ISTANBUL BILGI UNIVERSITY
INSTITUTE OF SOCIAL SCIENCES
CLINICAL PSYCHOLOGY MASTER'S DEGREE PROGRAM

ASSOCIATIONS BETWEEN DYADIC ADJUSTMENT AND PSYCHOLOGICAL SYMPTOMS: A PRELIMINARY STUDY FOR ASSESSING THERAPEUTIC CHANGE FOR COUPLES

HAZEL IRMAK ARAÇ
114649001

ASSIST. PROF. DR. YUDUM AKYIL

ISTANBUL
2019

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ÇİFT UYUMU VE PSİKOLOJİK SEMPTOMLAR ARASINDAKİ İLİŞKİ: ÇİFT TERAPİSİNİN ÇİFTLERDEKİ ETKİSİNE DAİR BİR ÖN ÇALIŞMA

HAZEL IRMAK ARAÇ
114649001

Tez Danışmanı:	Dr. Öğr. Üyesi Yudum Akyıl	İstanbul Bilgi University
Jüri Üyesi:	Dr. Öğr. Üyesi Alev Çavdar Sideris	İstanbul Bilgi University
Jüri Üyesi:	Dr. Öğr. Üyesi Senem Zeytinoğlu	Özyeğin University

Tezin Onaylandığı Tarih : 09/01/2019

Toplam Sayfa Sayısı: 108

Anahtar Kelimeler (Türkçe)	Anahtar Kelimeler (İngilizce)
1) Çift Uyumu	1) Dyadic adjustment
2) Çift İlişkisi	2) Dyadic relationship
3) Bireysel Semptomlar,	3) Individual symptoms
4) Sistemik Terapi	4) Systemic Therapy
5) Çift Terapisi	5) Couple Therapy

ACKNOWLEDGEMENTS

First of all, I would like to thank to my family who gave all kinds of support and courage and to my second family in Istanbul. I am very grateful as for they always stand behind my decisions by believing in me.

It is my pleasure to learn and educated on Couple and Family track which is developing in Turkey. I would like to thank all my professors, supervisors and to clinical psychology program as for skilled on systemic perspective; assessing a person as a part of the system, focusing on the process rather than context, to be able to ask circular questions and working on relationships in different ways.

I would like to thank Yudum Akyıl as my thesis advisor and my supervisor that support me throughout my clinical psychology education. Afterwards, I thank to Alev Çavdar Sideris and Senem Zeytinoğlu who accepted to be my advisors; for their feedbacks and supports. I would like to thank to project assistants Nilüfer Tarım, Ezgi Kılıç and Berivan Kızılocak for their assistance on data collecting and accessing.

Besides, I would like to thank to Tuğçe Nur Doğan, Elif Ece Sözer, İlkem Coşkun, Ayşegül Uğurlu and Altuna Türkoğlu for their supports. I am very thankful for all of my friends and my family who kindly understood and supported my disappearing for a while to write this thesis.

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ABSTRACT

The main purpose of this study is analyzing the relation between individual symptoms of married people and their dyadic adjustment scores. The other purpose of the study is looking at the relation between individual symptoms and dyadic adjustment after three months of systemic therapy. The scales that were used in this study were collected from individuals, couples and families working with interns of at the Psychological Counseling Center of Istanbul Bilgi University. 23 women who currently are in a romantic relationship were used for the purposes of this study. The sample is formed up of female participants because of the majority of the participants who applied for psychotherapy was female and they had less missing information. Individual (Brief Symptom Inventory) and relational (Dyadic Adjustment Scale) data received from the participants in the first session are compared with the data obtained three months later for examining the relationship between these constructs as well as to see how these scores change during the therapy process. The analysis shows a negative correlation between dyadic adjustment and individual symptoms before therapy. This relationship is seen as weakened after three months of systemic therapy. After three months of therapy, it was observed that as dyadic adjustment scores of individuals increased (especially dyadic satisfaction and affection expression), individual symptoms decreased (especially depression, anxiety, negative-self and somatization). In order to understand these conclusions in detail, changes in the relational and individual symptom scores of four women in couple therapy, have been examined descriptively. The results were discussed in the light of the existing literature and clinical and research implications were addressed.

Keywords: Dyadic Adjustment, Dyadic Relationship, Individual Symptoms, Systemic Therapy, Couple Therapy

ÖZET

Bu araştırmanın en temel amacı; evli çiftlerde görülen bireysel semptomlar ve çift uyum düzeyi arasındaki ilişkiyi incelemektir. Araştırmanın bir diğer amacı ise, üç aylık sistemik terapi süreci sonundaki çift uyum düzeyi ve bireysel semptomların ilişkisine bakmaktır. Bu araştırmada kullanılan ölçekler İstanbul Bilgi Üniversitesi Danışmanlık Merkezi'nde stajyerler ile çalışan birey, çift ve ailelerden toplanmıştır. Araştırmada, romantik ilişkisi olan 23 kadından alınan datalar kullanılmıştır. Terapiye başvuran katılımcılarının çoğunun kadın olması ve doldurdukları ölçeklerde eksik bilgilerin bulunmaması sebebi ile kadın katılımcılardan alınan ölçekler kullanılmıştır. Terapi sürecinde ilişkisel (Çift Uyum Ölçeği) ve bireysel semptom (Bireysel Semptom Envanteri) puanlarının ve bu iki kavram arasındaki ilişkinin nasıl değiştiğini anlamak için ilk seansta alınan bireysel ve ilişkisel semptom dataları, üç aylık terapi süreci sonunda alınan data sonuçları ile karşılaştırılmıştır. Analiz sonuçlarına göre terapiye başlamadan önceki dönem içerisinde çift uyum düzeyi ve bireysel semptomlar arasında negatif bir ilişki bulunmuştur. Üç aylık sistemik terapi süreci sonucunda çift uyumu ve bireysel semptomlar arasındaki ilişki zayıflamıştır. Üç aylık terapi süreci sonunda, bireylerin çift uyum puanları yükseldikçe, (özellikle çift doyum ve çift duygu ifade) bireysel semptomlarının (özellikle depresyon, kaygı, olumsuz benlik ve somatizasyon) azaldığı görülmüştür. Bu sonuçları daha detaylı anlamak için çift terapisi sürecindeki dört kadın danışandan alınan bireysel ve ilişkisel semptom puanları betimleyici olarak incelenmiştir. Sonuçlar literatür ışığında tartışılmış, araştırma ve klinik uygulamalar ele alınmıştır.

Anahtar Kelimeler: Çift Uyumu, Çift İlişkisi, Bireysel Semptomlar, Sistemik Terapi, Çift Terapisi

CHAPTER I

INTRODUCTION

Human as a social being, needs to be connected to and in interaction with other people for continuing his healthy living. Within the developmental phases, initially the first relationship is established with the primary caregiver, which continues with the relationships formed with friends and with a romantic partner. Being in an intimate relationship with a significant other is one of the most vital necessities of human beings (Akar, 2005). In 1938, first study on marriage is presented by Terman, Butterweiser, Ferguson, Johnson and Wilson (1938) analyzing the fundamental differences separating happy marriages from unhappy ones. Today, this question is still relevant, and studies are still conducted for reaching to possible answers. Studies show that individual needs of people such as relating and belonging, sexual needs, productivity, psychological well-being, happiness and peace are mostly satisfied within the dyadic relationship (Polat, 2014). Thus, the quality of the dyadic relationship is related to individuals' life quality.

Dyadic adjustment evolving through a harmonious relationship plays a vital role in life and it effects individuals' mental health. Relationship discord, arising from the unchanging problematic patterns of interaction, is a chronic stressor for the partners. Whisman and Baucom (2012) indicate that psychiatric disorders may occur due to interpersonal stressors. It is seen that individuals develop psychological symptoms and often apply for psychological support because of the conflicts and maladjustment in the marital life (Bloom et al., 1978). On the other hand, psychological symptoms can also negatively affected couple adjustment by increase conflict in relationship. Examining the patterns in this intimate zone is important both individually and socially.

The literature search for the direction of relationship between dyadic adjustment and mental health, although failing to reach to precise findings about the direction of this relationship. Latest studies aim to understand the nature of

this relationship by accepting the bidirectional nature of this relationship and by focusing on the influence of systemic therapies on the treatment of psychological problems (Davila, 2001, Rehman, Gollan, & Mortimer, 2007).

Most therapeutic approaches search for the effects of and aim to psychological problems by different therapeutic methods with individual view, but it is also possible to solve the individual problems reflected upon the intimate relationship or past experiences within the relationship. Current studies focusing on the diagnosis and treatment of mental disorders claim that individual disorders should also be evaluated within the systemic environment individual lives in (Pinquart, Oslejsek, & Teubert, 2016). In systemic model, family members and therapist constitute an ecosystem which becomes a fruitful context for the healing of the system and all members in it. Seeing that couple relationship impacts individual well-being in various terms it is seen that examining individual symptoms with a systemic perspective is very efficient on protecting mental health. Determining the conflict areas in the relationship and understanding the impacts of those conflicts on the individual will facilitate the designation of psychological support services which can be used for prevention and treatment of individual symptoms people develop in relationships.

In this study, it was aimed to explore the association between dyadic adjustment and psychological symptoms of woman in Turkey. Moreover, by obtaining data in two time points in therapy, it was also aimed to gain more information about how individual and relational symptoms change throughout three months of therapy. Couple and family therapy is a newly emerging academic field in Turkey and there are not many clinical studies investigating relationship between different presenting problems, and psychotherapeutic process and outcome studies are very scarce. With this preliminary study, we intend to fill a gap in the literature and also come up with recommendations for future research and clinical work.

In the following sections initially systemic theory and how it approaches to couple relationship is presented. Furthermore, the notion of dyadic adjustment and

the factors associated with it are expressed. Following this, the association between individual symptoms and dyadic adjustment is analyzed based on the related literature. Finally, individual symptoms are examined based on the systemic theory and research about the treatment of individual symptoms through systemic model is revealed.

1.1. SYSTEMS THEORY

Gaining greater impact by 1950s, Systemic Theory expressed that intimate relationships are not a sum total of behaviors, but a totality of interactions formed by the individual experiences of the partners (Selvini-Palazzoli, Boscolo, Cecchin & Prata, 1978). According to systems theory, the characteristics of an organism or a living system is more than the sum total of the individual characteristics of parts constituting that system and the structure of the system arises from the interpersonal interactions and relations of those parts (Becvar & Becvar, 1996). Degrading the system into smaller isolated parts does not give the general information about the system itself. Like in all living systems, homeostasis is established and protected through the circular interactions and behaviors of the members of family. The notion of circularity in the theory is influenced by the notion of cybernetics affirmed by Bateson (1972). The notion of cybernetics explain that families are constantly changing, dynamic systems which is then used for explaining the circularity of interactions by the Milan Group who gave the name “Systemic Therapy” to the practice (Selvini-Palazzoli, et al., 1978).

Earlier studies which focus on couple relationship assumed that individual differences such as personality characteristics, culture, individual history, past experiences, habits, values, choices and behaviors are affected by the couple relationship. According to systemic theory, interpersonal interactions of two people cannot be solely explained based on the characteristics of the partners, but they should be considered as dynamic and changing patterns constantly impacting each other and getting impacted by the social context as well (Carey, Spector, Lantinga, & Krauss, 1993; Fidanoğlu, 2007; Lim & Levy, 2000). Focusing on

interpersonal relationships and expectations, repetitive causality between interactions and symptoms, systemic oriented therapists use family members' perception of problems, resources and possible solutions by mobilizing all members and all resources (Retzlaff Sydow, Beher, Haun, & Schweitzer, 2013).

More importantly, systemic therapy focuses on analyzing how family members behave in manners that perpetuate the presenting complaint (Nichols & Tafuri, 2013). This is not about pointing multiple people to be blamed but about showing the circularity of the development of the problems. The circular approach to problems widens the focus from individuals towards patterns of interactions by avoiding cause-effect relationships (Nichols & Tafuri, 2013). Instead of joining families in the unfruitful search of the guilty one, circular thinking helps families to understand that problems emerge through ongoing sets of interactions. The members who are labelled as "sick" or "problematic" may be behaving in certain way in order to refrain from damaging the homeostasis. However, such conflictual cases occur in times when the interpersonal relations get firmer or when resistance to change is seen in the system. Such alarming situations may be arising from the members' incompetence to being flexible or from the continuation of invalid belief systems. This form of psychotherapy apprehends psychological symptoms in the social system people live in (Pinquart et al., 2016). The central aim is helping individuals to take the responsibility of their very contributions to the system and changing the conditions which contribute to the emergence of the individual symptoms (Pinquart et al., 2016; Stratton, 2010). Circular thinking helps to see how family members' or partners' actions may be perpetuating the problems and helps to discover how individual members contribute to the resolution conflicts. This perspective empowers family members or partners to become their own agents of change (Nichols & Tafuri, 2013). The change of the system is only possible with the changing of all members in the family not through the change of the member who has the psychopathology (Carr, 2014).

Systemic therapy aims identifying the symptoms, realizing new and formerly unknown perspectives, analyzing channels of communication and interaction, suggesting appropriate interventions for change, helping individuals to

take the responsibility of his contributions to the system and strengthening the resources by developing an integrative hypothesis (Stratton, 2005).

1.2. DYADIC ADJUSTMENT

The concepts of couple relationship, couple adjustment, relationship satisfaction, marital satisfaction are subjects of different studies and receive the attention of many researchers who aim to understand and to draw the psychological portrait of a qualified romantic relationship. How the relationship is formed, what do people feel during the journey, what the quality of the marriage is, how it affects the individuals within it or how its quality is measured are issues the researchers focus on (Tutarel-Kışlak & Göztepe, 2012). Kalkan (2002) explains that happiness is highly related to the level of adjustment to social environment. When two people form a romantic relationship, they get adapted to each other as well as to important life changes and they become an adjusted couple. As they get adapted to each other and to the changing life, they become an adjusted couple (Akar, 2005; Gülerce, 1996). Dyadic adjustment is defined as "the capacity of adaptation and problem solving" (LeMasters, 1957, p. 229). Furthermore, problems arising from the changing life-conditions take place within the relational zone, which make a couple move back and forth between more difficult or happier time-periods in a relationship (Gurman, 1975; Yüksel, 2013). Thus, Gurman (1975) argues that dyadic adjustment is defined through the impacts of those changing life conditions on the relationship.

What constitutes dyadic adjustment isn't the individual perception of the individuals but the quality of the relationship. Thus, the capacity of running a qualified relationship of both partners is important in the dyadic adjustment. Spanier (1976) considers couple adjustment as the output of a relational process that can be determined by certain criteria such as; situations that cause problems between couples, interpersonal tensions and concerns, satisfaction between couples, commitment to each other, and consensus on important matters for the continuity of the relationship. Dyadic adjustment emerges as partners reach on a

consensus on their differences which may cause problems, on interpersonal tensions and anxieties, on relational satisfaction and commitment, and on specific issues which are vital for the continuation of the dyadic relationship (Spanier, 1976). Also, according to Spanier (1976), dyadic adjustment is obtained as the spouses adapt to changing life-cycle circumstances in accordance with each other.

Couple adjustment is defined and examined in various ways (Erdoğan, 2007). According to Tutarel-Kışlak and Göztepe (2012) couple adjustment is a process in which couples attempt to repeat certain relational systems and situations they have learned from their family of origins and past experiences. Sabatelli (1988) describes couple adjustment as a relationship in which spouses communicate effectively, where there is not much disagreement in important areas of marriage, and where disagreements are resolved to equally please both sides. Kocadere (1995) and, Şener and Terzioğlu (2002) argue that for the couples to be adjusted to each other it is necessary for them to have an effective interpersonal communication, to have similar values and goals, to take decisions collectively, to be concurrent on their relationships with the extended family, on leisure activities and on the management of domestic economy. Similarly, Özgüven (2000) suggests that healthy and adjusted couples, share and understand their emotions, have an empathic approach towards each other, accept the individual differences, receive and show affection, cooperate, use humor, fulfill each other's' primary needs, solve problems without conflicting, appreciate each other, spend leisure time together, have faith in the relationship and have the capacity of coping with difficulties. Yüksel (2013) states that marital adjustment can be evaluated in terms of interpersonal differences leading to conflicts among couples, interpersonal tensions and anxieties, relational satisfaction, relational commitment and similarity of opinions on vital relational issues.

