Couple Intimacy and Relationship Satisfaction:
A Comparison Study between Clinical and Community Couples

Dissertation

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Abstract

Research has consistently demonstrated that partners tend to report high levels of relationship satisfaction when they feel intimate with each other. Conversely, a lack of intimacy is often associated with relationship distress, and is one of the common reasons couples seek therapy. However, little is known about distressed couples’ intimacy experiences, especially as compared with their satisfied counterparts. Couple therapists may not know which aspect of intimacy (e.g., emotional or sexual) distressed couples may be lacking, particularly when limited information is given. Using Bowen’s (1978) concept of differentiation as a framework, the current study aimed to explore how distressed treatment-seeking couples’ (clinical couples’) emotional/sexual intimacy experiences differ from those of satisfied non-treatment-seeking couples (community couples), and whether emotional/sexual intimacy is associated with relationship satisfaction similarly or differently among these couples. A total of 92 couples participated in this study: 46 clinical couples and 46 community couples. MANOVA and independent t-tests were conducted to examine the differences in the levels of differentiation, emotional and sexual intimacy, and relationship satisfaction among these couples in the clinical and community groups. The between-group similarities and differences in the associations between differentiation, emotional/sexual intimacy, and
relationship satisfaction were tested using structural equation modeling and group invariance comparison strategies. The results demonstrated that distressed treatment-seeking couples’ levels of differentiation, emotional and sexual intimacy, and relationship satisfaction were significantly lower than those of satisfied, non-treatment-seeking couples. However, the associations between these constructs were mostly similar among the clinical and community groups. The level of differentiation of a relationship was found to be positively associated with partners’ emotional and sexual intimacy experiences, except for female sexual intimacy, in both groups. The associations between emotional/sexual intimacy and relationship satisfaction varied by gender and group (clinical or community), thus yielding interesting yet unexpected findings. For example, while the association between differentiation and male sexual intimacy was significant in both groups, the magnitude of the path was greater for clinical male partners than for those in the community group. Also, the association between male sexual intimacy and male relationship satisfaction was significant only among the clinical couples, not among the community couples. Overall, the findings of this study indicate that differentiation of a relationship plays an important part in partners’ intimacy experiences as well as in their relationship satisfaction, suggesting “how to intervene” with distressed couples’ intimacy concerns. By helping increase distressed couples’ levels of differentiation, therapists may be able to enhance those couples’ intimacy and relationship satisfaction, possibly to the levels experienced by satisfied, better-differentiated couples who are not seeking therapy.
Dedicated to my family
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As I am finishing up four years of intense education and training in the Couple and Family Therapy program at the OSU, part of me is filled with joy and happiness for what “I” have done. However, what surpasses this joy and happiness is my gratitude for those who have made this accomplishment possible. Looking back, I realize that my memories of graduate school are full of warm and grateful moments that far outnumber the moments of self-doubt and struggle. Though some might question my sanity, I have honestly enjoyed being a graduate student a lot, and the past four years have been one of the happiest periods in my life. I would like to take this opportunity to thank all of those who have made my graduate school years meaningful and enjoyable.

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Chapter 1: Introduction

The term intimacy is broadly defined as individuals’ subjective experiences of closeness and connectedness with their romantic partners, which emerge from couple relationship processes that involve self-disclosure, mutual trust and validation, empathy, and acceptance (e.g., Moss & Schwebel, 1993; Prager, 1995; Schaefer & Olson, 1981; Sternberg, 1986, 1987; Waring, 1984, 1988; Wynne & Wynne, 1986). Research evidence abounds demonstrating that couple intimacy is a significant contributing factor in positive relationship outcomes. Partners who report high levels of intimacy tend to be highly satisfied and maintain long-term, stable relationships (e.g., Goodman, 1999; Greeff & Malherbe, 2001; Patrick, Sells, Giordano, & Tollerud, 2007). Conversely, lack of intimacy is one of the reasons for low levels of relationship satisfaction and relationship dissolution (e.g., Kingsbury & Minda, 1988; Waring, 1988).

Intimacy is an important issue in couple therapy as well. Treatment-seeking couples often complain about a lack of intimate feelings as their issue (e.g., Crowe, 1997; Doss, Simpson, & Christensen, 2004; Lundblad & Hansson, 2005), which therapists identify as one of the risk factors that can seriously damage romantic relationships (e.g., Geiss & O’Leary, 1981; Whisman, Dixon, & Johnson, 1997). Even if unidentified, couples’ intimacy concerns can contribute to other relational issues, such as jealousy and
a lack of a sense of security (e.g., Crowe, 1997). However, little is known about distressed treatment-seeking couples’ intimacy experiences, especially as compared with their satisfied non-treatment-seeking counterparts. Although it may be reasonably assumed that distressed couples struggle more with low levels of intimacy than satisfied couples, few empirical studies exist to support this assumption. If distressed couples suffer more from a lack of intimacy than satisfied couples, therapists would need to know specifics about distressed couples’ intimacy issues in order to employ effective interventions in a timely manner.

The objectives of the current study were to fill the research gaps by comparing two groups, distressed couples seeking therapy (clinical couples) and satisfied non-treatment-seeking couples (community couples), in terms of their intimacy and relationship satisfaction. Bowen’s Family Systems Theory, particularly his key concept of *differentiation of self*, was used as a framework to conceptualize the project. Intimacy in this study was defined as having multiple facets, and it was assessed in two of those facets – emotional and sexual – in order to investigate more specific details of intimacy issues. By doing so, the main goal of this study was to demonstrate how clinical and community couples are similar or different when it comes to their relationship processes concerning emotional and sexual intimacy.

**Intimacy based on Togetherness and Individuality**

According to Murray Bowen’s Family Systems Theory (Bowen, 1978; Kerr & Bowen, 1988), the most desirable family relationship processes occur when family
members are connected with one another while still maintaining their sense of self. Bowen coined the term differentiation of self to describe one’s capacity to distinguish thoughts and feelings, and to preserve his or her sense of self (individuality) while being connected to important others (togetherness), such as romantic partners (Bowen, 1978; Kerr & Bowen, 1988). Even under stressful interpersonal situations, well-differentiated partners are better able to calm themselves and make rational decisions about their relationship. Conversely, poorly differentiated partners are more likely to demonstrate emotional reactivity; being overwhelmed by their emotions under stress, partners are more likely to simply react rather than to respond to each other. Their emotional reactivity may be expressed through withdrawal, counterattack, and defensiveness of self (Bowen, 1978; Kerr & Bowen, 1988). According to Bowen, well-differentiated partners are therefore more likely to maintain both togetherness and individuality in their interactions when dealing with relational stress than those with lower levels of differentiation.

Theoretically, individuals are likely to choose their mates at similar levels of differentiation, and a romantic relationship thus may present a certain level of differentiation based on both partners’ levels of differentiation (Bowen, 1978). When both partners are poorly differentiated, their relationship tends toward fusion and emotional cutoff (Bowen, 1978; Kerr & Bowen, 1988). Partners in a fused relationship may perceive their relationship in terms of their sense of “we-ness” only, while those in an emotionally cut-off relationship may not allow interpersonal connectedness at all (Karpel, 1976). Therefore, neither fusion nor emotional cutoff is a representation of a
balanced sense of togetherness and individuality. Fusion may be an extreme manifestation of togetherness at the expense of individuality, and emotional cutoff may only allow individuality at the expense of togetherness.

Partners’ levels of differentiation of self may also determine the extent to which they develop and maintain intimacy in relationships (Patrick et al., 2007; Schnarch, 1991, 1997). It can be assumed from Bowen’s theory that partners in well-differentiated relationships are expected to develop and maintain intimacy in “healthy” ways more so than those in less differentiated relationships. They may express their own intimacy needs as well as being open to their partners’ needs, may agree to disagree on intimacy-related concerns without having excessive fear of rejection, and may tolerate relational stress together without undermining intimacy. Consistent with these theoretical assumptions, existing empirical studies also support the idea that intimacy is established upon partners’ sense of togetherness and individuality, which are likely to coexist in highly differentiated relationships. Many studies describe intimacy as a relational construct that requires partners’ self-disclosure, mutual validation, love, and care (e.g., Laurenceau, Feldman Barrett, & Rovine, 2005; Mitchell et al., 2008). Also, partners’ sense of self and individuality are considered prerequisites for a desirable intimate union (e.g., Beyers & Seiffge-Krenke, 2010; Lester & Lester, 1998; Malone & Malone, 1987; Schnarch, 1991, 1997).

In sum, Bowen’s differentiation of self seems to be a plausible concept that explains partners’ ability to form and maintain intimacy. However, most empirical research on this topic tends to emphasize either togetherness or individuality; studies that
conceptualize couple intimacy based on both togetherness and individuality are relatively rare. Further, Bowen’s Family Systems Theory has not been well used in the intimacy literature. This is somewhat surprising, especially considering the relevance of and the importance of the theory to the field of couple and family therapy.

**Differentiation, Intimacy, and Relationship Satisfaction**

Both theory and empirical studies support the idea that highly differentiated relationships tend to be satisfying (Bowen, 1978; Kerr & Bowen, 1988; Lim & Jennings, 1996; Peleg, 2008; Skowron & Friedlander, 1998). This may not mean that well-differentiated relationships are conflict-free. Rather, partners in such relationships are probably better able to manage conflict and stressful interpersonal situations, and their high levels of relationship satisfaction may be attributed to their ability to recover from conflict. For example, partners in a relationship with any level of differentiation may be inclined to avoid their relationship when they are experiencing serious conflict or disagreement with their partners. It is also understandable that partners may sometimes ignore their own opinions and needs because they are afraid of making their partners upset, or because they fear rejection. While such responses to stressful situations may be natural, partners in a highly differentiated relationship would be less likely to react in these ways. Compared with those in a poorly differentiated relationship, these well-differentiated partners would still be able to choose to stay connected with their partners even in times of conflict (togetherness) without sacrificing their sense of self (individuality) (Bowen, 1978; Kerr & Bowen, 1988).
Since most treatment-seeking couples tend to seek therapy when in relationship
distress (e.g., Veroff, Kulka, & Douvan, 1981), it could be assumed that their distress is
related to their levels of differentiation. Revisiting the association between differentiation
and intimacy (e.g., Schnarch, 1991), and the association between intimacy and
relationship satisfaction (e.g., Greeff & Malherbe, 2001), it may also be that treatment-
seeking couples’ relationship distress is influenced by their frequently reported intimacy
concerns, which manifest with their lower levels of differentiation. If these assumptions
are true, therapists may be able to help enhance distressed couples’ relationship
satisfaction, as well as intimacy, by increasing partners’ levels of differentiation.

**Intimacy in Couple Therapy**

Therapists tend to identify couples’ intimacy-related concerns as challenging
problems to treat (e.g., Geiss & O’Leary, 1981; Whisman, Dixon, & Johnson, 1997). This
may be partly because they lack a clear understanding of treatment-seeking couples’
intimacy issues, specifically how intimacy relates to relationship satisfaction or distress.
Relationship researchers tend to agree that it is difficult to define and assess intimacy
(e.g., Patrick et al., 2007), and this observation may be supported by therapists’
experiences in therapy sessions as well. Distressed couples in therapy might simply
report that they do not “feel close or connected” to each other, which could leave their
therapists uncertain about which aspect of intimacy the couples are lacking.

Considering that a romantic relationship can be experienced and evaluated
according to different aspects simultaneously, it seems important to consider partners’
relationship satisfaction as it relates to different aspects of intimacy. For example, while partners’ emotional and sexual aspects of intimacy are likely to be related (Haning et al., 2007), there is no guarantee that their experiences of emotional and sexual intimacy will always be compatible. Some partners might report high levels of emotional intimacy despite their low levels of sexual satisfaction. On the other hand, partners might feel connected only when they engage in sexual activities but feel emotionally disconnected in daily interactions. Potential gender differences should also not be overlooked, as males and females might place importance on different aspects of intimacy. Both sexual scripts and existing studies generally suggest that men tend to demonstrate greater interest in the sexual aspect of intimacy than women, while women are more likely than men to value emotional closeness and warmth (e.g., Hook, Gerstein, Detterich, & Gridley, 2003; Ridley, 1993; Talmadge & Dabbs, 1990; Vohs, Catanese, & Baumeister, 2004). Therefore, male and female partners’ relationship distress may be due to either emotional or sexual intimacy (or both) to varying degrees. Unfortunately, many existing studies tend to test only one aspect of intimacy (e.g., Cordova, Gee, & Warren, 2005; Litzinger & Gordon, 2005), or they combine different aspects of intimacy to create one “overall” intimacy measure (e.g., Laurenceau et al., 2005) without considering their distinctive effects on relationship outcomes. As a result, less is known about which aspect of intimacy (e.g., emotional or sexual) may or may not have an impact on males’ and females’ relationship satisfaction when both aspects are taken into account.

One way to understand distressed couples’ (clinical couples’) intimacy and its effects on relationship satisfaction may be to compare these couples with their satisfied,
non-treatment-seeking counterparts (community couples). While the objectives of therapy vary according to each client, one of the ultimate goals for couple therapy is to help distressed couples become independent of therapy and be able to maintain satisfying relationships on their own. Therefore, a between-group comparison may present a meaningful picture of how similar and/or different clinical couples’ intimacy and relationship satisfaction are from those of community couples. The current study was designed to empirically test this research question with the purpose of increasing therapists’ understanding of distressed couples’ intimacy issues as compared with those of satisfied couples.

The Current Study

The main purpose of this study was to investigate the association between differentiation, emotional/sexual intimacy, and relationship satisfaction among distressed treatment-seeking couples (clinical couples) and satisfied non-treatment-seeking couples (community couples). The current study had three objectives.

First, this study explored potential similarities and differences between the clinical and community couples in their levels of differentiation, emotional/sexual intimacy, and relationship satisfaction. It was hypothesized that clinical couples would be less differentiated, less intimate (emotionally and sexually), and less satisfied with their relationship than community couples. Second, this study tested the theoretical associations between the constructs. The theory-driven conceptual model is presented in Figure 1. Lastly, this study explored how these associations would be similar or different
across the two groups. In the model in Figure 1, the effects of partners’ intimacy experiences on their own and their partners’ relationship satisfaction were examined simultaneously to test couples’ relationship processes that involve intimacy. The main hypothesis was that across the two groups, higher levels of differentiation would be associated with higher levels of emotional and sexual intimacy, which in turn would be associated with higher levels of relationship satisfaction, both within individual partners as well as between partners.

Significance to the Field

The findings of this study have the potential to enhance the quality of couple therapy service as well as its effectiveness. While existing studies tend to suggest that couple therapy is effective in increasing intimacy (e.g., Brooks, Guerney, & Mazza, 2001; Dandeneau & Johnson, 1994), they do not necessarily provide detailed information about treatment-seeking couples’ unique and distinctive intimacy issues that may be different from those of satisfied couples. The current study’s findings would help therapists begin treatment knowing “where to start” in addressing distressed couples’ intimacy issues, especially when the clients themselves provide little information. Considering that many treatment-seeking couples terminate therapy after only a few sessions (e.g., Hansen, Lambert, & Forman, 2002), early assessment and interventions are imperative in couple therapy. In this sense, the current study would contribute to the field of couple and family therapy by helping therapists conceptualize and intervene in distressed couples’ intimacy issues before it is too late. Furthermore, through their
therapists’ timely assistance, distressed treatment-seeking couples may not only enhance their intimacy experiences but also possibly increase their relationship satisfaction to the levels experienced by satisfied, non-treatment-seeking couples.
Chapter 2: Literature Review

The desire for intimacy is considered one of the basic human needs and explains individuals’ behaviors in relationships (e.g., Baumeister & Leary, 1995; Boszormenyi-Nagy & Krasner, 1986; Bowlby, 1988; Ryan & Deci, 2000; Sheldon, Elliot, Kim, & Kasser, 2001). Individuals tend to pursue meaningful relationships to stay close and connected with important others, and the lack of such experiences may have a negative impact on their physical and psychological well-being (e.g., Sarason, Sarason, & Gurung, 2001). The need for intimacy is also a primary reason that individuals develop and maintain committed romantic relationships (e.g., Schaefer & Olson, 1981). When partners feel intimate with each other, their relationship is more likely to be satisfying and stable (e.g., Greeff & Malherbe, 2001; Schaefer & Olson, 1981). Conversely, partners’ lack of intimacy is likely to lead to negative relationship outcomes, including relationship dissolution (e.g., Kingsbury & Minda, 1988; Waring, 1988), and is one of the most frequently reported problems among distressed couples seeking therapy (e.g., Crowe, 1997; Doss, Simpson, & Christensen, 2004).

Despite its importance, however, intimacy has been somewhat understudied, partly because the construct has been difficult to define and operationalize (e.g., Patrick et al., 2007). In the literature, a wide variety of definitions of intimacy have been
suggested (see Heller & Wood, 1998; Moss & Schwebel, 1993; Prager, 1995; Schaefer & Olson, 1981; Schnarch, 1991; Waring, 1984, 1988). These definitions, nevertheless, tend to share one common theme: “intimacy” refers to partners’ feelings of closeness and connectedness, which are established based on their mutual self-disclosure, validation, and acceptance (e.g., Perlman & Fehr, 1987). This commonly-accepted characteristic of intimacy has been widely used in existing empirical studies to refer to the “general” sense of couple intimacy (e.g., Laurenceau et al., 2005; Pielage, Luteijn, & Arrindell, 2005). Other studies, however, describe intimacy as a multidimensional construct that can be assessed with different aspects of a couple relationship (Schaefer & Olson, 1981). Among them, emotional and sexual aspects of intimacy have received focused research attention as they relate to couples’ relationship satisfaction (e.g., Dandurand & Lafontaine, 2013).

