Predictors of Outcome in Emotionally Focused Marital Therapy

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ABSTRACT

The present study assessed the impact of client/relationship variables in predicting outcome in a dynamic/experiential approach to marital therapy. On the basis of an examination of the theoretical assumptions underlying this approach, three predictor variables were assessed: attachment, self-disclosure, and trust. Outcome criteria included 1) marital satisfaction level, 2) marital satisfaction gains, 3) intimacy level, and 4) therapist rating of improvement. It was hypothesized that couples presenting with higher levels of attachment, self-disclosure and trust would be more likely to be maritally satisfied, as indicated by a higher level of marital satisfaction and intimacy at posttreatment and at follow-up. It was also hypothesized that couples presenting with lower levels of attachment, self-disclosure and trust would be most likely to make the largest gains in marital satisfaction at posttreatment and at follow-up, and receive a high rating of improvement from their therapist at termination. Thirty-four couples were provided with 12 sessions of Emotionally Focused Marital Therapy (EFT). Couples were assessed at pretreatment, posttreatment, and at a three-month follow-up.

Couples who were most likely to be maritally satisfied at termination indicated a higher level of couple-therapist alliance at the end of the third session. Couples who were most likely to be maritally satisfied at follow-up consisted of: a) females who indicated a higher level of faith (trust) in their partner at intake, and b) partners who indicated a higher level of the therapeutic alliance at the end of the third session.

For individuals, males who were most likely to be maritally satisfied at termination were, at intake, most likely to engage in a higher level of proximity-seeking (attachment). Males who were most likely to be maritally satisfied at follow-up were with females who indicated a higher level of faith in their partner.

Couples who were most likely to make the largest gains in marital satisfaction at termination indicated a higher level of therapeutic alliance by the end of the third session. Couples who were most likely to make the largest gains in marital satisfaction at follow-up: a) indicated a lower level of marital satisfaction at intake, b) consisted of males who indicated a lower level of use of attachment figure at intake, and c) indicated a higher level of couple-therapist alliance at the end of the third session.

For individuals, males who were most likely to make the largest gains in marital satisfaction at termination were older and had been rated as being less emotionally expressive by their partner at intake. Males who were most likely to make the largest gains in marital satisfaction at follow-up were older at intake.

There were two additional criteria of outcome: intimacy level and therapist rating of improvement. Results revealed four significant predictors of the level of intimacy. First, the couple's general level of intimacy at intake was the strongest predictor of the couple's general level of intimacy at follow-up. Couples with a higher level of intimacy at intake tended to have a higher level of intimacy at follow-up. Second, couples who established a higher level of alliance with the therapist by the end of the third session tended to show a higher level of intimacy at follow-up. Third, one aspect of trust, the females' level of faith significantly predicted those males who were likely to have the highest level of intimacy at follow-up. Fourth, the females' level of apathy self-disclosure at intake significantly predicted her follow-up level of intimacy.

The fourth criteria of outcome was the therapist rating of improvement at posttreatment. There was only one significant predictor of therapist rating of improvement. Couples who had established a higher level of alliance by the end of the third session were most likely to have been rated as improved by therapists.

Conclusions and suggestions for future research were made on the basis of the results of this study.

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CHAPTER I INTRODUCTION

A substantial body of research in marital therapy has developed over the last two decades. Within this broad category of research activity, several major trends have emerged. The first research trend has been to determine the efficacy of marital therapy in general. This research has found that marital therapy in general is effective in alleviating marital distress in couples receiving treatment compared to a waiting-list control group (Gurman & Kniskern, 1978; Baucom & Hoffman, 1986; Jacobson & Addis, 1993). Given the research evidence supporting the efficacy of marital therapy, the second research trend has been to focus attention on comparative outcome studies that compare two or more different approaches to marital therapy. The general conclusion has been that, with certain exceptions, few significant differences, in terms of outcome, have been found among the various approaches to marital therapy (Hahlweg & Markman, 1983; Baucom & Hoffman, 1986). These findings suggest that no one treatment modality is significantly more effective than another.

The fact that comparative research has been generally unable to establish the superiority of any one particular approach to marital therapy and the fact that there is a high level of variability in couples' response to marital therapy (Jacobson, Follette & Elwood, 1984), has signalled the need for researchers to investigate predictors of outcome in marital therapy with the ultimate goal of matching specific couples to specific approaches (Jacobson, 1984; Jacobson, Follette & Elwood, 1984; Bennun, 1985; Baucom & Hoffman, 1986; Snyder, Mangrum, & Wills, 1993). Thus, the current trend in marital therapy, similar to individual psychotherapy, is research that focuses upon factors that might be influential in determining outcome in specific approaches.

Researchers in both individual and marital therapy are currently investigating three factors that appear to be influential in determining therapy outcome: characteristics of clients, therapist interventions, and the client-therapist interaction (Garfield & Bergin, 1978; Bergin & Garfield,

1986; Jacobson & Addis, 1993; Snyder, Mangrum, & Wills, 1993). In particular, client variables have begun to receive considerable attention.

Many authors have stated that the client is the most important variable in determining outcome in psychotherapy (Frank, 1979; Strupp, 1973). According to a panel of experts engaged in psychotherapy practice and research, it has been estimated that two-thirds of therapy outcome variance is due to clients' efforts (Prochaska & Norcross, 1982). This would suggest that client variables might be more important for outcome than therapist variables (Prochaska & DiClemente, 1986). Frank (1974), in a review of 25 years of psychotherapy research, concluded "that the most important determinants of long-term improvement lie in the patient" (p.339). As a result, it appears essential that in order to increase our understanding of the effectiveness of psychotherapy, research is needed to establish the specific forms of psychotherapy that are beneficial for specific clients and to define the characteristics of both client and therapy that have led to successful outcome (Bergin & Lambert, 1978; Frank, 1979). Recent findings in the individual psychotherapy literature suggesting that successful outcome is a function of a congruence between client personality and psychotherapeutic approach (Berzins, 1977; Beutler, 1979; Beutler & Mitchell, 1981; Beutler, 1983; Calvert, Beutler, & Crago, 1988) confirm the usefulness of matching clients to a therapeutic approach in order to increase the likelihood of successful outcome.

In a similar vein, current marital therapy research has been conducted to ascertain the couple characteristics that are associated with positive outcome. Marital therapy researchers view the couple's relationship as the client in outcome studies. The client/relationship variables that have been investigated thus far include age, length of marriage, divorce potential, level of commitment, positive feelings, power inequality, personality factors, symptom correlates of marital distress such as depression, and psychopathology. Some client variables that have been investigated are associated with the relationship (i.e length of marriage, divorce potential, level of commitment, positive feelings) and some client variables may be

viewed as individual variables which impact on the relationship (i.e. depressive symptoms, psychopathology, level of affiliation, level of independence). Hereafter, both types of client variables will be referred to as relationship variables in that they have been chosen for their hypothesized impact on the marital relationship.

Previous research that examined relationship variables as predictors of marital therapy outcome has selected variables without regard to the theory or intervention strategies of that particular therapeutic approach (i.e. Jacobson et. al., 1986; Snyder, Mangrum , & Wills, 1993). For the most part, previous studies have selected variables on the basis of demographic characteristics such as age and length of relationship or general observations of maritally distressed couples such as positive or negative emotional affect, divorce potential, depressive symptomatology and psychopathology in one partner. For purposes of advancing the field of marital therapy, studies are needed that select relationship variables that are related to the clinical interventions, goals and/or theoretical aims of the particular therapy in question.

As well, the majority of the research studies that have examined the association between relationship variables and marital therapy outcome have focused on Behavioral Marital Therapy (BMT). This research has begun to identify which couples are the most and least likely to benefit from BMT. In comparison, the dynamic/experiential approaches to marital therapy have produced little research (Gurman & Kniskern, 1978; Baucom & Hoffman, 1986; Jacobson & Addis, 1993; Snyder, Mangrum, & Wills, 1993). Thus, there is a need within the marital therapy field to assess couples' responses' to "nonbehavioral" approaches so that we can further our understanding of which couples benefit from which treatment approaches to increase the likelihood of successful outcome for all types of couples.

One alternative approach to Behavioral Marital Therapy is Emotionally Focused Marital Therapy (EFT). EFT is a dynamic/experiential approach to marital therapy that is currently recognized as the second most empirically validated marital therapy approach (Alexander, Holtzworth-Munroe & Jameson,

1994). Randomized controlled trials have shown EFT to be very effective at reducing marital distress in the general population (Johnson & Greenberg, 1985a, 1985b; James, 1991; Goldman & Greenberg, 1992), and in couples with a depressed partner (Dessaulles, 1991). Moreover, in one comparative study, EFT has been found to be superior to behavioral marital therapy in increasing marital satisfaction, increasing intimacy and reducing target complaints reported by couples prior to therapy (Johnson & Greenberg, 1985a). Although recent research has identified several in-therapy processes related to outcome in EFT (Johnson & Greenberg, 1988), no research studies have yet examined which relationship variables predict successful outcome when EFT is the treatment modality. Thus, there has been a dearth of research investigating which types of couples are most likely to benefit from this approach.

The purpose of the present study is to assess the contribution of three relationship variables in predicting outcome in EFT. In contrast to previous studies, the three relationship variables in this study will be selected on the basis of the theoretical assumptions underlying this approach.

First, the literature identifying associations between predictor/relationship variables and marital therapy outcome will be reviewed. Next, a description of EFT will be presented with an emphasis on the basic theoretical assumptions underlying this approach. A description of those relationship variables that are theoretically linked to this approach will follow. Finally, hypotheses concerning the association between these relationship variables and outcome in EFT will be presented.

Review of the Literature

In general, the relationship variables that have been investigated to date can be classified into five categories: 1) demographic variables, 2) relationship characteristics, 3) personality factors, 4) symptom correlates of marital distress, and 5) psychopathology. This section will review those studies that have attempted to determine an association between these relationship variables and outcome in marital therapy. First, studies that have investigated various demographic characteristics of couples will be presented. Second, there will be a discussion of those studies investigating relationship characteristics and outcome. Third, a discussion of those studies that have assessed the association between personality factors and outcome will be presented. Fourth, a discussion of those studies that have identified symptom correlates of marital distress as predictors of outcome will be presented. Fifth, studies that have investigated psychopathology and outcome will be presented. Finally, conclusions based on this review of the literature and implications for this study will be highlighted.

Demographic Variables

The first attempts to relate relationship variables to marital therapy outcome focused on demographic variables. One of these demographic variables was age. Several studies have suggested that younger couples benefit more from behavioral marital therapy (BMT) than older couples (Turkewitz & O'Leary,1981; Baucom, 1984; Hahlweg, Schindler, Revenstorf, and Brengelmann, 1984; Bennun, 1985). For example, Turkewitz and O'Leary (1981) conducted a comparative outcome study of 30 couples assigned to either behavioral marital therapy or communication therapy. They found that the mean age of the couple was the strongest predictor of outcome. The correlations ranged from -.52 to -.76. Further analyses revealed that younger couples changed more in behavioral marital therapy while older couples responded better to communication therapy.

In another study that assessed the relation between age and outcome, Baucom (1984) randomly assigned 72 maritally distressed couples to one of four treatment conditions consisting of variations of behavioral marital therapy. In order to replicate the findings of Turkewitz and O'Leary (1981), couples were divided into two groups on the basis of age: a younger-couple group with a mean age of 25.1 and an older-couple group with a mean age of 37.2. Analyses revealed that younger couples improved significantly more than the older couples on a self-report measure in which a person indicates the amount of behavior change desired of the spouse in specific areas of marital interaction. However, there were no significant effects of age on the Marital Adjustment Scale, a frequently used measure to assess global marital satisfaction.

Other research, however, has not found age to be related to outcome (Freeman, Leavens,& McCulloch, 1969; Crowe, 1978; Mendonca, Lumley, & Hunt, 1982; Jacobson, Follette, & Pagel, 1986; Snyder, Mangrum, & Wills, 1993). Moreover, in a recent study designed to replicate the findings of previous research that suggested a significant assocation between age and outcome, Jacobson et. al.(1986) included more psychometrically sound criterion variables and more rigorous statistical analyses than those used in previous research. For example, these authors used a more established measure of marital satisfaction (i.e Dyadic Adjustment Scale). As well, due to the fact that pretreatment marital satisfaction accounted for 37% of the variance in posttreatment marital satisfaction, these authors partialled out the effects of pretreatment marital satisfaction on outcome. These researchers provided 60 couples with 12 sessions of behavioral marital therapy. These authors did not find a significant association between age and outcome.

Other demographic variables that have been examined but not found to relate to marital therapy outcome have included length of marriage, number of previous marriages, and number of children (Freeman, Leavens, & McCulloch, 1969; Crowe, 1978; Hahlweg, Schindler, Revenstorf, and Brengelmann,1984; Bennun, 1985; Snyder, Mangrum, & Wills, 1993). For example, Crowe (1978) assigned 42 couples to three forms of conjoint marital therapy: behavioral,

insight-oriented and supportive-control style. Couples received between 5-10 sessions. Many demographic variables were examined for their prognostic significance including social class, duration of marriage, duration of problem and presence of children. None of these variables had a significant influence on outcome. In one therapeutic approach, the behavioral one, educational level was negatively correlated with outcome. That is, the uneducated couples obtained higher scores on marital adjustment at the end of therapy than the educated couples. It is important to note that this finding was obtained with a sample of five couples.

In another major study that assessed demographic variables relating to outcome, Hahlweg and his associates (1984) assigned 85 maritally distressed couples to either BMT, Communication Therapy conjoint, Communication Therapy conjoint-group, or a waiting-list control group. Demographic characteristics such as length of partnership and number of children were assessed. There were no significant correlations between these variables and marital therapy outcome.

In a more recent study that assessed demographic variables relating to outcome, Snyder, Mangrum & Wills (1993) assigned 55 couples to either behavioral or insight-oriented marital therapy. Couples received up to 25 sessions with an average of 18.9 sessions of behavioral marital therapy and an average of 19.0 sessions of insight-oriented marital therapy. Demographic characteristics such as age, race, education, occupational status, length of marriage, number of previous marriages, and number of children were assessed. Results suggested that none of these variables were significantly predictive of outcome at posttreatment. At four-year follow-up, occupational status was significantly related to outcome. Couples were more likely to be divorced or maritally distressed four years following therapy if partners were either unemployed or were employed at unskilled labour.

Relationship Characteristics

A second focus of research has been to investigate the association between relationship characteristics and outcome in marital therapy. One such example is level of commitment (Beach & Broderick, 1983). Commitment was selected on the belief that a certain level of commitment between partners may be necessary to maintain the willingness to resolve problems in the face of insecurity and instability. In this study, 42 couples who were provided between 10-15 sessions of behavioral marital therapy were asked to read a definition of commitment developed by the authors and to rate themselves on a 0 to 100 scale to indicate how commited they are to their marriage. For females, the level of commitment prior to therapy predicted gains in marital satisfaction at the end of therapy. In contrast, for males, less commitment at intake was associated with greater gains in posttreatment marital satisfaction.

There are several problems with these findings. First, this measure has been used in only one study and has not been proven to be a valid and reliable measure of commitment. For example, these authors reported a low level of concurrent validity for husbands. Second, the level of pretreatment marital satisfaction was not partialled out of the regression analyses. This could be a problem given that pretreatment marital satisfaction has been known to contribute substantially to the variance in post-therapy marital satisfaction (Jacobson et. al., 1986).

Another relationship characteristic that has been investigated is the amount and intensity of emotional affection between partners. Emotional affection was selected in recognition of the powerful influence that the presence or absence of affection may have in the couple's motivation to improve their relationship. From an exchange theory perspective, a couple with a certain level of affection will likely exhibit interactions that are positively reinforcing. These positive interactions may reinforce the willingness to improve the relationship. There is evidence that positive emotional affection towards partner at intake is predictive of successful

outcome in both behavioral marital therapy and communication therapy (Hahlweg, Schindler, Revenstorf, and Brengelmann,1984; Turkewitz & O'Leary,1981; Crane, Newfield, & Armstrong, 1984; Snyder, Mangrum, & Wills, 1993). For example, Hahlweg and his associates (1984) assigned 85 maritally distressed couples to either BMT, Communication Therapy conjoint, Communication Therapy conjoint-group, or a waiting-list control group. Sets of predictor variables were formed into three groups: 1) the intensity and duration of conflict, 2) the quantitiy and quality of affection/intimacy, and 3) demographic characteristics such as age, length of partnership and number of children. Measures used included self-report questionnaires and a marital interaction observation rating system. Results suggest that only the emotional-affective quality of the relationship predicted successful outcome in marital therapy. Specifically, these researchers identified the following three factors as indicative of an unfavourable prognosis in marital therapy: 1) the female scores low on the PFB Togetherness /Communication Scale, 2) both partners score low on the PFB Tenderness Scale, and 3) the frequency of sexual interaction is less than twice per month. These authors concluded that the quality of emotional affection is predictive of outcome.

Recently, there have been concerns raised about the validity of these findings (Jacobson et. al., 1986). For example, in order to analyze predictors for successful outcome, Hahlweg and his associates (1984) rated a couple as successful when 1) both partners rated their relationship as somewhat happy (i.e. a rating of three or more on a scale of one to five on a General Happiness Rating Scale), and 2) at least one partner scored one or more points higher on the Marital Adjustment Scale when compared to the pretest score. There are problems with this approach. First, the General Happiness Rating Scale has not been proven to be a reliable and valid measure for assessing marital satisfaction. Second, this commonly used method of classifying couples as either "improved" or "not improved" results in a great loss of information (Jacobson et. al., 1986). Valuable information such as the degree of improvement and whether a couple remained in the distress range has been lost.

Turkewitz and O'Leary (1981) also investigated the association between the degree of emotional affection between partners and outcome. In this comparative outcome study, 30 couples were assigned to either behavioral marital therapy or communication therapy. One of the predictor variables measured was the extent of positive feelings between partners. Positive feelings, was assessed by the Positive Feelings Questionnaire (PFQ), a self-report questionnaire designed to measure the extent of positive feelings a person experiences in various aspects of the relationship. These researchers found that positive feelings that partners have towards each other, prior to therapy, are positively correlated with changes in the female's marital satisfaction as a result of marital therapy.

A more recent study that investigated the association between level of emotional affection and outcome was conducted by Snyder, Mangrum, & Wills (1993). In this study, 55 couples were assigned to either behavioral or insight-oriented marital therapy. Couples received up to 25 sessions with an average of 18.9 sessions of behavioral marital therapy and an average of 19.0 sessions of insight-oriented marital therapy. The degree of emotional affection between partners at intake was assessed by the Marital Satisfaction Questionnaire, a self-report measure of relationship functioning. Results suggested that couples with a high level of negative marital affect at intake were more likely to remain maritally distressed at posttreatment and four-year follow-up. These researchers utilized hierarchical regression analyses to determine the contribution of the predictor variables after controlling for pretreatment marital satisfaction. Their use of a multivariate prediction model has been recommended to increase knowledge regarding predictors of success in marital therapy (Jacobson et. al., 1986). This study was one of the few studies that utilized statistically stringent methods to assess the impact of emotional affection on marital therapy outcome.

There are several problems in assessing positive affection. First, it seems intuitively obvious that the more satisfied a couple is prior to therapy, the more likely they will be maritally satisfied at the end of therapy. In fact, research suggests that the pretreatment level of global

marital satisfaction, as measured by the Dyadic Adjustment Scale, is highly correlated with outcome and accounts for 37% of the variance in marital satisfaction following behavioral marital therapy (Jacobson et. al.,1986). Another problem with investigating emotional affection is that it is too general in scope to be able to identify the key ingredient(s) underlying positive feelings. For example, it may be that a high degree of emotional affection/positive feelings toward a partner may be indicative of high levels of trust in the relationship. Predictor variables such as positive feelings need to be more specific so that marital researchers can identify the factors influencing both marital satisfaction and marital distress. Thus, the assessment of emotional affection and/or global marital satisfaction as a predictor variable does not increase our understanding of the factors that influence marital satisfaction or the therapeutic interventions that are necessary in the process of increasing marital satisfaction among distressed couples.

A more recently investigated relationship characteristic was power inequality between partners (Whisman & Jacobson, 1990). Whisman and Jacobson (1990) provided 31 distressed couples with an average of 23 sessions of behavioral marital therapy. Prior to onset of therapy, the degree of each couple's power balance/imbalance was assessed from observations of partners' discussion of the events of their day. Results suggested that, after controlling for the effects of pretreatment marital satisfaction, the couple's power inequality prior to therapy predicted treatment outcome at posttest and six-month follow-up. Thus, couples with a greater power inequality at intake were more likely to benefit from behavioral marital therapy.

The fourth relationship characteristic that has been assessed was the couple's problem-solving skills (Snyder, Mangrum, & Wills, 1993). In this major study assessing numerous predictor variables, 55 couples were assigned to either behavioral or insight-oriented marital therapy. Couples received up to 25 sessions with an average of 18.9 sessions of behavioral marital therapy and an average of 19.0 sessions of insight-oriented marital therapy. Problem-

solving was assessed on a self-report measure of relationship functioning (Marital Satisfaction Inventory, Snyder, 1981). Results suggested that couples with a wide variety of problem-solving deficits at intake were more likely to be classified as maritally distressed and/or be divorced at four year follow-up.

Personality Factors

The third major focus of research has been to investigate personality factors that relate to outcome in marital therapy. There have been three studies that attempted to establish a relation between personality factors and marital therapy outcome (Baucom & Aiken, 1984; Jacobson et. al., 1986; Snyder, Mangrum, & Wills, 1993). The personality factors that have been assessed were the level of masculinity/femininity and the level of affiliation/independence.

Three studies have focused on masculinity/femininity (Baucom & Aiken, 1984; Jacobson et. al., 1986; Snyder, Mangrum, & Wills, 1993). In the first study, Baucom and Aiken (1984) examined masculinity and femininity on the basis of previous research that suggested that both of these personality factors were related to a couple's marital satisfaction level. Masculinity, defined as possessing a goal-oriented, instrumental approach and femininity, defined as possessing an interpersonally-oriented, sensitive and understanding approach, were both perceived by these authors as being necessary to deal with conflict in the relationship. In this study, 54 non-distressed and 54 maritally distressed couples were assessed in order to determine the association between masculinity, femininity, and marital satisfaction. The maritally distressed couples were given marital therapy. Masculinity and femininity were assessed using a scale that was developed from items on the California Psychological Inventory. Individuals obtaining high scores on the masculinity scale "view themselves positively overall, have confidence in themselves in achievement-oriented and social interactions, and behave in ways to assume direct control over their environments" (p.439). Individuals obtaining high scores on the femininity scale "place a major value on interpersonal relationships and are

attuned to the needs and feelings of others (p. 439)". These authors found that the female's level of femininity prior to treatment was significantly correlated with increases in marital satisfaction for both partners at the end of treatment. Masculinity did not predict outcome.

In a study designed to assess the validity of the above findings concerning femininity and marital therapy outcome, Jacobson and his colleagues (1986) criticized the above study on the basis of utilizing an unproven measure of femininity, categorizing couples into only two groups as either "improved" and "not improved", and relying on statistical analyses that did not partial out the contribution of pretreatment marital satisfaction to posttreatment marital satisfaction. In contrast to Baucom and Aiken's study, Jacobson and his colleagues used the Bem Sex Role Inventory and partialled out the contribution of pretreatment marital satisfaction on posttreatment marital satisfaction. It was found that the level of masculinity and femininity did not then predict marital satisfaction at the end of treatment.

In the third study that attempted to determine an association between masculinity/femininity and marital therapy outcome, Snyder, Mangrum, & Wills (1993) assigned 55 couples to either behavioral or insight-oriented marital therapy. Couples received up to 25 sessions with an average of 18.9 sessions of behavioral marital therapy and an average of 19.0 sessions of insight-oriented marital therapy. These authors used measures to assess masculinity/femininity that were similar to the measures used by Baucom and Aiken (1984). Results suggested that couples who, at intake, indicated lower scores on the Femininity scale were more likely to be classified as maritally distressed at four year follow-up. There were no significant findings at termination. These authors concluded that couples who exhibited lower "emotional responsiveness" at intake were less likely to improve following marital therapy.

The other personality factor that has been assessed in the marital therapy outcome literature was the interaction between affiliation and autonomy among partners (Jacobson et. al., 1986). In this study, 60 couples were provided

with 12 sessions of behavioral marital therapy, although couples were able to receive up to 16 sessions if necessary. On the basis of clinical descriptions of couples exhibiting an affiliation/independence pattern whereby one partner seeks intimacy and closeness and the other seeks activities that promote autonomy and independence (Jacobson and Margolin, 1979), it was believed that this paradoxical, negative interaction pattern within couples would be highly resistant to change in marital therapy and would prevent couples from achieving a high level of marital satisfaction. In this pattern, one partner seeks to affiliate with the other partner who, in turn, seeks independence. This interaction is self-reinforcing. The more the affiliative partner seeks contact, the more the independent partner will seek to withdraw. As well, the more the independent partner seeks independence, the more likely the affiliative partner feels the need to seek contact. This pursue-withdraw pattern has been noted to be problematic in marital therapy by various clinicians and researchers (Jacobson & Margolin, 1979; Wile, 1981; Gottman & Levinson, 1986; Greenberg & Johnson, 1986; 1988). Preferences for affiliation and independence were assessed on two subscales of the Edwards Personal Preference Scale, a self-report personality inventory. Various analyses indicated that a highly affiliative wife and a highly independent husband were less likely to benefit from behavioral marital therapy. Jacobson and his colleagues referred to this variable as the "degree of traditionality" within the couple. They concluded that the degree of traditionality was negatively correlated with successful outcome in behavioral marital therapy.

Symptom Correlates of Marital Distress

A fourth set of relationship variables that has been investigated in relation to outcome in marital therapy is symptom correlates of marital distress. Symptom correlates of marital distress were obtained from clinical descriptions of distressed couples presenting for therapy. One symptom of marital distress that has been investigated is divorce potential. Previous research suggested that the more steps taken toward divorce prior to onset of

behavioral marital therapy (BMT), the less likely that there will be increases in marital satisfaction at the end of therapy (Beach & Broderick, 1983; Ewart, 1978b; Hahlweg et. al., 1984). Moreover, these couples were more likely to drop out of therapy (Ewart, 1978b).

Recent research, however, has not found divorce potential to be significantly predictive of success in BMT (Jacobson et. al., 1986). In contrast to other studies, divorce potential was assessed in this study by the Marital Status Inventory. The Marital Status Inventory has been found to possess very good reliability and validity (Weiss & Cerreto, 1980). In contrast, the other studies utilized individualized scales that had not been formally evaluated. As well, in contrast to other studies, this study utilized a more rigorous statistical approach by partialling out pretreatment marital satisfaction. The spouse with the highest score was used in the analyses. Based on previous findings, it was predicted that couples in which at least one spouse had taken concrete steps toward divorce would be less satisfied with their relationship following BMT. No significant findings were obtained. These authors attributed the positive findings in other studies to the use of unreliable and unproven measures and poor statistical methodology.

Another symptom correlate of marital distress that has been investigated was depressive symptoms. This variable was selected due to the high incidence of depressive symptoms reported by those seeking marital therapy (Jacobson, 1984). Inconsistent findings have been obtained regarding the association between pretreatment levels of depression and outcome. In one study, 60 couples were provided with 12 sessions of behavioral marital therapy, although couples were able to receive up to 16 sessions if necessary (Jacobson et. al., 1986). In this study, the number of depressive symptoms was obtained from the Problem Description Questionnaire, a checklist of presenting psychiatric symptoms used at the University of Washington. Results suggested that couples with a partner who endorsed a high number of depressive symptoms at intake were more likely to be maritally satisfied at termination but not at follow-up. In contrast, Snyder, Mangrum & Wills (1993) found that a high level of

depression at intake, as measured by significant T scores on the MMPI Depression Scale, was negatively related to behavioral and insight-oriented marital therapy outcome at termination and at 4-year follow-up. In this study, 55 couples were randomly assigned to either behavioral or insight-oriented marital therapy and were provided with an average of 18.9 sessions of behavioral marital therapy and an average of 19.0 sessions of insight-oriented marital therapy.

Psychopathology

A fifth major focus of research has been to investigate the association between psychopathology and marital therapy outcome. There have been inconsistent findings with respect to psychopathology as a predictor of outcome in marital therapy (Bennun, 1985; Sher, Baucom & Larus, 1990; Snyder, Mangrum, & Wills, 1993). Bennun (1985) assigned 45 couples to 10 sessions of conjoint behavioral marital therapy, group marital therapy or a one-partner treatment modality. Results suggested that couples presenting with phobias, anxiety and/or obsessive-compulsive behavior were less likely to exhibit change in these target areas at posttreatment or at the six month follow-up. In a similar vein, Sher, Baucom and Larus (1990) assigned 35 couples into three groups: a) distressed couples in which one member exhibits a significant level of depression but no other psychopathology (as measured on the MMPI Depression scale), b) distressed couples in which one member exhibits a significant level of psychopathology other than depression (as measured on other MMPI clinical scales), and c) distressed couples with no significant levels of depression or psychopathology. Couples were given 15 sessions of cognitive behavioral marital therapy. Results suggested that couples with one member who exhibited psychopathology were least likely to meet the criteria for clinically significant change. The results of both of these studies suggest that specific psychopathology may be a prognostic indicator of unsuccessful outcome in behavioral marital therapy.

In contrast, Snyder, Mangrum, & Wills, (1993) found that, in general, the

couple's level of psychopathology was insignificant in predicting outcome in both behavioral and insight-oriented marital therapy. In this study, 55 couples were provided with an average of 18.9 sessions of behavioral marital therapy and an average of 19.0 sessions of insight-oriented marital therapy. Psychopathology was assessed on the MMPI clinical scales. A measure of the overall level of psychopathology in the relationship was obtained by calculating the mean of scales 1-4 and 6-9 on the MMPI. The only significant finding was that couples who obtained lower scores on the MMPI K(Correction) scale at intake were more likely to be classified as maritally distressed at four-year follow-up. These authors concluded that couples with lower "psychological resilience" at intake were least likely to be maritally satisfied following marital therapy.

Summary of the Research Literature

There are several conclusions that can be made on the basis of a review of the literature. First, in general, demographic variables such as length of marriage, number of previous marriages, and number of children have not been found to be related to outcome in marital therapy, with the exception that couples who were older and who were either unemployed or employed at unskilled labour were found to be less likely to benefit from marital therapy. However, more recent studies have found no significant correlation between age and outcome.

Second, studies assessing relationship characteristics have suggested that couples with a high level of negative marital affect and/or a high level of "emotional disengagement" (Jacobson & Addis, 1993) including a low frequency of sexual contact, less togetherness, tenderness, and emotional responsiveness were less likely to benefit from marital therapy. Moreover, couples with a female partner who indicated a high level of commitment to the relationship and couples who indicated a high level of power inequality at intake were more likely to improve following behavioral marital therapy.

Third, research assessing the association between personality factors and outcome has provided inconsistent findings with respect to masculinity, femininity and marital therapy outcome. In two studies, a high level of femininity was associated with successful outcome. In contrast to these findings, a third study found that the couples' level of femininity and masculinity was not predictive of outcome. Research has also suggested that couples with a high number of problem-solving deficits and highly "traditional" couples with a female indicating a high level of affiliation and a male indicating a high level of independence were less likely to be maritally satisfied following behavioral marital therapy.

Fourth, research that assessed the relation between symptom correlates of marital distress and marital therapy outcome has also provided inconsistent findings. This area of research has selected predictor variables on the basis of observations of maritally distressed couples seeking therapy. Two variables have been assessed in the research literature: the number of steps taken toward divorce and the degree of depressive symptoms at intake.

Finally, there have been inconsistent findings with respect to psychopathology and marital therapy outcome. Two studies have suggested that couples who have one partner who exhibited some form of psychopathology were less likely to be maritally satisfied following marital therapy. The third study found that an overall level of psychopathology as well as specific psychopathological symptoms, as measured on the MMPI scales, were not significantly related to outcome.

It is important to note that, although the degree of pretreatment marital distress was not the focus of past research, several studies have suggested that the couples' pretreatment level of marital satisfaction at intake was significantly related to marital therapy outcome (Jacobson et. al., 1986; Whisman & Jacobson, 1990; Snyder, Mangrum & Wills, 1993). For example, in one study, the pretreatment marital satisfaction level accounted for 37% of the variance in posttreatment marital satisfaction and 30% of the variance in follow-up marital satisfaction (Jacobson et. al., 1986). In another study, the pretreatment marital satisfaction level accounted for 28% of the variance in

posttreatment marital satisfaction and 46% of the variance in follow-up marital satisfaction (Whisman & Jacobson, 1990). Thus, the results of these studies suggest that those couples who were severely distressed at intake were less likely to be maritally satisfied following marital therapy.

Implications for This Study

The above review of the research literature contains several important implications for research assessing predictors of success in marital therapy. First, there have been inconsistent findings with respect to demographic characteristics such as age, personality factors such as masculinity and femininity, and symptom correlates of marital distress such as divorce potential and depressive symptoms. It has been suggested that the inability of previous research to obtain consistent results is due to poor and varied methodology (Jacobson et. al., 1986; Snyder, Mangrum & Wills, 1993). This includes the use of unreliable measures, classifying couples into two basic groups of "improved" and "not improved" that eliminate important information, employing differing operationalizations of outcome (e.g. absolute levels of distress at outcome vs. change scores), and not excluding the contribution of pretreatment marital satisfaction that has been found to contribute significantly to posttreatment marital satisfaction. When proven and reliable measures as well as sound statistical analyses were employed in a recent study (Jacobson et. al., 1986), very few significant findings were obtained: age, divorce potential, and femininity/masculinity were not predictive of outcome in behavioral marital therapy.

Prior research implies then that it is necessary to utilize more statistically reliable measures for defining successful outcome and to utilize more rigorous statistical analyses for assessing the impact of predictor variables on outcome. For example, multiple regression analyses have been recommended as being the most reliable manner of assessing the contribution of predictor variables on marital therapy outcome beyond that attributable to

pretreatment marital satisfaction (Jacobson, Follette, & Pagel, 1986; Snyder, Mangrum, & Wills, 1993). In this procedure, the pretreatment marital satisfaction level is entered first and the predictor variable is entered second. The dependant variable is the posttreatment and follow-up marital satisfaction level.

Second, most of the previous research that analyzed the association between relationship variables and outcome focused on a behavioral approach to marital therapy (Jacobson & Addis, 1993; Snyder, Mangrum, & Wills, 1993). With one exception (i.e Snyder, Mangrum, & Wills, 1993), there has been a dearth of research relating relationship variables to outcome in empirically validated dynamic approaches to marital therapy. The investigation of relationship variables relating to outcome in more dynamic approaches will allow us to ascertain the responses of particular couples to this approach so that the field of marital therapy can begin to differentiate the responses of couples to various therapeutic approaches.

Third, previous research has attempted to identify the variables predictive of outcome in marital therapy without regard to the fundamental process of that particular therapy. The majority of studies have focused on relationship variables such as age, length of relationship, divorce potential, level of commitment, emotional affection and masculinity and femininity. For the most part, the selection of these variables has been on the basis of previous studies that suggest an association between these variables and marital satisfaction. For purposes of advancing the field of marital therapy, it has been suggested that the selection of relationship variables should be related to the clinical interventions, goals and/or theoretical aims of the therapy in question (i.e. Jacobson et. al., 1986; Snyder, Mangrum , & Wills, 1993). This will allow the marital therapy field to differentiate which strategies and interventions are most effective with specific couples to increase the probability of successful outcome for that particular therapeutic approach. The fact that no marital therapy outcome study has attempted to identify relationship variables that are uniquely relevant in terms of theory and clinical practice to the fundamental approach of the therapy in question

may account for the lack of progress in this endeavour as well as the inconsistent findings. It would seem to be crucial then, to select relationship variables that are theoretically linked to a particular approach to marital therapy and to begin to study predictors of success in other kinds of therapy such as dynamic approaches rather than in behavioral marital therapy.

Another implication is that it seems logical and relevant that this kind of research should explore relationship variables that are theoretically relevant to our general understanding of intimate relationships and that have clear implications for altering such relationships. However, with the possible exception of masculinity/femininity and affiliation/independence, the majority of the relationship variables previously selected have not increased our understanding of intimate relationships. For example, the study of predictor variables such as demographic characteristics, divorce potential, depressive symptoms, and psychopathology do not advance our investigation of the intricate dynamics of intimate relationships. As theories of intimate relationships have become more sophisticated in their analyses of marital problems, other variables such as attachment, self-disclosure and trust have been proposed as relevant to understanding marital relationships (Weiss, 1978; Hendrick, 1981; Holmes & Rempel, 1989; Jacobson & Margolin, 1979; Hazan & Shaver, 1987; Collins & Read, 1990; Waring, 1981; Waring & Chelune, 1983). For example, it has been suggested that trust is a central aspect in the development and maintenance of intimate relationships (Hendrick, 1981; Holmes & Rempel, 1989). Yet, there has been a complete lack of research relating trust to attempts to resolve interpersonal conflict (Rempel, Holmes, & Zanna, 1985).

