UNIVERSITY OF GHANA, LEGON

A STUDY OF ANXIETY AND DEPRESSION AS CONSEQUENCES OF MARITAL DISTRESS AND THE EFFECT OF COGNITIVE-BEHAVIOURAL THERAPY

BY

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DECLARATION

I declare that, except for references to other peoples' works which have been duly acknowledged, this research work carried out in the Department of Psychology, University of Ghana, Legon, under the supervision of Prof. S. A. Danquah and Dr. Benjamin Amponsah is the result of my own research and it has neither in part nor in whole been presented elsewhere for any degree.

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DEDICATION

Dedicated to the memory of my late uncle, Kingsley Atta Darko and my mum Faustina Frimpong

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May God bless you all and let your dreams come to pass

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ABSTRACT

The purpose of this study was to examine some of the psychological morbidities (anxiety, and depression) that could result from marital distress and how effective cognitive behavioural therapy could be used to ameliorate these adversities

One hundred and fifty married couples (74males and 76females) participated in this study. The age range for the husbands was 28-56years and 22-53years for the wives. Three instruments including Beck's Depression Inventory, Fear of Negative Evaluation Scale and Dyadic adjustment scale were used for the data collection. The Statistical Package for Social Sciences (SPSS) version 11 was used for the data analysis. The specific tests used were the two- way ANOVA, independent sample t-test and Pearson Product Moment correlation.

The results obtained from this study showed that couples with high level of distress reported more depression than couples with low of distress. There was no significant difference between highly distressed females and highly distressed males on the depression measure. Findings also showed that highly distressed couples experienced more anxiety than low distressed couples on the anxiety measure. It was also found that couples with low level of education suffered more distressed than couples with high level of education. Again, Pearson Product Moment Correlation showed a positive correlation between marital distress and depression, and positive correlation between anxiety and depression. Finally, couples who went through therapy reported significant reduction in anxiety and depression than those who did not. Clinical implications that were found from this study included the need for collaboration between medical practitioners and psychologists in tackling problems among distressed couples. Some recommendations and suggestions were finally given for future research

CHAPTER ONE

INTRODUCTION

Human life is multidimensional and it is characterized by physical, social, emotional and spiritual needs. These needs, just like Maslow's hierarchy of needs, are not met simultaneously, although some might overlap. From observation, marriage is one of such needs that cut across all of these dimensions. Marriage has been defined by Cambridge international dictionary of English (1995) as "a legally accepted relationship between a woman and a man in which they live as husband and wife, or the official ceremony which results in this"

It can be realized from experience that physically, one needs a spouse to give assistance or support in combating the hassles daily life presents. For example, starting a family together and seeing to the welfare of their offspring. Simply put, marriage ensures procreation and enables couples to take good care of their children .It also enables them to put money together for joint ventures. Socially, society expects that at a particular point in one's life, marriage should become inevitable (Bird & Melville, 1994). Examples of such instances are at a certain age, when one attends school to a certain level or after learning a trade, and after one has secured a job. Thus, after laying a good foundation for your life it becomes very appropriate and dignifying to marry. When the social clock catches up with you and there is no sign of interest in marriage society might conclude that there is something wrong with you. In order for people to enhance their self-esteem and to earn respect in the society, they marry and that puts them in a particular class. Marriage also serves an emotional purpose for the spouses involved. Bird and Melville (1994) noted that people regard marriage and family life as an arrangement to satisfy the need for intimacy. In a survey conducted by Veroff, Duovan and Kulka (1981), they found that 56% considered the emotional support marriage

offers as the nicest thing in marriages. It is known from experience that after certain developments have taken place within an individual, the heart and the complete human system crave for attachment usually from the opposite sex. There is usually a great relief when one finds the right spouse. Spiritually, our religious friends argue that God originally created marriage. It has been documented in the Holy Bible that God after creation, pronounced the first man and woman to live as husband and wife as noted by Van Pelt (2000). From the elaboration above, it is apparent that marriage serves a number of purposes.

For many people a happy marriage is one of life's great satisfactions. Failure to marry therefore denies some people the satisfaction they might have enjoyed in marriage. People marry because the two parties, involved are in love with each other. It seems clear that there is a natural connection between romantic love and marriage (Sabini, 1992)

Philips (1988) asserts that every person who is happily married is a successful person even if he has failed in everything else. Perkins (1989) also noted that marital happiness often reflects the degree to which husbands and wives relate as intimate friends and lovers, and this clearly is the first dimension of successful marriage. According to Sabini (1992), life is an exciting business and marriage family should be pretty exciting, for in these relationships, above all, people have the opportunity to live for others. It has been claimed that a well functioning marriage is an important ingredient for higher levels of personal well being. For instance, Eshleman and Stack (1998) conducted a research in 17 countries, which included United States. It was found that the advantages of the married appear to hold true for a specific indicator of well-being, global happiness. Enough evidence was found which support the assertion that married couples have higher level of personal well being than persons of

any unmarried status. This shows that the aim of every marriage is geared towards personal well being of the partners.

In the face of these good observations about marriage, not every marriage enjoys the kind of happiness expected between couples. Some couples wish they were never married at all because the kind of happiness they expected to enjoy has become an illusion. Some marriages are characterized by distress instead of happiness. This can be seen daily in our communities. as well as in the media that a number of marriages are highly distressed, and do not endure the test of time. According to recent census data in the U.S. 50% of first marriages end in divorce, one of life's most stressful events (Bird & Melville, 1994). Numerous articles attest to the fact that the divorce rate is on the ascendancy. Sabini (1992) asserts that in the U.S the divorce rate has increased substantially over time. In 1967, there was 0.3% divorce per 1000 people in the U.S, in 1979, the divorce rate rose to 5.3% per 1000 people in the U.S. It has also been found that most divorced people marry again. For example, those aged between 65 and 74 in 1980, 80% of those whose marriages ended in divorce remarried by 1980. More of them will remarry before they die (Glick & Lin, 1986). This indicates that people who leave marriages see marriage as important aspect of human life but due to certain obstacles, they back off only to try again to see how successful they would be in the new relationship.

Even though some people opt for divorce rather than going through marital distress, a good number of them do not consider divorce as an alternative. That is to state that no matter the depth of distress in their marriages, some couples do not consider divorce as the best way of tackling the problem. This is how Sabini (1992,p599) a social psychologist puts it; "It is not true that all unhappy marriages end in divorce- some stay together for the sake of the children or for religious or other reasons" For example, it has been estimated that approximately 20%

of all married couples are experiencing marital distress at any given time. (Association for the advancement of behavior therapy, 1998) Despite the risk associated with marriage, almost 90% of the population in the U.S choose to marry at least once, and nearly 75% of divorced individuals choose to remarry (Association for Advancement of Behaviour Therapy, 1998) It is therefore imperative to understand marital distress and its consequences on individuals' well being.

The word 'marital' has to do with marriage and has been defined already as a legally accepted relationship between a man and woman in which they live as husband and wife, or the official ceremony that results in this. The Cambridge International Dictionary of English(1996) defines distress as "a great mental or physical suffering such as extreme sadness, worry or pain, or the state of being in great danger and therefore needs an urgent help.' The Cambridge international dictionary of English (1995) also defines distress as great suffering of the mind or body, pain or great discomfort or state of danger or great difficulty.

In view of the aforementioned definitions, marital distress means the accumulation or the pile up of unresolved conflicts between legally married couples that take their toll on the couple with physical, emotional, marital and spiritual consequences. According to Adu-Gyamfi (1989), this definition covers such problems as spouse abuse, domestic violence-wife/husband beating, sexual unfaithfulness, communication problems and many more. Some authors have described it as a "syndrome"- a set of symptoms, which represent a physical or emotional or psychological disorder. This term, however, does not include divorce and the divorced (Addae-Mensah, 1979; Adu-Gyamfi, 1989).

Although couples become unhappy with their marriages for a variety of reasons, several recurring themes are frequently associated with marital distress. The Association for advancement of behaviour therapy (1998) categorizes them into three main areas. The most frequent problem reported by unhappy couples is poor communication. Spouses often feel that their partners are making excessive demands or requesting much more than they can give. Other spouses feel that their partners are too withdrawn or do not share or open up enough. In addition, distressed couples often avoid talking about problems in their relationships as they end up arguing and fighting with each other. These communication problems often result in spouses feeling bad about themselves, their partners, and their relationships.

Secondly, unrealistic expectation that spouses may hold about their marriage or about each other is one of the problems frequently associated with marital distress . Spouses may for example believe that their partners should know what they are thinking and feeling without asking. Additionally, distressed spouses are likely to make negative explanations for their partners' behaviour. For instance, distressed couples are more likely to accuse their partner for anything bad that occurs in the relationship.

A third problem frequently associated with marital distress as categorized by the Association for the advancement of behaviour therapy, is lack of intimacy or loving feelings between spouses. It has been asserted that the strong emotion that couples experience during courtship naturally decline over time in most relationships and many spouses become upset when they observe such a decline. They may perceive this natural decline as a loss of loving feelings, which is then often associated with a decrease in demonstrations of affection and in interest in sexual activities.

From the above, one can conclude that anytime couples are distressed, it becomes very difficult to work together and achieve common goals. Although some couples, as known from experience, do whatever possible to hide their distress from the public. That is , whenever there is a third person in their environment they pretend to be on very good terms. However, in the absence of other people their homes are more or less a battlefield. After exhausting all known mechanisms to hide it from the public, some couples explode and engage in certain overt actions like fighting openly, refusing to talk to other partner and neglecting their mates. When this happens at home, then the atmosphere in the house becomes more stressful even than the job place. Meanwhile, an ideal home should be able to offer the necessary support, comfort, joy, love, friendliness and peace. So that after the daily hassles for daily bread and the stress from the working environment, the home should serve as a safe anchorage for rest, relaxation and sharing ideals together. Unfortunately, among distressed couples an ideal home is far fetched and some people feel more relaxed outside their homes.

The consequences of this sad event are numerous and sometimes elude the comprehension of an ordinary person. Evidence indicates that individuals who have problems in their marriages are more likely to have a variety of psychological problems, including depression and alcoholism (Coyne & Downey, 1991). When you compare individuals who are married and getting along well with their spouses with those who are unhappy in marriages, the latter is more likely to be clinically depressed (Beach & O'Leary, 1993; Bird & Melville, 1994). Distressed spouses are also more susceptible to physical health problems (Bird & Melville, 1994).

Another problem that couples who experience marital problems report is violence within the relationship. Almost one-third of all married couples will experience violence at some time in their marriage, with distressed spouses being at greater risk (Dent, Derberg, Simon, & Sussman,2002) Marital violence can have a major impact on the relationship and on the psychological, as well as the physical well being of each spouse. Finally, childhood behavioural problems are more common in families in which the parents are unhappily married. A number of studies have found that children exposed to marital distress, particularly to violence in the home, are at greater risk for their own emotional problems (Bouman & Margolin, 1992)

In a nutshell, marriage is intended for good and people who enter marriage do not expect the otherwise to happen. In one way or the other, all the blissful expectations are not realized and couples sometimes regret for making the decision to marry the particular spouses they married. Nevertheless, it is not very different elsewhere. Where it is different, couples have made an extra effort to add ingredients to their marriage for a better taste. The responsibility is therefore each spouse's to take the necessary steps and repair the despair in their marriages rather than thinking that things will work out without effort. Failure to do this has serious consequence on ones-physical, social, psychological and spiritual life. Even under the best of circumstances and with a good match in a partner, a successful marriage requires continual assessment, communications, commitment, willingness to change, and hard work (Bird & Melville, 1994)

COGNITIVE BEHAVIOUR THERAPY

Cognitive-Behaviour therapy is a combination of two very effective kinds of psychotherapy namely cognitive therapy and behaviour therapy.

Cognitive therapy teaches that certain thinking patterns can cause symptoms by giving a distorted picture of what is going on in one's life, and making the person feel anxious, depressed or angry for no good reason, or provoking one into ill-chosen actions (Bush, 2000; Hawton, Salkovskis, Kirk, & Clark, 2001).

Behaviour therapy helps weaken the connections between troublesome situations and habitual reactions to them. Reactions such as anger, fear, depression, self defeating or self damaging behaviour. It again teaches how to calm the mind and the body, so one can feel better, think more clearly and make better decisions (Bush, 2000) The goal of therapy is to teach people with the problems the skills they need to enhance their functioning (Bootzin, 1975).

When combined into CBT, Behaviour and cognitive therapy provide effective tools for stopping symptoms and getting a patient's life on a more satisfying track.

Cognitive-Behaviour therapy assumes that maladaptive or faulty thinking patterns cause maladaptive behaviour and 'negative' emotions. The treatment focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behaviour and emotional state.

Beck and Ellis pioneered cognitive therapy in 1960 (Burns, 1980). It assumes that maladaptive behaviours and disturbed mood or emotions are the result of inappropriate or irrational thinking patterns, called automatic thoughts. Individuals react to their own distorted viewpoint of the situation instead of reacting to the reality of a situation. For example, a person may conclude that he is a failure in life just because he has failed in one thing.

Cognitive therapists make their patients aware of these distorted thinking patterns and change them, a process known as cognitive restructuring (Burns, 1980; Hawton et al., 2001)

Behavioral therapy trains individual to replace unwanted behaviours with desirable behavioural patterns. It does not focus on uncovering or understanding the unconscious motivations that may be behind the maladaptive behaviour.

Cognitive behavioural therapy uses a number of different techniques to help patients uncover and examine their thoughts and change their behaviours. They include the following:

Behavioural homework assignments: Patients are frequently requested to complete homework assignments between therapy sessions. These may consist of real life "behavioural experiment where patients are encouraged to try out new responses to situations discussed therapy sessions (Bush, 2000; Hawton et al., 2001)

Cognitive rehearsal: The patient imagines a difficult situation and the therapist guides him through the step-by-step process of facing and successfully dealing with it. The patient then works on practicing, or rehearsing, these steps mentally. When the situation arises in real life, the patient will draw on the rehearsed behaviour to address it. (Bush, 2000; Hawton et al., 2001)

Journal: Patients are asked to keep a detailed diary recounting their thoughts, feelings and actions when specific situations arise. The journal helps to make the patients aware of his or her maladaptive thoughts and to show their consequences on behaviour. In later stages of

therapy, it may serve to demonstrate and reinforce positive behaviours. . (Bush, 2000; Hawton et al., 2001)

Modeling: The therapist and patient engage in role-playing exercises in which the therapist acts out appropriate behaviours or responses to situations (Bush, 2000; Hawton et al., 2001)

Conditioning: The therapist uses reinforcement to encourage a desired behaviour. It can also be used to extinguish unwanted behaviours by imposing negative consequences. (Bush, 2000; Hawton et al., 2001)

Systematic Desensitization: Patients imagine a situation they fear, while the therapist employs techniques to help the patient relax, helping the patient cope with the fear reaction and eventually eliminate the anxiety altogether. By repeatedly pairing a desired response with a fear-producing situation, the patient gradually becomes desensitized to the old responses of fear and learns to react with feelings of relaxation. (Bush, 2000; Hawton et al., 2001)

Validity Testing: Patients are asked to test the validity of the automatic thoughts and schemas they encounter. The therapist may ask the patients to defend or produce evidence that a schema is true. If the patient is unable to meet the challenge, the faulty nature of the schema is exposed. . (Bush, 2000; Hawton et al., 2001)

Cognitive behavioural therapy is a collaborative, action-oriented therapy effort. It empowers the patient by giving him an active role in the therapy process and discourages any over dependence on the therapist that may occur in other therapeutic relationships.

