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Cognition and Relationship Maladjustment: Development of a Measure of Dysfunctional Relationship Beliefs

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The cognitive components of relationship distress have received increasing recognition from marital therapists. In particular, attention has focused recently on the beliefs people hold about intimate relationships and how these beliefs may adversely affect relationship quality. The present article describes the development and validation of an inventory measuring five such dysfunctional relationship beliefs. This Relationship Belief Inventory (RBI) was administered to clinical and nonclinical couples along with measures of marital functioning and a questionnaire assessing irrational beliefs about self. Results demonstrated internal consistency, convergent validity, and construct validity for the RBI scales. These findings and the inventory's utility are discussed.

The cognitive components of relationship distress have received increasing recognition from marital therapists (e.g., Dryden, 1981; Ellis & Harper, 1975; Epstein, 1982; Hurvitz, 1970; Jacobson & Margolin, 1979; O'Leary & Turkewitz, 1978; Stuart, 1980). In particular, attention has focused recently on how holding certain beliefs about relationships may diminish interpersonal satisfaction, limit positive expectancies regarding treatment, and impede partners' collaboration for mutual change. Epstein and Eidelson (1981), for example, found that measures of spouses' specific relationship beliefs were indeed associated with measures of marital maladjustment, negative expectations concerning treatment outcome, and preference for individual over conjoint therapy. This article reports the development and validation of an inventory designed to aid in the systematic assessment of five such dysfunctional beliefs about intimate relationships.

Disagreement is destructive: Satir (1967) has described how spouses may believe that disagreements regarding values, attitudes, goals, or preferences are threats to a secure, loving relationship. Although interpersonal differences can produce conflict in any relationship, an individual's belief that disagreements represent a lack of love or even a sign of imminent divorce is likely to create additional difficulties. Satir notes that the person holding this belief tends to attempt conflict resolution by coercion or avoidance of direct communication. These nonproductive approaches have been further detailed by Raush, Barry, Hertel, and Swain (1974).

Mindreading is expected: Also viewed as dysfunctional is the belief that partners who truly care about and really know one another should be able to sense each other's needs and preferences without overt communication. This expectation generally results in disappointment, misperception, and escalation of conflict (Gottman, Notarius, Gonso, & Markman, 1976; Jacobson & Margolin, 1979; Lederer & Jackson, 1968). The person who believes in "mindreading" may put less effort into clear communication and then experience dissatisfaction when his or her partner fails to respond as desired.

Partners cannot change: The belief that intimate partners can change neither themselves nor the quality of their relationship is considered dysfunctional because it represents a "terminal hypothesis" (Hurvitz, 1970) in which there is no hope for problem amelioration. An individual with such low efficacy expectations is likely to experience diminished satisfaction with a relationship, feel

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less committed to it, and make fewer active attempts to constructively resolve conflicts (Doherty, 1981).

Sexual perfectionism: Believing that one must be a "perfect" sexual partner is also likely to produce relationship distress because it acts as an impediment to sexual arousal and performance (Kaplan, 1974; Walen, 1980; Zilbergeld, 1979). Focusing on sex as a task can elicit negative emotions (e.g., anxiety), inhibit sexual responsiveness, and thereby reduce the pleasure derived from the relationship.

The sexes are different: Finally, the belief that men and women differ dramatically in their personalities and relationship needs is likely to encourage stereotyped perceptions of one's partner and diminish sensitivity to his or her idiosyncratic desires and characteristics. Moreover, attributing interpersonal conflict to such stable factors may contribute to increased blaming, to an expectation of low efficacy in solving relationship problems, and to other "helplessness" responses regarding the relationship (Doherty, 1981).

Scales were developed to measure each of these five dysfunctional relationship beliefs. The reliability and validity of the scales were evaluated with both clinical and nonclinical couples.

Method

Participants

Two separate samples were used in the development of the Relationship Belief Inventory (RBI). Forty-seven couples beginning marital therapy participated in the preliminary item analysis and selection phase. These clients, predominantly middle-class and college educated, had a mean age of 32.6 years (range from 20 to 63 yrs.). They had been married an average of 7.3 years (range from 1 to 38 yrs.) with a mean of .9 children (range from 0 to 5). Their mean score on the Locke–Wallace Marital Adjustment Scale (MAS; Locke & Wallace, 1959) was 86.2 (range from 48 to 120).

