

Examining the relationship between perceived acceptance and depression and the potential
moderating role of commitment

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May 2017

Introduction

Acceptance is a relatively new construct within the field of clinical psychology. Cordova (2001) defines acceptance as a change in behavior regarding a negative, aversive stimulus that cannot be changed. He emphasizes that the situation does not change, but rather the individual's evaluation and/or reaction to it does. This change typically goes from avoidant behavior (e.g. criticizing, complaining, or controlling) to an ability to maintain contact with the negative stimulus in a calm manner. Furthermore, he claims that the individual's report of the situation also changes from seeing the given stimulus as noxious to tolerable, or even attractive. Hayes, Luoma, Bond, Masuda, & Lillis (2006) similarly define acceptance as an alternative to avoidance. They emphasize that acceptance is an ability to engage with something viewed as aversive without futile or dangerous attempts to change it. Thus, acceptance can be a useful strategy in contexts in which something cannot be changed (e.g. chronic pain). The study of acceptance has been positively received by many therapists, as there are many situations in which traditional change strategies are ineffective (Cordova, 2001).

Acceptance has been embraced in couples therapy as a strategy to use when partners are unable or unwilling to change, such as on their personal views on daily life practices such as money management and child raising (Cordova, 2001). Within this context, acceptance is defined as an acknowledgment of a partner's flaws in an open and receptive manner (Jacobson & Christensen, 1996). Integrative Behavioral Couple Therapy (IBCT; Christensen, Jacobson, & Babcock, 1995), an intervention that seeks to foster acceptance among couples, is related to an increase in marital satisfaction (Christensen et al., 2004). In IBCT, a therapist will often have the couple think of a specific event that left negative feelings and help them engage in acceptance by empathizing with how the other felt during the situation, detaching oneself from the problem,

and acknowledging and curbing the responses the situation triggers. The slow and steady success of IBCT in promoting relationship satisfaction is likely due to couples developing their ability to respond to conflict and relationship struggles in accepting ways (Christensen et al., 2004).

Acceptance also appears to have utility in a brief-intervention context. Hawrilenko, Gray, & Cordova (2016) found, through the Marriage Checkup (MC; Cordova et al., 2005), a brief intervention based on IBCT, that acceptance has a pivotal role in both short and long-term increases in relationship satisfaction. Overall, it appears as if acceptance training is a useful strategy when working with couples (Hawrilenko et al., 2016; Christensen et al., 2004).

While acceptance is certainly important for relationship health, research has yet to identify whether the benefits arise from an increase in an individual's personal acceptance, an increase in their partner's acceptance, or a combination of the two. Acceptance in this study is conceptualized as the extent to which an individual perceives that his/her partner accepts him/her. From an attachment perspective, perceived acceptance is likely an important component of relationship health as it will likely allow an individual to feel safe and loved within the relationship. While research in the area of perceived acceptance is lacking, this construct may be related to the notion of social support. As social support describes the extent to which an individual feels that he or she can rely and confide in others (Sarason, Levine, Basham, Sarason, 1983), this is likely related to perceived acceptance as one's perception of how much another individual acknowledges his or her flaws is likely related to how much that individual feels as if he or she can rely on them. Perceived social support is negatively correlated with depressive symptomology among a variety of contexts (Stice, Ragan, & Randall, 2004; Grav, Hellzen, Romild, & Stordall, 2012), and peer-support groups have been efficacious in reducing symptoms of depression (Pfieffer, Heisler, Piette, Rogers, & Valenstein, 2011). Within the context of

marriage, perceived social support from one's spouse is negatively correlated with one's depressive symptomology at the same point in time (Dehle, Larsen, & Landers, 2001). This pattern of findings provides some indirect support that perceived acceptance from one's partner may be related to levels of depression.

Depression and Romantic Relationships

Not only has depression been related to social support, but it is also associated with a number of other relationship variables that may be related to acceptance. Individuals in lower quality relationships tend to have higher rates of depressive symptomology (Whisman, 2001), and depression is related to higher levels of relationship distress (Whisman & Baucom, 2012), declines in relationship satisfaction, increased conflict, decreased problem solving skills, and decreased marital satisfaction and quality (Vujeva & Furman, 2011; Beach, Katz, Kim, & Brody, 2003; Dehl & Weiss, 1998; Whisman & Bruce, 1999). A relevant theory related to the study of depression and couples relationships is the Marital Discord Model (Beach, Sandeen, & O'Leary, 1990), which focuses on marital discord as a risk factor for the development of depression among married couples. Within this model, decreased social support and increased hostility from one's partner are identified as key factors that may increase the likelihood of depression. More recently, this theory has been expanded to include family relationship and couples outside of marriage (Beach, 2014) and has been renamed the Couple and Family Discord Model of Depression (CFDM). While this model has expanded and changed, it still holds low levels of support as a key factor related to depression. In addition to social support and hostility, perceived acceptance is also likely related to the construct of perceived criticism. Among a sample of hospitalized people with depression, perceived criticism by one's partner is associated with

higher relapse rates (Hooley & Teasdale, 1989). As such, acceptance is expected to have a negative relationship with depression.