A variation of cognitive behavioural therapy that needs to be mentioned here is called Rational Emotive Behaviour therapy. A psychologist Albert Ellis developed it in 1955 (Ellis, 1989). REBT is based on the belief that a person's past experiences shape their belief system and thinking pattern. People form illogical and irrational thinking patterns that become the cause of both their negative emotions and further irrational ideas. REBT focuses on helping patients discover these irrational beliefs that guide their behaviour and replace them with rational beliefs and thoughts in order to relieve their emotional distress.

Another approach to cognitive behavioural therapy is self-instructional or self talk and was pioneered by Donald Meichenbaum in the 1970s (Meichenbaum, 1975). This approach focuses on changing what people say to themselves, both internally and out loud. It is based on the assumption that an individual's action follows directly from this self-talk. This type of therapy emphasizes teaching patients coping skills that they can use in a variety of situations to help themselves. The technique used to accomplish this is self-instructional inner dialogue a method of talking through a problem or situation as it occurs.

DEPRESSION

Depression has been implicated as having bi-directional effect on marital quality. That is, depression in a spouse negatively affects marital quality (Coyne, Kahn & Gotlib, 1987) and marital discord can also predict later increase in depression symptoms (Beach, & O' Leary, 1993).

A person said to be depressed exhibit certain characteristics which in psychological terminology refers to as major depressive episode. Among these characteristics are the following as found in the DSM –IV:

For most of nearly everyday the patient reports depressed mood or appears depressed to others.

For most of nearly everyday, interest or pleasure is markedly decreased in nearly all activities.

Although the patient is not dieting, there is a marked loss or gain of weight (such as 5% in one month) or appetite is markedly decreased or increased nearly everyday.

Nearly everyday the patient sleeps excessively or not enough observable psychomotor activity. Nearly everyday others can see that the patient's activity is speeded up or slowed down.

Fatigue: Nearly everyday there is tiredness or loss of energy.

Self-worth: Nearly everyday the patient feels worthless or inappropriately guilty. These feelings are not just about being sick they may be delusional.

Concentration: As noted by the patient or by others, nearly everyday the patient is indecisive or has trouble thinking or concentrating.(Morrison, 1995)

Death: The patient has had repeated thought about death (other than the fear of dying) or about suicide (with or without a plan), or has made a suicide attempt.

As noted above, a brief introduction has been given about depression. It must however, be noted that this study is not about depression disorders. Rather, it is about distressed couples and the level of anxiety and depression they suffer as a result of marital distress. Put in a different way, it is a study of anxiety and depression as consequences of marital discord/distress or conflict, not anxiety and depression disorder predicting poor marital.

CAUSAL FACTORS OF DEPRESSION

Depression may have various causes but the following: Behavioural, Cognitive and Biological factors will be considered here.

Behavioural Factors

Two major approaches under behavioural perspectives are extinction; which focuses on external reinforcers; and aversive social behaviour, which focuses on interpersonal processes (Bootzin, Acocella & Alloy, 1993) Many behaviourists regard depression as the results of extinction (Fester, 1965; 1973; Lewinson, 1974) Lazarus (1968) puts it this way; depression is ''function of inadequate or insufficient reinforcers (pp.84). That is, once behaviours are no longer rewarded people cease to perform them. They therefore become inactive and withdrawn and for that matter depressed according to the interpersonal view, depressives have an aversive behavioural style in which they try to force "caring" behaviour from people who, in the depressives view, on longer care enough (Bootzin et al., 1993) Instead of love, however, what they get in return is antipathy and withdraw, which simply aggravates the depressed persons feeling of rejection (Coyne, 1976). Consistent with the interpersonal model, some studies have found that rejecting responses from friends and family may act to maintain or exacerbate a person's depression (Hokanson, Rubert & Welker, 1989; Swan, Wenzlaff & Krull, 1992)

Cognitive Perspective

Cognitive theorists hold that a critical variable in depression is the cognitive change. It is the way people think about themselves, the world and the future that gives rise to the other factors involved in depression (Bootzin et al., 1993).

Seligman (1975) has suggested that depression may be likened to a phenomenon of learned helplessness in animals he proposed that depression is a reaction to inescapable or seemingly inescapable stressors, which served to teach the individual that he or she lacks control over reinforcement and therefore discourages any adaptive responses. Shrout, Link Dawhrenwend,Skodol, Stueve and Miretsnik (1989) found in consistent with this formulation event for depression it is often some kind of uncontrollable loss. Abramson, Metalsky, and Alloy (989) changed the theory from helplessness to a hopelessness theory. To them, depression depends not just on the belief that there is a lack of control over reinforcement but also on the belief that negative events will persist or recur. It is this hopelessness that is the immediate cause of depression. Beck (1985) argues that depressed people have negative schemas about themselves, the world, and the future ("I'm unlikable nothing ever goes right; tomorrow will be just as bad as today") According to Beck (1967, 1976), this negative bias is the fundamental cause of depression. In support of Beck's claim, various studies have indicated depressives selectively attend to and remember more negative than, positive information about them (Kuiper, Olenger, & McDonald, 1976)

Biological Factors

Hereditary: Family studies have shown that first –degree relatives of people with bipolar mood disorders are more likely than other people to develop this disorder (Bootzin et al.,1993) This prevalence rate for first degree relatives of bipolar patients is 17% whereas in the general population the prevalence rate is 0.4% to0.8%(Strober,Morrell,Burroughs,Lampert,Danforth, Freeman ,1998)

Twin studies also support the role of genetic inheritance in the mood disorder as noted by Wortman and Loftus (1992) Identical twins are significantly more likely to both suffer major depression than are fraternal twins (McGuffin & Katz, 1989)

Biochemical: Hormones imbalance has been implicated in the development of depression .One theory is that depression is due to a malfunction of the hypothalamus, a portion of the brain known to regulate mood (Bootzin ,Acocela, & Alloy, 1993. Since the hypothalamus affects not only mood but also many other functions that are disrupted in the course of depression such as appetite and sexual interest, some researchers (e.g, Kraines, 1976) suggest that the hypothalamus may be the key to depressives disorders.

ANXIETY

Anxiety plays an important role is human functioning in the sense that it enables people to work a little harder to meet deadlines. Thus, anxiety is part and parcel of human existence. People worldwide feel it in moderate degrees and it is an adaptive response. Paul (1977) asserts that without it, we could probably all be asleep at our desks Bootzin, Acocella and Alloy (1993) also assert that we would expose ourselves to considerable trouble and danger without anxiety. Anxiety impels us to do a lot of things that in furs help us to avoid or minimize dangerous consequences. For instance, being a little anxious about our health impels people to go for medical checkups, being anxious about how well we would fare in exams enables us to study for exams. Simply put, anxiety enables us to lead longer and more productive lives. This does not mean that we should feel anxiety most of the time, rather, we should feel anxiety some of the time. Some people however, feel anxiety most of the time and it interferes with their daily functioning.

For these people it is not an adaptive response. It is a source of extreme distress, relievable only by strategies that limit freedom and flexibility.

Anxiety is a state of fear and apprehension that affects many areas of functioning it has several focuses and in some cases it is unfocused. According to Bootzin, Acocella and Alloy (1993) anxiety involves three basic components and these are:

(a) Subjective reports of tension, apprehension, sense of impending danger, dread and expectations of inability to cope;

(b) Behavioural responses such as avoidance of the feared situation, impaired speech and motor functioning, and impaired performance on complex cognitive tasks; and finally

(c) Physiological responses including muscle tension, increased heart rate and blood pressures rapid breathing, dry mouth, nausea, diarrhea, and dizziness.

There are different types of anxiety and they all come under one broad topic known as anxiety disorders. Among these types, as coded by DSM-IV are the following: Panic disorder, Generalized anxiety disorder, Phobic disorders, obsessive compulsive disorder and post traumatic stress disorder.

Panic disorder is a common anxiety disorder in which the patient experiences Panic Attacks (usually many, but always more than one) and worries about having another. These panic attacks are usually uncued, though situational predisposed attacks can also occur. In panic attack, anxiety begins suddenly and unexpectedly and mounts to an almost unbearable level. The person sweats, feels dizzy, trembles, and gasps for breath. The pulse quickens and the heart pounds. Nausea, chest pains, choking, feelings numbness, and hot flashes or chills are also common. Some patients usually develop agoraphobic within just a few weeks. Thus patients avoid situations that they associate with panic attacks. But other panic disorder patients don't have agoraphobia.

Generalized anxiety disorder is a chronic state of diffuse anxiety (Bootzin, Acocella & Alloy, 1993). The symptoms are relatively unfocused; the nervousness is low key and chronic, and there are no panic attacks. Some patients may be able to state what makes them nervous, others however cannot. The DSM-IV defines the syndrome as unrealistic and excessive worry about several event or activities. The most common areas of worry are family, money, work, and health (Barlow, 1986). Associated with this anxiety and worry, the patient has three or more of the following symptoms, some of which are present for over half the days in the past six months feelings of being restless, edgy, Keyed up, Tiring easily; Trouble concentrating; Irritability; Increased muscle tension and trouble sleeping (initial insomnia or restless, unrefreshing sleep) (DSM-IV).

Phobic disorders involve an intense fear of some object or situation, which actually poses no threat, and the avoidance of the phobic stimulus. Phobic disorders have two sub types, specific phobia and social phobia. Patients with specific phobias have unwarranted fears of specific objects or situations. The most common ones are phobias of animals, blood, nights, and travel by airplane, being dosed in and thunderstorm (Morrison, 1994). The anxiety produced by exposure to these stimuli may be a Panic attack or more generalized anxiety, but it is always directed at something specific. Social phobia is a fear of appearing clumsy, silly, or shameful and of having this behaviour observed by others. People suffering from social phobia do everything possible to avoid performing certain actions in front of other people for fear of embarrassing or humiliating themselves. For example, there is always an intense fear that they may be choking when eating in public, trembling when writing or being unable to perform when speaking or playing a musical instrument.

Obsessive-compulsive disorder as the name suggest is a combination of obsession and compulsion. Obsessions are thoughts, beliefs, or ideas that recur and abominates a person's thinking pattern. These thoughts come automatically and may even see senseless or unpleasant to the person.

Compulsions are acts (either physical or mental) performed repeatedly in a way that the person realizes is neither appropriate nor useful compulsions may be simple acts such as uttering or thinking a word or phrase against an obsessive thoughts and may be as complex as elaborate dressing, washing or bedtime rituals that can take up hours everyday. Most patients have both obsessions and compulsions, which usually result in anxiety and dread. Patients usually recognize them as being irrational and want to resist them.

Posttraumatic stress disorders are acute psychological reactions to intensely traumatic event events much more disturbing than most ordinary human troubles. Survivors of combat are the most frequent victims, but it is also encountered in people who have survived other disasters both natural and man-made (Morrison, 1994). These include rape, floods, abductions, and airplane crashes and also threats that may be posed by a kidnapping or hostage situation. The patient repeatedly relives the events in one of these ways: intrusive, distressing recollections (thought image); Repeated, distressing dreams; Through flashbacks hallucinations or illusions, feeling or acting as if the event were recurring (include experience that occur when intoxicated or awakening); marked mental distressing in reactions to internal or external ones that symbolize or resemble some parts of the event; physiological reactions (such as rapid heart beat, elevated blood pressure in responses to these cues.

Although, there are other classifications of anxiety disorders in DSM IV mention will not be made of them since the emphasis of the study is not on anxiety disorders.

In conclusion, depression and anxiety may have different causal factors; marital distress has been implicated as being among those factors. This study will therefore examine depression and anxiety resulting from marital distress among couples in Ghana. Cognitive behavioral therapy will be the major psychotherapy to be used to help spouses who are found to be highly distressed.

CAUSAL FACTORS OF ANXIETY

Several perspectives give explanations as to why certain problematic behaviour results. Three perspectives will be basically discussed in this work about the etiology of anxiety disorders, namely, behavioural, cognitive and biological perspectives.

Behavioural Factors

According to behavioural researchers anxiety results from faulty learning (Bootzin,Acocella & Alloy, 1993). On how we learn anxiety, one prominent theory of anxiety disorders is that they are engendered through avoidance learning (Mowrer, 1948). This theory involves a two-stage process; Firstly in the course of the person's experiences, some neutral stimulus is paired with aversive stimulus and thus, through respondent conditioning, becomes anxiety arousing. Secondly, the person avoids the conditioned stimulus, and since this avoidance results in relief from anxiety (for instance, negative reinforcement) the avoidance response via operant conditioning, becomes habitual. This two-stage theory, however, does not explain many features of anxiety disorders(Merckelbach, Detuiter, & Van D en Hout ,1989) They have argued that while some anxiety patients do report traumatic conditioning experiences, others do not.

Cognitive Perspective

Cognitive theorists argue that cognitive process play an important role in the acquisition of anxiety responses (Bootzin et al., 1993). Cognitive events such as mental images and verbal self statements can also engender anxiety responses (Cook, Mineka,& Welkenstein,1985). People can also acquire anxiety responses vicariously, by watching others react with pain to a given stimulus (Bootzin et al., 1993). Even monkeys have learned to be afraid just by watching other monkeys respond with fear to an unfamiliar object in a laboratory studies (Mineka, Davidson & Cook, 1984). What all this suggests is that cognitive processes have a central role in explaining the acquisition of anxiety. According to this perspective, the problem with anxiety disorder patients is that they misperceive or misinterpreted stimuli, internal and external, hence their symptoms (Bootzin et al., 1993)

Biological factors

Hereditary: A great deal of genetic research on anxiety disorders have been conducted in the last decade, and the syndrome that appears to be most likely to have a genetic basis is panic disorder (Bootzin et al., 1993) One study found that the risk of first degree relatives was 25%, as opposed to 2% for the first-degree relatives of normal controls (Crowe, Noyes, & Paulus, 1983) Twin studies which are more informative have also implicated genes in panic disorder (Bootzin, 1993) in one Norwegien study, the concordance rate for panic disorder in monozygotic twins was 31% as opposed to 10%for dizygotic twins ((Fyer, Mannuzza & Gallops,1990).

OCD runs in families and the concordance rate has been found to be about twice as high in MZ twins as in DZ twins (Carey & Gottesman, 1981). A study of the first-degree relatives of

simple phobia found them to be three times more likely to have phobias than first-degree relatives of normal controls (Fyer, Mannuzza & Gallops, 1990).