Unfortunately, neither the general sense of intimacy nor the specific aspects of intimacy have been defined or assessed clearly, and intimacy still remains a vague and abstract construct in the literature. In many studies, the general sense of intimacy (e.g., feelings of closeness and connectedness derived from self-disclosure and acceptance) tends to be used interchangeably with the emotional aspect of intimacy (e.g., Mitchell et al., 2008). Similarly, the definition of the sexual aspect of intimacy has also been vaguely defined, although it tends to be more clearly distinguished from the general sense of intimacy. Very little is known about differences between physical intimacy, sexual intimacy, and other indicators of the sexual aspect of intimacy, such as sexual satisfaction. While some have defined sexual intimacy as “the experience of sharing general affection and/or sexual activity” (Schaefer & Olson, 1981), the majority of
existing studies have used the term without clearly defining it (e.g., Byers & Lewis, 1988; Shuttleworth, 2000).

This ambiguity in the understanding of intimacy can lead to other issues in clinical settings, namely that therapists may not know how to conceptualize distressed couples’ intimacy concerns. One of the potential issues is that the widely agreed-upon definition of intimacy tends to focus primarily on partners’ feelings of closeness and connectedness without considering how their sense of self would play a role in their experiences of closeness and connectedness. Some therapy-related literature has also used the term “intimacy” as a relational phenomenon that may not include a balance with individual partners’ autonomy (e.g., Rovers et al., 2007). Such dichotomous conceptualization of intimacy and autonomy can be misleading and may imply that intimacy only refers to the degree to which partners maintain togetherness in their relationship. However, there is evidence that intimacy is also facilitated when partners have firm and solid self-concepts, which enable them to identify themselves as separate individuals in relationships with their partners (e.g., Beyers & Seiffge-Krenke, 2010). If this is true, when a lack of intimacy is a primary concern for a treatment-seeking couple, therapy may need to address how much individual partners appreciate themselves as well as their relationship. A lack of intimacy may be attributed to partners’ low levels of perceived togetherness; at the same time, it is also possible that their lack of sense of self keeps them from feeling secure during their intimate encounters.

In the current study, the construct of intimacy was understood as partners’ subjective feelings of closeness/connectedness that can be experienced in emotional and
sexual aspects of their relationship. It was also postulated that both emotional and sexual intimacy are best established and maintained within the couple relationship processes that allow for both togetherness and individuality. Bowen’s Family Systems Theory was used as a framework in conceptualizing such relationship processes. This chapter consists of concise review sections of Bowen’s theory and its implications for couple intimacy. Further, limitations in the intimacy literature are discussed in relation to clinical as well as research areas.

**Intimacy through the Lens of Bowen**

Murray Bowen’s Family Systems Theory asserts that interpersonal relationships demonstrate the interplay between togetherness and individuality (Bowen, 1978; Kerr & Bowen, 1988). In this theory, individuals’ needs for both togetherness and individuality must be met to establish healthy interpersonal connections. In a “healthy” relationship, partners need not sacrifice their sense of self to stay together; at the same time, togetherness in their relationship is not undermined for the sake of each partner’s sense of self. The desirable relationship may allow the involved partners to stay together while being accepted for *who they are*. When either of these needs is frustrated, partners may experience distress and dissatisfaction in their relationship.

Individuals have varying degrees of the ability to meet their needs for togetherness and individuality, and this ability is associated with what Bowen termed
differentiation of self (Bowen, 1978; Kerr & Bowen, 1988). Differentiation of self is defined as one’s intrapsychic ability to separate thought processes from feeling processes, especially in stressful situations (Bowen, 1978; Kerr & Bowen, 1988). According to Bowen, well-differentiated individuals are able to think clearly in the presence of intense emotions, and this ability keeps them from reacting in stressful situations or to others’ reactivity. This ability enables them to experience emotions as well as think about their current situation and determine when and how decisions may need to be made. Conversely, more poorly differentiated individuals may not be able to think clearly under stress because their thought processes are inhibited by their emotions. These individuals may react under stress as if there is only one way to handle the situation without knowing that they actually have other options. Their actions may be based almost solely on their feeling processes (Friedman, 1991).

Bowen (1978) asserted that individuals tend to pair with someone who has a level of differentiation that is similar to their own. It may be because highly differentiated individuals’ patterns of thinking, feeling, and interacting with others are very different from those of poorly differentiated individuals; individuals with similar levels of differentiation are thus more likely to easily “click” with each other (Bowen, 1978). For this reason, a relationship tends to present manifestations of a certain level of differentiation, which often can be observed in how partners interact with each other in managing their needs for togetherness and individuality. The term distance regulation is used to describe such interaction patterns that emerge in relationships (see Anderson & Sabatelli, 1992). In a relationship with a high level of differentiation, distance regulation
patterns would allow for both togetherness and individuality so that neither partner has to sacrifice his or her self or the relationship. In other words, healthy patterns of distance regulation allow for the “I” (self) within the “we” (the relationship). In contrast, distance regulation patterns that emerge in a poorly differentiated relationship only allow for either the “I” or the “we” (Karpel, 1976).

When the level of differentiation is low and emotional reactivity is high, distance regulation patterns that emerge are likely to manifest as fusion and emotional cutoff (Bowen, 1978; Kerr & Bowen, 1988). In a fused and/or cut-off relationship, partners’ needs for togetherness and individuality are not met, and their unconscious efforts to seek these unmet needs may create tension and anxiety (Bowen, 1978; Kerr & Bowen, 1988; Skowron & Friedlander, 1998). According to Bowen, partners in a fused relationship may not have the ability to maintain individuality in the relationship; they may become attached to one another to the extent that there is no sense of self. Those partners may not think of themselves as separate individuals who can have different opinions. For them, having disagreements may mean rejection and a lack of support, and they may find it hard to agree to disagree. In attempts to seek their needs for individuality, however, fused partners may reactively withdraw from each other in emotionally charged situations. In an emotionally cut-off relationship, on the other hand, partners might look self-sufficient and indifferent in isolation, but they may actually be trying to run away from the relationship because they cannot tolerate togetherness in times of disagreement or rejection. Therefore, in both fused and cut-off relationships, partners’ needs for togetherness and individuality are not met simultaneously, because they constantly
attempt to obtain either togetherness or individuality in extreme degrees. Such attempts result in creating repetitive and dysfunctional distance regulation patterns in their relationship (see Anderson & Sabatelli, 1992; Bowen, 1978; Kerr & Bowen, 1988).

According to Bowen theory, partners’ levels of differentiation and distance regulation patterns in their relationships determine their relationship satisfaction (Bowen, 1978; Kerr & Bowen, 1988). Well-differentiated partners, preserving their solid sense of self, are highly adaptive and resilient under relational stress. Their relationships are less likely to undergo tempestuous phases and are more likely to remain functional, stable, and satisfying (e.g., Lim & Jennings, 1996; Miller, Anderson, & Keala, 2004; Skowron, 2000; Skowron & Friedlander, 1998). In contrast, partners in poorly differentiated relationships tend to engage in conflict in order to manage anxiety, which is derived from their inability to balance togetherness and individuality. They may attempt to connect with each other through conflict because they do not know how else they can engage with each other and obtain togetherness. Or, they might be attempting to obtain individuality through conflict when they feel “smothered” in their relationship; again, these partners may not see other options for preserving their sense of self without conflict. By engaging in conflict, partners in a poorly differentiated relationship may attain togetherness and individuality, but they do so by hurting each other (Bowen, 1978; Kerr, 1988; Kerr & Bowen, 1988). These patterns are ineffective and dysfunctional, and they do not help partners become satisfied and secure in their relationship.

In addition to the association between differentiation and relationship satisfaction, several studies have done further research on the gender differences.
Tremblay and colleagues (2002) suggested that the level of differentiation may be more important for male partners’ relationship satisfaction than for female partners’. Other studies have assessed more specific indicators of differentiation and found that partners’ relationship satisfaction is associated with different indicators of differentiation depending on gender. For example, Peleg (2008) found that female partners’ relationship satisfaction was only associated with emotional cutoff, whereas male partners’ satisfaction was also related to other indicators of differentiation, including emotional reactivity and “T” position (the degree to which one holds a solid sense of self).

**Intimacy based on Togetherness and Individuality**

Although Bowen did not specifically define or elaborate on intimacy in relation to togetherness and individuality, his concept of differentiation of self certainly provides a way to conceptualize how healthy forms of couple intimacy could develop and keep relationships functional and satisfying. Unlike more common understandings of intimacy as a primarily relational construct, Bowen would argue that intimacy is best established and maintained when both togetherness and individuality needs are met in a relationship. When either togetherness or individuality prevails over the other, it is likely that partners’ intimacy experiences become less fulfilling. In fused relationships that lack individuality, partners may not feel intimate themselves and may question their partners’ intimacy experiences, no matter how much time they spend together and how many times they are
assured of their partners’ love and affection. The lack of individuality in their relationships would make them continue to feel insecure and desperate even in close connection with their partners. In cut-off relationships lacking togetherness, partners may avoid intimate encounters due to their fear of losing self; their hidden belief might be that if they stay close, their sense of individuality would be undermined for the sake of togetherness. Therefore, Bowen’s theory seems to suggest that partners in a highly differentiated relationship are likely to present higher levels of intimacy. While these theory-driven postulations still call for further empirical support, extant literature supports the idea that intimacy is established and maintained based on partners’ individuality as well as togetherness.

**Intimacy and Togetherness**

A more popular understanding of intimacy is that it is a relational phenomenon: the outcome of relationship processes between partners. For example, the interpersonal process model of intimacy (Reis & Patrick, 1996; Reis & Shaver, 1988) proposes that couple intimacy is formed and maintained in communication processes in which partners disclose information about themselves and respond to each other’s self-disclosure. Intimacy formation processes can be better facilitated when partners are willing to reveal their vulnerabilities to each other and mutually validate each other’s self-disclosure with love and care (Laurenceau, Feldman Barrett, & Pietromonaco, 1998; Laurenceau et al., 2005). In addition, it is important that the partner who receives validation feels genuinely understood by his or her partner (Lippert & Prager, 2001). Partners involved in such
processes are more likely to develop and maintain intimacy in their relationship, compared with those who do not experience these processes. It should also be noted that some level of relationship functioning may be required for these processes to occur. Extremely distressed partners may be afraid of revealing their emotions and may have a hard time accepting their partner’s validation. Even if the intimacy processes are initiated, these partners may be inclined to impede the processes by invalidating their partners’ self-disclosure or questioning the authenticity of their partners’ validation (Clements, Cordova, Markman, & Laurenceau, 1997; Gottman, 1994).

More specific aspects of intimacy, such as sexual forms of intimacy, can also be facilitated or impeded by couple relationship processes. Partners’ sexual and nonsexual self-disclosure (Byers & Demmons, 1999) and the quality of their sexual communication (Cupach & Comstock, 1990) can either increase or decrease their perceived sexual aspect of intimacy. These findings suggest that partners who are open to sharing their sexual issues and concerns may be better able to work together to make their sexual relationship more satisfying. Again, such intimacy processes in the sexual domain of a relationship are also influenced by the levels of relationship functioning and partners’ perceived relationship satisfaction (e.g., Young, Denny, Young, & Luquis, 2000). Partners may find it easier to express themselves sexually when they feel loved and safe (e.g., Barrientos & Páez, 2006; Theiss & Nagy, 2010), and when they perceive equality and fairness in their relationship (e.g., Henderson-King & Veroff, 1994). Conversely, a lack of such security and trust may result in increasing partners’ anxiety during sexually intimate encounters; they may become afraid of initiating or engaging in sexual interactions due to their fear
of rejection or lack of trust in the other (e.g., Brassard, Shaver, & Lussier, 2007; Theiss & Nagy, 2010). Similarly, those with high levels of anxiety and avoidance tendencies are less likely to feel sexually satisfied themselves, which is likely to lower their partners’ sexual satisfaction as well (Butzer & Campbell, 2008).

To summarize, these studies support the idea that couple intimacy is a relational construct, which is developed, facilitated, and maintained by relationship processes between partners; partners’ sense of togetherness is thus essential for positive intimacy experiences. One of the implications of togetherness may be that partners tend to monitor each other’s intimacy experiences, and one’s own experience of intimacy cannot be totally independent from his or her partner’s experience in the relationship (see Sternberg, 1986). Partners who do not monitor the experience of the other may demonstrate symptoms of what Bowen would call emotional cutoff. As intimacy may be an outcome of partners’ conjoint work as a couple, a lack of mutual attention to and understanding of each other’s intimacy experiences are likely to lower the levels of both partners’ intimacy as a result (e.g., Heller & Wood, 1998).

**Intimacy based on Individuality**

Although the formation and maintenance of couple intimacy is relational, it also requires partners’ sense of individuality. Several theoretical models of intimacy as well as empirical studies suggest that individuals need to establish their self-identity in order to experience true intimacy with their partners (e.g., Beyers & Seiffge-Krenke, 2010; Cassidy, 2001; Lester & Lester, 1998; Schnarch, 1991). In this sense, intimacy may
require individuals’ ability to “know oneself” and to preserve autonomy while maintaining connectedness with others (Cassidy, 2001; Malone & Malone, 1987). By developing an understanding of their sense of self as separate individuals, partners can have more freedom to be themselves in expressing their thoughts, feelings, and needs. In truly intimate relationships, therefore, partners’ individuality does not have to be sacrificed for the sake of togetherness. Individual partners’ self-evaluation and self-concept also determine the degree to which they develop and maintain intimate relationships. For example, individuals who perceive themselves as strong and completely self-reliant might be less likely to acknowledge their own and their partners’ intimacy needs (e.g., Prager & Roberts, 2004). Similarly, those who are perfectionistic may also find it difficult to remain close to others, especially if they are afraid of revealing their vulnerability and weaknesses (e.g., Martin & Ashby, 2004).

Some other studies have specifically focused on the sexual aspect of intimacy. Findings included that those who were confident with their sexuality and their body image were more likely to have positive sexual intimacy experiences (e.g., Holt & Lyness, 2007; Wiederman, 2000); that individuals who had higher sexual self-esteem and sexual assertiveness (i.e., being able to express their sexual needs) tended to be more capable of increasing their sexual satisfaction (e.g., Ménard & Offman, 2009); and that partners’ sense of autonomy may be required for healthy forms of sexual intimacy (e.g., Perel, 2008; Schnarch, 1991, 1997).

Concerning this association between individuality and intimacy, attempts have been made to investigate individuals’ self-concept formation in relation to the quality of
their early relationships with caregivers. Attachment styles have been widely studied in this regard. Studies have demonstrated that those who had secure attachment with their primary caregivers tend to see themselves as loveable and perceive their partners as trustworthy and reliable in later romantic relationships (e.g., Bartholomew, 1990; Bartholomew & Horowitz, 1991). Feeling secure about themselves, these individuals may find it easier to be open and vulnerable with their partners during intimate encounters. In contrast, those who were insecurely attached with their caregivers may have difficulties establishing stable intimate relationships, as they might not be able to believe that they deserve love and care, and that their partners genuinely care about them.

Altogether, these findings support the idea that satisfying intimacy experiences require partners to uphold a firm sense of self, self-knowledge, confidence, and awareness of their own needs. While togetherness is an important component of intimacy formation, intimacy may be meaningful only if partners are aware that they are separate persons who can accept their differences, yet still can choose to stay together (e.g., Holmes, 1997). When partners place an excessive amount of importance on their relationship in the belief that “self” does not exist without it, this type of relationship may demonstrate what Bowen would call fusion.
Limitations in the Current Literature

Systemic Consideration of Intimacy

The idea that intimacy requires togetherness and individuality implies that couple intimacy formation would be best facilitated in a highly differentiated relationship in which these two needs are well-balanced. However, few studies have investigated couple intimacy with respect to partners’ or the relationship’s level of differentiation. This research gap is partly attributed to the lack of a systemic conceptualization of intimacy development. The current literature is replete with studies on the “facilitators” or “barriers” of couple intimacy and relationship satisfaction, and they tend to focus on other observed relationship phenomena, such as partners’ communication patterns, self-disclosure, mutual validation, and so forth. In contrast, fewer attempts have been made to explore couple intimacy issues at a systemic level. According to Bowen’s theory, when intimacy formation and maintenance are understood in terms of togetherness and individuality, differentiation of a relationship may be the underlying factor that determines partners’ intimacy experiences. If this holds true, the level of differentiation of a relationship could be the distinguishing factor between more intimate and less intimate relationship experiences.

This assumption may have implications particularly for therapists working with distressed couples complaining about a lack of intimacy. Considering that the level of differentiation is positively associated with relationship satisfaction (Bowen, 1978; Kerr & Bowen, 1988), it is possible that treatment-seeking couples’ relationship distress and
their intimacy concerns are both manifestations of lower levels of differentiation in relationships. Being more prone to fusion and cutoff, poorly differentiated partners’ experiences of intimacy would be inhibited because of their tendency to sacrifice self for the relationship, or sacrifice the relationship for self. As their needs for togetherness and individuality are not met simultaneously, they are more likely to show symptoms of emotional reactivity, which may cause relationship distress. On the other hand, satisfied couples who are supposedly more differentiated than distressed couples may be better able to maintain intimacy based on well-balanced togetherness and individuality. If this is the case, therapists would be able to help distressed couples with their intimacy issues by addressing their ability to balance togetherness and individuality (differentiation of self) so that their experiences of intimacy and relationship satisfaction would become similar to those of satisfied couples.

Unfortunately, extant literature provides little information regarding distressed couples’ and satisfied couples’ intimacy experiences within the framework of differentiation. Existing studies that compared these two groups demonstrate that overall, non-distressed couples tend to show more positive communication patterns and conflict resolution skills (e.g., Billings, 1979; Christensen & Shenk, 1991; Margolin & Wampold, 1981), less negative personality traits (e.g., Gattis, Berns, Simpson, & Cristensen, 2004), and more mutual support and responsiveness (e.g., Sprenkle & Olson, 1978) than distressed couples. However, surprisingly little research attention has been given to couple intimacy issues among distressed versus satisfied couples. Therefore, little is known or confirmed about whether distressed couples would present significantly
different levels of intimacy than satisfied couples, and whether the association between intimacy and relationship satisfaction would be the same across the two groups. This research gap can be particularly challenging for couple therapists working with distressed couples who often report lack of intimacy as an issue. Not knowing how their clients’ relationship distress may be attributed to intimacy issues in a way that is similar or different from satisfied non-treatment-seeking couples, therapists may be uncertain about “how to help” distressed couples’ unique and distinctive relationship processes around intimacy. This would in turn keep them from employing appropriate interventions in a timely manner.

