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Relational ethics, depressive symptoms, and relationship satisfaction in couples in therapy

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Abstract

The purpose of this study was to examine depressive symptoms and relationship satisfaction in a sample of 68 other-sex couples seeking therapy at a large university clinic using the construct of relational ethics. Relational ethics is a central concept in contextual therapy theory, an integrative, intergenerational, strengths-based approach to family therapy. The construct of relational ethics includes aspects of trust, loyalty, and entitlement that are transmitted through generations. In this study, depressive symptoms and low relationship satisfaction were conceptualized as problems related to relational ethics in one's family of origin and current partner relationships. Using the Actor Partner Interdependence Model (APIM) to analyze dyadic data collected prior to beginning therapy, we found evidence to support our hypotheses. Specifically, we found significant actor effects between relational ethics in one's family of origin and depressive symptoms, as well as between depressive symptoms and low relationship satisfaction for both male and female partners. We also found significant actor *and* partner effects for relational ethics in current relationships, depressive symptoms, and relationship satisfaction. Our results have important clinical implications for couple therapy where one or both partners experience mild to moderate depressive symptoms and low relationship satisfaction. Application of contextual therapy theory in intervention development is discussed.

Keywords: Contextual therapy, relational ethics, depression, relationship satisfaction, dyadic data analysis

Introduction

Contextual therapy theory is an integrative, strengths-based framework that was developed by Ivan Boszormenyi-Nagy and others (Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991). The idea of fairness or justice is central to the theory and is highlighted in the dimension of relational ethics (Boszormenyi-Nagy & Krasner, 1986). Although a popular construct used by clinicians to treat various populations, relational ethics is less examined in research studies (Grames, Miller, Robinson, Higgins, & Hinton, 2008). The main objective of this study was to investigate the association between relational ethics and symptoms of depression and relationship satisfaction in a clinical sample of other-sex couples. The association between depression and relationship satisfaction is complex and has been studied extensively (e.g., Rehman, Gollan, & Mortimer, 2008). There is still, however, a need to further understand relational mechanisms using theoretical frameworks to guide better relational interventions in the treatment of depression and relationship satisfaction (Beach & Whisman, 2012). In this study we sought to examine whether relational ethics in family of origin and current partner relationships are associated with depressive symptoms and relationship satisfaction in both male and female partners. In answering this question our aims were two-fold: (1) to provide further validation of relational ethics as a useful clinical construct in therapy with couples; (2) to contribute to the literature examining relational processes of depression and relationship satisfaction.

Relational Ethics

Relational ethics is a major construct in contextual therapy theory that conceptualizes human suffering as embedded within a bio-psychosocial-cultural framework (DuCummon-Nagy, 2002). Ethics here do not denote moral values; rather, they refer to fairness or a balance of give and take that sustains relationships (van Heusden & van den Eerenbeemt, 1987). Relational

ethics is operationalized to include concepts of trust, loyalty, and entitlement that may be

assessed in relationships (Hargrave, Jennings & Anderson, 1991). Trust is the primary relational

resource through which we learn how to interact with others (Hargrave & Pfitzer, 2003).

Whether earned or inherent, it is essential as a relational resource that fosters viable relationships

(Boszormenyi-Nagy & Krasner, 1986). Loyalty refers to the bond that exists between parents

and their children and later with other significant figures in an individual's life. Entitlement

refers to an ethical "guarantee" of being cared for that arises in a relationship (Boszormenyi-

Nagy & Krasner, 1986). These are earned through actions that merit trust. For instance,

providing a caring, nurturing environment for one's partner may not only enhance

trustworthiness, but may also entitle the "giver" to receive care.

Contextual therapy theory suggests that symptoms of individual and interpersonal ill

health are related to an overall imbalance in giving and receiving of due credit (Boszormenyi-

Nagy et al., 1991), and a lack of genuine dialogue that fosters reciprocity and concern for one

another (Krasner & Joyce, 1995). Individuals' ability to maintain a balance of give and take in

relationships depends on their early life experiences with their family of origin (also known as

vertical relationships, Hargrave & Pfitzer, 2003). Lack of due care in early relationships may

lead to the development of destructive entitlement, which predisposes individuals either to over-

give or over-receive care (Boszormenyi-Nagy & Krasner, 1986). Typically, as a result of an

imbalanced caregiver-child relationship, individuals may become parentified (where they are

asked to take on adult-like responsibilities before being developmentally ready) or experience

loyalty conflicts (where they may be forced to either consciously or unconsciously choose

between competing interests). According to the theory, lack of due care in early relationships

may decrease one's self-worth and increase individual vulnerability for development of

symptoms such as depression. This lack of due care also impacts levels of trust and may carry

forward to the individual's adult relationships (also known as horizontal relationships) in the

form of difficulties in either giving freely to and caring about the partner or receiving and

acknowledging care from the partner, which impacts perceptions of fairness in relationships

(Hargrave & Pfitzer, 2003) and relationship satisfaction.