Biochemistry: Valium and Librium, which belong to a chemical group called the benzodiazepines have been used to relieve anxiety (Bootzin, Acocella & Alloy, 1993; Wortman, Loftus,& Marshall, 1992).The benzodiazepines work by enhancing activity of the neurotransmitter GABA, which in turn inhibits certain neurons and dampens excitement of the central nervous system (Bender, 1990; Costa & Guidotti, 1985). Because benzodiazepines bind to specific receptors in the brain, some theorists have argued that there must be a natural occurring neurotransmitter, similar in chemical structure that has essentially the same anxiety reducing effects (Wortman et al., 1992).It is, however ,doubtful that this process underlies all anxiety conditions for certain types of anxiety, those experienced as generalized tension, are more responsive to the benzodiazepines than other anxiety conditions such as panic disorder (Bootzin et al., 1993)

COMORBIDITY OF ANXIETY AND DEPRESSION

A trend in study of anxiety and depression is the increasing evidence of that comorbidity or co occurrence of depressives and anxiety disorders (Alloy, Kelly & Mineka, 1990; Klerman, 1990) The symptomatologies of the two disorders show considerable overlap, such that people diagnosed as having one are more likely to meet the other criteria for the other as well, either simultaneously 'intraepisode comorbidity' or at different times in the in their lives 'lifetime comorbidity' (Bootzin et al.,1993). According to Fyer ,Liebowitz, and Klein (1990),people in these two diagnostic groups also tend to respond to the same antidepressant drugs .Heninger (1990), also noted that these people share similar endocrine abnormalities ,

and have family histories of both anxiety and depressive disorders (Merikangus, 1990;Weisman, 1990)

According to Carson (1988), feelings of depression frequently accompany phobias. Again, individuals suffering from generalized anxiety disorders are oversensitive in interpersonal relationships and frequently feel inadequate and depressed. Individuals experiencing generalized anxiety disorder report various symptoms; many of these individuals show mild depression as well as chronic anxiety (Downing & Rickels, 1974)

These findings according to Carson et al. (1988) are not unexpected in view of their generally gloomy outlook on the world. That is to say, all these findings go a long way to show that anxiety and depression can coexist in one patient although one might dominate the other.

Hawton et al. (2001) have also argued that anxiety state patients are often depressed as well as anxious and in some cases similar cognitive treatment techniques can be used for dealing with both depression related thoughts and anxiety-related thoughts.

Rationale

It has been established that approximately 50% of first marriage end in divorce and for those that do not end in divorce many are characterized by unhappiness (Bird & Melville, 1994). It is also estimated that approximately 20% of all married couples are experiencing marital distress at any given time (Association for advancement of Behaviour Therapy, 1998).

This study was conducted to come out with ways of helping married couples who go through series of marital problems make their marriages better. In Ghana, a number of studies conducted indicated that marital conflict is on the increase. For example, Pappoe and Ardayfio (1998) conducted a study on violence in marriage. About 74% of males and 71% of

females among all the ethnic groups studied reported wife beating occurred in their communities. It is therefore important to understand marital distress and its impact on the couples.

Again, most of the studies that have been conducted emphasized women suffering violence in marriage. This study was therefore intended to establish whether men also suffer from marital distress and its consequences in the same way women do.

Aims

The aim of this study is to identify the extent of distress couples experience in their marriage. Also, to identify whether marital distress could lead to anxiety and depression. Finally, to find how marital distress and its psychological consequence could be reduced to the barest minimum.

Objectives

a) To help couples become aware of the areas in the marriage that are distressed i.e. source of distress in their marriage, so that solutions would be found immediately rather than wait till problem becomes worse.

b) Couples found to suffer from anxiety and depression will be taken through cognitive – behaviour therapy.

c) To equip couples with the necessary techniques to avert or reduce marital distress.

STATEMENT OF HYPOTHESES

1. High distressed couples will be more depressed than low distressed couples
2. High distressed females will be more depressed than high distressed males
3. High distressed couples will experience more anxiety than low distressed couples.
4. Couples with high level of education will be more distressed than couples with low level of education.
5. There will be significantly positive correlation between distress and depression
6. There will be positive correlation between anxiety and depression.
7. Couples who go through intervention will show a significant reduction in depression and anxiety than couples who do not

OPERATIONAL DEFINITION OF TERMS

High Distressed Couples: High distressed couples referred to those couples who scored high on the marital distress measure.

Low distressed couples: Low distressed couples referred to couples who scored low on the Dyadic Adjustment Scale (Modified.)

High Educational Level: Subjects with Diploma, Post Secondary qualification and university degree were categorized as high educational level.

Low Educational Level: Low education referred to any subjects with General Certificate Examination Advance Level and below.

Gender/ Sex: The terms gender and sex were used interchangeably to refer to either male or female.

Married Couples: Married couples referred to couples who have been legally married or any such official ceremony that results in that.

Marital Distress: The terms marital distress, marital discord and marital conflict were used interchangeably to refer to unresolved conflicts between legally married couples that take a toll on the couple with physical, emotional, marital and spiritual consequences.

CHAPTER TWO

LITERATURE REVIEW

This session reviews some of the various researches that have been conducted on marital distress. It will therefore look at the form marital distress take, some causes of marital distress and the consequences it can have on an individual and the family as, whole.

Marital Distress

According to Kondor (1997), many marriages in Ghana could be described as distressed, unhappy and discord but have not yet ended in divorce. Evidence abounds in the media thus radio programmes and the newspapers report about distressed marriages. Although the percentage of distressing marriages is not known in Ghana, one can be certain that it is becoming rampant. It is evident by the number of couples who make complaints at the offices of Women and Juvenile Unit of the Ghana Police Service. It has been estimated that about fifteen cases concerning conflicts in marriages are heard daily (Commander of Police, WAJU, Kumasi, 2004).

Amuzu (1997) argues that women sustain injuries as a result of marital violence which includes bruises, acts, broken bones, miscarriages, permanent injuries such as damage to the joints, partial loss of hearing or vision, scars from burns, knife wounds and even deaths. The incident of physical abuse against women is prevalent in this country. Only few women, however, report or even admit being victims of domestic violence. Most of the time this is done to keep the family together. The victims continue to cling to the relationship hoping that some changes would eventuality happen that would make the situation better.

In Canada and US, it has been estimated that at least 1 in 10 women has been assaulted by the intimate male partner (Dutton, 1988). Many women who seek supportive counseling to effect change in their lives have already suffered a prolonged period of chronic abuse. In their study of marital violence, Rosenbaum and O' Leary (1981) reported that 70% of the women in their sample had experienced abuse, prior to and during the first year of marriage and the average duration of the marriage prior to contact with a marital violence clinic was 12years. Although such abuse is unhealthy to ones well being, women are very reluctant to leave such relationships. Various reasons have been offered us to why they stay in such hostile environment. Sometimes too, any decision to leave the relationship may also be accompanied by increase risk to the women's life and safety. Schutte, Malouff and Doyle (1988) identified some of the pressures and threats of further harm directed toward women when they attempt to end the relationship in which they have been violated by physical, sexual, or psychological force. These include the risk from the violent spouse as well as from societal force that historically conspired to limit their choices. It stands to reason that any move away from an abusive spouse may involve a prolonged and complex process.

The severity of risks to abused women remains tragically daunting. A recent Canada study found that intimate femicide (women killed by current or estranged husbands or boyfriends between 1974 and 1990 accounted for 60 % of all homicide cases in which the perpetrator had been identified (Fine & Kurdek, 1992).

Rinck (1990) wrote that women who are subjected to physical and emotional violence develop a lifestyle of "learned helplessness". Such women have been exposed to maltreatment for a long time but do not have any skills to help themselves, are fed up, have given up life and learned to live with the problems of abuse, torture both physical and

psychological, thus they are distressed. Such couples have developed ineffective substitute for dealing with conflicts that erupt in the relationship.

Various studies have indicated that whenever individuals feel hopeless and helpless for a long period it can result in depression. This is attested to by the reformulated theory of depression as the product of learned helplessness (Abraham, Seligman & Teasdale, 1978). Walker (1979) first applied the theory of learned helplessness to battered women. She described battering incidents in an intimate relationship as typically following three stages, thus the tension building phase, the explosive battering phase; when the acute violence occurs, and the calm and loving respite phase characterized by contribution and acts of kindness from the batterer. In another study, Walker (1984) elaborated in her definition of learned helplessness by including the motivational construct of apathy, the cognitive construct of problem solving difficulty, and the affective constructs of depression and low self-esteem. Walker (1985) concluded that there was evidence that learned helplessness in women battered by an intimate partner, resulted both from prior childhood abuse as well as from the abusive adult relationship itself. Walker's introduction of the learned helplessness concept has played a significant role in subsequent examination of psychological and behavioral characteristics in women abuse in relationship (Blackman, 1989; Campbell, 1989) When people sustain high level of stress over long periods and lack the coping resources to solve their problems such chronic symptoms appear: low energy, inability to think clearly, lapses in being able to take care of routine daily tasks, ruptures in friendships and family relationship, flattened emotional responsiveness and weakened resistance to illness. Men have also suffered violence from their spouses. Safo (1997) argues that women also commit violence against men almost as often as men do against women. The abuse is mostly psychological taking the form of name-calling, criticism, etc thus eroding a partner's self esteem.

In the US, Behrens, Bret and Sanders (1994) reported that marital dissatisfaction is the most common presenting problems in adult seeking psychological services. They noted that poor communication and dissatisfaction with interactions, assessed premaritally, are strong predictors of marital distress. They indicated that several marital distress prevention programmes have been developed. These target communication behaviour of premarital and lead to improved relationship satisfaction, lower levels of marital violence, and diminished probability of marital dissolution.

PATTERNS OF MARITAL CONFLICT

A further review of the literature highlights the observable patterns of marital conflict. In the first Annual Review of Psychology chapter on marital interaction, O' Leary and Smith (1991) noted that distressed couples emit statements that are more negative and fewer positive statements and show greater reciprocation of negative behaviours during problem-solving interactions. Gottman (1979) concluded that level of negative affect reciprocity is consistent across different types of situations. With regard to behavioral sequences, escalating, negative sequences during conflict are associated with marital distress, and both frequency sequences of negative behavior are more pronounced in couples where physical aggression is found (e.g. Burman, John & Margolin, 1992; Gottman, 1993). In fact, one of the greatest challenges for couples locked into negative exchanges is to find an adaptive way of exiting from such cycles (Weiss & Heyman, 1997). This is usually attempted through responses designed to repair the interaction (e.g. Meta communication, "you are not listening to me") that are typically delivered with negative affect (for example, irritation, sadness). Distressed couples tend to respond to the negative affect, therefore continuing the cycle. This makes their interaction more structured and predictable; in contrast, non-distressed couples appear to be

more responsive to the repair attempts and are thereby able to exit from negative exchange early on. Their interaction sequences appear more random and less predictable (Weiss & Heyman, 1997). An interaction pattern in which the wife raises issues and the husband withdraws has often been noted by clinicians and has received empirical confirmation. For example, Robert and Krokoff (1990) found dissatisfied couples displayed more husband withdraw wife withdraw sequences. However, it appears that demand withdraw patterns and the use of other influence tactics vary as a function of whose issue is being discussed during conflict (Heavy, Christensen & Mallamuth, 1995)

McGonagle (1992) collected data from a community sample about the frequency of overt disagreements and found a modal response of once or twice a month. A sub sample that kept diaries reported similar rates and when contacted three years later reported the same rate of disagreement. These findings are consistent with a broader literature indicating that patterns of coping tend to be stable across occasions (Stone & Neale 1984). Noller, Feeney, Bonnell, and Callan (1994) found that conflict patterns were stable over the first two years of marriage but that couples lower in satisfaction showed somewhat less stability, more positive in their reported responses to conflict after the first year of marriage. In short, there is greater net negativity, reciprocity of negative behaviour, more sustained negative interactions and escalation of negative interactions among distressed couples. Moreover, conflict behaviour seems to be relatively stable over time (Gottman, 1993; Weiss & Heyman, 1997)

Researchers wanted to find out whether marital conflict is more likely in certain content area. It was found that dating, newlywed and established married couples complain about sources of conflict ranging from verbal and physical abusiveness to personal characteristics and behaviour (e.g, Buss, 1989). Perceived inequity in division of labour is associated with both

marital conflict and more male withdrawal in response to conflict (Kluwer, Heesink,& Van de Vliert,1997). Likewise, conflict over power is strongly related to marital dissatisfaction (Kurdek. 1994, Vangelistic & Huston, 1991). Reporting problems with spousal extramarital sex, problematic drinking or drug use is predictive of divorce (Amato & Rogers, 1997), as are wives reports of husband's jealousy and foolish spending of money. Similarly reporting greater problem severity (Lindale, Clement, & Markman, 1994) increases prediction of divorce. Even though it is often not reported to be a problem, relationship violence among newlywed predicts divorce, as does the presence of psychological aggression (Ehrensaft & Vivian, 1996)

Such findings highlight the need to be vigilant with regard to the effects of conflict area (Baucom, Shoham, Meuser, Daiuto, & Stickle, 1998) and perceived problem difficulty. Some types of problems may be associated with both poorer marital outcomes as well as poorer problem solving behaviour, leading to spurious conclusions if problem solving is examined in isolation. Also, if some problem areas are associated with an elevated divorce rate, samples of intact couples selected later in marriage will underestimate the extent to which such problem occur and create difficulty for married couples (Glenn, 1990). Finally, Leonard and Roberts (1998) noted that perceived efficacy or utility of problem discussion might vary with problem area, leading to changes in the relationship between problem solving behaviour and satisfaction as a function of problem area. Accordingly, investigations of how marriages succeed and fail may benefit from assessments of problem content and personal resources (Leonard & Roberts, 1998).

Some researchers have argued that cognitions can influence conflict behaviour. Within the context of the social learning framework that has guided interaction research, cognitive processes have been used to account for patterns in observed behaviour. For example the finding that satisfied spouses are less likely to respond negatively after displaying negative affect as listener, (thereby avoiding escalation, Gottman, Markman, & Notarius, 1977; Notarius & Markman, 1993) is attributed to their ability to edit thoughts during conflict. Attempts to investigate directly the relation between cognition and behaviour have yielded encouraging result.

There is increasing evidence that explanations or attributions for negative marital events (for example, partner comes home late from work) can increase the probability of conflict behaviour (e.g, he only thinks about himself and his needs') Such conflict promoting attribution are related to (a) less effective problem solving behaviour (Bradbury & Fincham, 1992) (b) more negative behaviour during problem solving and support-giving tasks (Miller & Bradbury, 1995), and (c) specific affects (e.g ,whining and anger) displayed during problem solving (Fincham & Bradbury, 1992). In addition, wives unrealistic relationship beliefs are related to higher rates of negative behaviour and lower rates of avoidant behaviour (Bradbury & Fincham, 1999). As regards behavioral sequences, wives conflict – promoting attribution and husbands' unrealistic relationship beliefs correlate with the tendency to reciprocate negative partner behaviour (e.g, Bradbury & Fincham, 1999). The removal of marital satisfaction from these relations shows that they do not simply reflect the spouse's sentiment toward the marriage (Bradbury, 1994). Finally, manipulating spouses' attribution for negative partner behaviour influenced distressed spouses' subsequent behaviour toward their partners (Fincham & Bradbury, 1988). Thus, both correlational and experimental

findings are consistent with the view that spousal cognitions, particularly attributions, influence marital behaviour.

