SATISFACTION IN CLOSE RELATIONSHIPS

Edited by

Robert J. Sternberg
Mahzad Hojjat

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CHAPTER 12

Acceptance in Couple Therapy and Its Implications for the Treatment of Depression

JAMES V. CORDOVA
NEIL S. JACOBSON

Depression frequently affects and is affected by intimate relationships. Long-standing problems within an intimate relationship can often set the stage for depression in at least one partner (Beach, Whisman, & O'Leary, 1994; Beach & Nelson, 1990; Beach & O'Leary, 1993; Brown, Adler, & Bifulco, 1988; Brown, Andrews, Harris, Adler, & Bridge, 1986; Brown & Harris, 1978; Brown, Lemryre, & Bifulco, 1992; Markman, Duncan, Storaasli, & Howes, 1987; Monroe, Bromet, Connell, & Steiner, 1986; O'Leary, Riso, & Beach, 1990; Paykel, 1979; Schaefer & Burnett, 1987; Waltz, Badura, Pfaff, & Schott, 1988). And even if the relationship itself is not the cause of depression, depression invariably has a major effect on the quality of a couple's relationship (Billings, Cronkite, & Moos, 1983; Birtchnell, 1988; Horwitz & White, 1991; O'Leary, Christian, & Mendell, 1994; Schuster, Kessler, & Aseltine, 1990; Weiss & Aved, 1978; Weissman, 1987). In either case, addressing depression as an issue for the couple is often the best way to deal with both the couple's distress and the individual's depression.

In this chapter we discuss the evolution of our thinking about couple therapy from a tradition focused exclusively on change toward one

that strives for a balance between change and acceptance. We also discuss what we mean by "acceptance" and how the principles of acceptance can be used both in and outside of therapy. In particular, we discuss depression as a couple issue and highlight the implications of the principles of acceptance for addressing depression in couple therapy.

RESEARCH ON COUPLE THERAPY AS A TREATMENT FOR DEPRESSION

Because depression more often than not occurs within the context of an intimate relationship, treating depression with couple therapy has been studied several times (Beach & O'Leary, 1992; Jacobson, Dobson, Fruzzetti, Schmaling, & Salusky, 1991; Foley, Rounsaville, Weissman, Sholomaskas, & Chevron, 1989). Two of these studies focused on traditional behavioral couple therapy (TBCT; Beach & O'Leary, 1992; Jacobson et al., 1991), and one focused on interpersonal psychotherapy for couples (Foley et al., 1989). The literature to date supports the following conclusions. First, TBCT has been shown to be an effective treatment for depression if a depressed person reports that marital distress is the cause of his or her depression. In other words, if a person presents with major depression *and* believes that he or she is depressed because of problems in his or her relationship, then TBCT is as effective in ameliorating depression as is cognitive therapy directed specifically at the symptoms of depression. In addition, in unhappy marriages with a depressed spouse, only TBCT had an effect on the quality of the marriage (as opposed to cognitive therapy), with approximately 40% of couples no longer distressed at the end of therapy (O'Leary & Beach, 1990, 1992). Therefore, although cognitive therapy might be just as effective a treatment for depression as TBCT, it does not address the co-occurring problem of relationship distress. In other words, TBCT appears to help alleviate the symptoms of depression *and* improve the quality of the relationship. Note, however, that the major qualifier for TBCT's success is that the depressed person attributes his or her depression to problems in the relationship. TBCT was not found to be as successful with couples in which the depressed individual did not blame his or her depression on the relationship. It is our contention that integrating the principles of acceptance into change-oriented TBCT creates a more effective treatment of depression, regardless of whether the depression is attributed to the relationship or to factors outside the relationship.

FROM TRADITIONAL TO INTEGRATIVE BEHAVIORAL COUPLE THERAPY

Behavioral marital therapy (Jacobson & Margolin, 1979)—or TBCT, as we are calling it in this chapter—has consistently been shown to be an effective treatment for couple distress (Baucom & Hoffman, 1986; Gurman, Kniskern, & Pinsof, 1986; Jacobson, 1978, 1984). TBCT has focused almost exclusively on trying to help partners achieve any and all changes they request from each other in therapy. Although this approach has been very successful in general, improving the relationships of between half and two-thirds of couples presenting for therapy (Jacobson, Schmaling, & Holtzworth-Munroe, 1987), concern remained for those couples that were not improving. Research had shown that these couples were not simply treatment-resistant, but that they were generally less able to change the problems from which they suffered. On average, the members of these couples were more severely distressed, older, and more emotionally disengaged (Baucom & Hoffman, 1986; Hahlweg, Schindler, Revenstorf, & Brengelmann, 1984), as well as more polarized on basic issues (Jacobson, Follette, & Pagel, 1986). Partners with these characteristics were less capable of being as collaborative and compromising as TBCT required. Those things that TBCT tried to help these couples change were, for all intents and purposes, unchangeable. Because of this, TBCT was mostly ineffective with these couples. In order to help such couples improve their relationships, it became apparent that therapy would have to help them come to terms with those things about their relationships that were unlikely to change. In other words, these couples had to learn to accept some unchangeable aspects of their relationships. The pursuit of this goal led to the development of integrative behavioral couple therapy (IBCT; Christensen, Jacobson, & Babcock, 1995; Jacobson, 1992; Jacobson & Christensen, 1996; Cordova & Jacobson, 1993). IBCT aims to integrate the traditional emphasis on promoting change with a new emphasis on promoting emotional acceptance.

WHAT DO WE MEAN BY "ACCEPTANCE"?

What exactly do we mean by "acceptance"? Acceptance has recently received a great deal of attention from behavioral psychologists and behavior therapists (see Hayes, Jacobson, Follette, & Dougher, 1994). Although the concept is not new to psychotherapy, it has only recently been given serious attention by more behaviorally oriented theorists. Traditionally, behavioral therapies have focused exclusively on promot-

ing overt behavioral change. Recently, however, behavior therapists have begun to recognize the importance of promoting emotional acceptance when more overt change is unlikely. This shift in emphasis has occurred only recently, perhaps because behavior therapists have been extremely successful in treating a wide range of problems using specifically change-oriented techniques, and have spent a great deal of time refining these techniques and testing their efficacy empirically. This type of work takes time and dedication, and this may be why therapists have only recently begun to focus on the limits of their change-promoting technologies. However, such limits do exist. Not all situations are amenable to overt change. Many of the problems that people struggle with are simply immutable. Very often, the healthiest response in such cases is to accept that those circumstances will not change and give up the struggle to change them. Acceptance, however, can mean many different things, and we want to be as clear as possible about what we mean when we use the term.

