# AN EVALUATION OF THE EFFECTS OF CONJOINT THERAPY AND INDIVIDUAL THERAPY ON SPOUSE ROLE ADJUSTMENT

by

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# CHAPTER I

## Introduction

As a result of federal legislation in the early and middle 1960's, there has been an extensive growth in community mental health centers. The needs of the mental health field have been so acute and broad in scope that new programs have been designed and implemented without a substantial basis in theory, research, or even practical experience. Developing a mental health program on the mere hope that it will be a contribution can no longer be afforded, either morally or financially. Mental health centers must become accountable for solving social problems through planned action. This requires effective program evaluation to discriminate between those programs having unexpected and undesirable consequences, and those which are, indeed, helpful.

In Oregon, there is an active program for evaluation of mental health services. Instruments and methods are being developed to measure the impact of the mental health services upon an individual's quality of life. The concept of quality of life (Bigelow & Brodsky, Note 1) incorporates adjustment from both social and individual points of view. This is particularly appropriate to community mental health work which is intended to foster the health of both individuals and communities.

Today most mental health centers are offering therapies to foster better marital and family relations. The rationale for these was restated in the 1978 report for the President's Commission on Mental Health. In the last decade, there has been an increasing emphasis on the use of family (conjoint) therapy, rather than individual therapy in treating marital and family problems (Olson, 1970). The theoretical

framework for conjoint therapy has been developed without empirical findings and the theory, in fact, is not at all systematic. There remains a need for a clear, tested rationale of family therapy for people having marital and family problems.

The present study follows on a previous evaluation research project, done in the Spring of 1978 at the Yamhill County Mental Health Program in McMinnville, Oregon (Bigelow, Chesla, & Brodsky, Note 2). This project used the Oregon Quality of Life Questionnaire, an instrument being developed in the state of Oregon, to measure the outcomes of psychotherapy offered at the Program. The results showed an overall improvement in the quality of life of clients, but there was also a significant decrease in spouse role adjustment. This negative finding may be explained by a number of factors. First, changes experienced by clients in individual therapy may have caused difficulty in the marriage; second, the instrument may fail to measure important aspects of marital adjustment which may have improved; and third, the marital adjustment may have "gotten worse before it got better" (i.e., the follow-up interval was too short). Gurman (1978) states that some cases of deterioration in therapy outcomes may reflect an intermediate stage of the therapeutic process.

To explore these possibilities, the present study was an effort to evaluate comparatively the effects of conjoint therapy and individual therapy on the quality of life of the individuals involved. This study was also an effort to broaden the conceptualization of spouse role adjustment as a specific area of the quality of life theory and to develop a more complete spouse role adjustment scale. In addition a longer

follow-up interval was used to determine if the individuals had "worked through" the intermediate stage of therapy to an improved level of adjustment.

## Review of Literature and Theoretical Formulation

In the following section, selected literature on the dependent and independent variables is reviewed. The dependent variables are the client's quality of life, and spouse role adjustment. Development of the concept of quality of life as a measurable mental health variable is examined including the status of information prior to this work and the reasoning behind the choice of this variable as a multidimensional measure of psychotherapy outcome. The concept of spouse role adjustment is centered on the ability of an individual to satisfy his/her hierarchical set of needs (Maslow, 1943) within a marriage. Research on the independent variable, type of therapy (conjoint and individual) for marital and family problems is also reviewed. The methodology employed in the empirical studies, their measuring instruments, the groups of subjects that received these therapies, and their findings are presented. Throughout the review, the theoretical formulations of these concepts and treatment modalities are developed.

### The Dependent Variables

Quality of life. Mental health professionals, behavioral scientists, and students of the humanities have devoted much effort to conceptualizing and measuring the quality of individual experience, in the clinic, in natural settings, and occasionally in the experimental laboratory. The work in clinical settings has typically involved small numbers of subjects and unsystematic conceptualization, making it difficult to generalize the

findings. There have been, however, a few national studies in which a developing trend in the conceptualization of quality of life can be discerned.

The concept of quality of life, used in the Oregon evaluation research program, is an outgrowth of the trends evidenced in the national quality of life surveys, together with some ideas taken from role and exchange theories. The four major national surveys, reviewed below, take the concepts of quality of life from a basic notion of happiness, through affect associated across life areas, to more substantive concerns, aspirations and satisfactions, to satisfactions of needs within physical and interpersonal domains.

The first major study of quality of life from the point of view of mental health, based on a probability sample of the American population, was carried out in 1957 by Gurin, Veroff, and Feld (1960). This national survey, requested by the National Commission on Mental Illness and Health, defined its major objectives in the following terms:

> a survey of the mental health of the nation, designed to investigate the level at which people are living with themselves - their fears and anxieties, their strengths and resources, the problems they face and the ways they cope with them. (Gurin, Veroff, & Feld, 1960, p. 3)

This study clearly had a mental health orientation and the measures used reflected the authors' attempt to conceptualize and assess the psychological health of their respondents. Their questionnaire asked for a report of any previous "breakdown" or need for psychological counseling, it presented a checklist of "psychiatric symptoms", it inquired into various forms of "worry", and included a single question

asking the respondent to report how "happy" he was--very happy, pretty happy or not too happy. This represents a rather sketchy notion of quality of life as consisting of aberration, distress, and service utilization. A more comprehensive concept was needed.

This study was followed by a number of others similarly concerned with the epidemiology of mental health, most of them based on limited samples and not directly related to quality of life. In 1961, however, Bradburn at the National Opinion Research Center initiated a program of research intended to establish national norms and trends for mental health-related behavior by means of periodic national surveys. In their initial study based on population samples in four midwestern communities, Bradburn and Caplovitz (1969) took as their basic measure of well-being the response to the Gurin et al. question: "Taking all things together, how would you say things are these days--would you say you are very happy, pretty happy, or not too happy these days?" In his second volume Bradburn pursued this theme and extended the concept of positive and negative affect into the realms of marriage and work (Bradburn, 1969). However, it is quite apparent that mental health consists of more than positive and negative affect.

The third major study (Cantril, 1965), was massive, comparing data on life satisfaction collected in 13 different nations (including the United States). Cantril used a device known as the "self anchoring striving scale". Cantril asked the individual to think of the "best life" and the "worst life" and to place himself at the point he thought he presently stood on a ladder ranging between these extremes. The step at which the person placed himself is Cantril's critical measure or the

"anchor". The interviewers were encouraged to draw out their respondents as to their hopes and fears regarding the future, and these open-ended comments were used to identify their concerns. Although Cantril tends to use the terms "happiness" and "satisfaction" interchangeably in his report, his emphasis is not on affective states as Bradburn's was, but on aspirations, needs, and satisfactions. This is a more substantive view of quality of life. His book is primarily devoted to a comparison of the concerns and satisfaction levels of the people in the various countries which he sampled.

Campbell, Converse and Rodgers (1976) published the fourth major study in the development of the concept of quality of life. Thus far the concept of quality of life had developed from general well-being to well-being across various areas of life to substantive concerns and satisfactions. Most of the previous studies of life experience had asked their subjects to describe their life as a whole without attempting to assess specific areas. Campbell, et al. focused upon the sense of satisfaction and dissatisfaction that the subjects in their national sample said they drew from 12 critical "domains" of life, such as their marriages, their jobs, and their housing. The study reports on these individual domains, their relationship to each other, and their respective contributions to the overall quality of life.

Campbell, et al. define the quality of life experience mainly in terms of the satisfaction of needs, although needs are not the organizing feature of their conceptual framework. As reported elsewhere (Campbell and Converse, 1972), they were originally attracted to Maslow's theory of a hierarchy of needs (1943) and would have liked to have

developed their study around his system of classification. The decision to inquire around the "domains" of life, instead of Maslow's needs, came because some of the variables in Maslow's theory, e.g. self actualization, are difficult to operationalize in language suitable for a national study.

Dalkey (1972) and Bateson (1972) disagree with Campbell, et al., (1976) that quality of life is defined by physical variables, such as "domains" of life. They propose that what people care most about are not episodes or things, as such, but the patterns and setting of their personal relationships.

Bigelow and Brodsky (Note 1) have chosen to develop their conceptual framework around Maslow's needs. They have also incorporated Campbell's "domains" and the personal relationships which Dalkey and Bateson emphasize. Bigelow and Brodksy carry forward the concept of quality of life by describing the adjustment of individuals to their environments in terms of role and exchange notions. Adjustment is viewed as an interaction consisting of (1) obtaining one's needs through opportunities which the environment offers (satisfaction), and by (2) using one's abilities to meet demands of the environment (performance). Meeting the environment's demands is the price of access to the opportunity structure. Adjustment, therefore, is seen from both the points of view of the individual and society. It is the simultaneous conditions of need satisfaction and satisfactory performance within one's environment.

Bigelow and Brodsky (Note 1) describe adjustment--the exchange of performance for satisfaction--in terms of role theory. Their view of human behavior is that much of one's effort is directed toward meeting the expectations of other people in a manner which is also rewarding to

oneself. These expectations are clustered into roles: self roles, interpersonal roles, productivity roles, and civic roles. To the extent such expectations are met, the individual is likely to have his needs satisfied. The adequacy of his role performance has important consequences for himself as well as for others. When role expectations are not met, maladaption becomes quite apparent to all concerned.

The concept of quality of life, from a mental health perspective, has shifted over time from general well-being, to affect regarding specific areas of life, to concerns and satisfactions across all areas of life, to satisfaction of needs in specific physical domains of life, to satisfaction in personal relationships, to a concept of satisfaction and performance (of needs described by Maslow) and performance (according to the norms of the community and expectations of "significant others") across the range of roles in which people must function to be considered mentally healthy or adjusted. In order to evaluate the effectiveness of any treatment program, one must have some operationalized idea of what one expects to see changed. This concept of quality of life--that quality of life, adjustment, and mental health, consist of satisfaction and performance in social roles--is the outcome variable which the present evaluation research project and the evaluation of the state mental health division has used to assess treatment impact. The present project has attempted to refine the Quality of Life concept by examining one of the roles, the spouse role, in greater detail.

Spouse role adjustment. One of the major problems in finding a measure of spouse role adjustment is that the conceptualization of this dependent variable--marital adjustment, marital happiness, marital

interaction, marital satisfaction, marital success, etc.--has been so inadequate (Waller & Hill, 1951; Kirkpatrick, 1963; Lively, 1969). Over 300 articles in which marital adjustment, or a related concept, is the dependent variable have been identified by Spanier (1976). He argues that it would be most fruitful to direct efforts at clarification of the problems in definition, conceptualization, and measurement. It is unrealistic to think that a single measurement of marriage adjustment will be satisfactory for all purposes but it would be desirable to develop a set of measures of different dimensions of marital adjustment related in a meaningful way, which could be used for a variety of research purposes. Such measures should emerge from a conceptualization of marital adjustment that might be useful for diagnosis and prediction, as well as for analysis of the outcome of therapy.

In this section, therefore, the literature on marital adjustment is discussed within a conceptual framework, emphasizing Maslow's hierarchy of needs and the Quality of Life concept of the relation of performance and satisfaction within need areas. The basic notion of exchanging performances for satisfactions is described. Then the needs as they are found in man are described together with the marital performances that meet the needs, and some of the appropriate therapeutic interventions.

Marriage can be considered an arrangement which provides an opportunity for two individuals to satisfy their needs, each one through the other's performances. Spouse role adjustment occurs when the abilities of the partners are such that each can meet the other's expectations and fulfill the other's needs. An individual's cognitive, affective and behavioral abilities enable him/her to exhibit a motivated, appropriate

performance or response. In clinical practice, the mental health professional often is concerned with the variable of the individual's abilities. For example, the therapist restructures cognitive abilities by insight therapy for the classical neurotic, or administers psychotropic medication to the chronic schizophrenic to improve his/her affective ability. The therapist may also improve behavioral abilities, e.g., communication training.

Maslow (1943) conceptualized human needs arranged in hierarchies of prepotency. That is to say, the appearance of one need usually rests on prior satisfaction of another, more prepotent need. The lowest level needs are the basic or physiological needs. These include food, shelter, medication, and sex. In a marriage there are arrangements to satisfy these needs. These arrangements are changing as a result of new concepts in female sexuality, changing work roles, the Women's Liberation Movement, and the "population explosion", with its implications for childbearing as a rationale for marriage (Laws, 1975). The need for sex, which is usually paired with the higher need for affiliation and sometimes with esteem and self actualization, is generally arranged as to the frequency, fashion, and time in which it will be satisfied. These basic needs, as a preoccupation or problem area, usually only emerge as such when they have been thwarted, such as in a medical illness. When the basic needs are satisfied, other higher needs emerge as our major concerns.

The need for safety is another basic need. It is expressed in the desire for orderliness and undisrupted routine. This need can be satisfied in a marriage by a trusting relationship in which no harm will come to one's self and valued possessions. It can also be met by the degree

to which one spouse is predictable and reliable in the expectations of the other. Problems in adjustment can arise here, especially with the neurotic, who has feelings of impending disaster. Often his/her expectations of the spouse are unrealistic.

The next hierarchial set of needs are those of affiliation. If both the physiological and safety needs are fairly well gratified, then there will emerge the love, affection and belongingness needs. In our society the thwarting of these needs is the most commonly found cause for maladjustment and more severe psychopathology. Furthermore, this set of needs is often best satisfied by means of a well adjusted marriage.

Many of the marital adjustment scales focus on the variables involved in meeting these needs. For example, Blood and Wolfe (1960) include companionship, understanding, love and communication in their comprehensive study of marriage. Although communication is an important means of meeting affiliation needs, communication is necessary for meeting all of the needs gratified through the marriage. Adequate communication is needed to satisfy even the most basic needs, such as the acquisition of food or the organization of the home. In this study, the investigator makes the assumption that communication is not an end in itself, but a means to very specific ends.

Sex can be viewed as a purely physiological need. But ordinarily sexual behavior is multi-determined. Sexual behavior is also instrumental to the satisfaction of the love and affection needs. In a well adjusted marriage, the performance of one spouse fulfills the expectations of the other for meeting his/her love, affection, and sex needs, and vice versa.

The need for self-esteem is defined as a need for a stable, firmly based, high evaluation of oneself. These needs are expressed through the desires for self-confidence and achievement. In a marriage these needs can be satisfied through respect and positive feedback from the spouse.

Over 30 years ago, Maslow (1942) stated that the best marriages in our society seem to be those in which the husband and wife are at about the same level of self-esteem or in which the husband is somewhat higher in self-esteem than the wife. Although the status of women has changed in this time, it still remains that one's self-esteem depends upon the power one has, and is accorded, to make choices. Power is, in part, a measure of one's worth. Marriages with equal power are conducive to good adjustment because both spouses derive equal self-esteem. This study assumes equal power to be not an end in itself but a means to a specific end, self-esteem.

In the clinical setting, one continually is confronted with clients whose self-esteem needs are not met. They typically are unassertive and are unable to stand up for their own rights, including those within their marriage. There are measures of power and decision making in many of the martial adjustment scales (Blood & Wolfe, 1960). In the present study it is assumed that power and decision making are indicators of self-esteem.

The need for autonomy arises after both the needs of affiliation and self-esteem have been dependably gratified. This need is expressed in the desire to be independent and to have a private space for self-growth. The need for autonomy differs from lower needs in that it is not as dependent on the physical and social environment for opportunities to be satisfied. The point of view in this study is that there can be

problems in a marriage when this need does not emerge simultaneously for both spouses. The emergence of the need for autonomy may be delayed if one has not satisfied lower needs. Under these circumstances, a spouse may not be able to understand the desires for autonomy in his/her spouse. We can see improvement in some marital cases, when the spouse who is not yet motivated by autonomy needs is helped to grow or when both are enabled to see the emergent nature of their conflict. Most measures of marital adjustment do not include estimates of autonomy.

The need for self actualization is at the top of Maslow's hierarchy of needs. It refers to the desire for self-fulfillment. As mentioned previously, others have not used Maslow's classification because of the difficulty in operationalizing the term. Self actualization is not a state one can attain. According to Maslow (1954, p. 54), "the average individual might be satisfied in perhaps 85% of his physiological need, 70% of his safety need, 50% of his affiliation need, 40% of his self-esteem need and 10% of his self actualization need."

Self actualization consists of a "peak experience" (Maslow, 1968), both in the sense of rarity and high satisfaction. The peak experiences are episodes or moments in which one is more fully him/herself. Not only are these the happiest and most thrilling moments, but they are moments of greatest maturity, individuation and fulfillment. As one meets more of his needs for self actualization, he/she has more peak experiences. Maslow saw it as a style of life for a few gifted individuals.

Self actualization is indicated by behaviors aimed at, or experiences of, achieving a personal standard of excellence, or ARÊTÉ (Pirsig, 1974, p. 377). Participation in activities and social processes in which one

continually experiences a fresh sense of appreciation is an indicator of self actualization. Some may experience this appreciation by communing with nature, others through their children, for a few through great music, and for some it lies in a challenging, growing, fulfilling intimate relationship with a peer (Maslow, 1950). Marriage can provide such opportunities for self actualization.

Obviously, it is unrealistic to think that a marital relationship could fulfill all need for self actualization. In marriages where there is a self actualizing style of life, it is not unreasonable to think that both spouses will share some of these peak experiences together and will support one another in pursuing this highest of need satisfactions. While we are unlikely to encounter a marital problem focused on the self actualization area, the facilitation of an occasional peak experience will add a great deal to the perception of satisfaction in a marriage.

Fulfilling one's needs at one level gives rise to new demands. The more marital partners yearn for fulfillment of higher order needs, the more frustration and failure may occur in functioning at a higher level. Farson, Hauser, Stroup, and Wienwe (1969) believe that some basically good marriages fail. Any marriage in which this sort of discontent emerges should be regarded as having a good prognosis because the marriage also has the capacity to develop abilities and change expectations and opportunities so as to meet the emergent needs. Although this type of failure in marriage may bring clients to the mental health clinic, it is more likely that the majority of maladjusted marriages that are seen involve unsatisfied lower needs, such as safety, affiliation, and self-esteem.

In summary, the concept of spouse role adjustment presented here consists of having one's needs met by one's spouse's performances, and vice versa. Physiological, safety, affiliation, esteem, autonomy, and self actualization needs of each partner are met by the other partner using his/her cognitive, affective, and behavioral abilities in the spouse role performances that are expected of him/her. Mental health treatment can improve adjustment by improving insight into the relation between performance and satisfaction; insight into the pattern of prepotency in emergence of the needs; and communication to facilitate performances, affective capacities, and behavioral abilities to make specific performances.

## The Independent Variable: Type of Therapy

Conjoint therapy. In this section, the literature on conjoint therapy for marital and family problems is reviewed. An attempt is made to integrate the concepts of conjoint treatment, although little conceptualization has, in fact, been put forward. Increasingly sophisticated studies (in terms of better theory, better measures, and better research designs) of the effectiveness of conjoint treatment are described and the evidence is weighed.

Although studies with experimental designs, in principle, yield more valid conclusions regarding outcomes, non-experimental studies contribute at least speculative knowledge. This section of the review of the literature focuses on those studies, many of them non-experimental, which involve the conjoint method of marital and family therapy.