It is difficult to make consensus on a single definition of couple adjustment because a variety of psychological, social, personal, and demographic factors are found to be related to dyadic adjustment. The initial studies to measure dyadic adjustment began in the 19th century (Zaider, Heimberg, & Iiada, 2010). Different

definitions were made by researchers and different measurement tools were developed. The first attempt to measure dyadic adjustment was made by Hamilton (1929). Hamilton (1929) used thirteen verbally answered cards to obtain satisfaction scores. Later, the researchers tried to measure dyadic adjustment by using different methods (Spanier, 1976). Marital adjustment was measured by three main approaches. First approach involves scales that use a total score measure which accept dyadic adjustment as a general factor. The amount of conflict between partners, the amount of shared activities, the level of perceived happiness and the perceived marital stability are analyzed. Marital Adjustment Test (MAT) developed by Locke and Wallace is one of the primary and well-known examples of this type of scales (Locke & Wallace, 1959). This scale is developed for measuring the quality of the marriage and used in many studies in the last 30 years as a valid and reliable tool (Tutarel-Kışlak, 1999). The standardization of MAT in Turkey is done by Tutarel-Kışlak (1999). The first question of MAT evaluates marital happiness. Other fourteen questions determine the level of cohesion between partners on the important interactional areas. The second approach suggested by Fincham and Bradbury (1987) and Sabatelli (1988) addresses particular concepts as predictor variables of the global perception of marital quality while measuring global perception of marital quality as a dependent variable. Norton's Quality Marriage Index (1983) is one of such tests.

Third approach assesses marital quality by measuring several sub concepts. Both multiple determinants of the general structure and sub concepts are utilized for evaluating marital success, marital satisfaction or marital adjustment. Thus, each sub concept can be used alone for evaluating the different dimensions of the general structure. Spanier's (1976) Dyadic Adjustment Scale (DAS) including subscales of dyadic consensus, dyadic cohesion, dyadic satisfaction and affectional expression is a widely used example of the third approach. Spanier (1976) developed DAS for evaluating different personal and relational characteristics such as disagreements, tendency to divorce, anger, jealousy, malfunctioning interactions or financial conflicts which are used for understanding marital adjustment. DAS is standardized by Fışıloğlu and Demir

(2000) in Turkey. In this categorization, dyadic satisfaction refers to sense of satisfaction for both partners along with the existence of factors creating the satisfaction (Scorsolini-Comin & Santos, 2012). Such an examination opens the way for understanding how each partner experiences marriage in terms of well-being, confidence in partner, resolution of conflicts and the sense of divorce. Moreover, dyadic consensus covers the perspective, shared ideas and agreed behaviors about key dimensions of marriage such as career organization, household tasks, values and social roles. This concept is understood through questions about family, goals, career decisions, time spent together and important values. The third domain, cohesion, involves the feeling of union sharing and integration among the partners. This dimension is examined via involvement in activities together, amount of exchange of ideas and the experience of working collectively in any project in life. Cohesion also includes shared intimacy and a feeling of connectedness which lead to the formation of a bond between partners which protects the relationship from the interference of external factors such as extended family, working hours or extra-marital affairs. The last dimension, affection expression is a subjective notion conveying couples' agreement or disagreement about the amount of displays of care, affection or sexual attraction.

1.2.1. Factors Affecting Dyadic Adjustment

Many studies are conducted for understanding which factors influence the dyadic adjustment and for analyzing dyadic adjustment based on various determinants. There is evidence to claim that while adaptive behaviors are related to dyadic adjustment, maladaptive behaviors are linked with maladjustment and relational distress (Beach & Whisman, 2012). According to Larson's (2003) triangle model in marriage, the factors determining dyadic adjustment are grouped under three categories, individual characteristics, couple characteristics and environmental factors which are then divided in two as problems and positive characteristics within themselves. While problems in individual characteristics are difficulties in coping with stress, dysfunctional thoughts, extreme reactivity,

extreme anger and offensiveness, untreated depression and extreme shyness; positive attributes are extroversion, flexibility, self-confidence, assertiveness, submission and love (Larson, 2003). Birtchnell and Kennard (1983) claim that some individual characteristics such as dependency, detachment and directiveness negatively affect the continuation of the relationship whereas characteristics such as dependability positively affect dyadic adjustment. Fidanoğlu (2006) analyzed the relation between humor style, anxiety level and dyadic adjustment among 225 married couples. The analysis revealed that higher humor capacity positively affects dyadic adjustment whereas the limited capacity of humor negatively affects dyadic adjustment.

Problems in couple characteristics are negative relational styles; positive characteristics are effective communication skills, problem solving skills, integration, closeness, power equity and compromise. Social and emotional supportive attitudes such as closeness, sharing of emotions and being understood by each other strengthen mental and social well-being of partners (Sayers, Kohn, & Heavey, 1998; Williams, 1997). Resolving differences through communication and the feeling of being understood are important factors separating happy couples from unhappy ones (Aktaş, 2009). Davis and Oathout (1987) studying with 264 romantic couples found that perspective shifting is also a very strong predictor of various behaviors affecting dyadic satisfaction. Furthermore, Tutarel-Kışlak and Çabukça (2002) argued that empathy is an important determinant of dyadic adjustment. The findings of Gottman (1998) shows that couples giving importance to equity in the relationship report higher dyadic adjustment. For couples who don't have the will to share, who don't need to resolve conflicts or who don't take decisions collectively, communication and interaction influence dyadic adjustment in a limited way (Basco, Prager, Pita, Tamir, & Stephens, 1992). Gottman and Krokoff (1989) also convey that communication behaviors such as defensiveness, obstinacy and avoidance decrease dyadic adjustment (Yüksel, 2013). Furthermore, the exaggerated expectations partners develop in the initial years of the marriage and the unfulfillment of those expectations in the following years negatively impacts dyadic adjustment (Kalkan & Ersanlı, 2008).

Environmental factors are family of origin characteristics, differentiation from family, social support, work stress, parenting stress and other external sources of stress (Larson, 2003). Terry and Kottman (1995) argue that support to each other, sharing of duties and responsibilities, struggling together to solve the problems and collectively supporting the household income increase a couple's adjustment. Couples, who set up the balance in spite of all different characteristics inherited by their family of origin and by their very personal experiences, succeed having an adjusted relationship (Mert, 2014). According to Aminjafari, Padash, Baghban and Abedi (2012), capacity of working, level of social support, social environment, positive feelings and the opportunity of gaining new skills and information strongly predict dyadic adjustment scores. On the other hand, in a study conducted among Pakistani couples, Batool and Khalid (2012) searched for the effects of demographic values and emotional intelligence on dyadic adjustment. The findings of this study revealed a negative correlation only between the number of children and dyadic adjustment. Overall, many studies stated common problem areas which cause deterioration in marriage are the continuation of dysfunctional interactional styles, problems related to sexuality, different gender role expectations, not being open and honest, non-empathic understanding, failing to adapt to cultural changes differently adjusting to changing life conditions, differences on income level, unemployment, extra-marital affairs, differences on child-rearing styles, having disabled kids or infertility (Özgüven, 2000). When compared to distressed or separated couples, those who are in adjusted and satisfying relationships have better psychological and physiological health and they experience better living conditions in terms of finances, child-rearing practices and longevity (Carr, 2014; Snyder & Halford, 2012).

1.3. COUPLE RELATIONSHIP AND PSYCHOLOGICAL WELL-BEING

1.3.1. Associations between Dyadic Adjustment and Psychological Symptoms

The concept of dyadic adjustment is utilized by many scholars for understanding how individuals in romantic relationships are influenced by interpersonal interactions. Studies approaching to dyadic adjustment as an outcome variable, accept interpersonal behaviors as predictors of relational well-being (Bradbury, Fincham, & Beach, 2000). Intimate relationships are vital sources of social support because when compared to non-cohabiting friends and relatives, individuals in marriage or cohabitation share the same space and time every day, they participate in various leisure activities together, they share financial and domestic responsibilities and this sharing of life creates both support and conflict (Carr & Springer, 2010; Robles, Slatcher, Trombello, & McGinn, 2014). Social support is one of the most documented factors affecting general health (Robles et al., 2014). Main-effect model suggests that greater social integration gives an individual identity, purpose, control, a perceived sense of security and embeddedness, besides providing reinforcement for health-promoting behaviors, regardless of whether one is under stress or not (Berkman, Glass, Brissette, & Seeman, 2000; Robles et al., 2014). In the stress-buffering model, adverse effects of outside stress are diminished by the existence of social support (Cohen & Wills, 1985). On the other hand, individuals in relationships characterized by conflict, dissatisfaction and decreased support are at higher risk for the occurrence of psychological disorders (Overbeek, Vollebergh, Graaf, Scholte, Kemp, & Engels, 2006). The relationship problems severe or chronic in nature, act as interpersonal stressors increasing the likelihood of the development of mental health problems (Funk & Rogge, 2007; Whisman & Baucom, 2012). Thus, by affecting the individuals in it, stressful intimate relationships are associated with the development of psychiatric symptoms and disorders (Donald, Whisman, & Paprocki, 2012). Furthermore, distressed relationships are found to be related with internalizing pathologies (Beach & Whisman, 2012; Proulx,

Helms, & Buehler, 2007), whereas relational satisfaction is associated with life satisfaction, higher self-esteem and happiness (Be, Whisman, & Uebelacker, 2013; Proulx et al., 2007). Furthermore, experiencing maladjustment and conflicts in intimate relationship is found to be related to higher demands for psychological support (Tutarel-Kışlak, 1999).

Many components of psychological well-being are analyzed in the relevant literature among married individuals who have mental problems. Having positive affect, higher self-respect and a belief that life is meaningful predict marital quality by increasing general well-being (Jabalamelian, 2011). Berry and Worthington (2001) similarly show that spouses in happier relationships have less psychological symptoms. Moreover, Levenson, Carstensen and Gottman (1993) suggested that marital satisfaction is positively related to general health and this relationship is found to be stronger for women when compared to men. Whisman (1999) interpreted the results from the National Comorbidity Survey, for covering the relationships between marital dissatisfaction and twelve-month prevalence rates of common Axis I psychiatric disorders in married people. The analysis shows that spouses with any anxiety, mood or substance-abuse disorders reported significantly higher relationship dissatisfaction than spouses without mental disorders. Furthermore, a 12-month longitudinal study of Whisman and Bruce (1999) conducted among married adults who aren't diagnosed with a mental disorder at baseline showed that marital discord is associated with increased risk of depression (Donald et al., 2012).

As conflictual relationships negatively affect mental health, existence of psychological problems negatively impact relationship adjustment. Psychological symptoms predict three major aspects of daily functioning: overall relationship sentiment, serious conflicts with one's spouse, and the quality of interactions, while individual symptoms generally showed the greatest associations with aspects of conflict (South, 2014). Specifically, mental health problems decrease positive marital elements such as couple cohesion, spousal dependability, and intimacy (Whisman & Baucom, 2012). Dyadic dissatisfaction increases negative marital elements such as verbal and physical aggression, severe spousal

denigration, criticism, and blame, thus hindering partners' personal well-being. For example, the partners of depressed individuals report that they experience a variety of burdens associated with living with the depressed person. Individuals are likely to differ in how well they adapt and accommodate to the changes brought on by their partner's mental health problems (Proulx et al., 2007). Such changes in mental health may lead to the withdrawal of one partner from the relationship or the increase of conflicts between partners. Therefore, irrespective of how they develop, mental health problems may increase the likelihood of relationship discord, which in turn may increase the likelihood of maintenance or recurrence of psychiatric symptoms (Whisman & Baucom, 2012).

1.3.1. Psychological Well-Being

Mental well-being is related to individuals' self-actualization, coping with daily life stress, working productively and effectively and living adaptively in the social field (Göztepe-Gümüş, 2015). On the other hand, relationship discord is associated with the occurrence, maintenance and recurrence of various mental health problems. Various measures are used for understanding which psychopathologies are related to relationship discord. Brief Symptom Inventory, as one of the widely preferred tools, measures the psychological problems that are associated with stress resulting from relational problems. BSI measures the mental health with a wide perspective and is also preferred because it is easy and fast for recognizing psychopathology (Savaşır & Şahin, 1997). BSI is also used in this study for examining the mental health of participants and for observing the change obtained through therapy. The psychopathologies diagnosed through BSI such as depression, anxiety, negative self, somatization and hostility are also the subscales. Depression subscale reveals the existence of unhappiness, loneliness and negative feelings towards self. Anxiety subscale examines the existence of nervous feelings. Negative self is related to the feelings of inefficacy, unworthiness and guilt. Somatization is related to having chronic pains without

physiologically explainable reasons. Hostility subscale covers the behaviors of anger and aggressiveness.

1.3.1.1. Depression

The link between marital adjustment and depression, and how this link is established receive major attention from scholars (Robles et al., 2014). Studies reveal the negative correlation between marital adjustment scores and depressive symptoms (Düzgün, 2009; Tutarel-Kışlak, 1999; Tutarel-Kışlak & Göztepe, 2012; Whisman, 2001). Depression is found to be related with marital discord (Robles et al., 2014) and similarly marital discord is associated with elevated risk of relapse in depressive symptoms (Kılıç, 2012). Longitudinal studies demonstrate that baseline levels of depressive symptoms predict marital stress and increased depressive symptoms at follow up measurements (Donald et al., 2012). This data among middle-aged participants is repeated among newlywed couples and the same results are obtained (Berry & Worthington, 2001).

The findings showing that people in unhappy romantic relationships gradually become more aggressive, anxious and alienated is relevant with the current studies of depression which argue that negative relational experiences increase the risk of depression (Akar, 2005). Repeating aggressive attitudes, lasting negative emotional states and experiences observed in maladjusted romantic relationships provide the conditions which give rise to negative affective mood observed in depressive individuals (Akar, 2005). The analysis of Johnson and Jacob (2000) shows that 50% of depressed people report lower levels of marital adjustment. Keeping in mind the bidirectional nature of depression and marital discord it can be said that spousal dysfunction in intimate relationships, whether emerging among non-depressed partners or not, becomes a stress factor for the later development of depression (Robles et al., 2014).

Studies focusing on women's scores of marital quality and depression reveal that women who have maladjusted relationships report higher levels of depression and stress (Johnson & Jacob, 2000) while men show dysthymia

(Whisman, Snyder, & Beach 2009). It is noteworthy that women are found to be reporting higher levels of depression when compared to men (Hafner & Spence, 1988; Whitton & Kuryluk, 2012). This situation suggests that gender role expectations and extended family factors may be strongly operating on women, defining women's relationships with their partners (Ünal et al., 2002; Yüksel, 2013). Erdoğan (2007) reports that 48% of women who experience marital discord also have depression (Tutarel-Kışlak & Göztepe, 2012).

Davila, Bradbury, Cohan and Tochluk (1997) argue that instead of trying to figure out whether marital discord or depression is a stronger predictor of human behavior, it is meaningful to focus on the interrelation of those mechanisms (Yüksel, 2013). According to Stress Generation Model demonstrated by Davila and colleagues (1997) depressed partners reflect their symptoms to the marital interaction which turns into a continuing cycle where both depressive symptoms and marital dissatisfaction increases. On the other hand, according to Marital Discord Model of Depression, that marital/familial discord associated with marital stress, loss of intimacy and loss of support increases the depression (Beach, Sandeen, & O'Leary, 1990). According to this model verbal and physical aggression, threat of separation or divorce, insulting, critical attitudes and blaming behaviors in marriage lead to depressive symptoms by increasing stress (Yüksel, 2013). The increased depression then leads to increased marital discord (Tuncay-Şenlet, 2012). These two analyses highlight the reciprocal nature of the relationship between marital dissatisfaction and depression (Tuncay-Şenlet, 2012).

1.3.1.2. Anxiety

Intimate romantic relationships also play important role on the onset of anxiety disorders (Overbeek et al., 2006; Whisman, 2007; Yüksel, 2013). Studies show that symptoms of anxiety are highly observed in maladjusted relationships (Dehle & Weis, 2002; Gürsoy, 2004; Yüksel, 2013). McLeod (1994) presents anxiety as one of the key negative emotions operating on marital distress.

Relationship distress is related with an elevated risk for generalized anxiety disorder (GAD), social anxiety disorder, and posttraumatic stress disorder (PTSD) (Priest, 2013; Zaider et al., 2010).

Emphasizing the association between social anxiety and marital adjustment Filsinger and Wilson (1983) demonstrate that as individuals' anxiety scores increase, their marital adjustment scores decrease. Besides, Overbeek and colleagues (2006) claim that baseline scores of marital qualities predicts the scores of anxiety at 2-year-follow-up. Furthermore, a relation between wives' anxiety scores and husbands' daily reports of stress is demonstrated by Zaider and colleagues (2010), in addition to wives' self-report on their husbands' role in aggravating or decreasing their anxiety levels (Pankiewicz, Majkowicz, & Krzykowski, 2012; Priest, 2013). Yonkers, Dyck, Warshaw and Keller (2000) suggest that marital discord is strongly correlated with GAD and the longer duration of symptoms (Priest, 2015). Bowen's family systems theory (Kerr & Bowen, 1988) presents the theoretical linkage of GAD and marital distress (Priest, 2015). According to this theory family abuse or violence and low differentiation may be leading to relational stress and chronic anxiety (Priest, 2015).

