A COMMUNICATION SKILLS TRAINING COMPONENT IN AN
EMOTIONALLY FOCUSED COUPLES THERAPY

by

PAUL S. JAMES

B.A., McMaster University, 1975
M.Div., Vancouver School of Theology, 1982
M.A., The University of British Columbia, 1984

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Department of Counselling-Psychology

The University of British Columbia
Vancouver, Canada

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ABSTRACT

The purpose of this constructive outcome study was two-fold: first, to investigate the effectiveness of two treatments, an Emotionally Focused couples therapy (EFT) and an Emotionally Focused therapy plus a communication skills training component (EFT+CT), compared to a wait-list control group; second, to investigate whether or not the addition of a communication skills training component (CT) would enhance the effectiveness of an Emotionally Focused couples therapy (EFT).

Forty-two moderately distressed volunteer couples were assigned randomly to one of two treatment conditions or to a wait-list control group. Couples in the EFT condition received 12 one-hour sessions; couples in the EFT+CT condition received eight hours of EFT and four hours of CT. Treatments were administered by 14 therapists, seven of whom were nested in each condition by random assignment. Ratings of therapists' interventions confirmed the treatment integrity of EFT in both treatment conditions and the treatment integrity of the CT component in the EFT+CT condition. Tests of equivalence showed that both treatment conditions were equivalent on pre-test levels of the dependent variables, demographic variables, therapist characteristics, and the quality of couples' working alliance with their therapists.

The first hypothesis was supported for certain outcomes but not for all. Both treatments achieved superior gains at post-test compared to the wait-list control group on a global measure of marital adjustment and a measure of target complaint improvement. The EFT+CT group also achieved superior gains at post-test on a measure of communication compared to the wait-list control. Although there were trends toward both treatments achieving superior gains on
measures of intimacy and passionate love at post-test compared to the wait-list control, these measures failed to reach significance.

Results indicated that the second hypothesis was not supported. There were no significant differences between EFT and EFT+CT at the post-test or four-month follow-up on a summary measure of marital adjustment or its four components (i.e., consensus, affectional expression, cohesion, satisfaction), nor on measures of communication, intimacy, and passionate love. The only significant difference was that the EFT condition maintained its gains in target complaint improvement at the four-month follow-up more effectively than the EFT+CT condition did.
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CHAPTER 1: INTRODUCTION

BACKGROUND OF THE PROBLEM

Marital distress is a widespread phenomenon in our society. One indicator of the prevalence of marital distress is the incidence of divorce. In Canada and the United States, one marriage in three currently ends in divorce (Adams & Nagnur, 1981; U.S. Bureau of the Census, 1976).

Another indicator of the prevalence of marital distress is the frequency with which people seek professional help for marital problems. On the basis of a nationwide survey, Gurin, Veroff, and Feld (1960) report that marital difficulties were the most frequently cited reason for consulting a mental health professional. It appears likely that many individuals who seek help for individual complaints and who are treated in an individual psychotherapeutic context experience marital distress. Sager, Gundlach, Kremer, Levy, and Royce (1968) surveyed clients in individual psychotherapy who had entered therapy because of individual complaints. These authors report that serious marital problems were later uncovered during the course of therapy among 50 percent of the clients, and marriage-related difficulties among another 25 percent.

Reviews of correlational studies relating marital status to well-being indicate that there is a positive association between marital status and the three main areas of well-being: physical health and mortality, mental health, and life satisfaction (Fehr & Perlman, 1985; Segraves, 1982). In other words, people who are married have better physical and emotional health, live longer, and are more satisfied with life than are people who are separated or divorced.
In reviewing studies relating marital distress to the well-being of adults and children, Segraves (1982) concludes that there is a negative association between marital distress and the well-being of adults and children. It would appear that the more distressed the marriage is, the poorer is the psychological-emotional well-being of spouses and children (e.g., Bradburn, 1969; Oltman, Broderick, & O'Leary, 1977).

There is some evidence that marital adjustment is more highly associated with well-being than marital status. Renne (1971) found that the unhappily married appeared to be in worse physical and psychological health than the divorced, and that in many ways the divorced population seemed to be better off than the unhappily marrieds. This study suggests that it is the quality of marriage rather than marital status that is most highly associated with well-being. Although neither the study by Renne, nor the studies reviewed by Segraves (1982) and Fehr and Perlman (1985), establish cause and effect relationships, these investigations do offer suggestive evidence that marriage, and in particular, healthy marriage, are correlated with personal well-being.