SOME CONSEQUENCES OF MARITAL DISTRESS

Although marital conflict or distress is sometimes necessary in straightening certain crooked areas in the marital relationship, it can also have negative consequence on the well being of the spouse involved and the family as a whole. Some researchers have argued that marital conflict has profound implications for individual well-being (Coyne & Downey, 1991; O'Leary & Smith, 1991). The link with depression is increasingly well established (Beach, Fincham, & Katz, 1998), and a link with eating disorders has been documented (Vand den Brouke. & Vandereyecken, 1996) similarly, associations have been noted for physical and psychological abuse of partners (e.g, O'Leary, Vivian, & Malone, 1992), male alcoholism (e.g., O'Farrell, Choquette, & Birchler, 1991) and early onset drinking, episodic drinking, binge drinking and out of home drinking (Murphy & Farrell, 1994). Marital conflict, however, appears less consequential for anxiety disorders (Emmelkamp & Gerlsma, 1994), which may reflect a complex association varying according to spouse's gender and type of anxiety disorder (Macleod, 1994)

Although married individuals are healthier on average than the unmarried (House, Landis,& Umberson,1988) marital conflict is associated with poorer health (Bouman & Margolin 1992; kiecolt-Glaser, Kennedy, Malkoff, Fisher, Speicher, & Glaser, 1988), and with specific illnesses such as cancer diseases and chronic pain (Schmaling & Scher, 1997). Marital interaction studies suggest possible mechanisms that may account for these links by showing that hostile behaviour during conflict relate to alteration in immunological (Kiecolt–Glaser, Glaser, Cacioppo, MacCullum,& Snydersmith, 1997) endocrine and (Malarkey, Pearl, &

Glaser, 1994) cardiovascular functioning (Ewarts, Taylor,Kraemer, & Agras,1991) . Although consequential for both husbands and wives marital conflict has more pronounced health consequences for wives (Gottman & Levenson 1992; Kiecolt-Glaser, Newton, Cacioppo, MacCallum, Glaser, & Malarkey, 1996; 97; Malarkey, 1994)

ANXIETY AND DEPRESSION

Depression is one of the psychological consequences people suffer from when there is a loss in their lives; it is therefore not unusual when couples who go through marital distress suffer from depression. Some researches have identified some types of loss that a woman experiences when her spouse has treated her abusively. Campbell (1989) pointed out that the abused woman loss of her expectation about herself and her relationship or of hope for a meaningful life could be felt whether or not the relationship end. Turner and Shapiro (1986) considered losses of idealized relationship, of roles associated with the relationship, and of security as important to acknowledge and address.

In their observation of depression widows and widowers, Parkes and Weiss (1983) documented an increase in illness and incidents of death in the first six moths of bereavements. Depression is also one of the most often studied aspects in a woman abused by a spouse. It was Walkers (1979) observation of depression in battered women that initially led her to posit learned helplessness as a theoretical framework for explaining the state that the abuse created.

Campbell (1989) has attempted to account for this phenomenon by viewing the depression outcome as similar to the grief experienced by women having serious difficulties in a

nonviolent intimate relationship. She noted similarities in the physical, behavioral and emotional responses of battered women and of non-battered women with serious relationship problems with a man. In her review of the relevant literature, Campbell was struck by the tendency to describe such responses pathological in battered women and situational in non-battered women going through marital dissolution. Her study was designed to compare two theoretical models, grief and learned helplessness, regarding their relative explanatory applicability for women battered by a spouse. Battered and non-battered women with serious problems in a spousal relationship were similar in most of the depression variables measured. The only difference between the two populations was that the battered woman, as compared with non-battered woman, demonstrated more frequent and more server physical signs of stress and grief and had considered more solutions to the relationship problems. Both the grief and learned helplessness model were found to have adequate explanatory power for battered and non-battered women.

Russell, Lipov, Phillips and White (1989) also compared intimate relationship in distress, but without violence. They used standardized measures of psychological and relationship features as well as structured assessment interview in comparing couples with equal levels of marital distress and similar help seeking behavior, but with different levels of violence. They found the abused women to be significantly higher in anxiety, fatigue, and confusion and significantly lower in vigor than were the distressed women. Levels of depression were marginally but not significantly higher among the abused women.

The aforementioned studies may have methodological constraints because they used multiple measures with relatively small population sample. They, however, make an important

contribution, in their consideration of abused women as more similar than dissimilar to other women experiencing distress and loss in a spousal relationship.

Depression and despair are perceived as the most typical concomitants to important loss (Dershimer, 1990). This is manifest by symptoms such as feeling of helplessness, meaninglessness, and lack of control (Rando, 1984).

Various studies conducted have examined the role of emotion in marriage. Some of the most strongly supported finding in couple's research involves negative affect.

For example, Fincham and Beach (1999) as well as Gottman (1998) found that rates of negative affect during marital interaction and reciprocity of negative affect (for instance, the exchange of negative affect between spouses) are two of the best predictors of marital quality.

Research conducted on negative affects, the physiological concomitants associated with those affects, or both tend to focus on anger and depression (Fincham, & Beach, 1999). The role of the depression has been examined largely through self-report questionnaires clinical interviewers. The result of this literature strongly supports a bi-directional relationship between depression and marital quality. Coyne, Kessler, Tal, Turnbull, Wortman, and Greden, (1987) indicated that depression in a spouse negatively affects marital quality and in another study, Beach and O' Leary (1993) demonstrated that marital discord predicts later increases in depression symptoms. This seems to result because it has been argued that anytime there is a loss in one's life depression is most likely. In marital discord there is a loss of control in the marriage and consequently brings about depression. Physiological arousal associated with anger has been measured directly in Gottman's (1998) research; with results indicating that physiological arousal during high-conflict interactions is highly predictive of declines in marital satisfaction over a 3year period (Levenson & Gottman, 1985).

The role of anxiety in marital quality has gone largely untested in couple's research. Meanwhile Baucom and Epstein (1990) identified anxiety specifically as one of four negative emotions believed to play an important role in marital distress. They realized from this study that not only can anxiety disrupt marital functioning, but poor marital functioning may elicit symptoms of anxiety .In spite of this claim, the treatment protocol lacks specific guidelines for treating heightened anxiety in marriage. This is a reflection of the lack of empirical information on the role of anxious affect in marital functioning.

Most studies done on anxiety in marriage have been limited to its role in sexual dysfunction, as in Kaplan's (1974) study, and in maintenance of agoraphobia by the non-symptomatic spouse. More recently, McLeod (1994) examined marital quality in couples in which neither one nor both spouses were diagnosed with an anxiety disorder. Couples with at least one spouse meeting criteria for panic disorder or generalized anxiety tended to report lower levels of marital quality.

Although these studies as argued by Dehle and Weiss (2002) highlight the negative impact of anxiety disorders on marital functioning, they do not address the association between the more common, sub clinical experience of state anxiety (also referred to as anxious affects) and marital functioning. It remains to be seen whether self-reports of cognitive and physiological arousal symptoms associated with state anxiety (as opposed to anxiety disorders of trait anxiety per se) are related to marital quality. Dehle and Weiss (2002) again argue that state anxiety may influence the processing of day-to-day marital events and partner behaviours in a way that contributes to deteriorating sentiment. For example, neutral spouse behaviours may be interpreted as negative by a spouse who is experiencing tensions and nervousness and is unable to relax. Processing neutral behaviours as negative would likely

increase the probability of a negative behaviour in response, thus affecting the quality of the interaction.

Dehle and Weiss (2002) carried out a study to assess whether the level of state anxiety predicts fluctuations in marital quality over time. To them, self reported state anxiety may influence subsequent marital adjustment at two levels: (a) a within –spouse association between self reported anxiety and self reported marital adjustment, and (b) a cross spouse association linking self-reported anxiety to partners' report of marital adjustment. These two levels were assessed using a community sample of 47 recently married couples (1- 3yrs). It was found that self and partner ratings of anxious mood predict subsequent marital adjustment; however, the pattern of association between self and partner ratings of state anxiety and later marital quality differ for husbands and wives'. For husbands, greater self reported anxiety symptoms predict subsequent decrease in husbands and wives' marital quality. Wives' anxiety symptoms are not significant predictors of changes in either their own or their partners' reports of marital quality.

It has again been asserted that the quality of current relationships, particularly as they are enacted in marriage, exerts a powerful influence on mental health. Supportive marital relationships may ameliorate the impact past (Birtchnell, 1980; Parker & Hadzi-Palovic, 1984; Quinton, Rutter, & Liddle,1984) and present adversities (Brown,Bhrochain & Harris 1975; Brown & Harris, 78) as well as contributing to mental health independently of adversity in its own right (Ingham & Miller, 1976; Bebbington & Tenant 1978; Henderson, Byrne, Duncan –Jones,Scott, Adcock,1980; Britchnell, 1988). Additionally, although poor marital relationships may precede symptoms (Birtchnell & Kennard,1983; Brown, Bhrochain,& Harris,1975; Henderson et al.,1980; Parker & Hadzi- Pavlovic ,1984). It is

considered that the association between marital relationships and psychological health operates in both directions: certain personality characteristics of the partners influence both relation and symptomatology, which with the passage of time reinforce each other (Birtchnell, 1988).

Collins and Hoyt (1971) noted that husband dominated marriages seem to be related to a high risk of psychological morbidity for both sexes than wife- dominated marriages because the former leads to more pronounced role conflicts. Schaffer and Keith (1980) also found that less joint decision making and deviance from egalitarian relationship patterns is a risk factor of depression in wives. We should, however, note that in both cases, that is the husband-dominated marriages and deviation from egalitarian relationship patterns suggests something is amiss. The expectations of individuals spouses are therefore not being met hence the depression and the high risk of psychological morbidity.

Zimmerman – Tansella conducted a study and Lattanzi, (1981) on the association between marital relationships, as measured by the Ryle marital patterns test, and symptoms of anxiety and depression as measured by the Interval General Health Questionnaire (1- GHQ). It was found that spouses' ratings of the quality of their relationship have effect on their psychological health. Logistic regression analyses showed that symptoms of anxiety and depression in wives were best predicted by low ratings of affection exchange. Anxiety in men was predicted by low affection ratings while depression was predicted by unemployment. Higher ratings of affection among wives related to less anxiety and less depression. Husbands' rating of total exchanged affection was the best predictor of husbands' anxiety with more total affection being related to less anxiety. This presupposes that anxiety and

depression can result when couples find that their marital relationship is short of affection and for that matter distressed.

EDUCATIONAL STATUS AND MARITAL DISTRESS

The level of education one has may influence one to either practice or avoid certain behaviour. This is to state that education has a strong influence on the way we behave. In the same manner, various researchers have found that education may contribute either to the success or failure of marriage.

According to Safo (1997) domestic violence could be found in the upper class, middle class as well as lower class homes. An example was given by Ahinful (1997) with a case of a couple who are University graduates who fought physically because of their disagreement on how to discipline their child. A study in US found that those who inflicted more serious injuries in their marital relationships are highly educated batterers (Alsdurt & Alsdurt, 1990). One can therefore say that marital distress is not limited to the less educated couples but cuts across board.

Some researchers have identified the disparity in spouses' educational attainment as one of the causes of instability in marriages. Asonye (1986) argues that the instability is more pronounced if the wife has higher educational qualifications and higher socio-economic status than the husband who traditionally should be the head of the family.

Due to this he may feel inferior to the wife and may employ various patterns of extreme behaviour to cover up his educational incompetence. This however, may result in the wife's feelings of uneasiness and therefore put up a behaviour that might fuel marital conflict.

Mcvey (1990) observed that marriages in which the disparity in educational attainment of husband and wife is great tend to be unstable because of differences in expectations and communication gap. He therefore proposed that similarity in the educational status of prospective husbands and wives should be considered important.

In this part of our world most women are disadvantaged when it comes to education. Women were not encouraged to seek higher education since their main role was housekeeping; thus taking care of children and cooking food for the family. This resulted in wide educational gap between husbands and wives and consequently different ideologies, which did not augur well for satisfactory marital functioning.

Literacy rates for women, have increased over the past few decades to at least 75% in most countries of Latin America and the Caribbean and eastern and South-eastern Asia, as a result of widespread promotion of universal primary education. This contributed to improving their family lives. Despite this effort, high rates of illiteracy among women still prevail in much of Africa and in parts of Asia. When illiteracy is high it almost always accompany by large difference in rates between women and men. This could as well be said to have contributed to the diverse problems women face in these parts of the world (UN Publication, 1995). From the above, one can conclude that problems in marriages for both men and women are not exempted.

Bird and Melville (1994) reported that education seems to negate gender difference in coping. The more education a woman has and the higher her job status, the more disposed she is to use problem-focused coping (Bird & Wakat, 1993; Schnitter & Bird, 1990). It was again that investment in education leads to enhanced employment opportunities and access to greater

power and additional coping resources. Employed women regularly indicate that their work roles are important sources of satisfaction and well being and consistently report less emotional distress than other women (Hall, Williams, & Greenberg, 1985; Kessler & McRae, 1982).

GENDER AND DEPRESSION

A person's gender is a powerful factor that causes him or her to behave and experience things differently. This result from the fact that biological differences exist and that determines what one sex can and cannot do. Additionally, the sexes have been stereotyped to behave in particular ways peculiar to each one of them. In this sense, it will not be unusual when males and females experience depression at a different rate.

Boyd and Weissman (1981) have argued that depending on how depression is classified we can expect that one in every four women and one in every eight men will suffer a clinical episode at some time in their lives. This according to Bebbington, Katz, McGuffin, Tennant and Hurry (1989) may be an under estimate.

According to Bootzin, Acocella and Alloy (1993), women are twice as likely to be diagnosed as depressives – a fact that investigators have tried to account for with theories ranging from hormonal differences between the sexes to differences in men's and women's thinking patterns to the changing social role of women. For example, one promising theory has to do with the way men and women respond to depressed moods. According to Nolen – Hoeksema (1991), women tend to ruminate about their sadness, focusing on their negative feelings and the causes and consequences of those feelings. In contrast, men tend to distract themselves

when they feel down - actively engaging in a hobby or sport. Since rumination prolongs depression, whereas distraction shortens it, women tend to engage in precisely the sort of behaviour when they are down that is likely to prolong and worsen their depressive symptoms (Nolen- Hoeksema, 1991).

CHAPTER THREE

METHODOLOGY

RESEARCH DESIGN

This study was both correlational and comparative. A study of the relationship between distress and depression ,as well as between anxiety and depression. It also made a comparison between low distressed couples and high distressed couples on anxiety and depression. Finally, it assesses the impact of intervention on anxious and depressed couples.

SAMPLE SELECTION

Subjects for this study were selected from Kumasi and Accra; the two busy cities where because of economic activities a lot of people migrate from their towns and villages to settle. This therefore makes the cities heterogeneous since a lot of people who migrate to these cities have varied background and come from different ethnic groups. These cities have also seen more developments in terms of infrastructure and basic amenities. Purposive sampling method was used to select married men and women. Participants were from some churches (Dzorwulu Pentecostal Church, Odorkor Methodist Church, Atico Pentecostal Church & Odorkor Presby), companies (Ghana Commercial Bank, Adum –Kumasi & Bank of Ghana, Kumasi) Social welfare (Regional office, Kumasi) and Women and Juvenile Unit of Ghana Police Service (WAJU, Central Police Station, Kumasi. In all, one hundred and fifty subjects participated in this study. A study of this size has the minimum power (.80) required to detect reliable non-trivial differences if they exist.