As noted above, acceptance is often the healthiest response to situations that are unlikely to change; therefore, acceptance is promoted in the context of the unalterable. Given a situation that is essentially unalterable, a person can respond in two different ways. One way is to struggle relentlessly to change the situation. This is often a reasonable response, given that so many situations can actually be changed for the better. However, when a situation cannot be changed, struggling to change it is not only ineffective, but exhausting, distracting, and eventually depressing. Ineffective, relentless struggle is often the option that has been chosen by people who present for psychotherapy riddled with anxiety, guilt, hopelessness, and depression. Obviously, struggling to change something unchangeable is a waste of time and energy, and it is definitely not what we mean by acceptance. Another response to the unchangeable is simply to resign oneself to the hopelessness of the situation and resolve to suffer in bitter silence. This is also not what we mean by acceptance. Hopeless resignation is often the hallmark of clinical depression and the usual end result of desperately engaging an unwinnable struggle. The healthiest type of acceptance is one that comes to terms with the unchangeable situation in a way that allows the person to disengage from the unwinnable struggle, gain a broader perspective on the situation, and once again begin the pursuit of meaningful activities.

Aspects of Acceptance: Toward a Definition

Our definition of acceptance has several interdependent parts. The first involves giving up the struggle to change that which cannot be changed.

Often it is the struggle to change the unchangeable that causes the most pain and suffering. Giving up the struggle involves people's identifying how they are struggling and learning to respond differently. It is a coming to terms with those situations in which efforts are wasted or destructive. It is the process of stopping, and thus freeing the time and energy to reevaluate.

Take, for example, the case of Bill and Nancy. Nancy's previous marriage ended when she discovered her first husband's infidelity. As a result, within her current marriage to Bill, she is constantly worried that Bill might cheat on her. She calls him several times a day and becomes upset if she doesn't know where he has been. She shows a great deal of jealousy and is frequently hurt and angry. Bill in turn is miserable. He feels punished for the previous husband's infidelity, and he resents not being trusted despite the fact that he has done nothing to earn Nancy's suspicion.

This situation can be characterized as resulting from the struggle on Nancy's part to change something essentially unchangeable—the fact that being in a relationship means being vulnerable. The unchangeable situation in this example is that Nancy has been hurt badly in the past and is now made vulnerable to similar pain by loving and trusting her current husband. She struggles against her own vulnerability by expending a great deal of time and energy worrying about Bill and trying to keep track of his whereabouts. As a result of her struggle, she, Bill, and the relationship suffer. Giving up the struggle in this example requires both Nancy and Bill to see the pattern that they are stuck in from a neutral perspective and to regard it as something for which neither of them is directly to blame. From this nonblaming perspective, they are in a better position to understand what is happening in their relationship without necessarily reacting to it. Nancy may at times feel vulnerable and insecure, but she can have those feelings and share them without entering into a relationship-damaging pattern. This giving up of the struggle against vulnerability necessarily suggests another aspect of acceptance: sitting still with that which will not change.

Sitting still with that which will not change means finding a way to tolerate whatever the aversive situation is, without engaging in the same efforts to change it and without running away. It comes from developing a new perspective from which to reevaluate the situation. Once one has given up the struggle to change something, one necessarily has to learn what to do instead. This can be hard, given that despite its ineffectiveness, the person has often become quite used to struggling. Furthermore, these types of behaviors are usually negatively reinforced (meaning that reinforcement is derived by avoiding some aspect of the aversive situation). In our example, although Nancy's attempts to be

invulnerable cause both her and Bill a great deal of distress, Nancy is reinforced to continue them because of a derived relationship between her hypervigilance and his not having an affair. In other words, Nancy may believe that despite the destructive effects of her jealousy, at least it is working to keep Bill faithful. If she can give up her attempts to defeat her own vulnerability within the relationship, then she must learn how to live with that vulnerability. This is the process of learning to tolerate aversive emotions without hiding from them or denying them (see Cordova & Kohlenberg, 1994). IBCT has incorporated several very useful methods for learning to tolerate negative circumstances.

A third aspect of acceptance is the process of moving beyond sitting still with the unchangeable and toward embracing it. In other words, real acceptance moves beyond simply tolerating and toward discovering those aspects of the situation that can be appreciated. For example, existential theorists, when discussing accepting one's own mortality, point to the power death has to imbue each moment of one's life with significance. Similarly, within our example, as Nancy comes to terms with her inherent vulnerability within an intimate relationship, she can begin to appreciate that those feelings of vulnerability are simply one necessary aspect of her love for Bill. To the degree that she avoids contact with her vulnerability, she also avoids contact with her strong positive emotions and true intimacy. In learning to embrace her vulnerability, she makes it possible for herself to experience the positive aspects of her relationship more fully. IBCT frequently works with couples in this respect to help them identify the positive aspects of negative circumstances.

The final aspect of our definition of acceptance involves seeking active, healthy responses in the face of an unchangeable situation. This may be the most important aspect of acceptance in terms of its beneficial effects on depression. Giving up the struggle frees all of the time and energy previously devoted to escape and avoidance for the pursuit of more healthy behavior (see Hayes, 1987; Dougher, 1994; Dougher & Hackbert, 1994). Hayes (1987) gives the example of an agoraphobic woman's giving up the struggle not to be anxious and going out to shop despite her anxiety. In our example, as Nancy gives up her struggle with vulnerability and learns to sit still with and embrace it, she places herself in a better position to do healthy things both for herself and for her relationship. Although Nancy cannot change the fact that she is vulnerable in her relationship, there are things she can do despite the anxiety that vulnerability creates. For example, she and Bill can both talk about their feelings of vulnerability and the fear and love underlying these feelings, as a means of building greater intimacy between them. Promoting such expressions of "softer" emotions is an essential component of the acceptance work of IBCT.

