

Relational problems and psychiatric symptoms in couple therapy

Lundblad A-M, Hansson K. Relational problems and psychiatric symptoms in couple therapy
Int J Soc Welfare 2005; 14: 256–264 © Blackwell Publishing, 2005.

This article describes couples attending family counselling in Sweden. The study group is compared with clinical groups and non-clinical groups. Self-rating instruments were completed by 317 women and 312 men to evaluate the following: marital satisfaction (DAS), expressed emotion (QAFM), family climate (FC), psychiatric symptoms (SCL-90) and sense of coherence (SOC). This group had several problems: marital relationships, disrupted family functioning, dyadic interactions characterised by criticism and open arguments, and multiple psychological symptoms. The women were especially discontent in the relationship, and they exhibited higher symptom strain and lower sense of coherence than the men did. Compared with non-clinical populations, this group was severely distressed and was similar to in-patient families in child psychiatric clinics. The low sense of coherence of the individuals in the group under study means that their sense of having a meaningful life and their ability to comprehend and manage problems were severely compromised. Adequate and comprehensive treatment within the framework of social programmes should be made available to these couples and others in a similar situation.

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Key words: distress, marital satisfaction, psychiatric symptoms, expressed emotion, couple therapy

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Accepted for publication April 26, 2004

Introduction

The connection between intimate relationships and physical and mental health has been documented in several different contexts (Rydén & Stenstrom, 1994). Women seem to be affected more often and more negatively by family problems, whereas men seem to experience more stress in their working life (Wahrborg, 1999). At all ages, men report higher marital satisfaction than do women (Hansson, Lundblad & Kaslow, 1994; Levenson, Carstensen & Gottman, 1993). Marital variables affect health status, but the effect is indirect and non-specific (Burman & Margolin, 1992).

Because the family is the foundation of personality growth and health of the children (Rydén & Stenstrom, 1994), the health of children is at risk in distressed families. Rates of acting out behaviour, depression, fear, addiction and psychosomatic symptoms may be elevated in distressed families (Hansson, 2001; SOU 1999:137). Conversely, a supportive family during childhood and early adulthood contributes to health even in middle age (Werner & Smith, 2001).

Previous research about couples' relationships has identified strong links between marital quality and health (Levenson et al., 1993). Compared with other important life domains, there is a strong association

between marital quality and global well-being (Glenn, 1990). Both mental and physical health appear to be related to marital status even though the associations are not simple ones. Marriage's protective effects on health seem to be stronger for men than for women, whereas marital functioning (quality) has a greater influence on women than on men (Kiecolt-Glaser & Newton, 2001; Levenson et al., 1993).

Research now indicates that marital distress is associated with suppressed immune function, cardiovascular arousal and an increase of stress-related hormones. For men, marriage, as an institution, seems to offer health-buffering effects, whereas women are more likely to experience health-related problems if the marriage is distressed (Gottman & Notarius, 2002). Women seem to be more negatively affected by emotional disengagement, whereas men are more negatively affected by conflicts (Johnson & Lebow, 2000).

In addition, family disruptions and marital problems are connected to – or increase the risk of – a range of family problems and may have a negative effect on the mental and physical health of family members (Bray & Nouriles, 1995). In Sweden, children with single parents (adjusted for socio-economic status and parents' addiction or mental illness) have shown an increased risk of psychiatric illness, suicide or suicide attempt,

injury and addiction compared with children in two-parent households (Ringback Weitoft, Hjern, Haglund & Rosén, 2003).

Expressed emotion (EE) appears to be a significant and robust predictor of the relapse of schizophrenia (Butzlaff & Hooley, 1998), although its mechanism for influencing well-being is still somewhat unclear. The expression of criticism and hostility was considered the most decisive dimension in predicting relapse in psychosis. Originally, EE was considered powerful and predictive in dimensions relating to attitudes towards the patient, but recently an interactional or circular pattern of intensification has been proposed (Hansson et al., 2003). The concept of EE has also been understood to influence depression and anxiety within marital relationships (Leff et al., 2000).

Recently, sense of coherence (SOC) has begun to be explored as a health-promoting approach to life and has also been viewed as a stress-reducing factor (Antonovsky, 1993). This makes the concept important to investigate in family relations and in public health as a resilient factor against stress (Werner & Smith, 2001).

These many individual and family contributors to health and disorder call for better understanding of the way family support or stress operates. In particular, mechanisms that result in the reduction of marital distress and the prevention of family disruptions should have high priority within social work research. If such mechanisms can be identified, social work practice strategies for altering them should be explored.

Family counselling

Family counselling in Sweden involves couple therapy, primarily within the context of municipal social welfare and church-affiliated family counselling (Hansson, 2001). Although often used (about 40,000–50,000 cases are treated through public services every year), there has been little empirical evaluation of couple therapy. Family counselling aims to help couples find constructive solutions to conflicts, to achieve an improved life together and to avoid a destructive separation (SOU 1994). Couple therapy also supports parents in their attempts to develop their parenting skills so that they will share the responsibility of raising their children as a couple or after a separation.