Another 100 couples, also predominantly college educated with middle-class backgrounds, participated in the subsequent instrument-validation phase. Fifty-two of these couples were recruited from the community through newspaper and radio advertisements. None of them had ever received marital therapy, and each spouse had a MAS score of at least 100. The mean age for this nonclinical group was 31.9 years (range from 18 to 69 yrs.). They had been married an average of 6.3 years (range from 1 to 39 yrs.) and had a mean of .6 children (range from 0 to 5). The other 48 couples were beginning marital therapy. Their mean age was 35.8 years (range from 23 to 69). These clinical couples had been married an average of 10.0 years (range from 1 to 34 yrs.) and had a mean of .9 children (range from 0 to 5).

Procedure

Scale development. Twenty marital therapists were contacted and asked to list those beliefs about intimate relationships that seemed to cause the most marital difficulties for their clients. The authors then generated an initial pool of 128 items to measure five of these presumably dysfunctional relationship beliefs, each cited by both several therapists and the clinical literature. This inventory was administered to the sample of 47 clinical couples. Each participant responded to the items on a 6-point scale ranging from "I strongly feel that this statement is true" to "I strongly feel that this statement is false." Based upon individual item variances, item-total correlations, and the authors' judgment of clarity of meaning, 12 items were selected to represent each of the five scales.

These 12-item scales were administered to the second sample (100 couples) and were subsequently further refined to 8 items on the basis of item-total correlations. For each scale, approximately one half of the items are positively keyed and one half are negatively keyed.

Sample items comprising the Disagreement Is Destructive scale are "When my partner and I disagree, I feel like our relationship is falling apart" and "I like it when my partner presents views different from mine." Mindreading Is Expected items include "People who have a close relationship can sense each other's needs as if they could read each other's mind" and "I do not expect my partner to sense all my moods." Representative items from the Partners Cannot Change scale are "I do not expect my partner to be able to change" and "If you don't like the way a relationship is going, you can make it better." Among the Sexual Perfectionism items are "A good sexual partner can get himself/herself aroused for sex whenever necessary" and "If my sexual partner does not get satisfied completely, it does not mean that I have failed." Finally, the The Sexes Are Different (MF) scale includes items such as "One of the major causes of marital problems is that men and women have different emotional needs" and "Men and women need the same basic things out of a relationship."

Scale validation. Validation of the RBI was conducted with the sample of 100 couples (48 clinical, 52 nonclinical). All of these participants completed the MAS and the Irrational Beliefs Test (IBT; Jones, 1968). The clinical couples also completed a Therapy Goals and Expectations Questionnaire, previously developed by the authors (Epstein & Eidelson, 1981). This instrument includes three measures of relationship distress found to be associated with dysfunctional relationship beliefs in clinical couples: (a) "Chance," which asks the client to estimate the likelihood of improvement with treatment, (b) "Relationship Goal," which measures the respondent's interest in improving versus ending his or her marriage, and (c) "Therapy Mode," which assesses the person's desire for conjoint versus individual treatment.

Table 1
Intercorrelations Among the Five Scales of the Relationship Belief Inventory

Scales	D	M	C	S	MF
D	—	—	—	—	—
M	.41*	—	—	—	—
C	.44*	.42*	—	—	—
S	.29*	.33*	.27*	—	—
MF	.21*	.24*	.29*	.17*	—

Note. $N = 200$; D = Disagreement Is Destructive, M = Mindreading Is Expected, C = Partners Cannot Change, S = Sexual Perfectionism, MF = The Sexes Are Different.
* $p < .05$.

Internal consistency was assessed by calculating the Cronbach alpha coefficient for each 8-item scale of the RBI. Convergent validity was difficult to establish because of the absence of any other validated measures of relationship beliefs. As a recourse, correlations between the RBI scales and the IBT were determined. The latter instrument measures Ellis's (1962) irrational beliefs about self and, therefore, could not be expected to be as highly related to the RBI scales as another measure of beliefs about relationships might be. Construct validity was evaluated by examining the correlations between the RBI scales and the respondents' marital-adjustment scores on the MAS. These correlations were determined both for the entire sample and for the clinical and nonclinical couples separately. In addition, for the 48 couples beginning marital therapy, the correlations between the RBI scales and the Chance, Relationship Goal, and Therapy Mode measures were calculated.

Results

The clinical and nonclinical groups differed signficantly in mean age, length of marriage, and number of children. Therefore, for the validity analyses, partial correlations controlling for the influence of these demographic variables were determined. In all cases, the corresponding changes in the magnitude of the associations (e.g., between the RBI scales and the MAS) were very slight. As a result, the original, unpartialled correlations are presented here.