Research on relational ethics. Tenets of contextual therapy have been widely endorsed

(Grames et al., 2008), and yet very few empirical studies have been conducted examining its

validity and impact. Early studies suggest preliminary support for the intergenerational

transmission of fair relating (Bray, 1993), and a significant association between relational ethics

and relationship satisfaction (Grames et al., 2008; Hargrave et al., 1991). Hargrave and Bomba

(1993) also found significant differences between single and married individuals on items

pertaining to family of origin relationships, with married individuals reporting more significant

issues with loyalty conflicts and entitlement. They postulated that individuals' experiences of

relational ethics in their family of origin change upon entering committed relationships and

continue to evolve with age. In a more recent study, (Grames et al., 2008) findings from a

national sample of 632 married individuals indicated an association between relational ethics in

family of origin and depression, with marital satisfaction acting as a mediating variable.

However, a significant drawback of these earlier studies is that data were mostly

collected from one partner of the couple, and did not account for the interdependence of dyadic

data. Thus, there is lack of information on how an individual's relational ethics is related to

one's own as well as one's partner's symptoms. The interdependence of such data may be

examined through the use of dyadic research designs (Oka & Whiting, 2013). Dyadic designs,

which may include collecting systemic data from both partners of a couple, and using statistical

analytic techniques to examine interdependence of relational variables, are much needed in couple and family therapy research (Wittenborn, Dolbin-MacNab, & Keiley, 2013). Further, most of the earlier studies were conducted with samples from general populations and not with clinical populations. From the perspective of theory and intervention development in clinical practice, it is pertinent to explore the association of relational ethics with symptoms that are most commonly presented in couple and family therapy such as depression and relationship dissatisfaction.

Depression, Relationship Satisfaction and Relational Ethics

Depression is established as a key, robust factor affecting relationship satisfaction and wellbeing (Bradbury, Fincham, & Beach, 2000; Fincham, Beach, Harold, & Osborne, 1997; Proulx, Helms, & Buehler, 2007; Rehman et al., 2008; Stack & Eshleman, 1998; Whisman, 2001a). Researchers do not have a consensus about the causal effect of depression on relationship satisfaction, but there is some evidence to suggest that the pathways are complex and influenced by gender and relationship factors (Beach, Katz, Kim, & Brody, 2003; Beach, Sandeen, & O'Leary, 1990; Beach, Fincham, & Katz, 1998; Chisholm, Everitt et al., 2000; Fincham et al., 1997; Kamen, Cosgrove, McKellar, Cronkite, & Moos, 2011; Leff, Vearnals, Wolff, Alexander, 2000; Proulx et al., 2007; Rehman, et al., 2008; Whisman 2001b). For instance, Whisman (2001b) demonstrated a greater effect size in the association between depression and marital satisfaction for women than for men. A recent study (Denton, Wittenborn, & Golden, 2012) also found that poor relationship quality predicted worsening of depression in female patients even after treatment of depression, suggesting a need to focus on relational processes associated with depression. In fact, many studies have identified an association between depression and relationship factors such as negative and hostile interactions

(Leff et al., 2000); negative marital communication and behavior (Gabriel, Beach, & Bodenmann, 2010); reassurance seeking (Davila, 2001); as well as partner criticism, expressed emotions, and dysfunctional attributions (Meuwly, Bodenmann, & Coyne, 2012), which have affirmed the recommendation for incorporating couple therapy in the treatment of depression (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998).