According to the couple's description of their problems, the most common reasons to attend couple therapy are communication problems, problem-solving difficulties, child guidance, financial problems and the regulation of closeness and distance (Lundblad & Hansson, 1996).

Psychosocial treatment is the primary mode of treatment. Psychotherapy is performed when resources are available. Most often short-term treatment is performed, usually encompassing fewer than 10 one-

hour sessions. Average charges are low (SEK 100–200 per session) as an encouragement to low-income clients.

More research is needed to describe the situations and circumstances of couples under 'normal conditions' and to study the importance of a good family climate for public health (SOU, 2000).

Background

In Sweden, only a few comprehensive empirical studies have examined couples attending family counselling. Because of this lack of research, neither the situation of these couples nor the results of their treatment, short-term or long-term, can be properly described or evaluated.

Family counselling is a fairly new activity within social work practice (established by law from 1995) (SOU, 1994) and enjoys growing popularity. It is important to obtain a deeper understanding of the requirements for treatment and prevention. It is also valuable to compare these couples with other groups. Moreover, because family distress and family disruptions have dramatically increased, it is important to view these families from a public health perspective.

Aims

The aims of this study are threefold: to examine women and men concerning their experience with distressed relationships and health using rating instruments; to examine gender differences in the study group; and to compare the subjects of this study with clinical and non-clinical groups with respect to marital satisfaction, family factors, psychological symptoms and sense of coherence, using rating instruments.

Method

This study is a multi-centre single group study that includes family counselling agencies in six Swedish communities. Participating agencies were chosen from a single geographical neighbourhood and because of the personal interest of sixteen therapists willing to participate in exploring the study's aims. During a two-year period (1998–2000), cohabiting and married couples were asked to participate in the study. Inclusion criteria required the couples to attend at least three sessions together and to have working knowledge of the Swedish language. Couples were informed about the study in the first session and signed a written agreement to participate. The self-rating instruments were completed individually by women and men during the first session. The study was meant to include corresponding post-treatment measures.

Several variables were registered for all visitors during the time of the study: age of the adults, number and ages of the children, kind of relationship, initial

problems, intentions and goals of treatment. The study group was compared with clinical and non-clinical groups to ascertain how couples who attended family counselling compare with other couples.

Subjects

The total number of cases (couples or sole visitors) studied was 2,012. Of these, 1,419 (71 per cent) cases had children younger than 18 years old. We excluded five categories of cases, a total of 1,419, when: the couples were already separated ($n = 402$), only one member of the couple participated ($n = 410$), consultation (only one session was requested) was the only service ($n = 421$), and when visitors were not fluent enough in the Swedish language ($n = 62$). Some cases ($n = 124$) were excluded from the study because the therapist had not asked them to participate, usually because their situation was judged to be too chaotic or one or both of the visitors were judged to have serious mental problems. These criteria resulted in 593 eligible cases (couples); the final study group consisted of 317 (53.5 per cent) couples, because 276 of the couples declined to participate.

Instruments

The Dyadic Adjustment Scale (DAS) measures the quality of a marital relationship. A high score indicates high satisfaction in each aspect (Spanier, 1976). The scale consists of 32 items with sub-scales on dyadic consensus, dyadic satisfaction, dyadic cohesion and affectional expression. The Swedish version has a satisfactory Cronbach's alpha and varied between 0.87 and 0.93 (Hansson et al., 1994). In this study, Cronbach's alpha varied between 0.86 and 0.91. The comparing clinical group consisted of couples in long-term marriages (Women M (SD) = 97.7(19.5); Men M (SD) = 106.4(18.9) (Lundblad & Hansson, 1996)). The comparing non-clinical group was composed for analysis and scale assessment (Women and Men M (SD) = 114.8(17.8) (Spanier, 1976)).

Questions about family members (QAFM) measures expressed emotion (Hansson & Jarbin, 1997). EE can predict psychosis, depression and anxiety in marital relationships (Leff et al., 2000). This self-rating instrument describes an interactional perspective between women and men. It consists of 30 items that describe a dyadic relationship with another family member. In the present study the questionnaire was homogenised by factor analysis, resulting in four factors: two factors concerning 'given EE' (critical comments and emotional over-involvement) and two factors concerning 'perceived EE' (perceived criticism and perceived emotional involvement). Expected differences between clinical and non-clinical groups were found. Cronbach's

alpha for critical comments was 0.87, for emotional over-involvement 0.81, for perceived criticism 0.73 and for perceived emotional involvement 0.69. In this study, Cronbach's alpha varied between 0.68 and 0.84. The comparing clinical group was a varied clinical group for testing a new questionnaire (Women and Men M (SD), PC = 2.07(0.67), PEI = 2.51(0.60); CR = 2.56(0.76), EOI = 2.71(0.64) (Hansson & Jarbin, 1997)). The non-clinical group was formed from mothers and fathers from the Twin Mom Study (GEMA) in Sweden (Women M (SD), PC = 1.56(0.53), PEI = 2.64(0.50), CR = 1.81(0.57), EOI = 1.95(0.50), Men M (SD), PC = 1.89(0.56), PEI = 2.80(0.50), CR = 1.61(0.47), EOI = 1.92(0.47) (Reiss et al., 2001a, 2001b)).