In the philosophy of conjoint therapy, the family is viewed as a system (Haley, 1962). Conjoint therapy, ideally, involves seeing the

family together during all the sessions. In practice individual sessions are used in addition to joint sessions. Involving family members in therapy causes them to jointly confront the issues. It differs from individual therapy by shifting the perspective from intrapersonal processes to the dynamic relationships of the individual with his/her environment. In the following paragraphs, the psychological implications of seeing the family together are described in terms that relate to the needs of individuals and how they are met using the quality of life theory.

The empirical study of marital and family therapy outcome is a relatively recent phenomenon. Of the roughly 75 investigations found, over 80% have been reported in the last 10 years (Gurman, 1972). In his review of outcome research on marital therapy, Gurman (1972) noted that most studies were methodologically weak and based on extremely small samples. He concluded that "although the practice of marital and family therapy has been with us for some time, the empirical investigations of this important area of clinical service are still at the earliest stages of developement." Others who have undertaken to review the literature, such as Olson (1970), Wells, Dilkes, & Trivelli (1972), Goodman (1973), Beck (1975), and Wells (1978) have also stressed the meager research literature in the field of marital and family therapy and the many methodological weaknesses of what is available. So the tested theoretical basis of marital and family therapy would seem sketchy and shaky.

One of the largest studies to investigate marital therapy was conducted by Beck (1966) at the Family Service Association of America. It was one of the few studies which has been undertaken to describe

systematically the conjoint marital therapy technique. While this study was not an empirical investigation of the effectiveness of the conjoint method, it was one of the first and best to survey marital therapists regarding their judgment about the relative value of the conjoint approach for both diagnosis and treatment of marital problems and under which conditions conjoint therapy is most useful. This project collected responses to 60 open-ended questions, resulting in 9,000 pages of material which were content analyzed. As a result, a major monograph (Couch, 1969) was published. The outcome criteria included change in presenting problems, in client's approach to problem-coping, in family relationships, and in individual family members. The results showed that the therapists' ratings of change were statistically significant for conjoint therapy, while the clients' ratings were just shy of statistical significance. These findings, at least, establish the consensus of professional opinion. The open-ended technique increases the likelihood that anything of significance, which was apparent to the subjects, was included. The quantification in such studies, however, is always suspect because it involves the subjective judgments of the quantifiers. This results in problems of validity.

The report on family therapy of the Group for Advancement of Psychiatry (GAP, 1970) is a descriptive study of 312 family therapists. Although the questionnaire data were not obtained from a random sample of family therapists, the report does provide a general overview of the field. It attempted to determine who was practicing family therapy, who the clients were, what goals the therapists had in treatment, what

conceptual frameworks were used and the ethical problems they encountered. The results of the study showed that 40% of the therapists were social workers and 40% were psychiatrists and psychologists. As the therapists began to learn more about the families of their patients, they began to see more clearly that the patient usually came from a disturbed family. Thus, they assumed the family is a causal factor in the etiology of individual psychopathology. At least, we might conclude, the family system is implicated in individual pathology and therefore ought to be included in treatment, probably conjointly. This is consistent with the theoretical formulation described earlier in the present paper--adjustment results from the interaction of the individual and his environment.

The following goals were judged by the therapists to be of primary importance: (1) improved communication, (2) improved autonomy and individuation, and (3) improved empathy. These goals seem related to the two themes of the quality of life theory--the needs of the individual for autonomy and individuation and the means of meeting those needs by improving communication and empathy.

The GAP report further differentiated two conceptual frameworks used in therapy. One emphasized the alteration of behavior by using communication theory and objectively measuring changes in behavior. This is an intervention which could contribute to the means by which individual spouse's needs are met by the performance of the other. The second approach focused more on altering the subjective feelings of family members. The latter is an intervention that most therapists practicing individual therapy would make. This intervention would seem most difficult with all the family members present. Most family

therapists were found to fall between these two positions.

Ehrenkranz (1967) compared 15 conjoint interview treated couples with 17 couples treated either individually or concurrently. She found numerous significant differences in technique, counselor "stance" and behavior, husband and wife variations as to how committed they were to their marriage, and generally that very different things can and do occur in different forms of marital therapy. However, no follow-up outcomes were studied.

To this point, the literature suggests the family is a system and is implicated in individual pathology. Conjoint therapy deals with the family together by jointly confronting issues, using communication and empathy-building in what family therapists, at least, believe to be a more effective modality than individual therapy. The empirical basis for conjoint therapy theory is weak.

The majority of studies of marital and family therapy do not involve control groups and use a global rating as the primary outcome measure. These global ratings are mostly from self-reports of the patients. The overall success rate is 66% (Wells, Dilkes, & Trivelli, 1972; Gurman, 1972; Beck, 1975). It is interesting to compare these ratings to similar global ratings of uncontrolled studies of individual psychotherapy which reported similar success rates with or without therapy (Eysenck, 1952; Frank, 1961).

These studies fail to provide convincing evidence of the outcome of therapy in three respects. First, they do not indicate what happens to comparable groups in the absence of treatment. Second, they fail to take into account that improvement may have been reported for some reason

other than real gains, such as a wish to please the therapist or a need to feel that the substantial investment was worthwhile. Third, they do not show how or why such improvements occurred, if they did. Answers to the first issue require control groups. Answers to the second require sensitive measures of outcomes with skillful questioning about changes. Answers to the third require strong conceptual frameworks to explain the relationship between the variables. Of the three deficiencies, the absence of conceptual frameworks is the most pressing. One cannot decide what to measure without a framework, nor can one meaningfully interpret any difference found (no matter how strong the research design) without a statement setting out the relevant variables and how they are supposed to interrelate.

Minuchin, Montalvo, Guerney, Rosman, and Schumer (1967) attempted to assess more adequately the outcome of family therapy. They treated 12 families who had a juvenile delinquent and used a matched control group of 10 families, having no delinquent children. Both groups were tested prior to therapy using the Family Interaction Appreciation Test and the Wiltwyck Family Task, an observational measure. The families in the experimental group were given the same tests at the conclusion of therapy and there was also a clinical evaluation of treatment. However, no post tests were given to the control group families.

Both measures focus on the actual interaction of the family members which is quite different from the traditional self-report measures. The pre vs. post scores on the Family Interaction Appreciation Test showed some improvement. This measure has been tested for its reliability and validity. The Wiltwyck Family Task, which showed no change, was

developed for this study and has not been standardized. Since there is a measured pre-post difference for the experimental group, but none for the control, the inference that change was due to treatment can be challenged.

Wells et al., (1972) state the major flaw of this study is a failure to match the control group on the most vital variable, presence of a delinquent child. While this study has some methodological weaknesses, it begins to look at interaction.

A systematic study of family therapy outcome and process was performed by Sigel, Rakoff, and Epstein (1967). In their study, 20 families received conjoint family therapy. There was no control group. Two measures were used. Ratings based on the family's interaction style were made by the therapist after the 2nd, 6th, and 12th sessions. After every session a questionnaire, the Family Category Schema, was also completed by the therapists and other therapists rated their reports for change in the family. These therapists' ratings of change were later combined to measure the outcome of the treatment. They found no relationship between the success of the treatment and the interaction scores at any of the three points during treatment. This study exemplifies the shift in the direction of studying interaction processes but does not tell us much except, perhaps, that better concepts and measures are needed to reflect changes.

Wells (1978) reports on a large-scale (N=275), carefully designed study conducted at McMaster University in Hamilton, Ontario, where moderately disturbed children and adolescents were treated with short-term systems oriented family therapy. This study, though uncontrolled,

used multiple outcome measures at termination of treatment and six-month follow-up which included therapist and client improvement ratings, Goal Attainment Scaling, and recidivism. Seventy percent were reported improved at termination by the therapists and the same proportion of client-rated improvement was found at follow-up. The less subjective measures also show substantial change. It is unfortunate that much of the work of the McMaster group is still unpublished, but their employment of the Goal Attainment Scaling demonstrates that outcome measurement can be quite specific and concrete for a non-behavioral family therapy.

A major advance in marital and family therapy outcome research in the past few years has been the appearance of a number of studies in which a comparison was made with an "untreated" control group (Alexander & Parsons, 1973; Katz, Krasinski, Philip, & Wieser, 1975; Klein, Alexander, & Parsons, 1975). These controlled studies of therapeutic outcome attempted to compare the consequences of formal therapy with "spontaneous recovery". Most of these studies, however, have been unable to establish definitive findings. This may be due to the unidimensional measurement employed. Alexander and Parsons (1973) and Klein, et al. (1975) used the amount of recidivism and Katz, et al. (1975) employed an observation of family interaction at pre and post therapy. These measures are unidimensional in that only one behavioral measure was used to determine outcome.

If conjoint therapy is to become firmly established as a method for therapeutic treatment, it must obviously demonstrate superiority in specific areas of outcome, relative to other available treatments. There

are a number of ways a therapy can be superior other than showing the greatest amount of improvement. A therapeutic approach might be equal to an alternative approach in producing improvement but could be superior in efficiency or in preventing deterioration.

Three studies have centered around comparing conjoint therapy as either an adjunct or an alternative to psychiatric hospitalization. Rittenhouse (1970) dealt with adult patients, while Wellisch, Vincent, and Ro-Trock (1976) treated adolescents.

Rittenhouse (1970) randomly assigned 72 subjects, all meeting criteria for admission to a state hospital, to either conjoint family therapy given in the home or a therapeutic milieu approach given in the hospital. Multiple measures of individual pathology, family and community functioning and readmission rate were assessed at 3, 6, and 12 month follow-up points. The conjoint family therapy group did significantly better in avoiding readmission to the hospital than the control group. The other results were insignificant.

Langsley, Machotka, and Flomenhaft (1971) randomly assigned 300 families with an identified patient judged to be in need of hospitalization, to either outpatient family crisis therapy or to hospitalization and standard treatment. Measures included social and personal functioning scales, as well as rehospitalization rates at base line, termination, 6 month, and 18 month follow-up. Final follow-up indicated that fewer of the family crisis therapy group were subsequently hospitalized, or if hospitalized, their stay was markedly shorter. Unfortunately, both Rittenhouse and Langsley confound the independent variable because in both studies subjects in the outpatient family therapy groups required

hospitalization, so the findings cannot be regarded as evidence for the singular effectiveness of family therapy.

Wellisch's work (1976) represents one of the best designed comparative studies of family therapy outcome currently available. Twenty-eight hospitalized adolescents were randomly assigned to either family therapy or individual therapy. Measures at pre and post treatment looked at a number of family interaction and communication variables based on client self-reports and blind ratings of videotaped sessions by independent judges. Differences in the groups were found to significantly favor family inpatient treatment as superior to individual inpatient treatment. The hospital studies could be interpreted as showing that conjoint treatment generates family support, as well as improved interaction and communication, for the identified patient, and thereby prevents the need for additional hospital care.

Almost no research exists comparing the outcomes of different forms of marital and family therapy in outpatient settings. Cookerly (1973) compared six forms of marriage counseling: individual interview, individual group, concurrent interview, concurrent group, conjoint interview, and conjoint group. This was a pilot study of 773 former marriage counseling clients of 21 marriage counselors. The procedure involved a search of a clinic's inactive files recording all marriage counseling cases involving at least three sessions and judging which of the six forms of marriage counseling predominated. Next, the center's post-counseling follow-up data were used to judge the client outcome into six categories, ranging from "divorced, poor" outcome to "married, good" outcome. The results suggest that different outcomes in marriage

counseling can be expected when different forms of marriage counseling are used. This study provided statistical support for the superiority of conjoint over individual and concurrent forms of treatment for marital maladjustment, except in special circumstances, such as couples obtaining divorces, and in situations requiring reduction of individual psychopathology. These findings are highly tentative because there were no controls for factors as age, type and severity of problem, socio-economic status, length of marriage, etc.

Altogether, the research and theory on conjoint therapy seem to indicate the importance of interaction between the spouses. The research suggests that communication and the generation of support are critical aspects of that interaction and ones that therapy may be able to influence. There is consensus as to the utility of conjoint therapy. However, there is no clear, systematic concept of what marital therapy is or how it is related to marriage adjustment. The absence of convincing evidence favoring conjoint therapy, then, is hardly surprising. Such evidence awaits a clearer conception of both marital adjustment and conjoint therapy, and of course, good measures and a good research design.

Individual therapy. The effect of psychotherapy on the untreated spouse is commonly noted in clinical practice; the allusions in the published literature to such effects are too numerous to catalog here. However, the number of investigators who have set themselves the specific task of studying the effects of psychotherapy on the untreated spouse is rather limited. Perhaps the best example of the few studies done on the adverse effects on the spouse of change in the patient is provided by Kohl (1962). Kohl studied 39 marital partners of inpatients treated

with psychotherapy at the Payne Whitney Psychiatric Clinic over a 10 year period. These cases were chosen for study because in every instance it had been necessary to include both partners in the total plan of treatment before the patient's improvement or recovery could be achieved and maintained. Several major types of pathological reactions among spouses of patients were found to occur in response to the patient's improvement: recurrence of alcoholism after a prolonged period of abstinence, threats of divorce, resentment expressed toward the therapist as well as toward treatment itself, and depression associated with acute anxiety.

Kohl's report is particularly important for it is one of the few attempts to study the effect of psychotherapy on the spouse. Further, if there is not conclusive evidence for the effectiveness of conjoint therapy, we have here at least, strong evidence for the adverse effects of individual treatment. There are several shortcomings to Kohl's study however, which leave crucial questions still unanswered. First, only those partners whose illnesses or sabotaging attempts brought them to the therapist's attention were studied. Since no attempt was made to look at the spouses of patients in general, the conclusions that can be drawn are limited. Obviously the cases studied are extreme examples, but the question is left unanswered as to whether or not some form of martial upheaval is the routine result of individual psychotherapy.

While Kohl was mainly interested in adverse reactions in spouses, there is some evidence to indicate that positive gains in the patient during therapy may spread through the family system, including not only the spouse but children and grandparents as well. Fisher and Mendell

(1958) studied 10 patients and various members of their families over periods of several years. Both patients and family members were evaluated by means of a clinical interview and projective tests before therapy and after marked improvement was noted during treatment. Clinical evaluation seemed to clearly indicate that significant changes in the patient (as judged by the therapist and the examining psychologist) are accompanied by clearcut changes in the other family members. The major shortcomings in this study lie in the difficulties inherent in the interpretation of clinical data: problems of subjectivity, reliability and validity of projective tests.

In short, we are left with a very unclear picture of the impact of conjoint therapy and a contradictory picture of the impact of individual treatment on spouses. What is needed is a better theoretical formulation of marital and family therapy, better instrumentation to measure the changes which occur in therapy, and better research design.

## Summary and Purpose

The importance of developing adequate instruments for the measurement of psychotherapy outcomes is crucial in mental health program evaluation. Although the conceptualization behind the Quality of Life Questionnaire is convincing in general, much work needs to be done in developing these ideas and their operationalization; so that the questionnaire will be a reliable and thoroughly valid measure of treatment outcome. The investigator has chosen to focus on spouse role adjustment. Aspects of spouse role adjustment have been discussed in a conceptual framework based on Maslow's theory. These variables--needs and how they are met--considerably expand the conceptualization of spouse role adjustment currently

used in the Oregon Quality of Life Questionnaire.

Marital and family outcome research is in an early, developmental stage. Comparative studies are needed to determine "What treatment, by whom, is most effective for this family with that specific problem and under which set of circumstances?" (Paul, 1967). The cited studies find that individual therapy may have deleterious effects, especially on patient's spouses, when treating marital and family problems, but individual treatment may also have beneficial impacts upon clients which spread to other members. It is unclear from the evidence whether conjoint treatment has any impact, although clinician opinion and the theory of conjoint approaches suggest impacts on communication, empathy, individuation, and autonomy.

The purpose of this study is three-fold: (1) to determine if individuals go through an intermediate stage of deterioration during the process of treatment for marital and family problems, (2) to further our conceptualization of spouse role adjustment by developing a scale to measure that adjustment and (3) to determine whether a difference exists in the effect of conjoint therapy and individual therapy on quality of life and more specifically spouse role adjustment.

## Hypotheses

Hypothesis 1 Clients show improvement a year after admission to treatment by reporting quality of life as better than before treatment.

Hypothesis 2 Clients show improvement, whether having received conjoint or individual therapy, in spouse role adjustment by reporting an increased satisfaction and performance in basic, safety, affiliation, self-esteem, autonomy, and self-actualization need areas.

Hypothesis 3 Conjoint therapy has a greater impact on quality of life than individual therapy.

Hypothesis 4 Conjoint therapy has a greater impact on spouse role adjustment than individual therapy.

# CHAPTER II

## Methods

### Setting

Yamhill County is located in the northwest part of Oregon's Willamette Valley, in a rural atmosphere 45 minutes from downtown Portland and 30 minutes from the state capitol. Of the 50,000 people who reside in the county, many commute to these metropolitan areas. While the general economy is agricultural, there has been new industrial development in the last decade.

The clinic of the Yamhill County Mental Health Program in McMinnville, Oregon was the setting of this study. The mental health program is a multiservice agency which handles an annual caseload of 700-800 clients. Services to clients with mental and emotional disturbances are directly provided by the county-operated clinic. Other services, such as the alcohol and drug programs, are provided by subcontract.

The clinic staff of two part-time psychiatrists, one psychologist, and six social workers, handle an annual caseload of 400-500 clients. Adult individual therapy, marital and family therapy, child guidance, and hospital follow-up are the basic services provided. One social worker does most of the intakes and the psychiatrists supervise the medications and do some therapy. However, the major portion of the therapy is conducted by five social workers and the psychologist. The latter is also responsible for all the psychological testing.

The six primary therapists, three male and three female, range in age from 27 to 40 years. Four of the therapists are married and three of these have children. All of the therapists have master's degrees from

accredited universities. Their work experiences range widely. One therapist was a faculty member of a social work school for 10 years, at one extreme, and one is a new graduate, at the other. They have worked with marital and family problems for an average of five years and they all offer help with marital and family problems using both individual and conjoint techniques.

The theoretical orientation of the therapists seems to be overwhelmingly eclectic. When pressed as to the most frequently used theory in their clinical practice, systems theory was mentioned by the social workers, along with communication and problem solving techniques. Most also use gestalt and transactional analysis techniques.

Therapists make the decision whether conjoint or individual therapy will be offered and clients may be assigned to therapists accordingly. They begin where the client is. For example, if a client is presenting intrapersonal issues the therapist will begin individual therapy, whereas, if the client presents interpersonal issues, a conjoint approach will be used. All of the therapists agree that this is their rationale for using an individual versus conjoint approach. It is assumed that their philosophical approach to clients changes with the type of treatment (i.e., when doing conjoint therapy, they focus on interpersonal issues and use appropriate techniques), as outlined in the review of literature.

While each therapist offers both individual and conjoint therapy, four of the social workers stated that they are more comfortable with conjoint therapy. They believe it is harder but more challenging and rewarding for themselves. One therapist stated she is more comfortable with individual therapy unless she is a co-therapist in conjoint therapy.