In summary, acceptance is a complex process, and our definition attempts to account for that complexity by elucidating four essential components of acceptance. We therefore define acceptance as a process of (1) giving up the struggle to change the unchangeable, (2) sitting still with and (3) embracing both the negative and positive aspects of the situation, and (4) actively engaging in healthy behavior despite that which cannot be changed.

What Acceptance Is Not

Given the definition of acceptance above, we believe it is equally important to point out what acceptance is not. As we have noted earlier, acceptance is not hopeless resignation. Hopeless resignation is one of the hallmarks of depression, and our approach to acceptance assumes an active engagement in life despite those things that cannot be changed. Acceptance also does not mean tolerating the status quo. As we enter the 21st century, men and women are continuing to negotiate their shared roles in the family, moving often toward more egalitarian relationships. By promoting acceptance in intimate relationships as a means of treating and preventing depression, we are not advocating that men and women accept unhealthy power differences within their relationships. Some things can be changed; some things can be accepted. As the well-known "Serenity Prayer" indicates, wisdom lies in knowing the difference.

TECHNIQUES FOR PROMOTING ACCEPTANCE

The acceptance techniques of IBCT fall into four broad categories: (1) empathic joining around the problem, (2) unified detachment from the problem, (3) developing tolerance for negative behavior, and (4) developing skills in self-care. We give a brief description of each technique here, and will provide more detailed descriptions when we discuss their application in the treatment of depression. Note that although traditional change techniques such as behavior exchange, communication training, and problem-solving training remain an integral part of IBCT, we are focusing here exclusively on the implications of the acceptance techniques for the treatment of depression within a couple therapy context. A full description of all components of IBCT is provided in other sources (Christensen et al., 1995; Jacobson, 1992; Jacobson & Christensen, 1996; Cordova & Jacobson, 1993).

Empathic Joining around the Problem

Empathic joining around the problem is one of the primary means toward emotional acceptance. "Empathic joining" refers to an increased emo-

tional understanding between partners; it provides a means of lessening the probability that the partners will become polarized, by increasing their capacity to understand each other. A distressed couple often enters therapy hurt and angry, and therefore the partners blame each other for the relationship's problems. Blame and defensiveness are the hallmarks of polarization and indicate that the partners have taken opposite sides on some contentious issues in their relationship. The goal with such partners is to help them approach their difficult problems as opportunities to draw closer emotionally and work collaboratively. Toward this end, each partner is encouraged to clearly communicate the softer emotions underlying the usual expressions of "hard" emotions, which put one partner in the role of the accuser and the other in the role of the accused. Hard emotions include anger, resentment, contempt, and righteous indignation. The most likely responses to hard emotional expressions are defensiveness and counteraggression. More often than not, expressions of hard emotions lead to escalating hostilities rather than to satisfactory resolutions.

"Soft" emotions, on the other hand, include such feelings as sadness, loneliness, insecurity, fear, and love. The expression of these emotions reveals a person's vulnerability within the relationship and is more likely to elicit empathy from the partner than defensiveness and anger. IBCT therapists assert that all expressions of hard emotions have softer emotions underlying them. Furthermore, developing a fuller understanding of each other's softer emotions helps intimate partners feel close to each other despite their common problems. This is because each partner is able to empathize with the sadness or fear the other person is experiencing, rather than making contact solely with the other person's anger. Generally people respond to expressions of soft emotions by drawing closer and providing comfort, rather than by feeling blamed and fighting back. As the partners become more open with their softer feelings, particularly about unchangeable situations, they are better able to create further intimacy within their relationship rather than further destruction.

Unified Detachment from the Problem

In conjunction with empathic joining around the problem, emotional acceptance is fostered by developing what we call "unified detachment from the problem." The goal of unified detachment is to help the couple develop a perspective from which both partners can come together as a team around a common problem without blaming each other. Instead of regarding each other as opponents, the partners are shown how they might approach common problems as a couple. Toward this end,

the partners are taught to recognize the common patterns they fall into in response to their problems. More often than not, distressed couples repeat one or two interaction patterns across a majority of their conflicts. For example, one of the most common is the "demand–withdraw" pattern, in which one partner approaches the other demanding some change, and the other simply withdraws either by leaving or by refusing to talk about it. In therapy, the members of a couple identify and talk about the common problematic themes that characterize their relationship. The therapist, in turn, points out that these themes are neither partner's fault and can be regarded as events that they can work together to oppose (if something can be changed) or to support each other through (if something is unlikely to change). The underlying message is that often it is not necessarily the particular issue that is causing problems, but the way in which the couple interacts around that issue.

Developing Tolerance for Negative Behavior

Perhaps one of the most important aspects of promoting acceptance is learning to tolerate those things in the relationship that cause distress but are unlikely to change. IBCT has several ways of promoting emotional tolerance for negative behavior. The first is the highlighting of understandable reasons—that is, emphasizing the historical or other motivations for each partner's behavior. This helps each partner to see that the other's behavior is not motivated solely by maliciousness, but is a reasonable response, given who the person is and where he or she comes from. It is generally easier to tolerate irritating or distressing behavior that is understandable and reasonable rather than malicious or mysterious.

The second method highlights the positive features of negative behavior. Both partners are helped to appreciate that their unresolvable problems may also have positive features that contribute to the health of their relationship. For example, if one partner is a spendthrift and the other is a skinflint, this difference may cause a great deal of conflict and distress in the relationship. However, it may also be true that these differences complement each other. In other words, the skinflint may assure that they as a couple save money well and spend wisely, whereas the spendthrift may assure that they enjoy some of what they have more often.

The third method for promoting tolerance involves preparing a couple for easily foreseeable slip-ups. The therapist and couple work together to anticipate problems the couple may encounter in the future, and prepare to deal with them in advance. For example, the patterns that have been identified in the relationship may very well continue to occur

throughout the course of the relationship. Given that this can be predicted, the couple can prepare for those inevitabilities. In general, it is simply easier to tolerate those things that can be predicted.

Developing Self-Care Skills

"Self-care" refers to the process of encouraging each partner to take personal responsibility for himself or herself as well as for the health of the relationship. It is particularly important during destructive interactions for each partner to take personal responsibility for his or her own well-being. Encouraging both partners to take personal responsibility for their own needs and the needs of the relationship changes the usual response to dissatisfaction from blaming to active coping.