There were 76 husbands representing 50.7% of the total sample and 74 wives representing 49.3% of the total sample. The participants were couples who had been married for at least one year. The reason was that many marriages had been known to have problems and may even end within the first two years of marriage.

There was no restriction on age. The age of participants ranged from 22 years to 56 years with the mean age of 35years. Age range for wives was 22years to 53years. For the husbands, the lowest age was 29 years and the highest age was 56 years with the mean age of 39years (See Table 7.4, p122)

Subjects for this study had varied educational levels and they were as follows: 46 of them had completed University, 21 had Diploma, eight had Post Secondary qualification, eight had General Certificate Examination Advance Level, six had completed Senior Secondary School, 29 had completed General Certificate Examination Ordinary Level, 19 had completed Junior Secondary School, 10 had Middle School Leaving Certificate and three of them had never been to school. For the purpose of this study, high education group included Post Secondary Education, Diploma and Degree holders; and low education group included General Certificate Examination Ordinary and Advance Level, Senior Secondary School, Junior Secondary School and Middle School Certificate Leavers (See Table 7.2, p 120)

Participants on average had been with their partners for 10yrs. Of all the couples, about 12% did not have children, 22. % had one child at home, 14. % had two (2) children, 22% had three children, 17. % had four children, 6. % had five children and 4.7% had six children (See Table 7.1, p119)

RESEARCH INSTRUMENT

Four instruments were used for the data collection in this study. These included the following:

DEMOGRAPHIC DATA: A self-designed questionnaire (See Sample in Appendix II, p124) was used to tap information such as age, occupation, educational background, number of years married and sex.

DYADIC ADJUSTMENT SCALE: A modified version of DAS (See Sample in Appendix II, p126) that has been used on the Ghanaian respondents by Anim (2000) was used to measure marital happiness and the extent of distress. The scale was originally designed by Spanier (1976) and has been frequently used to measure marital satisfaction as noted by Bird and Melville (1994). This instrument is commonly used in both research and clinical settings (Heene et al., 2003). It contains a total score and 4 sub scores: Satisfaction (10 items), Cohesion (5 items), Consensus (13 items), and Affectional expression (4 items). This scale has been proven to differentiate between distresses and non distressed couples (Spanier, 1976). This scale was a four point likert type and had a highest score of 132 points with 33 points being the lowest. The highest score indicated highest distress whereas the lowest score indicated lowest distress. The range for this scale was 132 – 33 = 99 and the mid point became 49. Therefore those who scored between 33 and 82 were classified as low distressed whereas those who scored between 83 and 132 were termed as high distressed. Using the SPSS version 11, the reliability for this test was 0.93 in the current study.

BECK'S DEPRESSION INVENTORY: The BDI (See Appendix, p132) was used to determine the level of depression among couples. Beck's, Ward, Mendelson, Mock and Erbaugh originally devised the BDI in 1961. It was revised in 1971 and made copyright in

1978 (Groth-Marnat, 1990). Both the original and the revised version have been found to be highly correlated 0.94 (Groth-Marnat, 1990).

The inventory consists of 21 groups of statements. Statements in each group describe the way an individual has been feeling over the week and the day in question. A score between 1-9 represents ups and downs that are considered normal; 10-19 represents mildly depressed; 20-25 – moderately depressed; 26 or more represents severely depressed (Hawton, Salkoviski, Kirk & Clark, 2001).

Beck's inventory has been reported to have a high reliability. Internal consistency ranges from 0.73 to 0.92 with a mean of 0.86 (Beck, Steers & Garbin, 1988). It demonstrates high internal consistency, with alpha co-efficient of 0.86 and 0.81 for psychiatric and non-psychiatric populations respectively (Beck et al., 1988). It has split half reliability co-efficient of 0.93 and test retest reliability ranges from 0.48 to 0.86, depending on the interval between retesting and type of population (Groth-Marnat, 1990).

FEAR OF NEGATIVE EVALUATION SCALE: This scale (See Appendix, p129) was used to measure the level of anxiety among couples. It has 30 items with true or false responses and it was designed by Watson and Friend (1969) to measure how apprehensive individual become base on their anticipation of being evaluated in particular situations .It has reliability co-efficient of .78 using Cronbach's alpha (1969). To make this scale appropriate for the study, it was modified to reflect husband and wife atmosphere. Certain wordings like 'others' and 'someone' that referred to anybody at all were replaced with 'spouse' restricting it to fit couples atmosphere. For example, statements like ' I am afraid that others will not approve of me ' and if I know someone is judging me it has little effect on me' were modified to read as

'I am afraid that my spouse will not approve of me' and 'If I know my spouse is judging me it has little effect on me' respectively. Using the SPSS version eleven (11) this scale had a reliability coefficient of .77

Low scorers (1-12) People who score low on this scale are often described as relaxed in social situations, dominant and open to new experience s.

Average scores (13-20) are people who are seen as fearful of entering social evaluative situations.

High scorers (21- 30) are people usually apprehensive about what other people think of them. This can cause less than enjoyable social and work relationships.

PILOT STUDY

A pilot study was done to ascertain whether prospective respondents would understand the questionnaire. A number of couples were approached to fill the questionnaire. They were however informed that the questionnaire was being tested to see how effective it would be in tapping the necessary information. They were told that if they had difficulty understanding any thing, they should make it known. The pilot study was for a period of one month, two weeks in Accra and the remaining two weeks in Kumasi.

Various respondents reported that the questionnaire was alright. The only thing some of them had problem with was a question which read "Do you kiss, hug or embrace your mate"?. To them, kissing takes place almost always during sex and therefore does not capture kissing and hugging, as it pertains to showing of affection. It was therefore modified to read as "Do you kiss, hug or embrace your mate to show affection other than sex?"

PROCEDURE

A letter of introduction from the head of Psychology Department Legon, which stated the title and purpose of the study, was taken to the various places. In the churches, school and companies, the pastor in charge, headmaster/headmistress and managers respectively, were informed of my mission. A letter of introduction as well as copies of the questionnaire was shown to them and permission was given.

At the Social welfare, the Metropolitan Director of Social Welfare as well as the Regional Director of Social Welfare was contacted. After showing them the introductory letter and copies of the questionnaire, they also gave the go ahead.

At Women and Juvenile Unit of the Ghana Police Service (WAJU), things were slightly different. After speaking to the Commanding Officer, she demanded that a letter should be sent through the Regional Records Department to the Regional Commander of Police before permission could be granted. Permission was granted following the submission of the letter and a copy of the introductory letter.

ETHICAL CONSIDERATION

Participants who took part in this study were not under any undue pressure to get involved. They voluntarily opted to be part of the study after the intention and the nature of the study was laid bare to them. A written consent was obtained from all those who participated in the study. They were advised that they have the right to opt out even before the work begins despite the initial agreement to take part; likewise they can leave if they so desire in the process of the work. They were assured of optimal confidentiality, and with this they felt very comfortable in responding to the questionnaire. Most of the questionnaires were collected on

the same day. Others, however, lasted for about a week due to the busy schedule of the respondents.

It is also important to mention that some of them were interviewed due to their low educational level. All participants were appreciated for taking part in the study. Participants were also debriefed about the whole work after their involvement and they were pleased to have taken part. This ethical consideration was observed through out this work.

SCORING

SECTION I: Dyadic Adjustment Scale was scored to differentiate high scorers and low scorers.

The highest score obtainable = 132

The lowest score obtainable = 33

Range: 132-33=99

Mid-point: 49

Therefore, from 33-82 were termed low distress; and from 83-132 high distress.

SECTION II: Beck's Depression Inventory

Total Score	*Levels of Depression*
1-9	Represents ups and downs considered normal
10-19	Represents mildly depressed
20-25	Represents moderately depressed
26 or more	Represents severely depressed

SECTION III: Fear of Negative Evaluation Scale

Total Score	*Levels of anxiety*
0-12	Low scorers
13-20	Average scorers
21-30	High scorers

INTERVENTION

PROCEDURE: Subjects who had high scores on both the anxiety and depression measures were randomly assigned to either the treatment or control group.. High scores indicated that they experienced more anxiety and depression. Subjects selected were in all 44 and consisted of 22 males and 22 females. Four of them however, refused to join because of their busy schedules. The number then came to 40, half of which represented males and females respectively.

Subjects were informed that the essence of the therapy was to see how effective the cognitive behaviour therapy is, and to help them develop skills to minimize anxiety and depression. They were assured of their confidentiality and were also told that they have the option to either participate in the intervention or discontinue.

The 40 participants were divided into two groups; those who went through the intervention, termed as the treatment group and those who did not go through intervention, also termed as the control group. Participants were asked to pick pieces of papers on which was written either 'T' or 'C'. All those who picked 'T' or 'C' were categorized into either the treatment group or control group. Those in the control group were asked to go and come back on the eighth week. The treatment group was taken through eight weeks intervention programme.

Participants in the treatment group received cognitive behavioural therapy while the control group did not.

They met once every week and the meeting day was scheduled to be on Fridays between 3 pm and 4pm. That was the time most of the participants were free from their daily activities. The room for the meeting was also available on Fridays.

Both groups were invited on the last day to fill the questionnaire on anxiety and depression, which was used to compare their scores before intervention. Printed material on refuting irrational thoughts were given to all of them to read at home. They were also encouraged to find alternative explanations to the automatic thoughts that keep bothering them.

Participants expressed happiness about the whole programme. They also suggested that such programmes are ran for all couples irrespective of whether they have problems or not since it can be a preventive measure for couples.

DATA ANALYSIS

The data analysis was done using the statistical package for social sciences (SPSS) version 11. Different statistical tests were employed to test the various hypotheses. As can be seen in the next chapter (Chapter Four), the first and second hypotheses which stated that highly distressed couples would be more depressed than low distressed couples, and highly distressed females would be more depressed than highly distressed males respectively, were tested using the two way Analysis of Variance (ANOVA). The third and fourth hypotheses which were highly distressed couples would experience more anxiety than low distressed couples, and couples with high education would be more distressed than couples with low education respectively, were also tested using independent sample t-test. The fifth sixth

hypotheses were tested using Pearson's Product Moment Correlation to examine whether positive relationship existed between depression and distress as well as between depression and anxiety. Finally, the seventh hypothesis, which predicted that couples who participated in the intervention programme would show a significant reduction in anxiety and depression than those who did not, was also tested using independent sample t-test.

CHAPTER FOUR

RESULTS

RETURN RATE OF QUESTIONNAIRE

In all, 160 questionnaires were given out, 80 to husbands and the other 80 to wives. However, not all questionnaires were returned. Ten (10) questionnaires (4 male; 6 female) were not returned for various reasons. The returned questionnaires comprised of, 74 from husbands and 76 from wives.

Fifty seven of the men were in the low distressed group and 19 in the high distressed group representing 38% and 12.7% respectively; whereas 52 of the women representing 34.7% and 22 representing 14.7% were in the low and high distressed group respectively.

HYPOTHESES

Hypothesis one

High distressed couples will be more depressed than low distressed couples.

Level of distress was found to have a significant effect on couples' depression levels [F (1, 146) =19.618, p <. 01] (Refer to Table 2). Couples with higher level of distress had a mean score of (10.049) as against their counterparts with lower level of distress (6.266). This means that couples with lower level of distress reported less depression than couples with higher level of distress. Thus couples level of distress impacts significantly on their depression levels. The hypothesis that high distressed couples will be more depressed than low distressed couples was therefore supported.

Hypothesis Two

High distressed females will be more depressed than high distressed males.

Table 1: Means and Standard Deviations on Measures of Depression by Level of Stress and Sex

Sex	Levels of distress	Mean	Std. Deviation	N
Male	Low Distress	5.947	4.868	57
	High Distress	9.842	4.140	19
	Total	6.921	4.969	76
Female	Low Distress	6.615	4.534	52
	High Distress	10.227	4.503	22
	Total	7.689	4.791	74
Total	Low Distress	6.266	4.702	109
	High Distress	10.049	4.289	41
	Total	7.300	4.881	150

The standard deviation scores as presented on Table 1 above show some amount of deviation of individual scores about their mean. A two-way ANOVA was performed to identity the source of the variance and to test whether the mean differences as shown on table one above were significant. The results of the 2-way ANOVA are presented in Appendix (See Table 7.6)

The results revealed that males did not differ significantly from their females on the depression measure. In other words, the mean difference between the mean scores of males

(6.921) and their female counterparts (7.689) on the depression measure did not reach statistical significance. Thus, sex did not have any significant effect on the depression levels of couples [F (1, 146) = .386, p = n.s.].

The 2-way ANOVA revealed a non-significant interaction effect between level of distress and sex on depression [F (1, 146) = .028, p = n.s.]. Thus the main effects of level of distress and sex are parallel to each other. In other words, none of the two independent variables influenced each other regarding their effects on depression. The hypothesis, that high distressed females will be more depressed than high distressed males is therefore not supported.

Hypothesis three

This hypothesis predicted that high distressed couples would experience more anxiety than low distressed couples.

Table 2: Independent samples t-test on Measures of Anxiety for Couples with Low level of Distress and their Counterparts with High Level of Distress.

Levels of distress	N	Mean	Std. Deviation	df	t	p
High Distress	41	12.908	4.997	148	2.894	<. 05
Low Distress	109	10.244	5.103			

Results from the independent-samples t-test showed a significant mean difference between the mean scores of high distressed couples (12.908) and low distress couples (10.244) on the anxiety measure. Thus couples' level of distress had a significant effect on their anxiety [t (148) = 2.894, p < 05]. The results further revealed that, high distressed couples experienced more anxiety than low distressed couples, since their mean score on the anxiety measure was significantly higher than low distressed couples. This therefore supports the hypothesis,

which argued that high distressed couples would experience more anxiety than low distressed couples.

Hypothesis four

It was hypothesized that couples with high level of education would be more distressed than couples with low level of education.

Table 3: Independent samples t-test on Measures of Distress for Couples with Low Level of Education and High Level of Education.

Levels of Education	N	Mean	Std. Deviation	df	t	p
Low education	75	73.25	17.77	148	4.245	<. 05
High Education	75	60.43	19.21			

The independent-samples t-test was used to determine whether educational level of couples had any effect on the distress level of couples. The results showed that, couples with lower level of education differed significantly from couples with higher levels of education on the distress measure [t (148) = 4.245, p <. 05]. Couples with low level of education suffered more distress than couples with high level of education. This is because the mean difference observed between the mean scores of couples with low level of education (73.25) and their counterparts with high level of education (60.43) were statistically significant. The hypothesis that "couples with high level of education will be more distressed than couples with low level of education" is therefore rejected.

Hypothesis five

It was hypothesized that there will be significantly positive correlation between depression and distress.

Results from the Pearson product moment correlation showed a significant relationship between measures of depression and distress [r = .51, p<. 01] (Refer to Table 4). The coefficient of determination for the relationship between measures of depression and distress was .26. This means that their level of distress could explain 26% of the differences in couples' scores on the depression measure. This therefore supports the hypothesis that there will be significantly positive correlation between depression and distress.

Hypothesis six

This hypothesis predicted that there will be significantly positive correlation between anxiety and depression.

Table 4: Pearson Product Moment Correlation between Measures of Depression Distress and Anxiety.