**Emotional and Sexual Intimacy**

Among various aspects of intimacy, emotional and sexual intimacy have been most emphasized as important correlates of couples’ relationship satisfaction. Research consistently demonstrates that couples’ relationship satisfaction is attributed to both emotional intimacy (e.g., Cordova, Gee, & Warren, 2005; Greeff & Malherbe, 2001) and sexual intimacy (e.g., Guo & Huang, 2005; Henderson-King & Veroff, 1994; Litzinger & Gordon, 2005; Sprecher, 2002; Yeh, Lorenz, Wickrama, Conger, & Elder, 2006). Unfortunately, many of these existing studies consider only one aspect of intimacy, either emotional or sexual, when investigating the association between intimacy and relationship satisfaction. These studies, therefore, define and assess the term “intimacy” without considering the possibility that intimacy could be assessed in multiple domains.
Moreover, some studies that measure both emotional and sexual aspects of intimacy often combine the two to create one “overall” intimacy measure (e.g., Laurenceau et al., 2005).

Understanding the effects of intimacy on relationship satisfaction by examining only one aspect of intimacy or a combined measure of intimacy can be misleading, because partners’ reports on intimacy may vary depending on which aspect of intimacy is being measured. For example, both traditional cultural scripts on sexuality and empirical studies have generally suggested that men tend to have a greater interest in sexual activity per se than women, and women value sexual interaction within the context of emotionally close, loving relationships more so than men (e.g., Hook et al., 2003; Ridley, 1993; Talmadge & Dabbs, 1990). These gender differences suggest that male partners’ intimacy experiences could be negative if their sexual needs are not met. Similarly, females’ unmet needs for emotional intimacy may counter their positive sexual intimacy experiences. Recent studies, however, challenge these gender stereotypes somewhat by demonstrating that women’s emotional intimacy is associated with their sexual satisfaction, and men’s sexual intimacy is related to relational factors at older ages (e.g., Carpenter, Nathan, & Kim, 2009). Another recent study (Yoo, Bartle-Haring, Day, & Gangamma, 2013) suggests that sexual intimacy is predictive of emotional intimacy for both husbands and wives in longer-term marriages. These findings suggest that a measure of one aspect of intimacy (either emotional or sexual) may not be fully representative of individual partners’ intimacy experiences, and that gender differences associated with different aspects of intimacy should be taken into account.
Another potential risk for considering only one aspect of intimacy is that the effect of either emotional or sexual intimacy on relationship satisfaction could be overestimated by not controlling for both intimacy domains. As an example, the importance of sexual intimacy on male partners’ relationship satisfaction could be inflated because the effect of their emotional intimacy on relationship satisfaction was not taken into account. In reality, emotional and sexual aspects of intimacy do not exist in isolation. Partners may have concurrent experiences of both emotional and sexual aspects of intimacy in their relationships, and their emotional intimacy is likely to be associated with their sexual intimacy (Haning et al., 2007). Therefore, simultaneously examining the effects of emotional and sexual intimacy on relationship satisfaction may present a more realistic picture of couple relationship processes.

Lastly, many existing studies about couple intimacy have neglected the possibility that individuals’ perceptions of their partners’ intimacy experiences could contribute to their own intimacy. In the literature, intimacy has tended to be assessed primarily with the respondents’ self-reporting of their own intimacy. However, couple intimacy processes involve both partners, and how one’s partner *seems* to feel about his or her intimacy experiences is likely to influence one’s own as well (see Sternberg, 1986). For instance, a female partner’s low level of sexual intimacy might be attributed to her knowledge of her partner’s dissatisfaction in sex. Similarly, a male partner might feel emotionally distant from his partner, knowing that his partner believes they always miscommunicate and misunderstand each other’s emotions (whether or not it is true). Considering that intimacy is formed and maintained in the relationship context, intimacy
may be more accurately assessed with partners’ perceptions of their own as well as their partners’ intimacy experiences.

**Pilot Study (April to October 2011)**

In an attempt to fill these research gaps, an instrument was developed based on preexisting assessments (e.g., Hudson, 1998; Schaefer & Olson, 1981). This instrument was purposefully designed to measure emotional and sexual intimacy as separate entities. The most distinctive feature of this instrument was that it measured individual partners’ own intimacy experiences as well as how they perceived their partners’ intimacy experiences. Therefore, instead of focusing only on partners’ intimacy at an individual level, this instrument intended to capture a relational component of intimacy by evaluating individuals’ perceptions of their partners’ intimacy as well.

A total of 10 items assessed couples’ perceived sexual intimacy, and 10 items assessed couples’ emotional intimacy (see Appendix A). The items were paired in such a way that the same question was asked twice: once regarding the respondent’s own intimacy, and once regarding the respondent’s perception of his/her partner’s intimacy. For example, sample items for sexual intimacy included “I am satisfied with my sex life with my partner” and “My partner seems satisfied with his/her sex life with me.” Sample items for emotional intimacy included “I feel comfortable with being emotionally vulnerable with my partner” and “My partner seems comfortable with being emotionally
vulnerable with me.”

To test this newly developed instrument, a pilot study was conducted over six months (from April to October, 2011). Participants were couples seeking therapy at the OSU Couple and Family Therapy Clinic, and both partners were given the instrument at the beginning of their first therapy session. A total of 23 couples participated. Responses were based on a 7-point Likert scale and were averaged to create one score for each of eight perspective subscales (four scores for emotional intimacy, and four scores for sexual intimacy): 1) the male partner’s perception of his own emotional intimacy, 2) the female partner’s perception of her male partner’s emotional intimacy, 3) the female partner’s perception of her own emotional intimacy, 4) the male partner’s perception of his female partner’s emotional intimacy, 5) the male partner’s perception of his own sexual intimacy, 6) the female partner’s perception of her male partner’s sexual intimacy, 7) the female partner’s perception of her own sexual intimacy, and 8) the male partner’s perception of his female partner’s sexual intimacy. The results of the pilot study demonstrated that this instrument was highly reliable. Cronbach’s alpha was .73 for males and .80 for females for their own emotional intimacy, and .76 for males’ and .68 for females’ perceptions of their partners’ emotional intimacy. For sexual intimacy, Cronbach’s alphas of .83 and .87 were yielded for males’ and females’ own sexual intimacy, respectively; partners’ perceptions of their partners’ sexual intimacy yielded alphas of .84 for males and .80 for females. Given the results of this pilot study, this piloted instrument was used in the current study.
The Current Study

The objectives of the current study were to resolve the limitations of the extant research by exploring couple intimacy and relationship satisfaction among distressed couples seeking therapy (clinical couples) and satisfied non-treatment-seeking couples (community couples), using Bowen’s concept of differentiation as a framework. Partners’ emotional and sexual aspects of intimacy were assessed separately with the piloted instrument. The goals and hypotheses of the current study are elaborated as follows.

**Goal 1.** This study will explore potential similarities and differences between the clinical and community couples in their levels of differentiation, their own emotional and sexual intimacy, their perceptions of their partners’ emotional and sexual intimacy, and overall relationship satisfaction.

*Hypothesis 1:* Clinical couples will have significantly lower levels of differentiation of self, emotional and sexual intimacy (both their own and their partners’), and relationship satisfaction, than community couples.

**Goal 2.** This study will establish and empirically test a theory-driven model (Figure 1) in which the associations between differentiation, emotional/sexual intimacy, and relationship satisfaction are examined.

*Hypothesis 2:* The theory-driven model will be empirically supported with appropriate fit among both clinical and community groups.

**Goal 3.** This study will explore how the associations between the constructs of interest may differ among the clinical and community couples.

*Hypothesis 3:* Although the levels of differentiation, emotional/sexual intimacy, and relationship satisfaction may differ (Hypothesis 1), the associations between the constructs will be similar across the two groups.

*Hypothesis 3a:* The levels of differentiation will positively predict both emotional/sexual intimacy and relationship satisfaction in clinical and community couples.

*Hypothesis 3b:* Partners’ intimacy experiences (both emotional and sexual) will positively predict their own as well as their partners’ relationship satisfaction.
Chapter 3: Methods

Sample & Procedures

Participants in this study came from two different populations: clinical and community. Both clinical and community groups consisted of different-sex couples only (i.e., male-female dyads).

Clinical Sample (Appendix C)

Data for the clinical sample were collected at the Ohio State University’s Couple and Family Therapy (CFT) clinic beginning in July 2012. This on-campus clinic is advertised online, and potential clients voluntarily initiate seeking services via phone calls. The clinic uses a sliding fee scale, with fees ranging from $10 to $65 per session depending on clients’ annual income and the number of dependents. The therapists are doctoral students in the Couple and Family Therapy program at the university, and their service is supervised by faculty members who are American Association of Marriage and Family Therapy (AAMFT) approved supervisors. This clinic serves about 75-100 new clients each year, including individuals, couples, and families. Clients include not only students, faculty members, and staff at the Ohio State University, but also community
members in the Columbus area.

For the current study, only clients seeking couple therapy were asked to participate, and this was the sole eligibility criteria; other relationship characteristics, such as relationship length or relationship status, were not used to screen participants. After obtaining consent to therapy at the beginning of the first session, the therapists explained both the purpose of the research and data collection procedures. Participating couples received a $20 reduction in their first session fees. They were asked to complete an intake questionnaire that included instruments measuring a few constructs in their relationships (e.g., differentiation, intimacy, relationship satisfaction) as well as their demographic information (e.g., age, education, income, and number of children). Although this intake questionnaire was given to all clients, only research participants’ responses were used for research. All information obtained in the clinic was kept in locked filing cabinets in the clinic office. Research-related forms (e.g., research consent form, HIPPA form, research questionnaires) were stored in separate files, not in the clients’ clinic case files. Forms used for data collection (intake questionnaire in this study) did not contain any identifiable information; the data were handled only by the case number and the partner number (e.g., partner 1 or 2) on the forms.

For the clinical sample, a total of 46 different-sex, treatment-seeking couples participated. Among these couples, the average age of the male partners was 31.30 years ($SD=7.55$, range 18-54), and the average age of the female partners was 29.85 years ($SD=6.44$, range 18-49). Thirty-seven male partners (80.4%) and 35 female partners (76.1%) were Caucasian American. The majority of them had education beyond a high
school degree (87% of males, 95.7% of females). On average, their combined annual income was $45,465.64 (SD=37010.68, range $0-150,000). Twenty-nine couples (63.0%) were “married” or “cohabiting,” and the rest of them reported their relationship as “partnered” or “dating” unions. Their relationship length ranged from 7 months to 30 years, with the average 5.88 years (SD=5.90). These couples had an average of 1.18 children (SD=1.43, range 0-6).

**Community Sample** (Appendix D)

Community couples were recruited from the Ohio State University campus area beginning in February 2013. The study was advertised via flyers posted across campus, explaining the purpose of the study as well as its voluntary nature. Interested individuals contacted the investigator for research participation via email. The investigator then replied to the individuals (one partner of a relationship) with the information about the purpose and procedures of the study as well as the limitations of privacy for online surveys. The individual partner was asked four eligibility criteria questions: 1) were both partners satisfied/happy with their relationship, 2) were they currently receiving couple therapy, 3) were both partners willing to participate in the study, and 4) could the individual partner provide his or her partner’s email address. When the individual stated that both partners were satisfied, were not in couple therapy, were willing to participate, and provided the other partner’s email address, the couple was considered eligible for the study. The investigator sent each partner of the eligible couple an email that contained the survey link from the Qualtrics website. This email also included the purpose and the
procedures of the study so that both partners (not just the partner who contacted the investigator) could make an informed decision about participation.

Those who agreed to participate were then able to complete the survey individually. Consent to participate in the research was obtained at the beginning of the survey, where respondents had to click “Agree” in order to proceed. Completion of the survey was entirely voluntary, and respondents were able to skip questions without answering. The survey included the same questionnaire as the one given to the clinical couples, with the exception of the questions related to depression, violence, medication, and substance abuse. Additionally, the same demographic information was collected (e.g., age, education, income, and number of children). Once they completed the survey, each partner received a $10 online gift certificate via email either from Starbucks or Barnes and Noble (i.e., $20 per couple). The email addresses provided by the participants during the initial contact were only used to pair the partners so that their responses referred to the same relationship and were removed from the dataset once the partners’ responses were linked.

Originally, a total of 50 couples from the community volunteered for this study. Among them, two couples were excluded because they did not meet eligibility criteria for this study after the data were collected; one couple was excluded because one partner of the couple did not complete the survey, and another couple was excluded because one partner from a relationship reported a significantly lower level of relationship satisfaction (2 out of 10) than the level reported by the other partner (8 out of 10). In addition, two same-sex couples were excluded to avoid confounding factors associated with partners’
gender. As a result, 46 “satisfied” couples were included in this study’s community sample. Male partners were 27.26 years old on average ($SD=11.58$, range 18-72), and female partners were 25.70 years old on average ($SD=9.79$, range 18-57). Thirty-eight male partners (82.6%) and 41 female partners (89.1%) were Caucasian American. The majority of them had at least a high school degree (91.3% of males and 100% of females). Their annual income was $35,876.19 on average ($SD=43,249.98$, range $0-150,000$). Thirteen couples (28.3%) were “married” or “cohabiting,” while 33 (71.7%) couples reported that they were either “dating” or “partnered.” The average of their relationship length was 4.52 years ($SD=7.26$, range 2 months–34 years). Few of these couples reported having children ($M=0.37$, $SD=0.88$, range 0-4).

**Measurements**

**Demographic Information**

Partners in both clinical and community samples were asked their age, gender, race/ethnicity, highest level of educational attainment, and combined annual income. In addition, information was gathered about their relationship status (e.g., “married,” “cohabiting,” “dating,” “partnered”), relationship length, and the number of children. Partners’ ages were coded in years and their relationship length was coded in months for data analysis. Their combined annual income was coded in dollars. As the majority of the participating partners reported that they had at least a high school degree, “higher than
high school” was coded as 1, and “less than high school” was coded as 0. Similarly, partners’ race/ethnicity was dummy coded as 1 if they identified as Caucasian and coded as 0 if they identified as another race/ethnicity (e.g., Black, Asian, “Other”). Partners’ relationship status was coded as 1 if they were living together (whether married or non-married) and 0 if they were dating/partnered but not living together.

**Differentiation of Self**

Individual partners’ levels of differentiation of self were assessed based on selected items from the Healthy Separation subscale of the Separation-Individuation Test of Adolescence (SITA; Levine, Greene, & Millon, 1986). Items in this instrument were reworded to reflect a romantic relationship between partners, rather than the relationship between an adolescent and parents. These reworded items, representing the degree of “healthy individuality” in a romantic relationship, were intended to measure how partners perceive themselves as individuals while still being connected with their partners. Thus, this was designed to assess Bowen’s concept of differentiation of self, which allows individuals to have a sense of self that exists separately from their relationship while also being engaged in, and feeling close in, the relationship.

A total of six items were used to assess partners’ sense of Healthy Individuality. Sample items included “Even though I’m very close to my partner, I feel I can be myself,” “My partner and I have some common interests and some differences,” and “I am comfortable with some degree of conflict with my partner.” Responses were based on a 5-point Likert scale, ranging from 1 (Strongly Disagree) to 5 (Strongly Agree), and
were averaged to create one score for each partner: male’s Healthy Individuality and female’s Healthy Individuality. Higher scores indicated higher levels of perceived healthy individuality in their relationships.

**Emotional Intimacy**

Partners’ perceptions of their own and their partners’ Emotional Intimacy were measured with the pilot instrument (see the above section “Pilot Study”). Individual partners’ own emotional intimacy was measured with five items, including “I mostly feel emotionally connected with my partner” and “I feel comfortable with being emotionally vulnerable with my partner.” Individuals’ perceptions of their partners’ emotional intimacy were measured with the same items, slightly reworded, such as “It seems that my partner mostly feels emotionally connected with me” and “My partner seems comfortable with being emotionally vulnerable with me.” Responses were based on a 7-point Likert scale (1 = Strongly Disagree, 7 = Strongly Agree) and were averaged to create two subscales of 1) partners’ perceptions of their own Emotional Intimacy, and 2) partners’ perceptions of their partners’ Emotional Intimacy. Higher scores indicated higher levels of emotional intimacy, perceived by partners themselves as well as their evaluations of their partners’ emotional intimacy.

**Sexual Intimacy**

Similarly, partners’ perceptions of their own and their partners’ Sexual Intimacy were measured with the same instrument. Partners indicated their ratings on a 7-point
Likert scale from 1 (Strongly Disagree) to 7 (Strongly Agree). How partners perceive their own sexual intimacy was measured with five items, including “I am satisfied with my sex life with my partner” and “I am open to talk about sex with my partner.” Their perceptions of their partners’ sexual intimacy were measured with the same five items, reworded to refer to what the person believed about his/her partner, such as “My partner seems satisfied with his/her sex life with me” and “My partner seems open to talk about sex with me.” Responses were averaged to create two subscales, each individual’s perception of his/her own and his/her partners’ Sexual Intimacy, with higher scores indicating higher levels of sexual intimacy.

**Relationship Satisfaction**

Couples’ overall relationship satisfaction was assessed using a self-reporting measure. Partners rated their relationship satisfaction based on a 10-point scale, ranging from 1 (Not at all satisfied) to 10 (Very satisfied). This single item has been used in previous studies in the clinic and was highly correlated with the Kansas Marital Satisfaction Scale (.86) (KMSS; Schumm, Nichols, Schectman, & Grigsby, 1983), a commonly used measure of relationship satisfaction.
Data Analysis

Goal 1. To explore potential similarities and differences between the clinical and community couples in terms of 1) differentiation as assessed by their sense of healthy individuality, 2) emotional intimacy, 3) sexual intimacy, and 4) overall relationship satisfaction

Multivariate Analysis of Variance (MANOVA) was conducted in order to examine how the combination of all study variables distinguishes the clinical and community groups. If the overall MANOVA test statistic is significant, it would indicate that the clinical and community couples’ responses on the study variables are significantly different when the correlations between the variables are taken into account. Since only two groups were compared in this study, follow-up analyses were conducted using the independent t-test on each variable. The results of these data analyses were expected to present descriptive information regarding whether the clinical and community couples differed on the variables of interest.