On the other hand, Pankiewicz and colleagues (2002) also suggest that while marital quality plays a vital role on the onset of anxiety disorder, the existence of anxiety may also be operating on the disruption of marital quality. People suffering from anxiety develop poor interpersonal relationships especially with romantic partners and close relatives (Pankiewicz et al., 2012). McLeod (1994), by analyzing couples with at least one partner diagnosed with anxiety, shows that being in an anxious state may impair the processing of daily marital events and interactions, neutral behaviors of one partner may be perceived as negative by the partner who is experiencing anxiety. It is also possible that people with anxiety may be engaging in interactions that results with negative reactions thus jeopardizing the potential of support and closeness (Zaider et al., 2010).

1.3.1.3. Somatization and Physical Health

Although being scarcer, the studies analyzing the relation between somatization, physical health and marital quality show that poor interpersonal relations leading to increases in stress hormones cause alterations in endocrine system (Berry & Worthington, 2001). Moreover, chronic endocrine stimulation is associated with poor immune functioning and cardiovascular diseases (Berry & Worthington, 2001; Yüksel, 2013). While greater negative affect is related to cardiovascular and neuroendocrine reactivity (Robles & Kiecolt-Glaser, 2003), emotional disclosure in the marital interaction is found to benefit immune functioning (Robles et al., 2014).

Study conducted by Fidanoğlu (2007) reveals that marital adjustment, similarity of ideas and expression of emotions are inversely related to somatization. Moore and Chaney (1985) emphasizes the relation between chronic pain and marital adjustment, showing that chronic pain is seen more among individuals in maladjusted relationships when compared to individuals in adjusted relationships (Fidanoğlu, 2007). As an example, Meana, Khalife and Cohen (1998) studying the dyspareunic pain among women showed that depressive symptoms, anxiety and maladjusted marriage are highly related to dyspareunic pain. Besides, researches revealed the association between marital stress and cancer, cardiovascular diseases and chronic pain, emphasizing that women report more negative health conditions when compared to men (Yüksel, 2013).

Nakao and colleagues (2001) analyzed the gender, marital status and somatic symptom characteristics of out-patients who applied to clinic. Their analyses show that women report more by number and more frequent symptoms of fatigue, headache, costiveness and sickness when compared to men, even the impacts of age, marital status, depression and anxiety are controlled (Yüksel, 2013). According to Birtchnell and Kennard (1983) the reason why women are more negatively impacted from marital stress in terms of general health is related to them investing more into relationship when compared to men. Besides gender, analyzing the cultural structure is meaningful for understanding the relation

between marital adjustment and somatization since in eastern cultures where emotions are not expressed directly, somatization among maladjusted spouses is expected to be higher than western cultures (Yüksel, 2013).

1.3.1.4. Hostility

The relation between hostility and health may be examined in terms of aggravated physiological reactivity to stressors, higher psycho-social vulnerability, increased interpersonal conflict and decreased relational support which all lead to the creation of a more hostile environment (Baron, Smith, Butner, Nealey-Moore, Hawkins, & Uchino, 2007; Brummett, Barefoot, Feaganes, Yen, Bosworth, Williams, & Siegler, 2000). Hostility, in terms of cognition contains the idea that people are not actually good or trustworthy. Studies reveal that hostile people have lower levels of social support and higher interpersonal conflict (Baron et al., 2007; O'Neil & Emery, 2002) which create an environment suitable to increased stress and depression (Brummett et al., 2000).

Marriage is a key context for understanding the interpersonal and intrapersonal dynamics of hostility. Studies show that existence of a hostile husband generates negative affect on women as well, but hostile affect impacts the well-being of both men and women (Brummett et al., 2000). Also, the relation between hostility and depression provides a context for commenting on the relation of hostility and health (Brummett et al., 2000). Miller, Marksides and Ray's (1995) research among 1125 Mexican-American men and women shows that higher irritability is associated to separation, divorce and not being married at follow up. One other study conducted among 53 newlywed couples demonstrate that higher hostility scores of males is related to greater decrements in marital quality over a three-year period (Baron et al., 2007). Uchino, Cacioppo, Malarkey and Glaser (1995) conducted an analysis of hormones (prolactin, epinephrine, norepinephrine, ACTH) and stress-related hormones in the blood (Fidanoğlu, 2007). Their analysis shows that stress level is related to hostile behaviors thus interpersonal negative relations continue to exist as partners fail to soothe

themselves (Fidanoğlu, 2007). Gottman (1998) explained the relation between hostility and marital quality suggesting that wives' high intensity of anger leads to a demand-withdraw pattern where women demand a change and men avoid that demand. Negative interpersonal communication and higher aggression is found related with marital adjustment (Göztepe-Gümüş, 2015; Tüfekçi-Hoşgör, 2013). Last, partner's hostility is also related to less favorable therapeutic outcomes while non-hostile attitudes are associated with better therapeutic outcomes (Priest, 2015; Zinbarg, Lee, & Yoon, 2007).

1.3.1.5. Negative Self

Rosenberg (1979) describes the notion of self as the sum of the emotions and thoughts an individual find in himself. On building up their notion of self, people are influenced from others by internalizing the views and attitudes directed to themselves thus beginning to see themselves the way others see, by comparing themselves to others and by attributing the reasons of various situations to their very selves (Cihan-Günör, 2007). Looking at the effects of marital adjustment on self-perception among married couples from different life-cycles, Schafer and Keith (1992) demonstrate that high marital adjustment is related to positive self-perception while marital discord is related to negative self-perception. Another analysis shows that self-respect is higher among married individuals when compared to divorced individuals. Examining the relation between gender, self-respect and marital quality Shackelford (2001) states that being exposed to extra-marital affairs and the complaints of jealousy and abuse coming from their wives, negatively impacts the self-respect of men. On the other hand, women's self-respect is negatively affected by their husbands' insults about their physical appearance (Cihan-Günör, 2007).

1.3.2. Effectiveness of Systemic Therapy

The growing literature since 2000 shows that systemic therapy grows as 70% (Pinquart et al., 2016). The positive effects were strong for the marital discord, psychosocial adjustment of couples, psychosexual difficulties and systems-related problems such as family abuse/violence (Carr, 2000; Binik & Hall, 2014; Stratton, 2005). Many studies claimed that systemic therapy is effective on encouraging the engagement in therapy of the family members in helping people to recuperate from these problems. Although the empirical findings for the benefits of systemic therapy on some disorders are still in early stages (Snyder & Whisman, 2003), many studies demonstrate that family therapy is effective on the treatment of conduct disorders, eating disorders, depression, substance abuse, chronic illness for adults, adolescents and children (Asen 2002; Cottrell & Boston, 2002).

Studies focusing on the relation between marital functioning and mental health reveal that in situations where people experience conflicts in their relationship the probability of positive outcome is lower in individual based therapy because individual based treatment models don't directly focus on the very problems experienced in the relational context which lead to the onset of mental disorders (Donald et al., 2012; Shadish, Montgomery, Wilson, Wilson, Bright, & Okwumabua, 1993; Whisman & Baucom, 2012). Similar studies demonstrate that relationship discord is related to poorer outcomes in individual psychotherapy (Donald et al., 2012). This suggests that intervening to relationship discord may positively impact the treatment of psychopathology (Whisman & Baucom, 2012). Even in cases where relationships problems are the outcome of one partner's psychopathology, positive changes in the symptoms may improve relationship discord (Whisman & Baucom, 2012). Once a relationship gets discordant, the patterns of interaction constantly reproduce itself (Epstein & Baucom 2002). So, the problematic interactional patterns in the relationship gain autonomy and keep existing even if the psychopathology of one partner improves (Whisman & Baucom, 2012). Also, even if the relationship problems predict one

partner's mental problems, healing the disorder without intervening on the relationship leaves people at risk of relapse of the disorder (Whisman & Baucom, 2012). On the other hand, improving relationship problems may appease an important stressor for the partner with psychopathology (Whisman & Baucom, 2012). This explains the positive outcomes obtained in couples' therapy on improving depression and relationship discord, even if the individual psychopathology is not targeted in the therapeutic process (Donald et al., 2012; Whisman, 2001).

In researching the relationship between individual and relational symptoms, the most common disorder that has been studied is depression. It can be argued that couple and family stress is a constant source of suffering for those with depressive symptoms (Beach & Whisman, 2012). Depressed individuals report higher marital discord than non-depressed people, and marital discord predicts increase of depressive symptoms and the onset of depression (Whisman & Beach, 2012). Wade and Kendler (2000), by comparing the baseline and 12-month follow-up depression scores of female twins, showed that higher marital problems predict the risk of major depression. Results of clinical trials show that couple therapy is influential in improving depressive symptoms and in derogating relational problems (Whisman & Beach, 2012). The results of meta-analysis conducted by Barbato and D'Avanzo (2008) stress that systemic couple therapy is comparable to individual based interventions in reducing depression and is also more influential than individual therapy in ameliorating relationship adjustment.

The couple therapy approach to treat depression aims increasing couple harmony through increased caring attitudes and support, couple activities and by reducing stressors in the relationship (Carr, 2014; Whisman & Beach, 2012). As such, by ameliorating communication, by creating problem solving techniques and by helping partners to anticipate and to be prepared for relapse, couple therapy improves both individual symptoms of depression and interpersonal dynamics (Beach & Whisman, 2012; Whisman & Beach, 2012). The initial phase of therapy focuses on aggravating the ratio of positive interactions, diminishing demoralization and flourishing hope by showing the possibility of change (Beach

& Whisman, 2012). In sessions structured by the therapist, clients are provided with positive within session experiences and are motivated to have similar experiences outside of the therapy room (Carr, 2014).

There is some evidence that intimate relationship problems and anxiety disorders often coexist and reinforce one another in a recursive way. Various studies show the affective outcome of systemic therapy with anxiety disorders such as agoraphobia, panic disorder, post-traumatic stress disorder (PTSD) and obsessive compulsive-disorder (OCD) (Carr, 2014). Often family systems unwittingly keep maintaining the limited lifestyle of the anxious member (Carr, 2014). Partners or family members usually become a part of the dysfunctional process by inadvertently establishing interactions which keep the symptoms vivid. Such situations may lead to relationship distress as suggested by Renshaw, Steketee and Chambless (2005). The main aim of systemic family and couples' therapy on dealing with OCD is disrupting those malfunctioning interactional patterns and providing tools to the non-obsessed members for helping the obsessed member to overcome his obsessions and compulsions (Carr, 2014). Systemic interventions constitute an atmosphere within which members can support recovery of the anxious member by transforming the beliefs and interactional patterns which reinforce the disorder. Zaider and his colleagues' study (2010) demonstrates that the intimacy of the relationship may be treated as a resource for healing the psychopathology considering the wives' claim on the efficiency of their husbands on decreasing their anxiety, which in turn positively impact the dyadic adjustment scores of wives. Studies conducted show that anxiety symptoms may exist after individual-based treatment (Priest, 2015). Study of Renshaw and colleagues (2005) reveals that besides being just as effective as individual therapy, systemic approach is most of the time more effective than individual based treatment models for healing OCD.

Treatment of somatization and physical illness is another research topic of family therapy literature. In cases of chronic illness such as cancer, chronic pain or heart disease, systemic therapy is offered as part of multimodal programme of medical care (Rolland, 1994). Interventions include psycho-education about the

illness and the needed accompanying emotional regulation capability (Carr, 2014). Therapy also becomes a support mechanism for both the person with illness and for other members in the family (Carr, 2014). In a meta-analysis constituted of fifty-two randomized controlled trials among 8,896 patients Hartmann, Bäzner, Wild, Eisler and Herzog (2010) showed that for a wide range of conditions such as heart disease, stroke, cancer and arthritis, systemic interventions result in better physical and mental health for the patient and other members of the family.

Several accounts suggest that relational interactions are effectively treated by systemic therapy. Besides being clinically instrumental for the treatment of various individual or relational problems (Snyder & Whisman, 2003; Fals-Stewart, Yates, & Klostermann, 2005; Stratton, 2005), systemic therapy is more beneficial since it helps more than one client at the same time and it changes the interactional context of the family within which people develop certain pathologies (Fals-Stewart et al., 2005). Transforming the familial context diminishes the risk of onset and relapse of various pathologies thus it guarantees that improvements achieved in individual therapy will not be undone when the patient returns to the family environment (Fals-Stewart et al., 2005). The resource/strength-oriented perspective it provides and positive reframing supporting this orientation lead to highly effective interventions in the relational context (Retzlaff et al., 2013). Besides in systemic perspective, even a small positive change obtained by a single member of the family will impact the whole system and will establish new forms of interactions (Fals-Stewart et al., 2005; Stratton, 2005).

There have been attempts to understand if marriage and family therapy is useful and if so, how useful it is. Furthermore, Benson, McGinn and Christensen (2012) suggest five principles commonly observed in effective couples therapy: changing the couple's perception of the presenting complaint towards a more objective, dyadic and contextualized view; diminishing dysfunctional emotionally triggered behavior; uncloaking emotional, formerly avoided thoughts; ameliorating constructive communication; elevating strengths and resources,

through a well-formulated clinical case which covers couple's interactional patterns leading to the formation of stress.

On the other hand, there have been evidence suggesting that psychotherapy isn't effective due to the very contributions of the different therapeutic models but rather, in all types of therapies, there are common effective change processes (D'Aniello & Fife, 2017). The four-factor model proposed by Lambert (1992) presents four common elements of change. Extra-therapeutic factors making 40% of change, relationship factors as contributing to 30% of change, model/technique factors as accounting for 15% of change and expectancy factors as making 15% of change. Extra-therapeutic factors are treatment setting, therapeutic alliance, therapist and client variables (D'Aniello, 2013). Therapeutic relationship, apprehended in terms of therapeutic alliance includes the bond between therapist and client, and the negotiation of goals and tasks in treatment (Balestra, 2017). The strength of the therapeutic alliance proposed as the most important therapist-related factor affecting therapeutic outcomes, regardless of the practiced model. Therapeutic alliance is impacted by three components: the client's characteristics, the relationship between therapist and client, and the person of the therapist (D'Aniello, 2013; Sprenkle, Davis & Lebow, 2009). The person of the therapist includes factors such as therapist's facilitative conditions, interpersonal style (Fife, Whiting, Bradford, & Davis, 2014), flexibility, respectful attitudes, trustworthiness, interest and openness, which positively impact the therapeutic relationship (Ackerman & Hilsenroth, 2003). The observable characteristics of therapist such as gender, race, age and training also contribute to therapeutic relationship (D'Aniello & Fife, 2017). Research shows that, a strong relationship between client and therapist is vital for a successful treatment (Balestra, 2017; Blow, Davis & Sprenkle, 2012). Who the therapist is thus becomes more important than the preferred technique for his/her professional role (Fife et al., 2014). Such components become more complex in family and couple therapy since there are more than one clients and more than one client-therapist relationships. The strong relationship between the therapeutic alliance and therapy outcome, directs clinicians to assess the therapeutic alliance day-to-day basis with

their clients. The Session Rating Scale (SRS) developed specifically as clinical tools for therapists to use during therapy (Duncan & Miller, 2013). SRS helps clinicians to understand client's perspective of the therapeutic alliance. SRS provides a tool for clients to evaluate the alliance they formed with the therapist on following items: the relational bond between the client and the therapist; agreement on the goals set for therapy; and agreement on the tasks decided in therapy. The client's opportunity to voice negative feelings and reactions to the therapist shows the strength of the therapeutic alliance. SRS encourages clients to detect alliance-related problems and to elicit those problems during sessions for helping clinicians to touch the issues during sessions and to change certain conditions to better serve client's needs and expectations. In situations where negative client experiences are reported, the use of self-report outcome instruments offer the therapist to make changes in the approach or style (Campbell & Hemsley, 2009).

Family and couple therapists must always give importance to building and maintenance of therapeutic alliance (Wilson, 2010). Just like therapist factors, client factors are also influential on therapy, regardless of the therapeutic model, since the personhood of the client, brought into the therapy room, is the most instrumental notion upon which the therapy is built (D'Aniello & Fife, 2017). Similarly, expectancy variables which is client's belief or expectation that therapy will be useful, impacts the outcome of therapy (D'Aniello & Fife, 2017). To analyze and to keep the track of the therapeutic relationship, therapist may either indirectly observe signs of erosion and alliance, may directly ask questions about the quality of the relationship or may actively measure the strength of alliance through different instruments (Wilson, 2010).

CHAPTER II

CURRENT STUDY

2.1. Scope of the Current Study

The main purpose of this study is getting more information about the relation between psychological symptoms and couple adjustment, which is an important component of dyadic relationship. As seen in the literature, an important relationship is found between dyadic adjustment and various psychological disorders. Although, the studies mostly cover depressive symptoms and anxiety, considerable amount of studies examined the relation of dyadic adjustment with problems of self-confidence, somatization and anger. The initial studies on the issue stress that psychological symptoms impact dyadic adjustment but the later studies emphasize the bidirectional nature of this relationship. The maladjustments in the dyadic relationship become stress factors for individuals, negatively affecting the mental health. It is important to examine the relationship between dyadic adjustment and psychological symptoms, without aiming to reach to a causation.

