are all hard emotions. Again, these results were the opposite of what the researcher predicted, as it was expected that demand behavior would be higher during one's own topic compared to partner chosen topic. Additionally, the researcher was struck by the level of anxiety observed, as soft emotions should be expressed at low levels for individuals who

demand. However, the level of anxiety may be impacted by the novel environment of being video-taped while discussing a relationship problem. Also, during the pre-treatment problem-solving videos the couples had not been selected for the study yet, which could have impacted their anxiety if they were highly motivated to be selected for treatment. Similarly, anxiety may be due to the challenging nature of the task, to discuss a problem in the relationship and try to resolve it as best as possible in 10 minutes. If couples have gone for lengthy periods of time being unable to successfully resolve the chosen issue, their anxiety may reflect the feelings they experience whenever approaching that unresolved issue in their daily lives. Future research should study more couples and review how often all husbands express hard emotions during their chosen topic, and compare that to the top two emotions observed overall. This is important because one person or a few people may be outliers who increase an emotion to high levels, but overall that emotion may not be expressed in the majority of the sample.

Research and Clinical Implications

When comparing the results of this study to previous research on emotions in couples, there were some similarities and differences. The current study provides additional evidence for the association between demanding behavior and hard emotion (anger and resentment, etc.) (Croyle & Waltz, 2002; Sanford, 2007). The top four emotions for husbands and wives combined were defensiveness, anxiety, hurt, and frustration. Of those four emotions, two are hard emotions (defensiveness and frustration), and two are soft emotions (hurt and anxiety). Although research has not categorized anxiety as a soft emotion, there is research that indicates fear is a soft emotion (Cordova et al., 1998). Fear and anxiety are not interchangeable; however, they are triggered by similar experiences, and the body reacts to them similarly as well (Thies & Travers, 2006). Moreover, one could argue that anxiety is a soft emotion because it expresses vulnerability, compared to hard emotions that focus on asserting power and control. Regarding hard emotions, defensiveness, aggression, scorn, and frustration were observed in all couples; and scorn was observed across both HT and WT. When looking at other emotions,

the soft emotion (hurt) was observed in four of the six couples, while the other emotions (e.g., affection, engaging, humor) were either not observed or observed at low levels (e.g., one or two instances).

This research also supports Sanford's (2007) conclusion that unhappy couples tend to express more overt anger and criticism than happy couples. High levels of marital distress were reported overall, with one individual reporting moderate levels of distress. Additionally, the emotions that were observed most frequently during demand behavior for both men and women were frustration and defensiveness. Baucom et al. (2012) also found that couples who struggle with communication and regulating their emotions have difficulty recalling, retaining, and learning new skills. To maximize an individual's cognitive processes, therapists may need to modify the way they teach skills and provide ample practice and repetition. Future research could look at how effectively couples learn new skills at the beginning of therapy compared to the end, along with how often the therapist provides feedback on how to properly use a skill.

Some consistencies existed in the observations of hurt emotions underlying demand behavior, leading to some important clinical implications. When hurt was expressed during demanding behavior, voice tone would decrease, and the pace of the conversation would slow. The withdrawing partner tended to stay quiet during expressions of hurt. No affection was seen to comfort the partner, although in one couple the withdrawer responded to the expression of hurt by saying that he was working on changing his behavior and was sorry. These results demonstrate that soft emotions help slow the pace of conversation, which could allow space for the withdrawer to speak. More importantly, it is an opportunity for the therapist to encourage the withdrawer to respond to the emotion in a way that does not attack, which may lead the demander to express additional soft emotions, along with creating a less volatile atmosphere. IBCT does a good job of initiating interactions like these. Techniques within IBCT involve the therapist encouraging partners to express soft emotions (i.e., empathic joining). The expression of soft emotions is designed to increase compassion, understanding, and intimacy. Expression

of hard emotion is discouraged because it communicates hostile anger, contempt, and intolerance, which leads the other partner to respond defensively or retaliate with anger, contempt, or intolerance (Cordova et al., 1998). Additionally, EFT focuses on helping individuals access their secondary emotions (e.g., anger) and reprocess or reorganize their experiences to then express the underlying primary emotion (e.g., sadness/fear). By doing this, negative responses (e.g., anger or silent withdrawal) decrease and expression of primary emotions increase (Johnson, 2004).

Regarding anxiety, Christensen and Heavey (1993) found that both husbands and wives reported feeling more anxiety when discussing the husbands' problem-issue than the wives' issue. The current research found support for husband anxiety, as two of the three husbands had anxiety as the first or second most observed emotion during husbands' topic. However, all three wives had no observed anxiety, or it was their least observed emotion during husbands' topic. It is interesting that wives in this study had little to no observed anxiety unlike in Christensen and Heavey's study, as anxiety disorders are more prevalent in females compared to males (Altemus, Sarvaiya, & Neill, 2014).

These findings regarding anxiety have clinical implications. If one is anxious during a problem topic discussion (i.e., the husband is anxious while trying to discuss his relationship problem or experiences in the relationship), it could impact how they communicate their thoughts and feelings and the amount of information they divulge. Therefore, it is important that the therapist understand the level of impact anxiety has on the individual and the relationship, and if it is severe consider referring to a psychiatrist for medication. Therapists can also foster skills for beginning and sustaining productive discussions around difficult or unresolved topics so that couples can continue to engage in these conversations once treatment ends. Therapists should review the unified protocol for couple's therapy, which integrates common principles of change found across multiple forms of therapy, along with discussing the importance and necessity of helping couples share avoided emotions (Benson, McGinn, & Christensen, 2012).

Avoidance of emotions or thoughts prevents couples from emotional closeness and support, by preventing them from working together to resolve issues (Christensen, 2010). When avoided emotions are divulged, it is important for the therapist to help the listening partner respond in a way that makes the other partner feel heard, rather than dismissed. If these interactions are positive (i.e., the individual expressing emotions feels heard) it will lead to more effective communication and problem-solving (Benson, McGinn, & Christensen, 2012). Additionally, a strategy employed by IBCT, “empathic joining” encourages individuals to describe more vulnerable emotions (soft emotions) to create an “empathic connection” between the couple during discussions (Christensen, 2010). Future research should look at this phenomenon in more depth, specifically how anxiety affects the number of thoughts/feelings the individual divulges, ways to support an anxious partner in initiating and sustaining difficult conversations, and help the other partner to understand and respond in ways that encourage productive discussion.

Recently, it has become more common that couples therapy addresses individual symptoms (e.g., anxiety), as intimate relationships are linked to individual’s physical and psychological well-being (Johnson, 2004). Literature also supports that generalized anxiety disorder (GAD) and relationship distress are related; a diagnosis of GAD is highly correlated with marital distress compared to other psychiatric disorders, except for alcohol use and bipolar disorders (Whisman, 2007). Additionally, when controlling sociodemographic variables, for every one unit of marital distress the likelihood of having GAD increases by 2.54 (Whisman, 2007). Therefore, it is important for therapists to know how to work with individuals who have anxiety, as the likelihood of individuals seeking couples therapy that also present with anxiety is high.

Negative communication between partners (e.g., threatening and blaming) has also been associated with GAD symptoms (Benson, 2014). Additionally, couples with a partner who rated high in GAD symptoms had high levels of negative behaviors compared to other couples

(Benson, 2014). Overall it seems that negative communication can increase anxiety (Benson, 2014; Johnson, 2004), therefore decreasing negative communication patterns may be key to decreasing anxiety. In IBCT this might entail using unified detachment and empathic joining to mindfully observe and discuss a problematic pattern of interaction/communication, and then validate what each partner expresses (Benson, 2014)

Conceptual and Methodological Limitations. The researchers acknowledge that there are several limitations. Regarding treatment design, the limitations in conducting qualitative research focus on the transferability of results (Baxter & Jack, 2008). Components that affect transferability include the difficulty of establishing dependability (reliability), unstandardized procedures, and small sample size (Baxter & Jack, 2008). Dependability refers to the stability of results over time and between researchers. This is challenging because of the small sample size (6 couples), along with the lack of previous research with which to compare findings to similar studies (Merriam, 2014). The study's trustworthiness (validity) is impacted by unstandardized procedures on how to conduct qualitative research (Merriam, 2014). Due to a lack of standardization, researchers can develop many different ways of testing a construct or phenomenon (Baxter & Jack, 2008). The researchers chose a qualitative methodology because it was an effective way to study the phenomenon of emotions underlying demand behavior. The results will hopefully be comparable to any future qualitative studies of this phenomenon.