Given the prevalence of marital distress, and the suggestive evidence that healthy marriage is related positively to personal well-being, it is no accident that the field of marital therapy has grown rapidly in the last decade (L'Abate & McHenry, 1983; Gurman, Kniskern, & Pinsof, 1986). Gurman et al. indicate that, particularly in the last decade, the impact of marital/family therapy on the professional mental health scene has been "astounding by almost any criterion" (p. 566).

As a result of this growth, Gurman et al. (1986) assert that reviews of
marital therapy studies "have now established convincingly that, in general, the practice of marital therapy leads to positive outcomes" (p. 570). This conclusion pertains to both the behavioral and nonbehavioral traditions of marital therapy research. Behavioral marital therapy (BMT) has been defined generally as the application of social learning and behavior exchange principles to the treatment of marital problems (Jacobson & Margolin, 1979). Hahlweg and Markman’s (1983) meta-analysis of 17 BMT studies found an average effect size of .92, suggesting that the typical couple receiving BMT improved more than 82 percent of untreated couples or couples receiving nonspecific treatment.

Gurman, Kniskern, and Pinsof (1986) use the category of nonbehavioral marital therapy to describe all the nonbehavioral 'brands' of couples therapy (e.g., experiential, psychodynamic, structural, strategic). Although the number of controlled studies in these approaches is quite limited, these authors conclude on the basis of uncontrolled studies that nonbehavioral marital therapies produce beneficial outcomes in about two-thirds of cases, and that their effects are superior to no treatment.

THE PROBLEM

The Emotionally Focused couples therapy (EFT) is a recently developed treatment package that emphasizes the role of affect and intrapsychic experience in an interactional context (Greenberg & Johnson, 1986a, 1986b). The broad goals of this integrated experiential-systemic approach are to increase the level of satisfaction and intimacy in couple relationships.

The EFT treatment package has been validated empirically by three,
outcome studies. Johnson and Greenberg (1985a) provided initial evidence of its effectiveness in a comparative outcome study contrasting EFT with Jacobson and Margolin's (1979) Cognitive-Behavioral marital therapy (CBMT) and a wait-list control. Both treatment groups made significant gains over untreated controls on measures of marital adjustment, goal attainment, intimacy levels, and target complaint reduction. EFT was superior to CBMT at post-treatment on marital adjustment, intimacy, and target complaint level, and on marital adjustment at ten week follow-up. Because CBMT has enough empirical support to be considered a standard, already established treatment (Jacobson, 1985), this differential outcome study demonstrated EFT to be an effective treatment.

Johnson and Greenberg (1985b) provided a partial replication of their original study (i.e., Johnson and Greenberg, 1985a) by treating the wait-list couples from the original study. Although the overall effect size on the total score of the Dyadic Adjustment Scale (Spanier, 1976) was .935 in the replication study compared to 2.19 in the original study, Johnson and Greenberg (1985b) report significant changes on most of the dependent variables that were used in the original study.

Goldman (1987) replicated Johnson and Greenberg's (1985a) study in a comparative outcome investigation contrasting EFT with an Integrated Systemic (IS) treatment (Greenberg & Goldman, 1984) and a wait-list control. Both treatment groups showed significant gains at post-test over untreated controls on measures of marital adjustment, conflict resolution, goal attainment, and target complaint reduction. There were no differential outcome effects between treatment groups at post-test.
At the four-month follow-up, whereas the IS group had maintained its post-treatment gains, the EFT group had dropped significantly on all measures except conflict resolution. At the one-year follow-up, Rempel (1987) reports that there were no longer significant differences between treatments. The EFT group had improved from the four-month follow-up levels back to levels comparable with its scores at termination.

Although EFT has been demonstrated to be more effective than no treatment, the question of what may be done to enhance its effectiveness remains. This question is all the more relevant in light of Goldman's finding that the EFT treatment did not maintain its post-treatment gains at the four-month follow-up.

A research strategy that asks this type of question is the constructive treatment strategy (Kazdin, 1978, 1980, 1986b). According to Kazdin, this strategy refers to developing a treatment package by adding components that may enhance its effectiveness. Because of the proliferation of therapeutic approaches, Kazdin (1978, 1980) notes that the empirical development of a treatment package is especially refreshing. Although the selection of components in this strategy may proceed atheoretically, ideally the selection of components in the constructive strategy has both a theoretical and an empirical basis (Kazdin, 1978, 1980).