It appears that, given the present state of research examining relationship variables as predictors of outcome in marital therapy, future research is needed and such research should be conducted with the following points in mind: 1) the selection of predictor variables should be on the basis of the theoretical approach under investigation as well as on the basis of advancing

our understanding of intimate relationships; 2) studies should utilize statistically reliable and valid criteria of successful outcome as well as rigorous statistical analyses to measure the impact of predictor variables on outcome, and 3) there is a need for the investigation of predictors of outcome in alternative approaches to behavioral marital therapy (BMT).

The purpose of the present study is to investigate the predictors of outcome in a dynamic/experiential approach to marital therapy, EFT. In order to select predictor variables that would be theoretically linked to EFT, a general overview of this approach to marital therapy will be presented in the following section. A presentation of the empirical evidence on EFT will follow. An examination of the theoretical assumptions that form the basis of this approach will then be presented highlighting the three predictor variables that appear to be theoretically and clinically significant in influencing outcome in this approach. Finally, hypotheses regarding the association between these three predictor variables and outcome in EFT are presented.

CHAPTER II: EMOTIONALLY FOCUSED COUPLES THERAPY (EFT)

Emotionally Focused Therapy (EFT) is an integration of systems theory and an experiential approach to therapy (Johnson & Greenberg, 1985a,1985b; Greenberg & Johnson, 1988). Systems theory emphasizes communication patterns between partners that maintain and reinforce a dysfunctional interactional pattern (Sluzki, 1978). The experiential approach emphasizes the expression of previously unexpressed affective states in the process of change (Perls, Hefferline & Goodman, 1951; Greenberg & Safran, 1987). The focus of EFT is to identify particular dysfunctional interaction patterns and to access underlying emotional experiences that maintain these patterns. The identification and exploration of underlying emotional needs leads to the discovery of new aspects of self that evoke new responses from the partner. The expression of previously unexpressed emotional needs such as acceptance and comfort facilitates a change in the interactional pattern such that there is increased accessibility and responsiveness within each partner. It is hypothesized that facilitating emotional experiencing will lead to different perceptions of self and partner and consequently, new perceptions of the relationship (Greenberg & Johnson, 1986)

In EFT, intrapsychic and interpersonal perspectives are combined in that interactional positions adopted by the partners are assumed to be maintained by both individual emotional experience and by the way interactions are organized. The therapist using EFT constantly moves between a focus on intrapsychic experience and interpersonal context and uses each to expand on and redefine the other. The goal of therapy is then to access, express, and reprocess the emotional responses underlying each partner's interactional position and thereby facilitate a shift in these interactional positions toward accessibility and responsiveness. This then results in a more secure and satisfying bond.

EFT is experiential in that it views partners as being active perceivers constantly constructing the meaning of their experience, including their

perception of self and partner, on the basis of their current emotional state. In this approach, emotional experience is considered to override other cues and provide a framework for the creation of meaning.

Similar to experiential therapies in general, the central focus of EFT is on the client's present experience and how the client processes that experience. The therapist from the beginning of therapy is involved in the validation, heightening, and expansion of whatever is poignant in each client's experience (Perls et. al., 1951; Rogers, 1951). Acceptance of the other's phenomenological world by the therapist and ultimately by the other partner, and validation of each partner's responses to that world, are key elements in therapy. The aspects of experience that are not attended to are brought into awareness, identified with, and integrated into the client's sense of self.

In experiential theory, it is not the feelings or needs that clients have that are problematic, but the disowning and disallowing of these feelings and needs (Greenberg & Johnson, 1988; Wile, 1981). Distressed partners are not viewed as expressing developmental deficits or infantile impulses or projections, and they are not viewed as in need of skill coaching to improve communication or problem solving. The assumption is that if each partner is able to access and own new aspects of self in a relationship, and redefine the relationship context in terms of these new experiences, then new adaptive responses will occur. A blaming, hostile, angry partner who accesses her longing for comfort and reassurance, for example, can then be encouraged to express this experience in such a way as to evoke a positive response from her partner. This then restructures the emotional bond and allows for greater closeness and a new set of positive interactions.

The EFT approach is systemic in that each partner's response is constantly framed in terms of the other's behavior and in terms of the reaction a particular response is likely to evoke in the other. There is a constant focus on the structure and process of interaction. The degrees of closeness/distance and dominance/submission are monitored as is the unfolding of automatic negative cycles such as " I attack because you withdraw"; "No, I withdraw

because you attack". The position each partner takes in the interaction is made explicit, expanded on and linked to underlying emotions. A blaming position might then be framed in terms of a desperate seeking for contact, and in terms of how the other spouse's behavior maintains this desperation. Such a frame allows for a new interaction to be structured around desperation rather than hostility. Certain emotional responses tend to be associated with particular positions; for example, when underlying feelings are attended to, blamers typically speak of being isolated, unloved, and deprived, withdrawers on the other hand often speak of feeling helpless, inadequate, unaccepted, and intruded upon (Greenberg & Johnson, 1988).

The therapist not only focuses upon and reframes interactions but also directs and encourages couples to enact problematic cycles in therapy, to explore emotional responses as they occur, and to restructure interactions by accessing underlying feelings. The therapist, for example, may direct a withdrawing husband to explicitly state to his spouse that he is intimidated and afraid to show himself in the relationship.

Clinical Strategies and Interventions

EFT is designed to be a brief form of psychotherapy in that treatment usually involves 8-20 sessions, the first two of which constitute assessment. EFT consists of a sequence of steps which the partners progress through and repeat at deeper and more relevant levels as therapy progresses. These steps are:

1. The delineating of conflict issues in the core struggle.
2. Identifying the negative interaction cycle.
3. Accessing unacknowledged feelings.
4. Reframing the problem in terms of underlying feelings.
5. Promoting identification with disowned needs and aspects of self.
6. Promoting acceptance of the partner's experience.
7. Facilitating the expression of needs and wants.

8. Facilitating the emergence of new solutions.
9. Consolidating new positions.

Empirical Research on EFT

This section will review the empirical research on EFT. First, a discussion of the outcome research will be presented. Second, a discussion of the process research will follow. Finally, a summary of EFT research and implications for this study will be presented.

To date, there have been six outcome studies on Emotionally Focused Therapy (Johnson & Greenberg, 1985a; 1985b; Goldman & Greenberg, 1992; James, 1991; Dessaulles, 1991; Dandeneau & Johnson, 1994). The first study (Johnson & Greenberg, 1985a) compared EFT and behavioral marital therapy (BMT). Forty five moderately distressed couples were randomly assigned to the two approaches or to a waiting-list control group. Couples in the treatment groups were provided with eight sessions of a particular approach by experienced therapists who were committed to their respective approaches. Results indicated that couples provided with EFT obtained higher ratings on marital satisfaction (as measured by the DAS, Spanier, 1976) and intimacy (as measured by the PAIR, Schaefer & Olson, 1981) after therapy compared with those couples provided with BMT. As well, EFT was more effective than BMT in reducing the couples' target complaints. This study is one of the very few controlled studies in which a more dynamically oriented marital therapy is contrasted to a behaviorally-oriented marital therapy.

In the second study, Johnson & Greenberg (1985b) assigned those couples who were on the waiting-list control group in the previous study to eight sessions of EFT with less experienced marital therapists than those used in the initial study. Results indicated that these couples showed significant changes in marital satisfaction, intimacy and target complaints. The effect size obtained in this study, however, was smaller than that obtained in the previous study. These authors have suggested that the smaller effect size may be due to the utilization of novice therapists.

In the third outcome study (Goldman & Greenberg, 1992), EFT was compared to an interactional systemic treatment. The interventions used in this treatment consisted of paradoxical interventions designed to alter the negative interaction pattern (Weeks & L'Abate, 1982). Forty two couples were randomly assigned to 10 sessions of either EFT, the interactional systemic treatment or to a waiting-list control group. Results indicated that, at termination, both treatments significantly improved the quality of marital relationships when compared to the waiting-list control group. Couples in this study were more severely distressed than the couples in the other two EFT outcome studies suggesting that EFT is effective in alleviating severe marital distress.

In the fourth outcome study, James (1991) attempted to determine whether the effectiveness of EFT could be enhanced with the addition of a four session communication skills package. In this study, one treatment consisted of twelve sessions of EFT and the other treatment consisted of eight sessions of EFT plus four sessions of communication skills training. Forty two distressed couples were randomly assigned to 12 sessions of either EFT, the EFT plus the communication skills, or to a waiting-list control group. Results indicated that both treatments made significant gains over untreated controls on measures of marital satisfaction and target complaint improvement but not on measures of psychosocial intimacy and passionate love. Both treatments proved to be equally effective on measures of marital satisfaction and target complaint improvement at termination of therapy. Results suggest that a skills component does not significantly add to the effectiveness of EFT.

In the fifth study, Dandeneau & Johnson (1994) compared the effects of interventions taken from EFT and Cognitive Marital Therapy (CMT) (Waring & Russell, 1980) on levels of intimacy, trust and marital satisfaction. Thirty-six non-distressed couples seeking to enhance their relationship were randomly assigned to either EFT or CMT or to a waiting-list control group. Couples in the treatment groups were provided with six sessions of one particular approach by therapists who reported a preference for that particular approach. Results indicated that both therapeutic approaches significantly improved the

levels of intimacy, trust and marital satisfaction at termination. However, at follow-up, there was a differential effect in favour of EFT on these three variables. These results suggested that an affect-oriented intervention such as EFT may be a more appropriate approach for increasing marital intimacy than a cognitive-oriented intervention such as CMT.

In a feasability study, Dessaulles (1991) assessed the comparative effectiveness of EFT and pharmacotherapy for the treatment of depression occurring concurrently with marital distress. Eighteen distressed couples in which the female partner was clinically depressed were randomly assigned to either EFT or pharmacotherapy for a 15-week treatment period. The severity of depression and level of marital distress were measured at pre and post-treatment and at six month follow-up. Results indicated that both treatments were equally effective in reducing the severity of depression at posttreatment. However, at follow-up, females assigned to the pharmacotherapy treatment were more likely to be depressed at follow-up than those females assigned to EFT. In addition, although EFT reduced the level of marital distress in both partners, the improvement was found to be significant only for the females. The findings from this study suggest that EFT may be effective in reducing females' severity of depression and their level of marital distress.

Given that the effectiveness of this approach to marital therapy has been empirically validated, research has recently focused on identifying the in-therapy processes that relate to outcome (Alden, 1987; Johnson & Greenberg, 1988). In these two studies, peak and poor sessions of a sample of couples were compared using a combination of therapists' and couples' reports of which sessions produced the most progress and change. A comparison of peak and poor sessions of therapy showed that peak sessions were characterized by deep experiencing and more affiliative interaction than poor sessions (Alden, 1987; Johnson & Greenberg, 1988). These two studies suggest that high levels of emotional experiencing and high levels of affiliative, accepting behaviors are associated with successful outcome in EFT.

There is recent evidence supportive of the hypothesized process of change

in EFT (Greenberg, Ford, Alden & Johnson, 1993). For example, in one study, couples' behaviour in session 7 of therapy was judged by independent raters to be significantly more supportive, affirming and understanding than couples' behaviour in session 2 of therapy. As well, in another study, independent raters judged the couples' interactions to include a significant increase in the level of responsiveness and understanding following a partner's intimate self-disclosure in contrast to the couple interactions prior to a partner intimate self-disclosure. The results of these studies support the EFT hypothesis that an intimate self-disclosure leads to a change in a couple's interaction toward increased levels of affiliation, responsiveness, and intimacy.

Summary of EFT Research and Implications for this Study

There are several conclusions that can be made with respect to research on EFT. First, research suggests that, in general, EFT is effective in alleviating marital distress. However, although EFT has been found to be effective, an examination of the outcome studies on EFT suggest that there is considerable variability in couples' response to this approach. For example, in a recent review of the clinical treatment effects of EFT, Johnson & Greenberg (1994) report the findings of seven outcome studies with respect to the percentages of recovery and improvement. Results suggest that the percentages of couples who could be considered to be maritally satisfied at posttreatment range from 46% to 79%. As well, the percentages of couples who could be considered to have improved at posttreatment range from 66% to 86%. These results suggest that although many couples could be considered to have benefited from EFT, there are couples who have not benefited from this approach. Moreover, this variability in EFT outcome is consistent with research suggesting a high level of variability in couples' response to behavioral marital therapy (Jacobson, Follette & Elwood, 1984). As well, research on BMT has suggested that although a majority of couples improved

their relationship through therapy, the improvement was substantial for only a minority (Jacobson, Follette, Baucom, Hahlweg & Margolin, 1983). Thus, studies are needed to determine which couples would be most likely to be maritally satisfied and which couples would be most likely to obtain large gains in marital satisfaction in EFT and indeed in all marital therapy approaches.

Second, on the basis of the process research in EFT, it appears that change is associated with heightened emotional expression, an increase in affilitiave behaviors, the taking of a self focus and the feeling that one's experience was validated by the therapist. Although EFT process research has identified several in-therapy processes that relate to change, studies are needed to identify those couples who may be more likely to exhibit a high level of emotional expression and/or affiliation during EFT. Moreover, the investigation of predictor variables may be beneficial in assessing prognosis for a specific couple and/or identifying which types of couples are most likely to benefit from such an approach. Such research may lead to the development of a theoretical model for predicting outcome.

In conclusion, it would be highly desirable to begin to develop a theoretical model for predicting outcome in EFT. The investigation of relationship variables as predictors of outcome may allow therapists to assess the couple's suitability for EFT. Moreover, based on this prognosis, modification or introduction of a particular intervention for a specific couple may enhance the probability of successful outcome for that particular couple. Thus, this type of research has the potential to enable the field of marital therapy to match a couple to a particular treatment approach in order to enhance the probability of successful outcome.

In order to select relationship variables that would be clinically and theoretically linked to EFT, as suggested by marital therapy researchers (Jacobson, Follette & Elwood, 1984; Snyder, Mangrum & Wills, 1993), the following section will examine the three theoretical assumptions with a view to selecting those variables that would be related to outcome in this approach.

Theoretical assumptions of EFT

EFT is an approach to marital therapy that is based on Bowlby's attachment theory (1969; 1973) in its conceptualization of the general nature of intimate relationships, including the nature of marital dysfunction and satisfaction. With respect to the treatment of marital distress, EFT is based on a synthesis of interactional systems theory (Jackson, 1965; Sluzki, 1978), and experiential theory (Perls, Hefferline & Goodman, 1951; Rogers, 1951).

This section will outline the three theoretical assumptions underlying the theory and practice of EFT: 1) the conceptualization of an intimate relationship in terms of an emotional bond, 2) the primary role of experiencing and expressing emotion in modifying intimate relationships, and 3) the process of change involving the enactment of new interactions rather than the attainment of skills or insight. Each of these assumptions will then be linked to a specific relationship variable.

ASSUMPTION 1

The first assumption of EFT is that the most appropriate manner of conceptualizing intimate relationships is that of an intimate bond. The EFT conceptualization of the nature of adult intimate relationships and the appropriate manner of treatment of such relationships is radically different from the more established Behavioral Marital Therapy (BMT). The behavioral approach to marital therapy (i.e. Jacobson, 1978; Weiss, 1978) is based on Thibaut and Kelley's (1959) social exchange theory. It posits that individuals in relationships are concerned with maintaining a favourable cost/benefit ratio. From this perspective, the basis of a good relationship is a successful quid pro quo arrangement where couples reinforce each other at an equitable rate over time (Stuart, 1976). In this exchange model, conflict arises when partners begin to use coercive tactics to modify the other's behavior in order to obtain more favourable exchanges rather than using positive reinforcement.

The implication for treatment is that the skills of positive behavior modification and negotiation are seen as the key to the maintenance of an intimate relationship. This conceptualization of relationships emphasizes negotiating skill and the use of rational control to change problematic behaviors. Treatment then consists of teaching couples the skill of rational bargaining so that they may contract for more satisfying exchanges (Stuart, 1976).

In contrast, the EFT conceptualization of intimate relationships is based on attachment theory which conceptualizes intimate relationships in terms of an emotional bond. A bond refers to the enduring affectional tie that one person forms to a specific other (Ainsworth, 1969; Bowlby, 1973) and the set of attachment behaviors aimed at maintaining closeness and contact with that significant other. In this theory, working models of self and other guide expectations and attachment behaviors but affect is considered to be the most powerful motivator and organizer of behavior.

From this perspective, a bond can be operationalized as a need for easy access to the attachment figure or partner; a desire for closeness to that figure, especially in times of stress; comfort and diminished anxiety when accompanied by the partner; and an increase in distress, protest, despair, insecurity and anxiety when the partner is inaccessible. The key factors, then, would appear to be accessibility and responsiveness (Bowlby, 1973; Ainsworth, 1973). Accessibility refers to the availability of the attachment figure, the ease with which this figure may be contacted when needed. Responsiveness refers to the willingness to be affected or influenced by the other and to recognize the other's needs or desires. The quality of such a bond is "continually defined by the process of interaction between the two participants" (Johnson, 1986, p. 261).

The institution of marriage tends to foster attachment in that it creates the context for familiarity and interdependence (Weiss, 1982). Attachment needs are increasingly being recognized as essential aspects of adulthood that form the core of the emotional bond in close relationships (Weiss, 1982; Johnson, 1986; West, Sheldon, & Reiffer, 1987; Hazan & Shaver, 1987;

Collins & Read, 1990).

Consistent with attachment theory, EFT views adults as possessing an innate need for emotional contact and security. EFT postulates that each individual has an innate need for and depends upon closeness with attachment figures, and this is considered healthy and adaptive rather than maladaptive or dysfunctional. The EFT therapy process validates these needs for closeness, emotional contact, and security that reside in each partner.

According to both EFT and attachment theory, each individual maintains an inner working model of self and other that is always in process. Based on previous interactions with significant others and the nature of present interactions, individuals develop beliefs about their own self-identity, their self-worth, and the availability and responsiveness of others to meet their needs, and act accordingly.

Both EFT and attachment theory view emotion as central to the development and maintenance of an attachment bond. From this perspective, affect serves to motivate and organize the attachment behaviors necessary to maintain closeness (Sroufe, 1979) and creates a framework for how an individual perceives his/her partner. In an intimate relationship, affect influences our perceptions of the other, motivates us to move towards or away from the other, and affective expression evokes responses in the other. Thus, from this perspective, emotional responses play a very large part in organizing the positions people take in intimate relationships.

Treatment Implications of Attachment Theory and EFT

On the basis of attachment theory, EFT views marital satisfaction in terms of the degree of closeness and security experienced in the relationship and each partner's level of accessibility and responsiveness to one another. From the EFT perspective, maritally satisfied couples have formed a secure emotional bond with each other. In contrast, EFT views marital distress in terms of the degree of alienation, isolation and emotional deprivation that

each partner experiences in the relationship as a result of the inability to satisfy normal needs for contact and intimacy. The inability of at least one partner to obtain much needed closeness from the other results in increased anxiety, anger, depression and/or emotional detachment. According to EFT, then, maritally distressed couples are struggling with an insecure bond.

The first implication for treatment would appear to be that treatment should focus on each partner's sense of security or, conversely, sense of deprivation and isolation in the relationship. In contrast to the behavioral therapist's focus on the partners' negotiating skills, the EFT therapist attempts to validate, explore and expand each partner's underlying feelings of fear, anxiety, isolation, and deprivation of emotional contact and to facilitate the expression of the basic need for increased security and emotional contact.

A second treatment implication is that the needs for contact and security which most couples express are to be considered as a natural part of being human. EFT views distressed relationships in terms of deprivation of healthy adult needs rather than as an arena for neurosis (Greenberg & Johnson, 1986b; Wile, 1981). From this perspective, relationship problems are not created by the expression of impulses or desires for contact and intimacy but rather from the denial or distortion of these desires. For example, an individual's inability to obtain much needed intimacy and closeness from her partner will eventually lead to a blaming, angry, and critical stance on her part. The effect of this blaming stance on her partner, however, leads him to assume a defensive, self-protective and withdrawing position. As a result, her needs for intimacy and closeness continue to be unsatisfied. From the EFT perspective, the validation and expression of such needs should then be the key aspect of the therapy process. The disclosure of vulnerability, in particular, seems to be a powerful tool to evoke contact and responsiveness from a significant other. For example, when this individual can access and express her longing for intimacy with her partner and reassurance that she is lovable, her partner is more likely to take a reassuring, responsive position.

A third treatment implication is that emotional experience is of primary

importance in intimate relationships. Emotional experience is a powerful source of information as to what partners need/desire from each other. The exploration and expression of emotional experience tends to lead to the formulation of needs. Once the underlying primary emotion is experienced, the therapist encourages both partners to express the needs and wants associated with these emotions. For example, " As I am aware of my fear, I realize that what I need from you is reassurance." From this perspective, the sharing of heightened emotional experience facilitates bonding and the growth of intimacy in that both partners become more accessible and responsive to one another. Thus, marital therapy should concern itself with affective experiences and should use these experiences to restructure the marital bond. EFT is particularly consistent with attachment theory in that it stresses, not insight into emotion, as much as a new synthesis of emotional experience which enables partners to become more accessible and responsive to each other's emotional needs. In both EFT and attachment theory, emotion is seen as a primary communication system and a source of adaptive behaviors.

Given the emphasis in EFT on the exploration and expression of needs for closeness, dependency, and reassurance, it may be that an individual's beliefs, perceptions and/or feelings regarding the appropriateness of and potential for meeting these needs in an intimate relationship may determine the couple's involvement in the therapy process. It seems logical to suppose that individual differences with respect to the major features that characterize adult attachment styles may influence the couple's ability and/or willingness to engage in a therapy that stresses and focuses on these aspects of a relationship. The major features that characterize adult attachment include the tendency to reduce distance from the attachment figure in times of stress, the degree to which physical separation, actual or anticipated, is perceived as nonthreatening to the attachment relationship, the ability to sustain confidence in the future of the attachment relationship, the extent to which exploration and adaptive response (coping with usual routines) are independent of the attachment figure's physical presence, the extent to which

both individuals report the need for an attachment figure (i.e. a provider of security) and be able to function as an attachment figure, the extent to which the attachment figure is perceived as reliably accessible and as responding appropriately and favourably to most of the individual's needs, and the extent to which the individual asks for the attachment figure's availability and responsiveness (West, Sheldon, & Reiffer, 1987; Weiss, 1982; Bowlby, 1969, 1973). Individuals who endorse most of these features are classified as securely attached while individuals who only endorse a few or none of these items are classified as insecurely attached.

Predictor Variable: Attachment Level

Although it is assumed in EFT that all maritally distressed couples are struggling with a specific bond that has become insecure, the extent to which individuals endorse these features of a secure attachment may significantly influence the therapeutic efforts to restructure this bond. EFT attempts to facilitate a new synthesis of emotional experience which enables partners to modify their interactional positions and become accessible and responsive to each other's emotional needs. Accessibility and responsiveness have been identified as being crucial to the development and maintenance of bonds. In a therapeutic process such as EFT, the exploration and expression of new aspects of the self, particularly of emotional vulnerability, directly promotes contact and trust, which then gives rise to new perceptions of the spouse and a new willingness to respond in a caring fashion. Since EFT emphasizes emotional experiencing and the importance of increasing the level of accessibility and responsiveness between partners, individual differences with respect to the level of comfort with closeness and interdependency and the belief that the partner is accessible and responsive may be a significant predictor of the extent of a couple's ability and/or willingness to use the EFT process to strengthen their bond.

The degree of security, or in other words, the extent to which individuals believe that others are available, accessible and responsive to their needs,

the extent to which they seek comfort from their partner in times of stress, and the extent to which they themselves feel comfortable in being their partner's attachment figure may have a significant positive impact on a therapeutic approach that emphasizes the expression of vulnerable emotions, needs and desires in facilitating intimacy and interdependency. From this perspective, then, the extent to which individuals possess attitudes and beliefs that are associated with a higher level of secure attachment would be expected to be positively correlated with the level of marital satisfaction following EFT. Thus, couples with a higher level of attachment security at intake would be most likely to be maritally satisfied at posttreatment and follow-up, as indicated by higher levels of marital satisfaction.

In contrast, individuals with a low level of attachment security are the most likely to feel alienated and emotionally isolated from their partner. These individuals may also be likely to emphasize autonomy, self-reliance, and to maintain distance from their attachment figure as a response to their lack of faith in each others' caring and responsiveness. In EFT, the sharing of heightened emotional experience would be expected to facilitate bonding and the growth of intimacy in that both partners are likely to become more accessible and responsive to one another. Couples with a lower level of attachment would be expected to become more emotionally interdependent through the EFT process and thus, most likely to make the largest gains in marital satisfaction following EFT. Thus, couples with lower attachment levels at intake are more likely to make large gains in marital satisfaction as indicated by marital satisfaction change scores but less likely to be considered maritally satisfied following therapy.

In summary, couples with a higher level of attachment security prior to onset of therapy would be expected to achieve a high level of marital satisfaction following EFT. Couples with a lower level of attachment security at intake are most likely to make large gains in marital satisfaction but are less likely to be considered maritally satisfied following EFT.

ASSUMPTION 2

A second theoretical assumption in EFT is that the experience and expression of emotion is a powerful pathway to altering a couple's interaction. This assumption is based on experiential theory (Perls, Hefferline & Goodman, 1951; Rogers, 1951; Greenberg, Rice, & Elliot, 1993). In an experiential view of human functioning, the individual's internal experiencing is regarded as the primary referent of therapy. From this perspective, people are regarded as functioning more effectively when they pay attention to all of their internal experiences. In this manner, people are then able to respond holistically to situations in adaptive ways. From this perspective, the manner in which people interrupt or interfere with their emerging awareness and experiencing has been seen as central to understanding individual dysfunction. A dysfunctional individual selectively attends to a restricted subset of experience and blocks off other experiences. The result is that some aspects of experience fail to be integrated and are disowned or disclaimed. In therapy, expanding the range of emotional experience is central so that previously unacknowledged aspects of self can be integrated into a more holistic self-concept. The experiential therapist attempts to expand the scope of experience which makes available potentially adaptive organismic feelings and needs.

EFT conceptualizes emotion as " a construction arising from a complex synthesis of concepts, schemas, and expressive motor responses which then form the basis for the perception of new experience and the creation of meaning" (Greenberg & Johnson, 1986, p. 3). This is different from cognitive-behavioral or rational emotive approaches where emotion is seen as a response to cognition. People in EFT are seen as "active perceivers, constructing meanings and organizing experience on the basis of current emotional states" (Greenberg & Johnson, 1986, p. 3).

EFT views affect as being a privileged source of information about our behavior in interpersonal situations. Affect guides us either toward or away

from people in our environment and thus, represents the connection between us and our environment (Greenberg & Johnson, 1988). In this framework, affect serves to motivate attachment behaviors necessary to maintain closeness (Sroufe, 1979) and acts as the framework for how an individual perceives his/her partner. Affect, in EFT, is not expressed for the sake of catharsis but serves as a biologically adaptive primary signalling system which tends to override other cues and dominate the creation of meaning. In an intimate relationship, affect influences our perceptions of the other, motivates us towards or away from the other, and evokes responses in the other. From this perspective, the underlying emotional responses help to organize the positions people take in intimate relationships. Furthermore, it is believed that certain core cognitions and/or cognitive-affective sequences are learned originally in specific affective states and are much more accessible when that state is re-experienced (Greenberg & Safran, 1984, 1987).

One of the major tasks in an emotionally focused approach to marital therapy is to access emotions. The therapist uses various interventions such as empathic reflection and evocative responding that facilitate a reprocessing of key emotional experiences. Emotional responses must be evoked by the therapist and experienced by the clients, as vividly and intensely as possible, otherwise no new aspect of self is realized and changes do not occur. The self-disclosure of affective experiencing facilitates a change in the negative interaction pattern such that there is increased accessibility and responsiveness within each partner. Partners begin to perceive each other as being emotionally vulnerable which elicits new responses such as compassion and protection. Accessing emotional experience, then, is considered to lead to different perceptions of self and partner and consequently, new perceptions of the relationship (Greenberg & Johnson, 1986). Thus, from this perspective, affect is a prime target and agent of change in treating marital conflict.

Predictor Variable: Affective Self-disclosure

EFT is based on the ability and/or willingness to self-disclose vulnerable emotional needs and feelings. One indicator of a couple's attitude towards emotion and their level of comfort with the expression of emotions is the extent to which both partners have engaged in affective self-disclosure prior to onset of therapy. It may be that those couples who have engaged in a moderate to high level of affective self-disclosure have been naturally able to incorporate self-disclosure into their interactions and/or feel comfortable with emotional expression. Thus, they may be more likely to perceive the benefits of emotional expression in an intimate relationship. These individuals may be more likely to allow themselves to explore new emotional territory in the presence of their spouse.

Second, couples who have engaged in prior affective self-disclosure may have been able to maintain a certain level of faith that the other will be responsive to and accepting of expressed emotions. Individuals who view their partners as more accepting will be more likely to explore and express their emotional needs and thus, would be more likely to be emotionally engaged in the therapeutic process than those individuals who believe that their partner is emotionally closed off.

The degree of affective self-disclosure, then, is pertinent to experiential theory in that couples who have engaged in some self-disclosure may be more likely to feel comfortable with and to perceive the benefits of emotional expression and to be less emotionally constricted. Partners must self-disclose their emotional needs from a position of vulnerability to create the change events which have been associated with increased marital satisfaction at termination of EFT (Johnson & Greenberg, 1988). According to EFT research and experiential theory, partners need to self-disclose as part of the reprocessing of emotion and the altering of interactional positions which then leads to increased marital satisfaction. For these reasons, it may be hypothesized that couples with higher levels of affective self-disclosure at intake would be more likely to be maritally satisfied at posttreatment and

follow-up, as indicated by higher levels of marital satisfaction.

In contrast, couples with lower levels of affective self-disclosure may exhibit a limited range of emotional expression as well as a high degree of inhibition or restriction of vulnerable aspects of self to partner. These emotionally inhibited couples would be expected to experience a very low level of emotional closeness and intimacy and thus, a low level of marital satisfaction. In this sense, couples with a low level of affective self-disclosure would be expected to have the largest room for improvement in terms of marital satisfaction. In EFT, the therapist attempts to provide a safe environment that is conducive to the exploration, validation, and expression of emotions. It would be expected that the expression of vulnerable emotions by low self-disclosing couples would facilitate an increased sense of intimacy and closeness between partners. These emotionally inhibited couples may be more likely to experience very significant, positive effects of emotional self-disclosure compared to emotionally expressive couples. Consequently, couples with lower levels of affective self-disclosure may be most likely to make the largest gains in marital satisfaction following EFT. Thus, it can be hypothesized that couples with lower levels of affective self-disclosure at intake are most likely to make large gains in marital satisfaction as indicated by marital satisfaction change scores but are less likely to be considered maritally satisfied following EFT.

ASSUMPTION 3

A third theoretical assumption in EFT is that a crucial part of the process of change involves the enactment of new interactions rather than the learning of new skills or the attainment of insight. The enactment of new interactions is assumed to occur through the reframing of each partner's position in terms of underlying emotional needs and desires for intimacy, acceptance and reassurance. The expression of these needs and desires tend to evoke more caring, empathic responses from the other and thus, lead to a more intimate,

secure bond and an increase in marital satisfaction. This assumption is based on a synthesis of interactional systemic theory, experiential theory and attachment theory.

Consistent with systems theory, EFT focuses on events in intimate relationships, not in isolation, but in the context in which they occur. The relationship between individuals and their communication patterns becomes the focus rather than the characteristics of the individuals themselves. In this sense, EFT relies on the concepts of interactional patterning and circular causality rather than individual dynamics and linear causality. For example, an individual nags and is angry because the partner withdraws, while the partner withdraws because this individual nags and is angry. Individuals are viewed as manifesting particular behaviors in response to contextual determinants. These circular interactions form consistent and stable patterns over time. The therapeutic task in treating conflict in relationships with the systems approach is to restructure these defensive, rigid, and repetitive interactions so that individuals will engage in new, flexible, and less defensive interactions.

One issue that may be problematic in the therapeutic attempts to create more flexible interactions is the extent of rigidity and/or defensiveness of the couple's pattern. In part, the rigidity or defensiveness of the pattern is based on each individual's negative expectations of the other. From a systemic perspective, one individual's negative expectations may have the effect of reinforcing the other's negative expectations. This cycle may be very difficult to break because changing these patterns involves risk and confronting the unknown. A large risk is involved for an individual to be able to venture beyond the familiar, predictable pattern.

In part, the EFT therapist attempts to facilitate an accepting environment conducive to the exploration of unknown emotional territory for both individuals. However, individuals need to take risks that put them in a position of emotional vulnerability in the other's presence. This emotional vulnerability consists of letting go of prior inhibitions, defenses and rigid expectations of the other's response to the expression of specific emotions.

In essence, the risk in disclosing unacknowledged emotions such as fear of abandonment or feeling inferior must be based on some faith that the other still cares and will be somewhat responsive to any show of emotional vulnerability. If not, then individuals will not put themselves in a position of vulnerability that is so crucial to the EFT process.

There appear to be three components that may influence the likelihood of success for the EFT therapist in creating more flexible, open and intimate interactions between partners: 1) the extent of the couple's rigid and defensive pattern, 2) the willingness to take emotional risks and attempt new interactions, and 3) some belief in the other's accessibility and responsiveness. Couples with a highly rigid and defensive pattern who are not willing to take risks that put them in a position of vulnerability and who do not believe that their partner will be somewhat responsive are less likely to complete the tasks set by the therapist and initiate new interaction patterns. As a result, these couples would be less likely to be maritally non-distressed following therapy. One factor that appears to be related to all these three components in the EFT process of changing interactions is trust.

Predictor Variable: Trust

There are several components in the definition of trust which relate to the three theoretical orientations underlying EFT. Trust has these components: 1) trust evolves out of past experience and prior interaction; 2) trust involves dispositional attributions that are made to the partner, such that he/she is regarded as reliable, dependable and concerned with providing expected positive outcomes; 3) trust involves a willingness to put oneself at risk, be it through intimate disclosure, reliance on another's promise or sacrificing present rewards for future gains; and 4) trust is defined by feelings of confidence or security in the caring responses of the partner and the strength of the relationship (Rempel, Holmes and Zanna, 1985). Moreover, trust involves a complex blend of cognitive and emotional elements. The aspects of trust

based on learning involve the person's expectations about their partner's reliability and dependability while the aspects of trust based on affective factors involve hope, a feeling of basic security, and the strength of the bond (Rempel, Holmes, & Zanna, 1985).

The first two components of trust are related to interactional systems theory. From this perspective, trust would appear to be strongly related to a couple's interaction. Very low levels of trust may play an important role in maintaining a rigid and defensive interaction pattern. People with lower trust levels may be more likely to expect or predict that their partner will act in an angry, critical, distant or defensive manner. They may be more likely to view their partner's motives as less positive. Compared to couples with a higher level of trust, they may see their partner as more self-centred, uncaring, intolerant, and unresponsive. People who are reluctant to express trust are in no position to risk giving their partner the benefit of the doubt. A context is then created in which both partners have less faith in one another and have less positive expectations for successfully satisfying their needs for contact, reassurance and acceptance. This results in both partners developing and maintaining self-protective, rigid positions. This cycle is very difficult to break because individuals need to take risks in order to restore their confidence that their partner cares for their well-being (Holmes & Rempel, 1989). In relation to the EFT process, then, very low trust levels may be associated with a highly rigid and defensive interaction pattern that is maintained by each partner's negative expectations and negative attributions of the other. In contrast, couples with a higher level of trust may be more able and/or willing to alter their negative perception of each other and may be less disposed to view their partner's positive behavior in therapy with suspicion. For EFT, the degree of trust between partners may influence the rigidity of the cycle and may determine the success of the therapeutic attempt to create more flexible, less defensive interaction patterns.

The third component of trust, the element of risk, is related to experiential theory. Extremely low levels of trust may be problematic in the

therapeutic attempt to access emotions underlying the negative interactional pattern. The risk, in EFT, consists of allowing new aspects of self to emerge in the session which leads to the formation of new interactions. In order to ask your partner to have your needs met, there has to be some degree of trust that your partner cares, will listen, and perhaps be responsive. If trust is extremely low, partners may be unwilling to begin to explore vulnerable emotions that imply a need to be met. This will have the effect of blocking or impeding therapeutic efforts to identify, explore and express underlying feelings of insecurity and the need to be responded to. Individuals with very low trust levels may be more likely to adopt risk aversive strategies; they will reject situations that put them in a position of vulnerability.

In contrast, individuals with higher trust levels would be expected to be able to set their doubts aside. These people will likely view positive behavior by the other without suspicion. Moreover, these couples may be more optimistic about their partner's ability to satisfy their emotional needs and thus, be more motivated in therapy to ask their partner to respond. For couples with some degree of trust, then, there is a greater probability of increasing the level of accessibility and responsiveness in the relationship and strengthening the attachment bond.