The psychologist stated that she is more comfortable with individual therapy and believes more of the conjoint family therapy clients are assigned to the therapists with more expertise and interest.

There is no structured supervision of therapy in this clinic for either individual or conjoint therapy. However, the therapists use each other freely for consultation. None of the therapists have ever attended a family therapy institute but conferences and workshops are paid for by the clinic depending on the annual budget. The types of conferences attended are decided upon by the interest of the therapists, although financial constraints seem to be the determining factor in which conferences are actually attended.

Sample

This study was conducted from the period of April through July, 1979. During this period, 110 new cases were opened at the clinic. Less than half of the cases presented marital and/or family problems. A convenience sample was used: the first 30 clients who entered the clinic after the study began and who fit the criteria for selection were asked to participate in this study as the intake group. There is no reason to suppose that these 30 clients would differ systematically from a random sample of clinic clients meeting the same criteria. The criteria for selection required that each subject had a marital or family problem identified either by the client or therapist and, in the opinion of the therapist, was contracting for a period of therapeutic intervention as opposed to an evaluation. Of the 110 marital and family cases, 32 met the criteria and two refused to participate in the study. This group of 30 cases will be hereafter referred to as the intake group.

Time restrictions prevented a longitudinal study. Hence members of intake and follow-up groups were selected from different cohorts at different time periods. The follow-up group consisted of an equal number of clients admitted to treatment from March to July, 1978. The criteria for selection of the follow-up group included that the subject had a marital and/or family problem as identified either by the client or therapist, and that the subject had had at least six therapy sessions in the last year. Of the 140 cases opened during the period of March to July, 1978, only 43 met the criteria for selection primarily because of the six session limit. Three refused to participate in the study and nine were unable to be contacted because they had moved without leaving forwarding addresses. The remaining 31 clients will be hereafter referred to as the follow-up group.

Since this study followed a research project conducted in the Spring of 1978, an attempt was made to include clients who were subjects from this previous study. The Oregon Quality of Life Questionnaire (except the new Spouse Role Adjustment Scale) had been administered at intake on these subjects. Of the follow-up groups, only seven subjects who had participated in the earlier project had received six sessions of treatment and were, therefore, eligible for this study's follow-up sample. These seven subjects provided an opportunity to compare intake and follow-up measures on Quality of Life on the same subjects.

Since the presence of a marital or family problem is not always clearly stated in the clinical records, the problem of selecting subjects with marital and family problems was dealt with in the following manner. All subjects assigned to the intake group were clients with marital

problems according to therapist assessment. Further, all subjects assigned to the follow-up group had marital problems in that they received (1) marital counseling or family guidance, both of which are addressed to marital problems and use either a conjoint or individual method, or (2) child guidance with parental involvement which is addressed to problems which the investigator has assumed related to marital problems. As Satir (1964) has so clearly stated:

> The parents are the architects of the family and the marriage relationship is the key to all other family relationships. When there is difficulty with the marital pair, there is more than likely problems in parenting. (Satir, 1964, p. 1)

Not all difficulties in parenting indicate a marital problem, so when there were doubts as to whether a marital problem existed or not, therapist opinions were obtained.

The intake and follow-up groups are similar in many ways and, therefore, perhaps comparable. A comparison of the two groups is found in Table 1. The major differences are in the "physical living situation", "length of marriage", and "number of years in the community" variables. These variables indicate a pattern of difference between the two groups. Members of the follow-up group, although not older in age, have longer marriages, have been in the community longer, and more often live in single family dwellings, all of which indicate the follow-up group to be more stable as compared to the intake group. It would appear that the more stable clients are more likely to come six sessions, and therefore, have a better chance of being included in the follow-up group. Less stable subjects originally in this group at intake have, presumably, succumbed to selective attrition.

TABLE 1

Demographic Comparison of Intake and Follow-up Groups

| Characteristic | Intake (N=30) | Follow-up (N=31) |
|---|---|---|
| Mean Age (Years) | 33 | 36 |
| Women | 82.8% | 80% |
| Ethnic Group (% White) | 89.7% | 96.8% |
| Living with Spouse | 86.2% | 83.9% |
| Type of Therapy Received | | |
| Individual Therapy | 16 | 17 |
| Conjoint Family Therapy | 14 | 14 |
| Mean Number of Therapy Sessions Received | 2* | 15 |
| Physical Living Situation | | |
| Single Family Dwelling | 75.9% | 96.8% |
| Apartment | 17.2% | 3.2% |
| Other | 6.9% | 0 |
| Mean Length of Marriage (Years) | 7.5 | 12.8 |
| Subjects with 2 or More Marriages | 11 | 10 |
| Amount of Education | | |
| Less than high school | 6 | 3 |
| High school graduate | 7 | 12 |
| More than high school | 17 | 17 |
| Mean Annual Household Income ($) | $15,116 | $16,200 |
| Mean Years in Community | 4.3 | 7.4 |

*Note: The 2 therapy sessions are an intake session and diagnostic session.

## Design

This study used a naturalistic, separate sample, pre-post therapy comparative group design. There is no reason to believe persons admitted in 1978 differ significantly from those admitted in 1979. Therefore, the intake and follow-up groups could have been, in effect, randomly selected. However, the six session criterion for inclusion in the follow-up group may have resulted in differences between the intake and follow-up groups which threatens the validity of inferences drawn from comparisons between them. In fact, there are some differences between the groups on demographic variables.

The follow-up group was further divided into two subgroups, depending on the therapy received, either conjoint or individual. The involvement of only one spouse (even when children were involved) constituted individual therapy. If both spouses were involved, therapy was defined as conjoint. Clients were selected from the files. Fourteen had received conjoint and seventeen had received individual, treatment programs.

## Procedure

Each subject in the intake group was contacted after two visits to the clinic--the intake interview and the first session with the therapist (which is considered a diagnostic session). At this time the therapist explained the evaluation study to the client and either introduced the investigator, or told the client that the investigator would be in contact by phone. Therapist contact, prior to the interview, allowed the therapist a chance to identify any subjects who would be adversely affected by the interview. The preliminary contact by therapists also reduced the uneasiness of being approached by an outsider. The

investigator believes this procedure accounts for the small number of refusals. This approach also made the intake and follow-up groups more comparable because it excluded those subjects who fit the criteria for the study but who did not follow through for evaluation. Unfortunately, this screening procedure has decided drawbacks. The selection and approval of the therapists could limit the generalizability of the findings.

The follow-up group was contacted by mailing a letter signed by the individual therapist explaining the evaluation study (see Appendix A).

The data were collected through a structured interview by the investigator and took place at a location which was convenient for the subject: clinic, public facility, or subject's home. Interviews were conducted with one spouse only of each family. The investigator was trained and monitored by the Program Impact Monitoring System (PIMS) Project under the direction of Dr. Bigelow of the Oregon Division of Mental Health (Brodsky & Bigelow, Note 3). The training and monitoring have been found to yield reliability in excess of 95%, even using interviewers without professional training and experience (Stewart & Olson, Note 4).

Data Analysis

Parametric statistics were used to analyze the data. Psychometric properties of the Spouse Role Adjustment Scale were assessed using the techniques developed by Scott (1960) with his homogeneity ratio and coefficient alpha (Cronbach, 1951). These techniques were used to determine concurrent and construct validity. The hypotheses were tested by using a one-way analysis of variance to compare the intake with follow-up groups and individual with conjoint therapy groups.

# CHAPTER III

## Measures

### Oregon Quality of Life Questionnaire

The Oregon Quality of Life Questionnaire (OQLQ) was used to collect the data. The questionnaire includes measures of functioning in four broad areas of adjustment: personal, interpersonal, productive, and civic. The instrument is based on the concept that mental health is the degree of adjustment between the individual's abilities and needs and the demands and opportunities of his situation. When a person receives services from a "helping agency", improvements in these areas are expected. The Oregon Quality of Life Questionnaire is used to measure the improvement.

The questionnaire is a self-report instrument in the form of questions with fixed alternative responses. Questions are asked about each area in a standard way and responses are presented, chosen, and recorded in a uniform fashion. This strict uniformity is absolutely crucial to the usefulness of the resulting data. Data gathered in this way can be used to compare the improvements realized by different groups of clients.

For the past two years, the Oregon Quality of Life Questionnaire (OQLQ) has been administered to clients at various mental health programs in the state of Oregon. Data have also been collected on a normal sample. Presently, psychometric analyses are being done on the scales to determine their reliability and validity. To date, these results are unpublished. However, the analyses indicate a high degree of homogeneity and concurrent validity of the measures in the four areas in the sense that the scale scores are able to discriminate between intake, follow-up and

community samples.

The following is a description of the scales comprising the OQLQ. The scale scores for each OQLQ scale are distributed over a range of 0 to 100, with 100 representing the highest level of mental health. For an examination of the questionnaire the reader is referred to Appendix B.

Personal Adjustment Scales

Affective status: The most widely recognized aspect of mental illness is feeling badly; of mental health, feeling well. This scale measures emotional status from a sense of well-being, at one extreme, to distress, at the other.

Independence: The abilities to meet day to day responsibilities, cope with ambiguity and conflict, and make decisions are tapped in this scale.

Interpersonal Adjustment Scales

Friend role: Adapting to the social environment requires effective interaction. In addition, interaction satisfies the individual's affiliation needs. This scale measures frequency of interaction with casual social contacts and the degree of pleasure or uneasiness experienced in these relations.

Close friend role: Close friendships provide more substantial satisfactions and require greater skill. The scale assesses the ability to establish and maintain intimate relationships, together with the enjoyment of them.

Spouse role: This six-item scale measures the amount of energy invested and satisfactions derived from spouse role performance.

Parent role: Adequacy in the parent role is a highly valued mental competency. This scale assesses involvement in children's activities, ability to meet their needs, and personal feelings of adequacy and enjoyment.

Social support: An aspect of mental health is the ability to mobilize support during situational crises. The amount of help available from family, friends, and community is assessed.

Adjustment to Productivity Scales

Employability: Movement toward full productivity depends on improvements in employability. Job locating skills, ability to handle stressful work or to relate to co-workers, and willingness to engage in additional job training are assessed. This scale, therefore, is sensitive even to improvements falling short of actual employment.

Job adjustment: Poor work, conflict with fellow-workers, and dissatisfaction are aspects of reduced mental health. Performance, satisfaction, and enjoyment are assessed.

School adjustment: Productivity includes working at improving skills and knowledge through education. For those enrolled in classes, items assess adequacy of work, interest level, problems in meeting requirements and interpersonal conflicts.

Other productive activity: After other productive activities (e.g., work), or in the absence of work, the individual's remaining time can be spent in fulfilling, satisfactory activities. Involvement in creative or self-improving activity, or in activities which benefit others is assessed.

Civic Adjustment Scales

Negative consequences of alcohol use: Mental health is adapting effectively and satisfactorily to community expectations. This scale assesses the negative consequences resulting from alcohol use. Negative consequences are seen in the areas of emotional disturbance, health, family relations, work, etc.

Negative consequences of drug use: The negative consequences of drug use are assessed in the above mentioned areas.

Spouse Role Adjustment Scale

An additional set of 77 questions developed by the investigator was added to the six question spouse role adjustment section of the Oregon Quality of Life Questionnaire, using the same standard format and presentation, except for five open-ended questions. The spouse role data, however, were analyzed separately from the quality of life data.

The procedure used in the development of the Spouse Role Adjustment Scale (SRAS) continues in the tradition of Terman (1938) and Locke and his colleagues (1958, 1959). The present scale, however, is the product of a process which attempted to go beyond the procedures used by Locke, his colleagues, and the developers of other marital adjustment scales (e.g., Burgess & Cottrell, 1939; Nye & MacDougal, 1959; Blood & Wolfe, 1960; Orden & Bradburn, 1968; Bienvenu, 1970; Spanier, 1976), by deriving the items of spouse role adjustment from a conceptual framework based on Maslow's hierarchy of needs. The process is described below:

1. All items used on the scales reported in the literature for marital adjustment and related concepts were identified and duplicates were eliminated, thus providing for further analysis a list of items

previously used at least once.

2. These items were classified by the investigator on the basis of the six needs in Maslow's need hierarchy: basic needs, safety needs, affiliation needs, self esteem needs, autonomy needs, and self actualization needs. (Examples of the items in each need area are found later in this section.) The majority of the items taken from the previous scales were assigned to the affiliation and self esteem variables. It appears that previous researchers have, in practice, taken the view that the majority of the needs met in marriage would be expected to fall into these categories.

3. In an initial screening process, items were screened as to their content validity by the investigator, paying particular attention to those items which showed the most discriminating power in the previous marital adjustment scales.

4. The items were rewritten with fixed alternative responses and in a form designed to focus on (1) the degree to which the individual reports his/her needs are satisfied, and (2) the performance of the individual toward meeting the needs of his/her spouse. An example of this satisfaction and performance form is the following. For need satisfaction: In the last month, how affectionate has your spouse been to you? Very affectionate-Quite affectionate-Slightly affectionate-Not at all affectionate. For performance: In the last month, how affectionate were you to your spouse? Very affectionate-Quite affectionate-Slightly affectionate-Not at all affectionate. New items were developed to tap areas of adjustment overlooked in previous measures such as in the areas of autonomy and self actualization.

The following is a list of the scale scores and examples of items from each of the need areas. For further examination the reader is referred to the conceptual framework presented in the review of literature and to Appendix C for a copy of the scale.

Basic Needs: The basic need scale is comprised of five satisfaction and five performance items. The scale scores for satisfaction are 5 to 20, with 20 reflecting better adjustment. The scale scores for performance are 5 to 20 and the combined scale scores (which include both satisfaction and performance items) are 10 to 40. An example of the type of question is the following. In the last month, how satisfied were you with the amount of money your spouse brought in? Very satisfied-Satisfied-Dissatisfied-Very dissatisfied.

Safety Needs: This scale is comprised of 14 items, seven satisfaction and seven performance. The scale scores are 7 to 28 for satisfaction and performance. Combined, the score range is 14 to 56. An example of a performance type of question in this area is the following. In the last month, how reliable were you toward your spouse? Very reliable-Quite reliable-Slightly reliable-Not at all reliable.

Affiliation Needs: Twenty-eight items comprise this scale. The scores for the 14-item satisfaction and 14-item performance subscales range from 14 to 56 and the combined score is 28 to 112. An example of a satisfaction type of question is the following. In the last month, how well did your spouse understand you and the things you said? Very well-Well-Poorly-Very poorly.

Self Esteem Needs: This scale is comprised of 10 items. Scale scores for satisfaction and performance subscales each range from 5 to

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Self Esteem Needs: This scale is comprised of 10 items. Scale scores for satisfaction and performance subscales each range from 5 to

20 and combined they range from 10 to 40. An example of a performance type of question in this need area is the following. In the last month, how good did you seem to make your spouse feel about him/herself? Very good-Quite good-Slightly good-Not at all good.

Autonomy Needs: This scale is comprised of eight items. The combined scale score is 8 to 32. Scale scores for satisfaction and performance are each 4 to 16. An example of the type of question in this need area is the following. In the last month, how much did your spouse go out without you? A great deal-Quite a bit-A little-None.

Self Actualization Needs: Two items comprise this scale. Scale scores for satisfaction and performance are 1 to 4. Combined scores are 2 to 8. The following is an example of this type of question. In the last month, was your spouse an interesting person to be with? Very interesting-Quite interesting-Slightly interesting-Not at all interesting.

Open-ended Questions: These five questions were asked to elicit in the subject's own words (1) how they would evaluate their marital relationship, (2) what problems brought them to the clinic, (3) what they were hoping would result from the program, (4) what happened at the program, and (5) what difference did the program make to their relationship.

# CHAPTER IV

## Results

This chapter is in two parts. The first examines the psychometric properties of the Spouse Role Adjustment Scale, which was developed and pilot tested in this exploratory study. The second part is a testing of the hypotheses, using both the Oregon Quality of Life Questionnaire and the Spouse Role Adjustment Scale as measures of change.

### Instrument Reliability and Validity

The psychometric analyses of the Spouse Role Adjustment Scale (SRAS) included 18 subscales derived from the spouse role measure. Each of the six need levels (Maslow's)comprising the SRAS were regarded as having two subscales: (1) items which focused on individual need satisfaction and (2) items which focused on the individual's performance to satisfy the needs of his/her spouse. In addition, the satisfaction and performance scales were combined in each need level. Because of this study's interest in producing a comprehensive measure of the concept of spouse role adjustment, the reliability and validity of the SRAS was determined for each of the component scales.

The subscales were tested for homogeneity by means of Scott's (1960) Homogeneity Ratio (HR). The HR represents the degree to which the researcher has defined the variable with sufficient precision; it backs up face validity. Mathematically, the HR is the average level of inter-item correlation and is represented as:

$$HR = \frac{\sigma_t^2 - \Sigma\sigma_i^2}{\{\Sigma\sigma_i\}^2 - \Sigma\sigma_t^2}$$

where $\sigma_\tau^2$ is the variance over subjects total scale scores, $\sigma_i^2$ is the variance over all items, and $\Sigma\sigma_i$ is the sum of the item standard deviations over all items.

A Homogeneity Ratio of .000 represents an average inter-item correlation of zero, whereas the maximum level of +1.00 could be reached only if items were perfectly correlated. The optimal range of this HR is from .15 to .30. Below .10, scales lack sufficient coherence to be adequate measures of a unidimensional construct; above .75, scales have excessively redundant items. The subscales of the SRAS had HR's (bottoms of Table 2 to 5) ranging from .138 to .536 which indicates adequate homogeneity. The autonomy satisfaction subscale is the least adequate. The self actualization satisfaction and performance subscales are single items, therefore HR's are not appropriate.

Instrument reliability was estimated from the formula known as Cronbach's Coefficient Alpha (1951):

$$\alpha = \frac{k}{k-1} \quad \frac{\sigma_t^2 \quad \Sigma\sigma_i^2}{\sigma_t^2}$$

where k is the number of items in the test, $\sigma_t^2$ is the variance over subjects in total test scores, $\sigma_i^2$ is the variance over subjects in scores on each item, and $\Sigma\sigma_i^2$ is the sum of item variances over all items. The magnitude of $\alpha$ depends on (1) the homogeneity of the test (average inter-item correlation) and (2) the length of the test. To decrease sources of irrelevant variance, such as social desirability, reversed items were included in SRAS. It should be pointed out that when efforts are made to decrease irrelevant variance, the Coefficient Alpha will actually be

lowered, but will be closer to the "true trait score" (Scott, 1968).

In order to claim that a scale measures the intended construct only (here, a specific need), it is necessary to show that the scale yields scores different from the scores of scales intended to measure the other contructs (other specified needs). If several subscales are similar except that they are supposed to measure different constructs, one may compare the correlation coefficients (Pearson's $\underline{r}$) between the subscales with their respective reliability coefficients ($\alpha$). To the extent the latter exceed the former, each subscale may be considered distinguishable and thus having discriminant validity (Scott, 1968).