Goal 2. To construct and test a model that fits with the theoretical assumptions

Structural equation modeling strategies were used in order to establish a model that fit the theoretical assumptions of Bowen’s theory and existing studies. The conceptual model in Figure 1 was used as a guide. Both measurement models and structural models were estimated. First, the observed variable indicators were used to create latent variables for Healthy Individuality in a relationship, Emotional Intimacy, and Sexual Intimacy. Several models were estimated using a single factor that would represent a couple’s level of differentiation and emotional/sexual intimacy, as well as two
factor models that would represent each partner’s perception of differentiation and emotional/sexual intimacy. Structural paths were established between the constructs in order to estimate the associations among them.

As this study was designed to explore both within-partner processes (intrapersonal processes) and between-partner relationship processes (interpersonal processes), the most appropriate model was the Actor-Partner Interdependence Model (APIM; Kashy & Kenny, 2000; Kenny, Kashy, & Cook, 2006). In the APIM, the effects of a partner’s characteristics on his or her own outcomes (actor effects) as well as the effects of a partner’s characteristics on his or her partner’s outcomes (partner effects) are investigated simultaneously (Kashy & Kenny, 2000; Kenny, Kashy, & Cook, 2006). Therefore, use of the APIM is an optimal way to examine the associations between differentiation (as assessed by Healthy Individuality in a relationship), emotional/sexual intimacy, and relationship satisfaction, for individuals (within-partners) as well as between partners. Testing the model, participating couples’ demographics, such as age, race, education, income, the number of children, relationship status, and relationship length, were included as control variables.

Goal 3. To compare clinical couples and community couples: testing for multigroup invariance (equivalence)

Based on the best model that resulted from Goal 2, a multi-group comparison was conducted between the clinical and community samples using Amos 20.0 (Arbuckle, 2011). In doing so, Byrne’s (2004) guidelines for multigroup invariance testing were generally followed. The objective of this goal was to investigate whether the established
model (from Goal 2) was invariant (equivalent) across the two groups and compare the magnitude of each non-invariant association between clinical couples and community couples.

First, the established model was tested for each group individually to ensure that it could be used as a baseline model. Second, once the baseline model was determined, the same model was tested for both groups simultaneously; if the model fit well for both groups, the model was used as the multigroup baseline model on which the invariance tests were compared. The multigroup baseline model was tested repeatedly with a set of the paths (or one path) being constrained as invariant across the two groups. The fit of the restrictive model was then compared with that of the multigroup baseline model by performing a chi-square difference test. Here, the null hypothesis was that “the constraints on the parameters are correct and do not cause a significant chi-square difference.” If there was a significant change in the model fit after constraining the paths as invariant, this implied that the parameters constrained were not invariant (not equivalent) across the two groups. The null hypothesis was then rejected, indicating that constraining the parameters to be equal was not correct. If the null hypothesis was retained, it suggested that assuming equivalence of the parameters was correct. In the current study, measurement model invariance was tested first with factor loadings constrained to be equal across the two groups, and then structural model invariance testing was conducted for associations between the factors.
Chapter 4: Results

There were three main goals in this study: 1) to explore similarities and differences between the clinical and community couples in their levels of differentiation, emotional/sexual intimacy, and relationship satisfaction, 2) to construct and empirically test a theory-driven model, and 3) to conduct a group comparison between the two groups. In this chapter, findings of the current study are presented in four sections. The results of preliminary analysis are discussed first, followed by the three goals of the study.

Preliminary results

The correlation coefficients, means, standard deviations, and Cronbach’s alphas of all study variables are reported in Table 1. For both clinical and community groups, most of the study variables were significantly correlated with one another at least to a moderate degree. As suggested by the high levels of correlation coefficients, partners were likely to perceive their partners’ intimacy experiences as similar to their own. For example, male partners tended to report high levels of their perceptions of partners’ sexual intimacy if their own sexual intimacy was high (.79 for clinical group, and .85 for community group). Similarly, female partners were likely to perceive their male partners
experiencing similar levels of emotional intimacy (.76 for clinical group, and .89 for community group).

**Goal 1. To explore potential similarities and differences between the clinical and community couples in terms of 1) differentiation as assessed by their sense of healthy individuality, 2) emotional intimacy, 3) sexual intimacy, and 4) overall relationship satisfaction**

Multivariate Analysis of Variance (MANOVA) was used to test the differences between the clinical and community groups across the study variables simultaneously, with clinical versus community group as the independent variable. Using Wilks’ statistic, the overall MANOVA test statistic was significant ($\Lambda=0.43$, $F(12, 75)=8.27$, $p < .001$); this indicated that the combination of the variables distinguished the clinical and community groups. Further, the results of the independent $t$-tests demonstrated that clinical couples’ reports on all study variables were significantly lower than those of community couples (Hypothesis 1).

**Differentiation of self.** Partners’ levels of differentiation of self were assessed in terms of their sense of healthy individuality: how much they perceive themselves as individuals while still being connected with their partners (togetherness). Clinical partners’ perceptions of their own healthy individuality were lower than those of community partners’. These between-group differences were significant for males’ healthy individuality ($t=-4.785$, $df=90$, $p < .001$) as well as females’ healthy individuality ($t=-5.021$, $df=67.981$, $p < .001$). The effect size (Pearson’s $r$) of these differences was .45 for males’ own healthy individuality and .52 for females’ own healthy individuality, all
indicating medium to large effect sizes (Cohen, 1988, 1992), when a value of 0 means no effect and 1 means a perfect effect.

**Emotional intimacy.** Clinical couples reported lower mean scores on emotional intimacy variables as compared with community couples. Male partners in the clinical group reported significantly lower levels of their own emotional intimacy than males in the community sample ($t = -4.690, df=76.915, p < .001, r=.47$), and so did female partners ($t = -7.141, df=69.943, p < .001, r=.65$). Clinical partners also tended to rate their partners’ emotional intimacy lower than community partners. Male partners’ reports on their perceptions of their female partners’ emotional intimacy ($t = -5.727, df=74.295, p < .001, r=.55$) and female partners’ reports on their perceptions of their male partners’ emotional intimacy ($t = -8.367, df=75.843, p < .001, r=.69$) were significantly lower than what community partners reported about their partners. The effect sizes of all these differences were medium to large.

**Sexual intimacy.** Clinical couples’ mean scores on sexual intimacy variables were also lower than those of community couples. Clinical partners’ perceptions of their own sexual intimacy were lower than those of community partners, for both males ($t = -3.880, df=72.960, p < .001, r=.41$) and females ($t = -4.920, df=63.415, p < .001, r=.53$). Further, clinical male partners’ perceptions of their female partners’ sexual intimacy ($t = -5.538, df=64.713, p < .001, r=.57$) and clinical female partners’ perceptions of their male partners’ sexual intimacy ($t = -5.578, df=66.909, p < .001, r=.56$) were significantly lower than community partners’ responses. These differences all demonstrated medium to large effect sizes.
**Relationship satisfaction.** Lastly, overall relationship satisfaction reported by clinical couples was lower than relationship satisfaction of non-treatment-seeking couples who claimed that they were “happy.” On average, both male partners ($t = -7.651, df=56.208, p < .001, r=.71$) and female partners ($t = -8.180, df=50.592, p < .001, r=.75$) in the clinical sample reported significantly lower levels of relationship satisfaction than those in the community sample.

**Goal 2. To construct and test a model that fits with the theoretical assumptions**

The second goal of this study was to construct a model based on Bowen’s Family Systems Theory (Bowen, 1978; Kerr & Bowen, 1988) and existing empirical evidence. To be consistent with the theory, one latent variable was created for differentiation of the relationship with two indicators: male partner’s healthy individuality and female partner’s healthy individuality. This latent variable was expected to capture the relationship level of differentiation by estimating both partners’ differentiation based on the degree to which they retain their self (individuality) while still being connected to each other (togetherness).

Partners’ emotional and sexual intimacy experiences were also treated as separate latent constructs, each having two indicators: their perceptions of their own and their partners’ emotional/sexual intimacy. That is, a partner’s emotional and sexual intimacy were estimated with 1) how he/she perceived his/her own emotional/sexual intimacy, and 2) how he/she thought about his/her partner’s emotional/sexual intimacy experiences. This decision was made based on the understanding that intimacy is a
relational construct; one’s intimacy is likely to be influenced by how he or she evaluates the other partner’s intimacy experiences (e.g., Sternberg, 1986). Therefore, similar to the latent variable for differentiation, these latent variables for emotional and sexual intimacy were expected to estimate the relationship level of emotional and sexual intimacy perceived by each partner.

Lastly, each partner’s relationship satisfaction was the outcome variable in this study, and two observed variables were created to estimate male and female partners’ relationship satisfaction, respectively. Also, both partners’ age, race (Caucasian = 1, Other = 0), educational attainment level (higher than high school = 1, less than high school = 0), income, the number of children, relationship status (married or cohabiting = 1, dating, not living together = 0), and relationship length were included in the model as control variables. However, partners’ race, level of educational attainment, income, and the number of children were not significantly associated with any other variables, most likely because of the lack of variability in these demographic variables. Therefore, control variables in the final model only included male partners’ age, female partners’ age, relationship status, and relationship length.

The final model is presented in Figure 2. This was the optimal model that best fit the data for both clinical ($\chi^2(54) = 76.02$, CFI=.952, RMSEA=.095) and community couples ($\chi^2(54) = 68.13$, CFI=.974, RMSEA=.076) respectively and was used as the baseline model for this study. The results of the confirmatory factor analysis (CFA) for the latent variables are reported in Table 2 for both clinical and community groups. The control
variables (partners’ age, relationship status, and relationship length) are not shown in the model to avoid making the figure overly complex.

**Goal 3. To compare clinical couples and community couples: testing for multigroup invariance (equivalence)**

Multigroup comparison analysis was performed using Amos 20.0 (Arbuckle, 2011). The procedure was three-fold: 1) testing for the baseline model (Figure 2) for both clinical and community couples simultaneously, 2) testing for measurement model invariance (for factor loadings) across the two groups, and 3) testing for structural model invariance across the two groups based on measurement invariance established.

**Multigroup unconstrained baseline model.** First, the baseline model (Figure 2) that was estimated for each group was tested again, estimating the parameters for clinical and community groups simultaneously. In order to distinguish this model (with both groups together) from the previously tested one (for each group separately), this model will be referred to as the *multigroup baseline model*, which estimates the baseline model for both clinical and community groups at the same time. None of the parameters in this multigroup baseline model were constrained to be equivalent across the two groups. The model fit of this least restrictive model was acceptable ($\chi^2_{(108)}=144.18$, CFI=.963, RMSEA=.061). The invariance testing procedure is summarized in Table 3, in which the multigroup baseline model is named as Model 1. The null hypothesis of this test is that the constraints on the parameters are correct and do not cause significant chi-square differences.
**Unconstrained vs. fully constrained model.** This study hypothesized that although clinical couples may report lower levels of differentiation, intimacy, and relationship satisfaction than community couples, the associations between the constructs would not differ across the two groups (Hypothesis 3). That is, it was expected that higher levels of differentiation would be associated with higher levels of intimacy and relationship satisfaction, and higher levels of intimacy would be associated with higher levels of relationship satisfaction across the two groups, at similar magnitudes (Hypothesis 3a/3b). In order to test these hypotheses, the multigroup baseline model (Model 1) was compared with the model in which all parameters (including both measurement and structural parameters) were constrained to be equal (Model 2). If these two models did not demonstrate a significant chi-square difference or loss of fit, it would suggest that all parameters were invariant (equivalent) across the two groups. If this was the case, there would be no need to test between-group invariance further. However, the results showed that the chi-square difference between the least restrictive model (Model 1) and the most restrictive, fully constrained model (Model 2) was significant ($\Delta \chi^2_{(19)} = 35.65, p < .05$), suggesting that not all parameters were invariant across the clinical and community groups. Therefore, further invariance tests were performed to identify which parameters were not equivalent across the two groups.

**Measurement model invariance.** In order to see whether the indicators of the latent variables functioned in the same way across the clinical and community groups, measurement model invariance was tested, particularly investigating for invariance of factor loadings. In the multigroup baseline model, there were five measurement models:
differentiation of the relationship, male emotional intimacy, female emotional intimacy, male sexual intimacy, and female sexual intimacy. Each measurement model had two indicators loading onto each latent variable (factor). For the invariance test, all the factor loadings of the measurement models were constrained invariant (equivalent) across the two groups. The model fit of this constrained model (Model 3) was then compared with that of the initial multigroup baseline model (Model 1) where no constraint was placed. As shown in Table 3, the chi-square difference between the two models was 7.24 (151.42 – 144.18) with 5 degrees of freedom. This change in the model fit was not significant ($p > .05$), suggesting the invariance of the factor loadings across the clinical and community groups. Therefore, it was ensured that the same constructs were being measured in both groups, and this model was retained for further invariance tests.

**Structural model invariance.** Having established factor loading invariance in the measurement models, further analysis was conducted to test for structural model invariance. This study’s primary interest was testing for invariance of the structural parameters between the main variables: differentiation, emotional and sexual intimacy, and relationship satisfaction. *Each* path was constrained one at a time, and the restricted model (with one parameter constrained) was then compared with Model 3, the multigroup baseline model with factor loadings constrained to be equal across the two groups. As shown in Table 3, the majority of the parameters were found to be invariant across the clinical and community groups. However, constraining the association between differentiation and male sexual intimacy (Model 5) resulted in significant loss in model fit, compared with Model 3. The chi-square difference between Model 3 and Model 5
was 5.98 (157.40 – 151.42) with 1 degree of freedom, which was statistically significant 
\((p < .05)\). Also, the chi-square difference between Model 3 and Model 14 (where the 
parameter on male sexual intimacy \(\rightarrow\) male relationship satisfaction was constrained) 
was marginally significant \((\Delta\chi^2(1) = 3.28, p = .070)\).

Based on these findings, the model was tested again with both paths 
(differentiation \(\rightarrow\) male sexual intimacy, and male sexual intimacy \(\rightarrow\) male relationship satisfaction) being free (unconstrained), while all other paths were constrained to be equal across the two groups. Compared with the model where all parameters were 
constrained to being equal \((\chi^2_{(127)}=179.83, \text{ CFI}=946, \text{ RMSEA}=.068)\), this partially 
restricted model (with the two parameters being free) provided a significantly improved 
model fit \((\chi^2_{(125)}=172.04, \text{ CFI}=952, \text{ RMSEA}=.065)\), with a chi-square difference value of 
7.79 with 2 degrees of freedom \((p < .05)\).

Figures 3 and 4 depict the final results of the multi-group invariance test for the 
clinical and community groups, respectively. The power of the final model was computed 
using computer software based on RMSEA value (Preacher & Coffman, 2006), which 
yielded the power of 0.87. This value exceeded the conventionally recommended level of 
power (Cohen, 1988, 1992) and demonstrated that the sample size of the current study 
was enough to minimize false negative errors. In both figures, thin straight lines represent 
invariant (equivalent) paths with significant associations for both clinical and community 
groups. Thin dotted lines represent invariant (equivalent) yet non-significant paths in both 
groups. Differentiation was positively associated with both male emotional intimacy 
\((\beta=1.09 \text{ for clinical group and } 1.40 \text{ for community group, } p < .001)\) and female emotional
intimacy ($\beta$=.59 for clinical group and .91 for community group, $p < .001$) in similar ways across the two groups. Also, differentiation was directly associated with male relationship satisfaction in both groups ($\beta$=.23 for clinical group and .56 for community group, $p < .05$), but not with female relationship satisfaction. Female relationship satisfaction was predicted by females’ own emotional and sexual intimacy. The association between female emotional intimacy and female relationship satisfaction was statistically significant ($\beta$=.30 for clinical group and .41 for community group, $p < .001$), and the association between female sexual intimacy and female relationship satisfaction was marginally significant ($\beta$=.19 for clinical group and .23 for community group, $p=.075$).

Two thick straight/dotted lines in Figures 3 and 4 indicate non-invariant (non-equivalent) paths across the two groups. Differentiation was significantly associated with male sexual intimacy in both groups, but at different magnitudes. The association between differentiation and male sexual intimacy was stronger among clinical couples ($B$=1.66, $SE$=0.37, $\beta$=.62, $p < .001$) than community couples ($B$=.60, $SE$=0.29, $\beta$=.35, $p < .05$). Also, the association between male sexual intimacy and male relationship satisfaction was significant in the clinical group ($B$=0.89, $SE$=0.45, $\beta$=.32, $p < .05$) but not in the community group ($B$=0.16, $SE$=0.29, $\beta$=.09, $p = .581$).

**Control Variables**

Several control variables were found to be significantly associated with the main variables. In the community group, male partners’ relationship satisfaction was
significantly associated with the couples’ relationship status. Compared with males who were “dating” or “partnered” and not living with their partners, those who lived together with their female partners (“married” or “cohabiting”) reported higher relationship satisfaction ($B=0.90, SE=0.38, \beta=.38, p < .05$).

Clinical couples’ intimacy and relationship satisfaction were influenced by multiple demographic factors. Both males’ and females’ sexual intimacy were negatively associated with their relationship length ($B=-0.01, SE=0.003, \beta=-.58, p < .05$ for males; $B=-0.01, SE=0.003, \beta=-.59, p < .001$ for females). Females’ sexual intimacy was also positively associated with their age ($B=0.09, SE=0.05, \beta=.46, p < .05$); older female partners tended to report higher levels of sexual intimacy. Lastly, male partners reported lower levels of relationship satisfaction as the length of the relationship was greater ($B=-0.02, SE=0.01, \beta=-.39, p < .05$), and female partners tended to report higher levels of relationship satisfaction when their male partners were older ($B=0.13, SE=0.06, \beta=.40, p < .05$).