For both theoretical and empirical reasons, couples communication skills training is an intervention that if added to EFT could well enhance the effectiveness of this treatment. Concerning the effectiveness of communication skills training, Gurman and Kniskern (1981) state:
The only treatment ingredients that have received consistently positive empirical support as facilitating the outcome of marital therapies, apparently regardless of the general mode of such therapies ... are those that increase couples communication skills...In fact, at this point, it is defensible to argue that increased communication skills, however they are achieved, are a *sine qua non* of effective marital therapy. (p. 749)

In their review of the effectiveness of controlled behavioral and nonbehavioral studies of communication skills training, Beach and O'Leary (1985) conclude that there is some evidence for the effectiveness of communication skills training, and that communication skills appear to be a reasonable target of intervention.

The widespread use of communication training is supported not only by evidence of its effectiveness in outcome studies, but also by process studies which indicate that distressed couples have deficits in communication skills. Gottman (1979) reports that distressed couples exhibit a variety of dysfunctional communication patterns. Weiss (1980), who has identified skill deficits in pinpointing and providing supportive/understanding communication, suggests that these skill deficits differentiate distressed from nondistressed couples.

The theoretical basis for investigating whether or not the addition of a CT component enhances the effectiveness of EFT, is the consensus in the marital therapy literature that effective communication is vital for healthy relationship functioning (e.g., Guerney, 1977; Jacobson & Holtsworth-Munroe, 1986; Navran, 1967; Satir, 1967; Watzlawick, Bavelas, & Jackson, 1967). As Beach and O'Leary (1985) state, "between marital therapists across many different schools
of therapy, there is a high level of agreement that effective communication is important for well-functioning marriage" (p. 1048).

This consensus concerning the importance of communication in couple relationships is recognized not only by authors in the field, but also by clinicians and distressed couples. Therapists in Geiss and O'Leary's (1981) survey (a) rated communication as the relationship area having the most damaging effect on marital relationships, (b) identified communication as the most important research priority, and (c) reported that the most common complaint of distressed couples is communication. Birchler (1979) indicates that the most frequently identified problem area reported by distressed couples is the lack of communication.

The empirical basis for the consensus that effective communication is vital to well-functioning marriage is primarily the consistent finding that communication correlates positively and significantly with marital satisfaction. For example, Schumm, Anderson, and Griffin (1983) cite 15 studies which report a positive, significant correlation between the Marital Communication Inventory (Bienvenu, 1970), a widely-used self-report measure of marital communication, and various measures of marital adjustment. Jacobson and Moore (1981) indicate that spouse-reported communication is the content category most highly correlated with daily marital satisfaction.

**PURPOSE OF THE STUDY**

The first purpose of this study was to investigate whether or not EFT alone and EFT in combination with the communication training (CT) component were more effective than no treatment. If either or both treatments were found
to be more effective than no treatment, this would lead to the test of the hypothesis of real interest in this study; namely, whether the two treatments differed significantly from each other. If the EFT treatment was more effective than no treatment, this would constitute an additional replication of the EFT treatment package. The second purpose, and the one of greater theoretical interest, was to investigate whether or not the addition of a communication skills training component would enhance the effectiveness of EFT.
CHAPTER II: LITERATURE REVIEW

In this chapter, the theory, treatment steps, and effectiveness of both the Emotionally Focused therapy (EFT) and the Relationship Enhancement (RE) communication skills training program are presented. This is followed by a discussion of the complementarity between EFT and RE, a discussion of certain issues pertaining to EFT and the communication training (CT) component, and a summary of the CT component.

EMOTIONALLY FOCUSED COUPLES THERAPY (EFT)

Description of EFT

The Emotionally Focused couples therapy (EFT) is an integrative experiential-interactional approach to couples therapy developed by Greenberg and Johnson (1986a, 1986b, 1988). From experiential perspectives, EFT borrows its emphasis on present intrapsychic experience, particularly the emotional responses underlying each partner’s stance toward the other; from interactional perspectives, EFT borrows its emphasis on the process of interaction, particularly negative interactional cycles (Greenberg & Johnson, 1986b).

EFT is experiential in that it views partners as active perceivers constantly constructing the meaning of their experience on the basis of their current emotional state. As in experiential therapies in general, the central focus is on clients’ present experience and how clients process their experience (Johnson & Greenberg, 1987). Therapists draw clients’ attention to aspects of their phenomenological world that are on the edge of awareness in order to help
clients identify with and integrate these aspects into their sense of self. In particular, therapists help partners to access and experience emotional responses underlying each partner's position toward the other in such a way as to change these interactional positions (Greenberg & Johnson, 1988).