This study aims to obtain detailed information about dyadic adjustment, an important characteristic of intimate relationship. The second aim is revealing the relationship between dyadic adjustment and psychological symptoms. Last goal is examining the change of dyadic adjustment scores of individuals receiving systemic therapy and revealing the relationship between the change in dyadic adjustment scores and psychological symptoms. The pre-therapy and post-therapy dyadic adjustment data of individuals receiving psychological support, is analyzed for observing the change in the scores. In the analysis, the dyadic and individual symptoms of 12 individuals who continued to therapy for 3 months, are statistically analyzed. In the later stage, the detailed information of four couples among those 12 individuals, who applied for couples' therapy, is focused on. Examining the relational and individual changes of four couples who applied for

couple therapy will help to understand what is experienced during three months of therapy.

Receiving detailed information about the elected couples will provide more extensive information about the similarities and differences among couples, and the change process. The initial and after therapy scores, the change in the general scores and subscale scores of those four couples are examined. The similarity and differences among partners in terms of scores, are also analyzed. Thus understanding the common and different factors among couples after three months of therapy, is aimed.

All the information gathered from this research will provide information to the ongoing research held in İstanbul Bilgi University Psychological Counselling Center. The obtained findings will be used both for further studies and for presenting extensive knowledge to intern therapists, teachers and supervisors in the center. It is possible to get information about the research based on this preliminary study. Although examining and presenting the cases in this manner isn't the best way to generalize the information and to report a causality, it is meaningful for analyzing and understanding the couples in a more detailed way, besides helping to reveal details which can go unnoticed in the general framework.

2.2. Method

2.2.1. Participants

The participants are individuals, couples and families who applied for psychological help to İstanbul Bilgi University Psychological Counselling Center, between October 1st, 2017 and August 1st, 2018, and who worked with intern therapists from Couples and Family Therapy branch of MA Program in Clinical Psychology. The initial evaluation of the participants are done by a clinical psychologist for the elimination of participants who are in need of urgent help or

who show symptoms of psychosis, eating disorders, trauma, autistic spectrum disorders, from the study. 47 applications are referred to couple and family therapists in the center between October 1st, 2017 and August 1st, 2018. Only 23 female participants who filled in the DAS and BSI are found eligible for the study. Among those 23 participants, 8 applied for individual therapy, 11 applied for family therapy and 4 applied for couple therapy. After the initial interview is done by a full-time therapist, 4 applications are referred to couple therapy, 4 of them are referred to individual therapy and the remaining 15 applications are referred to family therapy. After three months of therapy only the data of 12 participants scales was available for further analysis, among those 23 individuals. The remaining 11 participants either did not complete fill the scales or dropped out before the termination process. After the data screening, the study continued with 12 participants. The number of sessions ranged between 8 and 13.

The therapist samples of this study were 7 couple and family intern therapists, who completed the theoretical education year and began their internship year in the psychological counseling center. All therapists are female and their ages range between 24 and 40. The intern therapists in the center received three hours of group supervision and one hour of individual supervision during the internship. the interns are informed about the steps to follow during the therapy, before their sessions began. All intern therapists are beginning therapists who are inexperienced on the profession although being educated about clinical interviewing and psychotherapy process. Among those 7 therapists, the clients of 5 therapists continued the therapy for three months.

2.2.2 Instruments

Two questionnaires are used: Dyadic Adjustment Scale and Brief Symptom Inventory

Dyadic Adjustment Scale (DAS): Is a scale developed by Spanier (1976) for examining the relationship quality and styles of perceiving the relationship of

married or cohabiting couples. The standardization of the scale into Turkish is done by Özkan (1995), and the validity studies are held by Yavuz (1995). Fışıloğlu and Demir (2000) standardized the scale into Turkish by measuring the reliability and validity. The internal consistency reliability score of the Turkish DAS is .92, which is very close to the value of the original DAS .96 (Spanier, 1976). Also, reliability scores of subscales of the Turkish DAS were as follows: Dyadic satisfaction: .83; Dyadic cohesion: .75; Dyadic consensus: .75; Affectional expression: .80.

DAS is 32-item Likert scale. Besides the total score, scores of 4 subscales are retrieved from the scale. The sub-scales are dyadic consensus, dyadic satisfaction, dyadic cohesion and affectional expression. Dyadic satisfaction includes questions about negative and positive thinking patterns, and aversive communication patterns. Dyadic consensus subscale includes 13 items examining the compliance of partners on issues important for the relationship. Dyadic cohesion subscale is composed of 5 items measuring the quality and the content of the time partners spend together (Mert, 2014). Last, affectional expression examines the level of harmony of affection expression styles among partners, based on 4 items. Dyadic satisfaction score is determined based on items 16-23, 31, 32. Dyadic consensus score comes from items between 24 and 28. Dyadic cohesion score is obtained through items 1-3, 5, 7-15. Affection expression subscore is composed of items 4, 6, 29 and 30.

The highest score which can be obtained from the scale is 151 while the lowest score is 0, cutoff scores 105,2 is used to differentiate between distressed and non-distressed couples (Fışıloğlu & Demir, 2000). Couples who have a total score more than 105,2 are non-distressed while couples who have a total score less than 105,2 are distressed.

Brief Symptom Inventory (BSI): BSI developed by Derogatis (1983) is used for doing a general psychological symptom check (Cihan-Günör, 2007). It is a short version of Symptom Check List (SCL-90-R). 53 items from all factors are elected among the 90 items of SCL-90-R according to the load of the items. The standardization, reliability and validity of the scale is done by Şahin and Durak

(1994). The Turkish standardization of the inventory is composed of five factors which are, anxiety, depression, negative-self, somatization and hostility. The internal consistency of the inventory is between.96-.95 and between .55 - .86 for the subscales (Savaşır & Şahin, 1997).

The inventory is a 53-items Likert scale, ranging between 0-4, 0 being "not at all" and 4 being "extremely". The scores range between 0 and 212. The total score obtained from the inventory demonstrates the frequency and type of individual symptoms. The total score for each subscale is obtained by dividing the subscale score in the number of items in that subscale. Increases in the scores of each subscale and in the total score show the intensity of psychological symptoms (Savaşır & Şahin, 1997).

Anxiety subscale is composed of 13 items examining the existence of nervous feelings such as fear, worry, tension, irritability, panic, chokes, sweating and increased breathing. Depression subscale, having 12 items, reveals the existence of sorrow, pessimism, unhappiness, loneliness, negative feelings towards self, suicidal tendency, loss of interest and difficulty on decision making. Negative self, being composed of 12 items is related to the feelings of inefficacy, unworthiness and guilt. Somatization is related to having chronic pains in stomach and chest, nausea, shortness of breath and numbness, without having physiological reasons, which is determined via 9 items. Hostility subscale covers the behaviors of anger, aggressiveness, distrustfulness, or the will to harm or hurt a person or an object. Hostility subscale includes 7 items.

Demographic Information of the clients such as age, gender, level of education, occupation, trauma history, family roles and family boundaries were available in the client database. The demographic information of the clients was available in the program database and was shared with the researcher after the data collection procedure.

2.2.3. Procedure

In this study, data is received from the research conducted in İstanbul Bilgi University Psychological Counselling Center by the intern therapists of Couples and Family Department of MA Program in Clinical Psychology. An ethics approval by Istanbul Bilgi University for this process and for the outcome study was already obtained. The participants filled the consent form which informs them that the study is on voluntary basis and the data will be confidential. In this consent form information regarding the procedure and the aim of the study are also shared.

Intern therapists are informed about the therapeutic process and the rules of the psychological counselling center, before they begin their sessions. They are also informed about the steps to follow in the therapeutic process. The clients are asked to fill various scales to learn about their psychological, relational status and their past traumas before their first sessions. Those scales are given to clients in every three months. Besides those scales, Session Evaluation Scale is filled by both the therapist and the client after each session which helps the therapists to follow the process and to develop potential intervention techniques.

First three sessions are designed as intake sessions. The clients are given information regarding the therapeutic process and are asked open ended questions about their presenting problems in the first session, for obtaining general information. This process continued during following evaluation sessions. Evaluation sessions continued until adequate information is received about clients' significant past experiences and resources. The family genogram is formed during the evaluation sessions. Next, therapeutic goals are determined according to the presented problem. After the evaluation sessions are completed and the goals are established, the therapists completed the systemic case formulation and began to design their therapeutic process.

In family therapy whole family is invited to intake session. Later, parent sessions are conducted and experiential techniques such as play, psychodrama and art are used to assess and intervene dysfunctional interactional and communication patterns, reorganize structure and promote closeness between family members. In couple therapy sessions the partners attend the first session together, the following two sessions are held individually to understand the individual needs of each partner and continues together with the couple. While working with couples, therapists aim to reveal the dysfunctional interactional patterns and to help the partners develop new and functional interactional patterns through various interventions. In individual therapy sessions, the symptom presented by the client is evaluated in systemic perspective to understand the function of the symptom in the system. The role of the client in the family, his emotional needs and the ways to express them are evaluated and worked on for increasing the awareness.

CHAPTER III

RESULTS

In the beginning, the data is presented in a detailed way for the purpose of the study. The data of the study is received among the individuals applied for therapy. Some of the data is extracted from the analysis because some of the participants didn't fill the scales, some of them dropped out before the scales are completed and some of the scales included missing answers. After the data is presented based on demographic variables and dyadic adjustment scores, the relation between dyadic adjustment scores and individual symptoms is examined. The first part includes quantitative information and statistical information about the data. Finally, the second part focuses on detailed information of the selected cases. The detailed information of couples applied for therapy is explained based on their subscale scores of dyadic adjustment and brief symptoms.

3.1. Demographic Information about the Participants

Demographic information includes the data obtained from female partners in couples (See Table 3.1.). The mean age was 36.62, the youngest being 22 and the oldest being 50 (N = 21). 23 participants whose information is available at time 1, are all female. The analysis and examination were based on female participants among couples and families applied for therapy. 4 of the participants applied for personal reasons while 18 applied to therapy for couple and family problems. 8 of those requested individual therapy, 4 requested having a couples' therapy and 11 of the participants applied for having family therapy. After the applications are evaluated 4 are referred to couple therapy, 4 are referred to individual therapy and the remaining 15 are referred to family therapy.

10 of the participants are not working, and 11 are working at the time of initial survey (N = 21). 3 of the participants have primary school degree, 3 of the participants have high school degree, 8 of the participants are college degree and 3 of the participants are master's degree (N =17). When the relations with parents are analyzed, 13 participants answered about their relations with their mothers. 2 of them explained this relationship as close, 9 of them explained it as distant. When female participants' relationships with their fathers are examined it is seen that 4 participants expressed this relationship as close while 9 of them expressed it as distant. Looking at their roles in the family, 10 of 15 participants called their roles as caregiver. The other participants expressed themselves as invisible, caregiver & accusing, accusing, caregiver & accusing & fragile and scapegoat & accusing. 7 participants explained the boundaries in the family as unclear, 4 participants as rigid, 3 participants as balanced and 2 participants as inconsistent. In terms of social relations, 11 participants informed it as normal while 7 participants answered as having good social relations. Among 23 participants whose demographic information is taken, 15 participants answered about the existence of past traumatic experience. Among those 15 participants, 12 have a past traumatic experience.

Among 23 participants whose intake data is available, only 12 participants' data was available after three months of therapy, so the further analysis of change is done based on the information of those 12 participants. Detailed information about those participants can be seen in Table 3.2.

Table 3.1. Demographic Information at Time 1

Participants (N=23)		N	%
Reason for Application	Personal	4	17.4
	Family (Couple & Children)	18	78.3
Type of Help Expectation	Individual Therapy	8	31.8
	Family Therapy	11	50.0
	Couple Therapy	4	18.2
Education Status	Primary School	3	17.6
	High School	3	17.6
	College Degree	8	47.1
	Master's Degree	3	17.6
Economic Status	Lower Middle	6	27.3
	Middle	9	40.9
	Upper Middle	7	31.8
Traumatic Story	Exists	12	52.2
	Doesn't Exist	3	13
Relationship with Mother	Distant	2	30.8
	Close	13	69.2
Relationship with Father	Close	4	8.7
	Distant	9	86.7
Role in the family	Invisible	1	6.3
	Caregiver	10	62.5
	Caregiver & Accusing	1	6.3
	Accusing	1	6.3
	Caregiver & Accusing & Fragile	1	6.3
	Scapegoat & Accusing	1	6.3
Family Boundaries	Unclear	7	43.8
	Rigid	4	25
	Balanced	3	18.8
	Inconsistant	2	12.5
Social Relationship	Poor	0	0
	Medium	11	61.1
	Good	7	38.9

Table 3.2. Demographic Information at Time 2

Participants (N=12)		N
Reason for Application	Personal	4
	Family (Couple & Children)	6
Type of Help Expectation	Individual Therapy	4
	Couple Therapy	4
	Family Therapy	4
Education Status	Primary School	2
	High School	2
	College Degree	6
Economic Status	Lower Middle	4
	Middle	5
	Upper Middle	2
Traumatic Story	Exists	9
	Doesn't Exist	1
Relationship with Mother	Distant	4
	Close	6
Relationship with Father	Close	1
	Distant	8
Role in the family	Invisible	1
	Caregiver	5
	Caregiver & Accusing	1
	Accusing	1
	Caregiver & Accusing & Fragile	1
	Scapegoat & Accusing	1
Family Boundaries	Unclear	3
	Rigid	3
	Balanced	3
	Inconsistent	1
Social Relationship	Poor	0
	Medium	7
	Good	4

3.2. Assessment of Change in Dyadic Adjustment and Individual Symptoms before and after Therapy

3.2.1. Scales Score Change at Two Point in Time

For comparing the pre-therapy dyadic adjustment scores of participants who applied to counseling center for receiving psychological support to normal population, and for examining the change in dyadic adjustment scores after three months of therapy, dyadic adjustment scores of participants are examined (See Table 3.3.). According to the intake data obtained from the participants the mean score for sum of DAS at Time 1 was 90.2, with a maximum of 134 and a minimum of 36 (N = 23). For the subscales, the mean score for affection expression was 7.4, with a maximum of 12 and a minimum of 0 (N = 23), the mean score for cohesion was 11.9, with a maximum of 21 and a minimum of 2 (N = 23), the mean score for consensus was 42.4, with a maximum of 61 and a minimum of 17 (N = 23), the mean score for satisfaction was 28.5, with a maximum of 47 and a minimum of 10 (N = 23). The DAS score was compared to the normal mean score of the survey internationally, which is 105,2. The mean DAS score (90.2) was significantly lower than normal population dyadic adjustment score, which is an observed situation among Turkish women (Fışıloğlu & Demir, 2000). At the same time the partners having a score above 105,2 are treated as adjusted couples. It is seen that participants who apply for therapy have DAS scores lower than the average. When the subscale scores are analyzed the highest score is seen in the subscale of consensus.

After the three months of therapy, the scales are given for keeping the track of clients' current situation, the following data is obtained (See Table 3.3.). The mean score for sum of DAS at Time 2 was 97.5, with a maximum of 125 and a minimum of 45 (N = 12). For the subscales, the mean score for affection expression was 8.75, with a maximum of 12 and a minimum of 5 (N = 12), the mean score for cohesion was 13.08, with a maximum of 21 and a minimum of 5 (N = 12), the mean score for consensus was 42.25, with a maximum of 58 and a

minimum of 15 (N = 12), the mean score for satisfaction was 33.42, with a maximum of 41 and a minimum of 103 (N = 12). The DAS score was compared to the normal mean score of the survey internationally, which is 105.2. The mean DAS score (97.5) was lower than the normal population score after three months therapy process. This result showed that the average score approximated to population normal, unlike the observed situation among intake data at Time 1.

Table 3.3. Mean and Standard Deviation for the Subscales of the DAS for Time 1 and Time 2

	Time 1				Time 2			
DAS	Min	Max	X	Sd	Min	Max	X	Sd
Affection	0	12	7.43	3.5	5	12	8.75	2.3
Cohesion	2	21	11.91	5.14	5	21	13.08	4.79
Consensus	17	61	42.35	12.73	15	58	42.25	11.77
Satisfaction	10	47	28.52	10.03	13	41	33.42	7.22
Total Score	36	134	90.22	27.76	45	125	97.5	21.27

When the individual symptoms data received from the participants is analyzed it is seen that the mean score for sum of BSI at Time 1 was 64.5, with a maximum of 152 and a minimum of 2 (N = 23). For its subscales, the mean score for anxiety was 14.6, with a maximum of 40 and a minimum of 0 (N = 23), the mean score for depression was 19.6, with a maximum of 38 and a minimum of 0 (N = 23), the mean score for hostility was 8.1, with a maximum of 22 and a minimum of 1 (N = 23), the mean score for somatization was 7.7, with a maximum of 26 and a minimum of 10 (N = 23).