Despite this, some studies have raised questions about the use of couple therapy in treating major depression due to insufficient evidence of its effectiveness (Gupta, Coyne, & Beach, 2003). A recent meta-analysis noted that while intervention for couples reduced relational distress, they did not decrease symptoms of depression (Barbato & D'Avanzo, 2008). The study also did not find a significant association between improvement in depression and relationship satisfaction, suggesting inconclusive evidence for the support of couple therapy for depression. However, Barbato and D'Avanzo's meta-analysis was conducted on eight controlled studies of treatments that primarily focused on current partner relationship (e.g., interpersonal couple therapy, behavioral marital therapy, and emotion- focused therapy) and not on family of origin influences which may have limited a comprehensive assessment of processes related to depression and satisfaction. For instance, from a developmental psychopathology perspective, depression in adulthood can be tracked to traumatic experiences in childhood such as abuse, neglect, and parental conflict that could in turn impact interpersonal relationships with their partners (for a comprehensive review of these factors see: Davila, Stroud, & Starr, 2009; Joiner & Timmons, 2009). Adverse childhood experiences involving emotional abuse have also been linked to increased lifetime risk for depression (Dube, Felitti, Dong, Giles & Anda, 2003; Chapman et al., 2004). In contextual therapy theory, adverse experiences in childhood, such as emotional abuse, are indicators of a lack of due care, where the child's need for a caring,

nurturing, and validating relationship with the caregiver is either lacking or missing. These early experiences are thought to have a profound impact on the balance of give and take in later partner relationships (Boszermenyi- Nagy & Krasner, 1983; Hargrave & Pfitzer, 2003).

Within the contextual therapy framework, difficult interpersonal interactions identified by previous research such as negative and hostile interactions (Leff et al, 2000) or expressed emotions and dysfunctional attributions (Meuwly et al., 2012) are symptoms of the underlying unacknowledged difficulties in relational ethics. The association between early experiences in family of origin and depression are documented in the existing literature (e.g., Davila et al., 2009). Additionally, depressive predisposition may be related to several types of behaviors that increase interpersonal difficulties in later intimate relationships. For instance, Joiner (2000) described the tendency of depressed persons to avoid interpersonal conflict or engage in excessive reassurance seeking behaviors. Conflict avoidance could be conceptualized in contextual therapy theory, for instance, as over-giving that over a period of time may contribute to feelings of frustration and dissatisfaction in one's relationship. Contextual therapy theory postulates that a fair balance of give and take (which evolves over time in a relationship) is key to maintaining healthy relationships (Boszormenyi-Nagy & Krasner, 1986). While individual vulnerability regarding one's self-worth may be related to a lack of care or of trustworthy relationships in family of origin, repetitive demands or expectations of constant reassurance from an intimate partner may feel unfair and may unintentionally produce a negative reaction in the partner. This partner's reaction, in turn, may contribute to depression chronicity (Joiner, 2000).

In their summary of existing literature on depression and marital discord, Beach & Whisman (2012) suggest that while there is a reciprocal relationship between depression and discord indicating a strong need to incorporate relational issues in therapy, there is also a need to

identify better treatment approaches because the response rate of currently available modalities is "less than adequate" (Beach & Whisman, 2012, p.202). Based on these findings, we propose that it may not be sufficient to devise techniques that address symptom-level issues only in the current relationship; rather, there is a need to develop interventions within frameworks that account for the complexity of depression (Coyne & Benazon, 2001) and its relationship to early adverse experiences (Chapman et al., 2004). Thus, in this study, we conceptualized depressive symptoms and low relationship satisfaction as indicators of this imbalance of give and take, and hypothesized that they will be associated with horizontal and vertical relational ethics.

Current Study

The current study builds upon a recent study (Author citation) that found preliminary associations among these variables. Mainly, variance in partners' reports of satisfaction were significantly predicted by female partners' reports of *greater* difficulties in horizontal relational ethics, male partners' reports of *lesser* difficulties in horizontal relational ethics, and higher levels of depressive symptoms in both partners. However, depression was used as a control variable in that study, and only horizontal relational ethics were examined. Further, the analytic method used did not allow for a close examination of the interdependence between the individual and the partner's depressive symptoms and relationship satisfaction. Considering the extant literature on the complex association between depression and relationship satisfaction, we sought to extend this investigation by specifically examining actor and partner effects of relational ethics and depressive symptoms on relationship satisfaction through estimation of the Actor Partner Interdependence model (APIM: Kenny, Kashy, & Cook, 2006) using the same sample of couples. Specifically, our research questions were: (a) are relational ethics in family of origin and current partner relationship associated with participant's own symptoms of depression and

relationship satisfaction?; (b) are relational ethics in family of origin and current partner relationship associated with participant's partner's symptoms of depression and relationship satisfaction? We hypothesized that: (a) difficulties in relational ethics in family of origin and current partner relationships will be associated with one's own experience of greater depressive symptoms and lower relationship satisfaction; (b) difficulties in relational ethics in family of origin and current partner relationships will be associated with partner's experience of greater depression and lower relationship satisfaction.