In Table 2, the intercorrelations ($\underline{r}$) of the combined subscales, which include both satisfaction and performance in each need area, are presented along with the Alpha Coefficients along the diagonal. Upon comparing the magnitudes of the Pearson's $\underline{r}$ with the Alpha Coefficients of each pair of subscales, it may be concluded that the scales are found to discriminately measure different constructs except in the case of the combined esteem subscale. The combined esteem scale is confounded with both the combined safety and combined affiliation subscales, which indicates that the items on the esteem scale are more closely correlated with these other scales than they are to each other.

Table 3 compares the satisfaction subscales. The safety satisfaction subscale is confounded with the affiliation satisfaction and the esteem satisfaction scales. Here again, as in Table 2, the esteem need level is confounded with safety and affiliation. This is repeated in Table 4 where esteem performance was again confounded with safety performance and affiliation performance. This finding points to the difficulty in

TABLE 2

Psychometric Properties of the Combined

(Satisfaction and Performance) Scales

| | Need Areas | | | | | |
|---|---|---|---|---|---|---|
| | Basic | Safety | Affil. | Esteem | Autonomy | Self-act. |
| Basic | (.768) | | | | | |
| Safety | .716 | (.888) | | | | |
| Affiliation | .751 | .841 | (.927) | | | |
| Esteem | .702 | .862 | .907 | (.783) | | |
| Autonomy | .121 | -.057 | -.185 | -.172 | (.610) | |
| Self-actualization | .743 | .716 | .812 | .756 | -.041 | (.698) |
| Homogeneity Ratio | .253 | .404 | .326 | .271 | .165 | .536 |

Note: Cronbach's alphas in the diagonal, Pearson's correlation r in the columns.

TABLE 3

Psychometric Properties of the Satisfaction Scales

| | Need Areas | | | | | |
|---|---|---|---|---|---|---|
| | Basic | Safety | Affil. | Esteem | Autonomy | Self-act. |
| Basic | (.765) | | | | | |
| Safety | .663 | (.831) | | | | |
| Affiliation | .620 | .870 | (.895) | | | |
| Esteem | .654 | .865 | .892 | (.764) | | |
| Autonomy | .164 | .021 | -.015 | -.026 | (.387) | |
| Self-actualization | .642 | .709 | .742 | .754 | -.065 | (.000) |
| Homogeneity ratio | .395 | .445 | .398 | .401 | .138 | .000 |

Note: Cronbach's alphas in the diagonal, Pearson's *r* in columns.

TABLE 4

Psychometric Properties of the Performance Scales

| | Need Areas | | | | | |
|---|---|---|---|---|---|---|
| | Basic | Safety | Affil. | Esteem | Autonomy | Self-act. |
| Basic | (.581) | | | | | |
| Safety | .508 | (.740) | | | | |
| Affiliation | .655 | .705 | (.832) | | | |
| Esteem | .431 | .636 | .734 | (.564) | | |
| Autonomy | -.003 | -.050 | -.318 | -.193 | (.506) | |
| Self-actualization | .447 | .499 | .648 | .463 | -.166 | (.000) |
| Homogeneity ratio | .222 | .339 | .270 | .208 | .205 | .000 |

Note: Cronbach's alphas in the diagonal, Pearson's $r$ in columns.

distinguishing self-esteem from affiliation and safety needs in marriage. We mean that one cannot measure independently things called safety, affiliation, and esteem; somehow they are all bound up together. It may be that the level of one's self-esteem has a bearing on one's ability to satisfy and provide for the safety and affiliation needs in a marriage. Also in Table 4, the basic performance subscale is confounded with the affiliation performance subscale. It may be that to meet one's spouse's basic needs, one must first be able to meet the spouse's affiliation needs, especially communicating with him/her.

Similar analyses are presented in Table 5 comparing the subscales of SRAS across both the satisfaction and performance areas. Three scales are confounded: (1) the safety performance with affiliation satisfaction and safety satisfaction, (2) esteem performance with safety satisfaction and affiliation satisfaction, and (3) autonomy satisfaction with autonomy performance. It may be that (1) in order to provide safety for one's spouse one may first need to have one's safety and affiliation needs met, (2) in order to promote one's spouse's esteem, one's safety and affiliation needs must be satisfied by one's spouse, and (3) in order to have one's needs for autonomy satisfied, one must provide room for the spouse to be autonomous.

From the comparison of the correlational coefficients (Pearson's $r$) and reliability coefficients ($\alpha$), it appears that spouse role adjustment is a global phenomenon made up of subcomponents of which only some have been distinguished. Further refinement of these scales would be needed to determine what dimensions of marital adjustment can be discriminated by a measure like SRAS.

TABLE 5

Psychometric Properties of the Satisfaction and Performance Scales

| | Need Areas | | | | | |
|---|---|---|---|---|---|---|
| | Basic Sat. | Basic Per. | Safety Sat. | Safety Per. | Affil. Sat. | Affil. Per. |
| Basic Sat. | (.765) | | | | | |
| Basic Per. | .457 | (.581) | | | | |
| Safety Sat. | .663 | .442 | (.831) | | | |
| Safety Per. | .592 | .508 | .830 | (.740) | | |
| Affiliation Sat. | .620 | .472 | .870 | .756 | (.895) | |
| Affiliation Per. | .605 | .665 | .704 | .705 | .826 | (.832) |
| Esteem Sat. | .654 | .443 | .865 | .723 | .892 | .738 |
| Esteem Per. | .324 | .431 | .594 | .636 | .624 | .734 |
| Autonomy Sat. | .164 | .256 | .021 | .025 | -.015 | .044 |
| Autonomy Per. | .003 | -.003 | -.160 | -.050 | -.299 | -.318 |
| Self actualization Sat. | .642 | .506 | .709 | .643 | .742 | .657 |
| Self actualization Per. | .525 | .447 | .545 | .499 | .673 | .648 |
| Homogeneity ratio | .395 | .222 | .445 | .339 | .398 | .270 |

| | Esteem Sat. | Esteem Per. | Autonomy Sat. | Autonomy Per. | Self-act. Sat. | Self-act. Per. |
|---|---|---|---|---|---|---|
| Esteem Sat. | (.764) | | | | | |
| Esteem Per. | .524 | (.564) | | | | |
| Autonomy Sat. | -.026 | -.014 | (.387) | | | |
| Autonomy Per. | -.261 | -.193 | .424 | (.506) | | |
| Self actualization Sat. | .754 | .420 | -.065 | -.097 | (.000) | |
| Self actualization Per. | .620 | .463 | .143 | -.166 | .536 | (.000) |
| Homogeneity ratio | .401 | .208 | .138 | .205 | .000 | .000 |

Note: Cronbach's alphas in the diagonal, Pearson's $r$ in columns.

The original expectation was that a well-adjusted marriage would provide the opportunity for an individual to satisfy all these needs. In Tables 2 to 5, there is a high positive correlation among all the scales, but one. This suggests that all the need areas (but one) are important in spouse role adjustment. However, autonomy seems to be independent of other aspects of marital adjustment. Autonomy is negatively but insignificantly correlated with all other SRAS subscales except the basic subscale (Table 2 to 5). That is to say, one may be autonomous whether or not one has a well-adjusted marriage.

The psychometric analyses presented here seem to indicate that spouse role adjustment is a global phenomenon with some subcomponents which can be discriminated by SRAS and some which cannot. Autonomy seems to be a quite distinct aspect of marital adjustment. Further analyses (e.g., factor analyses), scale development, and application to other subject populations (e.g., non-clinical) may result in adequate discrimination of the dimensions of spouse role adjustment proposed in this study.

In short, the reliability of the scales seems adequate and therefore these scales can be used as measures of spouse role adjustment. The scales do have face validity and content validity, although criterion validity and construct validity have not been established.

Tests of the Hypotheses

The first hypothesis is that clients show improvement a year after admission to treatment by reporting quality of life as better than before treatment. The appropriate test of this hypothesis is a one-way analysis of variance (t-test) of the difference between measures at intake and

follow-up on the same subjects or on comparable groups. A one-way analysis of variance was computed for the difference between the intake and follow-up groups in the present study, although there is no assurance that the two groups are, in fact, comparable. No significant differences were found between the intake group, which has had no treatment, and the follow-up group, which has experienced treatment over at least six sessions (Table 6). There were trends toward improvement in all adjustment areas except spouse role and social support. This hypothesis, therefore, is not supported by the data.

Data at intake and at follow-up are not from the same subjects. It is possible that selective attrition, for example, may account for the lack of difference between intake and follow-up. That is, clients who improve as a result of treatment may do so prior to six sessions, or, on the contrary, those clients who get worse may drop out of treatment within six sessions.

A further test of the hypothesis that treatment has an impact on quality of life can be made by comparing intake and follow-up scores for those seven subjects on whom both intake and follow-up measures were taken. Table 7 indicates that six of the seven subjects did not improve, which is consistent with the findings in Table 6 and with the results of a previous study (Bigelow, Chesla, & Brodsky, Note 2). Therefore, we can have further confidence in the negative results.

The previous study done at Yamhill County clinic, which used a three month follow-up, discovered a significant negative impact on Spouse Role Adjustment. One of the purposes of the present study was to determine if this deterioration would be reversed over a longer follow-up period (i.e., one year). Table 8 compares scores at intake, three months, and

TABLE 6

Comparison of Intake and One Year Follow-up Groups on OQLQ

| Scales | Intake $\bar{X}$ | N | Follow-up $\bar{X}$ | N | p |
|---|---|---|---|---|---|
| Personal Adjustment | | | | | |
| Affective Status | 55.26 | (30) | 59.53 | (31) | 0.381 |
| Independence | 65.42 | (30) | 70.83 | (31) | 0.150 |
| Interpersonal Adjustment | | | | | |
| Friend Role | 74.07 | (30) | 75.81 | (31) | 0.645 |
| Close Friend Role | 64.29 | (28) | 65.29 | (30) | 0.857 |
| Spouse Role | 62.07 | (29) | 58.06 | (31) | 0.485 |
| Parent Role | 71.67 | (24) | 73.57 | (28) | 0.660 |
| Social Support | 73.56 | (30) | 70.32 | (31) | 0.424 |
| Adjustment to Productivity | | | | | |
| Employability | 70.60 | (26) | 76.04 | (27) | 0.139 |
| Job Adjustment | 82.99 | (12) | 82.77 | (22) | 0.970 |
| School Adjustment | 81.67 | (5) | 85.42 | (2) | 0.649 |
| Other Productive Activity | 30.93 | (30) | 31.90 | (31) | 0.725 |
| Civic Adjustment | | | | | |
| Negative Consequences of Alcohol | 94.50 | (19) | 97.56 | (23) | 0.254 |
| Negative Consequences of Drugs | 98.04 | (19) | 98.46 | (19) | 0.553 |

Note: Range of $\bar{X}$ = 0 to 100.

p less than .05 needed for differences to be significant.

TABLE 7

Comparison of Intake and One Year Follow-up OQLQ Scores for Same Subjects (N=7)

| | Number Worsened | Number Improved | Mean Intake | Mean Follow-up |
|---|---|---|---|---|
| Personal Adjustment | | | | |
| Affective Status | 4 | 3 | 45.32 | 51.95 |
| Independence | 1 | 4 | 56.25 | 63.69 |
| Interpersonal Adjustment | | | | |
| Friend Role | 1 | 4 | 69.45 | 75.96 |
| Close Friend Role | 0 | 6 | 53.97 | 71.43 |
| Spouse Role | 6 | 1 | 50.00 | 50.00 |
| Parent Role | 2 | 4 | 51.43 | 58.10 |
| Social Support | 2 | 5 | 60.96 | 68.57 |
| Adjustment to Productivity | | | | |
| Work at Home | 2 | 5 | 57.14 | 60.95 |
| Employability | 1 | 4 | 67.50 | 71.63 |
| Job Performance | 1 | 2* | 83.33 | 79.17 |
| Other Productive Activity | 1 | 3 | 26.19 | 27.79 |

Note: Insufficient data were available to determine School Performance, Alcohol, and Drug Scores.

*Two subjects, in addition, were employed at follow-up who had not been employed at intake.

TABLE 8

Comparison of Trends of Improvement Over One Year For Yamhill and Statewide Client Samples on OQLQ

| Scales | | Intake X | Intake N | 3 Month X | 3 Month N | 1 Year X | 1 Year N | p |
|---|---|---|---|---|---|---|---|---|
| Personal Adjustment | | | | | | | | |
| Affective Status | | | | | | | | |
| | Yamhill | 49.43 | (69)** | 52.95 | (33) | 59.53 | (31) | 0.043* |
| | Statewide | 54.32 | (640) | 61.18 | (109) | 57.30 | (91) | 0.002* |
| Independence | | | | | | | | |
| | Yamhill | 62.93 | (68) | 58.59 | (32) | 70.83 | (31) | 0.016* |
| | Statewide | 63.92 | (609) | 69.08 | (107) | 67.21 | (85) | 0.005* |
| Interpersonal Adjustment | | | | | | | | |
| Friend Role | | | | | | | | |
| | Yamhill | 71.32 | (68) | 68.86 | (33) | 75.81 | (31) | 0.210 |
| | Statewide | 70.02 | (622) | 73.51 | (108) | 72.85 | (88) | 0.058 |
| Close Friend Role | | | | | | | | |
| | Yamhill | 61.28 | (64) | 58.52 | (30) | 65.19 | (30) | 0.357 |
| | Statewide | 59.05 | (563) | 63.60 | (98) | 57.72 | (82) | 0.056 |
| Spouse Role | | | | | | | | |
| | Yamhill | 61.42 | (54) | 46.76 | (18) | 58.06 | (31) | 0.055 |
| | Statewide | 63.74 | (347) | 62.32 | (46) | 58.21 | (65) | 0.188 |
| Parent Role | | | | | | | | |
| | Yamhill | 65.97 | (48) | 68.80 | (25) | 73.57 | (28) | 0.124 |
| | Statewide | 69.32 | (291) | 71.36 | (54) | 72.54 | (59) | 0.302 |
| Social Support | | | | | | | | |
| | Yamhill | 67.65 | (68) | 64.12 | (34) | 70.32 | (31) | 0.363 |
| | Statewide | 66.11 | (616) | 66.23 | (108) | 62.70 | (89) | 0.294 |
| Adjustment to Productivity | | | | | | | | |
| Employability | | | | | | | | |
| | Yamhill | 71.11 | (53) | 71.73 | (28) | 76.04 | (27) | 0.261 |
| | Statewide | 70.48 | (546) | 74.36 | (99) | 69.89 | (72) | 0.020* |
| Job Adjustment | | | | | | | | |
| | Yamhill | 78.16 | (29) | 76.47 | (17) | 82.77 | (22) | 0.372 |
| | Statewide | 76.25 | (324) | 79.58 | (61) | 74.38 | (47) | 0.171 |
| School Adjustment | | | | | | | | |
| | Yamhill | 75.46 | (9) | 64.29 | (7) | 85.42 | (2) | 0.294 |
| | Statewide | 71.95 | (41) | 72.22 | (15) | 67.26 | (7) | 0.824 |
| Other Productive Activity | | | | | | | | |
| | Yamhill | 31.15 | (61) | 28.82 | (32) | 31.90 | (31) | 0.525 |
| | Statewide | 29.75 | (624) | 32.98 | (107) | 29.25 | (90) | 0.052 |
| Civic Adjustment | | | | | | | | |
| Negative Consequences of Alcohol | | | | | | | | |
| | Yamhill | 94.52 | (27) | 95.92 | (9) | 97.56 | (23) | 0.445 |
| | Statewide | 87.99 | (434) | 95.45 | (47) | 86.96 | (64) | 0.010* |
| Negative Consequences of Drugs | | | | | | | | |
| | Yamhill | 98.14 | (29) | 98.18 | (11) | 98.46 | (19) | 0.974 |
| | Statewide | 94.60 | (425) | 98.20 | (63) | 93.80 | (53) | 0.092 |

Note: Range of $\overline{X}$ = 0 to 100. *Statistically significant difference.
**Indicates 1978 and 1979 intake subjects.

one year follow-up using both the data collected in the present study and that collected by Bigelow, Chesla, and Brodsky (Note 2).

In Table 8 no statistically significant differences were found among the intake, three month, and one year follow-up groups in the Spouse Role scale. It is interesting to note that Spouse Role Adjustment of clients at intake for Yamhill is similar to that of a statewide client sample, as are the one year follow-up scores. Only the three month Yamhill follow-up seems particularly out of line with the statewide sample. Either marital adjustment among Yamhill clients "gets worse before it gets better" or the three month finding is spurious. It is unlikely that the Yamhill Mental Health Program has, in fact, a negative impact on marital adjustment. However, the Spouse Role measure does not reflect any positive impact.

It appears that all programs have a positive impact on Personal Adjustment. These data lend some support to the hypothesis that treatment has an impact on quality of life. However, these significant differences emerge only when both intake samples (from the present and previous studies) are merged.

The second hypothesis is that clients show improvement, whether having received conjoint or individual therapy, in Spouse Role Adjustment by reporting an increased satisfaction and performance in basic, safety, affiliation, self-esteem, autonomy, and self actualization need areas. The old Spouse Role scale did not reflect any improvement due to treatment. One of the purposes of this study was to see if a more complete assessment of spouse role adjustment would reveal improvement in need areas that the old scale did not. The appropriate test of this hypothesis

is a one-way analysis of variance (t-test) of the difference between measures at intake and follow-up on the same subjects or on comparable groups. A one-way analysis of variance was computed for the differences between the intake and follow-up groups on the SRAS, although there is no assurance that the two groups are, in fact, comparable. In Table 9 only one need area seems to have been affected by treatment.

The performance of subjects in the autonomy need area improved significantly. Curiously the autonomy scale in Tables2 to 5 is negatively and only slightly correlated with the other spouse role scales which suggests that autonomy is not a component of global spouse role adjustment, i.e., people may be more or less autonomous in their marriages regardless of their general adjustment in the marriage. Furthermore, treatment appears to focus in on this unique aspect of marital adjustment whereas there is no impact on the more generally emphasized aspects of spouse role adjustment, such as affiliation or self-esteem needs. This is consistent with the goals of the clinicians, as reported to the investigator. It may be that treatment offered at the clinic can do nothing helpful for a marriage but enable the individuals to become more autonomous in the marriage.