The family climate scale (FC) is a list of 85 adjectives selected to reflect different aspects of the emotional atmosphere in the family (Hansson, 1989). Four independent factors were identified: closeness (CL), distance (DI), expressiveness (EX) and chaos (CH). An index was calculated for each of the factors. Cronbach's alpha was 0.98 for closeness, 0.91 for distance, 0.71 for expressiveness and 0.92 for chaos. In this study, Cronbach's alpha varied between 0.97 and 0.78. The factor 'expressiveness' was excluded in this study. The comparing clinical group consisted of mothers and fathers of adolescents treated at five units for Intensive Family Therapy in Sweden (Women M (SD), CL = 1.06(0.93), DI = 0.84(0.69), CH = 1.74(1.33), Men M (SD), CL = 1.17(0.89), DI = 0.71(0.54), CH = 1.61(1.33) (Sundelin, 1999)). The comparative non-clinical group consisted of mothers and fathers from the Twin Mom Study (GEMA) in Sweden (Women M (SD), CL = 2.11(0.72), DI = 0.19(0.36), CH = 0.22(0.60), Men M (SD), CL = 2.06(0.76), DI = 0.23(0.41), CH = 0.22(0.62) (Reiss et al., 2001a, 2001b)).

The symptom checklist (SCL-90) (Derogatis, Lipman & Covi, 1973) is a widely used measure containing 90 items that refer to expressions of psychosomatic and emotional distress. A low score on this questionnaire is considered to be an indication of 'good mental health'. The questionnaire was standardised to Swedish conditions (Fridell, Cesarec, Johansson & Malling Andersen, 2002). Cronbach's alpha was 0.98. In the study for GSI (Global Severity Index), Cronbach's alpha was 0.95. The comparative clinical group consisted of mothers and fathers of in-patient adolescent patients at a child psychiatric clinic (Women M (SD), GSI = 57.5(48.5), Men M (SD), GSI = 40.2(44.9) (Hansson & Cederblad, 2001)). The non-clinical comparative group was composed to standardise the rating instrument for Swedish conditions (Women M (SD), GSI = 44.1(39.6), Men M (SD), GSI = 28.8(28.8) (Fridell et al., 2002)).

The SOC instrument measures a person's stress-resilience capacity, and as such becomes a health-promoting factor (Antonovsky, 1993). SOC consists of

29 items with 7 alternatives for each item. The scores vary between 29 and 203. In earlier studies, this instrument has shown a satisfactory validity and reliability, with a Cronbach's alpha of 0.89 (Antonovsky, 1993; Hansson & Olsson, 2001). In the present study, Cronbach's alpha was 0.91. The comparative clinical group consisted of couples in long-term clinical marriages (Women M (SD) = 139.1(23.4), Men M (SD) = 146.5(22.5) (Lundblad & Hansson, 1996)). The first non-clinical comparative group was drawn from a longitudinal Swedish population study on mental health (Women M (SD) = 150.8(24.5), Men M (SD) = 154.9(18.4) (Hansson & Olsson, 2001)). The second non-clinical comparative group consisted of network couples in long-term marriages (Women M (SD) = 153.7(19.4), Men M (SD) = 157.0(18.3) (Hansson et al., 1994)).

A limitation of the study was that we did not have access to the same clinical or non-clinical group for all the rating instruments, which would have been preferable.

Statistical methods

The statistical methods used in the study were paired t-test for differences between women and men in couples, unpaired t-test for differences between independent groups and X² for frequency differences. Multiple regression analysis was used to explain psychiatric symptoms and SOC from the couple's relationship, and an analysis was made of the correlation between psychiatric symptoms and SOC.

Results

The women participating in the study had a mean age of 36.8 years (SD 8.1), and the men had a mean age of 39.1 years (SD 8.2). Approximately 75 per cent of the participants were between 30 and 49 years old, and 60 per cent were under 40 years old.

The occupations of the group's members were classified to estimate how well the study group compared with the general population in Sweden. In the occupation dimension the study group was similar to Swedish population characteristics for adults aged 18–64 years (SCB, 1995a).

Participants versus other visitors

Initial data on intentions and goals of treatment were collected from all clients during the time of the study. Participating couples intended to improve their relationship to a greater extent than did other groups (the excluded cases) attending counselling (X² = 27.1, p < 0.0001, DF = 4), and there was a difference between the participants and the 'refusing' couples (X² = 25.4, p < 0.0001, DF = 4). Many of the women and men who chose not to participate in the study had vague or diversified treatment goals.

Marital satisfaction (DAS)

Marital satisfaction was assessed using the Dyadic Adjustment Scale (DAS). Comparisons were made with clinical and non-clinical groups.