Table 1 presents the intercorrelations among the five scales of the Relationship Belief Inventory; Table 2 presents the RBI scale means and standard deviations for the total sample ($N = 200$) and for the clinical ($N = 96$) and nonclinical ($N = 104$) respondents separately. The intercorrelations ranged from a high of $r = .44$ between Disagreement is Destructive and Partners Cannot Change scales to a low of $r = .17$ between the Sexual Perfectionism and The Sexes Are Different scales.

Reliability

The Cronbach alpha coefficients for the five RBI scales ranged from .72 to .81. The alpha values for the Disagreement Is Destructive, Mindreading Is Expected, Partners Cannot Change, Sexual Perfectionism, and The Sexes Are Different scales were .81, .75, .76, .72, and .72, respectively.

Convergent Validity

All of the RBI scales except The Sexes Are Different were significantly positively correlated with the IBT, which measures irrational beliefs about self. The *r*s for the RBI scales with the IBT (in the order of the above paragraph) were .31, .21, .14, .28, and .11, respectively ($N = 200$; $p < .05$ for the first four scales).

Construct Validity

As Table 3 indicates, for the combined sample of clinical and nonclinical couples, scores on all five RBI scales were significantly negatively correlated with MAS scores. The

Table 2
Means and Standard Deviations for the Five Relationship Belief Inventory Scales

	Combined ($N = 200$)		Clinical ($N = 96$)		Nonclinical ($N = 104$)	
Scale	*M*	*SD*	*M*	*SD*	*M*	*SD*
D	13.07	5.77	15.64	5.71	10.70	4.75
M	14.97	5.14	15.55	5.40	14.43	4.86
C	11.38	5.23	12.69	5.50	10.16	4.67
S	16.63	5.56	16.63	5.59	16.63	5.55
MF	13.38	5.78	14.08	5.48	12.73	6.00

Note. Maximum scale score is 40; minimum is 0. A higher score indicates greater adherence to a particular dysfunctional belief. D = Disagreement Is Destructive; M = Mindreading Is Expected; C = Partners Cannot Change; S = Sexual Perfectionism; MF = The Sexes Are Different.

Table 3
Simple Correlations Between the Relationship Belief Inventory (RBI) Scales and the Locke–Wallace Marital Adjustment Scale For the Combined, Clinical, and Nonclinical Samples

RBI scale	Marital Adjustment Scale		
	Combined (N = 200)	Clinical (N = 96)	Nonclinical (N = 104)
D	−.57*	−.40*	−.43*
M	−.24*	−.28*	−.19*
C	−.38*	−.53*	.00
S	−.18*	−.33*	−.21*
MF	−.25*	−.26*	−.25*

Note. D = Disagreement Is Destructive; M = Mindreading Is Expected; C = Partners Cannot Change; S = Sexual Perfectionism; MF = The Sexes Are Different.
* $p < .05$.

correlations ranged from a high of −.57 for the Disagreement Is Destructive scale to a low of −.18 for the Sexual Perfectionism scale.

Although the table also reveals that the findings were similar for the clinical and nonclinical groups considered separately, there were some differences. The largest discrepancy between the two groups is the correlation between the RBI's Partners Cannot Change scale and the MAS. This correlation was statistically significant (r = −.53) for the clinical couples but was nonsignificant (r = .00) for the nonclinical participants. In addition, neither Mindreading Is Expected nor Sexual Perfectionism scores were as strongly related to MAS scores in the nonclinical group as in the clinical group.

Table 4 presents the correlations between the RBI scales and the Chance, Relationship Goal, and Therapy Mode measures for the present sample of clinical couples and for a clinical sample from a previous investigation (Epstein & Eidelson, 1981); this latter group completed the 12-item versions of the Disagreement Is Destructive, Mindreading Is Expected, and Partners Cannot Change scales only. In all cases, the correlations for the current sample were stronger than the corresponding correlations for the other sample.

For the present clinical participants, scores on the Disagreement Is Destructive, Mindreading Is Expected, and Partners Cannot Change scales were significantly negatively correlated with rated likelihood of treatment success, desire to maintain the relationship, and interest in conjoint therapy. By comparison, Sexual Perfectionism scores were correlated with Chance and Therapy Mode scores but not with Relationship Goal scores; The Sexes Are Different scores were unrelated to any of the measures of the Therapy Goals and Expectations Questionnaire.