The EFT approach is interactional in that each partner's response is constantly framed within the context of the other partner's behavior. There is a constant focus on the structure and process of interaction. Therapists assess the degrees of closeness/distance and dominance/submission in the interaction, as well as identify negative interactional cycles (Johnson & Greenberg, 1987). The goal of EFT is also interactional: to change negative interactions such that new, more intimate interactions emerge.

Like other integrative approaches to couples therapy (e.g., Feldman, 1982; Gurman, 1981; Wile, 1981), EFT emphasizes the importance of both the intrapsychic and interactional levels of experience. This focus on both self and context is considered necessary because an exclusive focus on either dimension misses important aspects of marital dysfunction (Greenberg & Johnson, 1988). Focusing on the intrapsychic level alone overlooks that partners are embedded in a social context which is highly influential in determining behavior. Observing the interactional process and its circularity in couples illuminates what is occurring in marital dysfunction. Focusing on the interactional dimension alone overlooks that partners do not just react and interact as a function of their partner's behavior but rather are individuals who have needs, construct personal views of reality, and are centers of agency and action. Observing the intrapsychic process helps to understand the idiosyncratic ways in which partner's contribute to and experience
marital distress. Greenberg and Johnson (1986b) describe the relationship between the intrapsychic and interactional dimensions as follows:

In an integrated experiential-systemic view, organization of both the individual subsystems and the whole, the couple system, can be seen as interdependent and as varying simultaneously and reflexively. For example, when the interaction is organized in a complementary fashion, such as "pursue-distance" or "attack-withdraw", the individuals can be seen as organized so that pursue and attack, or distance and withdrawal, are the dominant aspects of their individual organization. This organization is maintained simultaneously and is supported by both (a) the negative interaction cycle (i.e., couple system functioning), and (b) some individual processes being more dominant in focal awareness (i.e., individual subsystem functioning). (p. 257)

Drawing on the attachment theory of Bowlby (1958) and object relations theorists (e.g., Fairbairn, 1952), EFT conceptualizes the marital relationship in terms of emotional bonds (Greenberg & Johnson, 1988). In this view, the marital relationship represents the primary adult emotional bond and is the social framework for the attainment of adult attachment needs of intimacy/connectedness. An important assumption is that adult attachment needs are legitimate and essential for healthy adult functioning. It is assumed that adults, like children, show the need for easy access to an attachment figure or partner, a desire for closeness to that figure especially in times of stress, and an increase in distress and anxiety when that partner is found to be inaccessible.

Consistent with this conceptualization, EFT conceives of marital distress in
terms of emotional bonds that have become threatened and insecure (Greenberg & Johnson, 1988). In distressed marriages, the emotional bonds have become damaged such that partners are deprived of healthy attachment needs of contact/comfort. Partners experience high levels of alienation, and demonstrate little responsiveness/accessibility to each other.

Distressed marital relationships are characterized by negative interactional cycles such as pursue-distance, attack-attack, and mutually-withdrawn. Although all couples experience one or a combination of these patterns to some extent, in distressed couples whose emotional bonds have been damaged, these cycles are more extreme. Within EFT's conceptualization of marriage as bonds, the excessive behaviors typical of spouses in extreme negative interactional cycles are viewed as misguided but well-intended attempts to reestablish the damaged emotional bond and to satisfy legitimate attachment needs.

In keeping with its conceptualization of marriage, the goal of EFT is to repair or restructure the emotional bond. Drawing on Buber's (1958) notion of an "I-Thou" dialogue, to restructure an emotional bond means to foster a genuine dialogue between partners which is nonexploitative, leads to reciprocal giving and mutual benefit, and produces increased accessibility and responsiveness between partners (Greenberg & Johnson, 1988). Such a relationship is characterized by a mutual interdependence rather than independence.

Given that the goal of EFT is to restructure an emotional bond, EFT is indicated for couples who want to increase the level of intimacy and satisfaction in their relationship. Johnson and Greenberg (1987) describe the indicators and contraindicators of EFT:
Positive indicators of suitability for EFT are presenting problems such as general marital dissatisfaction and alienation, lack of intimacy and power struggles, and interactional patterns such as blame and withdrawal. Contraindications include any condition under which the experience or expression of vulnerability is not likely to be adaptive or respected. Such conditions are found in violent relationships or in situations of emotional divorce, where one partner's agenda for therapy is to facilitate leaving the relationship. (p. 554)

Johnson and Greenberg (1987) also suggest that the existence of some basic trust and the desire to respect the other's vulnerability are prerequisites for a successful outcome.