Methods

Procedure

Data from couples seeking therapy at a large Midwestern University's couple and family therapy clinic were analyzed in this study. The clinic receives about 75 new clients including individuals, couples, and families each year.   As part of a larger study, all clients were offered the opportunity to participate. A concession of $10 in their session fee was offered for their participation. Therapists explained the procedures, obtained consent, and collected self-report questionnaires from participants before the start of the first session. This study was approved by the University's Institutional Review Board prior to data collection. For this study, data collected from couples from February 2007 through July 2008 were analyzed. Data from 72 couples were initially available. Data from three couples were excluded due to missing demographic information and large number of incomplete items on the questionnaires. Data from one same-sex couple was also eliminated in order to maintain homogeneity of the sample. Thus, we used data from a total of 68 other-sex couples gathered at baseline before they began therapy.

Sample

Approximately half of the sample was married (51%) and about a quarter (24%) was in a cohabiting relationship. About 11% reported being separated or divorced; 6% reported being in a dating relationship, 7% reported being single, and about 3% did not answer the question. All participants presented at baseline as a couple; it is possible that partners' report of their relationship status differed, or some may have reported a prior relationship status along with a current one (for instance, divorced and dating). The relationship duration ranged from one to thirty with a mean of seven years ($SD = 5.4$). The mean age was 32 years ($SD = 9.28$) for male participants and 30 years ($SD = 7.34$) for female participants. Most participants were Caucasian (78%), 6% identified as African-American and 4.4% as Hispanic. One participant identified as Native American. Around 20% also reported "Other" as their race/ethnicity which respondents chose if none of the pre-identified categories adequately described them. Some participants identified more than one category listed in the demographic questionnaire. The majority (72%) reported an income of less than $39,999. This sample was representative of the clientele served by the clinic, which operates on a sliding fee scale and provides services to members of the city's larger community. Presenting problems were not specifically gathered for this study. However, clinical records indicated that most couples sought therapy for "conflict" and/or "communication issues."

Measures

The Relational Ethics Scale (RES; Hargrave et al., 1991), which consists of 24 items rated on a five point Likert-type scale, was used to measure relational ethics in the family of origin (vertical) and current partner (horizontal) relationships. Both vertical and horizontal

subscales have 12 items on a five-point Likert-type scale and include items measuring trust and justice, loyalty, and entitlement. Some examples of the items are: "I could trust my family to seek my best interests" (vertical trust and justice); "No matter what happened, I always stood by my family" (vertical loyalty); "I felt my life was dominated by my parents' desires" (vertical entitlement); "I do not trust this individual to look out for my best interests" (horizontal trust & justice); "This person stands beside me in times of trouble or joy" (horizontal loyalty); "I take advantage of this individual" (horizontal entitlement). Scoring on the negative items are reversed such that lower scores on the overall scale as well as the subscales indicate greater difficulties in the dimension of relational ethics (Grames et al ., 2008). The possible range of scores is from 12 to 60. Cronbach's alpha was .87 for the entire scale and .88 and .83 for the vertical and horizontal subscales, respectively. In this study, we examined scores on the vertical and horizontal subscales separately to distinguish the relative influence of relational ethics in family of origin and current relationship on depressive symptoms and relationship satisfaction. We did not include the total RES scores in this analysis. The mean scores for the vertical subscale were 41.20 (SD = 10.16) for females with a range of 23 to 60 and 44.70 (SD = 8.32) for males with a range of 14 to 57; for the horizontal subscale, the mean scores were 39.86 (SD = 8.03) for females with a range of 22 to 59 and 42.87 (SD = 6.65) for males with a range of 29 to 60, indicating that female partners experienced greater problems in relational ethics in both family of origin and current partner relationships.