Discussion

The Relationship Belief Inventory was developed to assess some of the beliefs about intimate relationships that contribute to relationship distress. In addition to adequate internal consistency and moderate evidence of convergent validity (with the IBT), all five RBI scales—Disagreement Is Destructive, Mindreading Is Expected, Partners Cannot Change, Sexual Perfectionism, and The Sexes Are Different—were negatively correlated with marital adjustment as measured by the Locke–Wallace Marital Adjustment Scale.

Table 4
Intercorrelations Between the Relationship Belief Inventory (RBI) Scales and the Chance, Relationship Goal, and Therapy Mode Measures of the Therapy Goals and Expectations Questionnaire for Two Clinical Samples

RBI scale	Chance		Relationship Goal		Therapy Mode	
	N_1	N_2	N_1	N_2	N_1	N_2
D	−.45*	−.20	−.36*	−.06	−.39*	−.37*
M	−.38*	−.17	−.27*	−.23*	−.41*	−.23*
C	−.60*	−.56*	−.51*	−.47*	−.45*	−.30*
S	−.27*	—	−.09	—	−.37*	—
MF	−.04	—	−.13	—	−.05	—

Note. N_1 represents the present clinical sample; results are based upon 73 observations (23 participants did not complete the Therapy Goals and Expectations Questionnaire). N_2 represents another clinical sample (Epstein & Eidelson, 1981); these results are based upon 94 observations with 12-item RBI scales (the S and MF scales were not given to these participants). D = Disagreement Is Destructive; M = Mindreading Is Expected; C = Partners Cannot Change; S = Sexual Perfectionism; MF = The Sexes Are Different.

Among the clinical couples, the RBI scales (except for The Sexes Are Different) were also negatively related to estimated likelihood of improvement in therapy, desire to maintain versus end the relationship, and preference for conjoint versus individual treatment. Thus, these relationship beliefs do indeed appear to be part of a maladaptive cognitive set regarding relationship functioning.

As a whole, the correlations between the RBI scales and the MAS tended to be somewhat lower for the nonclinical sample than for the clinical group (especially for Partners Cannot Change). This pattern of results suggests that the individual who has achieved a successful adjustment in his or her marriage may be better prepared to withstand the potentially damaging influences of these dysfunctional relationship beliefs. Perhaps one of the mediating variables is the nondistressed person's ability to exercise cognitive flexibility, identifying and gaining perspective on his or her own "irrationality" (e.g., Meichenbaum, 1977). These interpretations, however, require empirical verification.

It should be noted that scores on the RBI scales were not particularly high even among the clinical participants (see Table 2), raising the question of whether people actually hold these dysfunctional beliefs to any significant degree. In this regard, two points must be considered. First, scores on any inventory will be influenced by how extreme is the wording of the individual items (e.g., the use of qualifying adverbs and adjectives). Level of item endorsement can easily—but artifactually—be increased or decreased simply by modifying this wording, and, therefore, conclusions cannot really be drawn without careful consideration of the actual items used. In the authors' estimation, many of the RBI items are "extremely" worded, perhaps accounting for their only moderate level of endorsement. Second, it should be recognized that it is not necessary for a person to *completely* embrace a particular belief in order for it to have detrimental effects on his or her relationships (just as a limited level of alcohol in the bloodstream can nevertheless produce severe consequences).

Continued validation of the RBI would be facilitated by obtaining both behavioral samples of couples' interactions as well as their own perceptions of these relationship episodes. In this way, the associations between particular beliefs and manifest behaviors or covert attributions could be examined. For example, individuals who believe that disagreement is destructive may engage in more avoidant communication and may attribute more negative intentions to their disagreeing partners than those who do not adhere strongly to this belief. Similarly, the correspondence between the belief that one must be a perfect sexual partner and incidence of sexual dysfunction could be investigated.

The present inventory appears to have utility in several areas: diagnosing specific cognitive components of relationship dysfunction, assessing cognitive changes in evaluating treatment outcome, initiating discussion of relationship beliefs in marital (or individual) therapy sessions, and anticipating individuals' resistance to conjoint treatment. The RBI, however, was not intended to provide a comprehensive assessment of all important dysfunctional relationship beliefs; currently, the authors are constructing additional scales to measure other beliefs about relationships. Given the absence of systematic procedures for evaluating dysfunctional cognitions regarding relationships, the current RBI represents a significant initial step toward developing an organized approach to cognitive assessment and treatment in marital therapy.

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