The individual symptoms scores obtained after three months of therapy reveal the following results (See Table 3.4.). The mean score for sum of BSI at Time 2 was 30.7, with a maximum of 68 and a minimum of 7 (N = 12). For its subscales, the mean score for anxiety was 7.1, with a maximum of 15 and a minimum of 2 (N = 12), the mean score for depression was 9.3 with a maximum of 19 and a minimum of 2 (N = 12), the mean score for hostility was 4.2, with a maximum of 10 and a minimum of 0 (N = 12), the mean score for somatization

was 3.9, with a maximum of 13 and a minimum of 0 (N = 12). A change is observed in individuals' individual symptoms scores after three months of therapy.

Table 3.4. Mean and Standard Deviation for the Subscales of the BSI for Time 1 and Time 2

	Time 1				Time 2			
BSI	Min	Max	X	Sd	Min	Max	X	Sd
Depression	0	38	19.57	10.92	0	19	8.8	6.1
Anxiety	0	40	14.57	9.67	0	15	7	4.9
Negative Self	0	35	14.65	9.18	0	24	7.6	7.1
Somatization	0	26	7.65	7.43	0	13	3.4	3.9
Hostility	1	22	8.09	5.32	0	10	3.83	3.3
Total Score	2	152	64.52	27.76	0	68	30.7	21.7

3.2.2. Associations between Dyadic Adjustment and Psychological Symptoms and its Subscales

One other purpose of the study is observing the relation between Dyadic Adjustment Scale and Brief Symptoms Inventory and to examine the relations between subscales. To see the relationship between the survey scores themselves, the descriptive statistics are followed up with correlations. Due to the sample size, Spearman's rank correlation is preferred over Pearson correlation, so all the correlations reported are nonparametric.

This study assumed that low levels of relationship adjustment is associated with high levels of the psychological symptoms. According to literature, a negative correlation was expected between dyadic adjustment and psychological symptoms. The DAS and BSI total scores were correlated, $r_s(23) = -.63$, $p = .001$, meaning as the score for DAS, and the couple's compatibility increased, the score for BSI, the psychological symptoms, decreased.

In order to examine the association of each subscale of dyadic adjustment with the sub scales of psychological symptoms, Spearman's rank correlation

coefficients were calculated (See Table 3.5.). Due to the sample size, Spearman's rank correlation is preferred over Pearson correlation, so all the correlations reported are nonparametric.

Focusing on the subscales further, the satisfaction subscale of DAS and all the subscales of BSI except hostility and negative self were negatively correlated meaning as the score for satisfaction increased, the score for the anxiety, depression and somatization decreased. The cohesion subscale of DAS and depression and negative-self subscales of BSI were negatively correlated, meaning as the score for DAS cohesion increased, the score for depression and negative-self decreased. The consensus subscale of DAS and all the subscales of BSI except hostility were negatively correlated meaning as the score of consensuses increased, the scores of anxieties, depression, somatization and negative self-decreased. The affection expression subscale of DAS and all the subscales of BSI except hostility were negatively correlated meaning as the score of affective expression increased, the scores of anxieties, depression, somatization and negative-self decreased.

Table 3.5. Correlation between the DAS and the BSI and their Subscales at Time 1

	Satisfaction	Consensus	Cohesion	Affection	DAS
BSI	-.47*	-.65**	-.40	-.64**	-.63**
Depression	-.45*	-.57**	-.45*	-.54**	-.58**
Anxiety	-.53**	-.67**	-.34	-.65**	-.63**
Somatization	-.48*	-.57**	-.33	-.44**	-.57**
Hostility	-.38	-.29	-.15	-.43	-.38
Negative Self	-.40	-.60**	-.39	-.59**	-.60**

** $p < .01$, * $p < .05$

To see the continuity in the relationship between the dyadic adjustment and psychological symptoms at Time 2, the correlations at Time 1 are followed up with correlations at Time 2 (See Table 3.6.). Due to the sample size, Spearman's

rank correlation is preferred over Pearson correlation, so all the correlations reported are nonparametric.

The DAS and BSI total scores were not correlated, meaning that the relationship of DAS and BSI scores became nonsignificant at Time 2, although the relationship between the survey scores were tighter at Time 1.

Table 3.6. Correlation between the DAS and the BSI and their Subscales at Time 2

	Satisfaction	Consensus	Cohesion	Affection	DAS
BSI	-.48	-.26	-.64*	-.34	-.48
Depression	-.44	-.25	-.66*	-.37	-.48
Anxiety	.05	-.21	.52	-.38	-.38
Negative Self	-.36	-.26	-.72*	-.22	-.49
Somatization	-.52	-.23	-.28	-.44	-.36
Hostility	-.30	- .12	-.47	-.21	-.29

** $p < .01$, * $p < .05$

3.2.3. Comparison of Dyadic Adjustment Scale Score and the Brief Symptoms Inventory Scores at Two Point in Time

To explore more details on the change of the dyadic adjustment score and psychological symptoms score after therapeutic process, the survey scores are compared with Wilcoxon signed-rank tests. This nonparametric measure is chosen due to the decreased sample size at Time 2.

A Wilcoxon signed-rank test showed some change in affective expression subscale of DAS, (Z = -1.94, p = 0.05), as evident in the change in the median affective expression score from 9 to 9.5. Another Wilcoxon signed-rank test showed some change in satisfaction subscale of DAS, (Z = -2.32, p = 0.02), and the median satisfaction score change from 27 to 35.

Table 3.7. Change in DAS and its Subscales from Time 1 to Time 2

DAS and its Subscales		
	Median at Time 1 (N = 23)	Median at Time 2 (N = 12)
Affection	9	9.5
Cohesion	11	13
Consensus	44	42
Satisfaction	27	35
Total Score	86	98

A Wilcoxon signed-rank test showed change in the total of BSI, ($Z = -2.90$, $p = 0.004$). This can be seen in change in the median total BSI score from 63 to 26. Focusing further on the subscales, this change continues in depression subscale of BSI, ($Z = -2.55$, $p = 0.01$), and this can be seen in the change in the median depression score from 20 to 8, as well as anxiety subscale of BSI, ($Z = -2.24$, $p = 0.03$) and the change in the median anxiety score from 15 to 6.5. A Wilcoxon signed-rank test also showed a change in negative-self subscale of BSI, ($Z = -2.65$, $p = 0.008$ and this can be seen in the change in the median negative self-score from 13 to 5. Somatization subscale of BSI was marginally significant, ($Z = -1.83$, $p = 0.067$) and this can be seen in the decrease in the median negative-self score from 5 to 2.

Table 3.8. Change in BSI and its Subscales from Time 1 to Time 2

BSI and its Subscales		
	Median at Time 1 (N = 23)	Median at Time 2 (N = 12)
Depression	20	8
Anxiety	15	6.5
Negative Self	13	5
Somatization	5	2
Hostility	6	3
Total Score	63	26

3.3. Detailed Examination of Four Couples in Couple Therapy

As seen in the statistical information provided above, the sample size is not adequate for testing hypotheses and for generalizing the results. Therefore, four couples, which have been chosen from 12 participants, will be explained descriptively in detail (See Table 3.9.). In the samples there are 4 families, 4 individual and 4 couple therapy applications and their test scores are used in the research. As the objective is to examine the relation between dyadic adjustment and individual symptoms, 4 couples applied for couple therapy, are chosen to examine. These couples will be examined according to demographic information and the change between dyadic adjustment and individual symptom scores.

When the scores of couples who applied for couple therapy are examined in detail, the reason of their application have been found as conflicts between them, couple intimacy problems and sexual problems. The issues that have been pointed in the therapy were parallel to couples' presenting problems. Sessions were continued after three months later. Only Couple 4 terminated their process. All four couples are married. Female participants were made the application for therapy. Participants' age range around 33 to 50. Their economic status range changed around middle, lower middle and upper middle. Except the male participant of Couple 2, all participants are Turkish and Sunni-Muslim. Male participant of Couple 2 is Alevi.

As it is seen, all female participants have traumatic history, but male participants do not. Except the male participant of the Couple 1, there is not any individual who is at risk. It is stated that, male participant of the Couple 1 has alcohol use problems. When the roles in the family have been examined, all female participants stated that they had caregiving role. On the other hand, female participant of the Couple 3 had accusing role; female participant of the Couple 4 expressed the roles of accusing and fragile besides the caregiving role. All male participants stated that they had invisible role in the family. Male participant of the Couple 4 added the scapegoat role. All the participants had medium or good levels of social relations.

Table 3.9. Demographic Information for Couples

	Couple 1		Couple 2		Couple 3		Couple 4	
	Woman	Men	Woman	Men	Woman	Men	Woman	Men
Reason for Application	Couple Therapy		Couple Therapy		Couple Therapy		Couple Therapy	
Type of Help Expectation	Couple Therapy		Couple Therapy		Couple Therapy		Couple Therapy	
Focus of Therapy	Couple attachment problems		Couple conflict, Sexual problems		Couple intimacy		Couple conflict	
No of Session	12		13		12		8	
Age	40	45	33	34	40	42	42	50
Education	Primary school	Primary school	Collage Degree	Collage Degree	High school	-	Primary school	Primary school
Occupation	House-wife	TV sector	Teacher	Teacher	Accounting	Sales Representative	House-wife	Self-employment
Economic Situation	Lower Middle	Middle	Middle	Middle	Middle	Middle	Lower Middle	Upper Middle
Country of Origin	Marmara	East Anatolia	Marmara	Central Anatolia	Marmara	Marmara	-	-
Ethnicity	Turkish	Turkish	Turkish	Turkish	Turkish	Turkish	Turkish	Turkish

Table 3.9. Demographic Information for Couples

Religion	Sunni	Sunni	Sunni	Alevi	Sunni	Sunni	Sunni	Sunni
Trauma Story	Physical violence, Sexual/ Emotional abuse	-	Physical/ Domestic violence, Emotional abuse	-	Physical/ Domestic violence, Neglect,	-	Early parent loss	-
Risk	-	Alcohol	-	-	-	-	-	-
Relationship with Mother	Close	Distant	Close	Distant	Distant	Close	Close	Distant
Relationship with Father	Distant	Distant	Distant	Distant	Distant	Distant	Death	Distant
Role in the family	Caregiver	Invisible	Caregiver	Invisible	Caregiver, Accusing	Invisible	Caregiver, Accusing, Fragile	Invisible, Scapegoat
Family Boundaries	Unclear	Inconsistent	Rigid	Balanced	Inconsistent	Rigid	Balanced	Rigid
Social Relationship	Medium	Medium	Medium	Medium	Medium	Medium	Medium	Good

When changes of scores of Dyadic Adjustment and Brief Symptom Inventory between initial and final measurement are examined in detail it is seen that dyadic adjustment scores of female participants were lower when they first applied for therapy. Especially two female participants who claim having the accusive and fragile in addition to the caregiver roles have the lowest dyadic adjustment scores.

Similarly, male participants have low dyadic adjustment scores except the male participant of the Couple 1 who has relatively higher dyadic adjustment score. Analyzing the change of scores from Time 1 to Time 2 it is seen that only Couple 1 showed increase in their dyadic adjustment scores. Also, dyadic adjustment of male participant of Couple 3 improved. Except these two participants, all other participants' dyadic adjustment scores increased even though their dyadic adjustment level remained lower than the average.

Table 3.10. Scale Scores at Time 1 and Time 2

	Woman				Man			
	DAS Time 1	DAS Time 2	BSI Time 1	BSI Time 2	DAS Time 1	DAS Time 2	BSI Time 1	BSI Time 2
Couple 1	97	119	55	11	118	127	21	13
Couple 2	93	98	22	7	76	83	67	13
Couple 3	86	99	75	41	85	116	26	20
Couple 4	49	86	152	56	80	103	33	31

When dyadic adjustment subscales are examined in detail, female participants had higher cohesion scores than male participants before they started to therapy. Similar relation is observed in the scores of male participants' satisfaction subscale. Before starting to therapy men had higher satisfaction scores than their wives. Also, Time 2 measurements reveal a higher consensus scores for male participants when compared to female participants.

When individual symptom scores are explored in detail, except Couple 2, female participants had higher individual symptoms than their husbands. Among

the four couples, female participant of Couple 4 has the highest BSI score. As it is seen this participant also showed the lowest score of dyadic adjustment. When the highest individual symptom score of the male participants are analyzed, a similar relation is detected. Between male participants, the participant who had the lowest DAS score showed the highest individual symptom score. When the change of the scale scores is examined it appears that BSI scores were lower at the initial measurement for all participants. The participant who had the highest change on the individual symptoms is the female partner of Couple 4; who also had the highest individual symptoms at initial measurement. When the subscales scores of Time 2 for individual symptoms are examined, it is found that female participants' scores decreased in all subscales. At the same time, the final measurement of subscale scores shows that the difference between individual symptom scores between partners decreased.

3.4. Zoom in the Individual Change

In this section, the female participants who had the highest and the lowest dyadic adjustment changes are portrayed descriptively, together with their partners' information. Among female participants, the female partner of Couple 2, showed the lowest change on DAS score and the female partner of Couple 4 showed the highest change. Therefore, Couple 2 and Couple 4 examined in detail.

3.4.1. Individual Process Change for Couple 2

The couple's reason for referral was conflict and sexual problems. Their therapy expectancy was couple therapy. The therapist decides to focus on intimacy, conflict and sexual problems. The couple participated in 13 sessions during the three months of therapy period. After three months, they continued the therapy.

Table 3.11. Change in DAS and its Subscales from Time 1 to Time 2

	Woman		Man	
DAS	Time 1	Time 2	Time 1	Time 2
Affection	5	7	3	5
Cohesion	15	19	7	11
Consensus	45	36	35	37
Satisfaction	28	36	31	30
Total Score	93	98	76	83

Table 3.12. Change in BSI and its Subscales from Time 1 to Time 2

	Woman		Man	
BSI	Time 1	Time 2	Time 1	Time 2
Depression	6	2	28	2
Anxiety	4	2	12	1
Negative Self	6	1	4	0
Somatization	5	1	11	6
Hostility	1	1	12	4
Total Score	22	7	67	13

The female participant is 33 years old and is from middle class in terms of socio-economic status. She is Turkish and her sect is Sunni. Her hometown is in Marmara region. She is the fifth of five siblings. She has a bachelor's degree and she work as a teacher. A traumatic history of physical violence, emotional abuse, and domestic violence has been reported by participant. She is not found in a risky situation. She described her relationship with her mother as close and with her father as distant. In a family which has rigid family boundaries, she had the role of caregiver. Her social relations are moderate.

The male participant was at the age of 34 and is from middle class in terms of socio-economic level. He is Turkish and his sect is Alevi. His hometown is in Central Anatolia Region. He is the second of two siblings. He has a bachelor's degree and he work as a teacher. He did not report any traumatic history or risky

situation. The participant described her relationship with her parents as distant. He had an invisible role in the family. His social relations are moderate.

The female participant had a low level of dyadic adjustment before therapy. When the dyadic adjustment subscale scores were examined in detail, it was observed that the lowest score was on the affective expression subscale. According to the scale scores obtained after the three-month therapy period, the female participants' dyadic adjustment score increased to 98. Although a positive change in all the dyadic adjustment subscales was observed, there was a decrease in consensus scores. The satisfaction scores increased the most. The least change was seen in the affection expression subscale. It was noteworthy that the scores of affection expression subscale were low in both initial and final DAS scores.

The total score of the individual symptoms evaluated before therapy was 22. Female participants' individual symptoms were low. According to the scale scores obtained after three months of therapy, the individual symptoms decreased further. The second scale score was 7. The hostility score remained the same while the other subscales decreased.

The male participant had a low level of dyadic adjustment before the therapy and had the least change in dyadic adjustment among male participants. He also had the lowest DAS score among male participants. These results did not change in the final measurement. He was the only male participant who had a lower DAS score than his wife. The lowest subscale scores of the participant were found to be in the subscales of cohesion and affection expression. At the end of the three-month therapy period, the couple's dyadic adjustment score increased according to the first scale scores, however it is important to note that the couple's dyadic adjustment level was still low. When the subscale scores were considered, there was a decrease in the satisfaction subscale, while a slight increase is seen in another subscale.

The total score of the individual symptoms evaluated prior to therapy was 67 points. It was found that male participant had more individual symptoms. The highest scores of individual symptom subscales were found to be on depression and hostility subscales. At the end of the three-month therapy period, the decrease

in individual symptoms was noteworthy according to the scale scores. The individual symptom score was 13. The most change was observed in depression and anxiety symptom scores. The negative-self score of the subscales was zero. Although the change in the dyadic adjustment score was less, the decrease in individual symptoms was noticeable.

It is observed that this couple was showing the lowest dyadic adjustment change among all four couples. When the relational and individual symptom scores of the couple were considered together, there was an increase in the total dyadic adjustment scores. However, both have a low level of dyadic adjustment. The affection expression subscales of couples before and after the therapy were low. At the end of the three-month period, the affection expression scores did not change much for both partners. At the end of the therapy period, consensus score of the female participant decreased and her husband received a similar score. While there was not much change in the dyadic adjustment score of the male participant, it was important to note that there was a decrease in the individual symptoms especially in depression and anxiety scores.