Furthermore, commitment may be relevant to the strength of the relationship between acceptance and depression. Whitton and Kuryluk (2014) found that among same-sex couples, relationship quality and depressive symptomology had a negative association that was particularly salient among couples scoring high in commitment and interdependence, or a belief that one's needs could be met by someone else. Couples who reported higher levels of relationship quality tended to report lower levels of depressive symptomology, and this relationship was especially strong among couples who reported high levels of a desire to be with their partner and low levels of belief that he or she could be happy with someone else. Because commitment may play a moderating role in the relationship between relationship quality and depression, it may similarly play a moderating role in a potential relationship between acceptance and depression.

Relationship Commitment

Commitment, which can be defined as a desire to be with someone beyond the present (Rusbult, 1983), is generally seen as positive aspect of romantic relationships as it often encourages individuals to make decisions that will be better for the couple in the long term and is predictive of later relationship stability (Stanley, Rhoades, & Whitton, 2010; Impett, Beals, & Peplau, 2001). Rusbult (1980), in her Investment Model, describes commitment as a product of (1) one's satisfaction with his or her relationship, (2) one's investments in it, and (3) the availability of other options. Commitment can be broken down into two main types: personal dedication and constraint commitment (Stanley & Markman, 1992). Personal dedication describes a commitment to the individual and is measured through items such as, "My

relationship with my partner is more important to me than almost anything else in my life”, whereas constraint commitment is a sense of commitment due to number of factors that are relevant to one’s relationship, such as children, pets, and income. Givertz & Segrin, (2005) found that there is positive relationship between relationship satisfaction and constraint commitment, which is moderated by personal dedication. In explaining their findings, they suggest that this relationship may be due to dissonance theory, in that people with high constraint commitment may rationalize this situation by forming an artificially higher view of their partner, leading to greater reports of relationship satisfaction.

Therefore, while commitment is generally viewed as a relationship strength, high levels of commitment may be distressing when one’s partner is not accepting. Constraint commitment, in particular, may play an important role in an individual believing that he or she cannot leave an unhappy relationship. Strube and Barbour (1983) found that women in abusive relationships were much more likely to leave the relationship if they had a job and had been in the relationship a shorter amount of time. Therefore, people may stay in relationships due to high levels of constraints even when relationship acceptance (both perceived and one’s own) is low. This feeling of entrapment may lead to depressive symptomology.

Furthermore, high levels of personal dedication to one’s partner may also feel entrapping when an individual does not feel accepted by his or her partner. Unlike constraint commitment, personal dedication may lead an individual to feel stuck in the relationship not because of the individual’s lack of other options, but because of the individual’s strong desire to stay with that partner. There are multiple ways in which this may play out. When individuals are very personally dedicated to their partners because they see their partner as better than any other potential partners but do not feel accepted by them, they might feel as if there is something

wrong with them, which may lead to depression. On the other hand, if individuals are personally dedicated to their partner because they feel as if their partner could not survive without them, this feeling of responsibility for their partner coupled with not feeling accepted by them, may lead to depressive symptomology.

Present Study

Thus, the present study will extend previous research by examining the relationship between acceptance and depression directly, as well as evaluating the role commitment plays in this relationship. While relationship satisfaction has been consistently shown to be related to depressive symptomology (Beach et al., 2003; Whisman & Bruce, 1999; etc.), no research has been done studying acceptance and depression. As the Marital Discord Model discusses, social support may be a key factor in this relationship (Beach, Sandeen, & O'Leary, 1990). Social support is negatively related to depressive symptomology (Dehle, Larsen, & Landers, 2001), which suggests a possibility that there is direct relationship between acceptance and depression as these are similar constructs. Furthermore, while commitment can often be a protective factor, its role in low quality relationships has not been evaluated.

The specific hypotheses are as follows:

1. Perceived acceptance will negatively predict depression such that when an individual perceives that their partner's acceptance of them is low, their level of depressive symptomology will be high.
2. Constraint commitment will moderate the relationship between perceived acceptance and depression. For individuals with high levels of constraint commitment, perceived acceptance will more strongly predict their depressive symptomology than for those individuals low in constraint commitment.

3. Personal dedication to one's partner will moderate the relationship between perceived acceptance and depression. For individuals with high levels of personal dedication, perceived acceptance will more strongly predict depressive symptomology than for those individuals low in personal dedication.