Both women and men in the study group (couple therapy) presented very low scores on dyadic adjustment (marital satisfaction) in total and on all sub-scales. The women scored significantly lower on satisfaction than did the men. When comparing the study group with another clinical group, 'long-term clinical marriages', the study group scored lower dyadic adjustment in total as well as on the sub-scales consensus and affectional expression (Lundblad & Hansson, 1996). Both women and men in the study group also differed significantly in all dimensions from the non-clinical group. This means that the study group compared with the clinical and non-clinical groups was severely distressed in terms of marital satisfaction (Table 1).

Table 1. DAS: Estimated differences between women and men in the study group and comparisons to clinical and non-clinical groups (M, SD).

	Couple therapy		Clinical group		Non-clinical group
	Women n = 316 M (SD)	Men n = 310 M (SD)	Women n = 33 M (SD)	Men n = 33 M (SD)	Women and Men n = 218 M (SD)
1	43.1 (9.5)	44.7 (9.4)*	48.5 (8.4)**	50.2 (8.6)**	51.9 (8.5)***/**
2	28.9 (6.7)	31.6 (6.4)**	30.0 (6.5)-	34.1 (6.1)*	40.5 (7.2)***/**
3	10.5 (4.4)	12.1 (4.3)**	10.7 (5.0)-	3.6 (4.2)-	13.4 (4.2)***/**
4	6.1 (2.5)	6.4 (2.3)*	7.4 (2.3)***	8.3 (2.3)***	9.0 (2.3)***/**
Total	88.6 (19.3)	94.5 (18.8)**	97.7 (19.5)**	106.4 (18.9)***	114.8 (17.8)***/**

Notes: 1 = Consensus, 2 = Satisfaction, 3 = Cohesion, 4 = Affectional expression. * = p < 0.05, ** = p < 0.01, *** = p < 0.001. Couple therapy = study group, clinical group (Lundblad & Hansson, 1996), non-clinical group (Spanier, 1976).

Table 2. QAFM: Estimated differences between women and men in the study group and comparisons to clinical and non-clinical groups (M, SD).

	Couple therapy		Clinical group		Non-clinical group	
	Women n = 316 M (SD)	Men n = 311 M (SD)	Women and Men n = 197 M (SD)	Mothers n = 648 M (SD)	Fathers n = 646 M (SD)	
PC	2.29 (0.84)	2.60 (0.82)***	2.07 (0.67)**/**	1.56 (0.53)***	1.89 (0.56)***	
PEI	2.52 (0.62)	2.77 (0.56)***	2.51 (0.60)-/**	2.64 (0.50)**	2.80 (0.50)-	
CR	2.81 (0.71)	2.34 (0.64)***	2.56 (0.76)***/**	1.81 (0.57)***	1.61 (0.47)***	
EOI	2.91 (0.62)	2.74 (0.62)***	2.71 (0.64)***/-	1.95 (0.50)***	1.92 (0.47)***	

Notes: PC = Perceived criticism, PEI = Perceived emotional involvement, CR = Critical remarks, EOI = Emotional over-involvement; ** p < 0.01, *** p < 0.001. Couple therapy = study group, clinical group (Hansson & Jarbin, 1997), non-clinical group (Reiss et al., 2001a, 2001b).

Table 3. FC: Estimated differences between women and men in the study group and comparisons to clinical and non-clinical groups (M, SD).

	Couple therapy		Clinical group		Non-clinical group	
	Women n = 295 M (SD)	Men n = 291 M (SD)	Mothers n = 84 M (SD)	Fathers n = 40 M (SD)	Mothers n = 631 M (SD)	Fathers n = 645 M (SD)
1	0.73 (0.73)	0.82 (0.80)	1.06 (0.93)***	1.17 (0.89)**	2.11 (0.72)***	2.06 (0.76)***
2	0.93 (0.76)	0.83 (0.76)	0.84 (0.69)-	0.71 (0.54)-	0.19 (0.36)***	0.23 (0.41)***
3	1.51 (1.28)	1.45 (1.23)	1.74 (1.33)-	1.61 (1.33)-	0.22 (0.6)***	0.22 (0.62)***

Notes: 1 = Closeness, 2 = Distance, 3 = Chaos; ** p < 0.02, *** p < 0.001.

Couple therapy = study group, clinical group (Sundelin, 1999), non-clinical group (Reiss et al., 2001a, 2001b).

Expressed emotion (QAFM). In the study group (couple therapy), differences between women and men on all sub-scales were noted. Men were more often the receivers of criticism and critical comments, whereas women expressed criticism more often and to a greater extent than did the men (Table 2). In other contexts, perceived emotional involvement has been interpreted as a positive factor (Hansson & Jarbin, 1997). In this context, men experienced more emotional involvement. The women in the study group seemed to be more affected by emotional over-involvement. High scores indicate significant emotional involvement and a strong response to what the other person is doing or feeling in a way that puts a strain on the relationship (Hansson & Jarbin, 1997).