APPLYING ACCEPTANCE TO TREATING DEPRESSION IN COUPLE THERAPY

The goal of IBCT with a couple that includes a depressed partner is to create a context in which both partners begin engaging in more active and effective behaviors in their relationship. This is accomplished by helping the couple create a positive balance between change and acceptance. One of the primary strengths of IBCT is the flexibility it allows the therapist to tailor treatment to the unique needs of each couple. Flexibility is particularly important in the treatment of depression, because within the context of an intimate relationship the onset of depression may occur through two different pathways, each affecting therapy in a different way. For some people, depression may result from a long history of distress in their relationships. For others, depression may result from circumstances outside of their relationships and may have little to do with how satisfied the persons were with their relationships prior to becoming depressed. In either type of case, however, the onset of depression has implications for a couple's relationship. In the first type, depression may compound existing problems in the relationship. In the second type, depression may create problems that were previously nonexistent.

Often the members of a couple may experience problems in their relationship for a long time before one partner begins manifesting the symptoms of depression (Ilfeld, 1976). Usually in such cases, the depressed partner openly identifies the problems in the relationship as the cause of his or her depression. When this is the case, IBCT works directly on the causes of the couple's distress, and depression can be regarded as a side effect of that distress. In such cases it is assumed that the depression will lift when the distress is alleviated. This initial treatment formulation may be altered, however, if over the course of therapy it becomes obvious that relationship distress is not the sole variable controlling the depression.

When, on the other hand, one partner's depression precedes the couple's distress, IBCT adjusts its focus to work directly on the depression and its effect on the couple's relationship. In general, the structure of therapy will be geared more heavily toward acceptance. Depression, simply given its nature, is not amenable to isolated relationship change strategies. The research bears out this assumption, in that people who do not attribute their depression to problems in their relationships are not usually helped by TBCT (Beach & O'Leary, 1992; Jacobson et al., 1991).

DEPRESSION: THE ABSENCE OF EFFECTIVE BEHAVIOR

When a therapist is treating a couple with a depressed member, it is important for the therapist to assess the presence and severity of the depression, based on the standard conceptualization in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (American Psychiatric Association, 1994). However, once depression has been diagnosed, we advocate a conceptualization of depression that is much less focused on the symptoms and much more focused on the depressed person's lack of active engagement.

Although there are many ways of conceptualizing depression, our view is that depression is best understood in terms of what a person *is not* doing, rather than in terms of what he or she *is* doing (see Ferster, 1973). In other words, we believe the most striking fact about the behavior of depressed individuals is that there simply isn't that much of it. In particular, depressed people do not do very many things that result in positive consequences. In fact, depression can be described as a deterioration in the active pursuit of positive consequences. The treatment of a depressed person, then, should focus on what has led to this deterioration. In fact, when depression occurs in the context of an intimate relationship, what has led to this deterioration determines a great deal about the optimal structure and course of treatment.

Other definitions of depression tend to focus exclusively on the symptoms of depression. These symptoms include making self-denigrating comments, focusing on the negative aspects of life, excessive crying, complaining, compulsive talking, excessive sleeping, excessive worrying or ruminating, thoughts of suicide, an inability to experience pleasure,

and generalized feelings of sadness. Our view is that a more effective approach to treating depression focuses not so much on removing the symptoms of depression as on replacing them with more active and positively reinforceable behaviors.

In addition to the fact that depressed people engage in very little behavior that results in positive consequences, much of the behavior they do engage in serves primarily primitive escape and avoidance functions (see Ferster, 1973). In other words, a great deal of a depressed person's behavior is in the service of decreasing contact with the aversive aspects of his or her life. These attempts at escape and avoidance are considered "primitive" because many of them only occur in the absence of more effective means of dealing with aversive situations or obtaining positive consequences. In other words, many of the symptoms of depression only occur because the depressed individual does not have more active and effective behavior available. Thus, in answering the question "What is depression?", our view is that depression is often what is left in the absence of more effective behavior.

In terms of treating depression within a couple therapy context, we believe it is most effective to focus on what has led to the stripping of the depressed person's repertoire and what is maintaining the absence of active engagement. In other words, what is it about the interaction between the person and his or her environment that has made the person vulnerable to depression? Briefly, we define a person's "repertoire" as all of the behavior available to that person within a specific context. Ferster (1973) identifies three ways in which a behavioral repertoire can increase a person's vulnerability to depression by decreasing the amount of effective behavior available. According to Ferster, depressogenic repertoires are (1) a rigid repertoire, (2) a repertoire that ineffectively avoids aversive situations, and (3) a repertoire that does not include sufficient exploratory behaviors. In short, a behavioral repertoire that is limited in its breadth, flexibility, or effectiveness increases a person's susceptibility to depression. In addition, such limitations necessarily increase a relationship's susceptibility to distress. We go over each of these vulnerabilities in turn, provide clinical case examples, and discuss how IBCT addresses these vulnerabilities.

A Rigid Repertoire

A rigid repertoire is basically one that does not adapt well to a changing environment. In other words, when things change, the person with a rigid repertoire does not change and/or responds by engaging in ineffective behaviors such as complaining and sulking. Although a rigid repertoire may work well within the appropriate circumstances, any

change in those circumstances can drastically reduce the effectiveness of the available behavior. For example, consider a young man who has grown up in a small town, but suddenly moves to New York to attend a university. Much of what he has learned about how to get along in the world—including how to meet people, where to go to have fun, and even how to get around—is suddenly no longer effective. Such a dramatic decrease in this person's repertoire of effective behavior greatly increases the likelihood that he will become depressed, especially if he is unable to work actively to acquire new behavior. His repertoire can be thought of as relatively rigid, in that it works well within a circumscribed environment, but when that environment changes dramatically he simply cannot adapt.

A person with a rigid repertoire is necessarily more vulnerable to depression, because the nature of circumstances, particularly in relationships, is change. Over the course of any relationship, both partners are likely to change in both subtle and dramatic ways. What each partner does for a living may change (frequently more than once in today's economy). What each likes to do for entertainment may change. In addition, politics, physical health, psychological health, financial health, habits, tendencies, predilections, and priorities all are subject to various degrees of change over time. A person with a repertoire devoid of the behaviors necessary to adapt to these changes is extremely susceptible to relationship distress and depression.