The seven subjects, who had both intake and follow-up measures taken and who were found not to have improved in six of the seven cases, gave detailed descriptions of the impact of treatment. Of the six cases that did not improve, one was due to divorce and the others had long term relationship problems in which they reported that their therapy either focused on alleviation of child behavioral problems or promotion of independence of one of the spouses, not on spousal interaction to increase

TABLE 9

Comparison of Intake and One Year Follow-up Groups on SRAS

| Scales | Intake $\bar{X}$ | N | Follow-up $\bar{X}$ | N | p |
|---|---|---|---|---|---|
| Basic Needs | | | | | |
| Satisfaction | 15.44 | (28) | 14.99 | (27) | 0.604 |
| Performance | 15.21 | (28) | 14.83 | (28) | 0.548 |
| Combined | 30.65 | (28) | 29.70 | (27) | 0.456 |
| Safety Needs | | | | | |
| Satisfaction | 22.47 | (30) | 21.78 | (31) | 0.527 |
| Performance | 22.30 | (30) | 22.32 | (31) | 0.974 |
| Combined | 44.77 | (30) | 44.10 | (31) | 0.714 |
| Affiliation Needs | | | | | |
| Satisfaction | 35.13 | (30) | 33.10 | (31) | 0.299 |
| Performance | 36.37 | (30) | 34.43 | (31) | 0.206 |
| Combined | 71.50 | (30) | 67.54 | (31) | 0.235 |
| Self-Esteem Needs | | | | | |
| Satisfaction | 14.23 | (30) | 14.10 | (31) | 0.863 |
| Performance | 15.04 | (30) | 14.03 | (31) | 0.076 |
| Combined | 29.25 | (30) | 28.13 | (31) | 0.349 |
| Autonomy Needs | | | | | |
| Satisfaction | 11.13 | (30) | 11.97 | (31) | 0.138 |
| Performance | 11.47 | (30) | 13.00 | (31) | 0.006* |
| Combined | 22.60 | (30) | 24.97 | (31) | 0.011* |
| Self Actualization Needs | | | | | |
| Satisfaction | 2.50 | (30) | 2.39 | (31) | 0.598 |
| Performance | 2.37 | (30) | 2.17 | (30) | 0.337 |
| Combined | 4.87 | (30) | 4.60 | (30) | 0.469 |

Note: *Statistically significant difference.

satisfaction or performance of basic, affiliation, or esteem needs. Subjects reported effects of treatment such as: "I was encouraged to do what I wanted." "I started looking at living my own life instead of confining myself at home." "It helped me cope with a husband who makes me out of control, so he can be in control." "I learned how to handle guilt and become more independent." "It made me stop drinking, stop spending money and work on the problems together instead of me making all the decisions." Most of the comments offered by the subjects indicated improvements in the area of autonomy which seems to be consistent with the treatment focus as reported by subjects, and by the therapists, and seems to be consistent with some of the statistical findings.

Treatment in and of itself whether conjoint or individual does not have a beneficial effect on spouse role adjustment except in the area of autonomy. However, it remains possible that some forms of treatment are helpful while others are not. The review of the literature indicates that the dynamics and expected outcomes of conjoint therapy are very different from those of individual therapy with marital and family problems. Therefore, the third hypothesis predicts that conjoint therapy has a greater impact on quality of life than individual therapy.

One test of this hypothesis would be a t-test of the difference between two change scores, one for conjoint and one for individual treatment. However, such a test would require the same subjects pre and post-treatment, which this study does not have. A test which is appropriate to the design of this study is a one-way analysis of variance comparing intake with individual follow-up with conjoint follow-up groups, although

we have no assurance that the groups are, in fact, comparable.

Table 10 reflects the relative impact of individual and conjoint therapies. Conjoint therapy had a positive effect on Independence whereas individual therapy had no effect. Hypothesis 3 is confirmed in this area. In other areas of quality of life there did not seem to be differential treatment impacts.

The fourth hypothesis is that conjoint therapy has a greater impact on spouse role adjustment than individual therapy. The appropriate statistical test for this hypothesis is similar to that for Hypothesis 3. A one-way analysis of variance comparing intake and individual follow-up and conjoint follow-up groups was computed on the SRAS data, although we have no assurance that the groups are, in fact, comparable. The data in Table 11 support this hypothesis only in the area of autonomy. It appears that conjoint treatment increased autonomy, but did not have a greater impact on marital adjustment in other areas, as measures by SRAS.

TABLE 10

Impact of Individual and Conjoint Therapies as Measured on OQLQ

| Scales | Group Means | | | | | | p |
|---|---|---|---|---|---|---|---|
| | Intake | | Follow-up | | | | |
| | | | Individual | | Conjoint | | |
| Personal Adjustment | | | | | | | |
| Affective Status | 55.56 | (30) | 56.60 | (14) | 61.94 | (17) | 0.490 |
| Independence | 65.42 | (30) | 64.29 | (14) | 76.23 | (17) | 0.037* |
| Interpersonal Adjustment | | | | | | | |
| Friend Role | 74.07 | (30) | 73.81 | (14) | 77.45 | (17) | 0.718 |
| Close Friend Role | 64.29 | (28) | 63.25 | (13) | 66.67 | (17) | 0.846 |
| Spouse Role | 62.07 | (29) | 60.71 | (14) | 55.88 | (17) | 0.648 |
| Parent Role | 71.67 | (24) | 68.89 | (12) | 77.08 | (16) | 0.282 |
| Social Support | 73.56 | (30) | 67.62 | (14) | 72.55 | (17) | 0.503 |
| Productive Adjustment | | | | | | | |
| Work at Home | 56.55 | (29) | 60.95 | (14) | 64.31 | (17) | 0.340 |
| Employability | 70.60 | (26) | 74.21 | (12) | 77.50 | (15) | 0.273 |
| Job Performance | 82.99 | (12) | 81.82 | (11) | 83.71 | (11) | 0.942 |
| Other Productive Activity | 30.93 | (30) | 27.77 | (14) | 35.29 | (17) | 0.139 |
| Civic Adjustment | | | | | | | |
| Alcohol | 94.50 | (19) | 97.50 | (10) | 97.60 | (13) | 0.519 |
| Drugs | 95.55 | (19) | 97.12 | (9) | 99.67 | (10) | 0.555 |

Note: p is the significance of the difference among the three groups using a one way analysis of variance test. *Statistically significant difference.

TABLE 11

Impact of Individual and Conjoint Therapies as Measured on SRAS

| Scales | Group Means | | | | | | p |
|---|---|---|---|---|---|---|---|
| | | | Follow-up | | | | |
| | Intake | | Individual | | Conjoint | | |
| Basic Satisfaction | 15.44 | (28) | 14.15 | (13) | 15.77 | (14) | 0.366 |
| Basic Performance | 15.21 | (28) | 14.38 | (14) | 15.29 | (14) | 0.503 |
| Basic Combined | 30.65 | (28) | 28.23 | (13) | 31.06 | (14) | 0.225 |
| Safety Satisfaction | 22.47 | (30) | 21.71 | (14) | 21.83 | (17) | 0.818 |
| Safety Performance | 22.30 | (30) | 22.36 | (14) | 22.29 | (17) | 0.998 |
| Safety Combined | 44.77 | (30) | 44.07 | (14) | 44.12 | (17) | 0.935 |
| Affiliation Satisfaction | 35.13 | (30) | 33.42 | (14) | 32.84 | (17) | 0.573 |
| Affiliation Performance | 36.37 | (30) | 33.62 | (14) | 35.10 | (17) | 0.357 |
| Affiliation Combined | 71.50 | (30) | 67.04 | (14) | 67.95 | (17) | 0.487 |
| Esteem Satisfaction | 14.25 | (30) | 14.21 | (14) | 14.00 | (17) | 0.968 |
| Esteem Performance | 15.04 | (30) | 13.64 | (14) | 14.35 | (17) | 0.140 |
| Esteem Combined | 29.25 | (30) | 27.86 | (14) | 28.35 | (17) | 0.620 |
| Autonomy Satisfaction | 11.13 | (30) | 10.86 | (14) | 12.88 | (17) | 0.010* |
| Autonomy Performance | 11.47 | (30) | 12.86 | (14) | 13.12 | (17) | 0.021* |
| Autonomy Combined | 22.60 | (30) | 23.71 | (14) | 26.01 | (17) | 0.008* |
| Self Actualization Sat. | 2.50 | (30) | 2.50 | (14) | 2.29 | (17) | 0.691 |
| Self Actualization Per. | 2.37 | (30) | 2.14 | (14) | 2.19 | (16) | 0.626 |
| Self Actualization Comb. | 4.87 | (30) | 4.64 | (14) | 4.56 | (16) | 0.763 |

Note: p is the significance of the differences among the three groups using a one way analysis of variance test. *Statistically significant difference.

# CHAPTER V

## Discussion

The research reported in this thesis is part of an ongoing evaluation program in the state of Oregon. One objective of this program is to develop a comprehensive measure of mental health and to test the quality of life theory upon which it is based. The Oregon Quality of Life Questionnaire (OQLQ) has been administered to approximately 1,000 persons of various known groups. Psychometric analyses, although not completed, indicate substantial homogeneity, concurrent validity, and reliability in excess of 95%. It is anticipated that this ambitious program will result in a quite adequate measure of mental health.

The psychometric data on the SRAS indicate that the conceptualization and measures possess content validity, but the alpha coefficients and interscale correlations suggest that satisfaction and performance may not be independent in the various need areas. Spouse role adjustment is to some extent an undifferentiated global construct (cf., the confounded relationship between self esteem and safety), but with some fairly distinct components (e.g. autonomy). It also appears that satisfaction of one's own needs may not be distinguishable from satisfaction of one's spouse's needs.

For purposes of this study the reliability of the SRAS scale scores are adequate and therefore, these scales are used as measures of spouse role adjustment. The scales appear to have face validity and content validity, although criterion validity and construct validity have not been established.

The outcome data and the investigator's impressions are that marital therapy, whether individual or conjoint, does not affect the marriage, other than by improving the autonomy of the clients, thus making the clients less dependent in their marriages. This could be interpreted in two ways: either the therapy at this clinic is not marital therapy, or therapy aimed at the marital dyad actually does not change the relationship but only the individuals. These findings are tentative because of some threats to the internal validity of the study which will be discussed below.

The major methodological threat to the internal validity of this study is its failure to assure equivalent groups for pre and post observations and for the two treatment modalities. The assumptions were made that (1) order of admission to the clinic and (2) case assignment to treatment modalities are essentially random. These assumptions cannot be proven, and, in fact, there is some reason to doubt the degree of randomness in these processes, which would be required by a true experimental design. Clinicians did screen clients for the study and assigned them to treatment modalities. However, few clients were screened out and no systematic bias in assignment to treatment conditions could be ascertained.

A more serious doubt exists as to the equality of intake and follow-up groups. There is no reason to question the randomness of order of admission. However, there is a problem with selective attrition. It was necessary to set out a criterion of six sessions of treatment in order to insure the possibility of treatment effect. There are only two ways to preclude the inequality of intake and follow-up groups, with the

criterion in place. One is to, post hoc, eliminate all subjects from the intake group who did not subsequently receive six sessions. The second is to study the same subjects at both intake and follow-up. The latter procedure was in fact done for seven subjects, although it was not possible to collect the SRAS at intake for these seven subjects. The results of these intake follow-up paired observations are consistent with the larger group scores.

The focus of this study was on how individuals meet their needs in a marital relationship. This focus may have missed some important phenomena in marital adjustment...phenomena upon which the clinic may have had impact. Furthermore, self-reported performance may not coincide with the observations of the other member of the marital dyad (whose needs are satisfied by that performance).

The design of this study called for the comparison of individual and conjoint marital therapies. One of the major assumptions was that conjoint marital therapy addresses more the interpersonal relationships within the marital dyad by picking out patterns of interaction, making the partners aware of those patterns, and changing the patterns so that the partners meet each others' needs more fully. On the other hand, individual therapy was assumed to focus more on intrapersonal issues. It was assumed that when therapists changed from individual to conjoint therapy, they changed their focus accordingly. In naturalistic, evaluation research one does not have control over the implementation of independent variables such as treatment modalities.

The threats to the internal validity of the study have been discussed above. While the findings are somewhat tentative due to these

threats, it still seems plausible that marital therapy has affected only autonomy within the marital relationship. Earlier it was suggested that either the therapists did not actually implement conjoint marital therapy, as the design assumed, or conjoint marital therapy does not, in fact, change relationships within a marriage. The prevailing belief about marital therapy is that it does improve (1) communication, (2) autonomy and individuation, and (3) empathy (GAP, 1970). It seems most likely, therefore, that the clinic is not improving communication which would be reflected in our affiliation and self-esteem scales. Perhaps this aspect of conjoint marital therapy is not being implemented in the clinic.

# CHAPTER VI

## Summary, Conclusions, and Recommendations

Community mental health programs are accountable for solving social or personal problems through planned action. However, evaluation tools and ways of measuring the effects of therapeutic programs are still in the developmental phase. This research effort was aimed at developing a concept and a measure of spouse role adjustment which one would expect to be affected by marital treatments. A concept based on Maslow's need hierarchy and a general quality of life theory was formulated. It was predicted that conjoint marital therapy would have a greater impact on and individual's quality of life, generally, and marital adjustment, specifically, than would individual marital treatment. A previous evaluation study in this clinic using a shorter measure had found deterioration in marital adjustment three months after intake. Therefore, this study applied a more comprehensive measure at one year after intake. The study was carried out in a community clinic to establish the effects of marital therapy as it is actually practiced in the field.

Spouse role adjustment is to some extent an undifferentiated construct, but with some distinct components, e.g. autonomy. The Spouse Role Adjustment Scale developed for this study has substantial reliability, face validity, and content validity, although criterion and construct validity have not been established.

Hypothesis 1 stated that clients show improvement a year after admission to treatment by reporting quality of life as better than before treatment. This was not confirmed. Hypothesis 2 was that clients whether having received conjoint or individual therapy, show improvement

in Spouse Role Adjustment by reporting an increased satisfaction and performance in basic, safety, affiliation, self-esteem, autonomy, and self actualization need areas. This hypothesis was not supported by the data except in the autonomy need area. Hypothesis 3 predicted that conjoint therapy has a greater impact on quality of life than individual therapy. This hypothesis was confirmed only in the Independence area. The fourth hypothesis was that conjoint therapy has a greater impact on spouse role adjustment than individual therapy. The data support this hypothesis only in the area of autonomy.

The marital therapy offered at this clinic, whether individual or conjoint, does not affect the marital relationship, other than by increasing the autonomy of the clients. It seems likely that the clinic is not improving communication, as one expects as a part of conjoint therapy. Perhaps this aspect of conjoint marital therapy is not, in fact, being implemented at the clinic.

On the basis of the present study, the following recommendations can be made:

1. The SRAS should be factor analyzed to identify the discriminable components of spouse role adjustment. It is likely that two or three factors will emerge from this analysis.

2. The SRAS should be applied to other subject populations, to establish criterion and construct validity.

3. It is important to have same sample, pre and post designs, which premit repeated measures analysis. This can be accomplished by ongoing evaluation research projects in mental health centers, which facilitate the collection of pre and post measures, separated by a sufficient span

of time, on the same subjects, and within common conceptual frameworks and basic instrumentation.

4. Selection criteria for subject samples in applied settings should be (a) very thoroughly operationalized, (b) clearly related to the conceptualized independent variable, and (c) once accepted by the clinic, rigorously implemented.

5. Random assignment to treatment condition is not often possible in clinical settings. Therefore, one should attempt to capitalize on chaotic assignment, being aware of the hazard of subject-treatment interactions.

6. Selective attrition is a certainty in clinical samples. Same-subject designs, where members of the intake group are lost or fail to meet criteria for inclusion in the follow-up group, can produce comparable pre and post comparison groups. However, this solution results in a restriction of generalizability.

7. Marital therapy is a highly specialized clinical practice. If clinicians claim to deliver marital therapy, they ought to clearly state its goals and practice the tenets of marital therapy. This can be accomplished through seminars and workshops in marital therapy techniques.

8. Actual treatments delivered should be analyzed to see if conjoint therapy differs from individual therapy.

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# APPENDIX A

## Letter of Solicitation

Mental Health Program
of
Yamhill County

Doug Thwaite, ACSW
Program Director

TELEPHONE 472-9371
Ext. 258

McMINNVILLE, OREGON 97128

Dear

In order for us to effectively evaluate how our services are helping our clients, we need your help. We would like some of your time to do what we call a "follow-up" interview. We do this with a sample of all clients who have come to our program. The information gathered will be used to help make our services more relevant and effective.

Within the next several days Nancy Price, from our office, will be contacting you personally to further explain the study. If you are willing to participate, she will ask you some questions about how you have been getting along and how you spend your time. The interview takes about 90 minutes and is completely confidential. We would really appreciate your help.

Thank you for your cooperation.

Sincerely,

# APPENDIX B

## Oregon Quality of Life Questionnaire

Oregon Quality of Life Scale Composition

A. Personal Adjustment

Affective Status (22 items)
Items 01-01 to 01-22 on pp. 1 to 2.

Tolerance of Unpleasant Affect (4 items)
Items 02-01 to 02-04 on p.3.

Basic Need Satisfaction (9 items)
Items 03-01 to 03-09 on pp. 3 to 4.

Independence (8 items)
Items 04-01 to 04-08 on p. 4.

B. Interpersonal Adjustment

Friend Role (6 items)
Items 05-01 to 05-06 on p. 5.

Close Friend Role (3 items)
Items 06-03 to 06-05 on pp. 5 to 6.

Isolation (9 items)
Items 06-02, 07-01 to 07-05 on pp. 5 to 6.

Spouse Role (4 items)
Items 08-01 to 08-04 on p. 6.

Parent Role ( 5 items)
Items 09-01 to 09-05 on p. 7.

Social Support (5 items)
Items 10-01 to 10-05 on p.7.

C. Adjustment to Productivity

Work at Home (5 items)
Items 11-01 to 11-05 on p. 8.

Employability (8 items)
Items 12-02 to 12-09 on pp. 8 to 9.

Job Performance (8 items)
Items 13-02 to 13-09 on pp. 9 to 10.

School Performance (8 items)
Items 14-03 to 14-10 on p. 10.

Other Productive Activity (6 items)
Items 15-01 to 15-06 on p. 11.

D. Civic Adjustment Scales

Alcohol (10 items)
Items 17-02 to 17-11 on p. 12.

Drug (10 items)
Items 18-02 to 18-11 on p. 13.