Therapeutic change is construed as the process of restructuring the emotional bond between partners. Consistent with their integrated view, therapeutic change occurs "both by change in people's view of themselves and by change in their context" (Greenberg & Johnson, 1986b, p. 257). In other words, therapeutic change may occur on either an intrapsychic or interactional level in a reciprocal or simultaneous manner.

A prerequisite of therapeutic change is the formation of a strong working alliance between the therapist and both partners. This alliance involves an agreement between the therapist and both partners as to the goal of therapy and the perceived relevance of the tasks involved in the therapy process (Bordin, 1979). It also involves an appropriate bond between the therapist and each client. This bond is characterized by a sense of safety and trust which is essential in a therapy which focuses on the exploration of emotional experience.
Although in EFT the therapeutic alliance is seen as a prerequisite for therapeutic change, it is not considered to be a mechanism of change in and of itself (Greenberg & Johnson, 1988). Instead, it is thought of as the soil for productive therapy, the condition without which therapy will not "take".

The primary mechanism of change in EFT is therapists helping partners to access and express previously unexpressed feelings that underlie the negative interactional cycle, and reframing the negative interactional cycle in terms of these feelings in order to restructure the relationship bond. Certain emotional responses (called primary emotions) tend to be associated with particular stable interactional positions occupied by distressed partners (Johnson & Greenberg, 1987). For example, blamers typically speak of being isolated, unloved, and deprived; withdrawers, on the other hand, often speak of feeling helpless, unaccepted, and intruded on. These primary emotions, when accessed and experienced by partners in a vivid, experiential manner, have the ability to modify partner’s dysfunctional interactional positions in relation to closeness/distance and dominance/submission, the two main dimensions of couple interaction. The expression of fear or sadness tends to evoke protection and compassion in the other partner, and can result in greater closeness. Anger or disgust produce clear personal and interactional boundaries, and can result in greater appropriate separateness and recognition by the other partner of one’s rights. The ability of primary emotional responses to modify dysfunctional interactional positions is reinforced by the therapist actively reframing the problematic behavior in the cycle (e.g., attacking, withdrawal) in terms of the previously unexpressed underlying emotional experience and actively encouraging new interactions in the light of this reframe. In this way the couple’s emotional
bond is restructured in terms of greater closeness and new interactions.

To illustrate the primary mechanism of change in EFT, take the example of a woman who characteristically pursues her husband by blaming and criticizing him because she has legitimate needs for love/support that are unmet in the relationship. If this woman becomes aware in a live, experiential manner that underneath her attacking behavior she feels unloved and afraid of abandonment, and if the therapist reframes this behavior in terms of her legitimate needs for love/reassurance, the woman may perceive herself differently (e.g., as having legitimate needs rather than being an immature person), and may be perceived differently by the spouse as well (e.g., as needing love/reassurance rather than as hostile).

These changes in perception may lead to new interactional patterns, and these new patterns may produce new perceptions in a reciprocally determined manner. Continuing the above mentioned example, the woman's new self-perception may prompt her to ask her husband for love and reassurance (this constitutes a new interactional pattern), and the woman's asking for what she needs may lead her husband to see her as more assertive (this constitutes a new perception of the partner).

Greenberg and Johnson's (1986b) primary mechanism of therapeutic change is predicated on three important conditions. The first condition is that the feelings that are accessed and expressed must be a particular category of emotions. Following Greenberg and Safran (1984, 1987), Greenberg and Johnson (1986a) contend that it is important to differentiate clinically three categories of emotion, because not all emotions are useful in the creation of therapeutic change. These
categories are primary, secondary, and instrumental emotions.

Primary emotions are biologically adaptive feelings which are experienced in response to specific situations. For example, the primary feeling of fear is expressed in response to a situation of threat; it is biologically adaptive because it prepares people to protect themselves. There are actional tendencies inherent in primary emotions. Primary emotions are best thought of as dispositions to act (Greenberg & Johnson, 1988). Emotion is an action tendency in the world, not just an internal state. Primary emotions function essentially as action dispositions which organize people to cope effectively with the environment.