**Summary of the Results**

The results of these data analyses fully supported Hypotheses 1 and 2. Clinical couples’ reports on differentiation, emotional and sexual intimacy, and relationship satisfaction were significantly lower than those of community couples, for both males and females (Hypothesis 1). Also, the theory-driven conceptual model (Figure 1) was empirically supported by the data across the two groups (Hypothesis 2).
Hypothesis 3 was partially supported with mixed results. The associations between the study variables were mostly similar across the clinical and community groups. In general, the levels of differentiation of the relationship were associated with both partners’ intimacy experiences (Hypothesis 3a), except for females’ sexual intimacy. While female partners’ emotional and sexual intimacy predicted their relationship satisfaction (Hypothesis 3b), male partners’ intimacy experiences were not associated with their relationship satisfaction except for clinical male partners’ sexual intimacy predicting their own relationship satisfaction. Also, no partner effects were found between intimacy and relationship satisfaction variables; partners’ emotional and sexual intimacy were not associated with their partners’ relationship satisfaction.

There were two paths for which parameters differed across the clinical and community groups: 1) the association between differentiation of the relationship and male sexual intimacy, and 2) the association between male sexual intimacy and male relationship satisfaction. The association between differentiation and male sexual intimacy was significant in both groups, but the magnitude of the path was greater among the clinical male partners than community male partners. There was no association between male sexual intimacy and male relationship satisfaction for community male partners, but there was for clinical male partners.
Chapter 5: Discussion

Intimacy is one of the commonly addressed topics in couple therapy. Treatment-seeking couples often report that they do not feel “intimate,” “close,” or “connected” with each other, and that their relationship distress is significantly attributed to a lack of intimacy. When faced with such vague statements, it becomes the therapist’s job to explore which particular aspects of intimacy (e.g., either emotional or sexual, or both) the couple is struggling with, potential gender differences, and any underlying issues that may be contributing to their complaints about intimacy. In general, couple therapy is known to be effective in enhancing intimacy among distressed couples (e.g., Brooks, Guerney, & Mazza, 2001). However, there is still a paucity of empirical research on treatment-seeking partners’ unique and distinctive intimacy experiences that are possibly similar to or different from those of satisfied, non-treatment-seeking couples. As a result, it is still unclear whether treatment-seeking couples tend to struggle with a lack of intimacy more than satisfied, non-treatment-seeking couples. If they do, what contributes to their difficulties with intimacy, and how are their intimacy experiences associated with relationship satisfaction similarly or differently from their counterparts? In addition to the evidence that couple therapy “works,” more detailed information about treatment-seeking couples’ intimacy issues is needed for therapists to intervene more effectively.
The current study aimed to fill the gaps in the literature by exploring treatment-seeking couples’ intimacy (both emotional and sexual) and relationship satisfaction from the perspective of Bowen’s Family Systems Theory. Bowen’s key concept of differentiation of self was used to conceptualize couple relationship processes around intimacy. Treatment-seeking couples’ relationship processes were then compared with those of satisfied non-treatment-seeking couples. Based on the belief that one of the goals of couple therapy is to help distressed couples become more satisfied with their relationship without therapeutic help, the between-group comparison was expected to show how similar and/or different the treatment-seeking couples’ relationship processes were from those of couples who maintain satisfying relationships without therapy. By doing so, this study intended to help therapists better understand their clients’ intimacy issues and employ more effective interventions that could increase their intimacy and relationship satisfaction to the levels experienced by satisfied non-treatment-seeking couples.

**Clinical couples, are they less satisfied and less intimate?**

Before discussing how to intervene with treatment-seeking couples’ intimacy issues, one may wonder if lack of intimacy is more of a struggle for treatment-seeking couples (clinical couples) or, rather, it is a common struggle for all couples with different levels of relationship satisfaction. That is, is a lack of intimacy a unique issue specifically
for clinical couples? Consistent with previous studies (e.g., Veroff, Kulka, & Douvan, 1981), this study demonstrated that clinical couples tended to be less satisfied with their relationship than those who believed that their relationship was satisfying without therapy (community couples). Further, it was found that those distressed clinical couples were less likely to feel emotionally and sexually intimate in their relationship than community couples, as also suggested by existing studies (e.g., Crowe, 1997; Doss, Simpson, & Christensen, 2004). These findings, altogether, suggest that the lack of intimacy might be a more unique struggle for distressed couples than for “happy” couples who are not receiving therapy.

Interestingly, not only did partners seeking therapy report lower levels of their own intimacy than non-treatment-seeking partners, but they also thought that their partners’ intimacy levels were lower. That is, clinical partners, who themselves felt less emotionally and sexually intimate with their partners, were less “confident” about their partners’ intimacy experiences as compared with community partners. In contrast, community partners were more likely than clinical partners to report that they themselves and their partners were both experiencing higher levels of intimacy in emotional and sexual domains of their relationship. Considering that intimacy is a relational construct that is formed by relationship processes between partners (e.g., Reis & Patrick, 1996; Reis & Shaver, 1988), these findings suggest a potential “vicious cycle” among distressed clinical couples. A partner’s intimacy-related struggles and dissatisfaction may have negative influences on the other partner’s intimacy experiences as well, because “knowing” one’s partner’s dissatisfaction can lower the other partner’s sense of security.
and confidence during intimate encounters; the partner’s lowered level of intimacy might then further worsen the already-dissatisfied partner’s intimacy experiences as a result. If this is the case, both partners might become gradually “shut down” emotionally and sexually even if they were pretty open and confident earlier in the relationship, and their levels of emotional/sexual intimacy may also decline within such a vicious cycle.

**Support for Theoretical Conceptualization**

The current study aimed to examine couples’ intimacy issues at a “system” level by exploring their relationship processes rather than focusing on the observed symptoms (i.e., the “content”). The findings of this study generally supported the presuppositions of Bowen’s Family Systems Theory. Regardless of the partners’ perceived relationship satisfaction, the level of differentiation of their relationship (as assessed by “healthy individuality”) was an important factor for the partners’ intimacy experiences. The associations between differentiation and emotional/sexual intimacy were quite similar among clinical and community couples, although the levels of emotional and sexual intimacy differed between the two groups (with clinical couples reporting lower levels). When the relationship allowed both partners to maintain individuality while still being together (togetherness), partners were more likely to feel emotionally and sexually intimate with each other, whether they were distressed or satisfied with their relationship in general. Thus, being a “self” in a relationship appeared to be an important prerequisite
for high levels of emotional and sexual intimacy. This finding is consistent with previous studies suggesting that intimacy requires a solid self-concept and identity (e.g., Beyers & Seiffge-Krenke, 2010), and differentiation may determine partners’ ability to develop and maintain intimacy with each other (e.g., Schnarch, 1991, 1997). It may be that in a poorly differentiated relationship, partners feel uncomfortable with honestly expressing themselves due to their fear of ruining the togetherness of their relationship. Believing that having different intimacy needs may threaten the sense of partnership between them (“we-ness”), these partners might try to sacrifice their own or their partners’ intimacy needs. Or, partners might be cut off to the extent that they completely avoid intimate encounters due to their uncomfortable feelings associated with closeness and connectedness. All these interaction patterns may be manifestations of partners’ emotional reactivity in a poorly differentiated relationship. Their needs for togetherness and individuality are not met in their relationship overall, and the area of intimacy is no exception to this.

The association between differentiation and intimacy established in this study may also imply that the “facilitators” or “barriers” of intimacy found in previous studies may only be the manifestations of the level of differentiation of a relationship. In attempts to identify what facilitates or impedes couple intimacy, many previous studies have focused on some other observed issues in a relationship that lacks intimacy. One example is communication patterns between partners. Studies have suggested that partners’ lack of effective communication patterns, such as self-disclosure and mutual validation, may impede their intimacy formation (e.g., Laurenceau et al., 1998;
Laurenceau et al., 2005; Mitchell et al., 2008). From a systemic perspective, however, ineffective couple communication may merely be one of the “symptoms” of unhealthy relationship processes just like intimacy issues are (as opposed to one causing the other). One recent study (Timm & Keiley, 2011) supported this assumption by demonstrating that the level of differentiation influences sexual satisfaction through sexual communication between partners. Therefore, communication may be more of a mediator in the association between differentiation and the sexual aspect of intimacy, rather than the ultimate cause of lack of intimacy. The findings of the current study, adding to extant literature, therefore imply that intimacy might “naturally” emerge in a relationship in which both partners are highly differentiated, and increasing partners’ levels of differentiation could address partners’ intimacy issues in a more fundamental way than simply trying to “fix” other observed symptoms (e.g., practicing communication and intimacy skills).

Within- and Between-Group Findings

Differentiation and Intimacy

The associations between intimacy and relationship satisfaction found in this study were somewhat inconsistent and only partially supported the hypotheses. It is noteworthy that while the between-group differences were not striking, interesting gender differences were found within each group. First, while the relationship level of
differentiation was associated with males’ emotional and sexual intimacy, only female emotional intimacy was influenced by the level. The relationship level of differentiation had nothing to do with female partners’ sexual intimacy in both distressed and happy couples. This is an interesting finding, especially considering that male sexual intimacy was associated with relationship differentiation regardless of the couple’s levels of relationship satisfaction.

Although interpreting this result may be beyond the scope of the current study, one of the possible reasons may be related to how females are socialized about their sexuality. In general, sexual scripts in this society tend to be highly gender-biased (Jackson & Cram, 2003). Men tend to be expected to have strong sex drives and desires, initiate sex, and play an active role in sexual situations. In contrast, sexual scripts for women focus more on passivity and other-oriented attitudes; females are expected to have lower levels of sexual desire than men, be less assertive and expressive in the sexual context, and prioritize others’ feelings and needs over their own (e.g., Byers, 1996; Morgan & Zurbriggen, 2007; Sanchez, Fetterolf, & Rudman, 2012). These sexual scripts influence not only how men and women interact in sexual situations, but also how they understand themselves and what they expect in sexually intimate encounters (Masters, Casey, Wells, & Morrison, 2013). Therefore, when such sexual scripts are accepted uncritically, females may conceptualize their own sexuality within a passive framework and behave accordingly in the sexual contexts. Following the cultural expectations of female sexuality, a female partner might dismiss her own sexual needs and may not know how to make a connection between her sense of self and sexuality. The findings of this
study suggest that such disconnections between females’ sexuality and sense of self might happen even in satisfying relationships with higher levels of differentiation. It may be that a female partner generally has a solid sense of self in most aspects of her life and relationship (differentiation), but such self-confidence and self-determination may not necessarily spill over to the area of sexual intimacy.

By contrast, this study showed that in both clinical and community groups male partners’ sexual intimacy was associated with the levels of differentiation of the relationship, and this association was stronger among clinical couples than community couples. Revisiting the previous discussion on gender socialization (based on sexual scripts), it is possible that males consider their sense of self in the sexual contexts more than other aspects of their relationship, as they tend to use sex to confirm their masculinity (e.g., Gilbert & Scher, 1999). If this is the case, male partners in distressed relationships who might already suffer from little sense of self (due to their lower levels of differentiation) could become particularly sensitive and more vulnerable during sexually intimate encounters, compared with satisfied males with higher levels of differentiation. In addition, considering how sexual intimacy was estimated in this study (with partners’ perceptions of their own and their partners’ intimacy), distressed male partners who lack a sense of individuality might also tend to have lower levels of confidence in their partners’ sexual intimacy. As they are more prone to thinking that their female partners are not sexually satisfied with them, their own sexual intimacy may become more vulnerable and insecure as a result.
Another explanation might be that for males, there is a “threshold” for the relationship level of differentiation necessary to support sexual intimacy, such that beyond this threshold any variation in differentiation is less influential on males’ sexual intimacy. In the community group of this study, the levels of relationship differentiation were higher, and thus may have met the threshold; therefore, it could be the case that higher levels of differentiation beyond the threshold had less of an impact on sexual intimacy for males in the community group. In the clinical group, however, differentiation levels were significantly lower and might have not met the threshold to support sexual intimacy for males; variation in differentiation in the clinical group could therefore have a greater influence on sexual intimacy for males.

**Intimacy and Relationship Satisfaction**

Second, another gender difference was demonstrated in the association between intimacy and relationship satisfaction. While females’ relationship satisfaction was directly associated with their intimacy, males’ intimacy did not seem important for their relationship satisfaction. Whether the relationships are perceived as “happy” or not, it appeared that for female partners, feeling emotionally and sexually intimate with their partners was an important factor for satisfaction with their relationship, supporting the well-established associations between emotional/sexual intimacy and relationship satisfaction (e.g., Greeff & Malherbe, 2001; Sprecher, 2002).

However, males’ intimacy and relationship satisfaction demonstrated a somewhat counterintuitive pattern, which is not consistent with previous research, either. Among
the satisfied couples, male partners’ relationship satisfaction was not associated with any of their intimacy experiences, either emotional or sexual. The only predictor for male relationship satisfaction in these “happy” relationships was the level of differentiation of the relationship. On the other hand, among distressed couples, male partners’ relationship satisfaction was associated with their sexual intimacy as well as differentiation of the relationship (but not emotional intimacy). These findings suggest that lack of sexual intimacy is an issue that contributes to treatment-seeking male partners’ relationship distress. By contrast, in “happy” relationships with higher levels of differentiation, participating in such a relationship may be good enough for male partners, again speaking to the concept of a threshold of differentiation. Once this threshold is met and/or exceeded, fluctuations in males’ satisfaction in the relationship may not be as directly influenced by their sexual intimacy experiences, compared with distressed, less differentiated males.

**Differentiation and Relationship Satisfaction**

Third, the level of differentiation of the relationship was predictive of male relationship satisfaction, but not female relationship satisfaction, among both clinical and community couples. Bowen did not necessarily suggest the differential effects of differentiation on males and females, so this finding somewhat challenges the theoretical presuppositions. However, a few previous empirical studies did suggest that differentiation can influence relationship satisfaction similarly or differently for males and females. The current study’s finding partially supports previous research (e.g.,
Tremblay et al., 2002) in that only males’ relationship satisfaction was associated with differentiation. However, it is also possible that it depends on how differentiation is measured. For example, in Peleg’s (2008) study, the level of differentiation was measured in four different areas: emotional reactivity, emotional cutoff, fusion with others, and “I” position. Peleg explained that while males’ relationship satisfaction was associated with all the indicators except for fusion, females’ relationship satisfaction was only connected to emotional cutoff. In the current study, however, differentiation was only assessed with partners’ general sense of self (individuality) in their relationship, and specific indicators of differentiation were not taken into account. Future studies may replicate the current study with differentiation measured in more specific areas in order to investigate which indicator of differentiation is associated with males’ and females’ relationship satisfaction similarly or differently. Such attempts could also examine whether female’s sexual intimacy is associated with specific manifestations of differentiation in the relationship, which could not be fully explored in this study.
Clinical Implications

According to Bowen’s theory, a poorly differentiated relationship is likely to be distressed (Bowen, 1978; Kerr & Bowen, 1988). Symptoms of low levels of differentiation can develop in any area of a couple relationship, and intimacy may be one of them. Intimacy can be a particularly sensitive area of a couple relationship because it requires both partners’ willingness to be open and vulnerable to each other (e.g., Nowinski, 1988; Sherman, 1993), and poorly differentiated partners might find it even more challenging to discuss and deal with their intimacy issues. The findings of this study, supporting Bowen’s theory, suggest that therapists could help enhance distressed couples’ intimacy as well as relationship satisfaction by increasing partners’ levels of differentiation (thus the level of differentiation of the relationship). The current section discusses a few possible clinical implications, provided that the current study’s findings may hold true and can be supported by further empirical studies.

Decreasing Reactivity in Therapy

Considering the vulnerable nature of the topic of intimacy, therapists should first create a non-threatening environment in which both partners can feel safe enough to talk about their intimacy issues (e.g., Sherman, 1993). By doing so, the therapist lowers the partners’ anxiety associated with intimacy, and partners are more likely to provide their therapist with more specific information about their intimacy concerns. More importantly, partners may be less likely to become reactive when they feel safe in
therapy, better enabling them to discuss sensitive intimacy-related issues without engaging in dysfunctional interaction patterns (see Schnarch 1991, 1997; Titelman, 1998).

**Conceptualization of the Issue**

Once the therapist develops rapport with the couple, and both partners become comfortable in therapy, the therapist may start helping the partners make connections between their differentiation and intimacy issues. The partners are now encouraged to conceptualize their intimacy issues in the context of the larger relationship processes, particularly the level of differentiation of the relationship (see Titelman, 1998). In clinical settings, it is often observed that treatment-seeking partners’ primary interest is to achieve “complete we-ness” in their relationship when intimacy is their main issue. However, based on Bowen’s theory and the current study, therapists working with couples who lack intimacy could help them realize that intimacy is not strictly togetherness; rather, partners’ intimacy may be better enhanced when both partners’ solid sense of self (individuality) is acknowledged. Such conceptualization could further provide the partners with the insight that their lack of intimacy is not simply one partner’s fault, and that their intimacy issues are actually their relational issues (not one individual partner’s). By doing so, the therapist helps the partners resist blaming themselves or their partners for their presenting issues while holding both partners accountable for their issues at the same time.
Analyzing How Reactivity Plays a Role

If treatment-seeking couples do have lower levels of differentiation as it appeared in this study, and thus have higher levels of emotional reactivity according to Bowen (1978, Kerr & Bowen, 1988), the therapist may then be able to facilitate discussion about how partners may have unknowingly engaged in dysfunctional, reactive interaction patterns. One of the plausible metaphors that could help partners’ understanding of their reactive patterns is reflex. Reflex responses, such as removing hands from an extremely hot object, do not require clear thinking – one automatically acts in reaction to the given situation. Similarly, partners in a poorly differentiated relationship may repeat dysfunctional interaction patterns without being able to think clearly, mostly in reaction to the overwhelming emotions at that moment (Friedman, 1991).