3.4.2. Individual Process Change for Couple 4

The couple's reason for referral was relationship conflicts. Their therapy expectation was couple therapy. The therapist decided to work on the conflicts presented by the couple. The couple participated in 8 sessions during the three-month therapy period. At the end of three months, the therapy was terminated.

The female participant was 42 years old and had a lower-middle income level. No information on race, religion, sect or country was given by the participant. She is the fourth of six siblings. She graduated from primary school and she is a housewife.

She reported early parental loss as a traumatic history. The participant did not have a risky situation. She stated that her father died and her relationship with her mother was close. She had caregiver, accusing and fragile roles as a family member. Her social relations were moderate.

Table 3.13. Change in DAS and its Subscales from Time 1 to Time 2

	Woman		**Man**	
DAS	Time 1	Time 2	Time 1	Time 2
Affection	0	10	5	10
Cohesion	12	6	8	9
Consensus	17	36	38	42
Satisfaction	20	34	31	42
Total Score	49	86	80	103

Table 3.14. Change in BSI and its Subscales from Time 1 to Time 2

	Woman		Man	
BSI	Time 1	Time 2	Time 1	Time 2
Depression	38	13	7	4
Anxiety	40	13	3	3
Negative Self	35	24	9	10
Somatization	22	2	5	7
Hostility	17	4	9	7
Total Score	152	56	33	31

The male participant was 50 years old and has a lower-middle income level. No information on race, religion, sect or country was given by the participant. He is the fifth of five siblings. He graduated from primary school and he is self-employed. He did not report any traumatic history or risky status.

Female participants' pre-therapy dyadic adjustment score was 49 and it was the lowest score among four couples. When the dyadic adjustment subscale scores were analyzed in detail, it was noticed that the affection expression subscale score was zero. Similarly, consensus subscale score was also quite low. After the three-month therapy period, the female participants' dyadic adjustment score increased to 86 but their dyadic adjustment level was still low. It was important to note that the affection expression subscale increased from 0 to 10. In the other subscales, while the cohesion subscale decreased, consensus and satisfaction subscale scores increased, respectively.

The female participants' individual symptoms were high. She had the highest individual symptom score among participants who continued therapy. Her individual symptom score was 152. All subscale scores of the participant were high, especially the anxiety symptoms. When the scale scores were considered, it was seen that their individual symptoms decreased considerably. Her individual symptom score was 56 at the end of the period. Depression, anxiety, somatization, negative-self and hostility scores decreased respectively. It was important to note that the traumatic history of this participant was the loss of the parents at an early age which is different from the other female participants.

The male participant had a lower level of dyadic adjustment before the therapy, but he had a higher score compared to his wife. According to the scale obtained at the end of the three-month therapy period, it was observed that the total dyadic adjustment score increased from 80 to 103. Despite the increase in all scores, it was seen that the highest increases were in affection expression and satisfaction subscales.

The individual symptom score of the male participant at the first evaluation was 33, a score which is quite low. It was observed that the highest score of the individual symptom subscales was on hostility. At the end of the three-month therapy period, the symptoms decreased to 31. He had the least changing symptom score among other participants.

When the relational and individual symptom scores of the couple were considered together, they both had an increase in the level of dyadic adjustment. It was noteworthy that both the satisfaction and consensus subscales increased. The affection expression subscale of the female participant increased from 0 to 10, and after three months, both had the similar affection expression scores. It was seen that the cohesion score was low and did not increase much. When the individual symptom scores were examined, it was observed that the female participant had the highest individual symptom score. While the symptoms of the male participant did not noticeably change within three months, there was a visibly decrease in the individual symptoms of the female participant.

When these two couples were examined, there were differences that distinguish them from the other couples. As it is seen in the research, the male partner of couple 2 was the only participant from a different sect, and the lowest change is observed in this couple. Compared with his spouse, he was the only male participant with a higher level of dyadic adjustment and had higher individual symptoms. Therefore, this separates them from other participants. Affection expression subscores of DAS in this couple were remained same in two measurements; pre-therapy to post-therapy. At the end of the three-month therapy period, there was no change in affection expression subscale. Another feature that distinguishes the Couple 2 was the education level. While the education level of the Couple 2 is university, the education level of the Couple 4 is primary school.

The highest change between two measurements was seen in the Couple 4. The female participant had the lowest dyadic adjustment score and the highest individual symptoms among all participants. It was seen that, unlike the traumatic stories of other female participants, she was the only one with early parental loss. However, considering the changes in points at the end of the three-month therapy period, it was seen that this couple obtained the highest change of dyadic adjustment and individual symptoms scores. Especially, the change in affection expression subscale was noticeable for this couple. While the first scale score was zero, it was noted that his final scale score increased highly and reached the same level with his wife.

It was seen that the affection expression subscale scores of the two couples before the therapy were low. At the end of the therapy, while there was not much change in Couple 2, the increase in Couple number 4 was noteworthy.

CHAPTER IV

DISCUSSION

This study focuses on the association between dyadic adjustment level and psychological symptoms, and the change of this association after three months of therapy, among individuals who applied for psychological support. The questions regarding these relations are discussed based on the literature review, on the data obtained through quantitative analysis and descriptive reports explaining the individual processes. In this section, initially the relation between relational and individual symptoms, and the relation between subscales of dyadic adjustment and individual symptoms are discussed. Later two couples whose initial and final scores differed the least and the most are examined in detail. The couples' demographic information and their DAS and BSI scores are explained in the light of the literature. After the findings related to the research questions are discussed, the limitations of the study and suggestions regarding the clinical usage of the obtained findings are presented.

4.1. Dyadic Adjustment and Factors Affecting Dyadic Adjustment

The average DAS score of 23 women who apply for couple or family therapy at the clinic was 90.22, lower than the average of the national non-clinical sample which is 105.2 (Fışıloğlu & Demir, 2000). Knowing that those individuals applied for receiving psychological support, lower DAS scores were expected (Fidanoğlu, 2007). Also, Tutarel and Kışlak (1999) suggest that marital discord and conflicts are associated with psychological disorders and increased demands for psychological support.

In this study female participants reported lower levels of dyadic adjustment scores when compared to men. Only one male participant, who also received the lowest DAS score among males, reported lower DAS score than his wife. One possible explanation for this difference could be the fact that usually it

is the women who apply for therapy. Therefore, they may be struggling more in the relationship or they may be more aware of these struggles. Literature shows that women see the marriage more negatively when compared to men (Fışıloğlu & Demir, 2000). Moreover, the relationship between general health and marital satisfaction is found to be stronger among females when compared to males (Birtchell & Kennard, 1983; Göztepe-Gümüş, 2015; Levenson, et al., 1993). Studies also demonstrate that gender role expectations and extended family factors affect women's perceptions regarding themselves and their relationships (Ünal et al., 2002; Yüksel, 2013) which in turn may be an important factor leading to the emergence of wider depressive symptoms among women, when compared to men (Hafner & Spence, 1988; Whitton & Kuryluk, 2012).

As suggested in the literature, the roles women undertake in their relationships may be negatively affecting their dyadic adjustment and satisfaction (Yüksel, 2013). When the female participants' roles in their family of origin are analyzed, it is seen that that they all are in a caregiver role. Caregiver position may render women to be more sensitive towards the relationship, to get more responsibility and in return, to get more emotionally impacted than their partners. Two females who reported lowest DAS scores among four couples, are also accusing and fragile besides their caregiver position. As suggested in the literature, the impacts of the role's women shoulder operate on the marital relationship (Levenson, et al., 1993). In relationships where women are responsible from both household labor and caregiving, existence of multiple roles converts the marriage into a stress factor for women. On the other hand, the relationships defined by traditional gender roles, by limiting women's self-expression and by retaining them from explaining their concerns regarding the marriage, put women into a stressed position within the marriage (Yüksel, 2013).

Literature also shows that the relationship with the family of origin is also influential on the dyadic adjustment (Larson, 2003). Considering the participants' relations with their family of origins, none of the participants reported a close relationship with their parents. This could be evaluated as a factor impacting individuals' dyadic adjustment. The literature demonstrated that individuals who

receive support from their parents are better at important marital dynamics such as problem-solving, communication, roles and emotional reactivity, when compared to individuals who haven't received support from their parents. Partners who have healthier and similar family of origins report higher dyadic adjustment (Cihan-Günör, 2007).

Analyzing the subscale scores of female participants applied for psychological support, it is seen that especially the average scores of cohesion and affection expression are lower when compared to other subscale scores. The subscales of cohesion and affection expression examine the emotional operations and closeness of partners. Other subscales are related to the cognitive operations of individuals. Lack of affection expression and the rareness of sharing are among important factors negatively affecting dyadic adjustment and leading couples to receive couples' therapy. Coyne, Thompson, and Palmer (2002) show the importance of exchanges of affection between partners in their study. They indicate that depressed women and their husbands' affectional expression attitudes are fewer than control group couples. Beyond the more typically examined issues of marital satisfaction and conflict, this study demonstrates the importance of increased likelihood of expressing affections in couple relationship and individual well-being. Considering that emotions are signals explaining individuals' expectations from and needs for significant others (Moser & Johnson, 2008), the deficiency on affection expression negatively affects interpersonal communication.

Another important aspect of marital relationship is cohesion. Among those four couples, cohesion subscale scores of male participants are lower than female participants. Turkish culture renders males uncomfortable with expressing their emotions and with requesting affective closeness, demanding the emotional connection in the romantic relationship (Yüksel, 2013). Besides requesting emotional support easier than men, women are better at speaking about their emotions and problems. Those differences may be explanatory factors for lower cohesion scores among male participants. On the other hand, when their requests for intimacy are rejected by their partners, individuals develop secondary

emotional regulation strategies. Those secondary strategies include behaviors such as clinging, pursuing or demanding behaviors, and deactivating attitudes involving detachment from emotions, avoidance of emotional involvement, and denial of the need for intimacy (Shaver & Mikulincer, 2002). The literature presents the importance of dyadic cohesion on dyadic adjustment and happiness. According to Coleman (1977) the intimate relationships develop in five phases: acquaintance, attachment, cohesion, conflict and resolution. As with the conflict phase the partnerhood evolves in addition to friendship and love among partners (Hatfield & Sprecher, 1986). The first three of the required phases to have a healthy relationship are related with dyadic consensus which shows the importance of marital closeness on dyadic adjustment. For the resolution of conflicts, consensus and closeness among partners are important notions. Larson (2003) claims assertiveness, submission and love as factors protecting the relationship.

4.1.2. Psychological Symptoms and Couple Relationship

The main purpose of the study is evaluating the relationship between DAS and BSI scores of participants. The statistical analyses demonstrate a negative association between these two variables. Examining the DAS and BSI scores of four couples in detail shows that, the female participant who received the lowest DAS score among women has the highest BSI score. Similarly, the male participant who has the lowest DAS score, reports the highest BSI score among male participants. These findings are parallel with the studies expressing that marital quality, dyadic adjustment and individuals' mental health are related with each other (Fidanoğlu, 2007; Robles et al., 2014; Tutarel-Kışlak & Göztepe, 2012; Yüksel, 2013). Individuals in relationships characterized by conflict, dissatisfaction and diminished support are at higher risk for the development psychological symptoms (Overbeek, et al., 2006). Also, satisfaction and happiness arising from an adjusted marital relationship protects mental health of spouses (Sardoğan-Karahan, 2005). The total BSI scores of 23 individuals applying for

psychological support is 64,22. The higher scores in BSI reveal the existence of psychological problems. It is noteworthy that individuals applying for psychotherapy received higher scores from depression, anxiety and negative-self dimensions of BSI. Considering that those individuals also received lower scores from DAS, higher scores of depressions, anxiety and negative-self demonstrates that relationship with the partner is influential on individuals' self-perception and emotions.

When examined in detail, findings reveal that female participants have higher BSI scores than their partners. The gender-based differentiation of dyadic adjustment and individual symptoms is one of the topics grabbing attention of scholars (Kılıç, 2012). The relationship between general health and marital satisfaction is found to be stronger among females when compared to males (Birtchell & Kennard, 1983; Göztepe-Gümüş, 2015; Levenson, et al., 1993). Gender is an important variable operating on the tendency to develop psychological disorders (Kılıç, 2012). When BSI scores of participants are analyzed it is seen that females receive higher scores than males on somatization, obsessive compulsive disorder, anxiety and in total (Kılıç, 2012). Another reason behind the higher BSI scores and lower DAS scores women report, could be the existence of traumatic experiences in their personal history. In all four couples applied for couple therapy, female partners reported the existence of a traumatic experience such as sexual or physical abuse and violence.

The analyses reveal a negative association between dyadic adjustment and depression, anxiety, negative-self subscales of BSI. This relationship is not observed between the hostility subscale of BSI and dyadic adjustment. There are various studies examining the relation between mental health and dyadic relationship showing a negative relation between the two. The literature specifically conveys the relationship between depression, anxiety and somatization subscales and dyadic adjustment. Whisman (1999) examining the relationship between DSM-IV Axis I disorder and marital satisfaction, demonstrates that the disturbance in dyadic satisfaction is associated with all psychiatric disorder. Schafer and Keith (1992) demonstrate that while higher

marital adjustment is related to positive self-perception, marital discord is related to negative self-perception. Overbeek and colleagues (2006) also reveal the negative association between marital quality and anxiety. Literature and our findings show that people in unhappy romantic relationships gradually become more aggressive, anxious and alienated, becoming vulnerable for the occurrence of mental disorders.

Although our analysis does not demonstrate an association between dyadic adjustment and hostility subscale, a negative relationship between two variables is presented in the literature (Baron et al., 2007; Brummett et al., 2000). The cultural structure is also meaningful for understanding the relation between marital adjustment and hostility symptoms. Due to the cultural influences, women have difficulty on expressing negative and aggressive behaviors and emotions. Because of the women's difficulties in expressing these emotions, hostile behaviors may not be reflected in scale scores. On the other hand, we know that somatization is seen widely among Turkish woman. Literature shows that relationship discord can be a cause of somatic problems (Yüksel, 2013). In predominantly collectivist eastern cultures, emotions are not expressed directly thus somatization is expected to be higher among maladjusted couples when compared to western cultures.

4.2. Process Change

Systemic therapy support is given to individuals, couples and families who applied for psychological support. Intern clinical psychologists, who have been trained in systemic therapy provided therapeutic interventions to and determined therapy aims with the clients, in line with the presented problems. Although there is no detailed information regarding the interventions the therapists used in therapy, it is expected that they will use the methods and interventions they learnt in their theoretical education year. Therapeutic process of the participants included the fundamental notions and methods of systemic therapy such as, including the family into the therapy, defining the problem in relational terms, giving hope to clients regarding their presented problem, increasing clients'

awareness through circular questions, disclosing the relational cycles which contribute to the emergence and continuation of the problems, encouraging the clients for the expression of their emotions and keeping the therapy focused on the process.

After three months of therapy, the initial negative association between relational and individual symptoms weakened. As stated in the literature, in systemic models' therapists do not work with the symptoms (Nichols & Tafuri, 2013). Systemic therapy aims to understand the relational problems leading up to the individual symptoms, instead of focusing on healing the individual symptoms. Systemic therapists do no aim a quick treatment of the individual symptoms however exploring and presenting the links between the system and the symptom helps all members of the system to contribute to change process. The change of the system is acquired with the changing of all members in the family (Pinquart et al., 2016; Stratton, 2010).

A change is also obtained on BSI scores of individuals after three months of therapy, which declined from 64.52 to 30.7. It is possible to argue that individual symptoms are reduced in therapeutic process although the results of this study are not generalizable for the positive effect of therapy due to the limited number of participants. However, common factors literature indicates that most of the change occur in the first three months of therapy (Sprenkle, et al., 2009). The most important factor affecting therapeutic outcomes is the strength of the therapeutic alliance regardless of the practiced model (Balestra, 2017). Also, the obtained findings are parallel with the previous studies analyzing the relationship between individual symptoms and systemic therapy (Carr, 2014; Prince & Jacobson 1995; Shadish et al., 1993). Systemic therapy approaches psychological symptoms through the social system people live in aiming to explore the conditions and behaviors contributing to the emergence and continuation of the individual symptoms (Pinquart et al., 2016). Mobilizing the resources and transforming the dysfunctional belief systems dominant in the system are important methods used in systemic therapy (Mert, 2014; Pinquart et al., 2016; Stratton, 2010). Intervening to relationship discord is found to be positively

impacting the treatment of various psychopathologies, reducing the stress of the system and helping the individuals to get recovered from their symptoms (Whisman & Baucom, 2012). Although the individual symptoms are not targeted, these findings explain the positive outcomes obtained in couple therapy on improving mental health and relationship discord (Donald et al., 2012; Whisman, 2001; Whisman & Baucom, 2012).