Primary emotions are useful in therapeutic change because of their ability to modify self-organization. EFT views an individual's current self-organization to be a function of those aspects of experience that are in immediate focal awareness (Greenberg & Johnson, 1988). At any time, there is a particular self-organization which dominates while other self-organizations are not in focal awareness. For example, at one point an individual may be organized as "vulnerable" and at another time as "assertive". If in therapy a partner who is typically organized as "placating" accesses primary anger, in that moment this partner becomes organized as "assertive". Because there are actional tendencies inherent in primary emotion (Greenberg & Safran, 1987), this new self-organization may have important implications for the relationship. Continuing this example, the partner who has become organized in the moment as assertive may set clear personal boundaries or demand to be treated differently. As Greenberg and Johnson note, "The self-organizing function of emotional action tendencies is crucial in couples therapy, in that what partners feel, strongly
influences what they do, how they act, and how they perceive their spouse" (1988).

Primary emotions are also useful in therapeutic change because of their ability to modify perceptions and interactions. When a partner becomes aware of a previously unacknowledged primary feeling, this experience may change both self-perceptions and interpersonal perceptions (e.g., a husband’s experience of a previously unacknowledged primary fear of engulfment may lead him to see himself as having a particular sensitivity concerning intimacy rather than as incapable of intimacy, and for his wife to perceive him as wanting intimacy but afraid). These changes in perception may lead to new interactional patterns, and these new patterns may produce new perceptions in a reciprocally determined manner. Continuing the previous example, the husband’s new self-perception may prompt him to make further intimacy producing self-disclosures to his wife (this constitutes a new interactional pattern), and the husband’s new behaviors may lead his wife to see him as desirous of intimacy (this constitutes a new perception of the partner).

Secondary emotions are learned dysfunctional emotional responses that are disruptive to therapeutic change. These emotions are secondary because they are reactions to more primary appraisals and underlying emotional responses:

Feelings of despondency or anger, for example, are often the end product of a complex chain of feeling and thinking. Focusing on the end product of the chain only serves to amplify or to entrench the dysfunctional affective reaction. The therapist must see these end-product feelings as reactive rather than primary affect; they may
be responded to for the purposes of maintaining rapport, but then should be by-passed or investigated in order to work with underlying precipitating factors. (Greenberg & Safran, 1987, p. 176).

Greenberg and Safran (1987) have identified a third category of emotion, instrumental emotion, which refers to feelings that "generate some form of secondary gain either in terms of interpersonal benefits or in providing a feeling of personal security" (p. 179). These feeling behaviors are characteristic ways in which clients react in order to control situations or manipulate the environment (e.g., feeling helpless in order to get attention or sympathy). As such, instrumental emotions are disruptive to therapeutic change. Therapists must interpret or confront instrumental emotions in order that clients become aware of the function of these feeling behaviors.

Because only primary emotion leads to therapeutic change, it is important that therapists make a clinical judgement as to whether a particular feeling is primary, secondary, or instrumental (Greenberg and Safran, 1987). This is a difficult task because a particular emotion may belong to any one of the three categories of emotion. For example, anger can be a primary affective response to being violated, or a secondary reaction to underlying hurt or fear, or an instrumental response used in order to control and manipulate others. As Greenberg and Safran note, the clinical assessment of emotion is made on the basis of clinical intuition. Clinical intuition involves observing and discriminating among a large number of indicators (e.g., voice, gesture, use of words, the context of the immediate discussion), and is acquired by means of apprenticeship.

The second condition upon which Greenberg and Johnson's (1986b) primary
mechanism of therapeutic change is predicated is that primary feelings must be experienced in a live manner. Although therapists' interpretations of primary emotions may function as an advance organizer to clients' experiencing these feelings, this is no substitute for clients actually experiencing their primary feelings in a live manner. Greenberg and Johnson (1986b) state this view:

For example, if a therapist interprets to a client that he or she feels hurt, and the client agrees but does not experience the hurt, no lasting change will take place. Even if the client conceptually believes that he or she feels hurt, and the partner thinks that he or she should feel more compassionate (i.e., they both attribute a different meaning to the situation), the degree of conviction to this belief is greatly enhanced by the actual experience and expression of both the hurt and the compassion. (p. 273)

The third condition upon which the primary mechanism of therapeutic change is predicated is that the new experience in one partner must lead to an expression of a need to the other and evoke a new acceptance, a new response, from the other. In other words, the new expression of emotion in itself is not enough to create change in relationship patterns (Greenberg & Johnson, 1988). The therapist must facilitate actively the expression of the felt-needs associated with primary emotion, and evoke a new response from the observing partner. Evoking such a response requires that the therapist be continuously making a process diagnosis to determine if the context is safe enough to evoke emotional responses such as vulnerability. If one spouse cannot accept the other's needs and respond in a positive manner, then this partner's blocks to responding are
explored. This third condition is reflective of the emphasis in EFT on creating change in relationship structure. As Johnson and Greenberg (1987) note, the goal in EFT is not the experience of emotion in itself, but the evocation and experience of primary emotion in order to change relationship structure.