Oregon Quality of Life Questionnaire (1979)

Department of Human Resources

*ese questions ask about how you have been feeling in the past week. Pleasant and pleasant feelings of several different kinds are covered.*

| | | |
|---|---|---|
| In the past week, how often have you felt very restless, unable to sit still, or fidgety? | 4 all the time<br>3 often<br>2 several times<br>1 none of the time | 01-01 |
| In the past week, how often have you enjoyed your leisure hours (evenings, days off, etc.): | 4 all the time<br>3 often<br>2 several times<br>1 none of the time | 01-02 |
| In the past week, how often have you felt preoccupied with your problems (can't think of anything else)? | 4 all the time<br>3 often<br>2 several times<br>1 none of the time | 01-03 |
| In the past week, how often have you been pleased with something you did? | 4 all the time<br>3 often<br>2 several times<br>1 none of the time | 01-04 |
| In the past week, how often have you felt unpleasantly different from everyone and everything around you? | 4 all the time<br>3 often<br>2 several times<br>1 none of the time | 01-05 |
| In the past week, how often have you felt proud because you were complimented? | 4 all the time<br>3 often<br>2 several times<br>1 none of the time | 01-06 |
| In the past week, how often have you felt fearful or afraid? | 4 all the time<br>3 often<br>2 several times<br>1 none of the time | 01-07 |
| In the past week, how often have you felt that things were "going your way"? | 4 all the time<br>3 often<br>2 several times<br>1 none of the time | 01-08 |
| In the past week, how often have you felt sad or depressed? | 4 all the time<br>3 often<br>2 several times<br>1 none of the time | 01-09 |
| In the past week, how often have you felt excited or interested in something? | 4 all the time<br>3 often<br>2 several times<br>1 none of the time | 01-10 |

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| | | |
|---|---|---|
| In the past week, how often have you felt angry? | 4 all the time<br>3 often<br>2 several times<br>1 none of the time | 01-11 |
| In the past week, how often have you felt that life was going just about right for you? | 4 all the time<br>3 often<br>2 several times<br>1 none of the time | 01-12 |
| In the past week, how often have you felt mixed-up or confused? | 4 all the time<br>3 often<br>2 several times<br>1 none of the time | 01-13 |
| In the past week, how often have you felt tense (uptight)? | 4 all the time<br>3 often<br>2 several times<br>1 none of the time | 01-14 |
| In the past week, how often have you felt good about decisions you've made? | 4 all the time<br>3 often<br>2 several times<br>1 none of the time | 01-15 |
| In the past week, how often have you had trouble sleeping? | 4 all the time<br>3 often<br>2 several times<br>1 none of the time | 01-16 |
| In the past week, how often have you felt like you've spent a worthwhile day? | 4 all the time<br>3 often<br>2 several times<br>1 none of the time | 01-17 |
| In the past week, how often have you had trouble with poor appetite, or inability to eat? | 4 all the time<br>3 often<br>2 several times<br>1 none of the time | 01-18 |
| In the past week, how often have you felt serene and calm? | 4 all the time<br>3 often<br>2 several times<br>1 none of the time | 01-19 |
| In the past week, how often have you had trouble with indigestion? | 4 all the time<br>3 often<br>2 several times<br>1 none of the time | 01-20 |
| In the past week, how often have you found yourself really looking forward to things? | 4 all the time<br>3 often<br>2 several times<br>1 none of the time | 01-21 |
| In the past week, how often have you had trouble with fatigue? | 4 all the time<br>3 often<br>2 several times<br>1 none of the time | 01-22 |
| Did _____ make any difference to the way you feel? | 5 greatly improved it<br>4 improved it<br>3 no effect<br>2 made it worse<br>1 made it much worse | 20-01 |

*erybody has unpleasant feelings sometimes: we wake up depressed, get upset or frustrated frightened. These questions ask how much difficulty you have had recently in handling ese unpleasant feelings.*

| | | |
|---|---|---|
| low much difficulty have you had handling feelings of depression? | 3 great difficulty<br>2 some difficulty<br>1 no difficulty | 02-01 |
| How much difficulty have you had handling being upset? | 3 great difficulty<br>2 some difficulty<br>1 no difficulty | 02-02 |
| How much difficulty have you had handling frustration? | 3 great difficulty<br>2 some difficulty<br>1 no difficulty | 02-03 |
| How much difficulty have you had handling being frightened or shaken up? | 3 great difficulty<br>2 some difficulty<br>1 no difficulty | 02-04 |
| Has _____ made any difference to how you handle unpleasant feelings? | 5 greatly improved it<br>4 improved it<br>3 no effect<br>2 made it worse<br>1 made it much worse | 20-02 |

*ese questions ask about your living situation, eating, income, transportation, and dical care. The purpose is to see if these needs are met to at least a minimum vel of satisfaction.*

| | | |
|---|---|---|
| How satisfied are you with your home--its state of repair, amount of room, furnishing, warmth, lighting, etc.? | 4 very satisfied<br>3 satisfied<br>2 dissatisfied<br>1 very dissatisfied | 03-01 |
| How satisfied are you with your home, considering the amount of privacy, your neighbors, security, etc.? | 4 very satisfied<br>3 satisfied<br>2 dissatisfied<br>1 very dissatisfied | 03-02 |
| Did _____ affect your living situation? | 5 greatly improved it<br>4 improved it<br>3 no effect<br>2 made it worse<br>1 made it much worse | 20-03 |
| *This question asks about how well your income covers things you must have--food, medicine, clothing, etc.* How adequate is your present income for your present needs? | 4 very adequate<br>3 adequate<br>2 inadequate<br>1 very inadequate | 03-03 |
| Are you worried about your future income covering the things you must have? | 4 terribly worried<br>3 quite worried<br>2 slightly worried<br>1 not at all worried | 03-04 |
| Did _____ affect the adequacy of your income? | 5 greatly improved it<br>4 improved it<br>3 no effect<br>2 made it worse<br>1 made it much worse | 20-04 |
| Can you get around town as you need for work, shopping, medical appointments, visiting, etc. ? | 4 can't get around at all<br>3 with much difficulty<br>2 with little difficulty<br>1 with no difficulty | 03-05 |

| | | |
|---|---|---|
| Did _____ affect your ability to get around the community? | 5 greatly improved it<br>4 improved it<br>3 no effect<br>2 made it worse<br>1 made it much worse | 20-06 |
| In the last month, have you had difficulty getting medical care? | 2 yes<br>1 no | 03-06 |
| Do you have a regular or family doctor? | 2 yes<br>1 no | 03-07 |
| Do you have medical insurance? | 2 yes<br>1 no | 03-08 |
| Do you know where to get emergency medical help? | 2 yes<br>1 no | 03-09 |
| Did _____ affect your medical care? | 5 greatly improved it<br>4 improved it<br>3 no effect<br>2 made it worse<br>1 made it much worse | 20-07 |

*hese questions ask how you handle making decisions, dealing with conflict, asserting ourself, etc.*

| | | |
|---|---|---|
| In the last week, how did you find shopping, paying bills, preparing meals, and generally looking after your basic necessities? | 4 very easy<br>3 fairly easy<br>2 rather difficult<br>1 very difficult | 04-01 |
| ...and how enjoyable was it? | 4 very enjoyable<br>3 fairly enjoyable<br>2 fairly unpleasant<br>1 very unpleasant | 04-02 |
| In the last week, how often did you go out? | 4 more than 3 times<br>3 2 or 3 times<br>2 once<br>1 never | 04-03 |
| When you receive broken merchandise, poor service, or are overcharged, how hard is it for you to complain to the store, dealer or company? | 4 can't do it at all<br>3 very hard<br>2 a little hard<br>1 not hard at all | 04-04 |
| When you want to join a conversation (e.g., at a party) how hesitant do you feel about doing so? | 4 can't do it all<br>3 very hesitant<br>2 slightly hesitant<br>1 not at all hesitant | 04-05 |
| When you are treated unfairly by someone you know well (family, close friend) how difficult is it for you to tell them so? | 4 can't do it at all<br>3 very difficult<br>2 slightly difficult<br>1 not difficult | 04-06 |
| How confident are you in the decisions you make for yourself (what to buy, where to live, what to do, etc.)? | 4 quite confident<br>3 some confidence<br>2 little confidence<br>1 no confidence | 04-07 |
| How often do you put off making important decisions until it is too late? | 4 always<br>3 often<br>2 occasionally<br>1 never | 04-08 |

| | | |
|---|---|---|
| )id _____ affect your ability to make lecisions, deal with conflict, and assert your- ;elf? | 5 greatly improved it<br>4 improved it<br>3 no effect<br>2 made it worse<br>1 made it much worse | 20-08 |
| *ese questions ask how you have been getting along with people in the last week.* | | |
| In the past week, how many times have you spoken with neighbors? | 4 more than 3 times<br>3 2 or 3 times<br>2 once<br>1 never | 05-01 |
| In the last week, how often have you spoken with people you saw at work or school or other daily activity? | 4 more than 3 times<br>3 2 or 3 times<br>2 once<br>1 never | 05-02 |
| Do you feel that people avoid you? | 4 all the time<br>3 often<br>2 occasionally<br>1 never | 05-03 |
| Do you feel that people are not nice to you? | 4 all the time<br>3 often<br>2 occasionally<br>1 never | 05-04 |
| How comfortable do you feel being around people? | 4 very uncomfortable<br>3 uncomfortable<br>2 comfortable<br>1 very comfortable | 05-05 |
| Last week, how often did you get to places where you could meet new people? | 4 every day<br>3 several times<br>2 once<br>1 not at all | 05-06 |
| Did _____ affect how you get along with people? | 5 greatly improved it<br>4 improved it<br>3 no effect<br>2 made it worse<br>1 made it much worse | 20-09 |
| *hese questions ask how you have been getting along with your close friends recently.* | | |
| How easily do you make close friendships? | 4 can't do it at all<br>3 with much difficulty<br>2 with a little difficulty<br>1 quite easily | 06-01 |
| Do you have any close friends? | 2 yes<br>1 no | 06-02 |
| *-(If "yes")* | | |
| In the last week, how much of your free time did you spend with close friends talking or doing things together? | 4 almost all<br>3 about half<br>2 very little<br>1 none | 06-03 |
| In the last month, how many times have you had contact by visit, phone, or mail with friends who live outside _____? | 4 quite often<br>3 several times<br>2 once<br>1 not at all | 06-04 |

| | | |
|---|---|---|
| How much trouble have you had in your close friendships? | 4 a great deal<br>3 quite a bit<br>2 a little<br>1 none | 06-05 |
| Did _____ make a difference in your close friendships? | 5 greatly improved them<br>4 improved them<br>3 no effect<br>2 made them worse<br>1 made them much worse | 20-10 |

*ese questions ask how you have been getting along with your family recently.*

| | | |
|---|---|---|
| What is your marital situation now? | 6 living together as married<br>5 married and living together<br>4 separated<br>3 divorced<br>2 widowed<br>1 never married | 07-01 |
| How many people live in the household with you? (give numbers) | __ ages 0-5<br>__ 6-17<br>__ 18-64<br>__ 65+ | 07-02 |
| Are there any children living with you for whom you are responsible (by birth or otherwise)? | 2 yes<br>1 no | 07-03 |
| In the last week, how much of your free time did you spend with the people with whom you live, talking or doing things together? | 4 almost all<br>3 about half<br>2 very little<br>1 none | 07-04 |
| In the last month, how many times have you had contact by visit, phone, or mail with family members who do not live with you? | 4 more than 3 times<br>3 2 or 3 times<br>2 once<br>1 not at all | 07-05 |
| *(If married or living as married)*<br>In the last week, how often have you gotten very angry with your spouse? | 4 every day<br>3 often<br>2 once or twice<br>1 never | 08-01 |
| In the last week, how often did you go out of your way to be nice to your spouse? | 4 all the time<br>3 often<br>2 several times<br>1 never | 08-02 |
| In the last month, how much have you enjoyed your spouse's company? | 4 a great deal<br>3 quite a bit<br>2 a little<br>1 not at all | 08-03 |
| How well are you getting along with your spouse? | 4 very well<br>3 well<br>2 poorly<br>1 very poorly | 08-04 |
| Did _____ affect your relationship with your spouse? | 5 greatly improved it<br>4 improved it<br>3 no effect<br>2 made it worse<br>1 made it much worse | 20-11 |

(If living with and responsible for children)

| | | |
|---|---|---|
| How much have you been involved with your children's activities recently? | 4 a great deal<br>3 a lot<br>2 a little<br>1 not at all | 09-01 |
| How much difficulty have you had meeting your children's demands for your attention recently? | 4 a great deal<br>3 a lot<br>2 a little<br>1 none at all | 09-02 |
| In the last week, how many conversations did you have with your children? | 4 more than 3<br>3 2 or 3<br>2 one<br>1 none | 09-03 |
| How much have your children annoyed you recently? | 4 a great deal<br>3 a lot<br>2 a little<br>1 not at all | 09-04 |
| How much have you enjoyed your children's company recently? | 4 a great deal<br>3 a lot<br>2 a little<br>1 not at all | 09-05 |
| Did _____ make any difference in the way you get along with your children?<br>___ | 5 greatly improved it<br>4 improved it<br>3 no effect<br>2 made it worse<br>1 made it much worse | 20-12 |

*There are some things we share with family and friends; some things we can count on them for. These questions ask about your family and friends, as you see them now.*

| | | |
|---|---|---|
| When something nice happens to you, do you want to share the experience with your family? | 4 always<br>3 often<br>2 sometimes<br>1 never | 10-01 |
| When something nice happens to you, do you want to share the experience with your friends? | 4 always<br>3 often<br>2 sometimes<br>1 never | 10-02 |
| How much would your family be of help and support if you were sick, or moving, or having any other kind of problem? | 4 a great deal<br>3 a lot<br>2 a little<br>1 none | 10-03 |
| How much would your friends be of help and support to you if you were sick, or moving, or having any other kind of problem? | 4 a great deal<br>3 a lot<br>2 a little<br>1 none | 10-04 |
| How much would anyone in the community, other than family and friends, be of help and support to you if you were sick, or moving, or having any other kind of problem? | 4 a great deal<br>3 a lot<br>2 a little<br>1 none | 10-05 |
| Did _____ affect the help and support you feel you can count on from family, friends, and others? | 5 greatly increased it<br>4 increased it<br>3 no effect<br>2 made it worse<br>1 made it much worse | 20-13 |

*These questions are about your experience with work at home, on the job, and in school.*

| | | |
|---|---|---|
| In the last week, how well have you kept up with your share of the housework (cleaning, laundry, shopping, errands)? | 4 completely done<br>3 quite well<br>2 fairly well<br>1 not at all | 11-01 |
| How much of the household money management (paying the bills, budgeting) do you do? | 4 all<br>3 most<br>2 a little<br>1 none | 11-02 |
| How much of the shopping for the household do you do (groceries, furnishings, supplies)? | 4 all<br>3 most<br>2 a little<br>1 none | 11-03 |
| In the last month, how much time did you spend fixing or changing things connected with your home (roof, redecorating, yard work, plumbing) or car? | 4 several days<br>3 a day or so<br>2 an hour or so<br>1 none | 11-04 |
| About how many hours per day do you usually spend preparing meals for the household? | 4 more than 3<br>3 1 to 3 hours<br>2 an hour or less<br>1 none | 11-05 |
| Did _____ affect your work in the home? | 5 greatly improved it<br>4 improved it<br>3 no effect<br>2 made it worse<br>1 made it much worse | 20-14 |

*These questions concern looking for a job. Even if you are not looking for a job, the questions ask about how you would feel.*

| | | |
|---|---|---|
| Do you feel you have any of the responsibility for getting an income for your household? | 2 yes<br>1 no | 12-01 |
| *(If "yes")*<br>How good an impression do you feel you would make in a job interview? | 4 very good<br>3 good<br>2 poor<br>1 very poor | 12-02 |
| How serious are any emotional problems you may have which would make it hard for you to find work? | 4 very serious<br>3 pretty serious<br>2 slightly serious<br>1 not at all serious | 12-03 |
| How comfortable do you feel going out to look for a job? | 4 completely<br>3 quite<br>2 fairly<br>1 not at all | 12-04 |
| How hard is it for you to stick to a job when it becomes unpleasant or boring or stressful? | 4 can't do it at all<br>3 very hard<br>2 a little hard<br>1 not at all hard | 12-05 |
| If you had a chance to get more job training, how willing would you be to get it? | 4 not interested<br>3 slightly willing<br>2 fairly willing<br>1 very willing | 12-06 |

| | | |
|---|---|---|
| How comfortable do you feel working with other people? | 4 not at all comfortable<br>3 fairly<br>2 quite<br>1 completely | 12-07 |
| *This question is about activities that you especially enjoy.* Please name some of your hobbies and special interests. | 4 more than 3<br>3 2 or 3<br>2 one<br>1 none | 12-08 |
| Please name some of the ways you would look for a job. | 4 more than 3<br>3 2 or 3<br>2 one<br>1 none | 12-09 |
| Did _____ make a difference in how easy it would be for you to get a job? | 5 made it much easier<br>4 made it easier<br>3 no effect<br>2 made it harder<br>1 made it much harder | 20-15 |
| *ese questions ask about your work on the job.* | | |
| Are you employed? | 4 full-time<br>3 part-time<br>2 irregularly<br>1 not employed | 13-01 |
| *-(If employed)* | | |
| In the last month, how much time did you miss from work? | 4 several days<br>3 a day or two<br>2 an hour or so<br>1 none | 13-02 |
| In the last month, how much difficulty did you have in doing your work? | 4 a great deal<br>3 quite a bit<br>2 a little<br>1 none | 13-03 |
| How did you feel about the quality of the work you did? | 4 very good<br>3 good<br>2 bad<br>1 very bad | 13-04 |
| How much conflict have you had with people while you were working? | 4 a great deal<br>3 quite a bit<br>2 a little<br>1 none | 13-05 |
| How interesting is your work? | 4 very interesting<br>3 moderately<br>2 slightly<br>1 it's boring | 13-06 |
| In general, how much do you like your job? | 4 really like it<br>3 like it<br>2 don't like it<br>1 hate it | 13-07 |
| In the last month, how many times did people complain about your work? | 4 more than 3 times<br>3 2 or 3 times<br>2 once<br>1 not at all | 13-08 |

| | | |
|---|---|---|
| In the past month, how many times did people say good things about your work? | 4 more than 3 times<br>3 2 or 3 times<br>2 once<br>1 not at all | 13-09 |
| Did _____ affect the way your job went last month? | 5 greatly improved it<br>4 improved it<br>3 no effect<br>2 made it worse<br>1 made it much worse | 20-16 |

*These questions are about how things are going at school.*

| | | |
|---|---|---|
| Are you enrolled in school, night classes, job training, etc.? | 4 full-time<br>3 half-time<br>2 less than ½ time<br>1 no | 14-01 |
| How many hours did you spend in any other informal studying, reading for job promotion, correspondence courses, home extension, etc.? | 4 20+ hours<br>3 8-20 hours<br>2 1-7 hours<br>1 none | 14-02 |
| —*(If enrolled in school)* | | |
| In the last week, how many classes have you missed from school? | 4 all week<br>3 a day or so<br>2 one or two classes<br>1 none | 14-03 |
| In the last week, how well have you kept up with your school work? | 4 completely<br>3 quite well<br>2 fairly well<br>1 not at all | 14-04 |
| How satisfied are you with the work you did for your classes last week? | 4 very satisfied<br>3 quite<br>2 a little<br>1 not at all | 14-05 |
| In the last week, how many times have you had problems with people at school? | 4 more than 3 times<br>3 2 or 3 times<br>2 once<br>1 none | 14-06 |
| In the last week, how interesting was your school work? | 4 very interesting<br>3 moderately<br>2 slightly<br>1 not at all | 14-07 |
| In general, how much do you like being in school? | 4 really like it<br>3 like it<br>2 don't like it<br>1 hate it | 14-08 |
| In the last week, how many times did anyone complain about your school work? | 4 more than 3 times<br>3 2 or 3 times<br>2 once<br>1 not at all | 14-09 |
| In the last week, how many times did anyone say good things about your school work? | 4 more than 3 times<br>3 2 or 3 times<br>2 once<br>1 not at all | 14-10 |

| | | |
|---|---|---|
| Did _____ help you get into, or back into, or stay in, school? | 2 yes<br>1 no | 20-17 |
| Did _____ affect the way school has gone for you? | 5 greatly improved it<br>4 improved it<br>3 no effect<br>2 made it worse<br>1 made it much worse | 20-18 |