Method

Participants

Participants were recruited to participate in a brief relationship checkup by use of advertisements, community events, and word of mouth, among other strategies. The program was deliberately marketed to all types couples, not just distressed couples. The couple called to enroll if they were interested in participating in the intervention. Upon enrollment, each couple was sent a questionnaire to be completed separately from his or her partner before participation in the intervention. Data from these questionnaires were utilized for this study.

Multiple rounds of the relationship checkup were given, and each varied slightly in the measures given. In total, 85 couples were provided all of the measures relevant to this study, so these were the only individuals used for these analyses. Of those, 49 couples were married, and 36 were cohabitating. There was a total of 84 females and 88 males. Individuals also reported their income, race, relationship length, and number/presence of children. Marital status and income were used as constraint commitments within this study.

Table 1

Descriptive Summary of Participants	
Race	
White	75.30%
African American	18.8%
Hispanic	5.9%
Asian or Pacific Islander	0.6%
American Indian/ Alaska Native	4.7%
Other	0.0%
Education	
Did not graduate from high-school	10.6%
High-School degree or equivalent	45.9%
Voc/Tech Certificate	10.6%
Associate's degree	10.6%
Bachelor degree	15.3%
Graduate degree	7.6%
Income	
None	21.8%
Less than \$10,000	18.8%
\$10,000-\$19,000	20.6%
\$20,000-\$29,000	12.9%
\$30,000-\$39,000	8.8%
\$40,000-\$49,000	4.7%
\$50,000-\$59,000	5.9%
\$60,000-\$69,000	0.6%
\$70,000-\$79,000	2.4%
More than \$80,000	1.8%

Measures

Acceptance. Perceived acceptance by partner was measured using the Relationship Acceptance Questionnaire Short Form (RAQ-SF; Wachs, Meade, & Cordova, 2008). This unpublished 16-

item Likert scale questionnaire assesses an individual's agreement to a given statement on a scale from 0-4, with higher scores indicating a higher level of agreement with the statement.

Statements such as, "My partner accepts my faults and weaknesses," were included. Possible scores on this measure range from 0-56, with higher scores indicating greater levels of perceived acceptance. Cronbach's alpha for this sample is .848.

Depression. Level of depressive symptomology was measured using the Center for Epidemiological Studies for Depression (CESD; Radloff, 1977). This 10-item Likert scale questionnaire included statements such as, "I couldn't get going." Possible scores ranged from 0-30, with higher scores indicating a greater degree of depressive symptomology. Internal consistency of this measure has been shown to be high ($\alpha=.85$; Radloff, 1977). Within this study, the internal consistency was .749.

Commitment. Commitment was measured using the Commitment Inventory- Short Form (CI-SF; Stanley & Markman, 1992). It includes statements such as, "My relationship with my partner is more important to me than just about anything else in my life." To each statement, level of agreement was denoted by a score from 0-6, with higher scores indicating more agreement. Possible scores on this measure ranged from 0-72, with higher scores indicating a greater degree of commitment. Each facet of this scale has an internal consistency of $\alpha=.75$ or greater (Stanley & Markman, 1992). Within this study, the internal consistency was .79.

Results

Data were analyzed using a series of multilevel models. Acceptance was first evaluated individually with depression. Our first hypothesis was supported, with perceived acceptance by one's partners negatively predicting one's own level of depressive symptomology. Next, we tested whether constraint commitment would moderate this relationship (we used income and

marital status as constraints-these were run in separate models). Surprisingly, neither of these variables significantly moderated the relationship between acceptance and depression. Lastly, we tested whether personal dedication would function as a moderating variable. This was supported, with the negative relationship between acceptance and depression being much stronger when personal dedication was high.

Table 2

Descriptive statistics and intercorrelations of study variables

	Married or Cohabiting Individuals (n = 170)			1	2	3
	Mean	SD	Range			
1. Acceptance	34.43	9.56	5 – 48	-	-.321**	.447**
2. Depression	11.54	5.21	3 – 28	-	-	-.236**
3. Commitment	59.59	9.77	18 – 72	-	-	-

** $p < .01$

Table 3

Multi-Level Model Predicting Depression from Acceptance and Income

Predictor	B(SE)	β	p
Acceptance	-.26(.07)	-.49	.00
Income	-1.51(.68)	-.63	.03
Acceptance x Income	.03(.02)	.43	.17

Note. Outcome Variable is Depression, $R^2(\text{within}) = .17(.05)$, $p < .00$

Table 4

Multi-Level Model Predicting Depression from Acceptance and Income

<i>Predictor</i>	<i>B(SE)</i>	<i>β</i>	<i>p</i>
Acceptance	-.45(.10)	-.25	.00
Marital Status	-.60(.27)	-6.28	.03
Acceptance x Marital Status	.45(.27)	.12	.10