The study group differed significantly, in a negative direction, from the clinical group. For women, there were differences except for 'perceived emotional involvement', and for men there were differences except for 'emotional over-involvement'. Both women and men in the study group differed significantly from the non-clinical group in all dimensions except for men in the 'perceived emotional involvement' category. The study group was more characterised by open criticism than were the comparison groups. In the dimensions of emotional involvement, this group was more distressed than others.

Family climate (FC). This self-rating instrument is meant to describe different aspects of the emotional

atmosphere of the family as a whole as described by the adults.

The women and men in the study group (couple therapy) agreed on the quality of the family climate, but family life was far from satisfactory. The study group was similar to the clinical families, but exhibited less closeness and chaos and more distance. The clinical group (IFTU) consisted of mothers and fathers in families where one or more children were, at the time of the study, in-patients at a child psychiatric clinic (Sundelin, 1999). These families suffered from many severe problems. This was not a strictly comparable group, but the comparison was made to get an idea of how the study group approximately related to other clinical groups. Women and men in the study group differed significantly from the non-clinical families in all dimensions. This means that the most distinguishing characteristic between the two clinical groups was that women in the study group experienced less closeness. Compared with the non-clinical group, there were expected differences in all dimensions.

Psychiatric symptoms (SCL-90). This questionnaire was used to assess psychological and emotional symptoms.

Both women and men in the study group (couple therapy) suffered from a number of symptoms. There was a significant difference between women and men in the study group in the total score and on all sub-scales except paranoid ideation and psychoticism.

Table 4. SCL-90. Estimated differences between women and men in the study group and comparisons with clinical and non-clinical groups (M, SD).

	Couple therapy		Clinical group		Non-clinical group	
	Women n = 311 M (SD)	Men n = 308 M (SD)	Women n = 97 M (SD)	Men n = 66 M (SD)	Women n = 707 M (SD)	Men n = 309 M (SD)
1	85.6 (47.6)	67.5 (46.4)***	57.5 (48.5)***	40.2 (44.9)***	44.1 (39.6)***	28.8 (28.8)***
2	10.1 (7.9)	7.2 (7.1)***	9.1 (8.9)-	4.8 (4.9)**	5.9 (5.8)***	4.2 (4.6)***
3	10.8 (7.3)	9.5 (6.7)**	6.4 (6.0)***	5.2 (6.5)***	6.5 (6.1)***	5.0 (5.3)***
4	8.6 (5.8)	7.1 (5.3)***	5.3 (5.2)***	4.8 (6.8)**	4.9 (5.1)***	3.0 (3.8)***
5	20.7 (10.5)	14.9 (9.9)***	13.3 (10.3)***	8.1 (8.4)***	9.4 (9.6)***	5.2 (6.4)***
6	10.2 (6.6)	8.3 (6.5)***	7.8 (6.6)**	4.5 (4.9)***	5.6 (5.4)***	3.3 (3.9)***
7	5.5 (4.3)	4.1 (3.6)***	3.3 (3.4)***	2.7 (3.6)**	2.3 (3.0)***	1.6 (2.2)***
8	2.1 (3.9)	1.3 (2.6)***	1.3 (2.9)-	0.8 (2.5)-	1.1 (2.8)***	0.6 (1.5)***
9	4.3 (4.0)	4.3 (3.8)-	3.1 (3.9)**	2.8 (3.5)**	2.5 (3.2)***	1.9 (2.7)***
10	5.1 (4.7)	4.5 (5.3)-	2.5 (4.0)***	2.8 (5.9)*	2.3 (3.7)***	1.4 (2.7)***

Notes: 1 = Global Severity Index, 2 = Somatisation, 3 = Obsessive-compulsive, 4 = Interpersonal sensitivity, 5 = Depression, 6 = Anxiety, 7 = Hostility, 8 = Phobic anxiety, 9 = Paranoid ideation, 10 = Psychotics; * p < 0.02, ** p < 0.01, *** p < 0.001. Couple therapy = study group, clinical group (Hansson & Cederblad, 2001), non-clinical group (Fridell et al., 2002).

Table 5. SOC: Estimated differences between women and men in the study group and comparisons to clinical and non-clinical groups (M, SD).

	Couple therapy	Clinical group	Non-clin. gr. 1.	Non-clin. gr. 2.
	Women n = 317 Men n = 311 M (SD)	Women n = 33 Men n = 33 M (SD)	Women n = 83 Men n = 65 M (SD)	Women n = 90 Men n = 90 M (SD)
Women	132.4 (23.2)	139.1 (23.4)	150.8 (24.5)***	153.7 (19.4)***
Men	139.1 (21.6)***	146.5 (22.5)	154.9 (18.4)***	157.0 (18.3)***

Notes: *** p < 0.001. Couple therapy = study group, clinical group (Lundblad & Hansson, 1996), non-clinical group 1 (Hansson & Olsson, 2001), non-clinical group 2 (Hansson & Lundblad, 1994).