When examined in detail, a decline is observed in all subscale scores of BSI. Especially depression, anxiety and negative-self subscales which were higher initially, declined after three months of systemic therapy. Studies which reached to similar results about the relation between systemic therapy and individual symptoms exist in the literature. The meta-analysis conducted by Barbato and D'Avanzo (2008) demonstrates that systemic couple therapy is as efficient as individual based interventions in the treatment of depression and more influential than individual therapy in increasing relationship adjustment. The study of Renshaw and colleagues (2005) also reveals that besides being comparable to individual therapy, systemic approach is more influential in the treatment of obsessive-compulsive disorder. In a meta-analysis constituted of fifty-two randomized controlled trials among 8,896 patients, Hartmann and colleagues (2010) showed that for different health conditions, systemic interventions lead to better physical and mental health conditions both for the patient and other members of the family. Explaining the difference observed in individuals through systemic perspective shows the bidirectional relationship between the individual and the system (Fals-Stewart et al., 2005; Stratton, 2005).

Couples in this study applied to psychological counselling center for different problems such as conflict, consensus or sexual problems, and the therapeutic aims are determined based on their presented problems. Although the issues that are focused on the therapy do not cover individual symptoms, the BSI scores of individuals declined after three months of therapy. This finding shows us the positive effect of couple therapy on the treatment of individual symptoms. When a couple relationship functions well it can provide the joy of sharing life's journey and it can be a source of support to manage life's stresses. When the

relationship is distressed and conflicted, it can be a source of great loneliness, angst and suffering (Snyder & Halford, 2012). The decline in individual symptoms is observed in all four couples participated in the study. The strong association of couple relationship distress with individual mental and physical health provides a rationale for applying couples therapy on the treatment of those individual problems. On the other hand, the difference between the individual BSI scores between partners declined after three months of therapy. Systemic therapy aims to increase communication between couples and with that to decrease polarization which leads up to increased intimacy among partners (Zaider et al., 2010). Obtaining similar individual symptoms after 3 months of therapy process shows that the polarization between couples is reduced in this sample.

Analyzing the DAS scores of female participants after three months of therapy, an increase from 90.22 to 97.5 is observed. Considering that the average score for Turkish participants is determined as 105.2 in standardization study conducted by Fışıloğlu and Demir (2000), the participants in this study remained below the average in dyadic adjustment. However, the limited number of participants, the decline in the number of participants from initial measurement to final measurement and the shortness of the therapeutic process for reaching to therapy goals could explain why the average DAS scores of participants remained below average. Nevertheless, the detailed analysis of the initial and final scores of four couples reveals that both female and male participants' DAS scores increased after three months of therapy.

Especially a significant change is obtained in the scores of affection expression and satisfaction subscales. Considering that in Turkish culture men develop limited skills on expressing and showing emotions, couples therapy helps them to develop their affective capacities which lead to increasing dyadic adjustment. Another possible factor which can explain the increase in dyadic adjustment is the open communication and increased understanding partners develop in couple therapy.

Although affection expression and satisfaction scores of participants are increased by therapy, the scores they received from consensus subscale did not

differ in the final measurement. The initial stage of systemic therapy includes the definition of problems by each partner and the disclosure of dysfunctional communication patterns which unveils partners' differing thoughts and attitudes (Beach & Whisman, 2012). Gaining the awareness regarding partner's different thoughts and problems has the potential to decrease the consensus and dyadic adjustment among spouses, which may be explaining why the consensus scores of participants did not significantly differ in this study. When the four couples are examined in detail, it is seen that the male participants' consensus scores are higher than their partners after therapy. The gender roles partners undertake in the relationship impacts partners' approach and mental involvement to issues necessitating consensus, putting women in a more concerned position. This gendered differentiation may be an explanatory factor for the lower consensus scores of female participants.

In addition, although the relation between DAS and BSI scores of participants decreased after three months of therapy, a negative association is observed between cohesion subscale of DAS and, depression and negative-self subscales of BSI. This finding, parallel with the previous studies, demonstrates that being approved and valued by, and being intimate with the partner is associated with self-worth (Moser & Johnson, 2008). Studies comparing differences between healthy and distressed married couples yield links between deep emotional bond, mutual caring, attraction and closeness, and overall happiness in life (Acevado & Aron, 2009; Riehl-Emde, Thomas, & Willi, 2003).

The statistical analysis yields a negative association between dyadic adjustment and individual symptoms and the strength of this relationship decreased after three months of therapy. While the total DAS scores increased, a decline is observed in total BSI scores. The change in relational and individual symptoms obtained after three months of therapy cannot be explained as solely resulting from therapy. The limited number of participants, the missing parts in participants' scales, the existence of drop-outs, the limited information regarding the therapeutic process and not having a control group prevents the researcher from reaching to generalizable results about the positive impacts of couples'

therapy. The literature on couples and family therapy includes a lately emerging field of research which aims to figure out common factors resulting in positive outcomes in therapeutic process (Sprenkle, et al., 2009). Especially the therapeutic alliance built between therapist and clients is expressed as leading to positive therapeutic outcomes (D'Aniello & Fife, 2017). Literature indicates that most of the changes occur in the first three months of therapy (Sprenkle, et al., 2009).In the initial stages of therapy, therapist aims to build up a qualified relationship with the clients and to explore the conflictual issues. Clients become more comfortable and capable in affection expression as they feel heard and understood. The non-judgmental attitude they observe in a third person facilitates the expression of emotions, which in turn result in the decrease of individual symptoms (D'Aniello & Fife, 2017). Considering that participants in this study filled the final measurements after three months of therapy, it is probable for therapists and clients to fail reaching to all initially determined therapeutic goals. However, the initial relationship between the therapist and the clients can explain the change in dyadic adjustment and individual symptoms. Using the data obtained from SRS filled by each client and each therapist after the sessions will be useful for analyzing the change observed in first three months of therapy in terms of therapeutic alliance. Evaluating the SRS scores obtained in the first session and after three months of therapy together with the observed changes will provide information regarding the impact of therapeutic alliance on therapy outcomes.

Finally, the male clients have more difficulty on showing and expressing their emotions and speaking about their problems due to cultural norms. Even the very act of being in the therapy room and finding an empathic atmosphere where they can express their emotions positively affects dyadic adjustment. Studies show that therapist's understanding, accepting and empathic attitude towards the clients positively influence therapy outcomes (Balestra, 2017). Furthermore, client's positive expectations regarding therapy (D'Aniello & Fife, 2017), the accordance of the client with the utilized therapeutic model and client's confidence in therapist are other factors contributing to positive outcomes in therapy (Blow et al., 2012; Fife et al., 2014).

4.3. Zoom in the Individual Process Change

4.3.1. Individual Process Change for Couple 2

When the dyadic adjustment scores of the female participant who changed the least and her partners data are examined in detail it is seen that their presenting problems are marital conflict and sexual problems. The literature suggests that existence of conflict and sexual problems negatively impacts dyadic adjustment. Binik and Hall (2014) demonstrate the bidirectional nature of sexual problems and marital conflict.

The factor differentiating this couple from other couples is their sectarian differences. The difference of sect is possible to indicate different family of origin structures and, different religious and cultural beliefs. Kocadere (1995), Şener and Terzioğlu (2002) argue that partners having similar values and life goals, taking decisions collectively and having similar relationships with their extended family are more adjusted to each other (Tutarel-Kışlak & Göztepe, 2012). Yüksel (2013) emphasizes the importance of the management of interpersonal differences and similarity of opinions on vital relational issues, for the development of marital adjustment. Considering this information, being from different religious sects can be negatively affecting this couple's dyadic adjustment.

Examining the subscale scores of DAS reveals that affection expression subscale of this couple is lower than other couples, which may be related to their presented sexual problems, as suggested in the literature (Polat, 2014). Özgüven (2000) states sexuality related problems as one of the problem areas causing deterioration in marriage. Other stated problem areas are, dysfunctional interactional styles, different gender role expectations, lack of honesty and openness, and failing to adapt to changes in life conditions.

Neither affection expression subscale scores nor total DAS scores significantly differ for this couple. Affection expression subscale scores changed only about 2 points for both partners. The limited change this couple obtained

may be due to the initial focus of therapy on problem areas, the differences on the definition of problems and spouses' limited skills of problem-solving. Three months of therapy may not be adequate to expect a strong change in the problematic areas. On the other hand, the consensus subscale of the female participant declined. This decline may be resulting from partners' exposure to each other's differing opinions on presented conflicts. Besides, the satisfaction subscale score of the male participant decreased after three months of therapy. Satisfaction subscale also measures partners' problem solving skills (Scorsolini-Comin & Santos, 2012). Although the different opinions are expressed more in the initial stages of therapy, reaching to a consensus about the differences and developing solutions may not be expected at this stage of the therapy. The newly emerging or newly voiced differences may be explaining the male participant's decreased satisfaction score. For gaining a better understanding regarding the differences in subscales, the content of therapeutic sessions should be analyzed.

When the participants' initial scores are examined, the BSI score of male participant is higher than his wife. The hostility and depression scores of the male participants were higher than other scores of the participants. Literature includes various studies analyzing the relation between depression and hostility, and dyadic adjustment (Davila et al., 1997; Tuncay-Şenlet, 2012). Baron and colleagues (2007) argue that the satisfaction scores of married individuals with higher hostility scores are lower and they experience more marital conflict. Studies reveal that verbal and physical aggression and critical attitudes among spouses lead to depressive symptoms by increasing stress, which in turn result in the increased depressive symptoms, demonstrating the reciprocal nature between marital discord and depression (Tuncay-Şenlet, 2012; Yüksel, 2013). The relation between hostility and depression is stronger among males. Last, partner's hostility is also related to less favorable therapeutic outcomes (Priest, 2015; Zinbarg, et al., 2007). Considering that this couple showed the lowest change after three months of therapy, all stated factors may be operating on this outcome.

On the other hand, a significant change and an approximation is observed in partners' BSI scores. The BSI score of male participants is decreased from 67

to 13. While the highest amelioration is observed in depression and anxiety scores, the score of negative-self subscale became zero. Clinical trials reveal that couple therapy is influential both in the treatment of depressive symptoms and relational problems (Whisman & Beach, 2012). Based on this finding, it is possible to argue that although not directly aiming individual symptoms, systemic perspective contributes to individuals' well-being by improving their relational problems and interactional skills. The fundamental principles and methods of systemic therapy such as, focusing on the interpersonal relationships, normalizing the differing definitions of problems, identifying individual strengths and resources, emphasizing positive changes and developing alternative solutions, give clients hope of change and make them feel heard and understood, resulting in the decline of individual symptoms (Beach & Whisman, 2012; Retzlaff et al., 2013).

4.3.2. Individual Process Change for Couple 4

The female participant, whose dyadic adjustment scores changed the most after three months of therapy, and her partner applied for couple therapy due to marital conflict. The female participants' initial dyadic adjustment score was the lowest and individual symptoms score was the highest of all female participants. All female participants in the study have a trauma history however this participant has a different traumatic experience, the loss of the parent at an early age. Losing one parent at an early age may be a factor which negatively impacted her mental health. The existence of a traumatic experience may be explaining the individual symptoms she reports. Literature includes studies examining the relation between parent loss and dyadic adjustment. Those studies reveal that when compared to individuals who lost their fathers, those whose fathers are still alive have higher dyadic adjustment scores (Fidanoğlu, 2007).

On the other hand, individual symptoms and educational status of the spouses are positively related (Kılıç, 2012). As the level of education increases, the scores of dyadic adjustment and emotional affection increased (Yüksel, 2013).

The partners in this couple are both graduated from primary school. The female participants' total dyadic adjustment score is the lowest among all female participants and her affection expression score is zero.

Although the male participant had a higher dyadic adjustment score compared to his partner, the total score is still lower than the average. On the other hand, his individual symptoms score is lower than his wife. Keeping this data in mind, it is possible to argue that the mental problems the female partner has may be negatively affecting dyadic relationship. Literature conveys that individual mental problems negatively impact dyadic adjustment (Donald, Whisman, & Paprocki, 2012). Whisman (1999) argues that existence of anxiety and mood disorders is significantly negatively related to relational satisfaction. In the case of this couple, the female participant has a high score in the anxiety subscale of BSI. The analysis reveals that depression, anxiety, somatization and negative-self subscales have a negative association with the affection expression subscale of DAS. The anxiety symptoms of female participant may be negatively affecting her intimate relationship with her partner. Study conducted by McLeod (1994) demonstrates that anxiety impairs the perception and processing of daily marital events and interactions. Studies also argue that anxious individuals may be jeopardizing the potential of support and closeness by engaging in interactions which trigger negative reactions from others (Zaider et al., 2010).

Both partners' dyadic adjustment scores increased after three months of therapy. Affection expression and consensus subscale scores also increased. The greatest increase is observed in female participant's affection expression score, which augmented from zero. Similarly, her partner's affection expression score increased too. The comfort the partners gained in the therapy room for openly communicating their thoughts and emotions may have positively impacted the marital relationship. On the other hand, the female partners' cohesion subscale score decreased. The reason for this decrease may be due to the inadequacy of the required time to reach a common decision on the integration of different ideas at the beginning of the therapy process.

The change of female participant's individual symptoms is also noteworthy. After three months of therapy, her scores of depression, anxiety, somatization, negative-self and hostility respectively declined. Considering that this participant initially had a high anxiety score, it is possible to argue that the therapeutic interventions contributed to her change process. Literature includes studies examining the impacts of systemic therapy on the treatment of anxiety (Renshaw et al., 2005). Systemic interventions constitute an atmosphere within which family members can support each other for the recovery of beliefs and interactional patterns which reinforce the anxiety. Zaider and his colleagues' (2010) study demonstrates that intimacy of the relationship is a resource for healing the psychopathology. In this manner it is possible to argue that the support male participant gave to his partner may be explaining the increase of their affection expression scores. Similarly, their increased dyadic adjustment scores show that a difference obtained through the evolvement of new interactional styles may positively affect the whole couple system (Fals-Stewart et al., 2005; Stratton, 2005). The change of the system is only possible with the changing of all members in the family not through the change of the member who has the symptoms (Carr, 2014).

4.4. Clinical Implications

This study emphasizes the relationship between dyadic adjustment and psychological problems. Although during this research the relational problems of individuals were focused upon, an improvement in their individual symptoms is also observed. Literature statistically shows the efficiency of systemic therapy on improving relational problems. On the other hand, there are also studies showing the positive impact of systemic therapy in healing individual symptoms. It is assumed that problems individuals experience in the past projected into the current intimate relationship and those individual conflicts can be resolved within the relational context. These findings demonstrate that couples and family therapy models not only improve relationship quality, but they also ameliorate the

individual problems. Couples and family therapists, by determining the conflict zones in the relationship, consider the impact of those problems upon the individual mental health.

Couples and family therapies can be developed for the treatment of specific disorders since the system, including the partners or other family members, can be used as a source through which individuals will receive support during the healing process. In partner-assisted interventions the spouse serves as a support and coaches in assisting the other partner with individual problems. Besides facilitating the treatment process, the inclusion of the system into the therapy may prevent the relapse of individual problems (Beach & Whisman, 2012; Fals-Stewart et al., 2005). Couples will also be able to use the coping skills they developed in therapy for overcoming various problems they may experience in future. Especially the support partners give each other should be considered while clinicians develop a treatment plan.

Furthermore, considering the impact of relational problems upon individual mental health, the evaluation and examination of relational problems is vital for individual therapy models. Research in the literature shows that couple therapy is more effective in treating individual symptoms if there are relational problems in individuals' life (Shadish et al. 1993; Whisman & Baucom, 2012). So, screening the relationship distress and assessing the couple relationship should be routinely conducted in clinical practice. This study also offers suggestions for the measurement and screening of relationship quality. It is important for clinicians working with different therapy methods to know each other's domains and to make appropriate guidance according to the needs of the client.

This study is important for pointing out the importance of the consideration of gender roles in systemic therapy practices in Turkey. In our country, women develop more psychological symptoms when compared to men. The cultural notions of the society are influential on this differentiation. The roles they undertake and the styles of self-expression they internalize, impact the intimate relationship. In the therapeutic process evaluation of gender-role attributions and expectations of the society is vital. Optimizing the interventions

according to very culture of each society both strengthens the relationship between therapist and client and supports client's motivation to continue to therapy. In Turkey, application for couple therapy seems to be more common for women. In order to facilitate psychological support and to normalize this process for men, awareness raising activities will be useful.

The findings of this study point out the importance of affectional expression and intimacy between partners on the evaluation of dyadic adjustment and individual symptoms. The study explains the importance of intimacy between partners based on the improvements observed in dyadic adjustment scores. Other than affectional expression, hostility appears as an important factor influencing dyadic adjustment. The results remark the impact of affective intimacy and the capacity of expressing negative emotions, on therapeutic process. Since the affectional expression, intimacy and expression of negative emotions depend on the cultural structure of the society, the cultural norms partners internalize should be examined.