Specific factors from the current study that affect transferability include the demographics and selection criteria of the participants (Merriam, 2014). There were a disproportionate number of Caucasian participants in the original sample (husbands: 79.1% and wives: 76.1%); most participants were college educated (average 16-17 years of education); the couples had to identify as heterosexual, married, and cohabitating and they had to be experiencing moderate to severe distress. This reduces the transferability to a more ethnically, educationally, and relationally diverse population. Additionally, only 12 participants' data were used, and although this is well within Yin's recommended number of participants for a qualitative

study, it does affect the transferability to other individuals (Yin, 2014).

Further limitations relate to the BARS training manual. Although the BARS has shown strong reliability with other coding systems that examine the same phenomenon, the lack of available direction and specificity of training to use the BARS could affect the current study's results (Johnson, 2002). For example, the BARS manual is only three pages long, gives a very brief description of how to use the scale, and requires no professional training to be used. In addition, there are limited existing research studies that have used the BARS, which could have helped guide the researchers in its implementation. Nevertheless, the researchers found it easy to determine ratings and consistently rated similar codes which increased dependability. It should be noted however that scorn and aggression were two emotions that the researchers disagreed on most frequently. In the beginning, the researchers had a difficult time differentiating between attacking comments/aggressive tone of voice (aggression) versus insulting/contemptuous comments/contemptuous voice (scorn). To resolve differences and build consensus on these two codes, the researchers reviewed the BARS manual, re-watched the 30-second clips, and discussed until agreement was reached. Overall, the researchers found the BARS useful for coding emotion because it uses nonverbal behavior instead of relying on self-report, as individuals may not be able to identify their emotion or may not feel comfortable identifying their emotion. The researchers observed this as most emotions were expressed through non-verbal behaviors instead of verbal expression (e.g., none of the individuals reported they were anxious when they were displaying nonverbal anxiety). Therefore, the BARS may be a useful tool for observing and describing emotions when individuals do not verbally express their emotions.

Regarding thematic analysis, there are strengths and weaknesses associated with the use of this qualitative methodology. One advantage is that it is flexible, which allows the researchers to adapt thematic analysis to fit their research study best (Braun & Clarke, 2006). It is also an easy and quick method to learn and implement along with its accessibility to

researchers with little or no experience, which is beneficial to the researchers who are conducting their first qualitative study (Braun & Clarke, 2006). Additionally, thematic analysis creates thick descriptions of the dataset and can highlight similarities and differences across the data, which is precisely what the researchers intended to accomplish in this study. A disadvantage of thematic analysis is that it is limited in its interpretation (e.g., only provides description; Braun & Clarke, 2006). Although flexibility is a strength, this flexibility creates a poor distinction on how to implement thematic analysis appropriately (Braun & Clarke, 2006); however, thematic analysis was a good fit for the study because the researchers had access to a rich data set of couple's therapy videos, and 10-minute pre-treatment problem-solving discussions that provided an ample amount of information to create those thick descriptions. Moreover, it was easy to highlight similarities and differences in observed emotions between individuals and wives versus husbands, which again allowed for rich descriptions of those phenomena. Researchers may have also been biased when viewing the 10-minute pre-treatment problem-solving videos as they watched the first ten sessions of couples therapy before they observed the problem-solving interactions. By watching the couples therapy videos first, the researchers may have developed a negative or position bias to certain individuals. The researchers watched the therapy sessions first with the intent of becoming familiar with the data, as suggested for qualitative research (Yin, 2014). Alternately, the researchers could have watched the 10-minute pre-treatment problem-solving interactions without first watching the couples therapy videos to decrease bias.

Innovation and Potential Contributions. Although there are limitations, the findings contribute to the body of literature on demand-withdraw. Most of the existing research focuses on how gender, socioeconomic status, culture, and age are related to demand-withdraw interactions; however how emotions are related to demand-withdraw interaction has rarely been a focus of study. In Baucom, et al., (2011, p. 579) the authors reported that "emotional arousal likely contributes to demand-withdraw behavior in complex ways that could be the subject of

future research.” The current research sheds light on this phenomenon by informing readers of the emotions that typically precipitate demand behavior overall, wife versus husband demand, and wife versus husband topic. Results suggested that behavior is complex, in that observed underlying emotions changed depending on who chose the topic and whether or not the demander was a male or female. The hope is that the results on this understudied topic within demand-withdraw interactions will engage other researchers to conduct more qualitative and quantitative research on the subject.

Future Research

Important directions for future research include further examination of the relationship between emotions and demand-withdraw behavior. Replication of this study is needed to determine if the top two emotions for wives and husbands remains consistent throughout different samples. The underlying emotions of behavior is an important area to study because it can assist in creating understanding and empathy for an individual and dyad, along with giving the clinician insight into the emotions that are driving a client’s or couple’s behavior; this insight, in turn, will ideally aid in treatment. Understanding the emotion-behavior link can also enrich case conceptualizations and treatments that focus on this connection, such as behavioral and cognitive-behavioral approaches.

Research not only has benefits for therapists but also for couples. It has been shown that being able to emotionally regulate one’s emotions leads to an increase in couple satisfaction (Bloch et al., 2014). By understanding the emotions underlying the negative interaction pattern, it can guide the couple in developing awareness and helpful ways to emotionally regulate. This finding suggests that it would be beneficial for clinicians to not only focus on communication skills and increasing positive interactions between the couple but also to focus on the couple’s emotions and emotional experiences.

There are also methodological considerations for conducting future research on this topic. For example, the researchers first viewed IBCT and TBCT videos to observe demand-

withdraw interactions; however, the therapist would stop the couple before one could see the pattern; therefore, the 10-minute pre-treatment problem-solving videos ended up providing a richer observation of the pattern, because a therapist was not present. If future research aims to study emotions underlying demand-withdraw in the context of therapy sessions, it would be helpful to select approaches to therapy that allow the demand-withdraw patterns to occur in more lengthy sequences, and that promote exploration of emotion linked with the behaviors. For example, an EFT approach would specifically focus on expanding and re-organizing key emotional responses (Johnson, 2004). EFT sessions may provide a rich view of the demand-withdraw pattern, as in EFT there is a strong focus on emotions and allowing the couple to engage in their typical pattern in vivo at the beginning of therapy.

Other important methodological directions for future research include replication of this study with more diverse couples (e.g., ethnicity and level of education), as the majority of the couples were Caucasian and possessed a bachelor's degree or higher. Based on the current study and other literature (Johnson 2002; Sanford, 2007a, 2007b) it is expected that with a more heterogeneous sample, hard emotions would remain the most observed emotions compared to others. Although the literature suggests that hard emotions would remain the most observed across a more heterogeneous sample, it would help to know if these results could extend to additional populations by conducting a study. Additionally, ethnic background/cultural identity may play a role in emotions expressed and would be another interesting research study. Moreover, it would be important to replicate this study with same-sex couples to evaluate whether or not the underlying emotions are similar or different compared to partners in heterosexual relationships. Holley, Sturm, and Levenson (2010) looked at the demand-withdraw pattern in same-sex couples compared to heterosexual couples. They found that the demand-withdraw pattern was seen regardless of the type of couple and that the partner with the greater desire for change was likely to demand (Holley, Sturm, & Levenson, 2010). Therefore, it is probable that if this study were replicated with same-sex couples, whoever was desiring change

(i.e., the demander) would likely be expressing more hard emotions compared to their partner. Lastly, it would be beneficial to replicate this study with a large sample size to determine whether or not the underlying emotions change depending on the number of participants.