*These questions ask about some of the ways you spend your time when you are not working the job, at home, or at school.*

| | | |
|---|---|---|
| In the last week, how much time did you spend actively participating in recreation and sports? | 4 20+ hours<br>3 8-20 hours<br>2 1-7 hours<br>1 none | 15-01 |
| In the last week, how much time did you spend on your hobbies (or creative pursuits, e.g., music)? | 4 20+ hours<br>3 8-20 hours<br>2 1-7 hours<br>1 none | 15-02 |
| Of the TV watching you did last week, how much time did you spend on really interesting programs? | 4 20+ hours<br>3 8-20 hours<br>2 1-7 hours<br>1 none 0 NA | 15-03 |
| In the last week, how much time did you spend window shopping? | 4 20+ hours<br>3 8-20 hours<br>2 1-7 hours<br>1 none | 15-04 |
| *Volunteer work is anything you do for someone else, on a fairly regular basis, that you don't get paid for.* In the last week, how much time did you spend on volunteer work? | 4 20+ hours<br>3 8-20 hours<br>2 1-7 hours<br>1 none | 15-05 |
| Not counting any time for which you were paid, how much time did you pass which you felt was boring and useless? | 4 20+ hours<br>3 8-20 hours<br>2 1-7 hours<br>1 none | 15-06 |
| Regarding the activities we've just talked about, did _____ affect how you spend your time? | 5 made it much more satisfactory<br>4 made it more satisfactory<br>3 no effect<br>2 made it less satisfactory<br>1 made it much less satisfactory | 20-19 |

*These questions are about any contact you, personally, may have had with police, courts, etc., in the last month. We are not interested in any wrong-doing--only in contact with legal agencies.*

| | | |
|---|---|---|
| Have you had any contact with legal agencies? | 2 yes<br>1 no | 16-01 |

*-(If "yes", what kind of contact did you have in each of the following areas...)*

| | | |
|---|---|---|
| Traffic-related | 2 yes<br>1 no | 16-02 |
| Drug-related | 2 yes<br>1 no | 16-03 |

| | | |
|---|---|---|
| Alcohol-related | 2yes<br>1no | 16-04 |
| Violence-related | 2yes<br>1no | 16-05 |
| Theft-related | 2yes<br>1no | 16-06 |
| Civil action (being sued) | 2yes<br>1no | 16-07 |
| Commitment hearing (regarding your mental health) | 2yes<br>1no | 16-08 |
| Did _____ affect any of your legal difficulties? | 5greatly reduced them<br>4reduced them<br>3no effect<br>2increased them<br>1greatly increased them | 20-20 |

*These questions are about drinking alcoholic beverages.*

| | | |
|---|---|---|
| Have you had anything alcoholic to drink in the last month? | 2yes<br>1no | 17-01 |

*—(If "yes")*

*People sometimes have problems with using alcohol. The following questions ask about problems you may have had with alcohol in the last month.*

| | | | | |
|---|---|---|---|---|
| Have you had problems with controlling your drinking? | 4very severe<br>3a lot | 2a few<br>1none | | 17-02 |
| Problems with controlling your behavior because of drinking? | 4very severe<br>3a lot | 2a few<br>1none | | 17-03 |
| Problems with your feelings (guilt, anger, depression) because of drinking? | 4very severe<br>3a lot | 2a few<br>1none | | 17-04 |
| Problems with your health because of drinking? | 4very severe<br>3a lot | 2a few<br>1none | | 17-05 |
| Problems with your parents because of drinking? | 4very severe<br>3a lot | 2a few<br>1none | 0NA | 17-06 |
| Problems with your friends because of drinking? | 4very severe<br>3a lot | 2a few<br>1none | 0NA | 17-07 |
| Problems with your spouse because of drinking? | 4very severe<br>3a lot | 2a few<br>1none | 0NA | 17-08 |
| Problems with your children because of drinking? | 4very severe<br>3a lot | 2a few<br>1none | 0NA | 17-09 |
| Problems with your job or school because of drinking? | 4very severe<br>3a lot | 2a few<br>1none | | 17-10 |
| Problems with your other activities because of drinking? | 4very severe<br>3a lot | 2a few<br>1none | | 17-11 |
| Did _____ affect any problems you may have had with alcohol? | 5greatly reduced them<br>4reduced them<br>3no effect<br>2increased them<br>1greatly increased them | | | 20-21 |

*These questions are about drugs.*

| | | |
|---|---|---|
| Have you used any drugs or medication of any kind, including prescription, over-the-counter, and street drugs in the last month? | 2 yes<br>1 no | 18-01 |

*(If "yes")*

*People sometimes have problems with the use of drugs or medications. The following questions ask about problems you may have had with drugs in the last month.*

| | | | | |
|---|---|---|---|---|
| Have you had problems with controlling your use of drugs? | 4 very severe<br>3 a lot | 2 a few<br>1 none | | 18-02 |
| Problems with controlling your behavior because of drug use? | 4 very severe<br>3 a lot | 2 a few<br>1 none | | 18-03 |
| Problems with your feelings (guilt, anger, depression) because of drugs? | 4 very severe<br>3 a lot | 2 a few<br>1 none | | 18-04 |
| Problems with your health because of drug use? | 4 very severe<br>3 a lot | 2 a few<br>1 none | | 18-05 |
| Problems with your parents because of drug use? | 4 very severe<br>3 a lot | 2 a few<br>1 none | 0 NA | 18-06 |
| Problems with your friends because of drug use? | 4 very severe<br>3 a lot | 2 a few<br>1 none | 0 NA | 18-07 |
| Problems with your spouse because of drug use? | 4 very severe<br>3 a lot | 2 a few<br>1 none | 0 NA | 18-08 |
| Problems with your children because of drug use? | 4 very severe<br>3 a lot | 2 a few<br>1 none | 0 NA | 18-09 |
| Problems with your job or school because of drug use? | 4 very severe<br>3 a lot | 2 a few<br>1 none | | 18-10 |
| Problems with your other activities because of drug use? | 4 very severe<br>3 a lot | 2 a few<br>1 none | | 18-11 |
| Did _____ affect any problems you you may have had with drug use? | 5 greatly reduced them<br>4 reduced them<br>3 no effect<br>2 increased them<br>1 greatly increased them | | | 20-22 |

*Some of the following opportunities exist where you live. These questions ask which you have used in the last month.*

| | | | |
|---|---|---|---|
| (YMCA, [illegible] pools, etc.)? | 2 yes | 1 no | 19-01 |
| Movie theatres, bowling alleys, and other entertainment? | 2 yes | 1 no | 19-02 |
| Churches? | 2 yes | 1 no | 19-03 |
| Social clubs? | 2 yes | 1 no | 19-04 |
| Community parks? | 2 yes | 1 no | 19-05 |
| Libraries? | 2 yes | 1 no | 19-06 |
| Museums? | 2 yes | 1 no | 19-07 |
| Welfare? | 2 yes | 1 no | 19-08 |

| | | | |
|---|---|---|---|
| Food stamps? . . . . . | 2 yes | 1 no | 19-09 |
| Social Security? . . . . . | 2 yes | 1 no | 19-10 |
| Public transportation (buses, etc.)? . . . . . | 2 yes | 1 no | 19-11 |
| Salvation Army or other hostel and meal services? . . . . . | 2 yes | 1 no | 19-12 |
| County health department? . . . . . | 2 yes | 1 no | 19-13 |
| Family planning? . . . . . | 2 yes | 1 no | 19-14 |
| Alcohol and drug abuse programs? . . . . . | 2 yes | 1 no | 19-15 |
| Children's services? . . . . . | 2 yes | 1 no | 19-16 |
| State hospital? . . . . . | 2 yes | 1 no | 19-17 |
| Counseling/guidance services (doctor, church, etc.)? . . . . . | 2 yes | 1 no | 19-18 |
| University health service (speech, hearing, etc.)? . . . . . | 2 yes | 1 no | 19-19 |
| Single Parents' Club? . . . . . | 2 yes | 1 no | 19-20 |
| Weight Watchers? . . . . . | 2 yes | 1 no | 19-21 |
| Alcoholics Anonymous? . . . . . | 2 yes | 1 no | 19-22 |
| Big Brother or other "buddy" programs? . . . | 2 yes | 1 no | 19-23 |
| Legal Aid? . . . . . | 2 yes | 1 no | 19-24 |
| County Juvenile Department? . . . . . | 2 yes | 1 no | 19-25 |
| Advocate groups (tenants' association, Consumers' Protection, Civil Liberties, Women's Rights, etc.)? . . . . . | 2 yes | 1 no | 19-26 |
| Vocational Rehabilitation? . . . . . | 2 yes | 1 no | 19-27 |
| Oregon State Employment Service? . . . . . | 2 yes | 1 no | 19-28 |
| Manpower Development and Training? . . . . . | 2 yes | 1 no | 19-29 |
| Sheltered Workshop? . . . . . | 2 yes | 1 no | 19-30 |
| Private employment counseling/placement services? . . . . . | 2 yes | 1 no | 19-31 |
| Community college? . . . . . | 2 yes | 1 no | 19-32 |
| Night school? . . . . . | 2 yes | 1 no | 19-33 |
| University classes? . . . . . | 2 yes | 1 no | 19-34 |
| Continuing educaton? . . . . . | 2 yes | 1 no | 19-35 |
| Business or vocational school? . . . . . | 2 yes | 1 no | 19-36 |
| Public school? . . . . . | 2 yes | 1 no | 19-37 |
| Experimental college? . . . . . | 2 yes | 1 no | 19-38 |
| Special interest groups (e.g., science fiction society)? . . . . . | 2 yes | 1 no | 19-39 |
| _____? . . . | 2 yes | 1 no | 19-40 |
| _____? . . . | 2 yes | 1 no | 19-41 |
| _____? . . . | 2 yes | 1 no | 19-42 |

20-62

r counselor may have done some of the things listed below. These questions ask how pful you feel these things were.

| | | |
|---|---|---|
| your counselor listen to you? [No = 0]<br>id listening have an effect?[No = 3]<br>Was listening helpful or harmful?<br>Helpful = 4 or Very Helpful = 5<br>Harmful = 2 or Very Harmful = 4 | 5 very helpful<br>4 helpful<br>3 no effect 0 NA<br>2 harmful<br>1 very harmful | 21-01 |
| your counselor care about you? [No = 0]<br>Did caring have an effect?[No = 3]<br>Was caring about you helpful or harmful?<br>Helpful = 4 or Very Helpful = 5<br>Harmful = 2 or Very Harmful = 1 | 5 very helpful<br>4 helpful<br>3 no effect 0 NA<br>2 harmful<br>1 very harmful | 21-02 |
| your counselor encourage you? [No = 0]<br>Did encouraging you have an effect?[No = 3]<br>Was encouraging you helpful or harmful?<br>Helpful = 4 or Very Helpful = 5<br>Harmful = 2 or Very Harmful = 1 | 5 very helpful<br>4 helpful<br>3 no effect 0 NA<br>2 harmful<br>1 very harmful | 21-03 |
| your counselor tell you about things (jobs, community rvices, relating to people, how one's mind works)? o = 0]<br>Did telling you about things have an effect? [No = 3]<br>Was telling you helpful or harmful? Helpful = 4 or Very Helpful = 5 Harmful = 2 or Very Harmful = 1 | 5 very helpful<br>4 helpful<br>3 no effect 0 NA<br>2 harmful<br>1 very harmful | 21-04 |
| your counselor attempt to calm your worries? [No = 0]<br>Did calming your worries have an effect? [No = 3]<br>Was attempting to calm your worries helpful or harmful?<br>Helpful = 4 or Very Helpful = 5<br>Harmful = 2 or Very Harmful = 1 | 5 very helpful<br>4 helpful<br>3 no effect 0 NA<br>2 harmful<br>1 very harmful | 21-05 |
| your couselor set limits for you? [No = 0]<br>Did setting limits have an effect? [No = 3]<br>Was setting limits helpful or harmful?<br>Helpful = 4 or Very Helpful = 5<br>Harmful = 2 or Very Harmful = 1 | 5 very helpful<br>4 helpful<br>3 no effect 0 NA<br>2 harmful<br>1 very harmful | 21-06 |
| f no counselor, mark NA = 0]<br>id your counselor have an effect on your problem? [No = 3]<br>as the counselor helpful or harmful?<br>Helpful = 4 or Very Helpful = 5<br>Harmful = 2 or Very Harmful = 1 | 5 very helpful<br>4 helpful<br>3 no effect 0 NA<br>2 harmful<br>1 very harmful | 22-01 |
| If no friends, mark NA = 0]<br>id friends have an effect on problem? [No = 3]<br>Was it helpful or harmful?<br>Helpful = 4 or Very Helpful = 5<br>Harmful = 2 or Very Harmful = 1 | 5 very helpful<br>4 helpful<br>3 no effect 0 NA<br>2 harmful<br>1 very harmful | 22-02 |
| id you receive medications supplied by _____? [No = 0]<br>Did medications have an effect on the problem? [No = 3]<br>Were the medications helpful or harmful?<br>Helpful = 4 or Very Helpful = 5<br>Harmful = 2 or Very Harmful = 1 | 5 very helpful<br>4 helpful<br>3 no effect 0 NA<br>2 harmful<br>1 very harmful | 22-03 |
| o you have any religious associations? [No = 0]<br>Did religious associations effect your problem? [No = 3]<br>Were religious associations helpful or harmful?<br>Helpful = 4 or Very Helpful = 5<br>Harmful = 2 or Very Harmful = 1 | 5 very helpful<br>4 helpful<br>3 no effect 0 NA<br>2 harmful<br>1 very harmful | 22-04 |

| | | |
|---|---|---|
| Did you have a counselor in other programs or a private counselor? [No = 0]<br>- Did other counselor(s) have an effect?<br>- Were other counselor(s) helpful or harmful?<br>Helpful or Very Helpful? Harmful or Very Harmful? | 5 very helpful<br>4 helpful<br>3 no effect 0 NA<br>2 harmful<br>1 very harmful | 22-05 |
| Did the passing of time have an effect on the problem? [No = 3]<br>- Was the passing of time helful or harmful?<br>Helpful = 4 or Very Helpful = 5<br>Harmful = 2 or Very Harmful = 1 | 5 very helpful<br>4 helpful<br>3 no effect<br>2 harmful<br>1 very harmful | 22-06 |
| Did you "drop in" to _____? [No = 0]<br>- Did "dropping in" have an effect on the problem? [No=3]<br>- Was "dropping in" helpful or harmful?<br>Helpful = 4 or Very Helpful = 5<br>Harmful = 2 or Very Harmful = 1 | 5 very helpful<br>4 helpful<br>3 no effect 0 NA<br>2 harmful<br>1 very harmful | 22-07 |
| Did keeping busy have an effect on the problem? [No = 3]<br>- Was keeping busy helpful or harmful?<br>Helpful = 4 or Very Helpful = 5<br>Harmful = 2 or Very Harmful = 1 | 5 very helpful<br>4 helpful<br>3 no effect<br>2 harmful<br>1 very harmful | 22-08 |
| Did being with people have an effect on the problem? [No = 3]<br>- Was being with people helpful or harmful?<br>Helpful = 4 or Very Helpful = 5<br>Harmful = 2 or Very Harmful = 1 | 5 very helpful<br>4 helpful<br>3 no effect<br>2 harmful<br>1 very harmful | 22-09 |
| Did you do physical activity? [No = 0]<br>- Did the activity have any effect on the problem? [No=3]<br>- Was the activity helpful or harmful?<br>Helpful = 4 or Very Helpful = 5<br>Harmful = 2 or Very Harmful = 1 | 5 very helpful<br>4 helpful<br>3 no effect 0 NA<br>2 harmful<br>1 very harmful | 22-10 |
| If no family, mark NA = 0]<br>Did your family have an effect on the problem? [No = 3]<br>- Was the effect helpful or harmful<br>Helpful = 4 or Very Helpful = 5<br>Harmful = 2 or Very Harmful = 1 | 5 very helpful<br>4 helpful<br>3 no effect 0 NA<br>2 harmful<br>1 very harmful | 22-11 |
| Did you attend group meetings at _____? [No = 0]<br>- Did the group meetings have an effect? [No = 3]<br>- Was the effect helpful or harmful?<br>Helpful = 4 or Very Helpful = 5<br>Harmful = 2 or Very Harmful = 1 | 5 very helpful<br>4 helpful<br>3 no effect 0 NA<br>2 harmful<br>1 very harmful | 22-12 |
| [If no family doctor, mark NA = 0]<br>Did the family doctor have an effect on the problem? [No=3]<br>- Was the effect helpful or harmful?<br>Helpful = 4 or Very Helpful = 5<br>Harmful = 2 or Very Harmful = 1 | 5 very helpful<br>4 helpful<br>3 no effect 0 NA<br>2 harmful<br>1 very harmful | 22-13 |
| Was there anything else that had an effect? [No = 0. If yes, write it down.]<br>- Was it helpful or harmful?<br>Helpful = 4 or Very Helpful = 5<br>Harmful = 2 or Very Harmful = 1 | 5 very helpful<br>4 helpful<br>0 NA<br>2 harmful<br>1 very harmful | 22-14 |

*These questions ask about the service you received at _____.*

| | | |
|---|---|---|
| Did you have any difficulty finding out about _____? | 2 yes 1 no | 23-01 |
| Did you have any difficulty getting into _____? | 2 yes 1 no | 23-02 |
| When you came to the program, did the receptionist make you feel comfortable? | 2 yes 1 no | 23-03 |
| Was the waiting room satisfactory--its comfort, privateness, quietness, etc.? | 2 yes 1 no | 23-04 |
| Was your first contact with a counselor satisfactory (when you discussed why you had come, etc.)? | 2 yes 1 no | 23-05 |
| Was your counselor's attitude toward you satisfactory? | 2 yes 1 no | 23-06 |
| [If no medications, mark NA = 0. If yes, then ask:] Was the process of getting medications satisfactory? | 2 yes 1 no | 23-07 |
| Was your counselor accessible to you--could you get to your counselor when you needed to? | 2 yes 1 no | 23-08 |
| [If there was no individual counseling, mark NA = 0. If yes, ask:] Were the individual counseling sessions with your counselor satisfactory? | 2 yes 1 no | 23-09 |
| [If there were no group sessions, mark NA = 0. If yes, ask:] Were the group sessions you had with counselors and other clients satisfactory? | 2 yes 1 no | 23-10 |

| | | |
|---|---|---|
| Did you have any trouble with appointments because of distance or time of the appointment, etc.? | 2 yes 1 no | 23-11 |
| Was the attitude of staff toward you, as a client, satisfactory? | 2 yes 1 no | 23-12 |
| [If interviewee is still participating in program, mark NA = 0. If not participating ask:] Was the decision to end your participation in the program at _____ made in a satisfactory way? | 2 yes 1 no | 23-13 |
| Are you satisfied with the way you are (were) charged? | 2 yes 1 no | 23-14 |
| Did you get the kind of service you wanted? | 2 yes 1 no | 23-15 |
| If you were to seek help again, would you go back to _____? | 2 yes 1 no | 23-16 |
| Do you have any comments, criticisms, or suggestions about _____? | 2 yes 1 no | |