Women and men in the study group also expressed more symptoms than did the compared clinical group. The clinical group consisted of parents of adolescents in in-patient treatment at a child psychiatric clinic (Hansson & Cederblad, 2001). Couples attending family counselling requested help with their relationship distress but not directly for personal matters; for this reason, these couples provided an approximate comparison in this dimension. The study group also differed significantly from the non-clinical population. The women and men in the study group exhibited a higher level of symptom strain than did the women and men in the clinical and non-clinical groups.

Sense of coherence (SOC)

This instrument is an important outcome measure of health (Antonovsky, 1985)

In the study group (couple therapy), the women scored significantly lower in SOC than did the men. In this respect, they differed from both the clinical and non-clinical comparative groups. There was no statistical difference between women and men in the study group compared with women and men in the clinical

group. Compared with the non-clinical groups, women and men in the study group scored much lower values.

To investigate how couple relations' variables explain psychiatric symptoms, we used multiple regression analysis. The dependent variable was SCL-90 (Psychiatric Symptoms), and the independent variables were DAS (marital satisfaction), QAFM (expressed emotion) and FC (family climate). We found significant regressions for both women and men (Women: n = 288, DF = 9, F = 5.98, p < 0.0001, R = 0.40. Men: n = 284, DF = 9, F = 7.04, p < 0.0001, R = 0.43).

To investigate how couple relations' variables explain SOC, we used multiple regression analysis. The dependent variable was SOC, and the independent variables were DAS, QAFM and FC. We found significant regressions for both women and men (Women: n = 293, DF = 9, F = 3.63, p < 0.0003, R = 0.32. Men: n = 286, DF = 9, F = 4.42, p < 0.0001, R = 0.36).

We investigated correlations between SOC and SCL-90 and found a correlation between SOC and psychiatric symptoms for both women and men (Women: n = 304, R = 0.64, p < 0.0001. Men: n = 304, R = -0.66, p < 0.0001). As can be seen, the correlation was approximately equal for women and men.

Discussion

The present study was designed to describe women and men in distressed couple relationships and to obtain a comparison with couples in other clinical and non-clinical groups. The investigation was based on a number of self-rating instruments.

Slightly more than half of the eligible couples were motivated to participate in the study. The majority of the participating couples had a mutual intention to improve their relationship through treatment. Those who chose not to participate either commented that their 'situation was still too difficult' or in many cases had divergent treatment goals. Couples in particularly chaotic situations, with acts of violence or serious mental impairments in one or both parties, were excluded for ethical reasons.

Because a high percentage of the eligible couples did not participate in the study, the overall condition of the couples attending this activity cannot be determined. The marital satisfaction of this group was low and differed from both the clinical and non-clinical groups. The clinical groups presented differences between women and men that corresponded to other findings, indicating that women are more affected by marital problems than are men (Levenson et al., 1993; Wahrborg, 1999). In the present study, the women and men were equally mentally affected in terms of the relational variables. The study group contained a younger population and the couples' relationships were shorter than in the 'long-term clinical marriages' group, and this may have influenced the differences between the groups. From other studies it is known that marital satisfaction tends to improve for middle-aged couples (Levenson et al., 1993).

The dyadic interaction was characterised by open criticism, most frequently expressed by women towards men. This finding indicates that these couples, if not offered treatment, run a risk of developing serious mental (Butzlaff & Hooley, 1998; Leff et al., 2000) and physical disorders (Johnson & Lebow, 2000).

The couples in the study group also showed a seriously distressed family climate, distress described in terms of low values of closeness and high values of distance and chaos. These findings can also be related to women's greater discontent when it comes to marital satisfaction. In the context of family therapy, dysfunctional families are described similarly (Hansson, 1989). This may be seen as a risk factor for developing physical and mental problems.

SCL-90 is a description of an individual's current mental status (Derogatis, Lipman & Covi, 1973). In this context, there was a significant difference between genders, a finding that corresponds in the main with findings in other groups (Fridell et al., 2002). The symptom profiles for women and men followed the

same pattern, but on most of the sub-scales there was a significant difference favouring men. Both sides obtained the highest scores in depression, obsession-compulsion and anxiety.

There are several ways to interpret the diversity in symptoms between women and men in the study group. That the women suffered more from symptoms could be explained by the fact that, compared with men, women generally express symptoms to a greater extent and are more inclined to seek medical treatment (SOU, 2000). The fact that the differences were extensive in this setting strongly indicates that women experience distressed relationships more severely than men do. Other studies support these findings (Levenson et al., 1993). The study group was severely distressed compared with the clinical group (Hansson & Cederblad, 2001), and this was also confirmed when compared with a Swedish norm group (Fridell et al., 2002).