Because it is primary, underlying feelings which, when experienced in a live manner, lead to therapeutic change, emotionally focused therapists need to be skilled in working with emotion. One therapist skill, as mentioned previously, is the ability to distinguish primary feelings from secondary or instrumental feelings. Another therapist skill is the ability to help partners bring primary, underlying feelings into awareness and to heighten these feelings. To this end, therapists are trained in such techniques as advanced accurate empathy, focusing clients' attention inward, drawing attention to and heightening nonverbal behaviors, and evocative responding (see the EFT treatment manual in Appendix A for a description of evocative responding).

In addition to these skills, in order to work effectively with primary feelings, emotionally focused therapists must feel comfortable with the expression and exploration of emotional experience. As Greenberg and Johnson (1986b) note, therapists "need to have sufficient experience in working with emotions to be able to promote the process of experiencing and expressing emotion so that they are carried through to completion rather than impeded by defences or anxiety" (p. 271).

The model of emotion which underlies EFT is a constructionist information-processing model (Johnson & Greenberg, 1987). Following Greenberg and Safran (1984, 1986), emotion is viewed as a construction from a number of
different information processing components rather than as an inference from behavior and the situation as proposed by earlier cognitive models of emotion (e.g., Schacter & Singer, 1962). In this view, experienced emotion results from the preattentive synthesis of three components: expressive motor information (i.e., elaborations of responses that were biologically in-wired in the neonate), implicit emotional schemas (i.e., representatives of representations of prior emotional experience which contain stored subjective reactions, stimulus features and physiological responses to earlier situations), and conceptual cognition (i.e., conscious and volitional processing of concrete experience). These components are all aspects of a person's current experience (much of which is out of awareness), and are continually being integrated to form conscious emotional experience. In this model, cognition and emotion are viewed as being complexly intertwined or fused rather than linearly related. Although conscious "thinking" and conscious "feeling" may be distinguished experientially, both feeling and thinking are deemed to involve cognitive and affective processes operating at an automatic level out of awareness (Greenberg & Johnson, 1988).

The constructionist information-processing model also assumes a network analysis of emotion. This means that the subsidiary components of the model are conceptualized as forming a network. Activating any one of the components of the network evokes the other parts of the network: "Thus the evocation in therapy of particular thoughts, meanings, memories or expressive motor reactions can be seen as having a priming effect on the other components and the whole network" (Greenberg & Johnson, 1988). Emotion is evoked in therapy by attending to and heightening available components using experiential techniques. That emotion is evoked in this manner indicates a consistency between the
techniques used to work with emotional experience in EFT and the model of emotion underlying EFT.

**Treatment steps**

The Emotionally Focused therapy has nine treatment steps, which will be presented in summary form (for a complete description, see the EFT manual in Appendix A). Although these steps are described in a linear sequence, earlier steps are returned to as required throughout the therapy. The steps are:

1. Define issues as presented.

   In this initial step, the therapist delineates conflict issues and describes attempted solutions. Each partner's perception of the relationship issues is explored and validated. This serves to establish a positive therapeutic alliance with each partner. The therapist begins to identify themes, such as control and separateness-connectedness, which are often the core issues in marital conflicts.

2. Identify negative interaction cycles.

   Once the therapist is clear about how each partner perceives relationship issues, the therapist identifies the negative interaction cycle or "dance" that the couple uses in relation to its issues. A pursue-distance cycle appears to be the most basic and frequently occurring interactional cycle in distressed couples. The therapist identifies this as the core negative cycle.

3. Access and accept unacknowledged feelings underlying problematic interactions.
Having identified the core interactional cycle, the therapist focuses upon accessing and validating the unacknowledged feelings that underlie the partners’ interactional positions in the problematic cycle. The therapist does this by attending to partners’ emotional responses at the periphery of awareness (e.g., vulnerabilities, fears, and unexpressed resentments). The therapist uses various techniques drawn from gestalt therapy and client centered therapy to facilitate this emotional experiencing.

4. The reframing of the problem.

The therapist reframes the problem behaviors of the partners in the negative interactional cycle in terms of the newly synthesized underlying emotional experiences, and relates their behaviors to legitimate unmet needs. The experience of strong and significant emotion, and the reframing of the interactional cycle in terms of this emotion, are powerful modifiers of the perceived meaning of behaviors in the cycle for both the experiencing and observing spouse.