The key to addressing this type of deficit is for the depressed person to begin to accept a certain lack of predictability in relationships, while at the same time learning specific skills for negotiating new ways of dealing with those changes that do occur. In general, the goal with a rigid repertoire is to foster flexibility. In other words, a person must increase the number of options he or she has for interacting with a changing environment. Within couple therapy, promoting emotional acceptance creates a more flexible emotional repertoire and sets the stage for more effective behavior in general.

For example, consider the case of Jack and Jill. When Jack and Jill initially presented for therapy, they were severely distressed and were beginning to consider separating. In addition, Jill was suffering several symptoms of depression that had been gradually worsening over the previous 6 months. Jack and Jill had met and married 6 years earlier in San Diego, following Jack's discharge from the Navy. They both described the first few years of their relationship in very positive terms. However, approximately a year and a half prior to their presenting for therapy, they had moved from San Diego to Seattle for Jack's job. Jill, who had been born and raised in San Diego, never seemed to adjust to the move. She complained of being alone most of the time, and she resented the

fact that Jack's schedule required him to work during the evenings. She felt abandoned by him and convinced that she wasn't an important part of his life. In response, she was often angry with him and felt irritable and depressed. She longed for San Diego and was beginning to consider leaving Jack and moving back home.

Jack, in turn, complained about their constant arguing. He felt he was constantly "walking on eggshells"around Jill, for fear of starting an argument or hurting her feelings. He complained that they spent little time together because they had few common interests, and recently because she was asleep or withdrawn most of the time he was home. He felt helpless in the face of her dissatisfaction and depression, was angry at her for "falling apart," and was beginning to think he might be better off without her.

Jill's slip into depression can be understood as resulting from what we are calling a rigid repertoire. She had been born and raised in the same house and the same neighborhood in San Diego. All of her friends were people she had either grown up with or gone to school with. The things she did for fun revolved primarily around the proximity of a warm ocean coast and an active night life. When she and Jack moved to Seattle, her repertoire of effective behaviors was devastated. She left her friends and family in San Diego, and since it seemed she had always simply had friends, she had never really learned how to go about making new friends. The work she had done had been within her father's business; thus, in addition, she had never had to actively pursue work. Jack's job required him to work a shift starting in the early afternoon and ending in the late evening. He had recently become involved in backpacking and had always been an avid skier, neither of which Jill particularly enjoyed. Thus Jill rather suddenly found herself without friends, without a job, and with a husband who spent most of his time at work and in the mountains. This drastic environmental change was exacerbated by the fact that Jill simply did not have within her repertoire the skills necessary to adapt to the change.

Although Jill's depression was not the sole focus of therapy, couple therapy was able to address it as a problem around which Jack and Jill could come together as a couple. Specifically, couple therapy addressed how they could come to terms with and begin to address the rigidity of Jill's repertoire. As a first step toward this goal, work was done in therapy to increase Jack and Jill's empathy for each other by helping them express their softer feelings. As noted above, they were both frustrated and quite angry with each other when first presenting for therapy. As a result, their in-session discussions were blaming, defensive, and righteously indignant. Work in therapy focused on helping each of them understand that indeed softer emotions were underlying their anger,

blame, and defensiveness. Jack was able to talk to Jill about feeling guilty that he had dragged her away from her home and feeling responsible for her suffering. Because he felt guilty, he reacted defensively whenever she complained about Seattle or said how much she missed San Diego. He was also able to talk about how helpless he felt to make things better for her, and how these feelings of helplessness made him frustrated, angry, and eventually withdrawn. They were also able to appreciate that these feelings of frustration and anger were ultimately rooted in how much he loved and cared about Jill. After all, if he didn't love her, why would he care that she suffered?

Jill, on the other hand, was able to talk about how frightened she was of her own depression and how helpless she felt to "snap out of it." She expressed feelings of guilt about her depression, about not having been able to get a job, and about the state of their relationship. She talked about how much she missed spending time with Jack, and she became able to see that her feelings of resentment and irritation were rooted in her desire to be closer to him. Most importantly, both Jack and Jill were able to express their compassion and caring toward one another.

In general, when the partners are talking about the depression, it is helpful for each partner to talk about the softer feelings elicited by the depression. It is important in terms of fostering acceptance for each person to understand clearly that a bout with depression is going to be hard on both individuals within the relationship, as well as on the relationship itself. Couple therapy works with the couple to bring to light the soft emotions underlying any anger and resentment, as well as any unspoken soft emotions elicited by the depression. Over the course of therapy, the partners work with the therapist to communicate and begin to deal with their feelings about the depression, including the loneliness, sadness, apprehension, hopelessness, and frustration that each of them may feel. The therapist also helps underscore the positive feelings often left unspoken, such as love, tenderness, compassion, empathy, caring, respect, and desire. As the partners begin to contact each other's softer emotions, they usually begin feeling closer to each other and more willing to join together in dealing with occurrences of depression.

In Jack and Jill's case, promoting greater empathy defused the anger and hurtfulness that they both brought into therapy; it also began to increase the flexibility of Jill's emotional repertoire. Given some emotional softening on their part, the therapist could begin to help them build their tolerance toward their recent history and toward the rigidity of Jill's repertoire. Because tolerance has its roots in understanding, it was fostered by highlighting the understandable reasons for both Jack

and Jill's recent behavior, as well as for Jill's difficulty in adapting to the move. It became obvious that Jill had simply been ill prepared by her experiences in San Diego to do the things that would have been necessary for her to adapt well to any move (e.g., actively pursuing work, friendships, and other positive experiences). By discussing these issues, Jack and Jill were able to appreciate that there were indeed understandable reasons both for their current predicament and for Jill's difficulty in adapting. The goal was to help Jack and Jill begin to remove some of the blame from each other and place it instead on the understandable circumstances. Understanding the roots of a person's rigid repertoire can in and of itself be therapeutic, because it prepares the couple for how to deal with its repercussions in the future.

In this particular example, as Jack and Jill became more collaborative with each other, they were able to begin to work together toward changing some of the problematic aspects of their relationship. The specific goal in regard to Jill's rigid repertoire became to broaden her repertoire slowly to include those things that would make her more effective in her current environment. Once Jack and Jill were able to observe and talk about Jill's difficulty in adapting, they were able to derive and implement several possible solutions. Jill began to try new activities and explore new interests. She also began to look into classes to brush up on her job-hunting skills and to make herself more marketable. In addition, Jack began to cooperate with Jill on increasing their socializing as a couple, so that they both could form larger social networks.