Not only does this study contribute to the demand-withdraw literature, but it also contributes to the literature regarding the use of the BARS. Although the BARS has strong trustworthiness with similar measures such as the SPAFF, it is not widely known or used in research. This is because most researchers will use a measure that is already commonly used and recognized. The SPAFF was developed first in 1989, while the BARS was created in 1998. By using the BARS, the researchers speak to the strengths (e.g., simple explanation on how to use, no cost, easy to determine ratings reliably with other coders) and weaknesses (e.g., lack of specificity of training, relatively short manual, and small number of qualitative/quantitative studies using the BARS) of using the measure. The use of the BARS in this study will hopefully increase the likelihood that fellow researchers will utilize the rating form when assessing emotions. Future research should utilize both the SPAFF and the BARS when coding observed emotions to demonstrate reliability across both measures. Moreover, it would be beneficial to research the effectiveness of using a 10-minute pre-treatment problem-solving interaction and whether it provides enough time to observe emotions underlying demand behavior. In viewing the 10-minute pre-treatment problem-solving interaction, the researchers were able to view a rich display of the couples' pattern; however, viewing a thirty-minute discussion may allow for a more in-depth problem discussion, which would most likely provide more opportunities to observe emotions.

As one can see, there is a vast amount of research to be completed on the topic of emotions and demand-withdraw interactions. The purpose of this study was to add to the limited research on emotions underlying demand behavior, in the hopes of not only adding to the literature base but also to spark interest in other researchers to carry on studying this phenomenon.

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APPENDIX A

Extended Review of the Literature

Authors, Year, Title	Focus	Source & Type	Key Points	Methods/Design	Measures/Data Collection	Sample
Altemus, M., Sarvaiya, N., & Neill, E. C. (2014). Sex differences in anxiety and depression clinical perspectives. <i>Frontiers in Neuroendocrinology</i> , 35 (3), 320-330.	Sex differences in the phenomenology of mood and anxiety disorders Sex differences in brain structure	Article	Women have twice the lifetime rates of depression and most anxiety disorders Puberty, menstrual cycle, pregnancy and menopause are triggers for onset, recurrence and exacerbation of affective disorders.	N/A	N/A	N/A
Baucom, B.R., Atkins, D.C., Eldridge, K., McFarland, P., Sevier, M., & Christensen, A. (2011). The language of demand/withdraw: Verbal and vocal expression in dyadic interactions. <i>Journal of Family Psychology</i> , 25 (4), 570-580.	Associations between vocally expressed emotional arousal, influence tactics and demand/withdraw behavior	Article Empirical study	Higher levels of demand/withdraw behavior were associated with greater use of manipulative and controlling influence tactics, higher levels of emotional arousal, and less frequent use of cooperative and compromising influence tactics. Demanders tended to express more arousal and to use more influence tactics than withdrawers.	Quantitative	Couples Interaction Rating System Latent Semantic Analysis Dyadic Adjustment Scale	130 seriously and stably distressed, married, heterosexual couples and in a community sample (N=38) of 18 married heterosexual and 20 dating heterosexual couples.
Baucom, B. R., Weusthoff, S., Atkins, D. C., & Hahlweg, K. (2012). Greater emotional arousal predicts poorer long-term memory of communication skills in couples. <i>Behaviour Research and Therapy</i> , 50 (6), 442-447.	Assessing long-term memory skills after attending behaviorally focused couples therapy. Assessing emotional arousal and long-term recall of communication skills.	Article Empirical study	Higher levels of emotional arousal were linked to fewer skills remembered 11 years after completing therapy. Women remembered more skills than men	Quantitative	The Kategoriensystem fuer partnerschaftliche Interaktion – used to assess nine positive and nine negative behaviors during conflict discussions Partnerschaftsfragebogen PFB [Partnership Questionnaire] - a 30 item instrument to measure marital quality	49 German couples
Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. <i>The Qualitative Report</i> , 13 (4), 544-559.	Guide for novice researchers to identify the different elements for designing and implementing qualitative case study research projects.	Article	Case study research can be used to answer simple to complex questions. The researcher can answer "how" and "why" questions.	N/A	N/A	N/A
Benson, L. A. (2014). <i>Integrative behavioral couple therapy for</i>	Treatment of generalized	Article	Negative communication	Quantitative	The dyadic adjustment scale	Study 1: 134

<p><i>generalized anxiety disorder</i>. Los Angeles: University of California, Los Angeles.</p>	<p>anxiety disorder is less effective compared to treatment of other anxiety disorders. When individuals are in distress they are less likely to respond to standard GAD treatments, which means that dyadic treatment (IBCT-GAD) may be beneficial to individuals who are in distressed relationships.</p>	<p>Dissertation</p>	<p>behaviors were associated with generalized anxiety disorder symptoms.</p> <p>Integrative Behavioral couple's therapy – GAD was associated with increases in relationship satisfaction and significant improvement in their GAD symptoms.</p>	<p>Case study</p>	<p>Structured Clinical Interview for DSM-IV</p> <p>Compass Outpatient Treatment Assessment System</p>	<p>married couples</p> <p>Study 2: 12 individuals (6 couples)</p>
<p>Benson, L. A., McGinn, M. M., & Christensen, A. (2012). Common principles of couple therapy. <i>Behavior Therapy</i>, 43 (1), 25-35.</p>	<p>Common principles in evidence-based couple therapies.</p>	<p>Article</p>	<p>Five common principles: (a) altering the couple's view of the presenting problem to be more objective, contextualized, and dyadic; (b) decreasing emotion-driven, dysfunctional behavior; (c) eliciting emotion-based, avoided, private behavior; (d) increasing constructive communication patterns; and (e) emphasizing strengths and reinforcing gains.</p> <p>Most individuals have not fully considered their partners perspective on their conflicts or how their own behavior may contribute to their relationship difficulties.</p> <p>CBT uses Socratic questioning to challenge their partners inaccurate beliefs about themselves and the other partner.</p> <p>Couples therapy is not appropriate for couples in which there is physical abuse.</p>	<p>N/A</p>	<p>N/A</p>	<p>N/A</p>

			Emotional avoidance can limit the couple's ability to experience emotional intimacy.			
			EFT emphasizes guided in session experiences f better communication.			
			TBCT and CBCT teach couples rules for communication and have them practice specific skills.			
Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. <i>Qualitative Research in Psychology</i> , 3 (2), 77-101.	Thematic analysis is a qualitative analytic method used in psychological research. Provides a step-by-step guide to thematic analysis.	Article	Thematic analysis is used to analyze and identify patterns within a data set. Describes data in rich detail. A theme indicates something important within the data relative to the research question. 6 steps to thematic analysis: familiarize yourself with your data, generate initial codes, search for themes, review themes, define and name themes, and produce the report.	N/A	N/A	N/A
Brody, L. (1984). Sex and age variations in the quality and intensity of children's emotional attributions to hypothetical situations. <i>Sex Roles: A Journal of Research</i> , 11, 51-59.	Age and sex differences in the quality and intensity of children's emotional attribution to stories with high affect content.	Article Empirical study	Boys attributed anger to themselves more frequently than girls did, while girls attributed sadness and fear to themselves more frequently than boys did. The intensity of emotional attributions decreased with age for both boys and girls.	Quantitative	10 affect-laden stories	72, seven, nine, and 11-year-old children with equal numbers of boys and girls.
Brody, L. (1999). <i>Gender, emotion, and the family</i> . Cambridge, MA: Harvard University Press.	Discusses the existence and development of gender differences in emotional expressions	Book	Men respond to negative situations with physiological arousal to a greater level than women do.	N/A	N/A	N/A