When intimacy becomes an issue, partners might ignore their own and/or their partners’ intimacy needs, or they might try to overcompensate their unmet needs for togetherness through obsessively pursuing emotional or sexual connections. In the middle of such interaction patterns, partners are less likely to step back and reflect upon why they tend to engage in the same interaction patterns repeatedly. The therapist may help the partners stop and think about what makes them react (see Titelman, 1998). Some partners might have avoided intimate encounters (e.g., being emotionally vulnerable or sexually close) due to their fear of rejection. Some others might have been obsessed with their sense of intimacy to the extent that there is no sense of self because they cannot deal with feelings of separateness. It is also possible that some partners believe that having
different intimacy needs means that they are incompatible. All these “reflexive” thoughts, behaviors, and interaction patterns have to be identified and discussed in therapy. Once partners have been made aware, their thoughts, behaviors, and interaction patterns are no longer reflexive; they now have more power to control their thoughts and behaviors in order to prevent repeated dysfunctional interaction patterns and are better able to make rational decisions even under stress.

The discussion about “what makes them react” can lead to a deeper level than the issues presenting in the current relationship. One of the possible topics is the partners’ family-of-origin experiences. Bowen’s theory suggests that individuals tend to replicate what happened in their family-of-origin in other relationships (Bowen, 1978; Kerr & Bowen, 1988). In order to see whether partners’ reflex-like thoughts, behaviors, interaction patterns originated from the family they grew up in, the therapist may initiate the conversations about what occurred in their family-of-origin. Possible questions may include whether each family member’s sense of self was respected in the family, whether togetherness was more valued at the expense of individuality (or the other way around), and how they perceived their parents’ relationship as a couple. It is possible that in their current relationship, partners might have unconsciously repeated their previous roles and interaction patterns exercised in their family-of-origin (Bowen, 1978; Kerr & Bowen, 1988; Titelman, 1998). For example, if they grew up in a family where no affection was explicitly expressed, they might find it difficult to initiate moves toward intimacy. If the partners grew up observing their parents only becoming close to each other in order to
make up for their intense arguments, the partners themselves might have unconsciously believed that having arguments is the only way to lead to couple intimacy.

When the therapist analyzes couples’ relationship processes regarding intimacy, his or her attention should also be directed to gender differences. The findings of the current study seem to call for attention to sexual intimacy in particular. It was found that females’ sexual intimacy, although important for their relationship satisfaction, was not associated with the relationship level of differentiation, while males’ sexual intimacy appeared to be meaningfully influenced by relationship differentiation. As differentiation in this study was assessed with the degree of partners’ acknowledgement of individuality, the therapist may be able to help both partners articulate how they perceive themselves in sexual contexts. Due to society’s sexual scripts (e.g., Jackson & Cram, 2003) and possibly their family-of-origin experiences, some female partners might not have considered the role of one’s self in a sexual context. In contrast, male partners might have placed great importance on sexual intimacy, to the extent that their general struggles with lack of individuality in the relationship have become overly associated with how they perceived their sexuality. These issues, like reflexes, may have played a role in partners’ intimate encounters without clearly thought out and recognized.

**Discussing Other Options and Choices**

After partners increase their understanding of themselves and their partners, and assess their relationship processes around intimacy, the therapist then should encourage them to develop alternatives (see Titelman, 1998). Now the partners may be better able to
make intentional decisions about what strategies they could *choose* to use when they feel insecure, rejected, disconnected, and distant from each other. Will they continue to adopt their previous reflexive patterns just because they feel more comfortable with them? Or, will they endure a level of discomfort in order to bring about changes in their relationship processes and subsequently enhance their intimacy experiences? A successful treatment would increase the likelihood of partners choosing to stop their dysfunctional interaction patterns and bring about new, constructive strategies to establish intimacy in their relationship in a way that does not compromise their togetherness or individuality.

**Strengths, Limitations, and Future Directions**

The current study’s several major strengths have the potential to contribute to the field of couple and family therapy. This is the first exploratory study that empirically investigates distressed treatment-seeking couples’ emotional/sexual intimacy and relationship satisfaction within the framework of Bowen’s Family Systems Theory, compared with satisfied, non-treatment-seeking couples. While extant literature is replete with information about how distressed couples’ communication behaviors and conflict resolution skills differ from their satisfied counterparts (e.g., Margolin & Wampold, 1981), this study expands the current literature by demonstrating that distressed treatment-seeking couples’ relationships tend to be less differentiated than those of satisfied couples, and that distressed partners tend to experience lower levels of
emotional and sexual intimacy than satisfied partners. These findings imply that the topic of intimacy should be addressed in therapy, and that it may be important to discuss partners’ intimacy experiences in different domains of their relationship (e.g., emotional and sexual).

Another strength of this study is its systemic consideration of intimacy and support for Bowen’s theory. Concerning what contributes to couple intimacy, existing studies have focused more on the “content” level of facilitators or barriers of intimacy, including communication patterns between partners. Employing more of a systemic perspective, this study went further to explore the relationship’s level of differentiation as the underlying force that may determine partners’ ability to experience emotional and sexual intimacy. Considering that Bowen’s theory has suffered from a lack of empirical evidence, this study contributes to the field by demonstrating that Bowen’s Family Systems Theory is a plausible framework for understanding couple intimacy. Further, the fact that the relationship processes around intimacy did not differ markedly among the distressed and non-distressed couples supports the general applicability of the theory.

However, this study is not free from limitations, and they must be acknowledged when interpreting the findings. First, both clinical and community groups were somewhat homogenous. The majority of the couples in both groups were mostly Caucasian and highly educated, and there was little variability in other demographics, such as the number of children and family income. Therefore, the findings of this study may not be generalized among other populations. For example, it is possible that ethnic minority couples’ understanding of the items that measured differentiation may not be the same as
that of Caucasian couples, which could yield different results. Also, more research is needed to examine whether the findings of this study would hold true among same-sex couples. The current study suggested some gender differences; if these were due to gender socialization, how would same-sex partners’ relationship processes around intimacy differ from those of different-sex partners? In order to investigate these research questions, future studies are definitely warranted to replicate the current study among more diverse populations.

Second, special attention should be given to the fact that both the clinical and community groups consisted of couples whose relationship status and relationship length differed. Some couples were married or living together, while some others were dating. The relationship length also ranged from a few months to a few decades. Although the analyses of this study took the effects of such variations into account, more rigorous investigations are needed in order to compare the relationship processes among married couples versus cohabiting or dating couples, as well as short-term versus long-term relationships. In future studies, it would be desirable to sample separate groups based on relationship status (e.g., married couples, cohabiting couples, and dating couples) and compare these groups. In addition to the lack of the eligibility criteria about relationship status and length, this study did not have screening procedures before the data were collected. For example, couples from the community were included in this study solely based on their self-report of high levels of relationship satisfaction, and this resulted in the exclusion of one couple. Future studies may be able to ensure eligibility of the sample by employing screening procedures before data collection. To replicate the current study,
volunteering couples for the community sample may need to be asked to complete a relationship satisfaction questionnaire first, and their eligibility may be determined based on their reported levels of satisfaction.

Third, measures of the constructs (differentiation, intimacy, and relationship satisfaction) may have limitations. One possibility is that community couples’ responses may be positively inflated because of a social desirability bias; as they volunteered for research participation as “happy” couples, they might have responded to questions in more positive ways. Similarly, clinical couples who sought therapy under stress might describe their relationship in more negative ways. Another measurement issue is the inability to take correlated measurement errors into account as a way to control for the biases described above. As each latent variable in the model only had two indicators, the measurement errors could not be correlated within each model due to model identification issues.

Fourth, although the tested model was theory-driven, this study’s findings may suggest limited empirical evidence for causal inferences between the constructs due to its use of cross-sectional data. Future studies should consider using longitudinal data with different time points of data collection. By doing so, the causal associations between differentiation, intimacy, and relationship satisfaction will be more clearly determined than in the current study. Further, the use of longitudinal methods will make it more plausible to test time-related mechanisms between the constructs. Potential research questions may include whether couple intimacy mediates the association between
differentiation and relationship satisfaction, and if changes in the levels of differentiation would lead to changes in the levels of intimacy and relationship satisfaction over time.

Lastly, there were several interesting, yet unexpected, findings, but exploring them was beyond the scope of this study. For example, differentiation of the relationship was associated with male relationship satisfaction only, but not with female relationship satisfaction. This finding only partially supports Bowen’s theory and needs to be re-investigated to confirm (or disconfirm) whether the effects of differentiation on relationship satisfaction differ according to gender. Also, further investigation is warranted to test the existence of a potential “threshold” of differentiation, which was hypothetically explained in this study. One way to test this hypothesis may be to explore whether there is a minimum adequate level of differentiation in relationships (e.g., “cut-off” level), and whether couples with certain levels of differentiation (or above) report significantly more positive intimacy experiences and relationship satisfaction, compared with couples whose differentiation levels are below this threshold. Such a threshold (or “cut-off” level) of differentiation, if found, will then suggest an idea of a baseline level of differentiation for well-functioning couple relationship processes.

Another unexpected finding of this study was the lack of “partner-effects.” Differentiation, intimacy, and relationship satisfaction were associated only for individual partners (within-partners), but not between partners. The lack of between-partner associations is inconsistent with a systems perspective of couple relationships as well as previous empirical findings on intimacy (e.g., Yoo et al., 2013). Despite the current study’s potential contributions, future research may need to study these unexplained
findings, ideally with a larger sample (i.e., 100 dyads in each group) as well as more rigorous research designs and methods.

**Conclusion**

Distressed treatment-seeking couples often complain about their lack of intimacy, and enhancing intimacy is thus considered one of the main goals for couple therapy. The findings of this study, within the framework of Bowen’s Family Systems Theory, suggested that couple intimacy can be strengthened when partners are able to maintain their sense of self (individuality) while remaining connected with each other (togetherness). Therefore, contrary to the popular understanding of intimacy as a primarily relational construct, couple intimacy may be best established based on a well-balanced state of togetherness and individuality in a relationship. In clinical settings, interventions for intimacy concerns may need to include increasing partners’ awareness of self within their relationship and their understanding of their relationship processes regarding intimacy. By doing so, successful couple therapy is expected to empower distressed partners to the extent that they could better regulate their emotions and make rational decisions about their relationship. The findings of the current study, though preliminary, further suggest that distressed treatment-seeking partners’ enhanced sense of self and ability to make “choices” in their relationship may contribute to increasing their
levels of intimacy and relationship satisfaction, possibly to the levels experienced by satisfied, non-treatment-seeking couples.
References


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Appendix A: Pilot Instrument
## Pilot Instrument (tested from April to October 2011)

<table>
<thead>
<tr>
<th></th>
<th>Partners’ perceptions of <em>their own</em> intimacy</th>
<th>Partners’ perceptions of <em>their partner’s</em> intimacy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emotional Intimacy</strong></td>
<td>I mostly feel emotionally connected with my partner.</td>
<td>It seems that my partner mostly feels emotionally connected with me.</td>
</tr>
<tr>
<td></td>
<td>I am available when my partner needs me emotionally.</td>
<td>My partner seems available when I need him/her emotionally.</td>
</tr>
<tr>
<td></td>
<td>I listen to and understand my partner’s emotions and feelings.</td>
<td>My partner seems to listen to and understand my emotions and feelings.</td>
</tr>
<tr>
<td></td>
<td>I feel comfortable with being emotionally vulnerable with my partner.</td>
<td>My partner seems comfortable with being emotionally vulnerable with me.</td>
</tr>
<tr>
<td></td>
<td>Most of the time, I am aware of my partner’s emotions, whether positive or negative.</td>
<td>Most of the time, my partner seems aware of my emotions, whether positive or negative.</td>
</tr>
<tr>
<td><strong>Sexual Intimacy</strong></td>
<td>I am satisfied with my sex life with my partner.</td>
<td>My partner seems satisfied with his/her sex life with me.</td>
</tr>
<tr>
<td></td>
<td>Most of the time, I want to have sex when my partner also wants sex.</td>
<td>Most of the time, my partner seems to want to have sex when I also want sex.</td>
</tr>
<tr>
<td></td>
<td>I care about my partner’s sexual pleasure, not just my own.</td>
<td>My partner seems to care about my sexual pleasure, not just his/her own.</td>
</tr>
<tr>
<td></td>
<td>I am open to talk about sex with my partner.</td>
<td>My partner seems open to talk about sex with me.</td>
</tr>
<tr>
<td></td>
<td>I think we are a good fit as sexual partners.</td>
<td>My partner seems to think that we are a good fit as sexual partners.</td>
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Appendix B: Tables and Figures
Table 1. Correlations, Means (M), Standard Deviations (SD), and Cronbach’s Alphas (α)

<table>
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<th></th>
<th>Mhi</th>
<th>Fhi</th>
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<th>Memo2</th>
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<th>Fem2</th>
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<th>Fsex1</th>
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* p < .05. ** p < .01.

Notes:
1. Community group shown above the diagonal, and clinical group shown below the diagonal
2. Mhi = Males’ healthy individuality; Fhi = Females’ healthy individuality; Memo1 = Males’ own emotional intimacy; Memo2 = Males’ perceptions of their partners’ emotional intimacy; Fem1 = Females’ own emotional intimacy; Fem2 = Females’ perceptions of their partners’ emotional intimacy; Msex1 = Males’ own sexual intimacy; Msex2 = Males’ perceptions of their partners’ sexual intimacy; Fsex1 = Females’ own sexual intimacy; Fsex2 = Females’ perceptions of their partners’ sexual intimacy; Mrelsat = Males’ relationship satisfaction; Frelsat = Females’ relationship satisfaction.
Table 2. *Confirmatory Factor Analysis (CFA)*

<table>
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<tr>
<th>Path</th>
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<th>Baseline Model (Community) CFA</th>
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</thead>
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<tr>
<td>Differentiation of the Relationship</td>
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</tr>
<tr>
<td>Mhi</td>
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<td>1.000 (.896)</td>
</tr>
<tr>
<td>Fhi</td>
<td>0.932 (.499) ***</td>
<td>0.339 (.387) .016*</td>
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<tr>
<td>Male Emotional Intimacy</td>
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<td></td>
</tr>
<tr>
<td>Memo1</td>
<td>1.000 (.654)</td>
<td>1.000 (.936)</td>
</tr>
<tr>
<td>Memo2</td>
<td>1.553 (.991) ***</td>
<td>0.879 (.851) ***</td>
</tr>
<tr>
<td>Female Emotional Intimacy</td>
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<td></td>
</tr>
<tr>
<td>Femo1</td>
<td>1.000 (.755)</td>
<td>1.000 (.891)</td>
</tr>
<tr>
<td>Femo2</td>
<td>1.500 (1.000) ***</td>
<td>1.456 (1.000) ***</td>
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<tr>
<td>Male Sexual Intimacy</td>
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<td>Msex1</td>
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<td>1.000 (.955)</td>
</tr>
<tr>
<td>Msex2</td>
<td>1.329 (.900) ***</td>
<td>0.981 (.891) ***</td>
</tr>
<tr>
<td>Female Sexual Intimacy</td>
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<tr>
<td>Fsex1</td>
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<td>1.000 (1.000)</td>
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<tr>
<td>Fsex2</td>
<td>0.773 (.864) ***</td>
<td>0.776 (.788) ***</td>
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</table>

†p < .10. *p < .05. ** p < .01. *** p < .001.
<table>
<thead>
<tr>
<th>Model</th>
<th>Constraints</th>
<th>$\chi^2$</th>
<th>df</th>
<th>$\Delta\chi^2$</th>
<th>$\Delta df$</th>
<th>$p$</th>
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<tr>
<td>Model 1</td>
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<tr>
<td>Model 3</td>
<td>Measurement model (factor loadings)</td>
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<td>113</td>
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<td>5</td>
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</tbody>
</table>

**Differentiation**

| Model 4   | → Male emotional intimacy                           | 153.21  | 114 | 1.79           | 1           | .181 |
| Model 5   | → Male sexual intimacy                              | 157.40  | 114 | 5.98*          | 1           | .014 |
| Model 6   | → Female emotional intimacy                         | 151.91  | 114 | 0.49           | 1           | .484 |
| Model 7   | → Female sexual intimacy                            | 152.68  | 114 | 1.26           | 1           | .262 |
| Model 8   | → Male relationship satisfaction                    | 153.07  | 114 | 1.65           | 1           | .199 |
| Model 9   | → Female relationship satisfaction                  | 151.42  | 114 | 0              | 1           | 1.00 |

**Male emotional intimacy**

| Model 10  | → Male relationship satisfaction                    | 153.33  | 114 | 1.91           | 1           | .167 |
| Model 11  | → Female relationship satisfaction                  | 153.63  | 114 | 2.21           | 1           | .137 |

**Female emotional intimacy**

| Model 12  | → Female relationship satisfaction                  | 153.58  | 114 | 2.16           | 1           | .142 |
| Model 13  | → Male relationship satisfaction                    | 152.48  | 114 | 1.06           | 1           | .303 |

**Male sexual intimacy**

| Model 14  | → Male relationship satisfaction                    | 154.70  | 114 | 3.28†          | 1           | .070 |
| Model 15  | → Female relationship satisfaction                  | 151.49  | 114 | 0.07           | 1           | .791 |

**Female sexual intimacy**

| Model 16  | → Female relationship satisfaction                  | 151.43  | 114 | 0.01           | 1           | .920 |
| Model 17  | → Male relationship satisfaction                    | 151.80  | 114 | 0.38           | 1           | .538 |

*p < .10. *p < .05. **p < .01. ***p < .001.