Finally, as a couple, they prepared for the fact that Jill might continue at times to have difficulty in adapting to new or changing situations. Time was spent predicting the changes they could anticipate and thinking about how they might work together to adapt more smoothly to changes in the future. This is called "preparing for slip-ups" and builds tolerance toward relationship difficulties that are likely to recur (such as difficulty in adapting to changing circumstances). As partners learn to tolerate future occurrences of common problems, those problems become less able to create severe distress. Furthermore, by definition, preparing for slip-ups helps creates a repertoire for responding flexibly to future problems, thus decreasing a person's vulnerability to depression.

An Ineffectively Avoidant Repertoire

A repertoire that ineffectively avoids or deals with aversive situations also increases a person's vulnerability to depression. It is simply the case that some means of dealing with unpleasant circumstances are more effective than others. Some people's capacity to deal with aversive situations is seriously limited. For example, a person growing up with a violent or alcoholic parent can learn that there is virtually nothing he or she can do to escape or deal with the family's problems. Studies on learned helplessness have shown that when aversive situations cannot be avoided, the most likely response is simply to stop trying (Miller & Seligman, 1975). In addition, a person's capacity to learn better ways of coping is limited by the distraction of unrelenting emotional agitation. Within the context of an intimate relationship, a person with a limited repertoire for dealing with aversive situations may simply resign himself or herself to problems that could be easily ameliorated, or, alternatively, may continue utilizing ineffective strategies in an unwinnable struggle. Under such circumstances, a person may learn to reduce contact with problems in the relationship through emotional withdrawal or through withdrawal into other areas of life such as work. These strategies may work to reduce contact with aversive situations, but are certainly not optimally effective. On the other hand, a person may perpetuate problems within the relationship by persistently engaging in those ineffective strategies that are available. With no repertoire for healthy acceptance, an entire category of effective strategies for managing conflict is simply unavailable. The ultimate result is that problems within the relationship are either perpetuated or left unresolved, and the person's chances of becoming depressed as a result are greatly increased.

Couple therapy addresses an ineffectively avoidant repertoire by helping the couple learn how to deal actively and effectively with all types of aversive situations, whether these are amenable to negotiated change or not. Take, for example, the case of Chuck and Diane. Chuck and Diane had developed a particularly destructive pattern of interaction around making day-to-day purchases. Chuck complained that Diane rarely consulted him and often spent too much money on things they simply didn't need. He complained that her spending was out of control and that she threw money away without thinking. He was especially angry that she didn't seem to take his concerns about their money seriously. This particular issue was a source of almost daily conflict between the two of them.

In turn, Diane complained that Chuck was completely obsessed with money, that he was tight-fisted, and that if it were up to him she would never spend money on anything. She said that she didn't consult him about purchases, because if she did he always said "no." She felt there was no point in talking with him about purchases, because it always led to an argument. She also complained that he had a double standard, because he bought the things he wanted and she never complained.

Chuck and Diane described an incident that exemplified their arguments in regard to this issue. Diane owned a tropical fish tank that

both she and Chuck enjoyed. Stopping at the pet store on the way home for fish food, she decided to buy a new fish for the tank. She reported in the session that she knew buying the fish was going to cause an argument, and that knowing this made her both anxious and angry. She said, "I can't believe I have to go through this for every little thing I want to buy. He has no right to tell me what I can and cannot buy, and I shouldn't have to beg him to buy a little $8 fish." She decided to buy the fish despite fully anticipating the blow-up that would result. When she arrived home, she showed the fish to Chuck, and he immediately became extremely angry. Chuck reported saying, "I'm sick and tired of you doing this. We can't afford to be throwing money away on all these animals. I should just kill them all and be done with it." Chuck was embarrassed to report that he had said this, and added that it was exactly like something his father would have said. Diane, in response, yelled that he wasn't going to lay a hand on her animals, and then began to call him every name she could think of. He responded by saying "Forget it" and withdrawing to the living room. Diane in turn withdrew to the bedroom and slammed the door. They spent the rest of the evening apart, and hard feelings continued through the next day.

When this incident was reviewed in therapy, it became apparent that it was a perfect example of a common theme. Since Diane felt sure Chuck would say "no" to anything she wanted to buy, she simply bought what she wanted anyway. She knew that this led to painful arguments, but she was willing to pay that price in exchange for the freedom to exercise her own best judgment about purchases. In turn, Chuck felt that he had so little control over Diane's spending that he had to take advantage of any chance to stop her from buying something. Therefore, any time she asked first before buying, he felt compelled to say "no." Chuck felt helpless, anxious about their money, and resentful that she seemed not to care. Diane felt stuck because she believed the only way she could ever get what she wanted was to tolerate these destructive arguments as a necessary evil.

This is a good example of what we mean by an ineffectively avoidant repertoire, because it illustrates the ultimate result of poorly managing aversive situations. Diane and Chuck remained in almost constant contact with the aversiveness of these destructive arguments because they had only one ineffective way of resolving their dilemma. Continual exposure to anger, resentment, and bitterness contributed greatly to Diane's feelings of depression. In addition, Chuck and Diane were actively avoiding each other, and therefore had completely eliminated any opportunities they might have had to learn better ways of solving this problem.

Couple therapy initially focused on fostering greater empathy between Chuck and Diane, because their interactions around this issue had become almost exclusively hostile. This work consisted of acknowledging the pain each partner was in as a result of their constant conflict, as well as the love and caring that still remained within the relationship. The therapist also explained that Chuck and Diane were stuck in a mutual trap. This trap was created by each of their understandable attempts to resolve the problem. The fact that Chuck felt the only way he could exert any control over Diane's spending was always to say "no" only made it more likely that she would not consult him in the future. This in turn made it more likely that he would continue to feel pressured to say "no" and struggle against her financial equality.