			<p>Women and school-aged girls express more empathy, distress, and sympathy via facial expressions, behaviors, words, and physiological arousal compared to boys.</p> <p>Women express anger using words while men express anger with more aggression and physical reactivity.</p> <p>Anger is expressed more toward men than women.</p>			
<p>Brody, L.R. & Hall, J.A. (1993). Gender and emotion. In M. Lewis & J.M. Haviland (Eds.), <i>Handbook of emotions</i> (pp.447-460). New York, NY: Guilford Press.</p>	<p>Reviews literature on the gender differences between men and women and their emotional expression, emotional experience, and nonverbal communication of emotions.</p>	Book	<p>Females are better at recognizing feeling in others and at verbally and facially expressing a wide variety of feelings.</p> <p>Gender differences in emotional functioning are partly due to peer and family socialization patterns.</p> <p>Females report more shame and guilt based emotions compared to men.</p> <p>Children aged 3-5 believed that males expressed anger more frequently while females expressed more fear, sadness, happiness.</p>	N/A	N/A	N/A
<p>Christensen, A. (2010). A unified protocol for couple therapy. In Baucom, D.H., Hahlweg, K., & Grawe-Gerber, M (Eds.), <i>Enhancing couples: The shape of couple therapy to come</i> (pp.33-44). Cambridge, MA: Hogrefe.</p>	<p>Describes a unified protocol for couple therapy based off information from TBCT, EFT, and IBCT.</p>	Article	<p>Couples therapy improves relationship quality and reduces the probability of divorce.</p> <p>There are five principles of change in couple's therapy: "provide contextualized,</p>	N/A	N/A	N/A

Christensen, A., & Heavey, C. L. (1990). Gender and social structure in the demand/withdraw pattern of marital interaction. <i>Journal of Personality and Social Psychology</i> , 59, 73–81.	Examined the effects of gender and social structure on the demand/withdraw pattern of marital conflict.	Article Empirical study	dyadic, objective conceptualization of problems, modify emotion-driven dysfunctional and destructive interactional behavior, elicit avoided emotion-based private behavior, foster productive communication, and emphasize strengths and encourage positive behavior.” Wife-demand/husband-withdraw interaction was more likely than husband-demand/wife-withdraw interaction. Husband and wife were more likely to demand when discussing a change they wanted and more likely to withdraw when discussing a change their partner wanted. Overall, men were more withdrawn than women	Quantitative	Demographic Inventory Child Rearing Changes Questionnaire Communication Patterns Questionnaire, Short Form Dyadic Adjustment Scale	31 couples
Cordova, J. V., Jacobson, N. S., & Christensen, A. (1998). Acceptance versus change interventions in behavioral couple therapy: Impact on couples' in-session communication. <i>Journal of Marital and Family Therapy</i> , 24 (4), 437-455.	Examined changes in couples' communication while attending either IBCT or TBCT. IBCT has an emphasis on promoting acceptance while TBCT has an emphasis on behavioral change.	Article Empirical study	IBCT couples expressed more non-blaming descriptions of problems and more soft emotions compared to TBCT during late stages of therapy. IBCT couples reduced their expression of hard emotions as therapy progressed.	Quantitative	Global Distress Scale of the Marital Satisfaction Inventory. 5 point scales for Soft Expressions, Detachment, Hard Expressions, and Engaging in the Problem.	12 martially distressed couples randomly assigned to IBCT or TBCT
Croyle K. L., & Waltz, J. (2002). Emotional awareness and couples' relationship satisfaction. <i>Journal of Marital & Family Therapy</i> , 28 (4), 435-444.	Examined the role of emotional awareness in couples' relationships and the effects of whether or not they responded to each other with soft or hard emotions.	Article Empirical study	When responding to couples' situations women were more emotionally aware than men were. Higher levels of emotional awareness and awareness of hard emotions were associated	Quantitative	The Dyadic Adjustment Scale Levels of Emotional Awareness Scale Couples' Emotional Awareness Scale Vocabulary section of the Wechsler Adult Intelligence Scale-Revised	56 heterosexual couples who had lived together for at least one year.

			with a decrease in relationship satisfaction for wives but not for husbands.			
			When there was a discrepancy between partners' levels of awareness this led to lower relationship satisfaction for both men and women.			
Dalgleish, T. L., Johnson, S. M., Burgess, M. M., Wiebe, S. A., & Tasca, G. A. (2015). Predicting key change events in emotionally focused couple therapy. <i>Journal of Marital and Family Therapy, 41</i> (3), 260-275.	The study looked at EFT, specifically the blamer-softening event which they believe helps individuals express and respond to partners' unmet attachment needs. The researchers wanted to see if this event created changes in marital satisfaction from pre-post therapy.	Article Empirical study	Results indicated that a softening event significantly increased marital satisfaction along with change in marital satisfaction from pre- to post therapy.	Quantitative Hierarchical linear modeling	Demographic Questionnaire Experiences in Close Relationships – Relationship-Specific Dyadic Adjustment Scale Post-Session Resolution Questionnaire Experiencing Scale Structural analysis of social behavior (SASB)	Thirty-two heterosexual couples
Eisenberg, N., Fabes, R., Schaller, M., & Miller, P. (1989). Sympathy and personal distress: Development, gender differences and interrelations of indexes. In N. Eisenberg, (Ed.), <i>Empathy and related emotional responses: New directions for child development</i> , (pp. 107–126). San Francisco, CA: Jossey Bass.	Examines developmental change in sympathy and personal distress, gender differences in sympathy and personal distress, and interrelations among indexes used to assess sympathy and personal distress.	Book	Gender differences in sympathy and personal distress increase with age. Females are better decoders than males of overt visual cues of another's emotional state. Elementary school girls more willingly report that they would experience sadness and fear in emotional situations compared to boys stating they would feel more anger. Females use more facial expressions of emotions compared to men. Older children's self-report of emotional	N/A	N/A	N/A

			experience is more consistent with the contact than those of young children.			
Eldridge, K. A., Sevier, M., Jones, J., Atkins, D. C., & Christensen, A. (2007). Demand-withdraw communication in severely distressed, moderately distressed, and non-distressed couples: Rigidity and polarity during relationship and personal problem discussions. <i>Journal of Family Psychology: Jfp: Journal of the Division of Family Psychology of the American Psychological Association (division 43)</i> , 21 (2), 218-26.	Investigated demand-withdraw communication	Article Empirical study	Results indicated that the greater demand-withdraw interaction during problem discussion led to greater distress. In this sample, they found more instances of wife-demand/husband-withdraw compared to husband-demand/wife withdraw.	Quantitative, Self-report Videotaped discussion	Communication Patterns Questionnaire--Wife-Demand/Husband-Withdraw subscale Communication Patterns Questionnaire--Husband-Demand/Wife-Withdraw subscale Couples Interaction Rating System Marital Discussion Questionnaire Marital Satisfaction Inventory-Revised-Global Distress Scale Dyadic Adjustment Scale Marital Adjustment Test	68 severely distressed couples and 48 non-distressed couples.
Eron, L. D. (1992). Gender differences in violence: Biology and/or socialization. In K. Bjorkqvist & P. Niemela, (Eds.), <i>Of mice and women: Aspects of female aggression</i> . San Diego, CA: Academic Press.	Female aggression There are gender differences in the directness, frequency, and harmfulness of aggression.	Book	There are gender differences in how one aggresses Biological factors do not make men more aggressive than women Aggression appears more stable for males compared to females. Boys who liked girls' games tended to be less aggressive in school compared to boys who did not and that correlation was still present after 10 years. When the boys and girls lacked interest in girl toys this predicted high levels of psychopathology scores in young adulthood.	N/A	N/A	N/A
Fagot, B., & Hagan, R. (1985). Aggression in toddlers: Responses to the assertive acts of boys and girls. <i>Sex Roles: A Journal of Research</i> , 12, 341–351.	Age differences in the prevalence of physical aggression.	Article Empirical study	2.3% of 5-year-old girls exhibit physically aggressive behaviors while .5% of 11-year-old girls were estimated to do so. 3.7% of 5-11-year-old boys	Quantitative Latent class analysis Maximum likelihood parameter	Three behavior items were used to assess children's physical aggression: (a) gets into many fights? (b) physically attacks people? (c) kicks, bites, or hits other children?	22,831 children aged 0-11 of those, 12,292 ranged in age from 5 to 11 years. There were approxima