**Notes:**

1. The null hypothesis was that “the constraints on the parameters are correct and do not cause a significant chi-square difference.”
2. $\Delta\chi^2$ = difference in chi-square values; $\Delta df$ = difference in degrees of freedom.
3. Model 2 and 3 were compared with Model 1 (multigroup baseline model); Models 4 to 17 were compared with Model 3 (multigroup baseline model with factor loadings constrained) for structural invariance testing.
Figure 1. Conceptual Model
Figure 2. Constructed Model
Figure 3. Results of the Between-group Invariance Test – Clinical Group

Notes:
1. Non-significant paths are shown as dotted lines.
2. Between-group invariant paths are shown as straight lines.
3. Between-group non-invariant paths are shown as thick lines.
Figure 4. Results of the Between-group Invariance Test – Community Group

$\chi^2_{(125)} = 172.04; \text{CFI} = 0.952; \text{RMSEA} = 0.065$

Note:
1. Non-significant paths are shown as dotted lines.
2. Between-group invariant paths are shown as straight lines.
3. Between-group non-invariant paths are shown as thick lines.
Appendix C: Research Documents for the Clinical Group

(Solicitation Letter, Research Consent Form, HIPPA,
& Intake Questionnaire for the Clinical Group)
Dear Client(s):

Welcome to the Ohio State Couple and Family Therapy Clinic. Our primary goal is to provide you with high quality therapeutic services in order to help you meet the needs that have brought you here. The following questionnaire is used by the clinic staff to make assessments of you and your partner and is part of your treatment here. The staff of the Couple and Family Therapy Clinic is also interested in documenting the effectiveness of the treatment you receive at the clinic for research purposes.

We would like you to participate in an ongoing study being conducted here at the Clinic. For the study you will be asked to complete this initial questionnaire as usual. Then, you will be asked to complete a short questionnaire after sessions 2 through 6. We encourage you to participate in this study. If you and your partner decide to participate you will get a $20 reduction to your first session fee.

You and your partner will not be identified in anyway in any of the reports that are written from this project. The only identifier we will be using for the data is your case number. Only clinic staff will have access to your file which would connect your name and case number. As explained on the consent form, we will maintain your confidentiality. If you elect not to participate in this project, this in no way will affect the services you receive at the clinic.

The following set of questions refers to you and your partner. This information will help us to get a quick "snap shot" of you and your partner as we begin our work with you, and also allow us to chart your progress through treatment.

If you do not wish to answer one of the questions, please skip that one, and go on to the next one. We hope that you will complete all the questions. This will provide your therapist with valuable information about you and your partner that will enable him/her to develop a treatment plan more quickly. The questionnaire should take you about 30 minutes to complete. When you have finished, please place the questionnaire in the envelope provided and give it to your therapist.

If you elect to participate in the research study, you will be asked to complete a form that should take you about 5 to 10 minutes to complete after your second through sixth sessions. It asks you about your relationship (if you are currently in one), your current and extended family relationships and how you feel about the progress of treatment. Once you have completed this 1 page form place it in the envelope provided and drop it into the box at the clinic door. Again, your participation in this part of the project is completely voluntary, but would help us to understand what factors contribute to the most effective treatment.

Thank you in advance for your time and attention to these questions and the project. If you have questions please feel free to ask your therapist, or me (614-688-3259). If for any reason these questions upset or concern you, please don’t hesitate to talk to your therapist about your feelings. If you don’t want to talk with your therapist about it and would like a referral to another therapist, please feel free to call me.

Sincerely,
Suzanne Bartle-Haring, Ph.D.
Professor Family Therapy
Principal Investigator
The Ohio State University Consent to Participate in Research

Study Title: The Ohio State University Couple and Family Therapy Clinic Research Protocol
Researcher: Suzanne Bartle-Haring, PhD

Sponsor:

This is a consent form for research participation. It contains important information about this study and what to expect if you decide to participate.

Your participation is voluntary. Please consider the information carefully. Feel free to ask questions before making your decision whether or not to participate. If you decide to participate, you will be asked to sign this form and will receive a copy of the form.

Purpose: Our primary goal is to provide you with high quality therapeutic services in order to help you meet the needs that have brought you here. As part of our mission, we are interested in finding out how therapy benefits couples such as yours and what contributes to treatment effectiveness. We have two ways of examining this. The first is through questionnaires and the second is through saving therapy session video for coding of the therapist-client interactions.

Procedures/Tasks: Before you begin therapy, we would like you to complete a questionnaire. The questions asked are about you, and your relationships with significant others. These questionnaires will be used to enhance therapy and as research tools in better understanding the therapeutic process. Under no circumstance will your information and your name be associated when reporting the data we collect. All information will be reported in aggregate form. To clarify, the questionnaires you will be given at your first session are part of the services you receive at the clinic. They will help us to get a quick “snap shot” of you and your family, as well as help us assess your progress. You will also be asked to complete a one page form after each session 2 through 6. Answering the questions on these questionnaires is completely voluntary. If you choose not to participate, this will not impact the services you receive at the clinic. The project currently ongoing in the clinic focuses on the impact of various relationships – with your partner, your immediate family and your extended family – on the outcome of treatment. When you decide to terminate therapy here, we will ask you to complete a termination questionnaire.
Duration:
If you choose to complete the questionnaires, the questionnaire that you will complete prior to therapy will take approximately 30-45 minutes to complete. You will also complete questionnaires after sessions 2-6 that will take approximately 5-10 minutes to complete each. The total duration of the questionnaire option will not last more than 6 therapy sessions and up to 1 hr 45 minutes to complete in total. The termination questionnaire will take approximately 30 minutes to complete. If you decide to stop participating in the study, there will be no penalty to you, and you will not lose any benefits to which you are otherwise entitled. Your decision will not affect your future relationship with The Ohio State University.

Risks and Benefits:
If you decide to participate in this study, the information you provide here will help us as we continue to refine the services we provide here at the clinic and in the mental health field in general. Understanding more about you and how you change over the course of early sessions of therapy will help us know how to better intervene with couples in the future.

Information about your alcohol or drug use, sexual attitudes, mental health, and violence in your relationship will be collected via surveys. The only possibility of “damage” to you would come from your disclosure of engagement in some sort of child abuse. As marriage and family therapists we are mandated to report child abuse to Child Protective Services. The research protocol does not ask for this sort of information, but as you participate in therapy, you may disclose this information. In such a situation, your records could be subpoenaed and thus, the clinic may be compelled to release your intake questionnaire data. The after session questionnaires are not part of the clinic record.

You may find yourself with uncomfortable feelings while you answer some of these questions. Please don’t hesitate to speak with your therapist about these feelings or ask us to make a referral to another therapist if you are uncomfortable speaking with your current therapist about these feelings. We do not foresee any other risks to you if you choose to participate in this study.

Confidentiality:
Efforts will be made to keep your study-related information confidential. However, there may be circumstances where this information must be released. For example, personal information regarding your participation in this study may be disclosed if required by state law. Also, your records may be reviewed by the following groups (as applicable to the research):

- Office for Human Research Protections or other federal, state, or international regulatory agencies;
- The Ohio State University Institutional Review Board or Office of Responsible Research Practices;

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DVDs of sessions are made solely for training purposes and are shared only between therapists and their supervisors. Sessions are taped over once you have terminated therapy.

**Incentives:**
If you choose to take part in the study and complete the questionnaires, you will receive a $20 reduction in your first session fee. In the event that your first session fee is less than the amount of incentive you receive, the remainder will be applied to the next session’s fees.

**Participant Rights:**
You may refuse to participate in this study without penalty or loss of benefits to which you are otherwise entitled. If you are a student or employee at Ohio State, your decision will not affect your grades or employment status.

If you choose to participate in the study, you may discontinue participation at any time without penalty or loss of benefits. By signing this form, you do not give up any personal legal rights you may have as a participant in this study.

An Institutional Review Board responsible for human subjects’ research at The Ohio State University reviewed this research project and found it to be acceptable, according to applicable state and federal regulations and University policies designed to protect the rights and welfare of participants in research.

**Contacts and Questions:**
For questions, concerns, or complaints about the study you may contact
Suzanne Bartle-Haring, PhD
135 Campbell Hall
1787 Neil Ave.
Columbus, Oh 43210
614-688-3259

For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact Ms. Sandra Meadows in the Office of Responsible Research Practices at 1-800-678-6251.

If you are injured as a result of participating in this study or for questions about a study-related injury, you may contact Suzanne Bartle-Haring, Ph.D. (614-688-3259)
Signing the consent form

I have read (or someone has read to me) this form and I am aware that I am being asked to participate in a research study. I have had the opportunity to ask questions and have had them answered to my satisfaction. I voluntarily agree to participate in this study.

I am not giving up any legal rights by signing this form. I will be given a copy of this form.

<table>
<thead>
<tr>
<th>Printed name of subject</th>
<th>Signature of subject</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AM/PM</td>
</tr>
<tr>
<td>Date and time</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Printed name of person authorized to consent for subject (when applicable)</th>
<th>Signature of person authorized to consent for subject (when applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AM/PM</td>
</tr>
<tr>
<td>Relationship to the subject</td>
<td>Date and time</td>
</tr>
</tbody>
</table>

Investigator/Research Staff

I have explained the research to the participant or his/her representative before requesting the signature(s) above. There are no blanks in this document. A copy of this form has been given to the participant or his/her representative.

<table>
<thead>
<tr>
<th>Printed name of person obtaining consent</th>
<th>Signature of person obtaining consent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AM/PM</td>
</tr>
<tr>
<td></td>
<td>Date and time</td>
</tr>
</tbody>
</table>
Title of the Study: The Ohio State University Couple and Family Therapy Clinic Research Protocol

OSU Protocol Number: 2012B0179

Principal Investigator: Suzanne Bartle-Haring, PhD

Subject Name__________________________________________________________

Before researchers use or share any health information about you as part of this study, The Ohio State University is required to obtain your authorization. This helps explain to you how this information will be used or shared with others involved in the study.

- The Ohio State University and its hospitals, clinics, health-care providers and researchers are required to protect the privacy of your health information.

- You should have received a Notice of Privacy Practices when you received health care services here. If not, let us know and a copy will be given to you. Please carefully review this information. Ask if you have any questions or do not understand any parts of this notice.

- If you agree to take part in this study your health information will be used and shared with others involved in this study. Also, any new health information about you that comes from tests or other parts of this study will be shared with those involved in this study.

- Health information about you that will be used or shared with others involved in this study may include your research record and any health care records at the Ohio State University. For example, this may include your medical records, x-ray or laboratory results. Psychotherapy notes in your health records (if any) will not, however, be shared or used. Use of these notes requires a separate, signed authorization.

Please read the information carefully before signing this form. Please ask if you have any questions about this authorization, the University’s Notice of Privacy Practices or the study before signing this form.
Those Who May Use, Share and Receive Your Information As Part Of This Study

Researchers and staff at The Ohio State University will use, share and receive your personal health information for this research study. Authorized Ohio State University staff not involved in the study may be aware that you are participating in a research study and have access to your information. If this study is related to your medical care, your study-related information may be placed in your permanent hospital, clinic or physician’s office records.

Those who oversee the study will have access to your information, including:

- The Ohio State University Couple and Family Therapy Clinic Staff
- Members and staff of the Ohio State University’s Institutional Review Boards, including the Western Institutional Review Board
- The Office for Responsible Research Practices

Your health information may also be shared with federal and state agencies that have oversight of the study or to whom access is required under the law. These may include:

- None

These researchers, companies and/or organization(s) outside of The Ohio State University may also use, share and receive your health information in connection with this study:

- None

The information that is shared with those listed above may no longer be protected by federal privacy rules.

Authorization Period

This authorization will not expire unless you change your mind and revoke it in writing. There is no set date at which your information will be destroyed or no longer used. This is because the information used and created during the study may be analyzed for many years, and it is not possible to know when this will be complete.

Signing the Authorization

- You have the right to refuse to sign this authorization. Your health care outside of the study, payment for your health care, and your health care benefits will not be affected if you choose not to sign this form.

- You will not be able to take part in this study and will not receive any study treatments if you do not sign this form.

- If you sign this authorization, you may change your mind at any time. Researchers may continue to use information collected up until the time that you formally changed your mind.
If you change your mind, your authorization must be revoked in writing. To revoke your authorization, please write to:
Suzanne Bartle-Haring, PhD
135 Campbell Hall
1787 Neil Ave.
Columbus, Oh 43210
614-688-3259

- Signing this authorization also means that you will not be able to see or copy your study-related information until the study is completed. This includes any portion of your medical records that describes study treatment.

Contacts for Questions

- If you have any questions relating to the research, please contact

  Suzanne Bartle-Haring, PhD
  135 Campbell Hall
  1787 Neil Ave.
  Columbus, Oh 43210
  614-688-3259

Signature

I have read (or someone has read to me) this form and have been able to ask questions. All of my questions about this form have been answered to my satisfaction. By signing below, I permit Suzanne Bartle-Haring, PhD and the others listed on this form to use and share my personal health information for this study. I will be given a copy of this signed form.

Signature________________________________________________________
(Subject or Legally Authorized Representative)

Name _____________________________________________________________
(Print name above)
(If legal representative, also print relationship to subject.)

Date___________ Time __________ AM / PM
OSU Clinic Intake Questionnaire

Date ____________ Case # ________ Person # _______ Therapist # ________

1. What is your age? ______
2. What is your gender? __________
3. How do you identify your sexual orientation? __________________
4. How do you identify your 
   1) Race? __________________
   2) Ethnicity? __________________
   3) Nationality? __________________
5. What religion or spiritual beliefs do you identify with? __________________
6. Circle your highest degree earned: 
   1) Less than high school 
   2) High school Diploma 
   3) GED 
   4) Some College 
   5) Professional Certificate 
   6) Associates Degree 
   7) Bachelor's Degree 
   8) Master's Degree 
   9) Professional Degree 
   10) Ph.D., MD, JD.
7. How many hours a week are you currently employed? 
   1) Less than 10 
   2) 10 to 20 hours 
   3) 21-35 hours 
   4) 35-40 hours 
   5) more than 40 hours
8. What is your occupation? __________________
9. What is your annual income (include the income of other adults with whom you share finances)? __________________
10. What is your current relationships status? (Circle all that apply.)
   1) Single 
   2) Dating 
   3) Partnered 
   4) Cohabiting 
   5) Married (first time) 
   6) Separated 
   7) Remarried 
   8) Divorced 
   9) Widowed 
11. What is your current relationship length? _________
12. If ever, at what age were you first married? ________
13. How many children do you have? ______
14. How many children do you currently have living with you? 
   1) Full-time? ________
   2) Part-time? ________
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. How many stepchildren do you have?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. How many stepchildren do you have living with you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Full-time? ______</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Part-time? ______</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Have you ever been to therapy before?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>18. Have you ever been to therapy for the same problem you are now seeking therapy for?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>19. Have you ever been in treatment for substance use?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>20. Has anyone in your family ever been to therapy before?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>21. Has anyone in your family ever been to therapy for the same problem you are now seeking therapy for?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>22. Has anyone in your family ever been in treatment for substance use?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>23. When you were growing up, was there ever violence between adults in the household?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If yes, was it:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Emotional?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Physical?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) Sexual?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Did you experience abuse or neglect during childhood?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If yes, was it:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Emotional?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Physical?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) Sexual?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) Neglect?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Is there violence in your current relationship?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If yes, is it:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Emotional?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Physical?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) Sexual?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
26. **Over the last 2 weeks, how often have you been bothered by any of the following problems?**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2) Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3) Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4) Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5) Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6) Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7) Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8) Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9) Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

27. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not difficult at all</td>
<td>Somewhat difficult</td>
<td>Very difficult</td>
<td>Extremely Difficult</td>
</tr>
</tbody>
</table>
28. Have you ever thought about hurting yourself?
   Yes                      No

29. Have you ever attempted suicide?
   Yes                      No

30. Are you currently on medication?  Yes      No
   - If so please list the medication:_______________________________________

31. Is any member of your family currently on medication?  Yes      No
   - If so, please list the member and the medication:
          _____________________________________________

32. On a scale of 1-10, how satisfied are you with your current intimate relationship?
    1  2  3  4  5  6  7  8  9  10
    not satisfied at all     very satisfied

33. On a scale of 1-10, how committed are you to your current intimate relationship?
    1  2  3  4  5  6  7  8  9  10
    not committed             very committed
Using the following scale, how often your partner has done the following?

1 = Never   2 = Seldom   3 = Sometimes   4 = Often   5 = Very often

_____ 1. My partner doesn’t censor his or her complaints at all. She or he really lets me have it full force.
_____ 2. My partner uses tactless choice of words when he or she complains.
_____ 3. There’s no stopping my partner once he/she gets started complaining.
_____ 4. When my partner gets upset, my partner acts like there are glaring faults in my personality.
_____ 5. When I complain my partner acts like he or she has to “ward off” my attacks.
_____ 6. My partner acts like he/she is being unfairly attacked when I am being negative.
_____ 7. Whenever my partner has a conflict with me, he/she acts physically tense and anxious and can’t seem to think clearly.
_____ 8. My partner feels physically tired or drained after he/she has an argument with me.
_____ 9. Whenever we have a conflict, my partner seems overwhelmed.
_____ 10. In an argument, my partner recognizes when he/she is overwhelmed and then makes a deliberate effort to calm down.
_____ 11. In an argument, my partner recognizes when I am overwhelmed and then makes a deliberate effort to calm me down.
_____ 12. In an argument, sometimes I use physical force to get my way.
_____ 13. In an argument, sometimes my partner uses physical force to get his/her way.
**Instructions:** We would like you to think about your relationship with your spouse or partner. Then we would like you to think about your partner or spouse’s relationship with you. You will notice that the items repeat. We are interested in your perspective on the relationships in your family. When thinking about the items use the following scale to say how much you agree or disagree with the statement.