The Revised Dyadic Adjustment Scale (RDAS; Busby, Christensen, Crane, & Larson, 1995), a reliable and valid 14-item instrument that differentiates dyadic adjustment in distressed and nondistressed relationships, was used to assess relationship satisfaction. This shortened version of the Dyadic Adjustment Scale (DAS; Spanier, 1976) has been used in numerous

studies in the last decade to assess marital satisfaction (Ward, Lundberg, Zabriskie, & Berrett, 2009) in both general (e.g., Knobloch, Miller, Bond, & Mannone, 2007; Hollist, & Miller, 2005) and clinical populations (e.g, McLean, Jones, Rydall, Walsh, Esplen, Zimmermann, & Rodin, 2008). There are three subscales with items measured on varying Likert scales– dyadic consensus (e.g., "How often do you agree on religious matters?") dyadic satisfaction (e.g., "Do you ever regret that you married (or lived together)?" , and dyadic cohesion (e.g., "How often do you have a stimulating exchange of ideas?"). The total score provides levels of relationship distress or satisfaction. The total possible range of scores is between 0 to 69. In general, low scores represent greater relationship distress. A cut-off point of 48 on the total score was used to assess distress (Crane, Middleton, & Bean, 2000). The reliability score for the entire scale in this sample was .86. Both male and female partners reported low relationship satisfaction, with female partners reporting lower satisfaction ($M = 37.9$, $SD = 10.66$) than male partners ($M = 41.4$, $SD = 8.34$). The range of scores for female partners was between 5 and 58 and for male partners it was between 25 and 60.

Additionally, levels of depression were assessed using the Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer &Williams, 2001), an instrument based on the DSM–IV criteria for assessing a range of depressive symptoms. It measures how often, in the last two weeks, one was bothered by a list of nine symptoms including "little interest or pleasure in doing things," "feeling down, depressed, or hopeless," and "feeling tired or having little energy." A final item asks, "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?" on a scale of "not difficult at all" to "extremely difficult." Scores on this nine-item measure indicate minimal (1-4), mild (5-9), moderate (10-14), moderately severe (15-19), and severe depression (20-27). The

PHQ-9 is considered a valid screening tool for symptoms of major and minor depression in clinical and general populations (Martin, Rief, Klaiberg, & Braehler, 2006). Cronbach's alpha for the entire scale was .86. Among female participants, about 20.6% were in the minimal range; 37.4% in the mild range; 19.1% in the moderate; 13.3 % in the moderately-severe; and 10.3% in the severe range. Among male participants, 39.7% were in the minimal range; 27.9 % in the mild; 19.2% in the moderate; 11.7% in the moderately-severe; and about 1.5% in the severe range. On average, female participants' levels of depression were slighter higher and in the mild-moderate range ($M = 9.89$, $SD = 6.34$) than their male partners, whose scores were in the mild range ($M = 7.31$, $SD = 5.53$).

There were a few missing items in the data set. On the RES the range of missing items was between two and five; on the PHQ-9 it was two and four; and on the RDAS it was between one and eight out of 136 possible data points for each scale from 68 couples. These missing data were replaced using the Series Mean option on SPSS, assuming that they were missing at random.

Results

Detailed descriptive and correlational statistics of this sample are presented in our earlier report (Author citation). Specifically, relational ethics scores in female partners' family of origin were significantly associated with relational ethics in current partner relationship, $r (66) = .420$, $p < .01$; and relationship satisfaction $r (66) = .369$, $p < .05$; and negatively correlated with their levels of depression, $r (66) = -.21$, $p < .05$. Female partners' report of relational ethics in current relationships was significantly correlated with male partners' report of relational ethics in the current relationship, $r (66) = .443$, $p < .01$. Male partners' report of relational ethics in current relationship was also significantly related to female partners' report of relationship satisfaction, r

(66) = .404, $p < .01$. However, male partners' report of relational ethics in their family of origin

and their levels of depression were not significantly correlated with any of the variables.

APIM Estimation

      In order to test the hypotheses, an Actor-Partner Interdependence Model (APIM) was

estimated using AMOS 19 (Arbuckle, 2010). The APIM is a specific form of Structural

Equation Modeling (SEM) that is useful in analyzing dyadic data as it accounts for the

interdependence of variables (Kenny et al., 2006). In this form of SEM, exogenous variables

(i.e., independent variables - the horizontal and vertical subscales of relational ethics), were used

to predict endogenous variables (i.e., dependent variables - relationship satisfaction and

depressive symptoms). The analysis of dyadic data through APIM allows for the assessment of

one's effect on themselves (actor effect) as well as one's impact on their partner (partner effect).

For instance, here the impact of female partner's relational ethics on her depression and

relationship satisfaction as well as on *his* depression and relationship satisfaction can be

investigated.