By discussing their mutual trap, partners become able to gain some perspective on their common problem. This is essentially the primary goal of unified detachment from the problem. Discussing Chuck and Diane's mutual trap as a common problem from which they both suffered and for which neither of them was specifically to blame created a context within which they could join together to commiserate about it, instead of simply blaming each other and feeling victimized. It furthermore provided for them an avenue through which they could talk about this problematic pattern without engaging in it. Finally, discussion of their mutual trap allowed the therapist to highlight for the couple that both partners had perfectly understandable reasons for the roles they played in this destructive pattern.

Often each member of a couple presenting for therapy is convinced that the other person is acting maliciously and is deliberately trying to hurt or anger him or her. Uncovering nonhostile reasons for the other's actions helps create a context for greater intimacy by decreasing blaming and counteraggression. Often the reasons for a partner's actions derive from his or her personal history. For example, Chuck's relentless concern about money resulted from his having been raised in a family that was constantly struggling to make ends meet and in which being financially conservative had been a matter of survival. Reasons other than historical ones may also exist. For example, Diane's failure to consult Chuck resulted from her feeling that this was the only way she could maintain any independence or power within the relationship. The main point of uncovering the understandable reasons for each person's behavior is to provide for each partner a more complete understanding of the other, thus fostering empathy.

In addition, the positive features of this difference between Chuck and Diane were highlighted, to counterbalance their exclusive focus on the more obvious negative features. Distressed partners often focus exclusively on the negative aspects of their relationship. However, fundamental differences within the relationship may have both negative

and positive connotations. When the positive connotations are highlighted, the couple gains a more complete picture of the relationship. For example, despite the fact that Chuck and Diane argued a great deal about her being a "spendthrift" and his being a "skinflint," these differences also provided a nice balance for them as a couple. Chuck's focus on saving money assured that both he and Diane would have the money they needed for emergencies, retirements, and large investments. In turn, Diane's willingness to spend money assured that both she and Chuck would be able to enjoy some of their money on a day-to-day basis. Highlighting the positive features of a couple's situation helps create tolerance by balancing out the negative aspects of that situation. As Chuck and Diane began to appreciate that their differences were neither maliciously motivated nor wholly negative, they became better able to tolerate the tensions these differences created.

Note that three of the four IBCT acceptance techniques were used to foster emotional acceptance around this issue. Efforts were made to promote empathic joining around the problem, unified detachment from the problem, and tolerance for the part each partner played in the problem (highlighting of understandable reasons, as well as appreciation of the problem's positive features). This emphasizes the fact that couple therapy interventions are not wholly independent components administered one at a time, but are instead used in different combinations, depending on the unique nature of the couple's problems.

Fostering emotional acceptance between Chuck and Diane in regard to their financial issues allowed them to see clearly how ineffectively they were dealing with this source of aversiveness within their relationship. It also allowed them to see that they were both suffering and that this mutual suffering contributed to Diane's depressive symptoms. Increased emotional acceptance allowed them to give up the unwinnable struggle to change each other, and thus freed up that time and energy for exploring other more effective ways of addressing their concerns. Emotional acceptance, in other words, created a context in which Chuck and Diane were able to collaborate on resolving this problem together. The therapist did not ask them to change the pattern they had developed. However, once they were able to identify and talk about this problematic pattern, they suggested their own strategy for changing it. In consultation with their therapist, they began regularly reviewing their finances as a couple, so that responsibilities could be shared and handling finances could remain independent of individual blame. Over the course of therapy, they reported that these meetings were going well and that each had a fuller understanding of the other's concerns.

A Limited Exploratory Repertoire

Still another type of repertoire that increases a person's vulnerability to depression is one that inhibits the normal exploration of the environment. Limited exploration necessarily stunts the growth of a person's repertoire, and a small repertoire is less effective, less adaptive, and less capable of dealing with aversive situations. Ferster (1973) points out that a nonexploratory repertoire may result from a history in which a child's primary caretaker is frequently unresponsive. If the child's early actions have little or no effect on the primary caretaker, then the child does not learn what to do or what to pay attention to in order to get his or her needs met. This stunted perceptual capacity limits the effectiveness of the environment to stimulate exploratory behavior. The less exploration there is, the less a person learns about how to behave effectively, and the greater his or her vulnerability to depression.

A limited exploratory repertoire may also influence intimate relationships, in that couples, like individuals, may be less susceptible to distress and depression if they continue to explore their environment for new shared activities and experiences. Unfortunately, if they cannot free themselves from their unwinnable struggles, then little time, energy, and motivation will be left for actively broadening their capacity for positive experiences. Consider again the case of Jack and Jill. As noted earlier, they argued frequently and had taken to spending less and less time with each other. In addition, the two of them enjoyed different things and had few common interests. Jack enjoyed outdoor activities like backpacking, skiing, and kayaking. Jill, on the other hand, enjoyed more urban activities such as nightclubs, plays, and dinner out. Jack was willing to engage in his interests on his own, but Jill was reluctant to go out without Jack. This situation contributed to Jill's depression by further limiting her opportunities to engage in positive activities. Her depression was also compounded by their mutual withdrawal, in that pleasant interactions between the two of them were becoming increasingly rare. It could be said that both Jill as an individual and Jack and Jill as a couple had limited exploratory repertoires, and that these limitations contributed both to Jill's depression and to the couple's distress. Jill as an individual was not actively exploring her environment for new enjoyable activities she might engage in. This was true in terms not only of things she might do socially, but of things she might do vocationally. Her repertoire was limited to things that were either currently impossible or unlikely. Therefore, as noted earlier, this necessarily smaller repertoire increased her susceptibility to depressive symptoms.

As a couple, Jack and Jill were no longer exploring their environ-

ment for new activities they could pursue together. Their mutual withdrawal and different interests had devastated their repertoire for shared activities. The fact that their repertoire of shared activities was small and by no means growing any larger was a major contributor to their distress as a couple. In general, they shared few pleasant activities, and their interactions consisted mostly of "walking on eggshells" and arguing.

Couple therapy approached the issue of Jack and Jill's mutual withdrawal by simply illuminating it as a recognizable pattern within their relationship. Each time they discussed an incident that resulted in their mutual withdrawal, it was discussed as an example of a common pattern. These patterns or themes were discussed in a nonblaming way; the therapist emphasized only that they should come to recognize the theme, and not that they necessarily had to change it. The theme was discussed as something that they could understand as a couple and commiserate about. Jack and Jill were thus able to gain some perspective on their pattern of mutual withdrawal and to recognize some of the negative side effects it was having on their relationship.