			tend to exhibit physically aggressive behaviors frequently.			tely 1,800 children per age group, half boys and half girls
			Physical aggression in girls decreases with age.			
			No age differences in the prevalence of physical aggression for boys.			
Fagot, B., Leinbach, M., & Hagan, R. (1986). Gender labeling and the adoption of sex-typed behaviors. <i>Developmental Psychology</i> , 22, 440–443.	Investigating the relationship between gender labeling and naturally occurring sex-typed behavior.	Article Empirical study	The children who successfully passed the gender-labeling task spent more time playing with members of their own sex. Girls who passed the task showed almost no aggression in the classroom. Children who did not know gender labels showed more preference for sex-typed toys. Boys who passed gender-labeling task had higher aggression than boys who failed, however, the scores were not significantly different.	Quantitative Two-way analysis of variance	Behavior observation Gender discrimination task	21 girls and 22 boys ranging in age from 21 to 40 months
Glick, I. D., Rait, D. S., Heru, A. M., & Ascher, M. S. (2015). <i>Couples and family therapy in clinical practice</i> . Chichester, West Sussex: John Wiley.	Family therapy and family-oriented evidence-based interventions	Book	Therapist should remain neutral on the decision on whether or not the couple should separate. The typical family in the first half of the twentieth century included a long courtship and a long-term marriage. In the second part of the twentieth century women in western cultures gained access to education and birth control and therefore the expectations of marriage and family.	N/A	N/A	N/A

			Cohabitation has become normative in the United States.			
			Functional families allow for flexibility and movement in response to stress			
Gross, J. J. (2002). Emotion regulation: Affective, cognitive, and social consequences. <i>Psychophysiology</i> , 39 (3), 281-291.	Discussion of two commonly used strategies for down-regulating emotion.	Article Literature Review	Reappraisal – changing the way a situation is interpreted to decrease its emotional impact. Suppression – inhibiting outward signs of inner feelings. Reappraisal is more effective than suppression. Suppression decreases behavioral expression but does not decrease emotional experience and impairs memory. Reappraisal decreases emotion experience and behavioral expression and has no impact on memory.	N/A	N/A	N/A
Heavey, C.L., Layne, C., & Christensen, A. (1993). Gender and conflict structure in marital interaction: A replication and extension. <i>Journal of Consulting and Clinical Psychology</i> , 61 (1), 16-27.	Are demand-withdraw behavior and satisfaction linked to who requests change?	Article Empirical Study	When husband chose the issue, wives and husbands did not differ in demand-withdraw behavior. When wives chose the issue, wives were more demanding and husbands more withdrawing. Husband demand- wife withdraw predicted an increase in wives' satisfaction a year later. Wife demand-husband withdraw led to a decline in wives' satisfaction a year later.	Quantitative Experimental Replication	Desired Changes Questionnaire (DCQ) Communication Patterns Questionnaire, Short Form (CPQSF) Post discussion Questionnaire (PDQ) Conflict Rating System (CRS)	29 married, heterosexual couples

Holley, S. R., Sturm, V. E., & Levenson, R. W. (2010). Exploring the basis for gender differences in the demand-withdraw pattern. <i>Journal of Homosexuality</i> , 57 (5), 666-684.	Power differences and the demand-withdraw pattern of interaction.	Article Empirical Study	Demand-withdraw pattern was seen regardless of type of couple. The more a person desires change the more that person will demand and the more their partner will withdraw for all couples. Overall, men and women are not inherently different in their likelihood to demand or withdraw but that whether or not they demand or withdraw may be related to unequal power. Demand-withdraw gender stereotypes may hold true because men may hold power over women,	Quantitative Self-report Between subjects Multiple Regression	Couples Interaction Rating System (CIRS) The Communications Patterns Questionnaire (CPQ)	63 heterosexual, gay, and lesbian couples. 21 heterosexual, 21 gay and 21 lesbian couples.
Huesmann, L., Guerra, N. G., Zelli, A., & Miller, L. (1992). Differing normative beliefs about aggression for boys and girls. In K. Bjorkqvist & P. Niemela, (Eds.), <i>Of mice and women: aspects of female aggression</i> . San Diego, CA: Academic Press.	Normative beliefs play a large role in regulating aggressive behavior and differences in normative beliefs are associated with individual differences in the tendency of humans to respond aggressively.	Book	By age 8, children have adopted characteristic patterns of aggressive behavior. Early aggressive behaviors are predictive of later aggressive behaviors. Girls display less aggression compared to boys because they learn that socially it is not acceptable to be aggressive while boys learn aggressiveness is appropriate and may even be desirable. Gender typing of aggression is seen during the early elementary school years. Boys in grade 2 indicate greater approval for aggression against girls.	N/A	N/A	N/A
Johnson, M. D. (2002). The observation of specific affect in marital	Psychometric properties of the SPAFF.	Article	Correlations between SPAFF coding and	Quantitative	SPAFF Version 1.0	172 newlywed couples

interactions: Psychometric properties of a coding system and a rating system. <i>Psychological Assessment</i> , 14, 423- 438.	Assess the validity of the BARS system as an alternative to the SPAFF.	Empirical study	BARS ratings were the same behaviors were positive and significant which indicates convergent validity. Anger/contempt was associated with lower marital satisfaction. Humor/affection was associated with higher marital satisfaction.	Behavioral Observation Intercorrelation	Inventory of Marital Problems The 15-item Marital Adjustment Test Behavioral Affective Rating Scale (BARS)	
Johnson, S. M. (2004). <i>The practice of emotionally focused couple therapy: Creating connection</i> . New York, NY: Brunner-Routledge.	Conceptualization of adult love and bonding processes. Principles of EFT. Stages and steps in relationship repair and recovery. EFT interventions and key change events.	Book	Couples' therapy is widening its audience to address more individual symptoms such as depression, anxiety, and chronic illness. Close relationships can protect people from physical and emotional disease. EFT draws attention to emotion and emotional communication. Emotion is an agent of change. EFT had lead to 70 to 73 percent recovery rate from marital distress in 10-12 sessions of therapy. EFT does not seem to have a problem with relapse after termination of services. EFT is outlined in three stages and nine steps. An EFT therapist is a "process consultant" that helps the couple reprocess their experience, focusing on their emotional experiences of the relationship. An EFT therapist is also a choreographer who also helps	N/A	N/A	N/A