On the basis of the theoretical assumptions regarding the process of change in EFT, it might be hypothesized that the higher the pretreatment level of trust between partners, the more likely they may have more confidence in the other's responsiveness, the more likely they will possess more positive expectations about their partner's reliability, and thus, the more likely they will take risks that put them in positions of emotional vulnerability. Thus, it is hypothesized that couples with a higher mean level of trust at intake are most likely to be classified as maritally satisfied at posttreatment and follow-up, as indicated by higher levels of marital satisfaction.

In contrast, couples with lower levels of trust at intake would be expected to exhibit a highly rigid and defensive interactional pattern, to possess negative expectations and attributions of their partner, and to be highly

reluctant to take emotional risks in EFT. They are also expected to indicate the lowest level of marital satisfaction at intake. As a result, they may be the least likely to be considered maritally satisfied following therapy. However, due to the EFT focus on the exploration and expression of underlying emotional needs for intimacy, acceptance and reassurance, couples with a lower level of trust at intake would be expected to exhibit a more dramatic change in terms of becoming more caring, responsive and empathic toward each other in their interactions than couples with a higher level of trust. Couples with a lower level of trust would be expected to make the largest gains in marital satisfaction, as indicated by marital satisfaction change scores.

In summarizing, it is hypothesized that couples with a higher level of trust at intake are most likely to be maritally satisfied but less likely to make large gains in marital satisfaction at posttreatment and follow-up. It is also hypothesized that couples with a lower level of trust are the most likely to make large gains in marital satisfaction but not be considered maritally satisfied at posttreatment and follow-up.

Summary of Predictor/Relationship Variables

On the basis of an analysis of the three assumptions underlying EFT, three variables have been proposed to be potential factors influencing outcome in this approach: 1) level of secure attachment 2) level of affective self-disclosure, and 3) level of interpersonal trust. Although these factors are hypothesized to be important in EFT, there is research evidence which suggests that these variables may be important in the development and maintenance of intimate relationships. The following section will outline the association between these variables and intimate relationships. As well, in order to deal with the concern that these variables may be correlated with one another, the following section will discuss the association among these predictor variables.

Attachment, Self-Disclosure, Trust and Intimate Relationships

Previous research has suggested that these three variables are important in developing and maintaining intimate relationships. There is research evidence that a couple's marital satisfaction level is positively related to attachment security (Collins & Read, 1990; Kobak & Hazan, 1991) and to their level of self-disclosure (e.g. Miller & Lefcourt, 1982; Waring & Chelune, 1983; Hendrick, 1981; Hansen & Schuldt, 1984). Research also suggests that trust is positively related to feelings of love and happiness in the relationship (Larzelere & Huston, 1980; Rempel, Holmes, & Zanna, 1985) and that marital dissolution involves a deterioration of trust between partners (Larzelere & Huston, 1980). For example, Larzelere and Huston (1980) found that separated and divorced individuals tended to have less trust for their ex-partners than dating, newlywed and married couples had for their partners. Finally, several studies have demonstrated that therapeutic approaches which emphasize increased self-disclosure between partners significantly improved the levels of intimacy, trust and marital satisfaction at termination (Waring, 1981; Dandeneau & Johnson, 1994).

The results of these studies suggest that attachment, self-disclosure and trust are important in developing a satisfying intimate relationship and key researchers in this area have suggested that these variables are in fact crucial concepts in understanding marital relationships (Weiss, 1978; Holmes & Rempel, 1989; Jacobson & Margolin, 1979; Hazan & Shaver, 1987; Collins & Read, 1990; Waring, 1981; Waring & Chelune, 1983). On the basis of previous research and the EFT assumptions then, it would be expected that maritally distressed couples recruited for this study would have lower levels of attachment, self-disclosure, and trust than maritally satisfied couples. It would also be expected that, as a result of the EFT process, couples will have become more securely attached, self-disclosing, and trusting, and thus, more maritally satisfied at posttreatment.

This positive association between marital satisfaction and the predictor

variables suggests that the concept of marital satisfaction is a composite of various elements which include attachment, self-disclosure, and trust. One difficulty in delineating these variables from marital satisfaction is that this concept (marital satisfaction) tends to be used in a vague and ambiguous fashion (Spanier, 1976). For example, marital satisfaction measures include such components as affectional expression (Spanier, 1976) which would be expected to comprise an aspect of self-disclosure. However, marital satisfaction measures also typically assess problem areas, conflict-resolution abilities, and the overall degree of happiness/unhappiness.

A second difficulty in understanding the relation between these predictor variables and marital satisfaction is how to interpret the directionality of the association. High levels of attachment security, self-disclosure and trust may influence the level of marital satisfaction in the relationship. It is equally plausible, however, that a couple's marital satisfaction level would influence the extent of attachment security, self-disclosure, and trust in the relationship. The most probable scenario may be that marital satisfaction, attachment, self-disclosure, and trust are related in an interdependent, interactional process whereby these variables reflect and influence each other.

Although there is some indication in the research literature that these variables are associated with each other, it appears that all three variables are conceptually distinct. First, trust has been associated with the levels of self-disclosure in a relationship (Altman & Taylor, 1973; Larzelere & Huston, 1980). For example, Larzelere and Huston (1980) obtained a correlation of .40 ($p < .01$) between depth of self-disclosure and trust among 20 married couples, although the overall correlation was .25 ($p < .01$) for the total sample size (40 dating couples, 20 newlywed couples and 20 married couples). However, the trust scale utilized in this study consisted of only eight items. Moreover, self-disclosure items also included non-relationship issues such as religion, family background, and work. Further research, utilizing a more comprehensive trust scale, suggests that trust is moderately related to a global rating of self and partner self-disclosure (Boon & Holmes, 1990). These authors obtained

correlations ranging from .32 to .46 ($p < .01$) between self and partner ratings of self-disclosure and trust in a sample of 113 married couples. On the basis of these correlations, these authors have concluded that trust is conceptually distinct from self-disclosure.

Second, there is evidence to suggest that comfort with closeness, a feature of a secure attachment, is positively related to trust (Boon & Holmes, 1990; Collins & Read, 1990). Although one study found that comfort with closeness is positively related to both men's and women's trust in their partner (Boon & Holmes, 1990), these authors obtained significant findings ($r = .37$, $p < .01$) in only one of the two samples of married couples. The larger sample ($n = 113$) did not generate positive findings in comparison with the smaller sample ($n = 70$). Moreover, another study found that comfort with closeness was positively related only to the men's trust in their partner (Collins & Read, 1990). These authors obtained significant findings ($r = .40$, $p < .001$) with a sample of 71 undergraduate dating couples.

One explanation for the inconsistent findings concerning the relation between trust and comfort with closeness may be due to the variety of measures used in the different studies. Moreover, the measures used in obtaining data in previous research are either revised versions of or, in some cases, completely different from the measures that were utilized in this study. In conclusion, although secure attachment may be positively related to trust, it appears that, given the moderate correlation, the two variables may be viewed as conceptually distinct.

Finally, with respect to the relation between self-disclosure and attachment level, although there is some indication of an association between a particular attachment style and self-disclosure (e.g. Bartholomew & Horowitz, 1991), there has been a lack of research in assessing the association between overall self-disclosure and overall level of secure attachment in an intimate relationship. Nonetheless, from an EFT perspective, it may be expected that couples with an insecure bond are less likely to engage in intensive emotional self-disclosure. Thus, there is likely to be

some association between these two variables.

In summary, on the basis of a review of the research literature, attachment, self-disclosure and trust appear to be central in the development and maintenance of satisfying intimate relationships. Moreover, although these variables may be related to each other, attachment, self-disclosure and trust appear to be separate and distinct concepts.

The following section will discuss the rationale of the study and will present the hypotheses of this study.

Rationale for This Study

It is clear that while the general efficacy of psychotherapy, both individual and marital, has been demonstrated, research is needed that investigates the factors influencing outcome. In reviewing the status of psychotherapy research, Garfield (1986) has stated that psychotherapy research must devote more attention to matching clients to therapeutic approach if we are to increase our understanding of therapeutic effectiveness. Thus, the need to differentiate therapeutic approaches that are appropriate for specific individuals has now been established in both general psychotherapy (Frank, 1979; Beutler, 1983) and marital therapy literature (Baucom & Hoffman, 1986; Jacobson, Follette, & Pagel, 1986; Snyder et. al., 1993).

Within marital therapy, it appears that previous research that examined relationship variables as predictors of outcome has selected variables without regard to the theory or intervention strategies of that particular therapeutic approach (i.e. Jacobson et. al., 1986; Snyder, Mangrum , & Wills, 1993). For the most part, previous studies have selected variables on the basis of demographic characteristics such as age and length of relationship or general observations of maritally distressed couples such as positive or negative emotional affect, divorce potential, depressive symptomatology and psychopathology in one partner. For purposes of advancing the field of marital therapy, the selection of relationship variables needs to be related to the clinical interventions, goals and/or theoretical aims of the particular therapy in question.

This study presents the first attempt to select relationship variables that would appear to be theoretically and clinically significant in influencing outcome in a particular approach to marital therapy. On the basis of a review of the theoretical assumptions underlying EFT, three variables appear to be theoretically and clinically significant in influencing outcome in this approach: attachment, self-disclosure, and trust. This study assessed whether different levels of attachment security, self-disclosure, and trust between

partners prior to onset of therapy influenced their willingness to become emotionally engaged in the therapeutic process and thus, to improve their relationship.

Second, most of the previous research has identified the responses of particular types of couples to behavioral marital therapy. At the present time, no individual difference variable or couple type has been linked with either positive or negative responses to more dynamic approaches to marital therapy. EFT is a dynamic/experiential approach that has been proven to be effective in alleviating marital distress and has been found to be as effective and, in some instances, superior to behavioral marital therapy in increasing intimacy (Johnson & Greenberg, 1985a). Although previous research has determined that EFT, in general, is effective and that specific in-therapy processes relate to outcome, no study has yet examined the relationship variables that are associated with outcome in this approach. Research investigating relationship variables that are positively and negatively associated with outcome in EFT will enable the marital therapy field in the future to differentiate approaches that are appropriate for particular types of couples with the ultimate goal of increasing the likelihood of successful outcomes.

Third, the majority of previous research in this area has not increased our theoretical understanding of the development, deterioration, and modification of intimate relationships. Variables that have been selected in past outcome studies such as demographic characteristics, divorce potential, positive emotional affect, and evidence of psychopathology in one partner have been based on general observations of maritally distressed couples. Thus, there is a need for further research to explore relationship variables that are theoretically relevant to our understanding of intimate relationships and that have clear implications for altering such relationships. This study was the first attempt to determine the association between variables such as attachment, self-disclosure, and trust that are deemed essential to the development and maintenance of intimate relationships and outcome in marital therapy.

Fourth, it has been suggested that the inability of previous research to obtain consistent results is due to poor and varied methodology (Jacobson et. al., 1986; Snyder, Mangrum & Wills, 1993). This includes the use of unreliable measures, classifying couples into two basic groups of "improved" and "not improved" that eliminate important information, employing differing operationalizations of outcome (e.g. absolute levels of distress at outcome vs. change scores), and not excluding the contribution of pretreatment marital satisfaction that has been found to contribute significantly to posttreatment marital satisfaction. In order to assess the impact of the predictor variables on outcome, separate multiple regression analyses for each predictor variable were conducted as suggested by prominent marital therapy researchers (i.e. Jacobson, Follette, & Pagel, 1986; Snyder, Mangrum, & Wills, 1993). In addition, this study utilized two secondary outcome criteria: the couple's intimacy level and a therapist rating of improvement following therapy.

Hypotheses:

On the basis of the reviewed literature, the following are the primary hypotheses in this study:

1. A higher mean pretreatment level of attachment, as measured on the Adult Attachment scale, will be positively associated with the posttreatment and follow-up mean marital satisfaction level, as measured on the Dyadic Adjustment Scale.

2. A lower mean pretreatment level of attachment, as measured on the Adult Attachment scale, will be negatively associated with gains in marital satisfaction at posttreatment and follow-up, as indicated by marital satisfaction change scores on the Dyadic Adjustment Scale.

3. A higher mean pretreatment level of affective self-disclosure, as measured on the Affective Self-Disclosure scale, will be positively associated with the posttreatment and follow-up mean marital satisfaction level, as measured on the Dyadic Adjustment Scale.

4. A lower mean pretreatment level of affective self-disclosure, as measured on the Affective Self-Disclosure scale, will be negatively associated with the gains in marital satisfaction at posttreatment and follow-up, as indicated by marital satisfaction change scores on the Dyadic Adjustment Scale.

5. A higher mean pretreatment level of trust, as measured on the Interpersonal Trust Scale, will be positively associated with the mean posttreatment and follow-up mean marital satisfaction level, as measured on the Dyadic Adjustment Scale.

6. A lower mean pretreatment level of trust, as measured on the Interpersonal Trust Scale, will be negatively associated with the gains in marital satisfaction at posttreatment and follow-up, as indicated by marital satisfaction change scores on the Dyadic Adjustment Scale.

Two secondary outcome criteria were included in this study: intimacy level and therapist rating of improvement. The following are the additional hypotheses:

7. A higher mean level of attachment, self-disclosure and trust will be positively associated with the level of intimacy at posttreatment and follow-up, as indicated on the Miller Social Intimacy Scale.

8. A lower mean level of attachment, self-disclosure and trust will be negatively associated with the therapist rating of improvement.

Although the hypotheses refer to mean couple scores, individual male and female scores on all of the above measures will also be analysed as suggested by Baucom and Mehlman (1984).

CHAPTER III: METHODOLOGY OF THE STUDY

Subjects

Subjects were recruited through newspaper and community advertisements describing a research project for couples wishing to improve their relationship. A total of 87 couples responded to these advertisements. Forty couples met the inclusion criteria. Of these couples, three couples declined participation in the study prior to onset of therapy, one couple was eliminated from the study and referred for alcohol-related therapy due to one partner's disclosure of alcohol abuse at the second session, and two couples dropped out of the study during therapy. One couple dropped out of the study after the first session and stated their wish to separate. The other couple dropped out of the study after 5 sessions due to a death in the family. Thus, 34 couples completed all the requirements of the study and were included in the analyses.

Of the 34 couples included in the study, the average length of relationship was 13.12 years (range = 1 - 42). The average age for females was 40.1 (SD = 11.0) and the average age for males was 43.2 (SD = 11.7). The age range for the total sample was from 22 to 69 years of age. The average length of education was 15.5 years (range = 10 - 22), the average annual gross family income was $45,000 (range = $18,000 - 110,000), and the average number of children was 1.44 (range = 0-4). Twenty four couples (70%) were married. The mean pretreatment level of marital satisfaction was 88.2 (range = 68.5 - 97). Thus, this sample was considered moderately distressed.

Inclusion Criteria

Couples were screened through telephone and assessment interviews using the following inclusion criteria:

1) presently living together and having cohabited for a minimum of

one year

2) free of alcohol or drug related problems
3) no psychiatric treatment or medication in the past year
4) presently not receiving other psychological treatment
5) no marital violence (contraindicated in Emotionally Focused Therapy; Greenberg & Johnson, 1988)
6) no history of physical and/or sexual abuse, unless intensive trauma-specific psychotherapy was undertaken prior to onset of study
7) the average of the couple's marital satisfaction score must have been less than or equal to 97 on the Dyadic Adjustment Scale, which is the cutoff point for marital distress (Spanier, 1976).

Therapists

There were 13 therapists in the study with an average of 12.9 months of supervised couples therapy experience (range = 2-24 months). Twelve therapists were Ph.D. clinical psychology interns at the Centre for Psychological Services at the University of Ottawa. One therapist had Master's level training at the Centre for Psychological Services. All therapists had prior exposure to EFT through group supervision. Throughout the study, therapists attended a weekly supervision group conducted by Dr. Susan Johnson-Douglas, one of the originators of EFT.

Treatment Setting

The Centre for Psychological Services of the University of Ottawa is a research and training facility that provides psychological services to the Ottawa-Carleton region. The Centre is staffed by registered psychologists who provide clinical supervision to doctoral-level interns in Clinical Psychology. The Centre has been accredited as a doctoral training facility by the American

Psychological Association.

This section presents the instruments, questionnaires, and forms used in this project.

Standardized Telephone Screening Procedure

The Telephone Screening Procedure was especially devised for the purposes of this study. It consisted of a standardized questionnnaire to be used by a research assistant to screen respondants to advertisements over the telephone. It included questions pertaining to the inclusion criteria for this study, some general information concerning requirements of subjects, as well as additional information in case callers require clinical referrals for problems such as substance abuse or alcoholism. The form also included space for appointment dates for purposes of assessment.

A copy of the Standardized Telephone Screening Procedure may be found in Appendix A.

Information and Consent Form

The purpose of the Information and Consent Form was to clearly inform potential subjects of the major procedures of the study, the requirements of subjects, and most important, the issue of confidentiality. Couples were reminded that their participation was voluntary and that they were able to withdraw from the study without penalty. Their signed consent was requested before the administration of screening instruments. As well, a confirmation of consent was included once they were accepted into the study.

The Information and Consent Form was approved by the University Human Research Ethics Committee prior to commencement of the study. A copy of the form is attached in Appendix A.

Demographic Data Questionnaire

The demographic data questionnaire allowed proper description of the population sampled for this study. Couples were asked questions pertaining to age, number of years of cohabitation, number of children, gross family income, whether they have had previous marital counselling, and whether they have been married previously. The demographic data questionnaire may be found in Appendix A.

Dyadic Adjustment Scale (DAS; Spanier, 1976)

The Dyadic Adjustment Scale (DAS) is a self-report questionnaire which yields an index of global couple adjustment. It is currently considered to be the instrument of choice for the assessment of marital adjustment in terms of reliability and validity. It was used in this study as an outcome measure to assess the level of marital satisfaction upon termination of EFT. The DAS was administered at pretreatment, posttreatment, and at three month follow-up.

Development of scale

The DAS was based on a factor analysis and on a detailed study of already existing marital adjustment scales. Beginning with an original item pool of 300 items previously used in all other scales measuring marital adjustment or a related concept, approximately 200 (selected primarily for their content validity) were included in a questionnaire which was administered to a sample of 218 married persons and 94 divorced persons along with a smaller sample of never-married cohabiting couples. Items which did not significantly discriminate between married and divorced samples were eliminated. A factor analysis was used to test the adequacy of the proposed definition of adjustment, verify the presence of hypothesized components, and to make the final selection of items indicative of dyadic adjustment. The final result yielded 32 items grouped into four components: satisfaction, cohesion, consensus, and affectional expression.

Reliability

Reliability was established for each of the component subscales as well as

for the total scale using Cronbach's Coefficient Alpha. Reliability coefficients ranged from .73 to .94 for subscales. The total scale reliability was computed at .96.

Validity

Content validity was determined by three judges who evaluated each item as to its relevancy to contemporary relationships, its consistency with nominal definitions of adjustment (Spanier and Cole, 1974, cited in Spanier, 1976) and for its careful wording with appropriate fixed choice responses. Items not meeting these criteria were eliminated.

Criterion validity was supported by the fact that for each item, the divorced sample differed significantly from the married sample. Furthermore, the mean total scale scores for the married and divorced samples were significantly different at the .001 level. Construct validity was established through factor analysis and a correlation with the most frequently used scale at the time, the Locke-Wallace Marital Adjustment Scale. Correlations with the Locke-Wallace were .86 for married respondents, and .88 for divorced respondents.

Scoring

Scoring of the scale is done by adding the different weights of each fixed response. The scale has a theoretical range of 0-151. Higher scores indicate less distress and better adjustment. The mean total scale scores were 114.8 for the married sample and 70.7 for the divorced sample. The distress cut-off point (97) has been set at one standard deviation (17.8) below the mean for the married sample. In other words, a couple scoring below 97 is considered to be distressed. Individual scores are summed and divided by two to obtain the couple's mean total score. To be included in this study, the mean total scale score for each couple must have been less than 97 but not less than 75. A copy of the DAS can be found in Appendix B.

The Miller Social Intimacy Scale (MSIS; Miller & Lefcourt, 1982)

This is a 17 item self-report measure of the maximum level of intimacy currently experienced in a given relationship.

Reliability

Cronbach alpha coefficients of .86 and .91 ascertain that the 17 items measure a single construct. Test-retest reliability was computed from two administrations of the test over a 2-month interval. Test-retest correlations were .96 ($p < .001$) over a 2-month interval and .84 ($p < .001$) over a 1-month interval.

Validity

Convergent validity was based on a high correlation (.71, $p < .001$) with a version of the Interpersonal Relationship Scale assessing interpersonal trust and intimacy in the marital relationship (Schlein, Guerney, & Stover, 1971, cited in Guerney, 1977). This measure also correlated inversely (-.65, $p < .001$) with the UCLA Loneliness Scale (Russel, Peplau, & Ferguson, 1978) thus adding to its convergent validity.

Construct validity was investigated by asking a group of subjects to complete the MSIS twice: once for their closest relationship and once for a casual relationship. Scores of tests describing closest relationships were significantly higher than for descriptions of casual relationships ($t = 9.18$, $p < .001$). Further exploration of construct validity was done by comparing mean intimacy scores of married subjects with those of unmarried subjects, and the scores of married subjects with those of couples in marital therapy. Mean intimacy scores were significantly higher for married than unmarried respondents ($t = 8.17$, $p < .001$). Mean scores were also significantly greater for the married sample than for the distressed clinic sample ($t = 6.14$, $p < .001$). Unmarried subjects scored significantly higher than married clinic subjects ($t = 2.56$, $p < .02$), which supports the MSIS as a more precise measure of intimacy than marital status.

Scoring

Ratings on the 10-point scales are summed to obtain the maximum level of intimacy currently experienced in the relationship. The theoretical range is 17-170. The total mean scores are for the unmarried sample: 137.5; for the married sample: 154.3; and for the clinic sample: 126.3. The standard

deviation for the total scores of the married sample was 9.3.

A copy of the MSIS can be found in Appendix B.

Attachment Questionnaire (AQ; West, Sheldon, & Reiffer, 1987)

This is a 35-item, self-report questionnaire designed to assess adult attachment in terms of seven criteria and provisions definitive of the unique function of reciprocal attachment in meeting security needs. The seven criteria are separation protest, use of attachment figure, availability , reciprocity, secure base, feared loss, and proximity seeking.

Development of Scale

The first step was the identification of the component features of adult attachment. Following the work of Bowlby (1969;1973), Ainsworth (1978) and Weiss (1982), these authors identified four criteria which distinguish the functional goal of achievement of security. Secure base is the extent to which exploration (moving away from home to participate in the larger environment) and adaptive response (coping with usual routines) are independent of the attachment figure's physical presence. Proximity-seeking refers to the tendency to reduce distance from the attachment figure in times of stress. Separation protest is the degree to which physical separation, actual or anticipated, is perceived as threatening to the attachment relationship and, therefore, results in responses to separation. Feared loss is the ability to sustain confidence in the future of the attachment relationship. Reciprocity was included as a fifth criterion to distinguish adult attachment from other forms of attachment (i.e. parental), which are complementary rather than reciprocal. Parental attachment consists of complementary infant behaviors that are consistently care-eliciting and parental behaviors that are consistently care-giving. In contrast, reciprocity describes a more flexible system; over time each partner in the relationship may display either behavior pattern. For adults, the expectation is that an individual will both require an attachment figure (i.e. a provider of security) and be able to function as an attachment figure.

In addition to the five criteria distinguishing adult attachment

relationships, these authors explicated two provisions of attachment relationships: availability/responsiveness and use of attachment figure. Availability is the extent to which the attachment figure is perceived as reliably accessible. Responsiveness refers to the extent to which the attachment figure is perceived as responding appropriately and favourably to most of the individual's needs. Use of the attachment figure is defined as the extent to which the individual asks for the attachment figure's availability and responsiveness.

The next major stage was the generation of a large item pool to comprise each scale. Jackson's (1970) sequential system for scale development was used to construct scales to assess each attachment feature. Items were nominated by clinicians and research workers. Additional items were obtained from interviews with patients and nonpatients. Each item was scrutinized for clarity, brevity, content saturation, scalar uniqueness, and relative freedom from bias. The resultant item pool consisted of 183 statements, balanced for positive and negative wording. The scales were administered to a sample of 40 patients and nonpatients who volunteered for the initial pool study. The second study consisted of 169 patients and 184 nonpatients.

Empirical testing of the scales was initiated to investigate the convergent validity of items within the scale and the discriminant validity between scales. On the basis of this testing, scales with alpha coefficients below .70 were revised (i.e elimination of items, factor analyses). The result is a measure with 35 items and seven subscales.

Reliability

The following are the respective internal alpha coefficients of reliability for each of the scales: Secure Base (.84), Separation Protest (.90), Proximity Seeking (.79), Feared Loss (.88), Reciprocity (.85), Availability (.86), and Use of Attachment Figure (.90). The total score reliability is .87. The two week test- retest reliabilities for the scales are: Secure Base (.76), Separation Protest (.76), Proximity Seeking (.82), Feared Loss (.81), Reciprocity (.67), Availability (.68), and Use of Attachment Figure (.77).

Validity

Construct validity was measured using factor analyses. A three factor orthogonal rotation does confirm the theoretical grouping of scales as attachment criteria (secure base, separation protest, proximity seeking, and feared loss), adult criterion (reciprocity) and attachment provisions (availability and use of the attachment figure). A two factor solution produces the same pattern, with reciprocity loading on factor 2.

Scoring

Each item is rated on a 5-point scale ranging from strongly disagree (1) to strongly agree (5). For each individual, the theoretical range of scores is 35-175. Both partner's total score is summed and divided by two to arrive at a mean score for each couple. Scores were reflected so that higher scores indicated more secure attachment.

The Relationship Trust Scale (RTS; Holmes, Boon & Adams, 1990)

The Relationship Trust Scale is a 30-item self-report inventory specifically designed to assess interpersonal trust in married or cohabiting couples. It was used in this study to assess the level of trust in the relationship.

Development of scale

The Rempel, Holmes and Zanna (1985) Trust Scale was substantially reconstructed in order to render it more compatible with recent empirical findings and theoretical speculation concerning issues of insecurity and adjustment in marriage in relation to interpersonal trust (Holmes & Boon, 1990), attachment styles (Collins & Read, 1990), and emotion (Gottman & Levenson, 1986). Five factors emerged from an analysis of the responses of 226 married subjects, reflecting perceptions of partner responsiveness, capacity to resolve conflict, partner dependability, faith in the partner, and concerns about dependency. A series of factor analyses produced a final scale of 30 items: Responsiveness (8 items), Dependability-Reliability (6 items), Faith in Partner's Caring (6 items), Conflict Efficacy (5 items), and Dependency

Concerns (5 items).

Reliability

Reliability was established for each of the component subscales as well as for the total scale using Cronbach's Coefficient Alpha. The standardized reliabilities for the subscales Responsiveness, Dependability-Reliability, Faith in Partner's Caring, Conflict Efficacy, and Dependency Concerns were .89, .83, .84, .84, and .83, respectively. The overall reliability was .89. Test-retest reliability was approximately .72 over a three-year period.

Validity

Construct validity was obtained by assessing the correlations between the RTS and measures designed to assess people's level of comfort in being close to their partner and believing in the availability and responsiveness of their partner (Boon & Holmes, 1990). This sample consisted of 70 married couples. As expected, there were significant correlations between scores on the trust scale and the couples' experiences in their relationship.

Discriminant validity of the revised scale was demonstrated by contrasts with measures of self-disclosure, ambivalence, and anger, for both the self and partner.

Scoring

Individuals are asked to respond to the 30 items on a 7-point scale ranging from strongly disagree (1) to strongly agree (7). The theoretical range of scores is 30-210. Scores for each of the subscales are added to provide an overall score. Scores have been reflected so that higher scores indicate a stronger presence of trust between partners. A couple's score is obtained by combining each partner's score and dividing by two. A copy of this scale can be found in Appendix B.

Emotional Self-Disclosure Scale (ESDS; Snell, Miller & Belk, 1988)

The ESDS is a self-report questionnaire that was developed to assess how willing people are to discuss eight specific emotions with three different recipients: male friends, female friends, and spouses/lovers. It will be used

in this study to assess the total amount of emotional expression between spouses/partners prior to onset of therapy.

Development of Scale:

Forty original items were developed to assess the eight distinct emotions proposed by Izard and Buechler (1980). From this perspective, emotions are seen to have neurophysiological, expressive, and experiential components and to provide direction and focus to human sensation, perception and cognition. The eight emotions are: sadness, happiness, jealousy, anxiety, anger, calmness, apathy, and fear. Seventy-nine undergraduate students were asked to respond to the 40 items. For each of the 40 items, the subjects were to indicate how willing they would be to discuss that topic with three different target persons: male friends, female friends, and spouses/lovers. A 5-point Likert scale was used with the following two poles: 1 = not at all willing to discuss this topic and 5= totally willing to discuss this topic. Each item was scored from 1 to 5 with higher scores indicating greater willingness to self-disclose to that particular person.

Reliability:

Two types of reliability analyses were conducted: Cronbach's alpha and test-retest. Cronbach's alpha for each emotion self-disclosed to a spouse/lover are: Depression (.91), Happiness (.93), Jealousy (.89), Anxiety (.91), Anger (.94), Calmness (.86), Apathy (.89), and Fear (.95). There is clear evidence that items on each subscale were coherent and internally consistent. The 12-week test-retest reliabilities for each emotion self-disclosed to a spouse/lover are: Depression (.75), Happiness (.72), Jealousy (.58), Anxiety (.70), Anger (.68), Calmness (.66), Apathy (.72), and Fear (.71). The authors conclude that the subscales on the ESDS are sufficiently reliable to use in research studies on emotional disclosure.

Scoring:

There are 40 items corresponding to the eight subscales (five items per subscale). With a range between 1 to 5 for each item, the scale yields a score ranging from 40 to 200 for each individual. Each individual's score of self-rating and partner rating is summed to produce a total individual score for

each partner. Both individuals' scores are summed and divided by two to arrive at an overall couple score. Higher scores indicate a greater level of self-disclosure in the relationship prior to onset of therapy. Individual analyses were conducted on the self-rating and partner-rating of self-disclosure.

Couples Therapy Alliance Scale (AS; Pinsof & Catherall, 1986)

The Couples Therapy Alliance Scale is a 29 item measure designed to assess the couple's perception of the therapeutic alliance, i.e. "that aspect of the relationship between therapist system and the patient system that pertains to their capacity to mutually invest in, and collaborate on, the therapy" (Pinsof & Catherall, 1986, p. 139). The AS instrument was used in this study to control for client-therapist relationship variables that have been shown to be important in predicting therapeutic outcomes (i.e Bergin & Garfield, 1986). It was intended to provide verification that the variance in outcome was not attributable to the quality of the therapeutic alliance between a couple and a therapist. It was administered after the third session to ensure that it picked up any differences in alliance which were expected to appear earlier rather than later in the overall treatment process.

Development of scale

The scale was developed to assess alliance along two theoretical dimensions: Content and Interpersonal System. The Content dimension includes the following categories: Task, the client's perception that tasks within therapy are relevant to presenting concerns; Goals, the degree of agreement between couple and therapist on goals of therapy; and Bond, the quality of the relationship between couple and therapist. These elements have been identified by Bordin (1979) as central components in the therapeutic alliance. The Interpersonal System dimension consists of viewing these key components in relationship to Self (Self-Therapist category), to the partner (Other-Therapist category), and to the couple as a whole (Group-Therapist category).

Items were generated for each of these six categories: 11 for Self, 11 for Other, and 7 for Group. The format of the scale requires the clients to rate

the extent to which they agree or disagree with a series of statements about the various features of the alliance. The ratings are made on a Likert 7-point scale ranging from completely agree (7) to completely disagree (1) with a neutral (4) midpoint.

Reliability

Two preliminary studies have been conducted to assess the test-retest reliability of the scale. Both studies were done at the Family Institute of Chicago with a non-psychotic population. The first study was completed with an earlier 5-point version of the scale which was administered to 12 couples (24 individuals) who filled out the scale twice, i.e after each of two consecutive therapy sessions approximately one week apart. The test-retest Pearson correlation coefficient was $r=.84$ ($p < .005$). The second study used the more recent 7-point version of the scale and administered it using the same procedure as in the first study. The overall scores yielded a Pearson reliability coefficient of .79 at the .005 level.

Validity

Preliminary results of studies testing the predictive validity have shown a positive ($p < .05$) correlation between the overall alliance score and patient progress (Catherall, 1984).

Scoring

Scores range from a low of 1 to a high of 7. Given that the measure consists of 29 items, the theoretical range of scores is 29-203. Higher scores are reflective of a higher quality of the alliance between the couple and therapist. The overall mean score for the couple was determined by adding each partner's overall score and dividing by two.

Therapist Rating Scale of the D.A.S. Factors

The therapist rating scale is designed to provide a measure of the therapist's assessment of the improvement in the couple's dyadic adjustment. It is based on the four factors that comprise the Dyadic Adjustment Scale. Although it was not used formally as a dependent variable, it was intended to serve as a validity check to determine if there were any discrepancies between

the therapist and a self-report measure of marital adjustment.

Although it would be desirable to obtain an acceptable minimum correlation between a self-report and the therapist rating of improvement in marital satisfaction (i.e. r >.70), it has been suggested that self-report measures better reflect the presenting subjective complaints of couples than observational and/or rating measures (Jacobson, 1985). Thus, a couple's self-report of how satisfied they are with their relationship must be considered the primary dependent measure in marital therapy outcome studies in which the goal of the investigations is to improve the quality of the relationship (Baucom, 1984).

Development of the Scale

On the original Dyadic Adjustment Scale (Spanier, 1976), a factor analysis was used to test the adequacy of the proposed definition of adjustment, verify the presence of hypothesized components, and to make the final selection of items indicative of dyadic adjustment. The final result yielded 32 items grouped into four components: satisfaction, cohesion, consensus, and affectional expression. The 10 items on this scale reflect the four components of the original scale. As well, the items on this scale have been taken directly from the original scale and transformed into questions. Moreover, due to the fact that the items that comprise the Satisfaction subscale account for 68% of the variance in test results (Spanier, 1976), there were more items on this rating scale that directly assess satisfaction. Thus, four items measure satisfaction, two items measure consensus, two items measure cohesion and two items measure affectional expression. A reliability analysis of the total scale score was conducted and is reported in the Results section.

Scoring

Therapists were asked to answer the questions upon completion of therapy with a particular couple. Therapists were asked to circle the appropriate word underlying each question that indicates the rating of improvement or deterioration. Words included as indicators of improvement or deterioration ranged from "very much improved" to "improved" to "same" to "worse" to "very

much worse". These words are assigned points ranging from 2, 1, 0, -1, -2. Thus, since there are 10 questions, the theoretical range of scores is 20 to -20 for each couple. Higher numbers indicate a higher rate of improvement in marital adjustment.

Implementation Checklist

A key concern in this study was to ensure that the therapy condition was faithfully implemented. In order to ascertain whether the interventions stipulated in the treatment manual have taken place, a checklist of therapist interventions was adapted for the purposes of this study from similar checklists used in previous studies (i.e Johnson & Greenberg, 1985; Dandeneau & Johnson, 1994). For each couple, half of the sessions (i.e six sessions) were randomly chosen. Two independent raters (doctoral interns with two years experience in EFT) were asked to screen a ten-minute segment twenty minutes into the session. Raters were provided with three hours of training in order to obtain an acceptable level of inter-rater reliability (i.e a minimum of .80).

The checklist consists of 16 interventions. Eight interventions have been selected from the EFT manual and are considered to be EFT interventions. Eight interventions that are considered to be non-EFT interventions have been included. A copy of the Implementation Checklist is included in Appendix A. Interventions considered to be specific to EFT are 1,3,5,7,9,11,13, and 15.

Procedure

Subjects responded to newspaper advertisments and community announcements outlining free marital therapy for maritally distressed couples (Please see Appendix A for the newspaper advertisement). Couples were contacted and completed the initial screening procedure over the phone. The screening procedure obtained information regarding the length of cohabitation, the presence of alcohol or drug abuse, and whether any member of the couple was currently receiving psychiatric or psychological treatment. A copy of the complete screening procedure can be found in Appendix A. After the initial

telephone screening procedure, couples who met the inclusion criteria were invited to come in for an assessment interview. Couples were informed that the assessment interview would be approximately 90 minutes in length.

At this interview, couples were given information on the procedure and requirements of the study and were assured of confidentiality of information. Each partner was asked to sign an information and consent form, reminding them that their participation was voluntary and that they were free to withdraw from the study at any time. Throughout these procedures every effort was made to respect the privacy, dignity and assessment tolerance limits of every subject. At each stage in the procedure, subjects were asked whether they were comfortable with the arrangements made and the requirements placed upon them. Every effort was made to satisfactorily address any concerns or difficulties that subjects may have experienced.

Couples then completed the DAS to determine their eligibility for the study. To be included in the study, the mean total score for the couple on the DAS must have been below 97 and above 75. If these requirements were not met, couples were advised immediately that they did not meet the requirements of this study and that if they wished they may be referred either to the Centre for Psychological Services or another service offering treatment(for referral agencies- See Initial Screening procedure Appendix A). If the couple satisfied the criteria on the DAS, they were informed immediately and asked to sign a confirmation of consent to participate in the study.