There was also a difference between women and men in the study group with respect to their SOC, but we found that relational problems explained the SOC to the same degree for both women and men. We also found a relatively high correlation between SOC and psychiatric symptoms. This outcome measure (SOC) has lately become interesting as a health-promoting approach to life and has also been viewed as a stress resilience factor (Antonovsky, 1993; Werner & Smith, 2001). In addition to relational distress and personal problems valid for women and men, they both expressed a low capacity for managing (manageability), understanding (comprehensibility) and finding meaningfulness in different situations. These dimensions should be seen as important coping strategies (Antonovsky, 1985). The significant difference between the women and men in the study group was not found in the other groups. This fact strongly emphasises the exposed situation of the women in 'the family with young children' group.

In this Swedish study, we found no differences between women and men in the explanation of symptoms and relational problems, SOC and relational problems, or in the correlation between SOC and psychiatric symptoms.

Couples in the study group are in a phase of their life where many engagements and spheres of interest should be included, and it is probably the most intense phase in the life of the family. The differences between women and men, other than relational distress and personal factors, could also be related to the differences in work between the genders (Frankenheuser, 1993). Women perform about two-thirds of the housework, feel more responsibility for childcare and are ambivalent about family life coexisting with gainful occupation. Defective financial equality, especially among cohabiting couples, together with issues of inequality of power (Hansson, 2001) may also contribute to these feelings. Bearing children as well as raising older children

coincides with wealth building, careers in skilled work and personal growth for the adults (SCB 1995a). There are many roles and tasks to fulfil and consequently many stressors.

One of the aims of the study was to get an understanding of how couples in counselling stand in relation to other groups. Compared with both clinical and non-clinical groups, these couples were severely distressed. Couples in this study displayed a range of problematic family functions and individual symptoms that were comparable to or more serious than those displayed by the adults in families with children suffering from serious psychiatric symptoms. Families attending a child psychiatric clinic are considered to have many and severe problems (Sundelin, 1999) that apply not only to the children. The health status of the children in families attending family counselling cannot be commented on in the present study. We know from this study only that they live in families where the parents suffer from mental disorders and where the family climate is characterised by distance and chaos, and where much criticism is expressed between the adults. It is well known that this type of family situation places a child's development of identity at risk (Hansson, 2001; Rydén & Stenstrom, 1994) and increases the risk of developing mental and behavioural problems.

Family counselling or couple therapy is a relatively new activity in social work practice in Sweden. Because the activity has not undergone extensive empirical evaluation, the extent and severity of couples' problems have been difficult to assess.

These findings underline the importance of considering ways to help families receive appropriate and timely assistance; otherwise, family problems could become so severe that the family unit will dissolve and children and parents will be affected psychologically and physically. To prevent children from developing severe disorders as a result of inferior family functioning, serious consideration should be given to implementing parental education and providing increased resources to meet the individual needs of single parents as integral parts of the treatment offered. Family counselling in the context of public health prevention should also be considered, especially in finding ways to encourage good health in women.

Acknowledgements

This study was supported by Borås Municipality and the Nordic School of Public Health, Gothenburg.