Couple therapy also highlighted for Jack and Jill that their different interests had positive as well as negative implications for their relationship. The negative implications were that having different interests resulted in their spending even less "quality time" together. Jack engaged in his outdoor activities alone, and Jill and he rarely if ever did the things she enjoyed. The untapped positive feature of this difference was that it provided more options from which they could choose in searching for things the two of them could do together. It had yet to be fully determined which of Jack's outdoor activities Jill might also enjoy. Jill had for the most part simply assumed that she would not like any of Jack's outdoor interests. In addition, they had not thoroughly explored Jill's interests for things they might enjoy together. Jack had also assumed that he would not like activities he had not yet even tried.

Along these same lines, couple therapy worked to help Jill understand the importance of pursuing her own self-care regarding the size of her effective repertoire. It also helped Jack to realize the importance of more active exploration of the environment, both for Jill as an individual and for the two of them as a couple. For Jill, taking responsibility for her own self-care entailed actively seeking out new sources of positive experience, as well as finding ways to resume engaging in those activities she enjoyed but was currently ignoring. Jack was encouraged to support her in this and to do what he could to facilitate her efforts to broaden her repertoire.

Promoting active self-care—the fourth IBCT acceptance technique—is often an important part of couple therapy, because it makes clear how important it is that each individual within the relationship take personal responsibility for his or her own welfare as well as for the welfare of the relationship. Emphasizing self-care helps to shift the burden for each individual's emotional well-being from his or her partner directly to the individual. This promotes within each partner a more active approach toward his or her own happiness; thus, it works to increase active exploration of the environment and to decrease the likelihood of unproductive cross-blaming.

Our view of acceptance as promoting healthy behavior despite negative circumstances fits well with viewing depression as resulting from a scarcity of effective behavior. Because of this, we believe that IBCT, with its emphasis on fostering emotional acceptance, may very well be a great deal more effective in terms of treating depression within a couple therapy context than previous behavioral couple therapies have been. IBCT creates a context in which partners can deal effectively with the problems within their relationship that may be unchangeable. Oftentimes working toward emotional acceptance is the most effective response a couple can make to circumstances that are unlikely to change. Because a broad repertoire of effective behavior may very well be the best defense against the recurrence of depression, fostering a capacity for emotional acceptance may contribute greatly to treating depression within a couple context. Chuck and Diane, for example, will probably continue to have different attitudes toward money. Struggling to try to change this difference will be not only ineffective, but ultimately quite destructive. For Chuck and Diane, the most effective response to this difference will be to learn how to tolerate it and appreciate it as an aspect of their relationship with both positive and negative features. The theory underlying IBCT posits that effective behavior is the key to ameliorating both a couple's distress and an individual's depression, and that a truly effective repertoire is capable of both change and acceptance.

IMPLICATIONS AND CONCLUSIONS

What are the implications of this approach for maintaining relationship satisfaction when one partner is depressed? The primary implication is that satisfaction depends heavily on a healthy balance of acceptance and change. In order to arrive at this balance a couple must learn how to distinguish problems that can be resolved through negotiated change from those that are unchangeable. Although this distinction may differ from couple to couple, there are some general guidelines that can be followed.

First, efforts at change should be limited to the types of problems

that are amenable to negotiation and compromise. In a very real sense, these are the only situations that can, in any sense, be changed. Partners can easily rip an otherwise meaningful relationship to shreds through ill-fated attempts to force a type of change that cannot be negotiated. For example, the partners cannot negotiate away emotional vulnerability, or differences between them in desires or beliefs. However, they can negotiate about what each partner does in the relationship and what they do together as a couple. For example, they can negotiate shared responsibilities for finances, household chores, and child care.

Those aspects of a relationship that are unlikely to change tend to fall into three broad categories. The first includes all those things that happen inside a person and cannot be consciously controlled, such as thoughts, feelings, predispositions, beliefs, perspectives, and natural tendencies. The second includes those things that could theoretically be changed, but only at the expense of diminishing one partner or the other. These include aspirations, independence, habits, hobbies, pastimes, and friendships. The third includes those existential truths about relating and intimacy that are often avoided or ignored. An example of such an existential truth is that intimate relationships are inherently dangerous. True intimacy necessarily involves the risk of loss, hurt, rejection, and disappointment. Intimate relationships are at times unavoidably painful. The closer two people are, the easier it is for them to hurt each other even unintentionally. As partners come to accept that they will sometimes hurt each other and that they are capable of recovering from such times, they in turn will become able to stay more open and less guarded within the relationship. Thus they will remain more open to genuine intimacy, despite the occasional hurt.

Another example of a truth in the third category is that relationships are inevitably imperfect, unknowable, impermanent, and complex. Striving for acceptance in intimate relationships helps couples deal with their inevitable imperfections. It helps partners realize that they *will* miscommunicate and misunderstand each other on occasion, and that they cannot always know each other's thoughts and feelings. Satisfaction is also fostered through coming to terms with the existential fact that even the best relationships end, through either divorce or death. Openly embracing intimacy's impermanence can deepen the partners' appreciation of each other immeasurably. Finally, maintaining a satisfying relationship with another human being is a complex and complicated enterprise. This, together with the other existential unchangeables, is the unavoidable price of admission to a genuinely satisfying and meaningful relationship.

A healthy balance of change and acceptance is particularly important when one member of a couple is depressed. In such cases, "change"

may refer to those things each partner can do to cope actively with the depression. For example, there may be specific things the depressed spouse can do to care actively for himself or herself when depressed, including seeking help early. In turn, the nondepressed spouse may need to foster a social support network to help him or her cope with the stress of nurturing a depressed spouse.

In terms of working toward healthy acceptance, it seems essential that the members of the couple learn to join together around the fact that one partner's depression is inevitably difficult for both. Actively preparing in advance for such times may reduce the stress on the relationship considerably. Although an episode of depression is difficult for both partners, relationship satisfaction can be maintained despite the depression. Maintaining satisfaction during such times may depend on nurturing compassion for each other through fully understanding the effects of depression, both on each person and on the relationship. Working together as a couple to cope with the depression fosters intimacy and removes blame. Finally, it is essential that the partners prepare in advance for future episodes of depression by discussing how they will cope with it as a couple.

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