Some interpersonal differences of individuals such as race, ethnicity, educational status and trauma history may be vulnerability factors for the emergence of certain psychological disorders or marital discord. For example, Kılıç (2012) and Yüksel (2013) demonstrate the impact of educational status on individual symptoms and couple adjustment. How individual differences impact the couple relationship should also be analyzed by clinicians.

On the other hand, although the individual symptoms of participants decreased after three months of therapy, their consensus scores did not significantly differ in some cases. This should be evaluated as a part of therapeutic process. Understanding the conflict zones and cycles of partners, emphasizing the individual definitions of problems is important in systemic therapy. Being exposed to the different ideas and emotions of the partner may be lowering individuals' consensus scores. Noticing this decrease in consensus and using it as a therapeutic tool for informing the clients appropriately will help clients to remain hopeful and motivated towards therapy, thus preventing potential drop-outs. Therapists should also be aware that initial stage of therapy is important in

bringing first order change. However, sometimes more time is needed for a second order change and for the change to be long-lasting.

Although various studies examine the dyadic relationship and the factors operating on it, very few process-studies are conducted in Turkey. This study is a preliminary analysis. The data used in the study are obtained from a process-study conducted in Istanbul Bilgi University Clinical Psychology M.A. Program Couples and Family Therapy branch. The findings of this study will provide information for the intern psychologists working in the counseling center of the university on the factors operating on relationships and the notions to pay attention regarding therapeutic process.

4.5. Limitations and Suggestions for Future Studies

In this study, a preliminary exploratory study was conducted by using the data of the process research carried out by Istanbul Bilgi University Clinical Psychology Couple and Family Program. This study aims presenting new insights about couple relationship and assessing the association between dyadic adjustment and mental health problems. In this study, the factors affecting the couple adjustment, and the change of the relational and individual symptoms after three months of systemic therapy were examined.

One of the limitations of the study is the usage of non-parametric tests for running the analysis due to the limited sample size. The number of participants is insufficient to obtain statistically valid results. Non-parametric tests do not reveal significant statistical data as do parametric tests. On the other hand, the data initially obtained from 23 participants could not be used for the final step of analysis, which is conducted to see the change between participants' scores after three months of therapy. After 11 participants who either dropped out or did not complete the questionnaires were excluded from the sample, the final analysis was conducted among 12 remaining participants.

Another limitation is the usage of the data of female participants. Only the detailed analysis of four couples, who applied for couple therapy, revealed the

information obtained from male participants. Although not presenting a statistically valid result, this implication helps researchers to observe the process and to gain insight about the individual and relational change process. The literature suggests that there are different factors affecting the dyadic adjustment and individual symptoms of women and men. However, most of the studies focus on the experiences of women. In this study, because most of the participants were female and because they had less missing information, the sample is formed up of female participants. The inclusion of both partners in the study sample is recommended for future studies. On the other hand, the results in this study are received from married individuals, therefore further studies are suggested to focus on the experiences of non-married couples too, for having more generalizable results.

The next limitation of the study is the lack of a control group. There is a need for the presence of a control group to test the validity of the results. It is known that the change of relational and individual symptoms in therapy process may be related to factors other than therapy. The presence of uncontrolled variables influences the implications of the results. Various variables, such as the number of sessions, the characteristics of the therapist, the absence of a single therapist, the past history of the therapist and the client, the changes in the individual lives of participants, are likely to affect the results.

Another limitation of the study is the duration of the research. A three-month process is not enough to observe changes in the therapy process. Longer treatment periods would allow us to observe the change more easily. Increased number of sessions would provide more statistically valid results. Similarly, not having information regarding the content of the therapy sessions limits the success of the analysis. For having a more detailed examination regarding the change of the relational and individual symptoms, analyzing the therapeutic content and interventions is necessary.

According to various studies conducted over the past 30 years, couple therapy provides clinically significant reductions in relationship distress. Furthermore, different forms of couple therapy are effective in treating individual

mental health problems and in helping individuals to cope with physiological disorders (Snyder & Halford, 2012). This study also indicates that couple therapy is useful in addressing relationship distress and couple-based interventions can be helpful in the treatment of individual mental health problems. However, extensive understanding is needed about the way relationship quality contributes to personal well-being of spouses and the change of this relationship throughout the therapy. The therapy process needs to be examined in a more detailed way, to gain a better understanding about the changes emerging during the therapy. Future studies may help to better understand the specific systemic therapy interventions contributing to change the relationship between dyadic adjustment and individual symptoms.

Therapist's effect also impacts the therapeutic process. Therapist's personal characteristics, psychological status, professional experience, combined with the utilized interventions and the perspective he/she has towards the presented problems impact the therapeutic process. Having deeper knowledge about the therapist could be beneficial for understanding the factors leading to change of the symptoms and change in the therapy. Analyzing the Session Evaluation Form directly filled by therapists after each session is suggested for further studies. The Session Evaluation Form should be including evaluative comments regarding the interventions the therapist found useful for that session, the emotional change of both therapist and client and the important moments occurred in that session. The therapists report will provide us a better understanding of the process, including the difficulties, the factors contributing to change, and the interventions that are helpful for having better outcomes.

Future studies should examine the importance of the common factors especially therapeutic alliance, in the cultural context. This study emphasizes that changes on symptoms may be related to the therapeutic relationship. So, the effect of the therapeutic relationship can be investigated at the beginning of the therapy process. In future studies, investigating the perceptions of the psychologists regarding specific psychological disorders and clients, may also be helpful to understand the relationship between relational and individual symptoms.

Even though the concepts such as couple relationship, dyadic adjustment, and marriage are universal, they include culture specific features. Several studies examining the effect of systemic therapy on the dyadic relationship and mental health are widely conducted. However, in Turkish literature, there are limited numbers of studies researching this very relationship. The effects of features specific to Turkish culture on the dyadic relationship and the change process in the therapy should be investigated. How Turkish population perceives the solution of intimate problems in a therapeutic environment should also be examined. The establishment of culture-specific interventions may provide clinicians knowledge for organizing more effective treatment plans to maintain individuals' mental health and to improve relational symptoms.

In the study, the effects of gender role expectations and attributions on couple relationship are discussed. The results indicate that women have more relational and individual symptoms than men and they are affected more by the marital relationship. It is known that the patriarchal structure dominant in our society may be playing an important role on the emergence of this difference (Yüksel, 2013). The social meanings and expectations behind these roles, define the way women and men express their feelings and thoughts. Especially in Turkish society, men refrain from expressing their emotions and problems, and women become the ones who voice the problems and start the therapy process. Studies researching how gender roles in our country affect the change in the therapy process are necessary. Further research on how these roles affect dyadic adjustment and therapy outcomes in our culture will contribute to the literature.

Moreover, the emotional expression is also one of the factors which is affected by culture (Tutarel-Kışlak & Göztepe, 2012). How partners express their feelings and thoughts affects the dyadic adjustment and the therapy process. The information on how emotional expression influences the therapy process in Turkish society and which interventions help partners get emotionally closer is required. It will be useful for future research to focus on culture-specific interventions and tools which facilitate emotional expression in the therapy process.

On the other hand, the emotional expressiveness is related with individuals' own attachment styles. The way people connect to each other is directly related to how they perceive and evaluate each other, and how they seek solutions to interpersonal problems. Adult attachment is an intrapersonal factor most likely operating on dyadic adjustment (Rennebohm, Seebeck, & Thoburn, 2017). It is also known that the individual attachment style is related to both individual mental health and dyadic relationship (Koruk, 2017). Thus, the relationship between attachment styles of partners and the benefits they receive from therapy process should be investigated by further studies.

CONCLUSION

Overall, the results of the current study are consistent with the literature, and they offer insights regarding the associations between dyadic adjustment and psychological symptoms, and how they might change in systemic therapy. On the other hand, the findings of the study provide preliminary findings for further research and contribute to our clinical understanding of systemic therapy process change.

Results show a negative association between individual symptoms and dyadic adjustment. This association got weaker after three months of therapy. The scores of satisfaction and affectional expressiveness subscales of DAS significantly changed. In terms of individual symptoms, a decline is observed in depression, anxiety, somatization and negative-self subscales, while the hostility subscale remained constant. Further studies should include higher number of participants for the detailed analysis of factors impacting the change in systemic therapy. In our country, there are limited numbers of studies examining how cultural structure influences the therapeutic outcomes. Thus, future studies should also consider the impact of cultural factors upon the therapeutic process and outcome.

In understanding the findings of this study, it should be kept in mind that this study is a preliminary exploratory study which aims to clarify the notion of

dyadic adjustment, to provide insight regarding the association of couple adjustment, psychological symptoms, and systemic therapy process. Clinical psychologists and couple/family therapists are requested to take into consideration the insights and assumptions presented in the current study while developing their formulations.

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APPENDICES

APPENDIX A: Dyadic Adjustment Scale

Çift Uyum Ölçeği

A. Pek çok insan ilişkilerinde anlaşmazlıklar yaşarlar. Lütfen aşağıdaki ölçek maddelerini eşiniz ve sizin için geçerli olan anlaşma ve anlaşmazlık derecesine göre cevaplandırınız.

	Her zaman anlaşırız	Hemen hemen her zaman anlaşırız	Nadiren anlaşamayız	Sıkça anlaşamayız	Hemen hemen her zaman anlaşamayız	Her zaman anlaşamayız
1.Aile ile ilgili parasal işlerin idaresi						
2.Eğlenceye ilgili konular						
3.Dini konular						
4.Sevgi gösterme						
5. Arkadaşlar						
6.Cinsel yaşam						
7. Geleneklere bağlılık (doğru ya da yanlış davranışlar)						
8.Yaşam felsefesi						
9. Ebeveynler ile ilişkiler						
10. Önemli olduğuna inanılan amaçlar, hedef ve konular						

11. Beraber geçirilen zaman						
12. Temel kararların alınması						
13. Ev ile ilgili görevler						
14. Boş zaman ilgi ve uğraşları						
15. Mesleki kararlar						

B. LÜTFEN 16-22 ARASINDAKİ SORULARI İÇİN SİZİ EN ÇOK TANIMLAYAN SEÇENEĞİ İŞARETLEYEREK CEVAPLANDIRINIZ.

	Her zaman anlaşırız	Hemen hemen her zaman anlaşırız	Nadiren anlaşamayız	Sıkça anlaşamayız	Hemen hemen her zaman anlaşamayız	Her zaman anlaşamayız
16. Ne sıklıkla boşanmayı, ayrılmayıya da ilişkinizi bitirmeyidüşünür ya da tartışırsınız?						
17. Ne sıklıkla siz veya eşiniz kavgadan sonra evi terkedersiniz?						
18. Ne sıklıkla eşinizle ilişkinizin genelde iyi gittiğini düşünürsünüz?						

19. Eşinize güvenir misiniz?						
20. Evlendiğiniz (ya da birlikte yaşadığınız) için hiç pişmanlık duyar mısınız?						
21. Ne sıklıkla eşinizle tartışırsınız?						
22. Ne sıklıklabir birinizin sinirlenmesine neden olursunuz?						

C. Lütfen aşağıdaki soruları cevaplandırınız.

	Her gün	Hemen hemen her gün	Ara sıra	Nadiren	Hiçbir zaman
23. Eşinizi öper misiniz?					

	Hepsine	Çoğuna	Bazılarına	Çok azına	Hiçbirine
24. Siz ve eşiniz ev dışı ilgilerinizin-etkinliklerinizin ne kadarına birlikte katılırsınız?					

D. AŞAĞIDAKİ OLAYLAR SİZİN VE EŞİNİZİN ARASINDA NE KADAR SIKLIKLA GERÇEKLEŞMEKTEDİR?

	Hiçbir zaman	Ayda birden az	Ayda bir veya iki defa	Haftada bir veya iki defa	Günde bir defa	Günde birden fazla
25.Teşvik edici fikir alışverişinde bulunmak						
26.Birlikte gülmek						
27.Birşeyi sakince tartışmak						
28.Bir iş üzerinde birlikte çalışmak						

E. Çiftlerin bazen anlaştıkları bazen de anlaşamadıkları çeşitli konular vardır. Son bir kaç haftada, aşağıdaki konuların fikir ayrılığına yol açtığı ya da ilişkide sorun yarattığı olmuş mudur?

	EVET	HAYIR
29.Seks için çok yorgun olmak		
30.Sevgi göstermemek		

F. LÜTFEN YÖNERGEYİ OKUYUP AŞAĞIDAKİ SORUYU CEVAPLANDIRINIZ.

31. Aşağıdaki seçenekler ilişkinizdeki mutluluk derecesini temsil etmektedir. Ortadaki nokta pek çok ilişkideki "mutluluk" derecesini temsil etmektedir. Lütfen, tüm durumları düşünerek, ilişkinizdeki mutluluk derecesini işaretleyiniz. **Lütfen tek bir seçeneği işaretleyiniz.**

Aşırı mutsuz	Oldukça mutsuz	Az mutsuz	Mutlu	Oldukça mutlu	Aşırı mutlu	Tam anlamıyla mutlu

G. LÜTFEN SORUYU OKUYUP CEVAPLANDIRINIZ.

32. Aşağıdaki cümlelerden hangisi ilişkinizin geleceği hakkında hissettiklerinizi en iyi tarif eder? **Lütfen tek bir seçeneği işaretleyiniz.**

	İlişkimin başarılı olmasını çok fazla istiyorum ve bunun İçin yapamayacağı hiç birşey yoktur.
	İlişkimin başarılı olmasını çok istiyorum ve bunun için yapabileceklerimin Hepsini yapacağım.
	İlişkimin başarılı olmasını çok istiyorum ve bunun için payıma düşeni yapacağım.
	İlişkim başarılı olması güzel olurdu, fakat bunun için şu anda yaptıklarımdan daha fazlasını yapamam.
	İlişkimin başarılı olması güzel olurdu, fakat bunun için şu anda yaptıklarımdan daha fazlasını yapmayı reddederim.
	İlişkim asla başarılı olmayacak ve ilişkimin yürümesi için daha fazla yapabileceğim bir şey yok.

APPENDIX B: Brief Symptom Inventory

Kısa Semptom Envanteri

Aşağıda, insanların bazen yaşadıkları belirtilerin ve yakınmaların bir listesi verilmiştir. Listedeki her maddeyi lütfen dikkatle okuyun. Daha sonra o belirtinin sizde, **bugün dahil, son bir haftadır** ne kadar var olduğunu yandaki bölmede, uygun olan yerde işaretleyin. Her belirti için **sadece bir yeri** işaretleyin.

Bu belirtiler son bir haftadır sizde ne kadar var?

	Hiç	Biraz	Orta Derece	Epeyce	Çok fazla
1. İçinizdeki sinirlilik ve titreme hali					
2. Baygınlık, baş dönmesi					
3. Bir başka kişinin sizin düşüncelerinizi kontrol edeceği fikri					
4. Başınıza gelen sıkıntılardan dolayı başkalarının suçlu olduğu duygusu					
5. Olayları hatırlamada güçlük					
6. Çok kolayca kızıp öfkelenme					
7. Göğüs (kalp) bölgesinde ağrılar					
8. Meydanlık (açık) yerlerden korkma duygusu					
9. Yaşamınıza son verme düşünceleri					
10. İnsanların çoğuna güvenilmeyeceği hissi					
11. İştahta bozukluklar					

12. Hiçbir nedeni olmayan ani korkular					
13. Sizi korkuttuğu için bazı eşya, yer ya da etkinliklerden uzak kalmaya çalışmak					
14. Kafanızın bomboş kalması					
15. Bedeninizin bazı bölgelerinde uyuşmalar, karıncalanmalar					
16. Günahlarınız için cezalandırılmanız gerektiği					
17. Gelecekle ilgili umutsuzluk duygusu					
18. Konsantrasyonda (dikkati bir şey üzerinde toplama) güçlük/zorlanmak					
19. Bedenin bazı bölgelerinde zayıflık, güçsüzlük hissi					
20. Kendini gergin ve tedirgin hissetmek					
21. Ölme ve ölüm üzerine düşünceler					
22. Birini dövme, ona zarar verme, yaralama isteği					
23. Bir şeyleri kırma dökme isteği					
24. Diğerlerinin yanındayken yanlış bir şeyler yapmamaya çalışmak					

25. Kalabalıklarda rahatsızlık duymak					
26. Bir başka insana hiç yakınlık duymamak					
27. Dehşet ve panik nöbetleri					
28. Sık sık tartışmaya girmek					
29. Yalnız bırakıldığında/kalındığında sinirlilik hissetmek					
30. Başarılarınız için diğerlerinden yeterince takdir görmemek					
31. Yerinde duramayacak kadar tedirgin hissetmek					
32. Kendini değersiz görmek/değersizlik duyguları					
33. Eğer izin verirseniz insanların sizi sömüreceği duygusu					
34. Suçluluk duyguları					
35. Aklınızda bir bozukluk olduğu fikri					