References

- Antonovsky A (1985). *Health, Stress and Coping*. San Francisco, Jossey-Bass.
- Antonovsky A (1993). The structure and properties of the sense of coherence scale. *Social Science and Medicine* 36: 725–733.
- Bray JH, Nouriles EN (1995). Treatment of marital conflict and prevention of divorce. *Journal of Marital and Family Therapy* 21: 461–473.
- Burman B, Margolin G (1992). Analysis of the Association between Marital Relationships and Health Problems: An Interactional Perspective. *Psychological Bulletin* 112(1): 39–63.
- Butzlaff RL, Hooley JM (1998). Expressed Emotion and Psychiatric Relapse. A meta-analysis. *Archives of General Psychiatry* 55: 47–552.
- Derogatis LR, Lipman RS, Covi L (1973). SCL-90: An outpatient psychiatric rating scale – preliminary report. *Psychopharmacological Bulletin* 2: 17–36.
- Frankenheuser M (1993). *Kvinnligt, manligt, stressigt* [Gender and stress]. Hoganas, Bra bocker.
- Fridell M, Cesarec Z, Johansson M, Malling Andersen S (2002). *Svensk Normering, Standardisering och Validering av Symtomskalan SCL-90* (Symptoms Checklist 90) [Swedish standards and validations of the SCL-90 symptom scale]. Statens Institutionsstyrelse, SiS [National Board of Institutional Care].
- Glenn ND (1990). Quantitative Research on Marital Quality in the 1980s: A Critical Review. *Journal of Marriage and the Family* 52: 818–831.
- Gottman JM, Notarius CI (2002). Marital Research in the 20th Century and a Research Agenda for the 21st Century. *Family Process* 41(2): 159–197.
- Hansson K (1989). *Familjeklimat. En adjektivlista for familjediagnostik* [Family climate. A list of adjectives for diagnosing families]. Lund, Psykologi i tillampning nr 1, Lund University.
- Hansson K (2001). *Familjebehandling på goda grunder – En forskningsbaserad oversikt* [Evidence-based Family Therapy]. Stockholm, Gothia.
- Hansson K, Cederblad M (2001). *Salutogen utredning och behandling – en kvasi-experimentell studie med inriktning på asociala ungdomar* [Salutogenic analysis and treatment of delinquent adolescents – a quasi-scientific study]. Lund. (Unpublished manuscript.)
- Hansson K, Jarbin H (1997). A new self-rating questionnaire in Swedish for measuring expressed emotion. *Nordic Journal of Psychiatry* 51: 287–297.
- Hansson K, Olsson M (2001). *Kansla av sammanhang – ett manskligt strävande* [Sense of coherence – a human striving]. *Nordisk Psykologi* 53(3): 238–255.
- Hansson K, Lichtenstein P, Reiss D, Cederblad M, Pedersen N, Neiderhiser J (2005). *Expressed emotion in a behaviour genetic perspective*. Project GEMA, Sweden. (submitted).
- Hansson K, Lundblad A-M, Kaslow F (1994). *Långa Äktenskap. En studie av par som varit gifta eller sambos i ca 25 år* [Long-term marriages in Sweden]. *Nordic Journal of Psychology* 4: 17–25.
- Johnson S, Lebow J (2000). The 'Coming of Age' of Couple Therapy: A Decade Review. *Journal of Marital and Family Therapy* 26(1): 23–38.
- Keicolt-Glaser JK, Newton TL (2001). Marriage and Health: His and Hers. *Psychological Bulletin* 127(4): 472–503.
- Leff J, Vearnals CR, Brewin G, Wolff B, Alexander E, Asen D, Dayson D, Jones E, Chisholm D, Everitt B (2000). The London Depression Intervention Trial. Randomised controlled trial of antidepressants v. couple therapy in the treatment and maintenance of people with depression living with a partner: clinical outcome and costs. *British Journal of Psychiatry* 177: 95–100.
- Levenson RW, Carstensen LL, Gottman JM (1993). Long-Term Marriage: Age, Gender, and Satisfaction. *Psychology and Aging* 8(2): 301–313.
- Lundblad A-M, Hansson K (1996). *Många par med långvariga relationer söker familjerådgivning* [Long-term Clinical Marriages in Sweden]. *Fokus pa Familjen* 1: 39–51.
- Reiss D, Cederblad M, Pedersen LN, Lichtenstein P, Elthammar O, Neiderhiser JM, Hansson K (2001a). Genetic probes of

- three theories of marital adjustment: Genetic and environmental influences. *Family Process* 40: 261–272.
- Reiss D, Cederblad M, Pedersen LN, Lichtenstein P, Elthammar O, Neiderhiser JM, Hansson K (2001b). Genetic probes of three theories of marital adjustment: recent evidence and a model. *Family Process* 40: 247–259.
- Ringback Weitoft G, Hjern A, Haglund B, Rosén M (2003). Mortality, severe morbidity, and injury in children living with single parents in Sweden: a population-based study. *Lancet* 361: 289–295.
- Rydén O, Stenstrom U (1994). *Hälsopsykologi, psykologiska aspekter på hälsa och sjukdom* [Health psychology, psychological aspects on health and illness]. Stockholm, Bonnier Utbildning AB.
- SCB (1995a). *Skilsmässor och separationer – demografi med barn och familj* [Family Disruptions – Demographics of Children and Families]. SCB 1995:1. Stockholm, Statistiska Centralbyran [Statistics Sweden].
- SCB (1995b). *Välfärd och ojämlikhet i 20 årsperspektiv 1975–1995* [Welfare and unequal conditions in a perspective of 20 years]. SCB 91:1995. Stockholm, Statistiska Centralbyran [Statistics Sweden].
- SOU (1994). *Regeringens proposition om familjerådgivning* [The government's proposition for family counselling]. SOU 1993/94:4. Swedish Ministry of Health and Social Affairs, Swedish Government's Official Reports. Stockholm.
- SOU (1999). *Hälsa på lika villkor; andra steget mot nationella mål for folkhälsan* [Health on equal terms – national targets for the nation's health]. SOU 1999:137. Swedish Ministry of Health and Social Affairs, Swedish Government's Official Reports, Stockholm.
- SOU (2000). *Hälsa på lika villkor – nationella mål for folkhälsan* [Health on equal terms – national targets for the nation's health]. SOU 2000:91. Swedish Ministry of Health and Social Affairs, Swedish Government's Official Reports, Stockholm.
- Spanier G (1976). Measuring Dyadic Adjustment: New Scales for Assessing the Quality of Marriage and Similar Dyads. *Journal of Marriage and the Family* 32: 15–28.
- Sundelin J (1999). *Intensive family therapy, a context for hopes put into practice*. Doctoral Dissertation, Lund University, Department of Child and Youth Psychiatry.
- Wahrborg P (1999). *Smärta i själ and hjärta* [Pain in the heart and soul]. Täby, Pfizer AB.
- Werner EE, Smith RS (2001). *Journeys from Childhood to Midlife: Risk, Resilience and Recovery*. Ithaca, NY, Cornell University Press.