	Depression	Distress	Anxiety
Depression	-	.51*	.23*
Distress	-	-	.14
Anxiety	-	-	-

N = 150, * p<. 01

Results from the Pearson product moment correlation showed a significant relationship between measures of depression and anxiety [r = .23, p<. 01]. The coefficient of determination for the relationship between measures of depression and anxiety was .053. This means that their level of anxiety could explain 5.3% of the differences in couples' scores on

the depression measure. This therefore supports the hypothesis that there will be significantly positive correlation between depression and anxiety.

Hypothesis seven

There was a prediction that couples who go through intervention will show a significant reduction in depression and anxiety than couples who do not.

Table 5: Independent samples t-test on Measures of Depression before intervention for couples (Treatment and Control group).

Groups	N	Mean	Std. Deviation	df	t	P
Treatment	20	11.70	3.06	38	.766	n.s.
Control	20	12.65	4.63			

The independent-samples t-test was used to determine the depression levels of couples who were given therapy (Treatment) and their counterparts who were not given any therapy (Control) on the depression measure. The results showed a non-significant difference between the two groups on their depression levels. Thus the mean difference between their mean scores on their depression measure did not reach statistical significance [t (38) = .766, p = n.s.]. Even though they did not differ on the depression measure, their mean scores indicated they were both experiencing some amount of depression. The depression scores after intervention for couples who had therapy and their counterparts who did not are presented on Table 6 below.

Table 6: Independent samples t-test on Measures of Depression after Intervention for Couples (Treatment and Control groups).

Groups	N	Mean	Std. Deviation	df	t	p
Treatment	20	5.60	1.50	38	8.67	<. 01
Control	20	13.00	3.510			

The results showed that couples who were given therapy and those who were not given any therapy differed significantly regarding their depression levels. Thus the mean difference between their mean scores reached statistical significance [t (38) = 8.67, p<. 01]. Couples who were given therapy reported less depression than their counterparts who were not given any therapy. This is because the mean score of couples who were not given any therapy (13.00) was significantly higher than couples who were given therapy (5.60). The mean scores of couples who were given therapy reduced significantly from 11.700 (mean score before intervention) to 5.6 (mean score after intervention). The mean scores for couples who were not given any Intervention, both before and after intervention did not show much difference.

Table 7: independent samples t-test on Measures of Anxiety before Intervention for Couples (Treatment and Control groups)

Groups	N	Mean	Std. Deviation	df	t	p
Treatment	20	12.250	5.300	38	.776	n.s.
Control	20	13.550	5.296			

The independent-samples t-test was used to determine the anxiety levels of couples who were given therapy (Treatment) and their counterparts who were not given any therapy (Control) on the anxiety measure. The results showed a non-significant difference between the two groups on their anxiety levels. Thus the mean difference between their mean scores on the anxiety measure did not reach statistical significance [t (38) = .776, p = n.s.). Even though they did not differ on the anxiety measure, their mean scores indicated they were both experiencing some amount of anxiety. The anxiety scores after intervention for couples who had therapy and their counterparts who did not are presented on Table 8 below.

Table 8: Independent samples t-test on measures of Anxiety after Intervention for Couples (Treatment and Control groups).

Groups	N	Mean	Std. Deviation	df	t	p
Treatment	20	6.65	2.58	38	7.009	<. 01
Control	20	14.15	4.03			

The results showed that couples who were given therapy and those who were not given any therapy differed significantly on the anxiety. Thus the mean difference between their mean scores reached statistical significance [t (38) = 7.009, p<. 01]. Couples who were given therapy reported less anxiety than their counterparts who were not given any therapy. This is because the mean score of couples who were not given any therapy (14.15) was significantly higher than couples who were given therapy (6.65). The mean scores of couples who were given therapy reduced significantly from 12.25 (mean score before intervention) to 6.65 (mean score after intervention). The mean scores for couples who were not given any intervention, both before and after intervention did not show much difference.

SUMMARY OF KEY FINDINGS OF THE RESEARCH

The main findings of the research are summarized below:

Couple with higher level of distress reported more depression than couples with lower of depression.

There was no significant difference between highly distressed females and highly distressed males on the depression measure.

Highly distressed couples experienced more anxiety than low distressed couples on the anxiety measure

Couples with low level of education suffered more distressed than couples with high level of education

Pearson Product Moment correlation showed a positive correlation between marital distress and depression

Pearson Product Moment correlation showed a positive correlation between anxiety and depression

Finally, couples who went through therapy reported significant reduction in anxiety and depression than those who did not.

CHAPTER FIVE

DISCUSSION

This study sought to examine the existence of anxiety and depression among couples, especially distressed couples. Furthermore, to identify of ways of minimizing anxiety and depression among those who would be found to experience these two variables.

It is apparent that marriage like any other journey is embarked upon with the hope that everything will be rosy and juicy. But those who have tasted it and gone through the ugly side of marriage will always have a very distinct idea of how and what marriage is. It therefore stands to reason that in every endeavour peoples' expectations are not always met. There is a saying that "he who expects much is always disappointed". From experience, marriage has been known to have both sweet and sour parts and those who have the requisite skills shall succeed even at the face of problems.

The following hypotheses were tested: Highly distressed couples will be more depressed than low distressed couples; Highly distressed females will be more depressed than highly distressed males; Highly distressed couples will experience more anxiety than low distressed couples; Couples with high level of education will be more distressed than couples with low level of education; Positive relationship will exist between depression and distress; Positive relationship will exist between anxiety and depression ; and couples who go through intervention will show a significant reduction in depression and anxiety than those who do not.

THE LEVEL OF DISTRESS AND DEPRESSION

The first hypothesis predicted that highly distressed couples would be more depressed than low distressed couples. The two- way ANOVA results supported this hypothesis. The low distressed couples differed significantly from the highly distressed couples on the depression measure. This means that couples who were in the high distressed group were more depressed than their counterparts in the low distressed group.

This result is in consonance with the results of other studies (e.g., Beach, Fincham & Katz, 1998; Fincham & Beach, 1999; 2001). Various researchers have indicated that marital conflict has profound implications for individual well- being (Coyne & Downey, 1991). Beach et al. (1998) noted that the link between marital distress and depression is well established. Again, results from a study conducted by Fincham and Beach (1999; 2001) strongly supports a bi- directional relationship between depression and marital quality. Beach and O'Leary (1993) also concluded in their study that marital discord predicts later increases in depression symptoms. Schmaling and Jacobson (1999) have also reported that marital distress is often associated with psychopathology and there is suggestive evidence that marital distress is largely responsible for the interactional anomalies seen in depression, anxiety and alcoholism (Schmaling, Whisman & Jacobson, 1987). Additionally, there is evidence that marital distress is the most common complaint to precede a depressive episode (Parkel, Myers, Dienelt, Klerman, Lindenthal & Pepper, 1969).

The above studies indicate that marital distress may play a causal role in at least some depressions (e.g, Hinchliffe, Hopper, & Robert, 1978). Some researchers have disputed or remained silent about the casual sequence, but have argued that a functional marriage can

decrease the likelihood of depression in an otherwise vulnerable individual (e.g., Hammen, 1991)

Marital distress predicting depression can be simply looked at in this way. Happiness in marriage is said to be one of life's great satisfactions for many people (Sabini, 1992). Marital happiness is the degree to which husbands and wives relate as intimate friends and lovers (Perkins, 1989). It is apparent that in distressed marriages the word intimacy is non-existent and therefore couples' expectation to enjoy happiness in marriage is shattered. This means that there is loss of expectation; hence the couples involved become depressed. Depression according to Blonna (1996) is a psychological consequence when we suffer a loss or tragedy or when things do not workout the way we would like. Turner and Shapiro (1986) outline three losses in problematic marriage and these are loss of idealized relationship, loss of roles associated with the relationship, and loss of security.

Additionally, people enter marriage and once married it is expected that their spouses become their closest pal. When couples are distressed neither of them has the time for the other since there will be no meaningful exchange of ideas between them. Marital distress, as noted by Heim and Snyder (1991) aggravates major stressors in the relationship and diminishes the support available from one's partner. Collagen (1998) identified that the presence of solid support militates against the harmful effects of environmental and personal stressors (Cohen & Wills, 1985). On the other hand, the absence of, or low levels of social support, has been linked to increases in the risk of depression (Brown, Andrews, Bifulco, Adler, & Bridges, 1986). Blonna (1996) has also said that it is not uncommon for people experiencing events such as abuse and neglect to become depressed.

Again, Sandberg and Harper, (2000) found that closeness to one's spouse seemed to buffer a number of potentially depressive factors including financial distress and physical frailty. Sandberg and Harper (2000) expanded their investigation of marital closeness to include variables representing three constructs: receiving emotional support, having a confidant, and reciprocity in marital closeness. The results showed that for both older women and men, depression scores were higher in marriages where a desire for increased support and closeness was unfulfilled. In other words, one of the most depressing situations is the desire for marital closeness and not being able to achieve it. Among distressed couples marital closeness can be partially or absolutely absent and this can result in depression; that is how come highly distressed couples are more depressed than low distressed couples.

Finally, distressed couples live in a web of unresolved problems; it is more or less a vicious cycle. The Association for advancement of behaviour therapy (1988) noted that marital distress comes with communication problems and lack of intimacy. As a result of these, problems that could have been tackled by talking it over are left unresolved and they become piled up. This makes the couples feel that they do not have control over the situation and learned helplessness sets in. Seligman (1975) argues that depression is the product of learned helplessness. That is to say, whenever people feel that they lack control over certain situation they become helpless and consequently depressed. This might account for why couples with high distress level experienced more depression than those with low distress level.

DISTRESS AND GENDER

The second hypothesis stated that highly distressed females would be more distressed than highly distressed males. The results from the two-way ANOVA indicate non-significant

interaction effect between level of distress and sex. This means that hypothesis two was not supported; although the mean score of highly distressed females which was (10.227) and that of highly distressed males (9.842) showed a difference in favour of women but was not statistically significant. This finding is contrary to what different studies have found. For example, Boyd and Weisman (1981) argued that one in four women and one in eight men can be said to be depressed depending on how depression is classified. Brown and Harris (1978) have also reported that the rate of depression among women in the industrialized nations is approximately twice the rate among men.

One reason that can be given to this finding is that the distressing factor is so powerful that it over shadows gender. That is to say that when couples are distressed they tend to suffer psychological consequences, in this case, depression at the same rate irrespective of whether they are males or females.

Additionally, a study by Zimmerman-Tansella and Lattanzi (1991) has shown that unemployment status and a wife who undermines her husband's dominance position seem to increase the vulnerability for depression symptoms in man by loss of self-esteem. It is likely that husbands who were in this study had their dominance position undermined by their wives hence experiencing depression at the same rate as the wives. This argument is being put forward because when couples are distressed there is not much cordiality; communication between couples is at its worst. There is difficulty with expressive and receptive communication skills, which are linked to a host of other complaints, like lack of understanding, insufficient attention to each other, etc. (Hawton et al., 2001)

Finally, Harper and Sandberg (1999) found that men are at a greater risk for depression in later life from a perceived loss of autonomous functioning than from relational quality. They therefore indicated that retirement or loss of mental or physical abilities, may pose a greater risk for depression in older men than relationship quality. In this study, the average age of the husbands was thirty – nine (39) years whereas the wives had average age of thirty – five (35) years. At age thirty – nine (39) people are considered mature enough to take responsibility and control over things around. High distressed husbands may feel that if by this time peace and understanding do not seem to prevail in their marriages, then they have more or less lost the physical and mental ability to ensure that issues between the couples are smoothly and effectively handled.

It appears that the husbands were older than the wives; and this coupled with high distress, perhaps explains why the men were depressed almost as equally as the women in this study instead of the old trend where depression in women is twice the rate in men.

DISTRESS LEVEL AND ANXIETY

The third hypothesis predicted that highly distressed couples would experience more anxiety than low distressed couples. The results from the independent sample t – test showed a significant difference between highly distressed couples and low distressed couples [$t(148)= 2.894, p<.05$] on the anxiety measure, with the mean scores of (12.908) (10.244) respectively. This means that highly distressed couples experienced more anxiety than low distressed couples. The result supports the hypothesis that highly distressed couples will experience more anxiety than low distressed couples.

This finding goes to confirm what Baucom and Epstein (1990) found. They identified anxiety to be one of four negative emotions believed to play an important role in marital distress. Moreover, they concluded that not only can anxiety disrupt marital functioning, but poor marital functioning may elicit symptoms of anxiety. That is to say anxiety can have bi-directional effect on distressed couples. Dehle and Weiss (2002) argued that state anxiety might influence the processing of day-to-day marital events and partner behaviours in a way that contributes to deteriorating sentiment. This could be so because a spouse who is experiencing tensions and nervousness may not be at ease to discuss pertinent issues relating to the relationship and this may therefore affect the quality of the relationship.

A possible explanation why highly distressed couples experience more anxiety than low distressed couples could be the fact that they do not get the necessary attention from their partners and this can make them feel unloved. This can then result in extreme worry and tension within the person. A study by Zimmerman – Tansella and Lattanzi (1981) on the association between marital relationships and symptoms of anxiety came to similar conclusion. They found that spouses' ratings of their quality of their relationship have effect on their psychological health. Specifically, the results showed that symptoms of anxiety in both wives and husbands were predicted by low ratings of affection exchange. This means that when couples are highly distressed, anxiety could be one of the psychological consequences that may affect them.

EDUCATION AND DISTRESS

It was hypothesized that couples with high level of education will be more distressed than couples with low level of education. The results obtained from the independent sample t- test showed a significant difference between the two groups on the distress measure. It however, turned out that couples with low level of education suffered more distress that couples with high level of education. The hypothesis that couples with high level of education would be more distressed than a couple with low education was not supported.

The finding from this study is consistent with what Anim (2000) found when he studied self-esteem and assertiveness as psychological factors affecting marital distress. He found that husbands and wives with low level of education experienced greatest distress.

It had been anticipated that couples with high education level would experience more distress because high education usually comes with working outside the house, unless of course, a decision has been reached for the wife to be a housewife. When couples engage in full time work then you can have each spouse working hard to make a mark in his or her field of work. This can have negative effect on marital quality. This assumption was, however, not confirmed. Instead, available literature indicates that when women have education it improves their family lives but when illiteracy is high it contributes to the diverse problems women face in these parts of the world (UN Publication, 1995). This happens because in Ghana and other parts of the world education almost always corresponds to having good jobs and therefore high salary. To this end, Bird and Melville (1994) noted that marriage improves well-being through the economic advantages provided by living in a two-income family. Belle (1990) also reported that the intimacy of the marital bond is often strained or broken by economic stress. All these mean that if more education could enhance employment opportunities and for that matter financial state, then problems that might have

resulted between couples for lack of finances do not happen at all are minimized or this could explain why couples with low level of education get more distressed than couples with high level of education.

Another explanation that can be given is that people educational background can equip them with problem solving abilities, which will therefore enable them to deal with problems that affect the quality of their relationship effectively. Bird and Wakat (1993) noted that the more education a woman has and the higher her job status, the more disposed she is to use problem focused coping; this enables her to directly attack the source of problems when they arise. Women with low education often rely on emotion focused coping strategies (crying, self blaming, seeking social support, etc) which although, reduce overall tension do not attack the source of the problem (Bird & Wakat, 1994). This means that when couples have more education they are more able to resolve their marital problems better, hence the reduction in marital distress. This can also account for the result that couples with more education were less distressed than those with less education.