			the couple restructure their dance.			
Johnson, M., Johns, A., Kitahara, J., & Ono, M. (1998). Behavioral affective rating scale. Retrieved from http://www.binghamton.edu/marriage-lab/pdfs/bars.pdf	Rating scale used to assess affect observed in dyadic interactions.	Manual	The BARS has a rating scale from 0 to 4 that is based on the individual's body language, facial expressions and tone of voice. A zero is the absence of the affect, 1 is mild, 2 is medium, 3 is strong, and 4 is extreme. There are ten affects: affection, humor, anxiety, and engaging, disengaging, defensive, aggressive, scorn, frustration, hurt. The BARS was developed as an alternative to the SPAFF.	N/A	N/A	N/A
Kiecolt-Glaser, J. K., & Newton, T. L. (2001). Marriage and health: His and hers. <i>Psychological Bulletin</i> , 127 (4), 472-503.	Reviews how marital relationships are related to physical health.	Article Literature Review	Marital functioning is substantial for the outcomes of one's health. Negative marital functioning influences depression and health habits and has direct influence on cardiovascular, endocrine, immune, neurosensory, and other physiological mechanisms. Social isolation is a major factor for morbidity and mortality. Non-married women have 50% greater mortality, compared with 250% for men. Unhappy marriages are associated with increased distress, and unmarried people are happier, on the average, than unhappily married people	Medline and PsycINFO were surveyed using the terms marital interactions, marital adjustment, marital quality, marital conflict, and marital satisfaction: it spans 1990 through December 1999, beginning where Burman and Margolin (1992) ended their literature review.	Inclusion criteria: studies that reported on physical health and/or physiological function. Studies where the dependent variable was marital quality were excluded. Studies that examined family functioning were not included if the marital relationship was not assessed separately.	N/A
Kluwer, E.S., Heesink, J.A.M., & Van De Vilert, E. (2000). The division of labor in close relationships: An asymmetrical	Couples' reports of hypothetical attempts to	Article Empirical study	When the wife desired change, wife demand – husband	Quantitative Self-report	Study 1: Written scenarios (paid work condition, housework condition, and child-care condition) where	Study 1: 121 husbands and 141

conflict issue. <i>Personal Relationships</i> , 7, 263-282.	maintain or change a gendered division of labor through conflict interactions.	withdraw was reported more frequently compared to husband demand-wife withdraw.	Between subject's design	participants were asked to write down how they and their spouse would deal with the described situation. Study 2: Communication Patterns Questionnaire.	wives with first and only child under 18 months old.	
		Conflict over housework was reported occurring more frequently compared to paid work and childcare.			Study 2: 128 couples with first and only child younger than 18 months.	
Madden, T. E., Barrett, L. F., & Pietromonaco, P. R. (2000). Sex differences in anxiety and depression: Empirical evidence and methodological questions. In A. H. Fischer (Ed.), <i>Studies in emotion and social interaction. Second series. Gender and emotion: Social psychological perspectives</i> (pp. 277-298). Cambridge, England: Cambridge University Press.	Review of the literature to address either or not there are gender differences in the expression and experience of anxiety and depression.	Book Literature review	Women express fear and sadness more than men do.	N/A	N/A	N/A
		Women express sadness more than men do.				
		Stereotypes contribute to sex differences in the expression of emotion. Additionally, stereotypes provide a foundation for socializing girls and boys about appropriate emotional behavior.				
		When women express fear or sadness, they are more likely to get an immediate positive response while men do not.				
		Women express more anxiety and depression than men do; however, it is not clear whether they actually experience more frequent/intense emotions.				

McHale, S., King, V., Van Hook, J. & Booth, A. (2016). <i>Gender and couple relationships</i> . New York, NY: Springer International Publishing.	Psychological, socioeconomic, and cultural perspectives on couples – particularly gender dynamics and the future of marriage. Changing impacts of work, parenting, and health benefits of marriage for both men and women.	Book	After 1949, the age at which someone married increase substantially. The number of people marrying is declining across all age groups. Dual-earner families have no predominated for almost half a century along with female-breadwinner families have increased and represent about a tenth of marriages.	N/A	N/A	N/A
Merriam, S. B. (2014). <i>Qualitative research: A guide to design and implementation</i> . Hoboken, NJ: Wiley.	Fundamental concepts of qualitative research.	Book	Qualitative research focuses on meaning in context, data collection emphasizes underlying meaning when one is gathering and interpreting data. Qualitative research is “an umbrella term covering an array of interpretive techniques which seek to describe, decode, translate, and otherwise come to terms with the meaning, not the frequency, of certain more or less naturally occurring phenomena in the social world.” Qualitative research is interested in how people interpret their experiences, how they construct their worlds, and what meaning they attribute to different experiences. The researcher is the primary instrument for data collection and analysis. Qualitative analysis is used to build concepts, hypotheses, or	N/A	N/A	N/A

			<p>theories when there is a lack of adequate information on a phenomenon.</p> <p>Words and pictures are used to convey what the research found instead of numbers.</p>			
<p>Papp, L.A., Kouros, C.D., & Cummings, E.M. (2009). Demand-withdraw patterns in marital conflict in the home. <i>Personal Relationships</i>, 16 (2), 285-300.</p>	<p>Spousal depression linked to demand-withdraw communication.</p>	<p>Article Empirical study</p>	<p>Depression was linked to husband demand-wife withdraw.</p> <p>Communication has a large impact on whether or not a relationship is healthy, is satisfying, and endures overtime.</p> <p>Demand-withdraw patterns were related to a greater likelihood of negative interaction (i.e., threat, verbal hostility, aggression) and higher levels of negative emotion (i.e., anger, sadness, fear).</p>	<p>Quantitative Diary Reports Hierarchical Linear Modeling</p>	<p>Center for Epidemiological Studies Depression Scale (CES-D) Marital Adjustment Test (MAT)</p>	<p>116 heterosexual couples</p>
<p>Proulx, C. M., Helms, H. M., & Buehler, C. (2007). Marital quality and personal well-being: A meta-analysis. <i>Journal of Marriage and Family</i>, 69 (3), 576-593.</p>	<p>Association between marital quality and personal well-being</p>	<p>Article</p>	<p>Marital dissatisfaction tends to lead to depressive symptoms.</p> <p>Marital satisfaction is associated with wives' life satisfaction.</p> <p>Higher levels of marital quality are associated with more optimal levels of personal well-being.</p> <p>When depressive symptoms increase, quality of intimate relationships (i.e., marriage) decline.</p>	<p>Meta-analysis of the literature through PsychInfo and EbscoHost</p>	<p>Dependent variables: depression, depressive affect, personal well-being, self-esteem, physical health, global happiness, and life satisfaction.</p> <p>Dissertations and unpublished reports were excluded. Inclusion criteria for the studies were: the work was published in English, the association between marital quality and some aspect of individual well-being was examined, (c) the assessment of marital quality and personal well-being was consistent with the conceptual definitions stated earlier, (d) at least one usable statistical measure of association was calculated, (e) the study was published since 1980, and (f) the</p>	<p>93 studies were analyzed</p>

			Gender and length of married were significant moderators between marital quality and personal well-being.			sample or subsample in the study was comprised only of married individuals.
Ross, C.E., Mirowsky, J., & Goldsteen, K. (1990). The Impact of the family on health: The decade in review. <i>Journal of Marriage and the Family</i> , 52 (4), 1059-1078.	An understanding of family and health; patterns of well-being.	Article Literature Review	Compared to married individuals, the non-married have higher levels of depression, anxiety, and other psychological distress. Marriage has more health benefits for men compared to women. Married people are more likely to report that they have someone they can rely on for emotional support. Emotional support decreases depression, anxiety, sickness, and mortality. When couples divorced, women suffered more of a loss of income while men suffered more of a loss of social support. People with children, do not have higher levels of well-being compared to nonparents. Children either increase distress or have an insignificant effect. Having children does not decrease distress.	N/A	N/A	N/A
Sagrestano, L.M., Heavey, C.L., & Christensen, A. (1998). Theoretical approaches to understanding sex differences and similarities in conflict behavior. In D. J. Canary & K. Dindia (Eds.), <i>Sex differences and similarities in communication: Critical essays and empirical investigations of sex and gender in interaction</i> (pp. 287-302). Mahwah, NJ: Erlbaum	Examines two schools of thought that address gender differences: individual differences approach where characteristic (e.g.,	Book	Men and women are biologically and physically different and therefore they will respond differently to certain types of stimuli and consequently behave differently.	N/A	N/A	N/A

biological sex) are examined to understand behavioral differences between groups. Social Structural approach where social context is examined to understand how behavior differs in social situations.