Upon agreeing to participate in the study, couples were asked to complete the following: the Relationship Trust Scale, the Miller Social Intimacy Scale, the Emotional Self-Disclosure Scale and the Adult Attachment Scale.

Upon completion of the questionnaires, couples were informed as to when they would begin to receive counselling. Couples were told that they would be contacted by a counsellor within the next week in order to set an appointment. Couples were informed that all sessions would be audiotaped for purposes of supervision.

All couples were notified that they must be willing to commit themselves to

attend twelve (12) consecutive sessions of EFT. This number of sessions was consistent with surveys that indicate that the mean number of office visits for people going to psychologists and psychiatrists is 12.5 and 10.9, respectively (Taube, Burns & Kessler, 1984). The two couples who chose to withdraw from the study during the course of the counselling sessions were asked whether they wish to be referred elsewhere for treatment and were given appropriate referral information. Following completion of the third session, couples were asked to complete the Couple Therapy Alliance Scale.

At the end of the twelfth (i.e. final) session, each couple was asked to complete the Dyadic Adjustment Scale and the Miller Social Intimacy Scale. Therapists were asked to complete the Therapist Rating Scale of the DAS Factors.

A three month follow-up was conducted by contacting subjects by telephone, and asking them to make an appointment to complete the follow-up outcome questionnaires:the Dyadic Adjustment Scale and the Miller Social Intimacy Scale. A full debriefing concerning the study was offered at that time.

Outcome Criteria

In order to test the hypotheses of this study, four outcome criteria were utilized, two primary and two secondary criteria. The first primary criteria of outcome was the absolute level of marital satisfaction at posttreatment and follow-up. This assessment allows for the observation of those couples and individuals who are most likely to indicate high levels of marital satisfaction and thus, be maritally satisfied following therapy. The second primary criteria was the marital satisfaction change scores from pretreatment to posttreatment and follow-up. This assessment allows for the determination of those couples and individuals who are most likely to make large gains in marital satisfaction.

In addition to the two primary criteria mentioned above, this study utilized two secondary outcome criteria: a measure of intimacy level and a therapist rating of improvement. A measure of intimacy was selected as an

additional outcome criteria due to the strong association between marital adjustment and intimacy (Larzelere & Huston, 1980; Waring et. al., 1981; Wynne & Wynne, 1986), even though intimacy is seen as a unique concept that is distinct from marital satisfaction (Dandeneau, 1990). Moreover, researchers investigating the psychological significance of marriage have provided evidence that intimacy in particular is an important indicator of psychological and physiological well-being (Cobb, 1976; Mitchell & Tricket, 1980; Fehr & Perlman, 1985; Gove, Style & Hughes, 1990). For these reasons, intimacy has been used as an outcome criteria in two previous EFT outcome studies (Johnson & Greenberg, 1985a; Dandeneau & Johnson, 1994). The inclusion of intimacy level as an additional outcome criteria in this study is a move toward a more comprehensive investigation and understanding of the association between these three predictor variables and the impact of EFT in improving intimate relationships.

Another secondary outcome criteria is a therapist rating of improvement. There was concern that the only measure of marital satisfaction was a self-report questionnaire. Given the potential of a reporting bias, it was felt that a therapist rating measure would be useful as a validity check. Thus, a therapist rating measure that was based on the four factors that comprise the Dyadic Adjustment Scale (a measure used to assess marital satisfaction) was used in this study. This therapist rating scale was given to therapists at the end of the final therapy session.

Data Analysis

Clinical Treatment Effects

The assessment of the overall clinical treatment effect has been suggested as important for determination of whether the differences observed are large enough to be worthy of making a real difference to individuals (Jacobson, 1985; Kazdin, 1986).

Two criteria for assessing clinically significant change in therapy have

been recommended in the research literature (Jacobson & Truax, 1991). The first measure of significant change is the number of couples who can be considered to be recovered and maritally satisfied, as indicated by their absolute level of marital satisfaction at posttreatment and follow-up. To be confidently considered recovered, a couple's marital satisfaction score must fall beyond that of a specific cut-off point. One of the recommended cut-off points is the midpoint between the mean pretreatment level of marital satisfaction for a given sample and the mean for the norms on a given measure. Thus, a couple obtaining a score greater than or equal to this midpoint will be considered recovered and maritally satisfied at posttreatment and follow-up.

A second measure of clinically significant change is to assess the degree of improvement as indicated by change scores. A "reliable change index" (RC) was utilized to determine if the magnitude of change for a given couple was statistically reliable beyond that attributable to measurement error (Jacobson & Truax, 1991). The reliable change index is the difference between pretreatment and posttreatment scores divided by the standard error of difference. The standard error of difference represents the difference expected as a result of measurement error between two scores obtained by an individual on the same test.

Analyses to Test the Hypotheses of This Study

In order to assess the relationship between the predictor variables and marital satisfaction level, two procedures were conducted. First, Pearson correlation analyses were conducted between the predictor variables and the marital satisfaction level for the couple and each gender. Next, separate multiple regression analyses were conducted for the predictor variable(s) found to be significantly correlated with marital satisfaction. In this procedure, the pretreatment marital satisfaction level was entered first and the predictor variable was entered second. The dependent variable was the posttreatment and follow-up marital satisfaction level, respectively. Separate

multiple regression analyses have been recommended in order to assess the unique contribution of the predictor variable in predicting posttreatment and follow-up marital satisfaction beyond that of the pretreatment marital satisfaction level (Jacobson et. al. 1986; Snyder, Mangrum, & Wills, 1993). These analyses assessed the contribution of the predictor variables in predicting those couples who were most likely to be maritally satisfied at posttreatment and follow-up.

In order to determine the relationship between the predictor variables and gains in marital satisfaction, Pearson correlation analyses were conducted between each predictor variable and marital satisfaction change scores for the couple and each gender. These analyses determined which couples and individuals were most likely to make the largest gains in marital satisfaction.

In order to assess the association between the predictor variables and intimacy level at posttreatment and follow-up, both Pearson correlation and separate multiple regression analyses were conducted in the same manner as the above analyses for assessing the association between the predictor variables and marital satisfaction level. These analyses assessed the contribution of the predictor variables in predicting those couples who were most likely to indicate high levels of intimacy at posttreatment and follow-up.

Finally, in order to determine which couples were most likely to have been rated as improved by their therapist, Pearson correlation analyses were conducted between each predictor variable and the therapist rating of improvement.

CHAPTER IV RESULTS

Data analysis was conducted in three major steps. First, preliminary analyses were conducted to test for assumptions regarding normality, linearity, homoscedasticity, and multicollinearity. Preliminary analyses were also conducted to test for assumptions regarding the reliability of the measures, the faithfulness of therapy implementation, the association between the couple demographic characteristics and outcome, the effect of the couple-therapist alliance on outcome, and gender equivalence on independent and dependent measures.

Second, analyses were also conducted to test assumptions regarding clinical treatment effects for couples at posttreatment and follow-up. These analyses determined the percentage of couples who could be considered maritally satisfied and to have significantly improved following EFT.

Third, Pearson correlation and multiple regression analyses were conducted to test the hypotheses in this study. In order to determine if there were significant associations between the predictor variables and marital satisfaction and intimacy level, a significance level of .05 was chosen. However, the alpha level was adjusted (Bonferroni correction) to reflect the number of separate multiple regression analyses for couples, females, and males, respectively. In order to detect significant associations between the predictor variables and marital satisfaction change scores, the alpha level was adjusted to reflect the number of Pearson correlation analyses for couples, females, and males respectively. The SPSS program (version 4.1) was used to conduct these analyses.

Preliminary Analyses

Preliminary analyses were conducted to determine if the independent and dependent variables as well as demographic characteristics and the alliance score met the criteria regarding assumptions of normality, linearity, and homoscedasticity (Tabachnik & Fidell, 1989). Analyses were conducted for

couples, females and males.

It has been suggested that extreme cases, referred to as outliers, are likely to have a disproportionate effect on the overall data and should be removed to reduce their influence. In order to identify univariate outliers, an inspection of z scores and histograms were undertaken on all independent and dependent variables. All of the variables were examined through the SPSS Frequencies program. For purposes of these analyses, a univariate outlier was defined as any case with a standardized score in excess of $\pm$ 3.00. Results revealed that all cases were within the acceptable limits.

Skewness and kurtosis were evaluated for each independent and dependent variable by dividing the values for skewness and kurtosis by their respective standard errors, thereby obtaining standardized scores. Values greater than 3.29 or smaller than -3.29 (alpha = .001) were considered to represent significant departures from normality. None of the variables deviated significantly from zero using a .001 alpha level. Due to the fact that these variables did not severely deviate from significance levels, no transformations were necessary. However, it is important to note that the female level of secure attachment displayed significant positive kurtosis (2.81) when alpha was at the .01 level. This suggests that the range of female scores on the attachment measure was limited (i.e too many cases close to the mean). The relevance of this finding with respect to some of the analyses will be discussed below.

The SPSS Regression program was used to examine the variables in order to assess the assumptions of multivariate analysis. A computation of the Mahalanobis distance was conducted using a .001 criterion level to identify multivariate outliers for couple, male and female scores for each predictor variable with the dependent variables: marital satisfaction level, marital satisfaction change scores, intimacy level, and therapist rating of improvement. Again, all cases were within the acceptable limits. Thus, no cases were eliminated from analyses.

An examination of the residuals plots and bivariate scatterplots revealed

that no variables violated assumptions for normality, linearity and homoscedasticity. Thus, no transformations were undertaken.

Further preliminary analyses were conducted to assess for multicollinearity using the SPSS Pearson Correlation program. The predictor variables were significantly correlated with each other: trust and attachment ($r\ (32)=.72$, $p<.01$); trust and self-disclosure ($r\ (32)=.52$, $p<.01$); attachment and self-disclosure ($r\ (32)=.43$, $p<.05$). Moreover, all three of the predictor variables were significantly correlated with the couples' pretreatment marital satisfaction level. These correlations may be found in Table C-1, Appendix C. The relevance of the finding that the predictor variables were correlated with the pretreatment marital satisfaction level will be discussed below.

Reliability analyses were conducted for each measure. Reliability was established for each of the component subscales as well as for the total scale using Cronbach's coefficient alpha. The sample used for the reliability analyses included all thirty-four couples who completed therapy. This gave a total N of 68 subjects (34 couples). As can be seen in Table 1, the reliability coefficients ranged from .65 to .93 for the subscales and from .84 to .92 for the total scale on the predictor measures. As can be seen in Table 2, the reliability coefficients ranged from .59 to .82 for the subscales and from .79 to .96 for the total scales on the dependent measures. These findings are consistent with the reported findings for these measures in the research literature.

Table 1

Reliability Statistics for Predictor Measures

(N = 68)

Relationship Trust Scale	
Responsiveness	.87
Dependability	.75
Conflict	.80
Faith	.84
Concern	.65
Total Score	.92
Adult Attachment Scale	
Secure Base	.76
Separation Protest	.77
Proximity Seeking	.74
Feared Loss	.74
Reciprocity	.73
Availability	.78
Use of Attachment Figure	.86
Total Score	.84
Self-Disclosure	
Depression	.91
Happiness	.92
Jealousy	.86
Anxiety	.88
Anger	.91
Calmness	.92
Apathy	.90
Fear	.93
Total score	.88

Table 2

Reliability Statistics for Dependent Measures

(N = 68)

	Pretreatment	Posttreatment	Follow-up
DAS			
Consensus	.69	.82	.79
Affect Expression	.72	.59	.63
Satisfaction	.62	.81	.82
Cohesion	.69	.79	.79
Total Score	.79	.90	.90
MILLER INTIMACY			
Total Score	.89	.92	.96
THERAPIST RATING			
Total Score		.86	

Implementation Checks

To confirm that the treatment was implemented faithfully in accordance to the treatment manual, a number of verification procedures were carried out. First, tapes of sessions picked at random were audited by the researcher during the course of the study and implementation was judged to be more than adequate. Second, sections of interviews were listened to in group supervision and the supervisor did not report improper implementation. In addition to this, an implementation check was conducted by two trained independent raters. These raters were doctoral students with a moderate familiarity with EFT. Both raters were provided with three hours of training in order to obtain an

acceptable level of inter-rater reliability. Inter-rater reliability was calculated on 15 randomly chosen sessions. Cohen's (1960) kappa coefficients were calculated to investigate reliability between the two raters. The overall percentage of agreement between raters assessing EFT vs. non-EFT interventions was 94%. This suggests that raters achieved a high level of agreement regarding appropriate EFT interventions. The overall percentage of agreement between raters differentiating specific within-EFT intervention strategies was 82.6%.

For the purpose of this implementation check, six sessions for each couple (a total of 204 sessions) were randomly selected to be coded according to the Implementation Checklist. (see Appendix A for Implementation Checklist). Eight interventions were selected from the EFT manual and considered to be EFT interventions. Eight interventions considered to be non-EFT interventions were also included. An intervention was defined as a complete therapist statement, the beginning and end of which was noted by the raters to ensure that they were both coding the same units. One ten-minute segment, twenty minutes into the session, was selected for coding. Of the 832 coded therapist interventions, 27 (3.2 %) were found to be inappropriate to the treatment condition being observed. The most common inappropriate intervention used was number 16, where the therapist asks each partner to disclose opinions, thoughts, and theories about what throughout the sessions has led to improvement. This type of therapist intervention occurred toward the end of treatment in response to a couple's statement of their ignorance of the process of change and/or anxiety about terminating treatment. The aim of this intervention would appear to be to increase the couple's awareness of the factors that have led to improvement (i.e. increased self-disclosure, affiliation and responsiveness between partners).

In summary, the small percentage of inappropriate interventions suggests that therapists were successful in implementing the EFT approach according to the treatment manual. Thus, implementation checks suggest that EFT was properly and faithfully implemented.

Demographic Characteristics and Outcome

Pearson correlation analyses were conducted to determine the association between couple demographic characteristics, marital satisfaction level, and marital satisfaction change scores as a comparison with previous results in the research literature. The demographic characteristics assessed were age, level of education, length of relationship, gross family income, and number of children. As can be seen in Table C-2, Appendix C, none of these variables were significantly related to the couples' posttreatment and follow-up marital satisfaction level at the .05 level. In order to determine the association between couple demographic variables and marital satisfaction change scores, the alpha level was adjusted (Bonferroni correction) to reflect the number of analyses ($p < .05/5 = .01$). None of these variables were significantly related to marital satisfaction change scores.

Individual analyses were conducted to determine the association between age, level of education and outcome for females and males, respectively. None of these variables were significantly related to outcome for females. For males, age was significantly related to their level of marital satisfaction at follow-up, $r\ (32) = .39$, $p < .05$. Multiple regression analyses were conducted to assess the contribution of males' age to the follow-up level of marital satisfaction after controlling for the pretreatment level of marital satisfaction. The males' pretreatment level of marital satisfaction accounted for 4% of the variance, $F\ (1,32) = 1.17$, $p > .05$ and the males' age accounted for 16% of the variance in their follow-up level of marital satisfaction, $F\ (1,31) = 6.46$, $p < .05$. The F values presented in this section represent the incremental F ratio. Incremental F values indicate whether a predictor variable is significant in predicting the posttreatment and follow-up marital satisfaction beyond that of pretreatment marital satisfaction. A summary of these results is presented in Table C-3, Appendix C. In order to determine the association between age and education and marital satisfaction change scores for females and males, the alpha level was adjusted (Bonferroni correction) to

reflect the number of analyses ($p < .05/2 = .025$). None of these variables were significant for females. The males' age was significantly related to their marital satisfaction change scores at posttreatment, $r\ (32) = .38$, $p < .025$, and at follow-up, $r\ (32) = .38$, $p < .025$. These results suggest that older males at intake were likely to be maritally satisfied at follow-up and were likely to make the largest gains in marital satisfaction at posttreatment and follow-up.

Therapeutic Alliance

The couples' alliance scale was given after the third session to control for alliance effects on treatment outcome. Pearson correlation analyses revealed that this measure was related to the couples' level of marital satisfaction at posttreatment, $r\ (32) = .47$, $p < .01$, and at follow-up, $r\ (32) = .53$, $p < .01$. Multiple regression analyses were conducted to assess the contribution of the alliance to the posttreatment and follow-up levels of marital satisfaction after controlling for the pretreatment level of marital satisfaction. The couples' pretreatment level of marital satisfaction accounted for 12% of the variance, $F\ (1,32) = 4.30$, $p < .05$ and the couples' alliance score accounted for 22% of the variance in their posttreatment level of marital satisfaction, $F\ (1,31) = 10.39$, $p < .01$. At follow-up, the couples' pretreatment level of marital satisfaction accounted for only 4% of the variance, $F\ (1,32) = 1.30$, $p > .05$ while the couples' alliance score accounted for 29% of the variance in the couples' marital satisfaction level, $F\ (1,31) = 12.73$, $p < .01$. A summary of these analyses is presented in Table C-4, Appendix C. Moreover, the therapeutic alliance was related to the couples' gains in marital satisfaction at posttreatment, $r\ (32) = .48$, $p < .01$, and follow-up, $r\ (32) = .50$, $p < .01$. Thus, the couples' alliance score was significantly related to both the couples' marital satisfaction level and marital satisfaction gains at termination and at follow-up.

Further analyses were conducted to determine which, if any, of the therapeutic alliance subscales was most powerful in predicting the couples' level of marital satisfaction at termination and follow-up. The scale was

developed to assess alliance along two theoretical dimensions: Content and Interpersonal System. The Content dimension included the following subscales: Task, the couple's perception that the therapist was helpful and that the tasks within therapy were relevant to presenting concerns; Goals, the degree of agreement between couple and therapist on goals of therapy; and Bond, the quality of the relationship between couple and therapist. The Interpersonal System dimension consists of viewing these key components in relationship to Self (Self-Therapist category), to the partner (Other-Therapist category), and to the couple as a whole (Group-Therapist category). In order to ascertain the contribution of these six alliance factors to posttreatment and follow-up marital satisfaction level, separate regression analyses were conducted controlling for the couple's pretreatment marital satisfaction level. The alpha level was adjusted (Bonferroni correction) to reflect the number of multiple regression analyses ($p < .05/6 = .008$). As can be seen in Table C-5, Appendix C, the regression analyses revealed that of the six alliance factors, the Task subscale accounted for the most variance in the couples' posttreatment and follow-up marital satisfaction level. The Task subscale accounted for 27% of the variance in the couples' posttreatment marital satisfaction level, $F(1,31) = 13.11$, $p < .008$, and 36% of the variance in the couples' follow-up marital satisfaction level, $F(1,31) = 18.20$, $p < .008$. It is also interesting to note that the Task subscale on the alliance measure accounted for more of the variance in the couple's level of marital satisfaction at both termination and follow-up than the couple's overall alliance level. Thus, this suggests that the Task subscale, which measures the couple's perception that the therapist was helpful and that the therapeutic tasks were relevant to their presenting concerns, was most significantly related to outcome.

A second finding with respect to the couple's level of alliance, as can be seen in Table C-6, Appendix C, was that the couples' alliance score was related to the couples' level of intimacy at termination, $r(32) = .46$, $p < .01$ and at follow-up, $r(32) = .50$, $p < .01$. Regression analyses revealed that the

pretreatment level of intimacy accounted for 37% of the variance F (1,32) = 18.03, p <.001 and the couples' alliance score accounted for 10% of the variance in the couples' posttreatment level of intimacy, F (1,31) = 5.83, p <.05. Moreover, the pretreatment level of intimacy accounted for 24% of the variance F (1,32) = 10.05, p <.01 and the couples' alliance score accounted for 16% of the variance in the couples' follow-up level of intimacy, F (1,31) = 7.83, p <.01. This suggests that the couples' alliance score was a significant predictor of their overall level of intimacy at termination and at follow-up.

A third finding is that the couples' alliance score was related to the therapists' ratings of improvement at termination, r (32)=.36, p <.05. The couples' alliance level accounted for 13% of the variance in the therapists' rating of improvement, F (1,32) = 4.75, p <.05. A summary of these analyses are presented in Table C-7, Appendix C.

These findings suggest that the stronger the alliance at the end of the third session, the more likely couples exhibited 1) higher levels of marital satisfaction at termination and follow-up, 2) more gains in marital satisfaction at termination and follow-up, 3) higher levels of intimacy at termination and follow-up, and 4) receive higher ratings of improvement from their therapist at termination.

Given the strong evidence regarding the alliance score as a predictor of outcome, analyses were conducted to determine the association between therapist experience level and the couples' alliance score. Therapist experience was determined by the number of months of supervised couple therapy experience. There were 13 therapists in the study with the lowest number of 2 months and the highest number of 24 months(mean = 12.9 months). Although there was a positive association between therapist experience and couple alliance level, it was not considered statistically significant, r (32)= .23, p >.05.

Gender Equivalence

Means and standard deviations were calculated for all independent and dependent measures and are presented through Table C-8 to Table C-13, Appendix C. In order to detect gender differences on independent and dependent measures, an independent samples t-test was used (Tabachnik & Fidell, 1989). As summarized in Table C-14, Appendix C, there were no significant gender differences at the .05 alpha level on general trust level, general attachment level, couple-therapist alliance level, and pretreatment, posttreatment and follow-up marital satisfaction levels, and intimacy levels. There were significant gender differences on the self-disclosure measure: Females were rated by themselves and their partners as being more self-disclosing and thus, had higher levels of overall self-disclosure than males at intake. Moreover, females obtained higher levels of combined self/partner ratings for all eight emotions than males at intake. A summary of the gender differences with respect to the specific emotions can be found in Table C-11, Table C-12, and Table C-13, Appendix C.

Treatment Effects

Clinically Significant Change

The reader will recall the two criteria for assessing clinically significant change in therapy: recovery and improvement (Jacobson & Truax, 1991). The first measure of significant change is the percentage of couples who can be considered to be recovered and maritally satisfied. To be confidently considered recovered, a couple's marital satisfaction score must fall beyond that of a specific cut-off point. One of the recommended cut-off points is the midpoint between the mean pretreatment level of marital satisfaction for a given sample and the mean for the norms on a given measure. In this study, the midpoint between the mean pretreatment level of marital satisfaction (88.2) and the mean for maritally satisfied couples on the Dyadic

Adjustment Scale (114) was 101. Thus, for purposes of analyses, scores on the DAS greater than or equal to 101 classified subjects as recovered. On the basis of this criteria for clinically significant change in psychotherapy, 17 couples (50%) were classified as recovered or maritally satisfied at termination and 24 couples (70%) were classified as recovered or maritally satisfied at follow-up.

A second measure of clinically significant change is to assess the degree of improvement as indicated by change scores. A "reliable change index" was utilized to determine if the magnitude of change for a given couple was statistically reliable beyond that attributable to measurement error (Jacobson & Truax, 1991). The reliable change index is the difference between pretreatment and posttreatment scores divided by the standard error of the difference. The standard error of the difference represents the difference expected as a result of measurement error between two scores obtained by an individual on the same test. It is computed by taking the square root of the standard error of measurement squared, multiplied by two. Jacobson and Revenstorf (1988) note that when the reliable change index "exceeds 1.96, it is unlikely ($p < .05$) that the magnitude of change could be an artifact of an unreliable measuring instrument." (p.135).

For the present study, with a standard deviation on the Dyadic Adjustment Scale of 7.9 (the couples' DAS standard deviation at pretreatment), and the reliability of the Dyadic Adjustment Scale, as reported by Spanier (1976), of .96, the standard error of measurement was calculated and found to be 1.58. The standard error of the difference was then calculated and found to be 2.234. Given a reliable change index of 1.96, a difference between pretreatment and posttreatment or follow-up of 4.5 (rounded to 5) points on the Dyadic Adjustment Scale was considered necessary for a change score to be deemed statistically reliable and not a result of measurement error alone. On the basis of this criteria, 27 couples (79%) in this study were considered to have exhibited a clinically significant improvement at termination and 28 couples (82%) were considered to have exhibited a clinically significant improvement at follow-up. A summary of the percentage of couples who recovered

and improved is presented in Table C-15, Appendix C.

In addition, couples were considered to have deteriorated on the basis of the reliable change index calculated for this study (Jacobson & Truax, 1991). A difference of 5 or more points between the posttreatment or follow-up DAS and the pretreatment DAS was considered signficant beyond measurement error alone. On the basis of this criteria, two couples were considered to have deteriorated at posttreatment and follow-up. The deterioration rates at posttreatment were -10.5 and -11.0 points on the DAS. The deterioration rates at follow-up were -5.5 and -10.5 points.

Effect Size

Another way of viewing a treatment effect is in terms of effect sizes (Cohen, 1977). Due to the absence of a control group, a repeated measures t-test for related samples was utilized to assess the effect size (Howell, 1989). Thus, the following formula was used:

$$\text{Effect Size} = \frac{\text{Follow-up DAS mean - pretreatment DAS mean}}{S*SQRT(\ 2\ (\ 1-r\ )\ )}$$

The S in this formula is the follow-up DAS standard deviation and the r is the correlation between the pretreatment DAS and follow-up DAS. To arrive at this formula, the follow-up DAS standard deviation is multiplied by the square root of the product of two multiplied by one minus r. In this study, the values for the follow-up DAS mean, the pretreatment DAS mean, and the standard deviation of the follow-up DAS were 107.5, 88.0, and 12.3 respectively. The effect size for this study at follow-up was 1.26. Thus, the large percentage of couples considered to have recovered and improved as well as the magnitude of the effect size would suggest that EFT was effective in alleviating marital distress in this sample.

Analyses were also undertaken to determine the association between the couples' pretreatment level of marital satisfaction and 1) posttreatment and

follow-up levels of marital satisfaction, and 2) posttreatment and follow-up marital satisfaction change scores. For the total sample, the pretreatment marital satisfaction level was significantly related to the posttreatment marital satisfaction level, $r\ (32) = .35$, $p < .05$, but was not significantly related to the follow-up marital satisfaction level, $r\ (32) = .21$, $p > .05$. This suggests that couples who are the least distressed at intake are likely to be more maritally satisfied at termination but not at follow-up. Regression analyses revealed that the pretreatment marital satisfaction level accounted for 12 % of the variance in the couples' posttreatment marital satisfaction level, $F\ (1,32) = 4.65$, $p < .05$ and only 4 % of the variance in the couples' follow-up marital satisfaction level, $F\ (1,32) = 1.54$, $p > .05$. These results suggest that the pretreatment level of marital distress was not a significant factor in predicting those couples who were most likely to be maritally satisfied following EFT.

For the total sample, the couples' pretreatment level of marital satisfaction was not significantly related to marital satisfaction change scores at termination, $r\ (32) = -.29$, $p > .05$, but was significantly related to marital satisfaction change scores at follow-up, $r\ (32) = -.39$, $p < .05$. This suggests that highly distressed couples made the most gains on the Dyadic Adjustment Scale at follow-up. In addition, the couples' pretreatment level of marital satisfaction was unrelated to the therapists' ratings. This suggests that therapists were likely to view severely, moderately and mildly distressed couples as being equally likely to improve. Moreover, the therapists' ratings were related to the couples' marital satisfaction levels at termination, $r\ (32) = .59$, $p < .01$ and follow-up, $r\ (32) = .62$, $p < .01$. This suggests a strong consistency between self-reports of marital satisfaction and therapists' ratings of improvement at outcome.

Couples were then classified on the basis of level of pretreatment marital satisfaction. Those couples obtaining a score below 81 (1 standard deviation from the mean pretreatment marital satisfaction level) were classified as severely distressed (7 couples). Those couples obtaining a score between 82-91 were classified as moderately distressed (13 couples). Those couples obtaining

a score at or above 92 were classified as mildly distressed (14 couples). Using Jacobson and Truax's (1991) criteria for clinically significant change, couples categorized as severely distressed were least likely to be classified as recovered at posttreatment and follow-up. However, severely distressed couples were most likely to improve at both posttreatment and follow-up. A summary of the percentage of couples who recovered and improved by degree of pretreatment marital distress is presented in Table C-16, Appendix C.

Therapist Effect

An analysis of covariance with the pretreatment marital satisfaction acting as a covariate was conducted to test for therapist effects, that is to examine if working with particular therapists predicted outcome. The results of the analysis of covariance suggest that there were no significant therapist effect on outcome at termination, $F(4,4) = 1.231$, $p>.05$, and at follow-up, $F(4,4) = 2.760$, $p>.05$.

Attachment

Analyses were conducted to determine if there was an association between level of attachment at intake and the four criteria of outcome: marital satisfaction levels, marital satisfaction change scores, intimacy and therapist rating of improvement.

Attachment and Marital Satisfaction Level

Analyses were conducted to determine the association between attachment and the posttreatment and follow-up levels of marital satisfaction using the SPSS Pearson Correlation program. As shown in Table 3, analyses revealed that the couples' mean attachment level at intake was not significantly related to their marital satisfaction level at termination and follow-up.

Additional analyses were conducted on the attachment subscales for couples, females and males. Results revealed that the couples' mean marital satisfaction level at posttreatment was positively related to the intake measures of the couples' level of proximity seeking, $r\ (32)=.36$, $p < .05$, and the males' level of proximity seeking, $r\ (32)= .37$, $p < .05$.

Table 3

Pearson Correlations between Attachment and Marital Satisfaction Level at Posttreatment and Follow-Up

	Couples		Females		Males	
Variables	Time 2	Time 3	Time 2	Time 3	Time 2	Time 3
Couples						
Mean Score	.19	.03	.19	-.11	.16	.19
availability	.12	.03	.06	.13	.21	.17
proximity seeking	.36*	.27	.22	.16	.41*	.28
feared loss	.22	.16	.13	.11	-.34*	.28
use of attachment	.15	.12	.09	.02	.13	.09
reciprocity	.08	.07	.11	.03	.02	.00
secure base	-.06	-.04	.07	.09	-.01	-.05
separation protest	.02	.04	.12	.13	.08	.09
Females						
Total Score	.20	.18	.17	.04	.20	.31
availability	.02	.07	-.15	-.00	.05	.06
proximity seeking	.22	.26	.17	.23	.16	.19
feared loss	.07	.09	.09	-.04	.11	.08
use of attachment	.12	.14	.31	.19	.17	.34*
reciprocity	.17	.19	.27	.11	.11	.16
secure base	.08	.10	-.02	.00	.08	.09
separation protest	.09	.10	.01	.07	.12	.13
Males						
Total Score	.07	-.14	.11	-.21	.03	-.04
availability	.12	.09	.02	.01	.10	.04
proximity seeking	.37*	.24	.15	.17	.47*	.31
feared loss	.22	.21	.16	.13	.30	.25
use of attachment	.13	.16	.17	.09	.24	.01
reciprocity	.09	.10	.05	.08	.03	.07
secure base	-.19	-.17	-.03	-.05	-.22	-.25
separation protest	.08	.07	.11	.10	.10	.13

Note: Time 2 = posttreatment Dyadic Adjustment score, Time 3 = follow-up Dyadic Adjustment score, * $p < .05$

Separate regression analyses were conducted to determine if the couples' and males' proximity seeking were predictive of outcome after controlling for pretreatment marital satisfaction levels. The alpha level was adjusted to reflect the number of analyses ($p < .05/2 = .025$). Analyses revealed that the couples' pretreatment marital satisfaction level accounted for 13% of the variance in outcome, $F(1,32) = 4.64$, $p < .05$. The couples' proximity seeking accounted for only 6% of the variance in outcome, $F(1,31) = 2.71$, $p > .025$, and males' proximity seeking accounted for 7% of the variance in outcome, $F(1,31) = 2.93$, $p > .025$. The F values presented in this section represent the incremental F ratio. Thus, both variables were non significant in predicting outcome after controlling for couples' pretreatment levels of marital satisfaction. A summary of these analyses is presented in Table 4.

Table 4

Summary of Multiple Regression of Attachment on Couples' Marital Satisfaction Level at Posttreatment

Variables	cdas2 (DV)	B	β	R square change (incremental)
cdas1	.36*	.548	.356	.13*
cproxsee	.36*	1.447	.271	.06
mproxsee	.37*	1.182	.282	.07

Note: cdas1 = couples' pretreatment mean Dyadic Adjustment Scale score, cdas2 = couples'posttreatment mean Dyadic Adjustment Scale score, cproxsee = couple's mean proximity seeking score, mproxsee = male's proximity seeking score,

Separate Regression analyses were conducted for each variable

* $p < .05$, ** $p < .05/2 = .025$

Individual analyses were conducted to determine if there was an association between attachment and marital satisfaction for each gender. None of the attachment subscales were significantly correlated with the females' marital satisfaction levels. As can be seen in Table 5, males were more likely to be recovered at posttreatment if, at intake, 1) the couples reported high levels of proximity seeking behaviors, $r\ (32) = .41$, $p < .05$; 2) the males reported high levels of proximity seeking behaviors, $r\ (32) = .47$, $p < .05$; and 3) the couples reported lower levels of fear of loss of relationship and/or partner, $r\ (32) = -.34$, $p < .05$. Separate regression analyses were conducted to determine if these variables would contribute to outcome beyond that of the males' pretreatment marital satisfaction. The alpha level was adjusted to reflect the number of regression analyses ($p < .05/3 = .016$). The males' pretreatment marital satisfaction level accounted for 14% of the variance in their own posttreatment level of marital satisfaction, $F\ (1,32) = 5.40$, $p < .05$, as shown in Table 5. The couples' proximity seeking behaviors accounted for 13% of the variance, $F\ (1,31) = 5.59$, $p > .016$, the males' proximity seeking behaviors accounted for 15% of the variance, $F\ (1,31) = 6.48$, $p < .016$, and the couples' fear of loss of the relationship accounted for 5% of the variance, $F\ (1,31) = 1.76$, $p > .016$. Thus, males were more likely to be maritally satisfied at termination if, at intake, the males indicated higher levels of proximity seeking behaviors.

Table 5

Summary of Multiple Regression of Attachment on Male's Posttreatment Marital Satisfaction Level

Variables	mdas2 (DV)	B	β	R square change (incremental)
mdas1	.38*	.475	.380	.14
mproxsee	.47*	1.897	.397	.15**
cproxsee	.41*	2.232	.366	.13
cferloss	-.35*	-1.193	-.233	.05

Note: mdas1 = male's pretreatment dyadic adjustment score, mdas2 = male's posttreatment dyadic adjustment score, mproxsee = male's proximity seeking score, cproxsee = couple's mean proximity seeking score, cferloss = couple's mean fear of loss of relationship score

Separate Regression analyses were conducted for each variable

* $p < .05$, ** $p < .05/3 = .016$

Moreover, the males' follow-up marital satisfaction levels were related to the females' use of attachment figure at intake, $r(32) = .34$, $p < .05$. Thus, males were more likely to be maritally satisfied at follow-up if, at intake, females reported high levels of use of attachment figure. As shown in Table 6, regression analyses revealed that the males' pretreatment marital satisfaction accounted for 4% of the variance in outcome, $F(1,32) = 1.18$, $p > .05$. After controlling for male's pretreatment marital satisfaction, the females' use of attachment figure accounted for only 8% of the variance in outcome, $F(1,31) = 3.53$ $p > .05$. Thus, females' use of attachment figure at intake was not significant in predicting the follow-up male marital satisfaction level.

Table 6

Summary of Multiple Regression of Attachment on Males' Follow-up Marital Satisfaction Level

Variables	mdas3 (DV)	B	β	R square change (incremental)
mdas1	.19	.220	.189	.04
fuseatt	.34*	1.176	.318	.08

Intercept = 79.97

Multiple R = .34
R square = .11
Adjusted R square = .06
Standard Error = 12.5

Note: mdas1 = males' pretreatment Dyadic Adjustment Scale score, mdas3 = males' follow-up Dyadic Adjustment Scale score, fuseatt = females' use of attachment score

* $p < .05$

In summary, hypothesis 1 that high levels of attachment would be related to marital satisfaction levels at posttreatment and follow-up was generally not supported. The only exception was the significant finding that males were more likely to be maritally satisfied at posttreatment if, at intake, males indicated high levels of proximity seeking.

Attachment and Marital Satisfaction Gains

Pearson correlation analyses were conducted to determine the relation between low levels of attachment and marital satisfaction gains as measured by

marital satisfaction change scores. As can be seen in Table 7, although the correlation between the the couples' mean attachment level and marital satisfaction gains was in the hypothesized direction, it was not significant at the .05 alpha level.

Additional analyses were conducted to determine the association between the attachment subscales and marital satisfaction gains for couples, females, and males. The alpha level was adjusted to reflect the number of Pearson correlation analyses ($p < .05/24 = .002$). The one finding at this level of significance was that couples who were most likely to make the largest gains in marital satisfaction at follow-up included males who indicated low levels of use of attachment figure at intake, $r\ (32) = -.51$, $p = .002$.