      Distinguishability. The first step in estimating APIM is to establish empirical

distinguishability of the dyad – that is, is there sufficient variance in the endogenous variables

between partners to warrant continued dyadic analysis? If there is no distinguishability, then

other suitable methods of analysis could be used.   In order to establish distinguishability, we

followed the omnibus test of distinguishability as outlined by Kenny, Kashy, & Cook (2006).

First, estimates for the unconstrained model were derived. The following fit indices were used in

this analysis (Hooper, Coughlan, & Muller, 2008): (a) the chi-square value to assess the

magnitude of discrepancy; (b) the Root Mean Square Error of Approximation (RMSEA); (c) the

Standardized Root Mean Square Residual (SRMR); (d) the Comparative Fit Index (CFI). Model

fit is indicated for values of 0.06 and below for RMSEA and SRMR, and greater than or equal to 0.95 for the CFI (Hu & Bentler, 1999). The parameters for this unconstrained model were: $\chi^2 = 0$, P =0.00, CFI=1.00, RMSEA = .284, SRMR =0.00, indicating a poor fit.

Next, the endogenous variables and the residuals (for both PHQ and RDAS) were correlated and their variances and co-variances were constrained to be equivalent. The residuals were correlated to account for any additional sources of non-independence that may affect the dyad that are not included in the model (Cook & Kenny, 2005). Correlating residuals allowed us to ensure that any remaining contributing factors not in the model were similar for both members of the dyad. This resulted in a loss of fit [x^2 (3) = 7.635, p = .054; RMSEA = .152, CFI = .445, SRMR = .029] thus indicating empirical distinguishability of the dyad. However, it was found that the disturbances of PHQ were not significantly correlated (β = 4.408, p = .225) while disturbances of RDAS scores were significantly correlated (β = 18.419, p < .001). Since the disturbances of depression were not significantly correlated, this correlation was not included in a revised model. This revised model had better fit than the original ($\chi2$ = 1.520, p = .218, CFI=.997, RMSEA = .088, SRMR =0.231). Next, each hypothesized actor and partner effects were constrained to be equal and the difference in the chi-square was examined to arrive at the best fitting model (Kenny et al., 2006). Table 1 shows the nested model comparisons and the chi-square difference tests.

Table 1 about here

Actor effects. The actor effects of vertical relational ethics on depressive symptoms were significant for male (β = .055, p <.05) and for female (β = .055, p <.05) partners indicating

that for both, difficulties in relational ethics in their family of origin were related to their

symptoms of depression. Actor effects of vertical relational ethics on relationship satisfaction

were nonsignificant and equivalent for both male and female ($\beta = -.025$, $p = .688$) partners.   The

actor effects of horizontal relational ethics on depression [$\chi^2 (1) = 4.889$, $p = .027$], as well as on

relationship satisfaction [$x^2 (1) = 4.126$, $p = .0422$] were significantly different for male and

female partners, suggesting a gender difference in the association between experiences of

relational ethics in current relationship and depressive symptoms and relationship satisfaction.

The actor effects of relational ethics in the current relationship (horizontal) on relationship

satisfaction were significant for both male ($\beta = .099$, $p <.001$) and female ($\beta = .097$, $p <.001$)

partners, indicating that difficulties in relational ethics were significantly associated with lower

relationship satisfaction for both partners. Thus, while difficulties in relational ethics in family

of origin relationships were associated with their own depressive symptoms, only difficulties in

relational ethics in current relationship were associated with their own report of lower

relationship satisfaction. Further, actor effects for depressive symptoms and relationship

satisfaction were significant and equivalent ($\beta = .073$, $p < 0.05$). In other words, participants'

symptoms of depression were significantly associated with their lower relationship satisfaction.

Thus, significant actor effects were noted for most pathways (Figure 1). Taken together, these

findings indicate that for both partners, difficulties in relational ethics in their family of origin

were associated with greater symptoms of depression; difficulties in relational ethics in the

current partner relationship were associated with lower relationship satisfaction; and their

depressive symptoms were associated with their report of lower relationship satisfaction.

   Partner effects. Partner effects of relational ethics in family of origin were non-

significant but equivalent for depressive symptoms ($\beta = .007$, $p = .892$) and relationship

satisfaction (β = -.059, p = .322). The partner effects of horizontal relational ethics were also

non-significant but not equivalent [x^2 (1) = 3.896, p = .0484] for male depressive symptoms (β =

.117, p = .208) and female depressive symptoms (β = -.192, p = .122)]. Significant and

equivalent partner effects were noted for horizontal relational ethics and relationship satisfaction

(β = .236 p < .001), indicating that male and female partners' experiences of relational ethics

were associated with their partner's report of relationship satisfaction in similar ways.