Girls use language to seek confirmation and reinforce intimacy with friends (usually small groups); boys interact in larger groups and use language that focuses on independence.

Men and women not only use language differently but they interpret that language differently as well.

The social structural perspective was supported based on research indicating that when discussing their own topics individuals are more likely to demand, whereas when discussing their partners topic, they are more likely to withdraw.

Men and women are more likely to engage in the demand-withdraw pattern when the woman is requesting the man to change compared to when the man is requesting the woman to change.

The individual differences perspective is supported because sex differences in a relationship expectations may result in women desiring more change compared to men.

Sanford, K. (2007a). The couples emotion rating form: Psychometric properties and theoretical associations. *Psychological Assessment*, 19(4), 411-421.

Validating measurement of hard, soft, and flat emotion.

Article
Empirical study

Hard emotion was related to power assertion, pursuit of self-centered goals, and negative communication.

Soft emotion was related to

Quantitative

Two-level; multivariate hierarchical linear model

Self-report

Positive and Negative Affective Schedule

Communication Patterns Questionnaire

Quality Marriage Index

Couples Emotion Rating Form

Study 1: 82 recently married couples in a series of conflict conversations

			expressions of vulnerability, pursuit of prosocial goals and positive communication.			Study 2: 1,239 married couples
			Flat emotion was related to withdrawal.			
Sanford, K. (2007b). Hard and soft emotion during conflict: Investigating married couples and other relationships. <i>Personal Relationships</i> , 14 (1), 65-90.	Investigated 2 types of negative emotion during interpersonal conflict.	Article	Hard emotion predicted increases in negative communication. Soft emotion predicted more nonthreatening form of communication.	Quantitative Hierarchical linear modeling	Study 1: questionnaire asked participants to recall three different specific incidents in which they had a conflict interaction with their spouse. For each situation, they were then asked to respond to a set of 35 items regarding their perceptions, thoughts, and emotions at the time of the incident. Twenty of the items formed the scales for the study, the remaining 15 items were filler items. Study 2: the questionnaire used in study 1 was modified in study 2 to be appropriate for relationships in general (e.g., friends, roommates, or romantic partners). Otherwise, the questions used in study 2 were identical to the questions in study 1.	Study 1: 236 married couples Study 2: 140 college students Study 3: 77 married couples
Schachter, S., & Singer, J.E. (1963). Cognitive, social, and physiological determinants of emotional state. <i>Psychological Review</i> , 69, 379-399.	How internal/external cues help people label and identify their emotions.	Article Empirical study	When an individual has no explanation for their psychological arousal many will use cognitions to label their state. When an individual does have an explanation for their psychological arousal they will not label this state in terms of an alternative cognition.	Quantitative Self-report Observation	Self-report on a variety of scales, the subject indicated their mood of the moment. The questions were: how irritated, angry, or annoyed would you say you feel at present, how good or happy would you say you feel at present,	27 male college students taking class in introductory psychology at the University of Minnesota
Snyder, D. K. (1997). <i>Marital satisfaction inventory, revised manual: MSI-R manual</i> . Western Psychological Services.	Discusses the revision and restandardization of the Marital Satisfaction Inventory. The purpose, use, and scale descriptions of the new MSI-R.	Book	The MSI-R measures the nature and extent of distress in a relationship through 150 true of false items. It is a self-report measure and take about 25 minutes to administer. It can be used to identify treatment goals in therapy, measure therapeutic gains, and identify	N/A	N/A	N/A

			relationship strengths and deficits.			
			There are 13 scales, two of which are validity scales, 1 global affective scale, and 10 additional scales measuring other dimensions of relationship stress (affective communication, problem-solving communication, aggression, time together, disagreement about finances, sexual dissatisfaction, role orientation, family history of distress, dissatisfaction with children, and conflict over child rearing).			
Snyder, D. K., Simpson, J. A., & Hughes, J. N. (2006). <i>Emotion regulation in couples and families: Pathways to dysfunction and health</i> . Washington, DC: American Psychological Association.	Cross-disciplinary approaches to emotion regulation.	Book	Self-report measures of emotional intelligence: Self-Report Emotional Intelligence Test and the Emotional Quotient Inventory.	N/A	N/A	N/A
			Ability based test: Multifactor Emotional Intelligence Test and the Mayer Salovey Caruso Emotional Intelligence Test.			
			Individuals own attachment styles well as their partner's attachment style contributes to their ability to regulate negative affect.			
			Insecure attachment leads to reduced resilience in times of stress.			
			Children's temperament can have an important influence on attachment and parent-child emotional reciprocity.			
			High levels of mothers'			

			expression of positive emotion and low expression of negative emotion predicted higher levels of children's social competence and low levels of externalizing problems.			
			Fathers who reported being more distressed by their children's expression of negative affect had children who were more likely to report using anger and negative emotions to cope with distressing vents.			
			Fathers who reported emotion and problem focused reactions to the expression of negative emotions had children who were less aggressive and disruptive as reported by teachers.			
Sperry, L., Brill, P. L., Howard, K. I., & Grissom, G. R. (1996). <i>Treatment outcomes in psychotherapy and psychiatric interventions</i> . Philadelphia, PA: Brunner/Mazel.	Addresses the importance of outcome studies and measures. Provides information on outcome measures currently being used in hospitals, primary care facilities, private practices, etc.	Book	Outcome measures allow practitioners to view progression of treatment over time. Clinicians first started out giving patient satisfaction questionnaires after which inventories and ratings of patient variables such as symptoms and functioning were developed, lastly monitoring outcome systems have been developed. The COMPASS is an example of an outcome measure that has three patient self-report scales – subjective well-being, current symptoms, and current life functioning which all combine into	N/A	N/A	N/A

			the mental-health index.			
			OUTCOME is a computerized program used in primary care settings that allows one to compare how a treatment plan for a client compares with regard to the duration, cost, and outcomes of treatment for other patients with similar presentations who had successful outcomes.			
Thies, K. M., & Travers, J. F. (2006). <i>Handbook of human development for health care professionals</i> . Sudbury, MA: Jones and Bartlett Publishers.	Textbook on human development from the perspectives of nurses, psychologists, nutritionists, educators, and exercise physiologists.	Book	In particular, for children and adolescents anxiety serves as a signal that care should be taken in a new/strange/potentially threatening situation. Short-term moderate anxiety can motivate individuals to learn new methods of adjusting to their environment and develop coping and problem-solving skills. Anxiety is a future oriented mood state. The most common reason for early intervention services is due to a speech/communication impairment or delay. Not only can learning disabilities affect academics it can also have a profound impact on the individuals daily social and emotional world. ADHD has a strong genetic and neurobiological origin and therefore should be present in the	N/A	N/A	N/A