Table 7

Pearson Correlations of Attachment and Marital Satisfaction Change Scores at Posttreatment and Follow-up

	Couples		Females		Males	
Variables	Time 2	Time 3	Time 2	Time 3	Time 2	Time 3
Couples						
Mean Score	-.18	-.31	-.09	-.34	-.23	-.19
availability	-.13	-.28	-.06	-.13	-.21	-.17
proximity seeking	-.13	-.09	-.13	-.16	-.28	-.20
feared loss	-.17	-.00	-.13	-.11	-.18	-.28
use of attachment	-.25	-.40	-.29	-.22	-.23	-.29
reciprocity	-.22	-.21	-.11	-.03	-.02	-.00
secure base	-.11	-.04	-.07	-.09	-.01	-.05
separation protest	-.02	-.04	-.12	-.13	-.18	-.19
Females						
Total Score	-.05	-.07	-.09	-.19	-.00	.08
availability	-.02	-.07	-.16	-.28	-.05	-.06
proximity seeking	-.22	-.26	.09	-.03	-.16	-.19
feared loss	-.07	-.09	.02	-.12	-.12	-.18
use of attachment	-.12	-.16	-.04	-.13	-.17	-.15
reciprocity	-.17	-.19	.09	-.14	-.15	-.26
secure base	-.08	-.10	-.05	-.12	-.08	-.19
separation protest	-.09	-.10	-.23	-.16	-.12	-.13
Males						
Total Score	-.22	-.40	-.03	-.31	-.34	-.38
availability	-.28	-.36	-.22	-.21	-.31	-.43
proximity seeking	-.14	-.14	-.12	-.19	-.26	-.08
feared loss	-.20	-.21	-.16	-.14	-.03	-.09
use of attachment	-.29	-.51*	-.28	-.39	-.26	-.44
reciprocity	.19	-.11	-.06	-.08	-.02	-.05
secure base	-.19	-.17	-.03	-.05	-.25	-.24
separation protest	-.09	-.17	-.14	-.10	-.10	-.13

Note: Time 2 = posttreatment Dyadic Adjustment change score, Time 3 = follow-up Dyadic Adjustment change score, * $p < .05/24 = .002$

In summary, hypothesis 2 that low levels of attachment would be related to marital satisfaction gains was not supported. However, the correlations for the most part were in the hypothesized direction. The one finding that reached the level of significance was that couples who were likely to make the largest gains in marital satisfaction at follow-up consisted of male partners who were reluctant to make use of their attachment figure at intake.

Attachment and Intimacy Level

Analyses were conducted to determine the association between attachment and posttreatment and follow-up intimacy levels. Pearson correlation analyses revealed that the level of attachment for both couples and each partner were unrelated to level of intimacy at termination and follow-up. Analyses were also conducted to determine the association between the attachment subscales and level of intimacy at outcome. Pearson correlation analyses showed that couples were likely to exhibit high levels of intimacy at termination if, at intake, 1) couples and females made use of their attachment figure(couples: $r\ (32)=.34$, $p < .05$; females: $r\ (32)=.37$, $p < .05$; 2) couples and females indicated high levels of reciprocity (couples: $r\ (32)= .36$, $p < .05$; females: $r\ (32)=.40$, $p < .05$; and 3) couples and males indicated high levels of proximity seeking behaviors, couples: $r\ (32)= .38$, $p < .05$; males: $r\ (32)= .35$, $p < .05$. A summary of these results is presented in Table C-17, Appendix C. In order to determine if these variables were predictive of couples' intimacy level, separate multiple regression analyses were conducted controlling for pretreatment couple intimacy level. The alpha level was adjusted to reflect the number of analyses ($p < .05/6 = .008$). Results revealed that the couples' pretreatment intimacy level accounted for 36% of the variance in outcome, $F\ (1,32) = 18.20$, $p < .05$. Moreover, none of these attachment subscales significantly added to the prediction of intimacy outcome after controlling for pretreatment levels of intimacy (couples' use of attachment figure, $F\ (1,31) = .614$, $p > .008$, females' use of their attachment figure, $F\ (1,31) = .153$, $p > .008$, couples' mean level of reciprocity, $F\ (1,31) = .003$, $p > .008$, females' level of reciprocity, $F\ (1,31) = .196$, $p > .008$, couples' mean level

of proximity seeking, $F\ (1,31) = .000$, $p > .008$, males' level of proximity seeking, $F\ (1,31) = .004$, $p > .008$). A summary of these results are presented in Table C-18, Appendix C.

Attachment and Therapist rating of improvement

Attachment levels were assessed to determine the impact on therapist rating of improvement at posttreatment. The overall attachment level for the couple and each gender was unrelated to the therapist rating of improvement, as can be seen in Table C-19, Appendix C.

Self-Disclosure

Analyses were conducted to determine the association between the level of self-disclosure at intake and the four criteria of outcome: marital satisfaction level, marital satisfaction change scores, intimacy and therapist rating of improvement.

Self-Disclosure and Marital Satisfaction Level

First, self-disclosure was assessed to determine its impact on marital satisfaction level. As can be seen in Table 8, the general level of self-disclosure for couples was unrelated to the couples' level of marital satisfaction at termination and follow-up. Thus, hypothesis 3 that higher levels of self-disclosure would be related to marital satisfaction levels was not supported. Additional Pearson correlation analyses were conducted to determine the association between self and partner ratings of self-disclosure and marital satisfaction level for couples, females and males, respectively.

Table 8

Pearson Correlations between Self-Disclosure and Marital Satisfaction Level at Posttreatment and Follow-up

	Couples		Females		Males	
Variables	Time 2	Time 3	Time 2	Time 3	Time 2	Time 3
cselfd	.13	.08	.15	.04	.09	.11
fselfd	.17	.16	.19	.13	.12	.15
fsds	.24	.14	.03	.04	-.04	.10
fsdp	-.01	.08	.23	.14	.19	.12
mselfd	.06	-.01	.07	-.06	.04	.04
msds	.16	.05	.16	.00	.12	.09
msdp	-.07	-.08	-.05	-.11	-.07	-.04

Note: Time 2 = posttreatment Dyadic Adjustment Scale score, Time 3 = follow-up Dyadic Adjustment Scale score, cselfd = couples' mean self-disclosure score, fselfd = females' self-disclosure score, fsds = female self rating of disclosure, fsdp = partner rating of female self-disclosure, msds = male self rating of disclosure, msdp = partner rating of male self-disclosure

Analyses were then conducted to determine if there was a significant relation between the various emotions and marital satisfaction level for couples, females, and males, respectively. None of these correlations were significant. A complete summary of the correlations between the eight emotions and marital satisfaction for couples, females and males are presented in Tables C-20 to Table C-21, Appendix C.

In summary, hypothesis 3 that higher levels of self-disclosure would be positively related to higher marital satisfaction levels was not supported.

Self-Disclosure and Marital Satisfaction Gains

The level of self-disclosure for couples was unrelated to the gains made in marital satisfaction at posttreatment and follow-up as can be seen in Table 9. The alpha level was then adjusted to reflect the number of Pearson correlation analyses between self and partner ratings of self-disclosure and couples', females' and males' marital satisfaction level ($p < .05/7 = .007$). Results revealed that each gender's posttreatment and follow-up marital satisfaction change scores were unrelated to their general levels of self-disclosure. The only significant finding was that males who were rated by their partners as being less self-disclosing made the largest gains in marital satisfaction at posttreatment, $r(32) = -.46$, $p < .007$. These results suggest that emotionally inhibited males are most likely to make the largest gains in marital satisfaction at termination.

Table 9

Pearson Correlations between Self-Disclosure and Marital Satisfaction Change Scores at Posttreatment and Follow-up

	Couples		Females		Males	
Variables	Time 2	Time 3	Time 2	Time 3	Time 2	Time 3
cselfd	-.11	-.15	-.04	-.13	-.14	-.12
fselfd	-.00	-.01	-.02	-.06	.02	.04
fsds	-.17	-.08	-.02	-.01	-.28	-.13
fsdp	.15	.06	-.01	-.07	.27	.17
mselfd	-.19	-.25	-.05	-.17	-.27	-.25
msds	-.08	-.17	-.12	-.24	-.01	-.04
msdp	-.25	-.23	.04	-.01	-.46*	-.39

Note: Time 2 = posttreatment Dyadic Adjustment Scale change scores, Time 3 = follow-up Dyadic Adjustment Scale change scores, cselfd = couples' mean self-disclosure score, fselfd = females' mean self-disclosure score, fsds = female self rating of disclosure, fsdp = partner rating of female disclosure, mselfd = males' mean self-disclosure score, msds = males' self rating of disclosure, msdp = partner rating of male self-disclosure,

* $p < .05/7 = .007$

Additional analyses were conducted to determine the association between the eight emotions and marital satisfaction change scores for couples, females and males. The alpha level was adjusted to reflect the number of Pearson correlation analyses ($p < .05/16 = .003$). None of these correlations were significant. A complete summary of the correlations between the eight emotions and marital satisfaction change scores for couples, females and males are presented in Table C-22 and Table C-23, Appendix C.

In summary, hypothesis 4 that low levels of self-disclosure would be related to marital satisfaction gains was generally not supported, although many of these correlations were in the hypothesized direction. The only

significant finding was that males who were rated by their partners as being less self-disclosing made the largest gains in marital satisfaction at termination.

Self-Disclosure and Intimacy Level

Analyses were conducted to determine the association between self-disclosure and the level of intimacy at posttreatment and follow-up. Pearson correlation analyses revealed that the couples' overall mean level of self-disclosure and each gender's self and partner rating of self-disclosure was unrelated to the level of intimacy at outcome for both couples and each gender. A summary of these correlations is presented in Table C-24, Appendix C.

Further analyses were conducted to determine the impact of the self-disclosure subscales on level of intimacy for each gender. For females, a complete summary of the Pearson correlations can be found in Table C-25, Appendix C. The one significant finding was that the females' self-rating of apathy at intake was related to the females' level of intimacy at follow-up, $r\ (32)=.44$, $p < .01$. This suggests that females were likely to report higher levels of intimacy at follow-up if, at intake, they reported high levels of apathy self-disclosure. A multiple regression analysis revealed that the females' pretreatment level of intimacy accounted for 13% of the variance in their own follow-up intimacy level, $F\ (1,32) = 4.68$, $p < .05$, and the female self-rating of apathy disclosure accounted for 11% of the variance in their own follow-up intimacy level, $F\ (1, 31) = 4.69$, $p < .05$. Thus, high levels of female apathy self-disclosure was predictive of their own intimacy level at follow-up. A summary of these analyses are presented in Table C-26, Appendix C.

For males, a complete summary of the Pearson correlations is presented in Table C-27, Appendix C. Results reveal that the males' level of intimacy at posttreatment was related to intake measures of self-rating of happiness self-disclosure, $r\ (32)= .37$, $p < .05$, and self-rating of depression self-

disclosure, r (32)= .34, p <.05. This suggests that males were likely to report higher levels of intimacy at posttreatment if, at intake, they reported high levels of happiness self-disclosure and high levels of depression self-disclosure. Separate multiple regression analyses were conducted to ascertain if these variables were predictive of males' posttreatment intimacy level after controlling for the males' pretreatment level of intimacy. The alpha level was adjusted to reflect the number of multiple regression analyses (p <.05/2 = .025). Results reveal that the males' self rating of happiness disclosure, F (1,31) = 2.02 , p >.025, and the males' self rating of depression disclosure, F (1,31) = 1.67 , p >.025, did not significantly add to the prediction of intimacy outcome. A summary of these analyses is presented in Table C-28, Appendix C.

Self-Disclosure and Therapist rating of improvement

Analyses were conducted to determine the relation between self-disclosure and therapists' rating of improvement for couples and each gender. The levels of self-disclosure for couples, females and males were unrelated to therapists' rating of improvement, as shown in Table C-19, Appendix C.

Trust

Analyses were conducted to determine the association between trust and the four criteria of outcome: marital satisfaction level, marital satisfaction change scores, intimacy level and therapist rating of improvement.

Trust and Marital Satisfaction Level

Analyses were conducted to determine the association between trust and the posttreatment and follow-up levels of marital satisfaction. As can be seen in Table 10, correlational analyses revealed that couples were more likely to be maritally satisfied, if, at intake, a) couples indicated high levels of trust, $r\ (32)=.37$, $p < .05$, high levels of perception of partner responsiveness, $r\ (32) = .35$, $p < .05$, high levels of perception of partner dependability, $r\ (32)=.35$, $p < .05$, and high levels of faith, $r\ (32)=.40$, $p < .05$; b) males indicated high levels of trust, $r\ (32)=.34$, $p < .05$, and high levels of confidence in conflict resolution, $r\ (32)=.37$, $p < .05$.; and c) females indicated high levels of faith, $r\ (32)=.39$, $p < .05$.

Table 10

Pearson Correlations between Trust and Marital Satisfaction Level at Posttreatment and Follow-up

	Couples		Females		Males	
Variables	Time 2	Time 3	Time 2	Time 3	Time 2	Time 3
Couple						
Mean Score	.37*	.27	.35*	.12	.32	.39*
faith	.41*	.35*	.30	.13	.30	.23
concern	.11	.12	.13	.04	.06	.18
dependability	.35*	.25	.28	.09	.27	.30
responsiveness	.35*	.24	.28	.12	.29	.31
conflict resolution	.27	.15	.30	.07	.18	.19
Females						
Total Score	.28	.24	.31	.15	.21	.29
faith	.39*	.44*	.34*	.25	.37*	.56*
concern	.01	.01	.01	.01	.02	.04
dependability	.27	.16	.32	.10	.18	.20
responsiveness	.26	.23	.28	.19	.19	.23
conflict resolution	.10	.03	.16	-.01	.02	.07
Males						
Total Score	.34*	.23	.29	.06	.33	.37*
faith	.31	.18	.19	.00	.36*	.36*
concern	.16	.16	.19	.07	.10	.23
dependability	.18	.20	.09	.03	.23	.35*
responsiveness	.32	.17	.29	.03	.29	.30
conflict resolution	.32	.22	.32	.15	.30	.27

Note: Time 2 = posttreatment Dyadic Adjustment score, Time 3 = follow-up Dyadic Adjustment score

* $p < .05$

Separate regression analyses were conducted to assess the contribution of these variables to the couples' posttreatment marital satisfaction level after controlling for the pretreatment marital satisfaction level. The alpha level was adjusted to reflect the number of analyses ($p < .05/7 = .007$). As can be seen in Table 11, the pretreatment level of marital satisfaction accounted for 13 % of the variance in the posttreatment level of marital satisfaction, $F(1,32) = 4.65$, $p < .05$. None of these variables significantly predicted the couples' posttreatment marital satisfaction level beyond that attributable to the couples' pretreatment marital satisfaction level.

Table 11

Summary of Multiple Regression of Trust Factors on Couples' Posttreatment Marital Satisfaction

Variables	cdas2 (DV)	B	β	R square change (incremental)
cdas1	.35*	.548	.356	.13*
ffaith	.40*	.537	.309	.08
cfaith	.41*	.556	.304	.07
mconflict	.37*	.418	.249	.04
cdepend	.35*	.456	.199	.03
cresponse	.35*	.305	.219	.03
ctrust	.37*	.336	.475	.03
mtrust	.34*	.078	.210	.03

Note: cdas1 = couple's mean pretreatment dyadic ajdustment scale, cdas2 = couple's mean posttreatment dyadic adjustment scale, cfaith = couple's mean faith score, cdepend = couple's mean dependability score, cresponse = couple's mean responsiveness score, ffaith = female's faith score, mtrust = male's overall trust score, mconflict = male's confidence in conflict resolution score, ctrust = couples' mean trust score

Separate regression analyses were conducted for each trust subscale

* $p < .05$, ** $p < .05/7 = .007$

The couples' follow-up level of marital satisfaction was related to the intake measure of the couples' mean level of faith r (32)=.34, p <.05. and the female's level of faith, r (32)=.44, p <.05. Separate regression analyses were conducted to assess the contribution of these variables to the couples' follow-up marital satisfaction level after controlling for the pretreatment marital satisfaction level. The alpha level was adjusted to reflect the number of analyses (p <.05/2 = .025). As can be seen in Table 12, results revealed that the couples's mean level of faith accounted for only 8% of the variance, F (1, 31) = 2.80, p >.025. The female's level of faith at intake accounted for 15% of the variance in the couple's follow-up outcome, F (1, 31) = 5.81, p <.025. These results suggest that only the females' level of faith, prior to onset of therapy, was a significant predictor of the couples' marital satisfaction level at follow-up.

Table 12

Summary of Multiple Regression of Trust on Couples' Follow-up Marital Satisfaction

Variables	cdas3 (DV)	B	β	R square change (incremental)
cdas1	.21	.335	.214	.05
ffaith	.44*	.735	.416	.15**
cfaith	.35*	.597	.321	.08

Note: cdas1 = couple's mean pretreatment Dyadic Adjustment Scale score, cdas3 = couple's mean follow-up Dyadic Adjustment Scale score, ffaith = female level of faith, cfaith = couple mean level of faith

Separate regression analyses were conducted for each predictor variable

* p <.05, ** p <.05/2 = .025

Analyses were conducted for individuals. For females, the female posttreatment marital satisfaction level was related to a) the couples' mean trust level, r (32)=.35, p <.05, and b) the female level of faith, r (32) = .34, p <.05. Separate regression analyses were conducted to determine if these variables were predictive of the females' posttreatment marital satisfaction level after controlling for the females' pretreatment marital satisfaction level. The alpha level was adjusted to reflect the number of analyses (p <.05/2 = .025). As can be seen in Table 13, results revealed that the females pretreatment marital satisfaction level accounted for 7 % of the variance, F (1,32) = 2.54, p >.05, the couples' mean trust score accounted for 7% of the variance, F (1,31) = 2.49, p >.025, and the female level of faith accounted for 7% of the variance F (1,31) = 2.44, p >.025. Thus, none of these variables were significant in predicting the females' posttreatment marital satisfaction beyond the females' pretreatment marital satisfaction level.

Table 13

Summary of Multiple Regression of Trust on Females' Posttreatment Marital Satisfaction Level

Variables	fdas2 (DV)	B	β	R square change (incremental)
fdas1	.27	.312	.271	.07
ffaith	.34*	.520	.282	.07
ctrust	.35*	.140	.285	.07

Note: fdas1 = females' Dyadic Adjustment Scale score, fdas2 = females'posttreatment Dyadic Adjustment Scale score, ffaith = female level of faith, ctrust = couple mean trust score

Separate regression analyses were conducted for each predictor variable

* p <.05, ** p <.05/2 = .025

For males, the males' posttreatment marital satisfaction level was related to the females' level of faith, $r\ (32) = .37$, $p < .05$, and the males' level of faith, $r\ (32) = .36$, $p < .05$. As presented in Table 14, separate regression analyses were conducted to assess the contribution of the females' and males' level of faith in predicting the males' posttreatment marital satisfaction after controlling for the males' pretreatment level of marital satisfaction. The alpha level was adjusted to reflect the number of analyses ($p < .05/2 = .025$). The males' pretreatment level of marital satisfaction accounted for 14 % of the variance in outcome, $F\ (1,32) = 5.40$, $p < .05$. The females' level of faith accounted for 11% of the variance, $F\ (1,31) = 4.58$, $p > .025$, and the males' level of faith accounted for 4% of the variance, $F\ (1,31) = 1.57$, $p > .025$, in the males' posttreatment marital satisfaction level. Thus, none of these variables was significant in predicting the males' posttreatment marital satisfaction level.

Table 14

Summary of Multiple Regression of Trust on Males' Posttreatment Marital Satisfaction Level

Variables	mdas2 (DV)	B	β	R square change (incremental)
mdas1	.38*	.475	.380	.14*
ffaith	.37*	.663	.334	.11
mfaith	.36*	.383	.232	.04

Note: mdas1 = males' pretreatment Dyadic Adjustment Scale score, mdas2 = males' posttreatment Dyadic Adjustment Scale score, ffaith = female faith score, mfaith = male faith score

Separate regression analyses were conducted for each variable

* $p < .05$, ** $p < .05/2 = .025$

The males' follow-up marital satisfaction level was related to a) the couples' mean trust score, $r\ (32) = .39$, $p < .05$; b) the females' level of faith, $r\ (32) = .56$, $p < .05$; and c) the males' trust score, $r\ (32) = .37$, $p < .05$, d) the males' level of faith, $r\ (32) = .36$, $p < .05$, and e) the males' perception that his partner is dependable, $r\ (32) = .35$, $p < .05$. Separate regression analyses were conducted controlling for the males' pretreatment marital satisfaction level. The alpha level was adjusted to reflect the number of analyses ($p < .05/5 = .01$). Results revealed that the males' pretreatment level of marital satisfaction accounted for 4 % of the variance. The females' level of faith accounted for 30% of the variance, $F\ (1,31) = 13.79$, $p < .01$, the couples' mean trust score accounted for 12% of the variance, $F\ (1,31) = 4.37$, $p > .01$, the males' trust score accounted for 11% of the variance in outcome, $F\ (1,31) = 3.95$, $p > .01$, the male's perception of partner dependability accounted for 10% of the variance in follow-up outcome,

F (1,31)= 3.70, p >.01, and the males' level of faith accounted for 9% of the variance, F (1,31) = 3.32, p >.01. A summary of these analyses is presented in Table 15. Thus, only the females' level of faith significantly predicted those males who were most likely to be maritally satisfied at follow-up.

Table 15

Summary of Multiple Regression of Trust on Males' Follow-up Marital Satisfaction Level

Variables	mdas3 (DV)	B	β	R square change (incremental)
mdas1	.19	.220	.189	.04
ffaith	.56*	1.017	.549	.30**
ctrust	.39*	.197	.401	.12
mtrust	.37*	.170	.428	.11
mdepend	.35*	.614	.332	.10
mfaith	.36*	.537	.349	.09

Note: mdas1 = males'pretreatment Dyadic Adjustment Scale score, mdas3 = males' follow-up Dyadic Adjustment Scale score, mtrust = males' trust score, ctrust = couples' mean trust score, ffaith = females' level of faith, mfaith = males' level of faith, mdepend = males' perception of partner dependability
Separate regression analyses were conducted for each variable
* p <.05, ** p <.05/5 = .01

In summary, hypothesis 5 that higher levels of trust would be related to higher levels of marital satisfaction was partially supported. First, couples were more likely to be maritally satisfied at follow-up if, at intake, females indicated a higher level of faith in their partner. Second, males were more

likely to maritally satisfied at follow-up if, at intake, females indicated a higher level of faith in their partner.

Trust and Marital Satisfaction Gains

Analyses were conducted to determine the association between the level of trust and marital satisfaction gains. As can be seen in Table 16, although the couples' mean trust score is correlated with their marital satisfaction change score in the hypothesized direction, it was not considered significant at the .05 alpha level.

Additional Pearson correlation analyses were conducted to ascertain the association between the various trust subscales and the posttreatment and follow-up marital satisfaction change scores for couples, females, and males. The alpha level was adjusted (Bonferroni correction) to reflect the number of Pearson correlation analyses ($p < .05/18 = .0027$). As can be seen in Table 16, although most of these correlations were in the hypothesized direction, there were no significant findings.

In summary, hypothesis 6 that low levels of trust would be related to marital satisfaction gains was not supported.

Table 16

Pearson Correlations of Trust and Marital Satisfaction Change Scores at Posttreatment and Follow-up

	Couples		Females		Males	
Variables	Time 2	Time 3	Time 2	Time 3	Time 2	Time 3
Couples						
Mean Score	-.05	-.13	.00	-.17	-.09	-.04
faith	.09	.04	.03	-.10	.12	.17
concern	-.25	-.21	-.17	-.23	-.24	-.12
dependability	.05	.00	.13	-.03	-.03	.04
responsiveness	-.03	-.13	.03	-.14	-.09	-.08
conflict resolution	-.12	-.22	-.03	-.22	-.16	-.15
Females						
Total Score	-.06	-.09	-.14	-.25	.04	.09
faith	.16	.20	.01	-.05	.27	.38
concern	-.23	-.19	-.30	-.30	-.08	-.02
dependability	.01	-.08	.09	-.09	-.07	-.06
responsiveness	-.03	-.05	-.16	-.21	.11	.13
conflict resolution	-.19	-.24	-.19	-.33	-.12	-.07
Males						
Total Score	-.02	-.12	.13	-.06	-.17	.14
faith	.01	-.10	.04	-.12	-.03	-.05
concern	-.16	-.14	.01	-.08	-.28	-.16
dependability	.07	.09	.10	.04	.02	.11
responsiveness	-.03	-.16	.18	-.05	-.23	-.23
conflict resolution	-.01	-.14	.14	-.03	-.17	-.20

Note: das2 = posttreatment dyadic adjustment score, das3 = follow-up dyadic adjustment score, dast2 = posttreatment dyadic adjustment change scores, dast3 = follow-up dyadic adjustment change scores, * $p < .05/18 = .0027$

Categorical Trust Question

Trust may be viewed as a pre-requisite or moderating variable for success in EFT rather than as a predictor variable. One manner of addressing this was to have couples answer a categorical question about their trust towards their partner. Couples who entered the study were asked: Do you trust your partner? Yes or No ? Couples would then be categorized into two groups for analysis.

Of the 34 couples included in the sample, there were 7 couples (20%) where the male or female partner indicated a lack of trust in their partner prior to onset of therapy. On the basis of the criteria of clinically significant change, results suggest that couples with a partner who indicated a lack of trust were less likely to be recovered and less likely to improve at termination and follow-up compared with couples without a partner who indicated a lack of trust. The percentages of those couples who recovered and improved on the basis of pretreatment categorical trust are presented in Table 17. Moreover, the couple who exhibited the most deterioration (i.e., 10.5 point drop from mean pretreatment DAS score to mean follow-up DAS score) had partners who both deteriorated independently at follow-up. For this couple, their combined and individual trust score were all below the mean for the sample's trust score and the male indicated a lack of trust in his partner. It appears that the couple that exhibited the most deterioration indicated lower levels of trust and had one partner who indicated a lack of trust on the categorical measure.

Table 17

Percentage of Categorical Trust Couples who Recovered and Improved

	Posttreatment		Follow-up	
	Recovered[a]	Improved[b]	Recovered[a]	Improved[b]
No-Trust (N = 7)	14.3 %	57.1 %	57.1%	57.1 %
Yes-Trust (N = 27)	59.2 %	85.2%	74.0 %	88.8%

Note: a = Couple Mean Dyadic Adjustment Score ≥ 101, b = Couple Mean Dyadic Adjustment Change Score ≥ 5

Trust and Intimacy Level

Analyses were conducted to determine the association between trust and intimacy levels at termination and follow-up. As can be seen in Table C-29 Appendix C, the couples' termination intimacy level was correlated with a) the couples' mean pretreatment trust score, $r\ (32)=.39$, $p<.05$, and the couples' level of faith, $r\ (32)=.42$, $p<.05$; b) the females' level of faith, $r\ (32)=.38$, $p<.05$; and c) the males trust score, $r\ (32)=.41$, $p<.05$, the males' level of faith, $r\ (32)=.35$, $p<.05$, and the males' perception of partner responsiveness, $r\ (32)=.42$, $p<.05$. Multiple regression analyses were conducted to assess the contribution of these variables after controlling for pretreatment intimacy level. The alpha level was adjusted to reflect the number of analyses
($p<.05/6=.008$). The couples' pretreatment level of intimacy accounted for 36% of the variance in their posttreatment intimacy score, $F\ (1,32) = 18.2$, $p<.001$. None of these variables were significant in predicting posttreatment

intimacy level beyond that of pretreatment intimacy level: couples' mean trust level, $F(1,31) = .054$, $p > .008$, couples' mean level of faith, $F(1,31) = 1.03$, $p > .008$, females' level of faith, $F(1,31) = .861$, $p > .008$, males' level of trust, $F(1,31) = .000$, $p > .008$, males' level of faith, $F(1,31) = .038$, $p > .008$, and males' perception of partner responsiveness, $F(1,31) = .000$, $p > .008$. A summary of these results is presented in Table C-30, Appendix C.

The females' posttreatment intimacy level was related to the intake measures of the couples' mean trust score, $r(32) = .34$, $p < .05$, the males' trust score, $r(32) = .35$, $p < .05$, and the males' perception of partner responsiveness, $r(32) = .38$, $p < .05$. Separate multiple regression analyses were conducted to assess the contribution of these variables after controlling for pretreatment intimacy level. The alpha level was adjusted to reflect the number of analyses ($p < .05/3 = .016$). The females' pretreatment level of intimacy accounted for 13% of the variance in their posttreatment intimacy score, $F(1,32) = 4.76$, $p < .05$. None of these variables were significant in predicting posttreatment intimacy level beyond that of pretreatment intimacy level: couples' mean trust level, $F(1,31) = .68$, $p > .016$, males' level of trust, $F(1,31) = 1.28$, $p > .016$, and males' perception of partner responsiveness, $F(1,31) = 2.29$, $p > .016$. A summary of these analyses are presented in Table C-31, Appendix C.

The males' posttreatment intimacy level was related to the intake measures of the couples' mean level of faith, $r(32) = .39$, $p < .05$, and the males' trust score, $r(32) = .35$, $p < .05$. Regression analyses were conducted to assess the contribution of these variables after controlling for pretreatment intimacy level. The alpha level was adjusted to reflect the number of analyses ($p < .05/2 = .025$). The males' pretreatment level of intimacy accounted for 36% of the variance in their posttreatment intimacy score, $F(1,32) = 18.21$, $p < .001$. None of these variables were significant in predicting posttreatment intimacy level beyond that of pretreatment intimacy level: couples' mean level of faith, $F(1,31) = 2.08$, $p > .025$, and males' level of trust, $F(1,31) = .03$, $p > .025$. These analyses are presented in Table C-32, Appendix C.

The males' follow-up intimacy level was related to the intake measures of

the couples' mean level of faith, $r\ (32)=.41$, $p<.05$, the females' level of faith, $r\ (32)=.45$, $p<.01$, and the males perception of partner dependability, $r\ (32)=.42$, $p<.05$. Regression analyses were conducted to assess the contribution of these variables after controlling for pretreatment intimacy level. The alpha level was adjusted to reflect the number of analyses ($p<.05/3 = .016$). The males' pretreatment level of intimacy accounted for 26% of the variance in their posttreatment intimacy score, $F\ (1,32) = 11.26$, $p<.01$. The females' level of faith accounted for 13% of the variance, $F\ (1,31) = 6.67$, $p<.016$, the males' perception of partner dependability accounted for 12% of the variance, $F\ (1,31) = 5.80$, $p>.016$, and the couples' level of faith accounted for 6% of the variance, $F\ (1,31) = 2.97$, $p>.016$. Thus, only the females' level of faith significantly predicted those males who were likely to have the highest level of intimacy at follow-up. A summary of these analyses are presented in Table C-33, Appendix C.

Trust and Therapist rating of improvement

Analyses were conducted to determine the association between the general level of trust for couples and individuals and therapist rating of improvement. As can be seen in Table C-19 Appendix C, although the Pearson correlations between the couple's and female's level of trust and therapist rating of improvement are in the hypothesized direction, none of the correlations were significant.

Association between Predictors and Alliance Level

Given the strong evidence regarding the alliance score as a predictor of outcome in EFT, analyses were conducted to determine which couples established a strong alliance. First, analyses were conducted to determine the association between the pretreatment level of distress and the alliance score. The pretreatment level of marital satisfaction was not significantly related to the couples' alliance level, $r\ (32)= -.00$, $p>.05$. This suggests that the

pretreatment level of marital distress does not hinder or facilitate the development of an alliance with the therapist. Second, analyses were conducted to determine the relation between the predictor variables and the alliance level. Pearson correlation analyses revealed that the couples' pretreatment mean trust score was related to the level of alliance, $r\ (32)=.36$, $p < .05$. Regression analyses were conducted to assess the contribution of trust to the alliance level. Trust accounted for 13% of the variance in the couples' alliance level, $F\ (1,32) = 4.43$, $p < .05$. It was then observed that the couples' mean level of self-disclosure was significantly related to the couples' alliance level when combined with trust. Consequently, the couples' mean level of self-disclosure was then added to the prediction equation to determine its contribution beyond that of trust. The couples' mean level of self-disclosure accounted for 12% of the variance in the alliance level, $F\ (2,32) = 4.62$, $p < .05$. The combination of trust and self-disclosure accounted for 24% of the variance in the couples' alliance level, $F\ (2,32) = 4.79$, $p < .05$, with trust positively related to alliance and self-disclosure negatively related to alliance. These results suggest that couples with high levels of trust and low levels of self-disclosure, prior to onset of therapy, were more likely to establish high levels of a therapeutic alliance after the third session. A summary of these analyses is presented in Table 18.

Table 18

Multiple Regression of Trust and Self-Disclosure on Couples' Alliance Level

Variables	calnce (DV)	B	β	R square change (incremental)
ctrust	.36*	.231	.353	.13*
cselfd	-.11	-.346	-.400	.12*

Intercept = 164.05

Multiple R = .49
R square = .24
Adjusted R square = .19
Standard Error = 15.6

Note: calnce = couples' alliance level at end of third session, ctrust = couples' mean trust score, cselfd = couples mean self-disclosure score,
* p <.05

CHAPTER V: DISCUSSION

The purpose of this study was to select relationship variables that would be predictive of outcome in an empirically validated dynamic/experiential approach to marital therapy. Such studies have recently been called for in order to facilitate matching of clients to optimal intervention strategies in both individual therapy (e.g. Beutler, 1979; Beutler & Mitchell, 1981; Beutler, 1983; Calvert et. al., 1988) and marital therapy (e.g. Jacobson, 1984; Jacobson, Follette & Elwood, 1984; Baucom & Hoffman, 1986; Snyder, Mangrum, & Wills, 1993; Alexander, Holtzworth-Munroe, & Jameson, 1994). Within marital therapy, previous predictor/outcome studies have selected variables on the basis of demographic characteristics or general observations of distressed couples without regard to the theory or intervention strategies of the particular therapeutic approach used to treat couples in the study. Moreover, most of the previous studies focused on outcome in behavioral marital therapy (BMT). Thus, with the exception of one study (Snyder, Mangrum, & Wills, 1993), there has been a dearth of research examining relationship variables that are theoretically and clinically significant in influencing outcome in empirically validated non-behavioral approaches to marital therapy. This study also attempted to select variables that would appear to be essential to the development and maintenance of intimate relationships. The study included the use of statistically reliable analyses for assessing the impact of predictor variables on outcome, an implementation checklist of the EFT intervention, and follow-up testing.

It was hypothesized that higher levels of attachment, self-disclosure and trust would be related to higher levels of marital satisfaction at posttreatment and follow-up. It was also hypothesized that lower levels of attachment, self-disclosure and trust would be related to marital satisfaction gains at posttreatment and follow-up. Additional hypotheses were proposed that higher levels of attachment, self-disclosure and trust would be related to higher levels of intimacy at posttreatment and follow-up and that lower levels

of attachment, self-disclosure, and trust would be associated with higher therapist ratings of improvement.

This section will first summarize the results of this study. A discussion of the results of this study in terms of demographic characteristics, therapeutic alliance, treatment effects, predictor variables, conclusions, limitations of this study, and suggestions for future research will follow.

Summary of Results

In general, preliminary results suggested that the measures used to assess the independent and dependent variables were reliable and therapists were successful in implementing EFT according to the treatment manual. Unexpectedly, analyses assessing the association between demographic characteristics and outcome revealed that older males at intake were likely to be maritally satisfied at follow-up and were likely to make the largest gains in marital satisfaction at posttreatment and follow-up.

Another finding was that the therapeutic alliance predicted the couples' level of marital satisfaction and intimacy at both posttreatment and follow-up, the gains in marital satisfaction, and the therapists' rating of improvement. Another significant finding with respect to therapeutic alliance and outcome is that the Task subscale on the alliance measure, which measures the couple's perception that the therapist was helpful and that the therapeutic tasks were relevant to their presenting concerns, was most significantly predictive of outcome. It appears that the couples' degree of improvement was related to their perception of the appropriateness of EFT tasks for their particular problem. Post-hoc analyses were undertaken to identify the predictors of the alliance. Couples with higher levels of trust for each other at intake were likely to establish a higher level of alliance with their therapist. Moreover, couples with higher levels of trust who also indicated lower levels of self-disclosure were the most likely to establish a higher alliance level.

There were two primary criteria of clinically significant change in this study: recovery and improvement. Jacobson & Truax's (1991) criteria for clinically significant change was utilized in order to determine recovery and improvement following EFT. In general, to be considered recovered in this study, couples and individuals must have obtained a score at or above 101 on the Dyadic Adjustment Scale. Results revealed that 17 couples (50%) can be classified as recovered or maritally satisfied at posttreatment and 24 couples (70%) can be classified as recovered or maritally satisfied at follow-up. Second, to be considered to have improved following EFT, couples and individuals must have obtained at least a 5 point difference on the Dyadic Adjustment Scale from pretreatment to posttreatment and follow-up. Results revealed that 27 couples (79%) in this study can be considered to have exhibited a clinically significant improvement at termination and 28 couples (82%) can be considered to have exhibited a clinically significant improvement at follow-up. Thus, the results of this study suggest that EFT, in general, was effective in alleviating marital distress in this study

Marital Satisfaction Level

Couples who were most likely to be maritally satisfied at termination indicated a higher level of couple-therapist alliance at the end of the third session. Couples who were most likely to be maritally satisfied at follow-up consisted of: a) females who indicated a higher level of faith in their partner at intake, and b) partners who indicated a higher level of therapeutic alliance at the end of the third session.