DISTRESS AND DEPRESSION (RELATIONSHIP)

Hypothesis five predicted that positive relationship would exist between distress and depression. Results from the Pearson Product Moment Correlation showed a significant relationship between measures of depression and distress. This result shows a strong relationship between distress and depression. The result therefore supports the hypothesis that a positive relationship exists between distress and depression. This means that when distress increases depression goes up and the vice versa. Likewise when distress reduces depression goes down among couples.

The association between judgment of relationship quality and depressive symptomatology has long intrigued family researchers (Clarkin, Haas & Glick, 1988). In fact, a large body of empirical evidence shows a robust association between depressive symptomatology and marital distress in the general population (Beach, Funcham & Smith, 1994; Gotlib & Beach, 1995).

It has been demonstrated that marital discord predicts later increases in depression symptoms (Beach, 1993). Other studies have also reported instances where depressive symptoms in a spouse result in poor marital quality. For example, Heenc,Buysse,& Van Oost (2000) found that couples with a depressive spouse presented a significantly lower level of marital adjustment compared to couples without a depressive spouse. To this extent, Heene (2000) have reported that although the current association of depressive complaints with marital distress remains sufficiently strong, the direction or nature of causal effects has not been empirically evaluated. It is however, important to note that the literature reviewed supports a bi-directional relationship between depression and marital quality (Fincham & Beach, 1999).

All said and done, what is important to this study is the fact that a positive relationship exists between marital distress and depression. That is to say a number of couples who are distressed have been found to suffer from depression. Likewise, couples with depression symptoms adjust poorly to marital relationship.

RELATIONSHIP BETWEEN ANXIETY AND DEPRESSION

It was hypothesized under hypothesis six that positive relation would exist between anxiety and depression. The result from the Pearson Product Moment Correlation revealed a significant relationship between measures of depression and anxiety. The relationship between anxiety and depression was however low. This means that anytime depression

increases anxiety will go up and the vice versa. Also, when a reduction in depression occurs, anxiety also reduces.

The finding from this study has been found by other researches. For example, Zimmerman-Tansella and Latanzi (1981) found symptoms of anxiety and depression as measured by the interval General Health Questionnaires among wives and husbands. They however, reported that depression in men was predicted by unemployment. First order correlation showed that anxiety and depression symptoms were significantly correlated in both sexes with a share variance of 41% for women and 27% for men. (Zimmerman-Tansella & Latanzi, 1981)

In explaining the correlation between anxiety and depression, researchers have pointed to co-morbidity; there is increasing evidence of co-occurrence of anxiety and depressive symptoms(Alloy,Kelly,Mmeka,Clement,1990;Bootzin,Acocella,&Alloy,1993; Klerman,1990) have also noted that the symptoms of the two disorders showed considerable overlap, such that people diagnosed as having one are likely to meet the diagnostic criteria for the other as well, either simultaneously or at different times in their lives.

Additionally, a study conducted by Fyer, Liebowitz, and Klein (1990) also concluded that people who are diagnosed as anxious or depressed tend to respond to the same antidepressant drug. Heninger (1990) also found that people who suffer from anxiety and depression share similar endocrine abnormalities.

In fact the picture being painted here indicates that it is not unusual to find positive correlation between anxiety and depression because previous studies have found that people who report of symptoms for the other might also meet the criteria for another. What this

thoroughly researched in a study after study and it has been shown to be as effective as drugs in treating both depression and anxiety.

Additionally, Baucom and Epstein (1990) argue that cognitive behavioral therapy is effective in altering behaviour that matters in relationships as well as couples interpretation of each other's behaviour. Christensen and Heavy (1999) also reported that cognitive behaviour therapy is effective on alleviating depression among distressed couples as well as improving the marital relationship.

The finding from this study and what other researchers have found indeed give a great support to the effectiveness of cognitive behavioral therapy. Not all researchers, however, agree with this conclusion (Elkin, Shea, Walkings, Imber, Stosky, Collins, Glass, Ilkonis, Leber, Docherty, Fiester, & Parloff, 1989)

CHAPTER SIX

SUMMARY, CONCLUSION, CLINICAL IMPLICATION AND SUGGESTION FOR FUTURE RESEARCH

SUMMARY

The purpose of this study was to examine some of the psychological morbidities (anxiety, and depression) that could result from marital distress and how effective cognitive behavioural therapy could be used to ameliorate these adversities. It became necessary to undertake this study because of the number of psychological problems couples go through and how it can affect their well-being. Sometimes to the point of committing suicide, homicide and the myriad problems it can have on their children's development.

One hundred and fifty married couples participated in this study; 74 of them were men and the remaining seventy six were women .The age range for the husbands was 28-56years and 22-53years for the wives.

Three instruments including Beck's Depression Inventory, Fear of Negative Evaluation Scale and Dyadic adjustment scale were used for the data collection.

The Statistical Package for Social Sciences (SPSS) version 11 was used for the data analysis. The specific tests used were the two- way ANOVA, independent sample t-test and Pearson Product Moment correlation.

The results obtained from this study are summarized below:

Couple with higher level of distress reported more depression than couples with lower of depression

There was no significant difference between highly distressed females and highly distressed males on the depression measure.

Highly distressed couples experienced more anxiety than low distressed couples on the anxiety measure.

Couples with low level of education suffered more distressed than couples with high level of education.

Pearson Product Moment correlation showed a positive correlation between marital distress and depression.

Pearson Product Moment correlation showed a positive correlation between anxiety and depression.

Finally, couples who went through therapy reported significant reduction in anxiety and depression than those who did not.

CONCLUSION

In conclusion, this study has added to our knowledge about the fact that problematic marriages could have psychological consequences on the well being of the couples involved. It has also brought to light that education is an important tool that can equip individuals in solving problems that might result in marital distress For example, problems that can be triggered by lack of finances can be put under control if couples have high educational level; in the sense that high education enhances employment opportunities (Bird & Melville, 1994), hence solid financial background.

Finally, this study has prompted us to pay attention to the kind of support that can be given to couples not only those who have problems in their marriages but those without problems as well. During informal interactions with some of the couples who took part in the therapy, they proposed that psychological support should be made available for couples and this will go a long way to prevent some of the problems in marriages.

CLINICAL IMPLICATION:

Firstly, the results from this study suggest that assessing and treating marital distress could be helpful in reducing anxiety and depression. That is to say that if marital distress could predict anxiety and depression, then instead of waiting for these psychological morbidities to develop, clinicians must as well offer marital couples the necessary skills to reduce marital distress. Sandberg and Harper (2000) noted that treating marital distress could be helpful in the struggle against depression in later life. It is also important to let couples know the various consequences of marital distress and to encourage them to reduce marital distress so as to reduce the various morbidities associated with it.

Secondly, the findings from the study suggest the need for collaboration between clinicians and medical practitioners in tackling problems among distressed couples. The reason behind this implication is that there is the tendency for couples who are distressed to interpret depression symptoms as medical rather than psychological. Informal interactions with couples during therapy couples revealed that some of them have made a number of visits to medical practitioners since they lost appetite for food, experienced insomnia, etc. and they thought something was wrong medically. One woman recounted that she went to her doctor a number of times because she was loosing weight. All remedies given did not seem to help this woman. The doctor eventually told the woman that she should go and find somebody to talk to. A specific instruction like " go and see a psychologist" or even a referral to a psychologist would have been better than generally saying she should talk to somebody. This calls for a very effective collaboration between psychologist and medical practitioners.

Thirdly, in Ghana a lot of people do not seem to know the functions of Clinical psychologists let alone going to them for treatment. Unlike other parts of the world, notably, in U.S and the European countries where people are knowledgeable about what psychologists do, hence the

need to go to them for appropriate consultation; such practices are absent or near absent in this country. This makes it nearly impossible for couples to present themselves to psychologists to help them overcome problems in their marriages. Coupled with this, is the fact that in Ghana there are elders, Pastors, Chiefs who serve as mediators and arbitrators in solving marital problems. They are seen as alternatives to psychologists in the Ghanaian culture. The unfortunate thing, however, is that such people usually do not have the requisite skill or training to resolve marital distress, since they resort to traditional ways of dealing with the problem. Since traditional ways are not professional ways, the couples involved may still be distressed and suffer various psychological morbidities. It is therefore incumbent upon psychologist to be proactive in educating the public about the kind of services they can offer, and also making themselves available to the general public.

Finally, more psychologists should be trained in handling marital distress. That is to say, more attention should be given to the marriages institution since problems in marriages may have wide array of repercussions in the well being of the individual and the family as a whole (Coyne & Downey, 1991). For example, Kiecolt-Glaser (1997) found that marital conflict could have effect on immunological functioning. Additionally, marital distress is associated with poorer health (Baucom & Margolin, 1992).

LIMITATIONS OF THE STUDY

Most studies come with a number of challenges that might affect the outcome of the studies; this study is no exception. Below are the limitations that might have affected this study in one way or the other

1 Participants for this study were selected from the urban setting. It makes it difficult, if not impossible to tell whether a similar result can be obtained when participants are selected from the rural setting.

2 Financial constraints did not allow to include more married couples; and to extend the period for the intervention programme.

3. Finally, unwillingness on the part of a number of potential participants delayed the speed of the study and this resulted in unnecessary pressure on the researcher

SUGGESTION FOR FUTURE RESEARCH

The following suggestions can be considered for future research:

1. Future research may look at the number of children in a family and the extent of marital distress; whether couples with more children suffer more marital distress than couples with small number of children
2. Future research may also look at the link between the marital distress and physical illness as well as other psychological morbidities
3. Again, further research could explore the effect of marital distress on the children's' academic performance and self-esteem.
4. Further, the number of years married can be considered, whether couples who have married for longer years experience more distress than couples married for few years

5. Finally, couples' religious background can be considered, whether it provides any coping mechanism for the distressed couples and the effect it has on the development of psychological morbidities.

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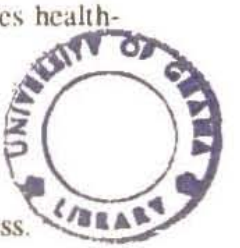

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APPENDIX I

TABLE 7.1: Summary of the number of children of participants

Number of children				
		Frequency	Percent	Valid Percent
Valid	None	18	12.0	12.0
	1.00	34	22.7	22.7
	2.00	22	14.7	14.7
	3.00	33	22.0	22.0
	4.00	26	17.3	17.3
	5.00	10	6.7	6.7
	6.00	7	4.7	4.7
	Total	150	100.0	100.0

TABLE 3.2: Summary of the level of education of participants

Level of education			
Level		Frequency	Percent
Valid	Middle School	10	6.7
	JSS	19	12.7
	GCE "O" Level	29	19.3
	GCE "A" Level	14	9.3
	Post Secondary	8	5.3
	Diploma	21	14.0
	Degree	46	30.7
	No education	3	2.0
	Total	150	100.0

TABLE 7.3:Summary of the percentages of husbands and wives in the low distressed and high distressed groups

Husband or wife * Levels of distress Cross tabulation				
		Levels of distress		Total
		Low Distressed	High Distressed	
Husband	Count	57	19	76
	% Of Total	38.0%	12.7%	50.7%
Wife	Count	52	22	74
	% Of Total	34.7%	14.7%	49.3%
Total	Count	109	41	150
	% Of Total	72.7%	27.3%	100.0%

Table 7.4 Summary of the means, median, minimum and maximum ages, and the number of years married for husbands and wives.

Statistics				
Husband or wife			Age	Number of years married
Male	N	Valid	76	76
		Missing	0	0
	Mean		39.1053	9.9634
	Median		38.5000	8.0000
	Minimum		28.00	.11
	Maximum		56.00	28.00
Female	N	Valid	74	74
		Missing	0	0
	Mean		35.1216	10.0541
	Median		34.0000	8.0000
	Minimum		22.00	1.00
	Maximum		53.00	37.00

Table 7.5: Summary of the means, median, minimum and maximum ages, and the number of years married for all participants put together.

Statistics			
		Age	Number of years married
N	Valid	150	150
	Missing	0	0
Mean		37.1400	10.0081
Median		36.0000	8.0000
Minimum		22.00	.11
Maximum		56.00	37.00

Table 7.6: Summary of 2 - way ANOVA results Showing the Effect of Level of Distress and Sex on Depression

Source	Sum of Squares	df	Mean Square	F	P
Sex	8.225	1	8.225	.386	n.s.
Distress Level	417.834	1	417.834	19.618	<. 01
Interaction	.593	1	.593	.028	n.s.
Error	3109.540	146	21.298		
Corrected Total	3549.500	149			

APPENDIX II

QUESTIONNAIRE

This questionnaire forms part of a research, which measures marital happiness or distress. This information will help counselors/therapists to know how to assist couples in their marriages in future. Could you please respond to each question, as it is applicable to you? No response is right or wrong; responses will be treated with the highest level of confidentiality.

Please kindly provide information on the following

Husband or Wife	Male [ ] Female [ ]
Age	e.g. 20yrsm 26yrsm 30yrs etc
Occupation	
Number of year's married	e.g. 2yrs, 3yrs, 4 yrs etc
Number of children	

Level of education e.g.

Middle School	.....
JSS	.....
SSS	.....
GCE O' level	.....
GCE A' level	.....
Post Secondary	.....
Diploma	.....
Degree	.....
Other	.....

MARITAL HAPPINESS SCALE

Most persons have disagreements in their marriages. Please indicate below the extent of agreement or disagreement between you and your partner for each item on the following list:

1. Almost always agree 2. Occasionally agree 3. Occasionally disagree 4. Almost always disagree.

1. Handling family money	1	2	3	4
2. Matters of entertainment	1	2	3	4
3. Religious matters	1	2	3	4
4. Showing of affection	1	2	3	4
5. Friends	1	2	3	4
6. Sex relations	1	2	3	4
7. Correct or proper behaviour	1	2	3	4
8. Ways of dealing with parents or in laws	1	2	3	4
9. Aims, goals, and things believed important	1	2	3	4
10. Amount of time spent together	1	2	3	4
11. Making major decisions career decisions	1	2	3	4
12. Household tasks	1	2	3	4
13. Leisure time interests and activities	1	2	3	4

Instructions: In the following items 1 = most of the time, 2 = occasionally, 3 = not often, 4 = never.

In general, how often do you think that things	1	2	3	4
between you and your partner are going well	1	2	3	4

14. Do you share your deep concerns with your partner?	1	2	3	4
15. Do you kiss, hug, or embrace your mate?	1	2	3	4
16. Do you and your mate engage in outside interests together?	1	2	3	4
17. Do you have interesting exchange of ideas?	1	2	3	4
18. Do you laugh together?	1	2	3	4
19. Do you calmly discuss something?	1	2	3	4
20. Work together on a project?	1	2	3	4

For this aspect, give your responses according to this order:

1(never), 2 (not often), 3 (occasionally), 4 (most of the time)

22. How often have you considered separation or ending your marriage?	1	2	3	4
23. How often do you or your spouse leave the house after a fight	1	2	3	4
24. Do you ever regret that you married or lived together?	1	2	3	4
25. How often do you and your partner quarrel?	1	2	3	4
26. How often do you and your partner become annoy with each other?	1	2	3	4
27. Being too tired for sex?	1	2	3	4

Give your responses to the five statements below according to the following:

1(quite positive), 2(slightly positive), 3 (slightly negative), 4 (quite negative)

28. How do you feel about you partner as a friend to you?	1	2	3	4
29. How do you feel about the future of your marriage?	1	2	3	4
30. How do you feel about the degree to which your partner understands you ?	1	2	3	4
31. Touching my partner makes me feel	1	2	3	4
32. My partner's physical appearance me feel.	1	2	3	4 makes

Circle the dot which best describes the degree of happiness of your relationship if you put all things together.