Thomas, S. P. (2005). Women's anger, aggression, and violence. <i>Health Care for Women International</i> , 26 (6), 504-522.	15 years of research on women's anger in the United States, France, and Turkey.	Article	<p>early stages of life.</p> <p>9% of women stated that they would express their anger to the person who angered them.</p> <p>Majority of women said they ruminated which made them feel more resentment.</p> <p>Anger is a confusing and uncomfortable emotion for women.</p> <p>The most difficult setting for women to express their anger appears to be in intimate relationships with men.</p> <p>Women who have higher social status report greater freedom in expressing their anger.</p> <p>The more education a woman possesses the more likely she feels comfortable expressing her anger.</p>	Literature Review	N/A	N/A
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Verhofstadt, L.L., Buysse, A., de Clercq, A., & Goodwin, R. (2005). Emotional arousal and negative affect in marital conflict: The influence of gender, conflict structure, and demand-withdrawal. <i>European Journal of Social Psychology</i> , 35 (4), 449-467.	During marital conflict, how do individuals respond (i.e., emotional arousal and negative affect)	Article Empirical study	The husbands who were less demanding and more withdrawing during marital conflict were less aroused after the discussion.	Quantitative Observational Self-report	Study 1 & 2: Emotional Arousal and Negative Affect Study 2: Couples Interaction Rating System	Study 1: 86 heterosexual Belgian couples married or cohabitating for at least 6 months. Study 2: 32 heterosexual Belgian couples
			Wives reported more emotional arousal and negative affect, as they were more withdrawing and less demanding.			
			Husbands experienced lower levels of emotional arousal and negative affect after a discussion of an issue where wife wants a change.			
			Higher levels of emotional arousal were associated with higher levels of negative affect for husbands and wives.			
			Husbands were more demanding during their chosen topic.			
			Wives there were no differences in the amount of demandingness and withdrawal across both types of discussions (husband versus wife topic).			
Vogel D.L., Murphy, M.J., Werner-Wilson, R.J., Cutrona, C.E., & Seeman, J. (2007). Sex differences in the use of demand and withdraw behavior in marriage: Examining the social structure hypothesis. <i>Journal of Counseling Psychology</i> , 54 (2), 165-177.	Examines the link between three aspects of marital power and demand-withdraw behavior.	Article Empirical study	Wives did not possess less decision-making ability or access to resources compared to their husbands.	Quantitative Self-report	Interaction Rating System Family Relational Communication Control Coding System Perceived Marital Power Scale Hollingshead's Two-Factor Index of Social Position Dyadic Adjustment Scale Communication Patterns Questionnaire--Short Form	72 heterosexual married couples.
			Wives displayed greater situational power (i.e., domineering and dominant behaviors) compared to their husbands during problem solving discussions.			
			The individual who exhibited demands was the one who			

			displayed the most domineering and dominant behaviors, while the individual who exhibited the most withdrawal displayed the least domineering and dominant behaviors during problem solving discussions.			
Whisman, M. A. (2007). Marital distress and DSM-IV psychiatric disorders in a population-based national survey. <i>Journal of Abnormal Psychology, 116</i> , 638-643.	Marital dissatisfaction Psychopathology Age and gender and moderator	Article, Empirical	Evaluated the association between a multi-item measure of marital distress and DSM-IV psychiatric disorders in a population-based survey of individuals in the United States in which there was no upper age exclusionary criterion. Evaluated whether the associations between marital distress and psychiatric disorders were moderated by gender or age Marital distress was associated with a range of psychiatric disorders	Quantitative Self-report survey	World Health Organization World Mental Health Survey Initiative version of the Composite International Diagnostic Interview *WMH-CIDI) based on DSM-IV 14 items (1,2,5,8,12,16,18,20,21,24, 25,26,27, and 28) from the Dyadic Adjustment Scale (DAS)	2,213 married individuals from National Comorbidity Survey Replication (NCS-R)

APPENDIX B
IRB Approval Letter



Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: September 12, 2016

Protocol Investigator Name: Emily Edwards

Protocol #: 16-06-305

Project Title: UNDERLYING EMOTIONS IN DEMAND-WITHDRAW PATTERNS OF COMMUNICATION

School: Graduate School of Education and Psychology

Dear Emily Edwards:

Thank you for submitting your application for expedited review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

Based upon review, your IRB application has been approved. The IRB approval begins today September 12, 2016, and expires on September 11, 2017.

Your final consent form has been stamped by the IRB to indicate the expiration date of study approval. You can only use copies of the consent that have been stamped with the IRB expiration date to obtain consent from your participants.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and will require a submission of a new IRB application or other materials to the IRB. If contact with subjects will extend beyond September 11, 2017, a continuing review must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

APPENDIX C

Behavioral Affective Rating Scale

Matthew D. Johnson
 Alexis Johns
 Jennifer Kitahara
 Mokoto Ono
 University of California, Los Angeles 1998

The Behavioral Affective Rating Scale (BARS) was developed as an alternative to SPAFF that uses rating scales instead of coding to assess affect observed in dyadic interactions. The validity and reliability of the BARS were described by Johnson (2002) and translated into Dutch by Lesley Verhofstadt at the University of Ghent.

Definitions and Examples

The BARS allows one to rate the affect in couples' interactions on a scale from 0 to 4 solely on the basis of the couples' body language, facial expressions, and tone of voice. The actual content of couples' interactions is not taken into consideration at all. A 0 is the absence of the affect, a 1 is mild, a 2 is medium, a 3 is strong, and a 4 is extreme. The following list includes examples for each of the ratings for all the affects.

It should be noted that during some periods of the interactions, none of the affects will be displayed. It is expected that the absence of these affects will be the rating most often used. The majority of the couples' affect will fall in the range of 0 to 2. It is also important to recognize that some of the behavioral affects need to occur only briefly during the 30-s interval to receive high ratings. This is because some behavioral affects are primarily mercurial in nature. An asterisk (*) identifies these affects. The remaining affects need to occur in longer duration to receive higher values.

**Affection*: genuine care, support, warmth, and tenderness.

Scores: 0 = absence
 1 = genuine smiles

2 = warm laughter
 3 = flirting, little love taps
 4 = holding hands, hugging, kissing.

**Humor*: genuine, honest smile or laughter in a positive and agreeable situation, with no ill intention shared by the couple.

Scores: 0 = absence
 1 = laughing smile

2 = genuine laughter
 3 = goofiness
 4 = uncontrollable laughter.

Anxiety: nervousness, tenseness, and discomfort.

Scores: 0 = absence

1 = anxious tone of voice, shifting

2 = nervous giggle, extended fidgeting 3 = stuttering

4 = sweating, panicky, skittish.

Engaging: showing positive involvement and focusing on the conversation.

Scores: 0 = absence

1 = steady, active eye contact, nodding

2 = steady, active eye contact, nodding, affirmative vocal cues

3 = steady, active eye contact, leaning, verbal cues, nodding

4 = steady, active eye contact, body contact, leaning, verbal cues.

Disengaging: displaying a total disinterest in the conversation and not listening.

Scores: 0 = absence

1 = extended break of eye contact

2 = over-talk

3 = closed body position, no eye contact 4 = totally unresponsive.

Defensive: self-justification.

Scores: 0 = absence

1 = shaking head, inward, defensive hand motions

2 = more adamant head shaking and inward hand motions 3 = aroused body posture, interrupting in spurts

4 = very animated, prolonged defensive motions.

Aggressive: attacking, accusing, forcefully communicating.

Scores: 0 = absence

1 = forceful tone of voice, pointing

2 = more aggressive tone of voice, outward hand motions

3 = prolonged forcefulness in the tone of voice and body movements 4 = in face, yelling.

Scorn: insulting, condescending, contemptuous, and sarcastic.

Scores: 0 = absence

1 = rolling eyes, light sarcastic tone of voice

2 = contemptuous voice, more sarcasm

3 = very condescending voice, withering looks

4 = dismissive body posture, extremely sarcastic.

Frustration: flustered, upset, loss of patience and tense.

Scores: 0 = absence

1 = sighing, tense body posture

2 = more sighing, holding head at an angle 3 = clenching teeth, slight stuttering

4 = so flustered unable to talk, red in face.

**Hurt*: genuine emotional pain, sadness, and wounded.

Scores:

BARS Procedure

0 = absence

1 = hurt look, passively looking down 2 = more expressions of sadness

3 = shaky voice, watery eyes

4 = crying.

First, raters watch the entire ten min. interaction continuously to obtain an overview of the interaction. This initial viewing of the interaction also makes tuning out the content of the conversation easier during the actual rating.

Second, raters view the interaction again, concentrating only on either the wife or husband. During this second viewing, the rater will stop the tape after each 30-sec. to rate the interval for the ten behavioral affects based solely on tone of voice, facial expression, and body movement.

Third, raters repeat the second step, this time rating behavioral affects of the other partner.

References

Johnson, M. D. (2002). The observation of specific affect in marital interactions: Psychometric properties of a coding system and a rating system. *Psychological Assessment, 14*, 423- 438.

Note

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