For individuals, males who were most likely to be maritally satisfied at termination were, at intake, most likely to engage in a higher level of proximity-seeking. Males who were most likely to be maritally satisfied at follow-up were older and were with females who indicated a higher level of faith in their partner at intake.

Marital Satisfaction Gains

Couples who were most likely to make the largest gains in marital satisfaction at termination indicated a higher level of therapeutic alliance by the end of the third session. Couples who were most likely to make the largest gains in marital satisfaction at follow-up: a) indicated a lower level of marital satisfaction at intake, b) consisted of males who indicated a lower level of use of attachment figure at intake, and c) indicated a higher level of couple-therapist alliance at the end of the third session.

For individuals, males who were most likely to make the largest gains in marital satisfaction at termination were older and had been rated as being less emotionally expressive by their partner at intake. Males who were most likely to make the largest gains in marital satisfaction at follow-up were older at intake.

Intimacy Level and Therapist rating of Improvement

There were two additional criteria of outcome: intimacy level and therapist rating of improvement. Results revealed four significant predictors of the level of intimacy. First, the couple's general level of intimacy at intake was the strongest predictor of the couple's general level of intimacy at follow-up. Couples with a higher level of intimacy at intake tended to have a higher level of intimacy at follow-up. Second, couples who established a higher level of alliance with the therapist by the end of the third session tended to show a higher level of intimacy at follow-up. Third, one aspect of trust, the females' level of faith significantly predicted those males who were likely to have the highest level of intimacy at follow-up. Fourth, the females' level of apathy self-disclosure at intake significantly predicted her follow-up level of intimacy.

The fourth criteria of outcome was the therapist rating of improvement at posttreatment. There was only one significant predictor of therapist rating of

improvement. Couples who had established a higher level of alliance by the end of the third session were most likely to have been rated as improved by therapists.

Demographic Characteristics

Although demographic characteristics were not expected to influence outcome, there was one significant finding. The males' age was significantly related to their marital satisfaction level and marital satisfaction change scores suggesting that older males benefited the most in EFT.

One possible explanation for this finding is that it is at midlife that many males discover the importance of connection and intimacy in their marital relationships (Levinson, 1977). In young adulthood, males measure their masculinity largely on the basis of successful competition and career advancement. However, in midlife, sex-role standards for many males give much greater weight to the development of interpersonal skills, the establishment of intimacy and a focus on the present instead of a constant striving for the future. From this perspective, older males are more likely to be internally aware and more willing to establish deeper levels of intimacy with others than younger males (Levinson, Darrow, Klein, Levinson, & McKee, 1976; Pleck, 1976; Brim, 1976; Barrows & Zuckerman, 1976). Older males' increased knowledge of and sensitivity to their inner self and outward behaviors in intimate relationships may be related to the males' ability and desire to engage emotionally in the therapeutic process and in interactions with their partner. Older males may then experience less anxiety at the prospect of becoming emotionally engaged in a therapeutic approach that emphasizes the exploration and expression of emotional needs and feelings and the fostering of an emotional bond between partners.

The finding that the males' age was positively related to outcome in EFT is in contrast to the finding in the research literature that age was negatively related to outcome in BMT (Baucom & Hoffman, 1986; Jacobson & Addis, 1993). The results of this study combined with previous research suggest that a

skills exchange orientation may be more relevant for couples containing younger males who are more likely to exhibit an instrumental orientation whereas an emotionally focused approach may be more relevant for couples containing older males who are more likely to exhibit an expressive orientation.

It is important to note, however, that due to the presence of inconsistent findings in the research literature with respect to age and marital therapy outcome, replication of these results is needed before conclusions can be made regarding the association between males' age and outcome in EFT.

Therapeutic Alliance

Although the level of couple-therapist alliance was not expected to influence outcome in EFT due to the lack of evidence in data collected in a previous study (Greenberg & Johnson, 1988), a strong, secure bond with the therapist is assumed to be crucial for engagement in the therapeutic tasks in this approach and in experiential therapies in general (Greenberg, Rice, & Elliot, 1993). There are two major tasks in EFT. One is to access emotions. The therapist uses various interventions such as empathic reflection and evocative responding to facilitate a reprocessing of key emotional experiences. A second major task in EFT is the enactment of new interactions such as the expression of previously disowned emotional needs and desires. The fact that the overall alliance level was significantly related to outcome confirms the EFT assumption that the more couples perceived their therapist as a caring, understanding and trustworthy individual, the more likely they were to emotionally engage in the therapeutic process and thus, to benefit from EFT.

A second finding with respect to the therapeutic alliance was that the Task subscale on the alliance measure was most significantly related to outcome. This suggests that the more the couple perceived the therapeutic tasks as being relevant to their problems, the more likely they were to be maritally

satisfied at the end of treatment. Because it is assumed in EFT that the most appropriate manner of conceptualizing intimate relationships is that of an intimate bond, the therapeutic tasks focus on validating each individual's need for closeness, emotional contact, and security. Thus, the results of this study suggest that the more the couple perceived the exploration of emotional experience and the validation of attachment needs as being relevant to their problems, the more likely they were to be maritally satisfied following EFT.

The strong finding with respect to the relation between alliance and outcome in this study is consistent with previous research suggesting that patient involvement, a key factor in the therapeutic alliance, is related to outcome in individual therapy (e.g. Gomes-Schwartz, 1978; Orlinsky & Howard, 1986; Windholz & Silberschatz, 1988; Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988). There have also been three studies that assessed the relation between the therapeutic alliance and marital therapy outcome (Holtzworth-Munroe, Jacobson, DeKlyen, & Whisman, 1989; Heatherington & Friedlander, 1990; Bourgeois, Sabourin, & Wright, 1990).

In one study assessing the association between therapeutic alliance and marital therapy outcome, Holtzworth-Munroe et. al. (1989) reported that therapists' and spouses' ratings of positive client behaviors (i.e. collaboration, active participation and homework compliance), were related to outcome in BMT. Couples with a higher level of marital satisfaction at posttreatment were rated by therapists and perceived themselves as being highly cooperative and active in the therapy sessions and compliant with respect to homework assignments.

It is important to note that the measure used to assess the therapeutic alliance in the Holtzworth-Munroe study was different from the one used in the present study. For example, the Holtzworth-Munroe study assessed the couples' level of cooperation, compliance, and active participation whereas the present study assessed the quality of the relationship between the couple and therapist such as the couple's perception that the therapist was understanding and caring, that the tasks within therapy were relevant to presenting concerns and that there was agreement between couple and therapist on goals of therapy.

It is possible that a specific kind of alliance may be a pre-requisite for successful outcome in BMT compared to EFT. For example, successful outcome in BMT may be partly a function of the level of cooperation between couple and therapist and/or the level of compliance on the part of the couple whereas successful outcome in EFT may be partly related to the development of a safe, accepting and trusting relationship between couple and therapist.

The other two studies employed the same measure of the alliance as the one used in the present study. In one study, Heatherington & Friedlander (1990) assessed the relation between alliance and the couples' perception of the quality of the therapy session immediately following the third to the sixth sessions. The one significant finding was that the Task subscale, which measures the couple's belief in the therapist's ability to understand them and be helpful, was correlated significantly with the couples' perception that the session had been valuable. In the other study, Bourgeois, Sabourin, and Wright (1990) assessed the relation between the therapeutic alliance after the third session and outcome for couples involved in a behavioral-humanistic marital therapy group. After controlling for pretreatment marital satisfaction scores, the alliance was unrelated to outcome for females and was very modestly related to outcome for males, accounting for 3 to 10% of the variance across different outcome measures.

There is some evidence then that a good therapeutic alliance is predictive of outcome in marital therapy. Moreover, there is evidence that the couple's belief that the therapeutic tasks were relevant and that the therapist was able to understand them and be helpful may be the most important factor in establishing a good working relationship. It can be argued that couples who were most cooperative and compliant in the BMT study (Holtzworth-Munroe et. al., 1989) may have viewed the therapeutic tasks as highly relevant to their particular problems. Thus, the extent of change in a couple's marital satisfaction level following marital therapy may be due in part to the couples' perception concerning the appropriateness of the therapeutic tasks to their specific problems.

Due to the strong association between alliance and outcome in this study, additional analyses were undertaken to identify if any of the variables at intake were predictive of the alliance level. The couple's level of trust at intake accounted for 12% of the variance ($p < .05$) in their alliance level by the end of the third session. It may be that couples with higher levels of trust at intake were more likely to risk becoming emotionally vulnerable, more likely to have faith that their partners would be responsive to the disclosure of emotional needs and thus, were more likely to become involved in the therapeutic process.

There are several difficulties interpreting the association between the therapeutic alliance and outcome. One is that a strong alliance by the end of the third session may be an early outcome of successful therapy (Stiles, 1988). It may be that, due to improvement very early in treatment, some couples may be able to form a stronger therapeutic alliance or engage in deeper self-exploration.

A second problem in explaining the strong relationship between alliance and outcome is the potential presence of other factors that promote a strong therapeutic alliance between client and therapist (Stiles, 1988). For example, Stiles (1988) suggests that the level of an individual's interpersonal skills may effect that individual's ability to develop a good working alliance with a therapist. It may be that a high level of social skills is necessary for forming positive relationships with others, including therapists. Thus, couples with strong interpersonal skills may be at an advantage in being able to quickly form a strong bond with their therapist.

A third problem with the interpretation of the association between therapeutic alliance and outcome is therapist responsiveness (Stiles, 1988). The strength of the therapeutic alliance may be due to the therapist's ability to adapt to the specific requirements of each couple. A therapist who is flexible and able to reframe the couple's problems in such a manner that the couple perceives the therapeutic tasks as being relevant and appropriate in resolving their issues will most likely be successful in establishing a strong therapeutic bond. Thus, a therapist's specific skills in responding to the

particular needs of a couple may influence the quality of the therapeutic alliance.

A final difficulty with the notion of therapeutic alliance is that, as suggested by the developers of the alliance measure used in this study (Pinsof & Catherall, 1986), the original framework for viewing the alliance in individual therapy research may be problematic when transfered to marital therapy research due to the presence of many more variables. For example, in individual therapy, there are client variables, therapist variables, and the client-therapist interaction variables. In contrast, within marital therapy, there are self, partner, and couple interaction variables as well as self-therapist, partner-therapist and couple-therapist interaction variables. Moreover, the relevancy and the kind of therapeutic alliance may be different in individual therapy compared to marital therapy. For example, the establishment of a good therapeutic alliance may have more of an impact on outcome in individual therapy compared to marital therapy. Thus, the notion of the therapeutic alliance in marital therapy needs to be further delineated and refined.

In conclusion, previous research has suggested that the therapeutic alliance is significantly related to outcome in individual and marital therapy. The theory of EFT and the results of this study suggest that the therapeutic alliance is particularly important in EFT. The question of whether the therapeutic alliance is best viewed as a non-specific factor that is fundamentally important in all therapies or is particularly important in experiential therapies, such as EFT, where the client is asked to engage in processes such as emotional exploration and disclosure, is an interesting one. Unfortunately, the results of this study are insufficient to answer this question. Future research is needed to determine what level and what kind of therapeutic alliance is desirable for successful outcome in specific therapeutic approaches.

Clinical Treatment Effects

In this study, utilizing Jacobson & Truax's (1991) criteria for assessing posttreatment marital satisfaction levels, 17 couples (50%) could be classified as recovered or maritally satisfied at termination and 24 couples (70%) could be classified as recovered or maritally satisfied at follow-up. This finding suggests that EFT was successful in treating the majority of couples in this study. By comparison, in a review of couple therapy research, Jacobson & Addis (1993) concluded that only 50% of couples were happily married following therapy. These researchers based their conclusion on a number of studies of which the majority were studies assessing outcome in BMT. In this respect, the results of this study were above the outcome norms for BMT.

A second issue with respect to clinical treatment effects is the effect size. In this study, the follow-up treatment effect was calculated to be 1.26. In a recent review of the clinical treatment effects of EFT, Johnson & Greenberg (1994) reported that the effect sizes range from .85 to 2.19 with an average effect size across studies being 1.4. Thus, the effect size for the present study is within the norm for EFT. In addition, the positive clinical treatment effects were obtained with a smaller number of sessions (12) than the optimal number of sessions (20) that have been recommended for EFT (Greenberg & Johnson, 1988). Moreover, the effect size in this study compares favorably to effect sizes reported for behavior exchange therapies (.78, Hahlweg & Markman, 1988) and behavior exchange plus skills training therapies (1.00, Shadish et. al., 1994).

A third issue with respect to treatment effect is the impact of the pretreatment marital satisfaction level on outcome. In this study, the couples' pretreatment level of marital satisfaction accounted for 12% of the variance ($p < .05$) in the couple's marital satisfaction level at posttreatment and only 4% of the variance in the couple's marital satisfaction level at follow-up. These small percentages are in contrast to those found by Jacobson, Follette and Pagel (1986) in a major study assessing outcome in BMT. Jacobson

and his colleagues found that the couples' pretreatment marital satisfaction level accounted for 37 % of the variance ($p < .001$) in the posttreatment marital satisfaction level and 30% of the variance ($p < .001$) in the follow-up marital satisfaction level. In another study assessing outcome in BMT, the couples' pretreatment marital satisfaction level accounted for 28 % of the variance in the posttreatment marital satisfaction level and 46% of the variance in the follow-up marital satisfaction level (Whisman & Jacobson, 1990). This comparison indicates that the couples' pretreatment marital distress level may be more of a factor in predicting outcome in BMT than EFT. This comparison suggests that BMT may be most appropriate for mildly distressed couples whereas EFT may be indicated for a wider variety of maritally distressed couples. However, it should be noted that this comparison is based on only one EFT study with a sample of 34 couples. Replication of these results would be needed before strong conclusions can be made.

A third issue with respect to treatment effect is the classification of couples on the basis of degree of pretreatment marital distress. In classifying couples into three categories of distress, a smaller percentage of couples who were classified as severely distressed were likely to be classified as recovered following therapy compared to those couples classified as moderately or mildly distressed (The follow-up marital satisfaction means for severely, moderately, and mildly distressed couples were 103.5, 108.1, and 109.5, respectively). The results of this study are consistent with other research suggesting that severely distressed couples are less likely to be recovered or maritally satisfied following behavioral and insight-oriented marital therapy (Baucom & Hoffman, 1986; Jacobson & Addis, 1993; Snyder, Mangrum, & Wills, 1993). However, those couples classified as severely distressed were most likely to improve following EFT. It appears that although highly distressed couples are less likely to be recovered following therapy, they are most likely to benefit from EFT. It may be that severely distressed couples simply require more treatment sessions than the number of sessions that are currently provided in research studies. For example, in this study,

couples were provided with 12 sessions of EFT. This number is lower than the optimal number of sessions (20) recommended by Greenberg and Johnson (1988). Thus, there is the possibility that the most severely distressed couples require more therapy sessions in order to become maritally satisfied. On the other hand, severely distressed couples may also require specific interventions that have not been fully developed at this point. The findings of this study together with previous studies suggest that the marital therapy field needs to focus on the successful treatment of severely distressed couples.

Predictor Variables

Attachment

The first hypothesis that couples with a higher level of attachment security at intake are most likely to indicate higher levels of marital satisfaction at posttreatment and follow-up was not supported. These results suggest that the assessment of the overall level of attachment security between partners does not predict who will be maritally satisfied following EFT. There are two possible explanations for the lack of significant findings. One possible explanation is that couples with varying levels of attachment security at intake are equally likely to be maritally satisfied following marital therapy. It may be that EFT is particularly effective in increasing the level of accessibility and responsiveness between partners and thus, restructuring the emotional bond between partners regardless of how insecurely attached couples were at intake.

An alternative explanation for the lack of significant findings is that the measure of the overall attachment security may not be particularly useful in predicting outcome in EFT. It is possible that specific attachment dynamics both within and between individuals may be more predictive of outcome in EFT than the general level of attachment security in the relationship. For example, four attachment styles have recently been empirically differentiated

in adults: secure, preoccupied, avoidant fearful, and avoidant dismissive (Bartholomew & Horowitz, 1991; Whiffen, Thompson, Blain, & Johnson, 1993). Thus, it may be that specific attachment styles rather than an overall measure of attachment security may be related to couples' responses to marital therapy. Future research attempting to determine an association between particular attachment styles and outcome in EFT is suggested.

The second hypothesis that couples with a lower level of attachment security at intake are most likely to make the largest gains in marital satisfaction was not supported. However, post-hoc analyses suggest that couples who were most likely to make the largest gains in marital satisfaction consisted of males who indicated a reluctance to seek their partner for emotional support and contact at intake.

The fact that couples who made the largest gains in marital satisfaction consisted of males who were less likely to seek their attachment figure for emotional comfort and support is consistent with the EFT assumption that maritally distressed individuals are emotionally isolated and alienated from each other and tend to have an insecure bond. There is research evidence that confirms this EFT assumption. In a study of married couples, the more likely males were to seek their partner for emotional comfort and support, the higher the level of marital satisfaction for both partners (Kobak & Hazan, 1991). Moreover, Kobak and Hazan found that males who indicated that they perceived their partner as being available and responsive and who indicated that they were able to rely on their partner were more likely to be maritally satisfied.

These males who were reluctant to rely on their partner were encouraged by the EFT therapist to express unacknowledged feelings and to turn to their partners for reassurance and support as an alternative to emotional disengagement. In EFT, it is assumed that emotionally withdrawn males' emotional self-disclosure evokes a more understanding, responsive and caring position from their partners and that this increased responsiveness from their partner further facilitates and reinforces an increase in emotional self-disclosure, trust and intimacy. These findings support the assumption within

EFT that an increase in each partners' emotional accessibility, availability and responsiveness will facilitate a more intimate bond and thus, increased marital satisfaction. It appears that females became more maritally satisfied in having their male partners increase their willingness to turn to them for comfort, support, and reassurance. This is consistent with observations in the research literature that maritally distressed females typically desire more closeness from their partners (e.g. Jacobson & Margolin, 1979; Peterson, 1979; Notarius & Pellegrini, 1987; Schaap, Buunk, & Kerkstra, 1988).

One possible explanation for the lack of significant findings with respect to the association between the females' overall attachment level and outcome is that the female level of attachment displayed significant positive kurtosis (2.81) when alpha was at the .01 level but not at the .001 level. This suggests that the range of female scores on the attachment measure was limited (i.e too many cases close to the mean). Thus, it is possible that either the attachment measure was limited in differentiating females with respect to attachment levels or that there was little difference in the females' level of attachment prior to therapy.

In summarizing the findings with respect to attachment, it appears that the overall level of secure attachment and the various factors underlying a secure attachment were not significant in predicting those couples who were most likely to be maritally satisfied following EFT. However, couples who made the largest gains in marital satisfaction at follow-up were couples with male partners who were reluctant to seek their partner for support and reassurance at intake.

Self-Disclosure

Hypothesis three, that couples with a higher level of self-disclosure are most likely to be maritally satisfied was not supported. In fact, the couples' overall level of self-disclosure at pretreatment was not significant in predicting any of the four criteria of outcome: level of marital satisfaction, gains in marital satisfaction, level of intimacy, and therapist rating of

improvement. Moreover, the expression of specific positive and negative emotions, with the exception of apathy, was unrelated to outcome. This suggests that the assessment of the couple's general level of self-disclosure as well as the disclosure of specific emotions in couples was not a useful predictor of outcome in EFT.

One explanation for the lack of findings is that EFT may be equally effective for emotionally expressive and inexpressive couples. In working with an inexpressive couple, for example, an EFT therapist would focus on reframing both partners' defensive, inexpressive, and withdrawing behaviors as an indication of their reluctance to express unmet needs for intimacy and contact and the concomitant feelings associated with these unmet needs such as anger and/or fear. The assumption within EFT is that the therapist's encouragement of the expression of previously unexpressed emotions for such couples facilitates bonding and the growth of intimacy so that both partners become more accessible and responsive to one another. For an inexpressive couple then, their level of success may have been dependent upon the EFT therapist's ability to create a safe and accepting atmosphere that would be conducive to the exploration and expression of previously unacknowledged emotions. The EFT process, when successful, can be very dramatic and empowering for emotionally inexpressive partners.

The lack of findings with respect to affective self-disclosure could also be taken as evidence that EFT is equally effective for those couples expressing high and low levels of both positive and negative emotions. For example, an EFT therapist helps a blaming, hostile, angry partner to access, acknowledge and express a longing for comfort and reassurance in such a way as to evoke a positive response from his/her partner. In this manner, the EFT therapist attempts to access the primary emotion of fear underlying the expression of a secondary emotion such as anger. The lack of findings with respect to negative emotions and outcome is in contrast to research suggesting that higher levels of negative affect at intake has been found to be associated with poor outcome in BMT (Hahlweg et. al., 1984; Bennun, 1985;

Snyder, Mangrum, & Wills, 1993), which does not specifically address affect. In this regard, it may be that EFT is the treatment of choice for couples exhibiting a high level of negative affect. However, a comparison between this study and others is limited since the scale used to measure affect in this study was different from other studies and lacked a composite score of negative emotions. Further research is needed to duplicate EFT's success with couples who exhibit high levels of negative affect and low general levels of self-disclosure.

The lack of findings with respect to positive feelings and outcome is consistent with research that suggests that positive affect had not been useful in discriminating satisfied from dissatisfied couples (Gottman, 1979). Moreover, in one study, a high level of female "positive verbal behaviors", defined by level of agreement, approval and humour, was associated with the deterioration in the level of marital satisfaction over a three year time span for both partners (Gottman & Krokoff, 1989). It may be that the expression of positive feelings by distressed females is not congruent with their inner feelings and/or is perhaps viewed with suspicion by their partners. In addition, another study has found that high levels of positive communication behaviors following BMT was associated with the likelihood of a couple separating three years later (Baucom & Mehlman, 1984), underlining the difficulty in predicting successful outcome from positive communication between partners. It may be that negative affect has a more powerful impact on marital satisfaction than positive affect and that the ratio of positive to negative feelings is most important in determining marital satisfaction (Gottman, in press).

Another possible explanation for the lack of findings may be that a simple positive/negative emotion categorization is insufficient for increasing our understanding of the intricate dynamics of intimate relationships (Gottman, in press). The presence of positive and/or negative affect between partners may be symptoms of more fundamental, underlying perceptions that partners have of each other, their relationship, and/or intimate relationships in general. Taken together, the results of this study suggest that outcome in EFT is more

a function of the ability and willingness of partners to become involved in the therapeutic process rather than their history of affective self-disclosure.

There were two significant findings with respect to self-disclosure. First, males who were rated by their partners as being less emotionally expressive made the largest gains in marital satisfaction at posttreatment. This suggests that EFT may be particularly indicated for men who are highly inhibited in expressing their emotions. One possible explanation for this finding is that EFT views marital distress in terms of the degree of alienation, isolation and emotional deprivation that each partner experiences in the relationship as a result of the inability to satisfy normal needs for contact and intimacy. Thus, the EFT process encourages partners to express emotional needs and to become more accessible and responsive to each other's needs. Results suggest that, through the process of EFT, emotionally inhibited males began to express previously unacknowledged emotions, to turn to their partner for emotional support and contact, and thus to become more maritally satisfied. Consistent with this assumption is research evidence suggesting that husbands who engage in a high level of emotional self-disclosure are more likely to be maritally satisfied (Hansen & Schuldt, 1984). Moreover, there is some research evidence that a difference in self-disclosure output (high self-disclosing females with low self-disclosing males) is related to lower levels of marital satisfaction for couples (Davidson, 1981) and for men (Hansen & Schuldt, 1984). This suggests that a difference in self-disclosure is distressing for partners. It may be that EFT raised the level of self-disclosure for males so that there was a more equitable exchange of emotional self-disclosure between partners and thus, higher levels of marital satisfaction.

An approach that emphasizes emotional expression and interdependence may be most appropriate for distressed males. Previous research suggests that males are less likely to be emotionally expressive than females (Levinger & Senn, 1967; Snell, Miller, & Belk, 1988; Snell, Miller, Belk, & Hernandez-Sanchez, 1989) and are likely to withdraw from their partner when maritally distressed

(e.g. Jacobson & Margolin, 1979; Peterson, 1979; Notarius & Pellegrini, 1987; Schaap, Buunk, & Kerkstra, 1988). Moreover, the male's tendency to withdraw has been found to be predictive of his partner becoming hostile (Roberts & Krokoff, 1990) and of a longitudinal decline in relationship satisfaction for both partners (Gottman & Krokoff, 1989). In contrast, conflict engagement, defined by the level of criticism, disagreement and anger expression, has been associated with longitudinal improvement in the level of marital satisfaction (Gottman & Krokoff, 1989). In conclusion, these studies highlight the potential destructiveness of the males' tendency to withdraw in response to marital distress. Thus, it appears that the EFT process provides these emotionally inexpressive males with a positive alternative to withdrawal and disengagement when dealing with marital distress.

A second significant finding with respect to self-disclosure was that the females' self-rating of apathy self-disclosure at intake was predictive of her own intimacy level at follow-up. Apathy self-disclosure refers to the tendency to express apathy, detachment, numbness, indifferentness, and lack of feeling. One explanation for this may be that the expression of apathetic feelings may allow both partners to remain emotionally engaged with each other rather than becoming angry or detached from each other. It may be that couples with a female partner who self-discloses apathetic feelings are less likely to become stuck in a rigid blame-withdraw pattern, where females mostly express anger toward their partner who, in turn, withdraws. For example, in previous research, wives have been found to be more negative and less neutral than their husbands (Notarius & Pellegrini, 1987) and distressed wives have been found to deliver more negative and longer negative sequences than their husbands (Schaap, Buunk, & Kerkstra, 1988). These findings suggest a destructive interactional pattern in which wives employ negative behaviors such as complaining/criticizing that escalate the level of conflict and husbands employ negative behaviors such as withdrawal, silence, and defensiveness that are designed to avoid confrontation and disagreements (Margolin & Wampold, 1981; Krokoff, 1987a; Gottman, in press). This rigid pattern of female anger and male withdrawal has been found to be generally

typical of couples seeking therapy (e.g. Jacobson & Margolin, 1979; Peterson, 1979; Notarius & Pellegrini, 1987; Schaap, Buunk, & Kerkstra, 1988). Furthermore, research suggests that this rigid demand-withdraw pattern leads to the increasing deterioration and dissolution of marriages (Levenson & Gottman, 1985).

It may be then that females who engage in higher levels of apathy self-disclosure may be communicating a problem to their partner without transmitting negative messages such as anger, hostility and criticism. As Gottman & Krokoff (1989) have suggested, neutral affect " may function as a probe for the clarification of the other's feelings " (p.50). Apathy in this study could be defined as a neutral affect. Perhaps females who indicate a higher level of apathy self-disclosure are employing a behavior that is less rigid, and perhaps less aversive to their husbands in order to increase the level of engagement in the relationship without evoking defensive withdrawal in their partner.

In general, the findings with respect to self-disclosure suggest that outcome in EFT does not appear to be a function of a couple's ability and/or willingness to self-disclose prior to onset of therapy. Results suggest that EFT may be indicated for both emotionally expressive and inexpressive couples and may be particularly effective in increasing the level of marital satisfaction for emotionally inhibited males.

Trust

The fifth hypothesis that couples with higher trust levels at intake are most likely to be maritally satisfied following EFT was partially supported. Couples who were most likely to be maritally satisfied at follow-up consisted of females with a higher level of faith in their partner at intake. Moreover, the females' level of faith was predictive of the males' level of marital satisfaction and intimacy at follow-up. It is important to note that the faith subscale on the trust measure reflects the perception that the partner is

responsive, caring and deeply committed to the relationship and thus, would not consider leaving the relationship "even if a better alternative were to come along". Moreover, it is the only trust subscale that asks respondents to indicate the extent of trust in one's partner and thus, it reflects the degree of confidence that the partner is trustworthy.

One explanation for this finding is that couples with a female partner who indicated a higher level of faith in her partner may have been more willing to turn to their partner for comfort and support at intake. This assumption was partly supported in this study. For example, the female level of faith was significantly related to the couple's mean level of trust in the relationship $r(32) = .54$, $p < .01$, and various subscales on the attachment measure including the couples' perception of each other as reliably accessible, $r(32) = .45$, $p < .01$, the females' use of attachment figure, $r(32) = .44$, $p < .01$, the females' perception of her partner as reliably accessible, $r(32) = .54$, $p < .01$, and the females' desire to be available and responsive to her partner, $r(32) = .33$, $p < .05$. These results suggest that couples with a female partner who has a high level of faith may be more trusting, accessible and responsive to each other and may be more comfortable being dependent on one another for comfort and support. Since the focus of EFT is to increase a couple's level of accessibility and responsiveness to each other, couples with a female partner who indicated a higher level of faith at intake may be farther along in this process prior to onset of therapy.

Another explanation is that couples with a female partner who indicated a higher level of faith may be involved in a more flexible, less rigid, and less negative interactional cycle. Support for this assumption is based on previous research evidence that trust is negatively related to a female's extreme desires for affiliation or autonomy and a male's extreme desires for autonomy (Holmes & Rempel, 1989). Moreover, these researchers found that the level of security in the relationship is related to each partner's ability to display less emotionally aversive and more open communication. This suggests that when partners lack trust in each other they may be more likely to fall into traditional, rigid roles with females seeking more affiliation and males

seeking more autonomy. This traditional and rigid pattern has been associated with an increase in the deterioration and dissolution of marriages (Levenson & Gottman, 1985) and a poor response to outcome in BMT (Jacobson, Follette, & Pagel, 1986). Females with a higher level of faith may then have been less likely to contribute to the escalation of a negative interactional pattern.

The above finding with respect to the association between trust and traditional sex roles suggests that couples who were classified as being "highly traditional" in Jacobson et. al.'s (1986) study may have been exhibiting symptoms that are associated with an underlying lack of trust in each other. This suggests that a lower level of trust between partners may have had a significant impact on outcome in BMT as well, although trust was not formally assessed. Further research confirming the association between trust and traditionality in maritally distressed couples may signal the need for marital therapy in general to assess interaction patterns associated with lower levels of trust and to develop specific intervention strategies for non-trusting couples.

A third explanation to account for the significant association between level of faith and outcome is that the level of faith in one's partner and in the relationship may be the key factor in maintaining the minimal level of trust necessary to maintain an intimate relationship. This assumption is supported by previous research which found that faith was the most significant predictor of both an individual's feelings of love and happiness in an intimate relationship and the perception of his/her partner as being motivated by unselfish concerns (Rempel, Holmes, & Zanna, 1985). These researchers suggest that individuals with faith expect that their partner will behave in a responsive and caring manner and are less likely to form global conclusions about their partner as being uncaring and unloving even though they perceive their partner as exhibiting negative behaviors. For these reasons, trust researchers have concluded that an individual's faith that a partner is intrinsically motivated to be responsive and caring is the most important aspect of trust (Rempel, Holmes, & Zanna, 1985; Holmes & Rempel, 1989). In

this study, females with a higher level of faith at intake may have maintained some confidence in their partner despite experiencing marital distress. As a result, they may have been more likely to give their partner the benefit of the doubt, and more likely to be accepting and responsive to their partner in the therapeutic process.

The finding that the female level of faith was predictive of the males' marital satisfaction and intimacy level at follow-up suggests that a female's faith in her partner may have significantly influenced the willingness of males to actively engage in the EFT process, and thus, to increase their level of marital satisfaction and intimacy. The EFT therapist attempts to facilitate an accepting environment conducive to the exploration of unknown emotional territory for both individuals. However, individuals need to take risks that put them in a position of emotional vulnerability in the other's presence. This emotional vulnerability consists of letting go of prior inhibitions, defenses and rigid expectations of the other's response to the expression of specific emotions. In essence the risk of disclosing unacknowledged emotions must be based on some faith that the other still cares and will be somewhat responsive to emotional vulnerability. Males may have been able to be more emotionally engaged in the EFT process if they were in a relationship with the more positive expectations and higher levels of openness that are associated with higher levels of faith and trust. In contrast, males with female partners who indicated a lower level of faith may have been more likely to engage in withdrawn and avoidant behaviors and have been more reluctant to become emotionally engaged during EFT. Thus, a miminal level of faith in one's partner at intake may be particularly important for males if they are to engage in a change process that involves them becoming emotionally vulnerable and asking their partner for support.

The finding that the female level of faith was significantly related to the couple's follow-up marital satisfaction level and the males' follow-up marital satisfaction and intimacy levels is consistent with previous research suggesting that successful outcome in BMT was predicted by the female's attitude towards her partner at intake. For example, previous research has

found that outcome in BMT was predicted by the female's positive feelings (O'Leary & Turkewitz, 1978; Turkewitz & O' Leary, 1981), the female's level of commitment (Beach & Broderick, 1983), the female's sense of "togetherness" (Hahlweg et. al., 1984), and the female's level of femininity (Baucom & Aiken, 1984). Baucom and Aiken (1984) define femininity as reflecting an individual's tendency to focus on interpersonal relationships and the ability to respond to the needs and feelings of others. These findings suggest that the quality of the female partner's attitude and feelings towards her partner at intake may influence her level of involvement in the therapeutic process and thus, the extent of improvement for couples in general.

The finding that a female's pretreatment attitude towards her partner influences outcome for the couple may be related to the fact that females are expected to be "relationship experts", and both females and males tend to assume that females are more responsible for relationships and better at keeping them on track (Rubin, 1985; Miller, 1986; Okin, 1989; Tannen, 1990). Because intimate relationships and interpersonal sensitivity are not promoted in masculine socialization, males are often less aware of (Wamboldt & Reiss, 1989) and less skilled in interpreting the nuances of personal interaction (Rubin, 1985; Christensen & Heavey, 1990; Wood, 1993). Consistent with this view is research which suggests that females are more likely than males to take an active role in responding to marital problems (Rusbult, 1987). In a summary of this research area, Thompson and Walker (1989) concluded that females "have more responsibility than their husbands for monitoring the relationship, confronting disagreeable issues, setting the tone of conversation, and moving toward resolution when conflict is high" (p.849). Due to the females' responsibility for nurturing intimate relationships, the females' attitude toward their partner at intake may impact their willingness to invest in the relationship and to respond to their partner in therapy and thus, may ultimately dictate the extent of the couples' improvement in marital therapy.

The fact that the female level of faith was predictive of outcome at

follow-up but not at posttreatment suggests that a high level of female faith in her partner may be particularly important for the couple if they are to continue to invest in the relationship and integrate the changes that were made in therapy into everyday life after treatment has terminated. A systemic self-reinforcing pattern may occur such that a higher level of faith at intake influences the extent of involvement and motivation in therapy on the part of female partners which, in turn, leads to an increased likelihood of significant and positive changes in males at posttreatment. If females perceive significant changes in their partner at posttreatment, this may have the effect of reinforcing or even increasing their faith in their partner. As a result, females may increase their willingness to be responsive to and supportive of their partner after completion of therapy and thus, are likely to increase their own and their partner's marital satisfaction level at three-month follow-up.

The sixth hypothesis that lower levels of trust would be related to large gains in marital satisfaction was not supported. Although many of these correlations were in the hypothesized direction, they were not significant. These findings suggest that, although individuals with lower levels of trust seem to make gains in marital satisfaction, they are not likely to make the largest gains in marital satisfaction.

One finding with respect to trust was that the overall level of trust between partners at intake was significantly related to their level of alliance with their therapist at the end of the third session, which was associated with positive outcome.

One possible explanation for this finding is that couples with higher trust levels may be more confident about their partner's ability to satisfy their emotional needs. As a result, they may be more likely to become emotionally engaged and more likely to experience the benefits of emotional self-disclosure very early in the EFT therapeutic process. By the end of the third session, couples with higher trust levels may be more likely to perceive the benefits of exploring vulnerable emotional needs and feelings and thus, they may be more collaborative with the therapist and more likely to perceive that

the EFT therapeutic tasks were relevant to their presenting concerns. In contrast, couples with lower trust levels may be expected to experience greater anxiety with the EFT therapeutic tasks. In fact, research suggests that individuals with a lower trust level would be more likely to fear the risks of being close to and dependent on their partner (Holmes & Rempel, 1989). Since EFT may be too anxiety-provoking for these couples, they may be less likely to engage in emotional self-disclosure and consequently, they would be less likely to experience the benefits of emotional expression. Thus, couples with lower trust levels may be highly reluctant to engage in the therapeutic tasks and may conclude that the therapeutic tasks are irrelevant to their presenting concerns by the third session. It may be that couples with lower levels of trust need more than three sessions to become collaborative with the EFT therapist and/or to perceive the importance of disclosing feelings.