<table>
<thead>
<tr>
<th>You about your Spouse/Partner</th>
<th>Strongly Disagree 1</th>
<th>Generally Disagree 2</th>
<th>Slightly Agree 3</th>
<th>Generally Agree 4</th>
<th>Strongly Agree 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Even though I’m very close to my partner, I feel I can be myself.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel so comfortable with my partner that I can tell him/her anything.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My partner and I have some common interests and some differences.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>I am comfortable with some degree of conflict with my partner.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Although I’m like my partner in some ways we’re also different from each other in other ways.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>While I like to get along with my partner, if I disagree with something he/she is doing, I usually feel free to say so.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel distant from my partner.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>I don’t feel related to my partner most of the time.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel like an outsider with my partner.</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel close to my partner.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Even around my partner, I don’t feel that I really belong.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am able to relate to my partner.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>I feel understood by my partner.</td>
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<tr>
<td>I see my partner as friendly and approachable.</td>
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<tr>
<td>I have little sense of togetherness with my partner.</td>
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<tr>
<td>Your Spouse/Partner about You</td>
<td>Strongly Disagree 1</td>
<td>Generally Disagree 2</td>
<td>Slightly Agree 3</td>
<td>Generally Agree 4</td>
<td>Strongly Agree 5</td>
</tr>
<tr>
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<tr>
<td>Even though your partner is very close to you, he/she can be him/herself.</td>
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<tr>
<td>Your partner feels so comfortable with you that he/she can tell you anything.</td>
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<tr>
<td>Your partner believes that he/she and you have some common interests and some differences.</td>
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<tr>
<td>Your partner is comfortable with some degree of conflict with you.</td>
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<tr>
<td>Although your partner sees him/herself as like you in some ways she/he also sees that you and he/she are different from each other in other ways.</td>
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<tr>
<td>While your partner likes to get along with you, if he/she disagrees with something you are doing, he/she usually feels free to say so.</td>
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<tr>
<td>Your partner would say that he/she feels distant from you.</td>
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<tr>
<td>Your partner would say that he/she does not feel related to you most of the time.</td>
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<tr>
<td>Your partner would say that he/she feels like an outsider with you.</td>
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<tr>
<td>Your partner would say that he/she feels close to you.</td>
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<tr>
<td>Your partner would say that even around you, he/she doesn’t feel that he/she really belongs.</td>
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<tr>
<td>Your partner would say that he/she is able to relate to you.</td>
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<tr>
<td>Your partner would say that he/she feels understood by you.</td>
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<tr>
<td>Your partner would say that he/she sees you as friendly and approachable.</td>
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</tr>
<tr>
<td>Your partner would say that he/she has little sense of togetherness with you.</td>
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</tr>
</tbody>
</table>
Use this scale for the next two sets of questions:

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Neutral</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

How do you feel about your intimate relationship with your partner?

___ 1. I am satisfied with my sex life with my partner.
___ 2. My partner seems satisfied with his/her sex life with me.
___ 3. Most of the time, I want to have sex when my partner also wants sex.
___ 4. Most of the time, my partner seems to want to have sex when I also want sex.
___ 5. I care about my partner’s sexual pleasure, not just my own.
___ 6. My partner seems to care about my sexual pleasure, not just his/her own.
___ 7. I am open to talk about sex with my partner.
___ 8. My partner seems open to talk about sex with me.
___ 9. I think we are a good fit as sexual partners.
___ 10. My partner seems to think that we are a good fit as sexual partners.

How do you feel about your emotional relationship with your partner?

___ 1. I mostly feel emotionally connected with my partner.
___ 2. It seems that my partner mostly feels emotionally connected with me.
___ 3. I am available when my partner needs me emotionally.
___ 4. My partner seems available when I need him/her emotionally.
___ 5. I listen to and understand my partner’s emotions and feelings.
___ 6. My partner seems to listen to and understand my emotions and feelings.
___ 7. I feel comfortable with being emotionally vulnerable with my partner.
___ 8. My partner seems comfortable with being emotionally vulnerable with me.
___ 9. Most of the time, I am aware of my partner’s emotions, whether positive or negative.
___ 10. Most of the time, my partner seems aware of my emotions, whether positive or negative.
For the next 3 questions, please answer once for you and once for your partner:

1. How often did you have a drink containing alcohol in the past year? Consider a “drink” to be a can or bottle of beer, a glass of wine, a wine cooler, or one cocktail or a shot of hard liquor (like scotch, gin, or vodka).
   
   1) Never  2) Monthly or less  3) 2 to 4 times a month  4) 2 to 3 times a week  5) 4 to 5 times a week  6) 6 or more times a week

<table>
<thead>
<tr>
<th>You</th>
<th>Your partner</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

2. How many drinks did you have on a typical day when you were drinking in the past year?
   
   1) 0 drinks  2) 1 to 2 drinks  3) 3 to 4 drinks  4) 5 to 6 drinks  5) 7 to 9 drinks  6) 10 or more drinks

<table>
<thead>
<tr>
<th>You</th>
<th>Your partner</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

3. How often did you have 6 or more drinks on one occasion in the past year?
   
   1) Never  2) Less than monthly  3) Monthly  4) Weekly  5) Daily or almost daily

<table>
<thead>
<tr>
<th>You</th>
<th>Your partner</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Think about the alcohol and drugs you might typically use and your partner might typically use. Please answer the following questions with those in mind:

For the next 5 questions, please fill in the following table:

<table>
<thead>
<tr>
<th>Question #1</th>
<th>You</th>
<th>Your partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question #2</td>
<td></td>
<td></td>
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<tr>
<td>Question #3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question #4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question #5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. People differ widely in how much they use alcohol and/or different drugs. Some people avoid alcohol/drugs altogether. Some use only a little. Others use more. Sometimes it is hard to tell how much is "too much." What do YOU think about your present use of alcohol/drugs? Please choose the number of the statement that is most true for you now. The choices are:

   1. I definitely use too much.
   2. I probably use it too much.
   3. I am not sure.
   4. I probably do not use too much.
   5. I definitely do not use too much.

2. Regardless of what a person thinks about his or her own use of alcohol/drugs, the important people around him or her form their own opinions. Sometimes loved ones or friends are concerned that a person is using too much. On the other hand, others may not be concerned at all. What do you think about how OTHER people view your use of alcohol/drugs?

   1. There definitely are important people in my life who think I use too much.
   2. Probably there are important people in my life who think I use too much.
   3. I am not sure whether any important people in my life think I use too much.
   4. Probably no important people in my life think I use too much.
   5. Definitely there are no important people in my life who think I use too much.
3. Alcohol/drug use can affect the family. For some families, alcohol/drugs have a dividing and destructive effect. Alcohol/drug use can result in hard feelings, arguments, sadness and distance, or even violence, making the family less happy. For others, the use of alcohol/drugs may be part of enjoyable family times. Overall, what has been the effect on your family of your use of alcohol/drugs?

1. I think it has had a very damaging effect on my family.
2. I think it has had a somewhat damaging effect on my family.
3. I think it has had no effect on my family.
4. I think it has had a somewhat positive effect on my family.
5. I think it has had a very positive effect on my family.

4. For some people, alcohol/drug use has a harmful effect on their loving relationships and on their sexuality. It may decrease their interest in other people or their ability to enjoy loving relationships. Some people are also less attractive to their partners because of their alcohol/drug use. Other people find that use of alcohol/drugs improves their loving relationships and sexuality. Sometimes use of alcohol/drugs is also an important part of meeting potential partners. Overall, what effect has your use had on your loving relationships and sexual fulfillment?

1. I think it has had a very negative effect.
2. I think it has had a somewhat negative effect.
3. I think it has had no effect, one way or the other.
4. I think it has had a somewhat positive effect.
5. I think it has had a very positive effect.

5. How important do you think it is for you to do something to change your present use of each of alcohol/drugs?

1. I definitely need to do something to change my use.
2. I probably need to do something to change my use.
3. I'm not sure whether I need to do something to change my use.
4. I probably do not need to do anything to change my use.
5. I definitely do not need to do anything to change my use.
Appendix D: Research Documents for the Community Group

(Advertisement Flyer, Online Research Consent Form, & Online Questionnaire)
ARE YOU *SATISFIED* WITH YOUR RELATIONSHIP?

If yes, consider participating in this study!

- **Who**: Couples (age 18+) who are “satisfied” with their current romantic relationships
- **What**: You and your partner can receive $20 in gift cards by participating in a short on-line survey.
- **Purpose**: Understanding couple relationship satisfaction in relation to couple intimacy (both emotional and sexual) among satisfied couples

For more information, contact Hana Yoo (yoo.161@osu.edu) or Suzanne Bartle-Haring (haring.19@ehe.osu.edu), in OSU Department of Human Development and Family Science.
Community Couples Questionnaire (Online)

Q1)

Thank you for your interest in this research study being conducted at The Ohio State University by Hana Yoo and Suzanne Bartle-Haring in Human Development and Family Science. Our primary goal is to investigate the association between couple intimacy, assessed in emotional and sexual domains, and relationship satisfaction. The questions asked in this survey are about you, and your relationship with your significant other. First, we will ask you a few questions about yourself. Second, you will be asked to rate several items regarding your emotional and sexual intimacy, and relationship satisfaction with your partner. Answering the questions in this survey is completely voluntary. You can skip questions, and also stop taking the survey at any time simply by closing your browser. If you choose to complete this survey it will take you about 30 minutes. If you find that some of these items and your responses to them make you uncomfortable for any reason and you would like to talk to someone about those feelings, please feel free to contact the Principle Investigator, Suzanne Bartle-Haring, Ph.D., (haring.19@osu.edu; 614-688-3259). She is a licensed Couple and Family Therapists and will be able to provide you with information about therapists in your area who could be of service to you. Efforts will be made to keep your information and responses confidential. However, because we are using the Internet, there is a chance that someone could access your online responses without permission. In some cases, this information could be used to identify you via your email account. Also, there may be circumstances where this information must be released. For example, personal information regarding your participation in this study may be disclosed if required by state law. Also, your records may be reviewed by the following groups (as applicable to the research): - Office for Human Research Protections or other federal, state, or international regulatory agencies; - The Ohio State University Institutional Review Board or Office of Responsible Research Practices. We hope that you will complete all the questions in this survey and would like to offer you a $10 gift certificate for your time in completing the survey. Information about how to receive your gift certificate is provided at the end of the survey. If you decide to stop participating in the study, there will be no penalty to you, and you will not lose any benefits to which you are otherwise entitled. Your decision will not affect your future relationship with The Ohio State University. For questions, concerns, or complaints about the study you may contact Suzanne Bartle-Haring, PhD 135 Campbell Hall 1787 Neil Ave. Columbus, Oh 43210 614-688-3259 haring.19@osu.edu For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact Ms. Sandra Meadows in the Office of Responsible Research Practices at 1-800-678-6251. If you agree to complete the survey please click on the “Agree” button below:

☐ Agree
Q2)
What is your age?

Q3)
What is your gender?
- Male
- Female
- Androgynous
- Transgender
- Other ____________________

Q4)
What is your sexual orientation?
- Heterosexual/Straight
- Homosexual/Gay/Lesbian
- Bisexual/Pansexual
- Queer
- Asexual
- Other ____________________

Q5)
How do you identify your race?

Q6)
How do you identify your ethnicity?
Q7) How do you identify your nationality?

Q8) What religion or spiritual beliefs do you identify with?

Q9) What is your highest level of education?
   - Less than high school
   - High school Diploma
   - GED
   - Some College
   - Professional Certificate
   - Associates Degree
   - Bachelor's Degree
   - Master's Degree
   - Professional Degree
   - Ph.D., MD, JD.

Q10) How many hours a week are you currently employed?
   - Less than 10
   - 10 to 20 hours
   - 21-35 hours
   - 35-40 hours
   - More than 40 hours
Q11)

What is your occupation?

Q12)

What is your annual income? Include the income of other adults with whom you share finances.

Q13)

What is your current relationships status? (Choose all that apply.)
- Single
- Dating
- Partnered
- Cohabiting
- Married (first time)
- Separated
- Remarried
- Divorced
- Widowed

Q14)

What is your current relationship length? (e.g., 2 years 10 months)

Q15)

How many children do you have? (if you don't have children, enter “0”)

Q16)

How many children do you currently have living with you full-time?

Q17)

How many children do you currently have living with you part-time?
Q18)

How many stepchildren do you have? (if you don't have stepchildren, enter "0")

Q19)

How many stepchildren do you have living with you full-time?

Q20)

How many stepchildren do you have living with you part-time?

Q21)

Have you ever been to therapy before? (as a couple - with your current partner)

☐ Yes

☐ No
**Q22)**

On a scale of 1 to 10, how satisfied are you with your current intimate relationship?

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</table>

Not satisfied at all  
Very satisfied

**Q23)**

On a scale of 1 to 10, how committed are you to your current intimate relationship?

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</table>

Not committed at all  
Very committed
Q24)

Using the following scale, how often does your partner do the following?

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very often</th>
</tr>
</thead>
<tbody>
<tr>
<td>My partner doesn’t censor his or her complaints at all. She or he really lets me have it full force.</td>
<td>○</td>
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<tr>
<td>My partner uses tactless choice of words when he or she complains.</td>
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<tr>
<td>There’s no stopping my partner once he/she gets started complaining.</td>
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</tr>
<tr>
<td>When my partner gets upset, my partner acts like there are glaring faults in my personality.</td>
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<tr>
<td>When I complain my partner acts like he or she has to “ward off” my attacks.</td>
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<tr>
<td>My partner acts like he/she is being unfairly attacked when I am being negative.</td>
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<td>○</td>
</tr>
<tr>
<td>Whenever my partner has a conflict with me, he/she acts physically tense and anxious and can’t seem to think clearly.</td>
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<tr>
<td>My partner feels physically tired or drained after he/she has an argument with me.</td>
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</tr>
<tr>
<td>Whenever we have a conflict, my partner seems overwhelmed.</td>
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</tr>
<tr>
<td>In an argument, my partner recognizes when he/she is overwhelmed and then makes a deliberate effort to calm down.</td>
<td>○</td>
<td>○</td>
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<td>○</td>
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</tr>
<tr>
<td>In an argument, my partner recognizes when I am overwhelmed and then makes a deliberate effort to calm me down.</td>
<td>○</td>
<td>○</td>
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<td>○</td>
<td>○</td>
</tr>
<tr>
<td>In an argument, sometimes I use physical force to get my way.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>In an argument, sometimes my partner uses physical force to get his/her way.</td>
<td>○</td>
<td>○</td>
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<td>○</td>
</tr>
</tbody>
</table>
Q25) How do you feel about your sexual relationship with your partner?

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Neutral</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am satisfied with my sex life with my partner.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<td>○</td>
</tr>
<tr>
<td>My partner seems satisfied with his/her sex life with me.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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</tr>
<tr>
<td>Most of the time, I want to have sex when my partner also wants sex.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Most of the time, my partner seems to want to have sex when I also want sex.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I care about my partner’s sexual pleasure, not just my own.</td>
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<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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</tr>
<tr>
<td>My partner seems to care about my sexual pleasure, not just his/her own.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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</tr>
<tr>
<td>I am open to talk about sex with my partner.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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</tr>
<tr>
<td>My partner seems open to talk about sex with me.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I think we are a good fit as sexual partners.</td>
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<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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</tr>
<tr>
<td>My partner seems to think that we are a good fit as sexual partners.</td>
<td>○</td>
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<td>○</td>
<td>○</td>
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</tr>
</tbody>
</table>
Q26) How do you feel about your emotional relationship with your partner?

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Neutral</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I mostly feel emotionally connected with my partner.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>It seems that my partner mostly feels emotionally connected with me.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I am available when my partner needs me emotionally.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>My partner seems available when I need him/her emotionally.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I listen to and understand my partner’s emotions and feelings.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>My partner seems to listen to and understand my emotions and feelings.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I feel comfortable with being emotionally vulnerable with my partner.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>My partner seems comfortable with being emotionally vulnerable with me.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Most of the time, I am aware of my partner’s emotions, whether positive or negative.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Most of the time, my partner seems aware of my emotions, whether positive or negative.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
Q27) Please think about your relationship with your spouse or partner. We would like you to answer these questions honestly and openly. If a statement has more than one part, please indicate your agreement with the statement as a whole.

<table>
<thead>
<tr>
<th>Even though I’m very close to my partner, I feel I can be myself.</th>
<th>Strongly Disagree</th>
<th>Generally Disagree</th>
<th>Slightly Agree</th>
<th>Generally Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel so comfortable with my partner that I can tell him/her anything.</td>
<td>○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My partner and I have some common interests and some differences.</td>
<td>○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am comfortable with some degree of conflict with my partner.</td>
<td>○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Although I’m like my partner in some ways we’re also different from each other in other ways.</td>
<td>○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>While I like to get along with my partner, if I disagree with something he/she is doing, I usually feel free to say so.</td>
<td>○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel distant from my partner.</td>
<td>○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don’t feel related to my partner most of the time.</td>
<td>○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel like an outsider with my partner.</td>
<td>○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel close to my partner.</td>
<td>○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Even around my partner, I don’t feel that I really belong.</td>
<td>○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am able to relate to my partner.</td>
<td>○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel understood by my partner.</td>
<td>○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I see my partner as friendly and approachable.</td>
<td>○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have little sense of togetherness with my partner.</td>
<td>○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Q28) Now think about how your spouse or partner might answer these questions when thinking about his/her relationship with you. If a statement has more than one part, please indicate your agreement with the statement as a whole.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Generally Disagree</th>
<th>Slightly Agree</th>
<th>Generally Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Even though your partner is very close to you, he/she can be him/herself.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Your partner feels so comfortable with you that he/she can tell you anything.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Your partner believes that he/she and you have some common interests and some differences.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Your partner is comfortable with some degree of conflict with you.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Although your partner sees him/herself as like you in some ways she/he also sees that you and he/she are different from each other in other ways.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>While your partner likes to get along with you, if he/she disagrees with something you are doing, he/she usually feels free to say so.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Your partner would say that he/she feels distant from you.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Your partner would say that he/she does not feel related to you most of the time.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Your partner would say that he/she feels like an outsider with you.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Your partner would say that he/she feels close to you.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Your partner would say that even around you, he/she doesn’t feel that he/she really belongs.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Your partner would say that he/she is able to relate to you.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Your partner would say that he/she feels understood by you.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Your partner would say that he/she sees you as friendly and approachable.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Your partner would say that he/she has little sense of togetherness with you.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>