Specifically, male and female partners' own experiences of difficulties in relational ethics in the

partner relationship were associated with their *partner's* report of lower relationship satisfaction.

The only other significant partner effect was between male and female partners' reports of

depressive symptoms and their partner's relationship satisfaction (males: β = .236, p < .05;

females: β = .073, p <.05).   Again, greater depressive symptoms were associated with their

partner's report of lower relationship satisfaction. This pathway was non-equivalent suggesting

a difference in the association between the variables for the partners. As mentioned earlier, this

could be related to the finding of a significant correlation between depressive symptoms and

relationship satisfaction in female partners only and not in male partners.

  Final model. The final model with equivalence constraints had a close fit to the data [χ^2

(8) = 8.968, p = .345, RMSEA = .043, NFI = .950, CFI = .994, SRMR = 0.0467]. The

significant pathways are shown in Figure 1. Considering the predominantly actor effects and

two significant partner effects, this model could be considered as an actor-oriented model with

significant couple oriented pathways (Kenny & Ledermann, 2010). The model predicted 60.2%

of the variance in satisfaction scores for female partners and 51.4% of the satisfaction score in

male partners, 10.8% of the variance in depressive symptoms in male partners and 7.9% in

female partners.   These differences may indicate a difference in the salience of relational ethics

for male and female partners as it relates to depression and satisfaction levels.

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Figure 1 about here

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Discussion

The purpose of this study was to examine the hypotheses of significant actor and partner

effects of relational ethics in family of origin and current partner relationships on depressive

symptoms and relationship satisfaction in a sample of other-sex couples seeking therapy.

Findings suggest partial support for the hypotheses. Specifically, we found significant actor

effects for relational ethics in family of origin and depressive symptoms; relational ethics in

partner relationship and relationship satisfaction; and depressive symptoms and relationship

satisfaction. We also found significant partner effects for relational ethics in current relationship

and relationship satisfaction as well as depressive symptoms and relationship satisfaction. The

findings of this study, while confirming the association between relational ethics and relationship

satisfaction (Grames et al, 2008; Hargrave et al., 1991), also point to a differential influence of

relational ethics in family of origin and partner relationships that warrants further investigation.

Actor Effects

An important finding was that relational ethics in family of origin was associated with

depression for *both* male and female partners. This confirms the contextual therapy theory

assumption that early life experiences influence symptoms or difficulties later in adulthood

(Boszermenyi-Nagy & Krasner, 1983). Particularly, the results suggest that difficulties in

relational ethics (i.e., in this study - lack of trustworthy relationships with caregivers, loyalty

conflicts, and destructive entitlement) experienced in one's family of origin may continue to have an impact in adulthood as well. Symptoms of depression, therefore, may be an indication that an individual's need for due care was not met in their family of origin. Thus, an examination of relational ethics in family of origin may be useful in clinical work with individuals who report depressive symptoms.

Additionally, depressive symptoms were also associated with lower satisfaction in the current partner relationship for both partners, which affirms earlier findings of studies linking depression and relationship satisfaction (for instance, Rehman et al., 2008). Further, given our finding that relational ethics in family of origin was associated with depressive symptoms, and depressive symptoms were associated with relationship satisfaction for both partners, the possibility of an indirect effect or mediating relationship should be explored in future studies.

Partner Effects

Another vital finding was the significant partner effect of depressive symptoms on relationship satisfaction for both partners. Thus, participants' depressive symptoms were associated with not just their own lower relationship satisfaction but were also associated with their partner's lower satisfaction. Additionally, participants' report of relational ethics in their current relationship was associated with, not only their own relationship satisfaction, but their partner's satisfaction, as well. Specifically, a lower horizontal relational ethics score was associated with lower relationships satisfaction for both partners. A lower score could indicate that the partner felt there was a lack of trust, a lack of fairness, or some imbalance of give and take. This perceived unfairness was related to both partners' reports of low relationship satisfaction.