Another finding with respect to trust was that couples with a partner who indicated a categorical lack of trust at intake were less likely to be maritally satisfied and to have improved at both termination and follow-up compared to couples without a partner who indicated a lack of trust. For example, only 57.1% of couples with a partner who indicated a lack of trust could be classified as recovered and maritally satisfied at follow-up. In contrast, 74.0% of couples where both partners did not indicate a lack of trust could be classified as recovered and maritally satisfied at follow-up. Moreover, only 57.1% of couples with a partner indicating a lack of trust could be considered to have improved compared to 81.4% of couples where both partners did not indicate a lack of trust who could be considered to have improved at follow-up. Third, the couple who exhibited the largest deterioration in marital satisfaction following EFT consisted of partners who both deteriorated, who obtained pretreatment trust scores below the mean trust scores for couples and each gender, and who had one partner who indicated a lack of trust.

The above findings with respect to trust suggest that some level of basic

trust in the relationship and/or partner is probably a prerequisite for being able to productively engage in EFT or perhaps in any form of marital therapy. A basic level of trust would enable couples to be motivated to take risks in therapy, to exhibit some hope and confidence in their partner, and show some flexibility in resolving their conflict. In EFT, couples without some basic trust might feel more certain that their partner will be unresponsive and thus, they would be highly reluctant to access emotions underlying their negative interactional pattern. This might then have the effect of blocking or impeding therapeutic efforts to identify, explore and express underlying feelings of insecurity and attachment needs.

In summarizing the findings with respect to trust, it appears that the central aspect of trust, faith, influences the outcome of EFT. A higher level of faith on the part of female partners appears to be associated with a good prognosis for therapy, particularly for males, while an indication of a complete lack of trust on the part of at least one partner seems to be associated with a poor prognosis. The findings of this study suggest that a basic level of trust is required for success in this type of marital therapy. Future research is needed to establish the basic minimum level of trust associated with successful outcome in EFT and in marital therapy in general.

It is important to note that although many of the predictor variables were correlated with posttreatment and follow-up marital satisfaction levels, they were not significantly predictive of outcome after controlling for the pretreatment level of marital satisfaction. A possible explanation for this is that the high correlations between the pretreatment level of marital satisfaction and the couples' mean scores on the three predictor variables may have lessened the power of these variables in predicting outcome.

Conclusions

On the basis of the results of this study, several conclusions can be made. First, trust appears to be the one predictor variable that had the most impact on outcome. Faith, the central aspect of trust, appears to be the strongest

pretreatment predictor of outcome in EFT. The female level of faith in her partner at intake was predictive of the couple's marital satisfaction level, and the male's marital satisfaction and intimacy level at follow-up. Moreover, the couples' mean level of trust was predictive of the couple's alliance level by the end of the third session, which was associated with positive outcome. In addition, a smaller percentage of couples with at least one partner who indicated a lack of trust could be considered to be maritally satisfied and to have improved following EFT compared to the percentage of couples who did not report a lack of trust.

Second, the combination of characteristics in males at intake that was associated with marital satisfaction change scores for couples and males in this study were a low level of self-disclosure and a reluctance to seek partner for comfort and support. The combination of these variables suggests that males who made the largest gains in marital satisfaction might be classified as avoidantly attached. This would be consistent with research evidence that avoidant individuals are less likely to engage in emotional self-disclosure (Kobak & Sceery, 1988; Bartholomew & Horowitz, 1991), admit the existence of negative affect and distress (Kobak & Sceery, 1988; Mikulincer, Florian, & Tolmatz, 1990), are less likely to use their partners as a source of reassurance during stressful situations (Bartholomew & Horowitz, 1991; Simpson, Rholes, & Nelligan, 1992), and are more likely to employ coping strategies that increase distance and disengagement between partners (Mikulincer, Florian, & Weller, 1993). Future EFT studies might assess the association between an avoidant attachment style and outcome

Third, the results of this study have several implications for the practicing EFT therapist. One implication is that the development of a strong alliance between the couple and therapist by the third session is crucial and strongly related to outcome in EFT. Moreover, the couples' perception that the therapeutic tasks are relevant to their relationship concerns appears to be important in influencing their involvement in the therapeutic process. For the EFT therapist, the results of this study confirm and reinforce the usefulness

of creating a safe, accepting and validating atmosphere for the exploration of emotional experience and the need to be vigilant for signs of deterioration in the alliance with the couple. Another implication is that EFT appears to be indicated for couples with varying levels of attachment insecurity and emotional expressiveness. Consequently, the EFT therapist need not be concerned about the likelihood of a successful outcome with couples who are very insecurely attached and/or are emotionally inexpressive. A third implication is that a high level of faith at intake, particularly for females, appears to be associated with a good prognosis for therapy. A final implication is that EFT can be expected to be particularly beneficial (in terms of marital satisfaction gains) for couples with a male partner who is reluctant to seek his partner for emotional support and who is emotionally inexpressive. These results suggest that EFT is indicated for couples with a male partner who is emotionally withdrawn, particularly if these males are paired with females with a basic level of faith in their partner.

Fourth, the results of this study suggest several negative implications with respect to the practice of EFT. One negative implication is that a low level of female faith in her partner and/or a complete lack of trust indicated by one partner seems to be associated with a poor prognosis. These results suggest that the EFT therapist needs to examine and build the level of trust/faith in individuals, particularly in female partners, very early in therapy. Another negative implication is that younger males do not benefit as much as older males from EFT. Younger males may be less likely to become emotionally engaged in the therapeutic process and thus, less likely to improve in therapy. These results suggest that the EFT therapist pay particular attention to couples containing younger males. The EFT therapist may need to build a very strong alliance with younger males early in therapy by exploring and validating any reluctance to focus on vulnerable, emotional aspects of self.

Limitations of this Study

A major issue in evaluating psychotherapy research is the extent to which findings may be generalized. The generality of the findings in this study need to be examined in light of the degree of resemblance to the clinical situation across such dimensions as population, manner of recruitment, therapists, treatment setting and assessment methods (Kazdin, 1980). First, the nature of the motivation of subjects responding to advertisements on free counselling sessions may be different from that of clients who are in emotional distress and who request therapy. Nevertheless, volunteers responding to advertisements were likely to be at least interested in receiving treatment even though they might not have sought out treatment without the advertisement.

A second limitation is that, unlike clients in a clinical situation, couples did not choose the particular type of treatment or therapist. Moreover, unlike clients in a clinical situation, they received marital therapy at no cost and for a specified number of sessions. These factors, which do not appear in a clinical situation, may have potentially influenced the willingness of clients to remain in therapy. However, the setting in which the treatment was conducted was very similar to the clinical setting, with the possible exception of audiorecordings of sessions.

Another limitation of this study is that treatment interventions were implemented by a majority of doctoral clinical interns who may have had less training and less experience than professional therapists. Some research data on EFT suggests that novice therapists may have greater difficulty helping clients access primary emotions than more experienced therapists (Johnson & Greenberg, 1985a; Johnson & Greenberg, 1985b). The use of more experienced therapists may have yielded somewhat different results.

A fourth limitation is that the pretreatment data collected relied on self-report questionnaires and did not utilize observational methods. There may have been reporting biases in these self-report questionnaires. However, the utilization of a therapist rating scale to assess improvement in marital

satisfaction at posttreatment was related to the couples' own self-ratings of improvement. This suggests that couples and therapists agreed as to who improved. Moreover, it has been suggested that self-report measures better reflect the presenting subjective complaints of couples than observational and/or rating measures (Jacobson, 1985). Thus, a couple's self-report of how satisfied they are with their relationship must be considered the primary dependent measure in marital therapy outcome studies in which the goal of the investigations is to improve the quality of the relationship (Baucom, 1984).

The fifth limitation is the small sample size and the absence of a control group. A much larger sample size may have yielded more robust findings. The presence of a control group may have provided a more rigorous assessment of the clinical treatment effect. However, the inclusion of a control group was not considered crucial due to the fact that the overall efficacy of EFT in alleviating marital distress has already been established (Alexander, Holtzworth-Munroe, & Jameson, 1994).

Suggestions for Future Research

Several challenges are posed by the results of this study. The first challenge is to further investigate trust and understand how it is that the level of trust affects the therapeutic process and outcome. Although it is known from the results of this study that trust is predictive of the couple's alliance level and that an aspect of trust (faith) is predictive of the couple's follow-up marital status and the male's follow-up marital status, we have no empirical evidence to confirm the EFT assumptions concerning the links between trust, alliance and outcome. It may be that a basic level of trust is necessary for couples to become maritally satisfied in marital therapy in general. Future research is then needed to fully investigate the minimum level of trust that is necessary for successful outcome in marital therapy.

A second challenge relates to the finding that males who possess characteristics that have been associated with an avoidant attachment style in previous research were likely to make the largest gains in marital

satisfaction in EFT. Thus, another challenge is for future marital therapy outcome research to utilize a large sample in order to determine the most effective approach for highly withdrawn/avoidant males.

A third challenge relates to the strength of the therapeutic alliance in predicting outcome in EFT. There are now two studies that suggest that patient involvement/compliance is predictive of outcome in marital therapy. Some marital therapy researchers have suggested that future research should examine the impact of patient characteristics on the therapeutic alliance (Holtzworth-Munroe, Jacobson, DeKlyen, & Whisman, 1989). Moreover, as Luborsky et. al. (1988) concluded in their extensive review of the individual therapy outcome literature, variables assessed in the very early stages of therapy are more powerful in predicting outcome than variables assessed either pretreatment or at the mid-point of therapy. It may be beneficial for future marital therapy outcome studies to assess non-specific variables in the early stages of couples therapy such as patient involvement/engagement that may be predictive of outcome.

The promise of studies such as this for the field of marital therapy is the increasing evidence that relationship variables at intake are predictive of outcome in marital therapy. Studies such as this will enable the marital therapy field to increase the clarity and precision in assessing a couple's prognosis for successful outcome and consequently, to devise optimal intervention strategies for particular couples to enhance the likelihood of successful outcome in a particular approach.

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APPENDIX A

STANDARDIZED TELEPHONE SCREENING PROCEDURE

Thank you for calling. We will be conducting a research study designed to identify various responses to a particular form of marital therapy specifically aimed at helping maritally distressed couples. The study has been approved by the Research Ethics Committee of the University of Ottawa and is conducted by counsellors experienced in working with couples. The project will be supervised by a registered psychologist in the province of Ontario.

Participation in the study involves both you and your partner coming in for a total of 12 counselling sessions of approximately one hour. The sessions will take place on a weekly basis. Your participation in this study is voluntary and you and your partner may withdraw from this project at any time without jeopardizing access to further counselling. To participate you will need to satisfy certain criteria. In a moment, I will ask you some questions that will help me determine if you might be suitable for this study. If you do seem suitable you will be asked to come in to the Centre for Psychological Services of the University of Ottawa to complete some questionnaires that will in fact determine if you can participate in this study. If you come in to complete these questionnaires you will be given more information about the study and will be asked to read and sign a consent form before completing the questionnaires.

I would now like to ask you some questions to see if you and your partner are suitable for this study. The nature of these questions may seem very personal and you may wish not to answer them.

1. Is your partner aware of your interest in participating in this study and has he/she consented to participate in the study? _____

(Answer must be YES)

2. Are you and your partner currently living together?_____

(Answer must be YES)

3.How long have you been living together? _____

(Minimum: 1 year)

4. Does either one of you experience problems related to alcohol or drugs?

___ (Answer must be NO)

If caller reports substance abuse ask if they wish to be referred for treatment elsewhere

Al-Anon 725-1727

Rideawood Institute

728-1727

R. O. H. 724-6508

5. Has either one of you received any psychiatric treatment or medication in the past year? _____

(Answer must be NO)

6.Are you currently receiving any form of psychological or psychiatric treatment? _____ (Answer must be NO)

7. Will either one of you be participating in any form of psychological or psychiatric treatment in the next three to four months? _____

(Answer must be NO)

Does not meet criteria

If the caller does not meet inclusion criteria, thank them for their interest in the study. Ask caller if he/she would like to be referred elsewhere for treatment.

Has the caller been referred elsewhere for treatment? _____

If yes, please specify:

Centre for Psychological Services _____

Family Service Centre of Ottawa _____

Ottawa Academy of Psychology _____

Ottawa Civic Hospital _____

Catholic Family Services _____

Royal Ottawa Hospital _____

Meets criteria

If couple meet all inclusion criteria, obtain the names of the potential subjects and their phone numbers.

Names:_____ Tel: (H) _____

Tel: (W) _____

_____ Tel: (H) _____

Tel: (W) _____

Set up appointment for completion of questionnaires and advise couple that this may take up to 1 1/2 hours.

Date _____ Time _____

Place: Centre for Psychological Services---give appropriate directions.

INFORMATION AND INFORMED CONSENT

The present study is designed for maritally distressed couples who wish to improve their relationship. The purpose of this research project is to assess several characteristics/traits in yourself, in your partner and in the interactions between both of you to determine if these characteristics are predictive of outcome in a particular form of couples counselling. The assessment of these characteristics will be conducted prior to onset of counselling. Each individual's evaluation of the relationship will be conducted both prior to and following couples counselling.

Major Procedure

If you agree to participate in this project, both you and your partner will be required to complete questionnaires in order to assess your suitability for this study. If you do not meet the inclusion criteria for this study, you will be given feedback on your initial testing and referred here or elsewhere for counselling if you so desire.

If you meet our criteria for participation, you will be asked to complete questionnaires that are part of this research study. You will then be assigned to a counsellor who will call you to arrange your first appointment. You will be seen for a total of twelve (12) sessions with the format being one week for each session. Each session will be approximately 1- 1 1/4 hours in length. Both you and your partner will be required to attend the sessions together each week. Sessions will be conducted by senior doctoral level interns under the supervision of Dr. Susan Johnson-Douglas, a registered clinical psychologist at the Centre for Psychological Services. All sessions will be audiotaped for supervision purposes and to ensure that the approach is faithfully implemented. The counselling sessions are free of charge and will take place at the Centre.

At the end of the final session, you will be asked to complete several self-report questionnnaires. This is estimated to take up to 30 minutes. As well, you will be contacted 3 months from the termination of the counselling sessions to complete follow-up questionnaires. Again, this is estimated to take up to 30 minutes. At this final meeting, you will be given a summary of the results of the study.

Counselling Approach used in this study

The particular approach to couples counselling that you will be offerred is called Emotionally Focused Couples Therapy. This form of couples counselling has been established to be successful in helping maritally distressed couples improve their relationship.

Confidentiality

Confidentiality of all audiotape recordings and written responses will be respected according to the ethical guidelines of the Ontario Board of Examiners in Psychology. Your names will be known only to the people who are directly involved in the research. These include the principal investigators, the clinical supervisor and your counsellor. Anonymity will be assured through the pooling of all data so that published results will be presented in group format and no individual or couple will be identified.

If researchers wish to keep certain recordings for training purposes, you will be asked to sign a consent form to this effect. All other recordings will be completely erased after the end of the study. Written responses to questionnnaires will be kept in a confidential file at the Centre for Psychological Services and will be destroyed at the end of the study.

I, _____, understand that I am being asked to participate in a study to examine specific couple characteristics that relate to success in a particular approach to marital therapy. I consent to the use of tape

recordings of counselling sessions and of my written responses to the questionnnaires for the purposes of this research with the understanding that all information gathered will be held in strict confidence within the limits of the law and according to the ethical principles of the Ontario Board of Examiners in Psychology, and that this information will be available only to those who are directly involved in this study.

I also understand that my participation in this study is voluntary and I may withdraw from this project at any time and/or request that tapes be erased without penalty and without jeopardizing access to further counselling.

I can contact either Dr. Susan Johnson-Douglas or Eran Talitman at the Centre for Psychological Services of the University of Ottawa (564-6875) to answer any questions or concerns that I may have. I also understand that debriefing on the more detailed procedures of the study will be offered after the completion of follow-up questionnaires, and summaries of the results will be sent to couples if requested.

I have received a copy of this information and consent form and I have read and understood it. I hereby agree to participate in the testing and in this research project if I am selected.

Signature:_____ Witness' signature:_____

Telephone (H) _____ (W) _____

Date:_____

DEMOGRAPHIC DATA QUESTIONNAIRE

Couple Number:_____

1. How many years have you lived together as a couple? _____
2. How many children do you have? _____
3. Have the two of you had any marital counselling before taking part in this project? Yes _____ No _____
4. Please check the category within which your gross family income falls:

___ Under $15,000

___ $15,000-25,000

___ $25,000-35,000

___ $35,000-45,000

___ $45,000-55,000

___ Above $55,000

** Questions 5 to 8 are to be completed by the FEMALE partner only:

5. Please state your age (in years) _____
6. What is your present occupation? _____
7. Have you had a previous marriage? Yes ___ No ____
8. Please indicate the highest level of education that you have completed to date:

___ Grade 10 or less

___ Grade 12 or less

___ 2 years of post secondary education

___ Community college diploma program

___ Bachelor's degree

___ Master's degree

___ Ph.D. degree

** Questions 9 to 12 are to be completed by the MALE partner only:

5. Please state your age (in years) _____

6. What is your present occupation? _____

7. Have you had a previous marriage? Yes ___ No ____

8. Please indicate the highest level of education that you have completed to date:

___ Grade 10 or less

___ Grade 12 or less

___ 2 years of post secondary education

___ Community college diploma program

___ Bachelor's degree

___ Master's degree

___ Ph.D. degree

IMPLEMENTATION CHECKLIST

Couple No. _____ Session No. _____ Rater _____

Instructions to raters: Place one check mark on the rating form beside an intervention each time that intervention is noted. An intervention is defined as a therapist statement.

Intervention Checklist

Definition of problematic event

1. ___ The problematic event is defined/redefined in terms of the emotions and needs underlying the positions taken in the relationship.

2. ___ The therapist elicits the couple's ideas/theories/beliefs about why the problematic event has developed.

3. ___ The therapist clarifies and elaborates the basic positions taken by the partners in the relationship.

4. ___ The therapist asks the couple to disclose biographical data that may be relevant to explaining why the relationship is the way it is, such as how the parents' marriage influenced their own.

Attacking behavior

5. ___ The therapist validates or develops the positions implied by negative behavior such as name calling; such behavior is interpreted in terms of underlying needs and feelings.

6. ___ Negative behavior such as blaming or name calling is immediately stopped with authority on the part of the therapist and/or is defused by asking the blamer's theory on how he/she was attracted to and got involved with such a person.

Process Focus

7. ___ The therapist probes for and heightens emotional experience, especially fears and vulnerabilities, clarifying emotional triggers and responses and focusing upon inner awareness.

8. ___ The therapist avoids and suppresses affective interchange, and/or behavioral interpretation, or confrontation. No feeling or behavior is accessed, confronted or interpreted.

9. ___ The interacting sensitivities underlying behavior are clarified and the meaning of individual emotional experience is interpreted in terms of the other partner and the relationship.

10. ___ The therapist invites the couple to speculate about general explanations they might consider for couples with similar problems and/or offers a possible theory to trigger the partners' thinking.

11. ___ Therapist keeps a focus on what is occurring in the present between partners.

12. ___ Therapist takes what is happening in the present and brings it back to the past, to their parents' relationship, to their background and upbringing.

Resolution of problematic event

13. ___ Therapist facilitates expression of affectively based needs and wants to the partner.

14. ___ Therapist helps each partner identify and express to the therapist his/her expectations from the other partner without basing them in feelings.

15. ___ Therapist helps clients to share their new perspective of each other and/or of the relationship, and to explore their new feelings in response to this new perspective.

16. ___ Therapist asks each partner to disclose opinions/thoughts/ theories about what throughout the sessions has led to improvement.

Newspaper Advertisement

COUPLES COUNSELLING

Couples who would like to improve their relationship are invited to participate in a research project at the University of Ottawa. Counselling is offered free of charge and is conducted by experienced therapists.

For more information, please call,

Eran Talitman

Centre For Psychological Services

University of Ottawa

564-6875

APPENDIX B

Circle One

Male Female

Name: _____

DYADIC ADJUSTMENT SCALE

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list. (Please a checkmark to indicate your answer).

	Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
1. Handling family finances	_____	_____	_____	_____	_____	_____
2. Matters of recreation	_____	_____	_____	_____	_____	_____
3. Religious matters	_____	_____	_____	_____	_____	_____
4. Demonstrations of affection	_____	_____	_____	_____	_____	_____
5. Friends	_____	_____	_____	_____	_____	_____
6. Sex relations	_____	_____	_____	_____	_____	_____
7. Conventionality (correct or proper behavior)	_____	_____	_____	_____	_____	_____
8. Philosophy of life	_____	_____	_____	_____	_____	_____
9. Ways of dealing with parents or in-laws	_____	_____	_____	_____	_____	_____
10. Aims, goals, and things believed important	_____	_____	_____	_____	_____	_____

11. Amount of time spent together						
12. Making major decisions						
13. Household tasks						
14. Leisure time interests and activities						
15. Career decisions						

	All the time	Most of the time	More Often Than Not	Occa-sionally	Rarely	Never
16. How often do you discuss or have you consi-dered divorce, separation, or terminating your relationship						
17. How often do you or your mate leave the house after a fight?						
18. In general, how often do you think that things between you and your partner are going well?						
19. Do you confide in your mate?						
20. Do you ever regret that you married (or lived together)?						
21. How often do you and your partner quarrel?						

22. How often do you and your mate "get on each others' nerves"?	_____	_____	_____	_____	_____	_____
		Every Day	**Almost Every Day**	**Occa-sionally**	**Rarely**	**Never**
23. Do you kiss your mate?		_____	_____	_____	_____	_____
		All of Them	**Most of Them**	**Some of Them**	**Very Few of Them**	**None of Them**
24. Do you and your mate engage in outside interests together?		_____	_____	_____	_____	_____

How often would you say the following events occur between you and your mate?

	Never	**Less than Once a Month**	**Once or Twice a Month**	**Once or Twice a Week**	**Once a Day**	**More Often**
25. Have a stimulating exchange of ideas	_____	_____	_____	_____	_____	_____
26. Laugh together	_____	_____	_____	_____	_____	_____
27. Calmly discuss something	_____	_____	_____	_____	_____	_____
28. Work together on a project	_____	_____	_____	_____	_____	_____

These are some things about which couples sometimes agree and sometimes disagree. Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks (Check yes or no).

	Yes	**No**	
29.	_____	_____	Being too tired for sex.
30.	_____	_____	Not showing love.

31. The dots on the following line represent different degrees of happiness in your relationship. The middle point, "happy", represents the degree of happiness of most relationships. Please circle the dot which best describes the degree of happiness, all things considered, of your relationship.

Extremely Unhappy	**Fairly Unhappy**	**A Little Unhappy**	**Happy**	**Very Happy**	**Extremely Happy**	**Perfect**

32. Which of the following statements best describes how you feel about the future of your relationship?

_____ I want desperately for my relationship to succeed, and would go to almost any length to see that it does.

_____ I want very much for my relationship to succeed, and will do all I can to see that it does.

_____ I want very much for my relationship to succeed, and will do my fair share to see that it does.

_____ It would be nice if my relationship succeeded, but I can't do much more than I am doing now to help it succeed.

_____ It would be nice if it succeeded, but I refuse to do any more than I am doing now to keep the relationship going.

_____ My relationship can never succeed, and there is no more that I can do to keep the relationship going.

MILLER SOCIAL INTIMACY SCALE

Couple no.: _____ M _____ F _____

Please use the following questions to describe your current relationship with your partner. We are interested in the relationship as it is, not in the way you think it should be. We would like to know what your relationship seems like to YOU. DO NOT try to figure out how your partner will see your relationship, but DO answer the questions by giving as true a picture of YOUR own feelings and beliefs as possible.
Be sure to read each item carefully and draw a circle around the number that best describes your answers to the questions.

	Very Rarely			Some of the Time					Almost Always
1. When you have leisure time how often do you choose to spend with him/her alone?	1	2	3	4	5	6	7	8	9	10
2. How often do you keep very personal information to yourself and do not share it with him/her?	1	2	3	4	5	6	7	8	9	10
3. How often do you show him/her affection?	1	2	3	4	5	6	7	8	9	10
4. How often do you confide very personal information to him/her?	1	2	3	4	5	6	7	8	9	10
5. How often are you able to understand his/her feelings?	1	2	3	4	5	6	7	8	9	10
6. How often do you feel close to him/her?	1	2	3	4	5	6	7	8	9	10

	Not Much			A Little					A Great Deal
7. How much do you like to spend time alone with him/her?	1	2	3	4	5	6	7	8	9	10
8. How much do you feel like being encouraging and supportive to him/her when he/she is unhappy?	1	2	3	4	5	6	7	8	9	10
9. How close do you feel to him/her most of the time?	1	2	3	4	5	6	7	8	9	10
10. How important is it to you to listen to his/her very personal disclosures?	1	2	3	4	5	6	7	8	9	10
11. How satisfying is your relationship with him/her?	1	2	3	4	5	6	7	8	9	10
12. How affectionate do you feel towards										

him/her?	1	2	3	4	5	6	7	8	9	10
13. How important is it to you that he/she understands your feelings?	1	2	3	4	5	6	7	8	9	10
14. How much damage is caused by a typical disagreement in your relationship with him/her?	1	2	3	4	5	6	7	8	9	10
15. How important is it to you that he/she be encouraging and supportive to you when you are unhappy?	1	2	3	4	5	6	7	8	9	10
16. How important is it to you that he/she show you affection?	1	2	3	4	5	6	7	8	9	10
17. How important is your relationship with him/her in your life?	1	2	3	4	5	6	7	8	9	10

Thank You

THERAPIST RATING SCALE OF THE D.A.S. FACTORS

Couple # _____ Therapist: _____

This scale is designed to obtain your assessment of the extent of the couple's improvement in their dyadic adjustment as a result of marital therapy. There are four factors of adjustment: 1) consensus, 2) satisfaction, 3) cohesion, and 4) affectional expression. There are 10 questions in this scale that relate to the four factors of relationship adjustment. Please circle the statement below each question that best describes your assessment of the couple's present level of functioning. Please be as objective as possible.

CONSENSUS

1. Have this couple improved in their ability to resolve differences?

very much.....improved.....same.....worse.....very much
improved worse

2. Have this couple been able to solve the main difficulty/issue that brought them to therapy?

very much.....improved.....same.....worse.....very much
improved worse

SATISFACTION

3. Have this couple improved on frequency and intensity of quarrels?

very much.....improved.....same.....worse.....very much
improved worse

4. Have this couple improved in their ability to confide in each other and be close?

very much.....improved.....same.....worse.....very much
improved worse

5. Have this couple improved their general marital satisfaction?

very much.....improved.....same.....worse.....very much
improved worse

6. Have this couple improved their general level of committment to the relationship?

very much.....improved.....same.....worse.....very much
improved worse

COHESION

7. Have this couple improved in their general level of companionship?

very much.....improved.....same.....worse.....very much
improved worse

8. Have this couple improved in their ability to enjoy each other's company (i.e exchange ideas, working together, engaging in outside interests together)?

very much.....improved.....same.....worse.....very much
improved worse

AFFECTIONAL EXPRESSION

9. Have this couple improved in their ability and willingness to show affection to each other?

very much.....improved.....same.....worse.....very much
improved worse

10. Have this couple improved in their sexual relationship?

very much.....improved.....same.....worse.....very much
improved worse

INTERPERSONAL TRUST SCALE

Couple # _____ Sex: M ___ F ____

Instructions

Please read each of the following statements carefully and decide whether or not you agree that it is true for your relationship with your partner. Indicate how strongly you agree or disagree by circling the appropriate number on the scale beside each statement. Please answer as accurately and honestly as you can.

1 = STRONGLY DISAGREE
2 = MODERATELY DISAGREE
3 = MILDLY DISAGREE
4 = NEUTRAL
5 = MILDLY AGREE
6 = MODERATELY AGREE
7 = STRONGLY AGREE

1. My partner has always been responsive to my needs and feelings. 1 2 3 4 5 6 7

2. I sometimes have concerns that my personal identity must be compromised to make our relationship work. 1 2 3 4 5 6 7

3. Resolving conflicts in our relationship is a give-and-take procedure. Though neither of us may be completely happy with any given solution, I'm usually satisfied that any action we take is in the best interests of our relationship as a whole. 1 2 3 4 5 6 7

4. I feel that my partner can be counted on to help me. 1 2 3 4 5 6 7

5. My partner is not someone who can always be relied on to keep a promise. 1 2 3 4 5 6 7

6. I feel extremely confident that my partner loves me. 1 2 3 4 5 6 7

7. When we are dealing with an issue that is important to me, I feel confident that my partner will put my feelings first. 1 2 3 4 5 6 7

8. If a better alternative were to come along, there is the possibility that my partner would at least consider leaving our relationship. 1 2 3 4 5 6 7

9. My partner is truly sincere in his/her promises. 1 2 3 4 5 6 7

10. Even when my partner and I are very angry with one another, we still know that we love each other fully and unconditionally. 1 2 3 4 5 6 7

11. My partner is perfectly honest and truthful with me.	1	2	3	4	5	6	7
12. Through our concerted efforts at problem solving, we have managed to cope with the stresses on our relationship very effectively.	1	2	3	4	5	6	7
13. Our marriage could easily be explained in terms of "(s)he contributes this" and "I contribute that". At times it doesn't feel like we're in it together.	1	2	3	4	5	6	7
14. It is sometimes difficult for me to be absolutely certain that my partner will always care for me. Too many things can change in our relationship as time goes on.	1	2	3	4	5	6	7
15. My partner and I are compatible enough that my personal needs can be realized in our relationship.	1	2	3	4	5	6	7
16. At times I am uncomfortable when I think about how much I have invested in my relationship with my partner.	1	2	3	4	5	6	7
17. In our day-to-day interactions, my partner consistently acts in ways that are very positive.	1	2	3	4	5	6	7
18. There are times when my partner cannot be trusted.	1	2	3	4	5	6	7

19. I am never concerned that conflicts and serious tensions can damage our relationship because I know we can weather any storm.	1	2	3	4	5	6	7
20. My partner is not necessarily someone others consider to be reliable. (S)he can't always be counted on.	1	2	3	4	5	6	7
21. My partner is deeply committed to our relationship.	1	2	3	4	5	6	7
22. Issues in our relationship don't seem to sort themselves out over time. They seem to build up, mushrooming into concerns that are out of proportion to the problem at hand.	1	2	3	4	5	6	7
23. My partner treats me fairly and justly.	1	2	3	4	5	6	7
24. My partner has proven to be a faithful person. (S)he would never be unfaithful, even if there was absolutely no chance of being caught.	1	2	3	4	5	6	7
25. I feel that my partner does not show me enough consideration.	1	2	3	4	5	6	7
26. When problems have surfaced in our relationship, we have shown considerable ability to work through them successfully.	1	2	3	4	5	6	7
27. My partner is a thoroughly dependable person.	1	2	3	4	5	6	7

28. I feel that I can trust my partner completely. 1 2 3 4 5 6 7

29. Our two styles of dealing with conflicts make me concerned about our capacity to confront problems that arise in our relationship. 1 2 3 4 5 6 7

30. My partner typically behaves in ways that are very rewarding to me. 1 2 3 4 5 6 7

31. At the present time, do you trust your partner? Yes ____ No ____

ATTACHMENT QUESTIONNAIRE

COUPLE NO. _____ M ____ F ____

In this questionnaire, you will find questions about your relationship to one special person in your life. We call this special person your "attachment figure". By attachment figure, we mean:

-Most likely, the person you are living with or romantically involved with.

- The person you'd be most likely to turn to for comfort, help, advice, love, or understanding.

-The person you'd be most likely to depend on, and who may depend on you for some things.

To answer the following questions, think of your husband, wife, common-law spouse, boyfriend or girlfriend. This person is your attachment figure.

The questions about your relationship with your attachment figure begin on the next page. Please think about each question and answer carefully, but do not worry if some questions are hard to answer exactly. Remember, this questionnaire is not a test; there are no right or wrong answers. Do the best you can and trust your own judgements.

1 strongly disagree	2 disagree	3 somewhat agree and somewhat disagree	4 agree	5 strongly agree

1. I feel comfortable with my attachment figure going away for a few days. _____

2. I turn to my attachment figure for many things, including comfort and reassurance. _____

3. I'm confident that my attachment figure will listen to me. _____

4. I enjoy helping my attachment figure whenever I can. _____

5. I have to force myself to keep going when my attachment figure is absent. _____

6. It's hard for me to believe that I'll always have my attachment figure's love. _____

7. I have to have my attachment figure with me when I'm upset. _____

8. I don't object when my attachment figure goes away for a few days. _____

9. I find it difficult to imagine turning to my attachment figure for help. _____

10. I'm confident that my attachment figure will try to understand my feelings. _____

11. I sympathize with my attachment figure when he/she is upset. _____

1 strongly disagree	2 disagree	3 somewhat agree and somewhat disagree	4 agree	5 strongly agree

12. The further I am from my attachment figure, the more insecure I feel. _____

13. I worry about losing my attachment figure. _____

14. When I'm upset, the most important thing is to be with my attachment figure. _____

15. I resent it when my attachment figure spends time away from me. _____

16. I talk things over with by attachment figure. _____

17. I worry that my attachment figure will let me down. _____

18. When my attachment figure feels insecure, I try to reassure him/her. _____

19. Being with my attachment figure is my only security in life. _____

20. I have a terrible fear that my relationship with my attachment figure will end. _____

21. I feel lost if I'm upset and my attachment is not around. _____

22. I feel abandoned when my attachment figure is away for a few days _____

1 strongly disagree	2 disagree	3 somewhat agree and somewhat disagree	4 agree	5 strongly agree

23. Things have to be really bad for me to ask by attachment figure for help. _____

24. When I'm upset, I am confident my attachment figure will be there to listen to me. _____

25. When my attachment figure needs to talk, he/she can count on me. _____

26. I can motivate myself when my attachment figure is away on a short trip. _____

27. I'm afraid that I will lose my attachment figure's love. _____

28. I'm not likely to run to my attachment figure every time I get upset. _____

29. I protest strongly when my attachment figure leaves on a trip. _____

30. I only turn to my attachment figure when I absolutely have to. _____

31. I can count on my attachment figure to be available if I need him/her. _____

32. I want to be available when my attachment figure needs me. _____

33. I feel much more insecure when my attachment figure is away. _____

1	2	3	4	5
strongly disagree	disagree	somewhat agree and somewhat disagree	agree	strongly agree

34. I'm confident that my attachment figure will always love me. _____

35. When I am anxious, I desperately need to be close to my attachment figure. _____

Emotional Self-Disclosure Scale(Self-Rating)

Couple No. ____ Male ____ Female ____

This is a measure designed to assess emotional disclosure. For each statement below, indicate how willing you have been to discuss that particular emotion with your spouse/partner. There are no right or wrong answers. Answer each statement as honestly as you can. Circle only one number for each statement that best describes you.

1	2	3	4	5
not at all willing to discuss this topic				totally willing to discuss this topic

1.	Times when you felt depressed	1	2	3	4	5
2.	Times when you felt happy	1	2	3	4	5
3.	Times when you felt jealous	1	2	3	4	5
4.	Times when you felt anxious	1	2	3	4	5
5.	Times when you felt angry	1	2	3	4	5
6.	Times when you felt calm	1	2	3	4	5
7.	Times when you felt apathetic	1	2	3	4	5
8.	Times when you felt afraid	1	2	3	4	5
9.	Times when you felt discouraged	1	2	3	4	5

10.	Times when you felt cheerful	1	2	3	4	5
11.	Times when you felt possessive	1	2	3	4	5
12.	Times when you felt troubled	1	2	3	4	5
13.	Times when you felt infuriated	1	2	3	4	5
14.	Times when you felt quiet	1	2	3	4	5
15.	Times when you felt indifferent	1	2	3	4	5
16.	Times when you felt fearful	1	2	3	4	5
17.	Times when you felt pessimistic	1	2	3	4	5
18.	Times when you felt joyous	1	2	3	4	5
19.	Times when you felt envious	1	2	3	4	5
20.	Times when you felt worried	1	2	3	4	5
21.	Times when you felt irritated	1	2	3	4	5
22.	Times when you felt serene	1	2	3	4	5
23.	Times when you felt numb	1	2	3	4	5
24.	Times when you felt frightened	1	2	3	4	5
25.	Times when you felt sad	1	2	3	4	5
26.	Times when you felt delighted	1	2	3	4	5

27.	Times when you felt suspicious	1	2	3	4	5
28.	Times when you felt uneasy	1	2	3	4	5
29.	Times when you felt hostile	1	2	3	4	5
30.	Times when you felt tranquil	1	2	3	4	5
31.	Times when you felt unfeeling	1	2	3	4	5
32.	Times when you felt scared	1	2	3	4	5
33.	Times when you felt unhappy	1	2	3	4	5
34.	Times when you felt pleased	1	2	3	4	5
35.	Times when you felt resentful	1	2	3	4	5
36.	Times when you felt flustered	1	2	3	4	5
37.	Times when you felt enraged	1	2	3	4	5
38.	Times when you felt relaxed	1	2	3	4	5
39.	Times when you felt detached	1	2	3	4	5
40.	Times when you felt alarmed	1	2	3	4	5

Emotional Self-Disclosure Scale (Partner-Rating)

Couple No. ____ Male ____ Female ____

This is a measure designed to assess emotional disclosure. For each statement below, indicate how willing your spouse/partner has been to discuss that particular emotion with you. There are no right or wrong answers. Answer each statement as honestly as you can. Circle only one number for each statement that best describes your partner.