# APPENDIX C

## Spouse Role Adjustment Scale

Spouse Role Adjustment Scale Composition

A. Basic Needs

Satisfaction (5 items)
Items 24-01 to 24-05 on p.1

Performance (5 items)
Items 24-37 to 24-41 on p.4

Combined (10 items)
Items 24-01 to 24-05, 24-37 to 24-41 on pp.1,4

B. Safety Needs

Satisfaction (7 items)
Items 24-06 to 24-12 on pp.1,2

Performance (7 items)
Items 24-42 to 24-48 on pp.4,5

Combined (14 items)
Items 24-06 to 24-12, 24-42 to 24-48 on pp.1,2,4,5

C. Affiliation Needs

Satisfaction (14 items)
Items 24-13 to 24-26 on pp.2,3

Performance (14 items)
Items 24-49 to 24-62 on pp.5,6

Combined (28 items)
Items 24-13 to 24-26, 24-49 to 24-62 on pp.2,3,5,6

D. Esteem Needs

Satisfaction (5 items)
Items 24-27 to 24-31 on p.3

Performance (5 items)
Items 24-63 to 24-67 on pp.6,7

Combined (10 items)
Items 24-27 to 24-31, 24-63 to 24-67 on pp.3,6,7

E. Autonomy Needs

Satisfaction (4 items)
Items 24-32 to 24-35 on pp.3,4

Performance (4 items)
Items 24-68 to 24-71 on p.7

Combined (8 items)
Items 24-32 to 24-35, 24-68 to 24-71 on pp.3,4,7

| | | |
|---|---|---|
| In the last month, how well did your spouse keep up with his/her share of household chores? | 4 very well 0 NA<br>3 well<br>2 poorly<br>1 very poorly | 24-01 |
| In the last month, how satisfied were you with the division of household chores like cooking, cleaning, house repair, yardwork, laundry, etc.? | 4 very satisfied<br>3 satisfied<br>2 dissatisfied<br>1 very dissatified | 24-02 |
| In the last month, how satisfied were you with the amount of money your spouse brought in? | 4 very satisfied<br>3 satisfied<br>2 dissatisfied<br>1 very dissatisfied | 24-03 |
| In the last month, how satisfied have you been with the way your spouse generally managed family money? | 4 very satisfied<br>3 satisfied<br>2 dissatisfied<br>1 very dissatisfied | 24-04 |
| In the last month, how well were your sexual needs satisfied by your spouse? | 4 very well<br>3 well<br>2 poorly<br>1 very poorly | 24-05 |
| In the last month, how afraid were you that your spouse was going to physically hurt you? | 4 very afraid<br>3 quite afraid<br>2 slightly afraid<br>1 not at all afraid | 24-06 |
| In the last month, how often have you felt your spouse placed you in a dangerous position (e.g., driving dangerously, ignoring safety measures, not locking doors, provoking others, etc.)? | 4 all the time<br>3 often<br>2 several times<br>1 none of the time | 24-07 |
| In the last month, how reliable was your spouse toward you? | 4 very reliable<br>3 quite reliable<br>2 slightly reliable<br>1 not at all reliable | 24-08 |
| In the last month, how comforting was your spouse toward you? | 4 very comforting<br>3 quite comforting<br>2 slightly comforting<br>1 not at all comforting | 24-09 |
| In the last month, how quarrelsome was your spouse toward you? | 4 very quarrelsome<br>3 quite quarrelsome<br>2 slightly quarrelsome<br>1 not at all quarrelsome | 24-10 |
| In the last month, how tense did your spouse seem toward you? | 4 very tense<br>3 quite tense<br>2 slightly tense<br>1 not at all tense | 24-11 |

| | | |
|---|---|---|
| In the last month, how frustrated did your spouse seem to be with you? | 4 very frustrated<br>3 quite frustrated<br>2 slightly frustrated<br>1 not at all frustrated | 24-12 |
| In the last month, how affectionate has your spouse been to you? | 4 very affectionate<br>3 quite affectionate<br>2 slightly affectionate<br>1 not at all affectionate | 24-13 |
| In the last month, how much of his/her free time did your spouse spend with you? | 4 almost all<br>3 about half<br>2 very little<br>1 none | 24-14 |
| In the last month, how well did your spouse seem to understand you and things you said? | 4 very well<br>3 well<br>2 poorly<br>1 very poorly | 24-15 |
| In the last month, how much did your spouse talk with you about your sexual relationship? | 4 a great deal<br>3 quite a bit<br>2 a little<br>1 not at all | 24-16 |
| In the last month, how much did you enjoy your spouse's company? | 4 a great deal<br>3 quite a bit<br>2 a little<br>1 not at all | 24-17 |
| In the last month, how much did your spouse talk with you about things you are interested in? | 4 a great deal<br>3 quite a bit<br>2 a little<br>1 not at all | 24-18 |
| In the last month, how loving was your spouse toward you? | 4 very loving<br>3 quite loving<br>2 slightly loving<br>1 not at all loving | 24-19 |
| In the last month, how irritable was your spouse toward you? | 4 very irritable<br>3 quite irritable<br>2 slightly irritable<br>1 not at all irritable | 24-20 |
| In the last month, how impatient was your spouse with you? | 4 very impatient<br>3 quite impatient<br>2 slightly impatient<br>1 not at all impatient | 24-21 |
| In the last month, how angry was your spouse with you? | 4 very angry<br>3 quite angry<br>2 slightly angry<br>1 not at all angry | 24-22 |

| | | |
|---|---|---|
| How many of your spouse's friends are your friends as well? | 3 more than I'd like<br>2 as many as I'd like<br>1 less than I'd like | 24-23 |
| In the last month, how much of your spouse's social activity have you shared in? | 3 more than I'd like<br>2 as much as I'd like<br>1 less than I'd like | 24-24 |
| In the last month, how many of your spouse's hobbies or special interests have you shared in? | 3 more than I'd like<br>2 as many as I'd like<br>1 less than I'd like | 24-25 |
| In the last month, how much has your spouse seemed to withdraw, sulk, or deliberately avoid speaking to you? | 4 a great deal<br>3 quite a bit<br>2 a little<br>1 none | 24-26 |
| In the last month, how often did your spouse seem to go out of his/her way to be nice to you? | 4 all the time<br>3 often<br>2 several times<br>1 never | 24-27 |
| In the last month, how much respect did you feel your spouse showed toward you? | 4 a great deal<br>3 quite a bit<br>2 a little<br>1 none | 24-28 |
| In the last month, how good did your spouse make you feel? | 4 very good<br>3 quite good<br>2 slightly good<br>1 not at all good | 24-29 |
| In the last month, how much of the family decision-making did you have a part in? | 4 almost all<br>3 about half<br>2 very little<br>1 none | 24-30 |
| In the last month, has your spouse been insulting and unpleasant to you? | 4 a great deal<br>3 quite a bit<br>2 a little<br>1 not at all | 24-31 |
| In the last month, how free did you feel to do the things you want, without your spouse? | 4 very free<br>3 quite free<br>2 slightly free<br>1 not at all free | 24-32 |
| How many of your friendships are dependent on your spouse? | 4 all most all<br>3 about half<br>2 very few<br>1 none | 24-33 |

| | | |
|---|---|---|
| In the last month, how much did you go out without your spouse? | 4 a great deal<br>3 quite a bit<br>2 a little<br>1 none | 24-34 |
| In the last month, how many of your hobbies or interests were dependent upon your spouse? | 4 almost all<br>3 about half<br>2 very few<br>1 none | 24-35 |
| In the last month, was your spouse an interesting person to be with? | 4 very interesting<br>3 quite interesting<br>2 slightly interesting<br>1 not at all interesting | 24-36 |
| In the last month, how well did you keep up with your share of household chores? | 4 very well 0 NA<br>3 well<br>2 poorly<br>1 very poorly | 24-37 |
| In the last month, how satisfied in general was your spouse with the division of household chores like cooking, cleaning, house repair, yardwork, laundry, etc.? | 4 very satisfied<br>3 satisfied<br>2 dissatisfied<br>1 very dissatisfied | 24-38 |
| In the last month, how satisfied was your spouse with the amount of money you brought in? | 4 very satisfied<br>3 satisfied<br>2 dissatisfied<br>1 very dissatisfied | 24-39 |
| In the last month, how satisfied has your spouse been with the way you generally managed family money? | 4 very satisfied<br>3 satisfied<br>2 dissatisfied<br>1 very dissatisfied | 24-40 |
| In the last month, how well did you seem to satisfy your spouse's sexual needs? | 4 very well<br>3 well<br>2 poorly<br>1 very poorly | 24-41 |
| In the last month, how afraid did your spouse seem to be that you were going to physically hurt him/her? | 4 very afraid<br>3 quite afraid<br>2 slightly afriad<br>1 not at all afraid | 24-42 |
| In the last month, how often have you placed your spouse in a dangerous position (e.g., driving dangerously, ignoring safety measures, not locking doors, provoking others, etc.)? | 4 all the time<br>3 often<br>2 several times<br>1 none of the time | 24-43 |
| In the last month, how reliable were you toward your spouse? | 4 very reliable<br>3 quite reliable<br>2 slightly reliable<br>1 not at all reliable | 24-44 |

| | | |
|---|---|---|
| In the last month, how comforting were you toward your spouse? | 4 very comforting<br>3 quite comforting<br>2 slightly comforting<br>1 not at all comforting | 24-45 |
| In the last month, how quarrelsome were you toward your spouse? | 4 very quarrelsome<br>3 quite quarrelsome<br>2 slightly quarrelsome<br>1 not at all quarrelsome | 24-46 |
| In the last month, how tense were you toward your spouse? | 4 very tense<br>3 quite tense<br>2 slightly tense<br>1 not at all tense | 24-47 |
| In the last month, how frustrated were you with your spouse? | 4 very frustrated<br>3 quite frustrated<br>2 slightly frustrated<br>1 not at all frustrated | 24-48 |
| In the last month, how affectionate were you to your spouse? | 4 very affectionate<br>3 quite affectionate<br>2 slightly affectionate<br>1 not at all affectionate | 24-49 |
| In the last month, how much of your free time did you spend with your spouse? | 4 almost all<br>3 about half<br>2 very little<br>1 none | 24-50 |
| In the last month, how well did you understand your spouse and things he/she said? | 4 very well<br>3 well<br>2 poorly<br>1 very poorly | 24-51 |
| In the last month, how much did you talk with your spouse about your sexual relationship? | 4 a great deal<br>3 quite a bit<br>2 a little<br>1 not at all | 24-52 |
| In the last month, how much did your spouse seem to enjoy your company? | 4 a great deal<br>3 quite a bit<br>2 a little<br>1 not at all | 24-53 |
| In the last month, how much did you talk with your spouse about things he/she is interested in? | 4 a great deal<br>3 quite a bit<br>2 a little<br>1 not at all | 24-54 |
| In the last month, how loving were you toward your spouse? | 4 very loving<br>3 quite loving<br>2 slightly loving<br>1 not at all loving | 24-55 |

| | | |
|---|---|---|
| In the last month, how irritable were you toward your spouse? | 4 very irritable<br>3 quite irritable<br>2 slightly irritable<br>1 not at all irritable | 24-56 |
| In the last month, how impatient were you with your spouse? | 4 very impatient<br>3 quite impatient<br>2 slightly impatient<br>1 not at all impatient | 24-57 |
| In the last month, how angry were you with your spouse? | 4 very angry<br>3 quite angry<br>2 slightly angry<br>1 not at all angry | 24-58 |
| How many of your friends are your spouse's friends as well? | 3 more than I'd like<br>2 as many as I'd like<br>1 less than I'd like | 24-59 |
| In the last month, how much of your social activity has your spouse shared in? | 3 more than I'd like<br>2 as much as I'd like<br>1 less than I'd like | 24-60 |
| In the last month, how many of your hobbies or special interests has your spouse shared in? | 3 more than I'd like<br>2 as much as I'd like<br>1 less than I'd like | 24-61 |
| In the last month, how much have you withdrawn, sulked, or deliberately avoided speaking to your spouse? | 4 a great deal<br>3 quite a bit<br>2 a little<br>1 none | 24-62 |
| In the last month, how often did you go out of your way to be nice to your spouse? | 4 all the time<br>3 often<br>2 several times<br>1 never | 24-63 |
| In the last month, how much respect did you show for your spouse? | 4 a great deal<br>3 quite a bit<br>2 a little<br>1 none | 24-64 |
| In the last month, how good did you seem to make your spouse feel about him/herself? | 4 very good<br>3 quite good<br>2 slightly good<br>1 not at all good | 24-65 |
| In the last month, how much of the family decision-making did your spouse have a part in? | 4 almost all<br>3 about half<br>2 very little<br>1 none | 24-66 |

In the last month, have you been insulting and unpleasant to your spouse? 24-67

4 a great deal
3 quite a bit
2 a little
1 not at all

---

In the last month, how free did your spouse seem to feel to do things he/she wanted, without you? 24-68

4 very free
3 quite free
2 slightly free
1 not at all free

---

How many of your spouse's friendships are dependent on you? 24-69

4 almost all
3 about half
2 very few
1 none

---

In the last month, how much did your spouse go out without you? 24-70

4 a great deal
3 quite a bit
2 a little
1 none

---

In the last month, how many of your spouse's hobbies or interests were dependent on you? 24-71

4 almost all
3 about half
2 very few
1 none

---

In the last month, were you an interesting person for your spouse to be with? 24-72

4 very interesting
3 quite interesting
2 slightly interesting
1 not at all interesting

---

How many times have you been married? 24-73
(enter actual number)

---

What is your annual household income? 24-74 24-75

00 = $0-499
01 = $500-1,499
02 = $1,500-2,499
03 = $2,500-3,499
04 = $3,500-4,499
05 = $4,500-5,499
06 = $5,500-6,499
07 = $6,500-7,499
08 = $7,500-8,499
09 = $8,500-9,499
10 = $9,500-10,499
and so on
99 = $98,500 and above

How would you evaluate your relationship in your own words? 24-76

Describe the problem which brought you to the mental health program? 24-77

What did you hope would result from going to the program? 24-78

What happened to you at the program? 24-79

What difference did the program make to your relationship? 24-80

# APPENDIX D

Consent Forms

# Yamhill County Mental Health Program
## Consent Form for OQLQ
## Intake Interview

*I, _____, herewith agree to serve as a subject in the investigation named, "An Evaluation of the Effects of Conjoint Therapy and Individual Therapy on Spouse Role Adjustment" by Nancy L. Price under the supervision of Dr. Florence Hardesty. The investigation aims at comparing quality of life and more specifically spouse role adjustment before and after treatment. The procedures to which I will be subjected are an interview before and after treatment which will focus on questions regarding:*

How I am feeling.

How I am getting along with family and friends.

How work is going.

Whether I am having any difficulties with alcohol and drugs.

Whether I have had any recent contact with the law.

Participation in this interview is completely voluntary.

I understand I am free to refuse to answer any question I do not wish to.

I understand that I can stop the interview if I wish.

Withdrawal from participation in the study at any time will have no effect on my relationship with or treatment at the Yamhill County Mental Health Program.

The information obtained will be kept confidential and will not become part of my mental health center record.

Anonymity will be ensured by the use of code numbers.

Information will not be released to anyone for any other purpose.

*I may benefit from these procedures by becoming more aware of my social adjustment. There are no risks for me. Nancy Price has offered to answer any questions I might have about my participation in this study.*

---

I have read or listened to the above information regarding the interview and I am willing to proceed with the interview.

I give my permission to allow the information collected in this interview to be used for research purposes only.

Date: _____

_____ Signature: _____

(Witness)

Yamhill County Mental Health Program
Consent Form for OQLQ
Follow-up Interview

*I, _____, herewith agree to serve as a subject in the investigation named, "An Evaluation of the Effects of Conjoint Therapy and Individual Therapy on Spouse Role Adjustment" by Nancy L. Price under the supervision of Dr. Florence Hardesty. The investigation aims at comparing quality of life and more specifically spouse role adjustment before and after treatment. The procedures to which I will be subjected are an interview before and after treatment which will focus on questions regarding:*

How I am feeling.

How I am getting along with my family and friends.

Whether the services helped me.

How work is going.

Whether I am having any difficulties with alcohol and drugs.

Whether I have had any recent contact with the law.

Participation in this interview is completely voluntary.

I understand I am free to refuse to answer any question I do not wish to.

I understand that I can stop the interview if I wish.

Withdrawal from participation in the study at any time will have no effect on my relationship with or treatment at the Yamhill County Mental Health Program.

The information obtained will be kept confidential and will not become part of my mental health center record.

Anonymity will be ensured by the use of code numbers.

Information will not be released to anyone for any other purpose.

*I may benefit from these procedures by becoming more aware of my social adjustment. There are no risks for me. Nancy Price has offered to answer any questions I might have about my participation in this study.*

---

I have read or listened to the above information regarding the interview and I am willing to proceed with the interview.

I give my permission to allow the information collected in this interview to be used for research purposes only.

Date: _____

_____ Signature: _____

AN ABSTRACT OF THE THESIS OF

NANCY L. PRICE

For the MASTER OF NURSING

Date Receiving this Degree: June, 1980

Title: An Evaluation of the Effects of Conjoint Therapy and Individual Therapy on Spouse Role Adjustment

Approved: [redacted] Thesis Advisor

Florence Hardesty, Ph.D.

Most mental health centers offer therapies to foster better marital and family relations. Centers must become accountable to discriminate between therapy programs having unexpected and undesirable consequences, and those which are, indeed, helpful. The present study follows on a previous evaluation research project which showed a significant decrease in marital adjustment after therapy. This negative finding may be explained by a number of factors. First, changes experienced by clients in individual therapy may have caused difficulty in the marriage. Second, the instrument may fail to measure important aspects of marital adjustment which may have improved. Third, marital adjustment may have "gotten worse before it got better".

To explore these possibilities, the present study was an effort to evaluate comparatively the effects of conjoint therapy and individual therapy on clients' quality of life. This study was also an effort to broaden the conceptualization of spouse role adjustment and to develop a

more complete spouse role scale. In addition a longer follow-up interval was used to determine if the individuals had "worked through" the intermediate stage of therapy to an improved level of adjustment.

This study used a naturalistic, separate sample, pre-post therapy comparative group design. Sixty subjects with marital and/or family problems were selected from different cohorts at different time periods from a mental health center's population. Data was collected by a structured interview using the Oregon Quality of Life Questionnaire and a newly developed Spouse Role Adjustment Scale, which are based on Maslow's theory of needs. Both instruments are reliable and have content validity. Further tests of validity are in process.

Two types of statistics are used to analyze the data. The psychometric properties of the Spouse Role Adjustment Scale are assessed using Scott's homogeneity ratio and Cronbach's coefficient alpha to determine construct validity. To some extent spouse role adjustment is an undifferentiated global construct, but with some fairly distinct components.

The hypotheses are tested by using one-way analyses of variance to compare the intake with the follow-up group and the individual with the conjoint therapy group. It appears that the marital and family therapy offered at this clinic, whether individual or conjoint, does not affect the marital relationship, other than by increasing the autonomy of the clients. It also appears that the conjoint therapy, more than individual therapy, might improve a client's autonomy in a marriage.