Note. Outcome Variable is Depression, $R^2(\text{within}) = .16(.05)$, $p < .00$

Table 5

Multi-Level Model Predicting Depression from Acceptance and Commitment

<i>Predictor</i>	<i>B(SE)</i>	<i>β</i>	<i>p</i>
Acceptance	1.01(.54)	.51	.06
Commitment	.58(.29)	.29	.05
Acceptance x Commitment	-1.75(.69)	-.01	.01

Note. Outcome Variable is Depression, $R^2(\text{within}) = .16(.05)$, $p < .00$

Discussion

Broadly speaking, these results indicate that perceived acceptance and depression are constructs that should be evaluated together within the realm of couple's therapy. Specifically, the results indicate that as perceived acceptance by one's partner increases, one's own level of depressive symptomology tends to decrease. This relationship is moderated by commitment, such that the negative relationship between perceived acceptance and depression is stronger when commitment is higher. Both of these findings were expected, as perceived acceptance is likely related to increased social support and decreased criticism, which are both related to depression (Dehle, Larsen & Landers, 2001). Income and marital status do not appear to play a role in moderating this relationship, which suggests that constraint commitment may be less

salient in this relationship than personal dedication. This result was not expected, as we anticipated that constraint commitments would have created a greater sense of “being stuck” in the relationship that we thought would have made low levels of perceived acceptance particularly salient to psychological health. Possible reasons for this finding will be discussed in the limitations and future directions section.

Clinical Implications

The results suggest that fostering acceptance among couples may help improve depressive symptomology. This finding is relevant not only to the individual’s well-being, but also to the couple’s relationship health, as depression is related to increased conflict and decreased problem-solving skills (Vujeva & Furman, 2011). However, the converse may also be true; improving an individual’s level of depressive symptomology may in turn increase the amount of acceptance he or she feels from his or her partner. In this case, improving an individual’s depression may improve the relationship by allowing the individual to feel more accepted by his or her partner, which may create greater feelings of intimacy and connectedness.

Furthermore, as commitment was shown to moderate this relationship, increasing commitment as well as acceptance within couple’s therapy may be a particularly effective strategy for improving relationship quality and individual well-being. Level of depressive symptomology was lowest when both perceived acceptance and commitment were high, therefore maintaining high levels of both of these constructs is likely important to relationship and individual health.

However, it is particularly important to note that increasing commitment in the absence of acceptance may be a particularly ineffective treatment strategy, as depressive symptomology was highest when commitment was high and perceived acceptance was low. This illustrates that

commitment may not be a positive relationship characteristic in and of itself, but may depend on other characteristics of the relationship.

Limitation & Future Directions

In the future, this research should be extended to a more diverse population, as this would allow for greater generalizability of the results. Furthermore, as this research was done exclusively on couples who were seeking a relationship intervention, future research should be done to demonstrate that the results of this study are not due to systematic differences in these individuals. Another weakness of this research is that it did not take into account partner data. By using an Actor Partner Independence Model in the future, the amount of variance in one's acceptance and depression scores accounted for by his or her partner's scores could be established. Finally, while self-report measures are a useful tool, it may be particularly interesting to use other methods to evaluate these constructs. In particular, operationalizing depression as a diagnosis of depression rather than using a self-report measure of level of depressive symptomology as we did in this study may be particularly relevant.

In addition to research addressing these limitation, there are many other possible avenues by which this topic could be explored in the future. First, these variables could be evaluated over the course of the intervention as a way in which to assess the direction in which the variables acceptance and depression are related. In other words, the following questions should be evaluated: does low perceived acceptance lead to depression? or does depression lead to low perceived acceptance? or is this relationship cyclical in nature? Another possible avenue for research would be to evaluate which facets of commitment are most salient in moderating this relationship. This study attempted to isolate personal dedication from constraint commitment, however, more research could be done in this area. First, other possible constraints could be

evaluated, such as number of children and number of shared investments. In addition to these constraints, other facets of commitment, such as beliefs regarding divorce, should be evaluated. Furthermore, all of these potential relationships should be evaluated while controlling for gender. As men are often the financial supporters of the family, constraint commitments may be more salient for women. Therefore, even though income and marital status were not moderators within this model, there may actually be a significant relationship when controlling for gender. Finally, as commitment was shown to not always be a beneficial relationship attribute, other situations in which increasing commitment may be harmful to individuals and the relationship should be evaluated.

Summary

In conclusion, this study was important as it was the first study we know of to evaluate the relationship between perceived acceptance and depression. A statistically significant relationship was found, with perceived acceptance negatively predicting level of depressive symptomology. Furthermore, personal dedication was found to moderate this relationship. This suggests that fostering both acceptance and commitment in couple's therapy may be a particularly effective strategy for both individual and relationship health, but that increasing commitment when perceived acceptance is low may be problematic.

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