1	2	3	4	5
not at all willing to discuss this topic				totally willing to discuss this topic

1.	Times when your partner felt depressed	1	2	3	4	5
2.	Times when your partner felt happy	1	2	3	4	5
3.	Times when your partner felt jealous	1	2	3	4	5
4.	Times when your partner felt anxious	1	2	3	4	5
5.	Times when your partner felt angry	1	2	3	4	5
6.	Times when your partner felt calm	1	2	3	4	5
7.	Times when your partner felt apathetic	1	2	3	4	5
8.	Times when your partner felt afraid	1	2	3	4	5
9.	Times when your partner felt discouraged	1	2	3	4	5

10.	Times when your partner felt cheerful	1	2	3	4	5
11.	Times when your partner felt possessive	1	2	3	4	5
12.	Times when your partner felt troubled	1	2	3	4	5
13.	Times when your partner felt infuriated	1	2	3	4	5
14.	Times when your partner felt quiet	1	2	3	4	5
15.	Times when your partner felt indifferent	1	2	3	4	5
16.	Times when your partner felt fearful	1	2	3	4	5
17.	Times when your partner felt pessimistic	1	2	3	4	5
18.	Times when your partner felt joyous	1	2	3	4	5
19.	Times when your partner felt envious	1	2	3	4	5
20.	Times when your partner felt worried	1	2	3	4	5
21.	Times when your partner felt irritated	1	2	3	4	5
22.	Times when your partner felt serene	1	2	3	4	5
23.	Times when your partner felt numb	1	2	3	4	5
24.	Times when your partner felt frightened	1	2	3	4	5
25.	Times when your partner felt sad	1	2	3	4	5
26.	Times when your partner felt delighted	1	2	3	4	5

27.	Times when your partner felt suspicious	1	2	3	4	5
28.	Times when your partner felt uneasy	1	2	3	4	5
29.	Times when your partner felt hostile	1	2	3	4	5
30.	Times when your partner felt tranquil	1	2	3	4	5
31.	Times when your partner felt unfeeling	1	2	3	4	5
32.	Times when your partner felt scared	1	2	3	4	5
33.	Times when your partner felt unhappy	1	2	3	4	5
34.	Times when your partner felt pleased	1	2	3	4	5
35.	Times when your partner felt resentful	1	2	3	4	5
36.	Times when your partner felt flustered	1	2	3	4	5
37.	Times when your partner felt enraged	1	2	3	4	5
38.	Times when your partner felt relaxed	1	2	3	4	5
39.	Times when your partner felt detached	1	2	3	4	5
40.	Times when your partner felt alarmed	1	2	3	4	5

COUPLE THERAPY ALLIANCE SCALE

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Instructions

The following statements refer to your feelings and thoughts about your therapist and your therapy right NOW. Each statement is followed by a seven point scale. Please rate the extent to which you agree or disagree with each statement AT THIS TIME.

If you completely agree with the statement, circle number 7. If you completely disagree with the statement, circle number 1. Use the numbers in between to describe variations between the extremes.

Completely Agree	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Completely Disagree
7	6	5	4	3	2	1

Please work quickly. We are interested in your FIRST impressions. Your ratings are CONFIDENTIAL. They will not be shown to your therapist or partner and will only be used for research purposes.

Although some of the statements appear to be similar or identical, each statement is unique. PLEASE BE SURE TO RATE EACH STATEMENT.

	Completely Agree	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Completely Disagree
The therapist cares about me as a person.	7	6	5	4	3	2	1
The therapist and I are not in agreement about the goals for this therapy.	7	6	5	4	3	2	1
I trust the therapist.	7	6	5	4	3	2	1
The therapist lacks the skills and ability to help my partner and myself with our relationship.	7	6	5	4	3	2	1
My partner feels accepted by the therapist.	7	6	5	4	3	2	1
The therapist does not understand the relationship between my partner and myself.	7	6	5	4	3	2	1
The therapist understands my goals in therapy.	7	6	5	4	3	2	1
The therapist and my partner are not in agreement about the goals for this therapy.	7	6	5	4	3	2	1
My partner cares about the therapist as a person.	7	6	5	4	3	2	1
The therapist does not understand the goals that my partner and I have for ourselves as a couple in this therapy.	7	6	5	4	3	2	1
My partner and the therapist are in agreement about the way the therapy is being conducted.	7	6	5	4	3	2	1
The therapist does not understand me.	7	6	5	4	3	2	1
The therapist is helping my partner and me with our relationship.	7	6	5	4	3	2	1
I am not satisfied with the therapy.	7	6	5	4	3	2	1

	Completely Agree	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Completely Disagree
The therapist understands my partner's goals for this therapy.	7	6	5	4	3	2	1
I do not feel accepted by the therapist.	7	6	5	4	3	2	1
The therapist and I are in agreement about the way the therapy is being conducted.	7	6	5	4	3	2	1
The therapist is not helping me.	7	6	5	4	3	2	1
The therapist is in agreement with the goals that my partner and I have for ourselves as a couple in this therapy.	7	6	5	4	3	2	1
The therapist does not care about my partner as a person.	7	6	5	4	3	2	1
The therapist has the skills and ability to help me.	7	6	5	4	3	2	1
The therapist is not helping my partner.	7	6	5	4	3	2	1
My partner is satisfied with the therapy.	7	6	5	4	3	2	1
I do not care about the therapist as a person.	7	6	5	4	3	2	1
The therapist has the skills and ability to help my partner.	7	6	5	4	3	2	1
My partner distrusts the therapist.	7	6	5	4	3	2	1
The therapist cares about the relationship between my partner and myself.	7	6	5	4	3	2	1
The therapist does not understand my partner.	7	6	5	4	3	2	1

APPENDIX C

Table C-1

Pearson Correlations between Predictor Variables and Pretreatment Marital Satisfaction Level

Variables	cdas1	ctrust	cattach	cselfd
cdas1	---	.64**	.58**	.37*
ctrust		---	.72**	.52**
cattach			---	.43*
cselfd				---

Note: cdas1 = couples' pretreatment mean dyadic adjustment score, ctrust = couples' mean trust score, cattach = couples' mean attachment score, cselfd = couples' mean self-disclosure score

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

Table C-2

Pearson Correlations between Demographic Characteristics and Marital Satisfaction at Posttreatment and Follow-Up

	Marital Satisfaction Level		Marital Satisfaction Gains	
Variables	Time 2	Time 3	Time 2	Time 3
Couples				
Age	.29	.30	.23	.22
Education	-.30	-.29	-.36	-.32
Length of Relationship	.02	.05	.08	.10
Income	-.12	-.02	-.11	-.01
Number of Children	-.00	-.00	.17	.15
Females				
Age	.15	.12	-.02	-.04
Education	-.03	-.12	.12	-.19
Males				
Age	.33	.39*	.38**	.38**
Education	-.29	-.32	-.31	-.32

Note: Time 2 = posttreatment, Time 3 = follow-up

* $p < .05$, ** $p < .05/2 = .025$

Table C-3

Multiple Regression of Males' Age on Males' Follow-up Marital Satisfaction Level

Variables	mdas3 (DV)	B	β	R square change (incremental)
mdas1	.19	.220	.189	.04
mage	.38*	.452	.408	.16*

Intercept = 66.35

Multiple R = .44
R square = .20
Adjusted R square = .15
Standard Error = 11.90

Note: mdas1 = males' pretreatment marital satisfaction level, mdas3 = males' follow-up marital satisfaction level, mage = males' age

* $p < .05$

Table C-4

Multiple Regression of Alliance on Posttreatment and Follow-up Marital Satisfaction

Variables	cdas2 (DV)	B	β	R square change (incremental)
cdas1	.35*	.542	.349	.12*
calnce	.47**	.336	.475	.23**
Intercept = -.76				
				Multiple R = .59
				R square = .35
				Adjusted R square = .30
				Standard Error = 10.2

Variables	cdas3 (DV)	B	β	R square change (incremental)
cdas1	.20	.316	.201	.04
calnce	.53**	.383	.534	.29**
Intercept = 15.98				
				Multiple R = .57
				R square = .33
				Adjusted R square = .28
				Standard Error = 10.5

Note: cdas1 = couples' pretreatment mean dyadic adjustment score, cdas2 = couples' posttreatment mean dyadic adjustment score, cdas3 = couples' follow-up mean dyadic adjustment score, calnce = couples' mean alliance score at end of third session

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

Table C-5

Summary of Multiple Regression of Alliance Factors on Posttreatment and Follow-up Marital Satisfaction

Variables	cdas2 (DV)	B	β	R square change (incremental)
cdas1	.35*	.542	.349	.12
task	.49*	.735	.517	.27**
goals	.37*	1.161	.380	.14
bonds	.45*	.980	.426	.18
self	.49*	.879	.492	.24**
other	.45*	.752	.452	.20**
group	.40*	1.467	.426	.18

Variables	cdas3 (DV)	B	β	R square change (incremental)
cdas1	.20	.316	.201	.04
task	.58*	.867	.603	.36**
goals	.44*	1.377	.445	.20
bonds	.45*	1.008	.433	.19
self	.55*	1.004	.554	.30**
other	.48*	.824	.489	.24**
group	.50*	1.807	.518	.27**

Note: cdas1 = couples' pretreatment mean dyadic adjustment scale score, cdas2 = couples' posttreatment mean dyadic adjustment score, cdas3 = couples' follow-up mean dyadic adjustment score,

* $p < .05$, ** $p < .05/6 = .008$

Table C-6

Multiple regression of Alliance on Posttreatment and Follow-up Intimacy

Variables	cmiller2 (DV)	B	β	R square change (incremental)
cmiller1	.60*	.510	.606	.37***
calnce	.46**	.266	.331	.10*
Intercept = 37.06				
				Multiple R = .69
				R square = .47
				Adjusted R square = .43
				Standard Error = 10.5

Variables	cmiller1	cmiller3 (DV)	B	β	R square change (incremental)
cmiller1	---	.49**	.564	.495	.24**
calnce	.25	.50**	.446	.408	.16**
Intercept = 6.63					
				Multiple R = .63	
				R square = .40	
				Adjusted R square = .36	
				Standard Error = 15.1	

Note: cmiller1 = couples' pretreatment mean Miller Intimacy score, cmiller2 = couples' posttreatment mean Miller Intimacy score, cmiller3 = couples' follow-up mean Miller Intimacy score, calnce = couples' mean alliance score at end of third session

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

Table C-7

Multiple regression of Alliance on Therapist Rating of Improvement

Variables	thrate (DV)	B	β	R square change (incremental)
calnce	.36*	.092	.364	.13*

Intercept = - 7.06

Multiple R = .36
R square = .13
Adjusted R square = .11
Standard Error = 4.2

Note: Thrate = therapist rating of improvement, calnce = couple mean alliance score at end of third session

* p <.05

Table C-8

Means and Standard Deviations of Dependent Variables

Variables	Time 1 M (SD)	Time 2 M (SD)	Time 3 M (SD)
DAS			
Couples	88.0 (7.9)	102.9 (12.1)	107.5 (12.3)
Females	87.3 (11.2)	102.3 (12.9)	106.4 (14.1)
Males	88.8 (11.1)	103.5 (13.8)	108.5 (12.9)
MILLER			
Couples	115.5 (16.4)	132.1 (13.8)	132.4 (18.7)
Females	116.5 (18.4)	133.5 (15.1)	133.9 (20.9)
Males	114.5 (22.1)	130.7 (17.0)	130.8 (22.3)
THERAPIST RATING			
Couples		8.4 (4.3)	

Note: Time 1 = pretreatment, Time 2 = posttreatment, Time 3 = follow-up, DAS = Dyadic Adjustment Scale, Miller = Miller Intimacy Scale, Therapist Rating = Therapist Rating of Improvement

Table C-9

Means and Standard Deviations of Trust scores

Variables	Couples M (SD)	Females M (SD)	Males M (SD)
TRUST	132.9 (25.9)	129.3 (28.1)	136.6 (32.4)
faith	31.1 (6.5)	31.3 (7.0)	30.7 (8.4)
responsive	33.7 (8.7)	32.7 (9.5)	34.7 (11.3)
depend	32.4 (5.2)	30.8 (7.3)	34.1 (7.1)
cconflict	18.4 (6.3)	18.2 (7.6)	18.6 (7.1)
concern	17.3 (4.4)	16.2 (5.4)	18.4 (6.0)

Note: trust = total score, faith = faith in partner's committment to relationship, responsive = perception that partner is responsive to one's needs and desires, depend = perception that partner is dependable, cconflict = confidence in conflict resolution, concern = concern about the future of the relationship

Table C-10

Means and Standard Deviations of Attachment scores

Variables	Couples M (SD)	Females M (SD)	Males M (SD)
ATTACHMENT	132.2 (9.7)	130.3 (13.7)	134.2 (12.7)
useatt	18.7 (3.4)	19.7 (3.5)	17.7 (4.6)
availab	17.6 (3.1)	17.1 (3.8)	18.1 (3.9)
proxsee	17.6 (2.3)	16.3 (2.9)	18.9 (2.9)
protest	20.4 (2.4)	19.7 (3.9)	21.1 (2.7)
recipr	20.1 (2.1)	20.0 (3.1)	20.1 (2.0)
secbase	20.4 (2.2)	20.1 (3.4)	20.6 (2.8)
ferloss	17.4 (2.7)	17.3 (3.5)	17.5 (3.8)

Note: ATTACHMENT = total score, useatt = use of attachment figure, availab = perception that one's partner is available, proxsee = extent of proximity seeking during stress, protest = extent of protest during partner absence, recipr = perception that one's partner will reciprocate caring and nurturance, secbase = perception that one's partner will be present when needed, ferloss = the extent of fear of loss of relationship

Table C-11

Means and Standard Deviations of Self rating on self-disclosure

Variables	Females M (SD)	Males M (SD)	t	df	p
Anger	18.3 (5.6)	15.8 (4.3)	2.09	66	.040
Anxiety	18.8 (4.0)	16.2 (4.4)	2.54	66	.013
Apathy	17.1 (5.2)	14.0 (4.1)	2.74	66	.008
Calmness	20.5 (4.1)	18.1 (4.3)	2.37	66	.021
Depression	18.2 (5.1)	15.7 (4.6)	2.18	66	.033
Fear	19.2 (5.0)	15.9 (5.1)	2.69	66	.009
Happiness	22.5 (2.9)	20.6 (4.1)	2.12	66	.037
Jealousy	17.1 (5.1)	16.4 (4.3)	.54	66	.589
Total	151.8 (29.9)	132.8 (30.7)	2.59	66	.012

Note: two-tailed probability

Table C-12

Means and Standard Deviations of Partner Rating on Self-Disclosure

Variables	Females M (SD)	Males M (SD)	t	df	p
Anger	17.2 (4.9)	13.8 (5.1)	-2.82	66	.006
Anxiety	18.0 (4.1)	14.7 (4.8)	-2.97	66	.004
Apathy	14.7 (4.0)	13.2 (5.5)	-1.28	66	.204
Calmness	17.0 (3.4)	16.5 (5.8)	-.38	53	.705
Depression	17.6 (4.5)	14.7 (4.7)	-2.53	66	.014
Fear	17.8 (4.2)	14.3 (5.5)	-2.93	66	.005
Happiness	20.5 (3.2)	19.4 (4.9)	-1.02	56.7	.312
Jealousy	16.3 (4.1)	13.6 (5.2)	-2.38	66	.020
Total	139.0 (25.5)	120.4 (33.8)	-2.56	66	.013

Note: two-tailed probability

Table C-13

Means and Standard Deviations of Total Self-Disclosure

Variables	Females M (SD)	Males M (SD)	t	df	p
Anger	17.8 (3.9)	14.8 (3.9)	-3.71	66	.001
Anxiety	18.4 (3.4)	15.5 (3.5)	-3.49	66	.001
Apathy	15.9 (3.8)	13.6 (3.8)	-2.97	66	.005
Calmness	18.7 (3.3)	17.3 (3.8)	2.41	66	.022
Depression	17.9 (4.1)	15.2 (3.5)	-2.97	66	.005
Fear	18.5 (3.8)	15.1 (4.2)	4.05	66	.000
Happiness	21.5 (2.6)	20.0 (3.6)	-2.72	66	.010
Jealousy	16.7 (3.6)	15.0 (3.9)	-2.27	66	.030
Total	145.7 (24.8)	125.3 (26.4)	-3.19	66	.004

Note: This represents the combined self and partner rating of self disclosure, two-tailed probability

Table C-14

Independent Samples t-test for Detecting Gender Differences on Independent and Dependent Variables

Variables	Females M (SD)	Males M (SD)	t	df	p
trust	129.3 (28.1)	136.6 (32.4)	-1.01	66	.316
attachment	130.3 (13.7)	134.2 (12.7)	-1.20	66	.233
Self-disclosure (self rating)	151.8 (29.9)	132.8 (30.7)	2.59	66	.012
Self-Disclosure (Partner rating)	139.0 (25.5)	120.4 (33.8)	-2.56	66	.013
Self-disclosure (combined average)	145.7 (24.8)	125.3 (26.4)	-3.19	66	.004
alliance	164.7 (21.2)	166.5 (16.9)	-.37	66	.710
das1	87.3 (11.2)	88.8 (11.1)	-.56	66	.580
das2	102.4 (12.9)	103.5 (13.8)	-.36	66	.718
das3	106.4 (14.1)	108.6 (12.9)	-.65	66	.520
miller1	116.6 (18.4)	114.5 (22.1)	.42	66	.673
miller2	133.5 (15.1)	130.8 (17.0)	.70	66	.486
miller3	134.0 (21.0)	130.9 (22.3)	.59	66	.555

Note:trust = individual trust score, attachment = individual attachment score, alliance = alliance score at end of third session, das1 = pretreatment dyadic adjustment score, das2 = posttreatment dyadic adjustment score, das3 = follow-up dyadic adjustment score, miller1 = pretreatment miller intimacy score, miller2 = posttreatment miller intimacy score, miller3 = follow-up intimacy score, two-tailed probability

Table C-15

Percentage of subjects who recovered and improved

%(N) Total Sample = 34

	Posttreatment		Follow-up	
	Recovered[a]	Improved[b]	Recovered[a]	Improved[b]
Couples	50% (17)	79% (27)	70% (24)	82% (28)
Females	56% (19)	76% (26)	67% (23)	82% (28)
Males	59% (20)	76% (26)	76% (26)	82% (28)

Note: a = Couples' Mean Dyadic Adjustment Score $\geq$ 101, b = Couples' Mean Dyadic Adjustment Change Score $\geq$ 5

Table C-16

Percentage of Couples who Recovered and Improved by Degree of Marital Distress

Total Sample = 34

	Posttreatment		Follow-up	
	a Recovered	b Improved	a Recovered	b Improved
Severe (N = 7)	14% (1)	86% (6)	57% (4)	100% (7)
Moderate (N = 13)	69% (9)	77% (10)	85% (11)	85% (11)
Mild (N = 14)	57% (8)	57% (8)	79% (11)	71% (10)

Note: a = Couples' Mean Dyadic Adjustment score $\geq$ 101, b = Couples' Mean Dyadic Adjustment change score $\geq$ 5

Table C-17

Pearson Correlations between Attachment and Intimacy Level at Posttreatment and Follow-Up

	Couples		Females		Males	
Variables	Time 2	Time 3	Time 2	Time 3	Time 2	Time 3
Couples						
Mean score	.24	.29	.27	.22	.26	.23
availability	.36*	.03	.06	.13	.21	.17
proximity seeking	.38*	.27	.22	.16	.11	.13
feared loss	.22	.16	.13	.11	.12	.09
use of attachment	.34*	.12	.09	.02	.13	.09
reciprocity	.08	.07	.11	.03	.02	.00
secure base	.06	.04	.07	.09	.01	.05
separation protest	.02	.04	.12	.13	.08	.09
Females						
Total Score	.24	.22	.23	.22	.19	.16
availability	.40*	.07	-.15	-.00	.05	.06
proximity seeking	.22	.26	.17	.23	.16	.19
feared loss	.07	.09	.09	-.04	.11	.08
use of attachment	.37*	.14	.31	.19	.17	.13
reciprocity	.17	.19	.27	.11	.11	.16
secure base	.08	.10	-.02	.00	.08	.09
separation protest	.09	.10	.01	.07	.12	.13
Males						
Total Score	.22	.24	.20	.12	.17	.14
availability	.12	.09	.02	.01	.10	.04
proximity seeking	.35*	.24	.15	.17	.09	.10
feared loss	.17	.21	.16	.13	.30	.25
use of attachment	.13	.16	.17	.09	.24	.01
reciprocity	.09	.10	.05	.08	.03	.07
secure base	-.19	-.17	-.03	-.05	-.19	-.12
separation protest	.08	.07	.11	.10	.10	.13

Note: Time 2 = posttreatment Miller Intimacy score, Time 3 = follow-up Miller Intimacy score, * $p < .05$

Table C-18

Multiple Regression of Attachment on Couples Posttreatment Intimacy Level

Variables	cmiller2 (DV)	B	β	R square change (incremental)
cmiller1	.60*	.507	.602	.36
cproxsee	.38*	.003	.001	.00
cuseatt	.34*	.631	.157	.01
crecipr	.36*	.068	.011	.00
fuseatt	.39*	.264	.067	.00
frecipr	.40*	.344	.078	.00
mproxsee	.35*	.057	.011	.00

Note: cmiller1 = couples' mean pretreatment Miller Intimacy score, cmiller2 = couples' mean posttreatment Miller Intimacy score, cproxsee = couples' mean proximity seeking score, cuseatt = couples' mean use of attachnment score, crecipr = couples' mean reciprocity score, fuseatt = female use of attachment score, frecipr = female reciprocity score, mproxsee = male proximity seeking score,

Separate Regression analyses were conducted for each variable

* $p < .05$, ** $p < .05/6 = .008$

Table C-19

Pearson Correlations between Predictor Variables and Therapist Rating of Improvement

Variables	Therapist rating of improvement
couples' mean trust level	-.06
female trust level	-.17
male trust level	.05
couples' mean attachment level	-.26
female attachment level	-.21
male attachment level	-.18
couples' mean self-disclosure level	-.14
female mean self-disclosure level	-.16
female self rating of disclosure	-.01
partner rating of female self-disclosure	-.09
male mean self-disclosure level	-.07
male self rating of disclosure	.16
partner rating of male self-disclosure	-.27

Table C-20

Pearson Correlations of Female Self-Disclosure Factors and Marital Satisfaction Level at Posttreatment and Follow-Up

	Couples		Females		Males	
Variables	Time 2	Time 3	Time 2	Time 3	Time 2	Time 3
Self rating						
Anger	.08	.09	.11	.12	.09	.12
Anxiety	.12	.13	.02	.08	.15	.17
Apathy	.17	.12	.03	.12	.11	.09
Calmness	.11	.03	.12	.09	.09	.04
Depression	.13	.19	.10	.16	.16	.19
Fear	.19	.20	.10	.13	.10	.12
Happiness	.21	.22	.19	.19	.15	.21
Jealousy	.04	.16	.04	.09	.04	.21
Partner rating						
Anger	.05	.04	.02	.07	.09	.11
Anxiety	-.10	-.09	-.13	-.13	-.06	-.10
Apathy	-.05	.01	.04	.02	-.12	.01
Calmness	.25	.19	.29	.15	.17	.20
Depression	-.02	-.04	-.06	-.07	-.08	-.09
Fear	-.07	-.06	.04	.09	.09	.09
Happiness	.24	.23	.21	.18	.18	.21
Jealousy	-.19	-.16	-.16	-.13	-.18	-.18

Note: Time 2 = posttreatment Dyadic Adjustment score, Time 3 = follow-up Dyadic Adjustment score,

* $p < .05$

Table C-21

Pearson Correlations of Male Self-Disclosure Factors and Marital Satisfaction Level at Posttreatment and Follow-up

	Couples		Females		Males	
Variables	Time 2	Time 3	Time 2	Time 3	Time 2	Time 3
Self rating						
Anger	.08	.09	.11	.12	.09	.12
Anxiety	.21	.09	.25	.05	.14	.12
Apathy	.07	-.01	.09	.01	.04	-.01
Calmness	.11	.03	.05	.09	.15	.16
Depression	.13	.19	.10	.16	.16	.19
Fear	.19	.20	.10	.13	.20	.18
Happiness	.18	.20	.19	.19	.15	.21
Jealousy	.07	-.03	.08	-.09	.05	.04
Partner rating						
Anger	.05	.04	.02	.07	.09	.11
Anxiety	.10	.29	.17	.23	.16	.11
Apathy	.05	.01	.04	.02	.12	.01
Calmness	.25	.19	.29	.15	.17	.20
Depression	.02	.14	.26	.17	.18	.29
Fear	.07	.11	.04	.09	.09	.09
Happiness	.24	.23	.21	.18	.18	.21
Jealousy	.10	.16	.17	.13	.18	.18

Note: Time 2 = posttreatment Dyadic Adjustment score, Time 3 = follow-up Dyadic Adjustment score,

* $p < .05$

Table C-22

Pearson Correlations of Female Self-Disclosure Factors and Marital Satisfaction Change Scores at Posttreatment and Follow-Up

	Couples		Females		Males	
Variables	Time 2	Time 3	Time 2	Time 3	Time 2	Time 3
Self rating						
Anger	.08	.09	.11	.12	.09	.12
Anxiety	.12	.13	.02	.08	.15	.17
Apathy	.17	.12	.03	.12	.11	.09
Calmness	.11	.03	.12	.09	.09	.04
Depression	.13	.19	.10	.16	.16	.19
Fear	.19	.20	.10	.13	.10	.12
Happiness	.21	.22	.19	.19	.15	.21
Jealousy	.04	.16	.04	.09	.04	.21
Partner rating						
Anger	.05	.04	.02	.07	.09	.11
Anxiety	-.10	-.09	-.13	-.13	-.06	-.10
Apathy	-.05	.01	.04	.02	-.12	.01
Calmness	.25	.19	.29	.15	.17	.20
Depression	-.02	-.04	-.06	-.07	-.08	-.09
Fear	-.07	-.06	.04	.09	.09	.09
Happiness	.24	.23	.21	.18	.18	.21
Jealousy	-.19	-.16	-.16	-.13	-.18	-.18

Note: Time 2 = posttreatment Dyadic Adjustment change score, Time 3 = follow-up Dyadic Adjustment change score,

* $p < .05/16 = .003$

Table C-23

Pearson Correlations of Male Self-Disclosure Factors and Marital Satisfaction Change Scores at Posttreatment and Follow-up

	Couples		Females		Males	
Variables	Time 2	Time 3	Time 2	Time 3	Time 2	Time 3
Self rating						
Anger	.08	.09	.11	.12	.09	.12
Anxiety	.21	.09	.25	.05	.14	.12
Apathy	.07	-.01	.09	.01	.04	-.01
Calmness	.11	.03	.05	.09	.15	.16
Depression	.13	.19	.10	.16	.16	.19
Fear	.19	.20	.10	.13	.20	.18
Happiness	.18	.20	.19	.19	.15	.21
Jealousy	.07	-.03	.08	-.09	.05	.04
Partner rating						
Anger	.05	.04	.02	.07	.09	.11
Anxiety	.10	.29	.17	.23	.16	.11
Apathy	.05	.01	.04	.02	.12	.01
Calmness	.25	.19	.29	.15	.17	.20
Depression	.02	.14	.26	.17	.18	.29
Fear	.07	.11	.04	.09	.09	.09
Happiness	.24	.23	.21	.18	.18	.21
Jealousy	.10	.16	.17	.13	.18	.18

Note: Time 2 = posttreatment dyadic adjustment change score, Time 3 = follow-up dyadic adjustment change score,

* $p < .05/16 = .003$

Table C-24

Pearson Correlations between Self-Disclosure and Intimacy Level at Posttreatment and Follow-Up

	Couples		Females		Males	
Variables	Time 2	Time 3	Time 2	Time 3	Time 2	Time 3
Cselfd	.17	.18	.08	.15	.21	.17
Fselfd	.17	.11	.05	.20	.17	.16
Fsds	.05	.23	.05	.26	.03	.13
Fsdp	.13	.08	.02	.04	.20	.10
Mselfd	.04	.11	.09	.06	.19	.13
Msds	.21	.08	.05	-.04	.30	.16
Msdp	.04	.11	.09	.15	-.02	.04

Note: Time 2 = posttreatment Miller Intimacy score, Time 3 = follow-up Miller Intimacy score, Cselfd = Couples' mean self-disclosure score, Fselfd = females' mean self-disclosure score, Fsds = females' self rating score, Fsdp = partner rating of female self-disclosure, Mselfd = males' mean self-disclosure score, Msds = males' self rating score, Msdp = partner rating of male self-disclosure

* $p < .05$

Table C-25

Pearson Correlations of Female Self-Disclosure Factors and Intimacy Level at Posttreatment and Follow-Up

	Couples		Females		Males	
Variables	Time 2	Time 3	Time 2	Time 3	Time 2	Time 3
Self rating						
Anger	.08	.18	.11	.12	.09	.12
Anxiety	.04	.18	.01	.20	.06	.11
Apathy	.27	.22	.30	.44*	.04	.14
Calmness	.31	.28	.30	.29	.20	.20
Depression	.13	.19	.10	.17	.16	.19
Fear	.11	.14	.25	.23	.10	.12
Happiness	.21	.12	.20	.19	.15	.21
Jealousy	.08	.26	.06	.26	.08	.19
Partner rating						
Anger	.05	.04	.02	.07	.09	.11
Anxiety	-.10	-.09	-.13	-.13	.06	.10
Apathy	.10	.16	.15	.26	.03	.02
Calmness	.25	.19	.29	.15	.17	.20
Depression	-.02	-.04	.06	-.07	.08	.09
Fear	-.07	-.06	.04	.09	.09	.09
Happiness	.17	.23	.11	.18	.17	.21
Jealousy	-.16	.01	-.03	.13	-.23	-.18

Note: Time 2 = posttreatment Miller Intimacy score, Time 3 = follow-up Miller Intimacy score,

* $p < .05$

Table C-26

Summary of Multiple Regression of Apathy Self-Rating on Females' Follow-up Intimacy Level

Variables	fmiller3(DV)	B	β	R square change (incremental)
fmiller1	.36*	.407	.357	.13*
fsapa	.44*	1.462	.363	.11*

Intercept = 79.04

Multiple R = .49

R square = .24

Adjusted R square = .19

Standard Error = 18.8

Note: fmiller1 = females' pretreatment Miller Intimacy Scale score, fmiller3 = females' follow-up Miller Intimacy Scale score, fsapa = females' self rating of apathy self-disclosure

* $p < .05$

Table C-27

Pearson Correlations of Male Self-Disclosure Factors and Intimacy Level at posttreatment and Follow-up

	Couples		Females		Males	
Variables	Time 2	Time 3	Time 2	Time 3	Time 2	Time 3
Self rating						
Anger	.08	.09	.11	.12	.09	.12
Anxiety	.24	.11	.12	.05	.27	.16
Apathy	.07	-.01	.09	.01	.04	-.01
Calmness	.11	.03	.05	.09	.15	.16
Depression	.15	.09	.11	.16	.34*	.19
Fear	.19	.20	.20	.13	.21	.18
Happiness	.18	.10	.19	.09	.37*	.22
Jealousy	.10	.01	.08	-.09	.19	.10
Partner rating						
Anger	.05	.04	.02	.07	.09	.11
Anxiety	.21	.12	.06	.04	.28	.17
Apathy	.05	.01	.04	.02	.12	.01
Calmness	.25	.19	.29	.15	.17	.20
Depression	.02	.17	.16	.17	.18	.29
Fear	.07	.11	.04	.21	.17	.12
Happiness	.12	.20	.21	.18	.28	.21
Jealousy	.12	.16	.15	.13	.18	.13

Note: Time 2 = posttreatment Miller Intimacy score, Time 3 = follow-up Miller Intimacy score,

* $p < .05$

Table C-28

Multiple Regression of Self-Disclosure Factors on Males' Posttreatment Intimacy Level

Variables	mmiller2(DV)	B	β	R square change (incremental)
mmiller1	.60*	.464	.602	.36**
mshap	.37*	.542	.216	.04
msdep	.34*	.109	.184	.03

Note: mmiller1 = males' pretreatment Miller Intimacy score, mmiller2 = males' posttreatment Miller Intimacy score, mshap = males' self rating of happiness self-disclosure, msdep = males self rating of depression self-disclosure
Separate Regression analyses were conducted for each variable
* $p < .05$, ** $p < .05/2 = .025$

Table C-29

Pearson Correlations of Trust and Intimacy Level at Posttreatment and Follow-up

	Couples		Females		Males	
Variables	Time 2	Time 3	Time 2	Time 3	Time 2	Time 3
Couples						
Mean Score	.39*	.21	.34*	.11	.32	.25
faith	.42*	.28	.33	.07	.39*	.41*
concern	.12	.04	.15	.06	.06	.01
dependability	.29	.26	.15	.07	.33	.32
responsiveness	.29	.20	.31	.14	.31	.20
conflict resolution	.28	.07	.32	.09	.17	.03
Females						
Total Score	.25	.13	.23	.04	.20	.18
faith	.38*	.33	.30	.10	.34	.45*
concern	-.01	-.04	.01	-.08	-.01	.01
dependability	.22	.06	.20	-.03	.19	.13
responsiveness	.23	.13	.22	.11	.17	.12
conflict resolution	.09	-.01	.13	-.01	.03	-.01
Males						
Total Score	.41*	.23	.35*	.15	.35*	.25
faith	.35*	.18	.27	.02	.33	.27
concern	.18	.10	.22	.17	.11	.01
dependability	.20	.32	.02	.14	.30	.42*
responsiveness	.42*	.19	.38*	.13	.33	.21
conflict resolution	.16	.15	.08	.09	.21	.19

Note: Time 2 = posttreatment Miller Intimacy score, Time 3 = follow-up Miller Intimacy score,

* $p < .05$

Table C-30

Summary of Multiple Regression of Trust on Couples Posttreatment Intimacy Level

Variables	cmiller2(DV)	B	β	R square change (incremental)
cmiller1	.60*	.507	.602	.36**
ctrust	.39*	-.017	-.033	.00
cfaith	.42*	.238	.361	.01
ffaith	.38*	.286	.145	.02
mtrust	.41*	.005	.013	.00
mfaith	.35*	.054	.033	.00
mresponse	.42*	.005	.005	.00

Note: cmiller1 = couples' mean pretreatment Miller Intimacy score, cmiller2 = couples' mean posttreatment Miller Intimacy score, ctrust = couples' mean trust score, cfaith = couples' mean faith score, ffaith = females' level of faith score, mtrust = males' trust score, mfaith = males' level of faith score, mresponse = males' perception of partner responsiveness score

Separate Regression analyses were conducted for each variable

* $p < .05$, ** $p < .05/6 = .008$

Table C-31

Multiple Regression of Trust on Females' Posttreatment Intimacy Level

Variables	fmiller2(DV)	B	β	R square change (incremental)
fmiller1	.36*	.296	.359	.13*
ctrust	.34*	.106	.183	.02
mtrust	.35*	.101	.219	.03
mresponse	.38*	.368	.279	.06

Note: fmiller1 = females' pretreatment Miller Intimacy score, fmiller2 = females' posttreatment Miller Intimacy score, ctrust = couples' mean trust score, mtrust = males' trust score, mresponse = males' perception of partner responsiveness score

Separate Regression analyses were conducted for each variable

* $p < .05$, ** $p < .05/3 = .016$

Table C-32

Multiple Regression of Trust on Males' Posttreatment Intimacy Level

Variables	mmiller2 (DV)	B	β	R square change (incremental)
mmiller1	.60*	.465	.602	.36**
cfaith	.39*	.545	.213	.04
mtrust	.35*	.015	.029	.00

Note: mmiller1 = males' pretreatment Miller Intimacy score, mmiller2 = males' posttreatment Miller Intimacy score, cfaith = couples' mean level of faith score, mtrust = males' trust score,

Separate Regression analyses were conducted for each variable

* $p < .05$, ** $p < .05/2 = .025$

Table C-33

Multiple Regression of Trust on Males' Follow-up Intimacy Level

Variables	mmiller3 (DV)	B	β	R square change (incremental)
mmiller1	.51*	.516	.510	.26**
ffaith	.45*	1.180	.368	.13**
mdepend	.42*	1.107	.346	.12
cfaith	.41*	.909	.270	.06

Note: mmiller1 = males' pretreatment Miller Intimacy score, mmiller3 = males' follow-up Miller Intimacy score, ffaith = females' level of faith, mdepend = males' perception of partner dependability, cfaith = couples' mean level of faith score,

Separate Regression analyses were conducted for each variable

* $p < .05$, ** $p < .05/3 = .016$