33*.....*.....*.....*

1	2	3	4
Very happy	happy	unhappy	very unhappy

EVALUATION SCALE

Carefully read each of the 30 statements listed below. Decide whether each statement is true (T) of false (F) as it pertains to you personally. If you are unsure which the better answer is, decide which one is slightly more applicable to how you are feeling at the moment and answer accordingly, Try to answer based on your first reaction to the statement. Do not spend too long on any item.

1. I rarely worry about seeming foolish to my spouse ..... True / False
2. I worry about what my spouse will think of me even when I know it does not make any difference ..... True/ False
3. I become tense and jittery if I know my husband is sizing me up .....True/ False
4. I am unconcerned even if I know my spouse is forming an unfavorable impression of me.....True/ False
5. I feel very upset when I commit some error in the house ..... True/ False
6. The opinions that my spouse has of me cause me little concern .....True/ False
7. I am often afraid that I may look ridiculous or make a fool of myself. True/ False
8. I react very little when my spouse disapproves of me..... True/ False
9. I am frequently afraid of my spouse noticing my shortcoming .....True/ False
10. The disapproval of my spouse would have little effect on me..... True/ False
11. If my spouse is evaluating me, I tend to expect the worst ..... True/ False
12. I rarely worry about what kind of impression I am making on my spouse. True/ False
13. I am afraid that my spouse will not approve of me .....True/ False
14. I am afraid that my spouse will find fault with me.....True/ False
15. My spouse opinion of me do not bother me ..... True/ False
16. I am not so upset if I don't please my spouse..... True/ False

17. When I am talking my spouse, I worry about what she/ he may be thinking about me..... True/ False

18. I feel that you cannot help making errors in the house sometimes, so why worry about it ... True/ /False

19. I am usually worried about what kind of impression I make..... True/ False

20. I worry a lot about what my spouse thinks of me ..... True/ False

21. If I know my spouse is judging me, it has little effect on me ... True/ False

22. I worry that my spouse will think I am not worthwhile.... True/ False

23. I worry very little about what my spouse may think of me..... True/ False

24. Sometimes I think I am too concerned with what my spouse thinks of me. True/ False

25. I often worry that I will do or say the wrong things..... True/ False

26. I am often indifferent to the opinions my spouse has of me ... True/ False

27. I am usually confident that my spouse will have a favourable impression of me... True/ False.

28. I often worry that my spouse won't think very much of me.....True/ False

29. I brood about the opinions my spouse has about me.....True/ False

30. I become tense and jittery if I know I am being judged by my spouse True/ False

BDI

This questionnaire consists of 21 groups of statements. After reading each group of statements carefully, circle the number (0,1,2 or 3) next to the one statement in each group which best describes the way you have been feeling the past week, including today, if several statements within a group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

0 I do not feel sad 1 I feel sad 2 I am sad all the time and I can't snap out of it 3 I am so sad or unhappy that I can't stand it	
0 I am not particularly discouraged about the future. 1 I feel discouraged about the future 2 I feel I have nothing to look forward to. 3 I feel that the future is hopeless and that things cannot improve	0 I don't have any thoughts of killing myself 1 I have thoughts of killing myself but I would not carry them out. 2 I would like to kill myself. 3 I would kill myself if I had the chance
0 I do not feel like a failure 1 I feel I have failed more than the average person 2 As I look back on my life, all I can see is a lot of failures. 3 I feel I am a complete failure as a person	0 I don't cry any more than usual. 1 I cry more now than I used to 2 I cry all the time now 3 I used to be able to cry, but now I can't cry even though I want to .

0 I get as much satisfaction out of things as I used to. 1 I don't enjoy things the way I used to 2 I don't get real satisfaction out of anything anymore 3 I am dissatisfied or bored with everything	0 I am no more irritated now than I ever am. 1 I get annoyed or irritated more easily than I used to . 2 I feel irritated all the time now. 3 I don't get irritated at all by the things that used to irritated me.
0 I don't feel particularly guilty 1 I feel guilty a good part of the time 2 I feel quite guilty most of the time 3 I feel guilty all of the time	0 I have not lost interest in other people. 1 I am less interested in other people than I use to be 2 I have lost most of my interest in other people. 3 I have lost all of my interest in other people.
0 I don't feel I am being punished 1 I feel I may be punished 2 I expect to be punished 3 I feel I am being punished	0 I make decisions about as well as I ever could 1 I put off making decisions more than I used to 2 I have greater difficulty in making decisions than before 3 I can't make decisions at all anymore.
0 I don't feel disappointed in myself 1 I am disappointed in myself 2 I am disgusted with myself 3 I hate myself	0 I don't feel I look any worse than I used to. 1 I am worried that I am looking old or unattractive.

	2 I feel that there are permanent changes in my appearance that make me look unattractive 3 I believe that I look ugly.
0 I don't feel I am any worse than anybody esle 1 I am critical of myself for my weakness or mistakes. 2 I blame myself all the time for any faults. 3 I blame myself for everything bad that happens.	0 I can work about as well as before. 1It takes an extra effort to get started at doing something 2I have to push myself very hard to do anything 3I can't do any work at all.
0 I can sleep as well as usual. 1 I don't sleep as well as I used to. 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep. 3 I wake up several hours earlier than I used to and cannot get back to sleep.	0 I am no more worried about my health than usual. 1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation. 2 I am very worried about physical problems and it's hard to think of much else. 3 I am so worried about my physical problems that I cannot think about anything else.
0 I don't get more tired than usual.	0 I have not noticed any recent change in

1 I get tired more easily than I used to. 2 I get tired from doing almost anything. 3 I am too tired to do anything.	my interest in sex. 1 I am less interested in sex than I used to be. 2 I am much less interested in sex now. 3 I have lost interest in sex completely.
0 My appetite is no worse than usual. 1 My appetite is not as good as it used to be. 2 My appetite is much worse now. 3 I have no appetite at all anymore.	
0 I haven't lost much weight, if nay, lately. 1 I have lost more than 5 pounds. 2 I have lost more than 10 pounds. 3 I have lost more than 15 pounds.	

APPENDIX III

Cognitive Behavioural Strategies

Treatments sessions and homework assignments are directed towards teaching participants to identify, question and test negative automatic thoughts. These skills are used to reduce depressive symptoms and later tackle life problems.

The Nature of negative automatic thoughts

The content of depressive thinking has been categorized by Beck (1976) in terms of "cognitive triad". This comprises distorted, negative views of:

1. The self (e.g. "I'm useless")
2. The current experience (e.g. I'm never right at doing things).
3. The future (e.g. I will never be able to do things right)

"Man is not disturbed by events, but by the view he takes of them" Epictetus.

Negative automatic thoughts are a product of errors in processing through which perceptions and interpretations of experience are distorted.

They Include:

- **Overgeneralization,** making arbitrary conclusion that one thing that happened to you once will occur over and over again, a depressed person who makes a mistake might conclude that: "Everything I do never succeeds".
- **Selective abstraction**, attending only to negative aspects of experiences. A person might conclude that "there was no pleasure today" because the person fails to enter pleasurable events to conscious awareness.

- **Dichotomous thinking**, thinking in extremes. This is the tendency to evaluate personal qualities in black – or – white or all – nothing categories. For example, a wife who expects the husband to call her on a phone before lunchtime might conclude the husband does not love her when he calls after lunchtime.
- **Personalization,** taking responsibility for things that have little or nothing to do with oneself. Thus a depressed person who failed to catch the eye of a friend in the street might think, "I must have done something to offend him".
- **Arbitrary inference**, jumping to conclusions on the basis of inadequate evidence. For example, a husband failed to talk to a wife one evening after because of how tired he was at work. The wife might conclude that "he does not want to talk to me again"
- **Emotional Reasoning**, taking your emotions as evidence for the truth. Examples of emotional reasoning include "I feel guilty. Therefore. I must have done something bad". "I feel overwhelmed and hopeless. Therefore, my problems must be impossible to solve". "I feel inadequate. Therefore, I must be a worthless person". This kind of reasoning is misleading because your feelings reflect your thoughts and beliefs. If they are distorted - as is often the case your emotions will have no validity.

The above and other cognitive distortions form the basis of most depressions, if not all. Behavioural and motivational symptoms are associated with expectation of negative outcomes. (e.g. "I can't do it"). Affective symptoms relate to cognitions, which differ in content according to the nature of the perceived impact on the personal domain. Sadness, for example, is associated with thoughts of loss, anxiety with thoughts of threat or risk. Cognitive symptoms may be precipitated or intensified by negative automatic thoughts. Thus, ruminations about current problems may hamper concentration and memory, leading to further distressing thoughts.

The Problem

Depressed people typically think in a biased, negative way. They have negative views of themselves (e.g. "I'm no good"), the world (e.g. "Life has no meaning"), and the future. Negative thoughts have several characteristics, which include the following .

- Automatic – they just pop into your head without any effort on your part
- Distorted – they do not fit all of the facts
- Unhelpful – they keep you depressed, make it difficult to change, and stop you from getting what you want out of life
- Plausible – you accept them as facts, and it does not occur to you to question them
- Involuntary – you do not choose to have them, and they can be very difficult to switch off.

Thoughts like these can trap you in a vicious circle. The more depressed you become, the more negative thoughts you have, and the more you believe them. The more negative thoughts you have, and the more you believe them the more depressed you become. The main goal of cognitive therapy is to help break out of this vicious circle.

OVERCOMING THE PROBLEM

We shall look at three steps to overcoming negative thoughts that result in depression.

Negative thoughts make one feels bad – anxious, sad depressed, hopeless, guilty and angry. Any time mood changes for the worse you must look back for the thought that has run through your mind at that moment.

Step I: Becoming aware of the negative thoughts. What can help you become aware of negative thought is to write them down as soon as they occur. This can be done on a Dysfunctional Thought Record. Write down the following:

1. The date and Time

2. The emotion(s) you felt. Give a rating out of 100 for estimating how bad you felt. This means that, a rating of O, would mean no emotion, 50 a moderate degree of emotion, and 100 an emotion as strong as it could be.

3. The situation: Where you were and what you were doing when you started to feel bad.

4. **The automatic thought(s)**: What thoughts were running through your mind at the time you started to feel bad. This should be recorded as accurate as possible

Step II Answering Negative Thoughts

Once you have learned to become aware of negative thinking, the next step is to evaluate the thoughts you identify and to look for more helpful and realistic alternatives.

There are four main questions that can help one find answers to negative thoughts.

1. What is the evidence? Do the facts of the situation back up what you think, or do they contradict it?

2. What alternative views are there? There are many different ways to look at any experience. How else could what has happened be interpreted? Get many alternatives as can be found, and review the evidence for and against them. Which alternative is most likely to be correct when you consider it objectively?

3. What is the effect of thinking the way you do?

How does it influence how you feel and what you do? What are the advantages and disadvantages of thinking this way? Can you find an alternative, which will be more helpful to you?

4. What thinking Errors are you making? Depressed people distort how they see their experiences in systematic ways. They jump to conclusions, overgeneralization from specific things that happen, take responsibility for things that are not their fault, etc. You need to find which of these errors you are making.

Rational Response

After evaluation of negative thoughts, which might help the person to become aware of how distorted the thoughts were, the next step is to find rational responses to the negative thoughts.

If the answers have been effective, you would find that your belief has decreased to some extent. It is, however, important to note that the negative thoughts do not disappear completely at one goal.

Taking action to test negative thoughts.

Rational response to negative thoughts may not be enough to convince you that they are incorrect. It is usually important to build up a body of experience, which contradicts them. This can be done by acting on rational responses which enables one to find out whether they are in line with facts and helpful, or whether they need to be changed. Taking action also allows for testing rational answers in the real world. It helps break the old habits of thinking and to strengthen new ones.

Relaxation Techniques

RATIONALE FOR RELAXATION

Anxious people have three different components to their reaction .

- a physiological component – increased heart rate, sweating, and muscle tension.
- a behavioural component - avoidance and trying to escape and
- a cognitive component(negative thoughts such as "I'm going to have heart attack", "I can not cope").

It is common for people to experience a physiological change, followed by a negative thought which increases the physiological reaction producing a vicious circle. An effective way of breaking this vicious circle is to focus on the physiological reaction and learn how to control it. Relaxation training therefore equips individuals to learn how to control the physiological reactions. IF the body is relaxed it is unlikely to experience increased heart rate and muscle

tension since the two cannot co – exist (incompatible behaviour, when one is present the other is absent)

Relaxation training

Progressive Relaxation

The commonest technique is the progressive relaxation technique. This is done by dividing the body into a series of muscle groups and each group is tensed and relaxed. By alternating tension and relaxation participants are taught to discriminate between these two states, and to become more aware of the parts of the body in which they are particularly tense.

Steps for progressive muscle relaxation:

1. Explain and model how the different groups of muscles should be tensed and relaxed.
2. Participants do various tensions – release exercise at the same time, with the therapist checking that these are done correctly.
3. Participants close their eyes and the therapist takes them through tensing and releasing the different muscle groups in the right order and at the right tempo. Tension is normally maintained for about 5 seconds, with subsequent relaxation of a muscle group lasting 10 -15 seconds. Normally each muscle group is tensed and relaxed only once.
4. After going through all muscle groups in this way the participants are asked to rate the degree of relaxation obtained using a 0 -100 scale. The same rating scale is later used to monitor progress during homework practice.

For the purpose of progressive relaxation, the body is divided into two parts. The first part comprises the relaxation of the hands, arms, face, neck and shoulders: and the second part comprises chest, stomach, lower back, thighs, buttocks, calves and feet.

Participants are asked to do homework assignment by practicing progressive relaxation for approximately 15 – 20 minutes, twice a day. Preferably at a place and time where they feel comfortable and unlikely to be interrupted. They are asked to keep a record of the time taken to relax, and the amount of relaxation achieved (0 -100 scale) during each practice.

CONSENT FORM

This study to find out, whether cognitive behavioral therapy has any effect on the levels of anxiety and depression. Participants will be divided into two groups: the treatment and control groups. All participants will fill various forms. Those who will record high levels of anxiety and depression will be taken through cognitive behavioural therapy. They would be expected to practice all the techniques that would be taught and read all printed materials given them. Those who consent to participate will be required to abide by the rules and follow all instructions.

Would you like to be part of the study? If yes, please sign below.

I.....consent to be part of the study.

That procedures and instructions have been fully explained to me.

I promise to abide by the rules and follow all instructions as expected.

.....

Signature

Date.....

..... Name.....

Signature

Witness.....