These emerging findings have significant implications in formulating clinical interventions. Most importantly, it suggests that an examination of family of origin relationships may help in assessment and treatment of depressive symptoms and relationship dissatisfaction. While findings are tentative and our methodology does not allow for an examination of the temporal order of symptomatology (that is, we do not know whether depressive symptoms predicted relationship dissatisfaction or vice versa) or the possible influence of depressive symptomatology on the retrospective reporting of difficulties in one's family of origin, the suggestion of an association should suffice at least for an assessment of early life experiences in couple therapy.

Clinical Implications

Contextual therapy theory, which suggests that foundations of trustworthiness and ethical relating laid in early years have implications beyond childhood into adulthood, proposes a comprehensive three-generational assessment (Krasner & Joyce, 1995). The goal of this assessment is to identify sources of relational stagnation as well resources for healing, which could in turn help clients change the ledger of unfair relating (Boszormenyi-Nagy & Krasner, 1986). The theory postulates that acknowledgment and validation of one's experiences of unfairness in relationships in addition to promoting ethical relating between family members unblocks stagnation and promotes healthy functioning (Boszormenyi-Nagy, 1997). Thus, hypothetically, in therapy with individuals and couples with depressive symptoms and/or relationship dissatisfaction, symptoms could be alleviated through a focus on issues of relational ethics such as trust, loyalty conflicts, entitlements, and more broadly on issues of fairness and justice.

One way that contextual therapists address issues of fairness and justice is the adoption of a multilateral stance whereby the therapist, rooted in the belief of multiple valid perspectives, sides with every person potentially impacted by therapy (Bernal, Flores-Ortiz, Rodriguez, Sorensen, & Diamond, 1990; Goldenthal, 1996). This requires contextual therapists to be aware of issues of ethical relating in not just the client's life, but also in their own. Examination and acknowledgment of sources of relational stagnation and resources, and the courage to face issues of fair relating in their own relationships are essential in practicing contextual therapy (Boszormenyi-Nagy & Krasner, 1986). Given the broad scope of contextual therapy as a bio-psychosocial-cultural framework (DuCummon-Nagy, 2002), the contextual therapist could incorporate concepts and techniques from other approaches in treatment (Goldenthal, 1996). However, adoption of a multidirected stance and a focus on relational ethics distinguishes this approach from other integrative approaches. Further, a therapist rooted in another model of therapy may be able to integrate multidirected partiality and issues of ethical relating into their own approach, provided there is a conceptual fit.

Limitations

Findings of this study should be interpreted within the context of its limitations. First, this sample may not represent clients at other clinics. Replication of the findings with a more geographically and culturally diverse sample is warranted. The absence of same-sex couples also should be noted. Given the differences based on gender in the salience of relational ethics in its association with depressive symptoms and relationship satisfaction in this sample of other-sex couples, it would be worthwhile to compare these findings with same-sex couples as well. Further, it is important to note that this sample consisted of male and female partners with mild to moderate levels of depression. As symptoms of depression were not a recruiting criterion, we

did not have a comprehensive assessment of depression. For instance, we did not ask about number of episodes of depression or its chronicity and other risk factors associated with depression (Coyne & Benazon, 2001). These are important to consider in future studies, as is inclusion of individuals with more severe and/or other forms of depression. Further, our sample size was not large enough to examine potential mediating influences of the variables, which would have shed more light on the specifics of the association. Power estimated using Preacher and Coffman (2006) was low (.22). Findings, therefore, should be treated as preliminary and warranting further investigation. Finally, the measurement of the Relational Ethics Scale itself needs further re-examination. Studies have found a lack of association between some of the subscales of the RES and relationship satisfaction (Hargrave & Bomba, 1993), suggesting that different items or ways of measuring relational ethics may be needed (Author citation). Additionally, it should be noted that while relational ethics is the hallmark feature of the contextual approach, we believe a comprehensive assessment of issues of fairness and justice (which is the essence of the approach) should include other dimensions of facts, individual psychology, and systemic transactions as well. In order to advance an empirical base for using the contextual therapy theory, attention should be paid to the challenges of measuring fairness and justice as conceptualized by it.

Conclusion

Our findings, while tentative, suggest the importance of examining relational ethics in family of origin as well as in partner relationships with individuals and couples reporting low relationship satisfaction and mild to moderate depressive symptoms. Findings indicate there is much to be gained from an examination of processes of relational ethics in both current as well as family of origin relationships. Further studies are required to understand the specific

mechanisms through which intergenerational transmission may be interrupted. These studies

will play a crucial role in legitimizing contextual therapy theory as a framework for intervening

in relationship dissatisfaction and depression.

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