5. Identifying with disowned feelings and needs.

Having redefined the interactional cycle in terms of underlying emotional experience and needs, the therapist asks the partners to identify with disowned aspects of their individual experience, and to deliberately engage in some of the behaviors associated with their previously disowned feelings and needs. This is an intrapsychically oriented intervention focusing on enacting disowned parts. Its rationale is to heighten partners’ awareness of their underlying needs and to gain some control of previously automatic behaviors in their cycle.
6. Acceptance of the partner’s experience.

In this step, the focus is on facilitating each partner’s acceptance of the other’s new emotional experiences. Such acceptance is in contrast to the usual pattern of reciprocal disqualification which occurs in distressed relationships. The therapist explores blocks to one partner’s ability to hear and accept the other’s experience, and interprets them in terms of that partner’s view of self, past learning in his or her family of origin, and catastrophic fears.

7. Facilitating the expression of needs and wants.

Given the mutual acceptance of each other’s underlying feelings, the therapist facilitates the partners’ disclosure of the needs and wants associated with these feelings, and helps them to examine the implications of their needs and wants as individuals.

8. The emergence of new solutions.

The increased clarity of the statement of the partners’ needs creates a context for new alternative responses or positions in the interactional cycle. These new alternatives constitute new solutions to the couple’s negative interactional cycle.

9. The consolidation of new positions.

The therapist helps the couple to consolidate their new position within a changed interactional cycle by encouraging them to metacommunicate about their relationship from a shared perspective in which both seek to fight to "draw" rather than to win.
Effectiveness of EFT

To date there have been three outcome studies evaluating EFT. The first controlled outcome study (Johnson & Greenberg, 1985a) compared the relative effectiveness of EFT and Jacobson and Margolin's (1979) Cognitive-Behavioral marital therapy (CBMT) approach. Forty-five moderately distressed couples were assigned randomly to one of these two treatments or to a wait-list control group. Eight sessions of each treatment were implemented by six experienced therapists who were nested within treatments. Both treatments made significant gains over a wait-list control group on the Dyadic Adjustment Scale (DAS) (Spanier, 1976), the Personal Assessment of Intimacy in Relationships Inventory (PAIR) (Schaefer & Olson, 1981), Goal Attainment Scaling (GAS) (Kiresuk & Sherman, 1968), and Target Complaints (TC) (Battle et al., 1966). Differential outcome effects for the two treatments were found. The EFT group means were significantly higher on the total DAS score, on the Satisfaction and the Cohesion components of this score, on Intellectual Intimacy and Conventionality, and on target complaint improvement. At two month follow-up, the first three measures just mentioned continued to differentiate between groups. Because CBMT has enough empirical support to be considered a standard, already established treatment (Jacobson, 1985), this differential outcome study demonstrated EFT to be an effective treatment.

In the second study, Johnson and Greenberg (1985b) provided a partial replication using a within-subjects design. Wait-list couples from the original study (i.e., Johnson & Greenberg, 1985a) served as their own controls during an eight-week waiting period, and then were given treatment by novice therapists.
Significant differences were not found between pre-assessment and post-wait means on any of the outcome measures. However, significant differences were found between post-wait and post-treatment means on all measures (i.e., total DAS, TC, GAS, and two subscales of the PAIR). Although there was a smaller effect size in this study than in the first study, this partial replication does indicate that EFT can produce significant changes in the quality of marital relationships when implemented by novice therapists.

In the third outcome study, Goldman (1988) provided a controlled replication of Johnson and Greenberg’s (1985a) study by comparing EFT to an Integrated Systemic (IS) treatment (Greenberg & Goldman, 1984) and a wait-list control. In this study, 42 couples were assigned randomly to EFT, to the IS treatment or to a wait-list control. The couples in this study were somewhat more distressed than the couples in the first study, with a mean total DAS score of 84.2 versus a score of 92.4. Ten sessions of each treatment were implemented by seven experienced therapists who were nested within treatments.

At termination, both treatment groups showed significant gains over wait-list controls on the Dyadic Adjustment Scale (DAS) (Spanier, 1976), the Conflict Resolution Scale (CRS) (Fournier, Olson, and Druckman, 1983), Goal Attainment Scaling (GAS) (Kiresuk & Sherman, 1968), and Target Complaints (TC) (Battle et al., 1966). There were no differential outcome effects between treatment groups.

At the four month follow-up, a significant interaction effect indicated that the EFT group had dropped significantly on three of the four measures (i.e., DAS, TC, GAS) between termination and the four-month follow-up, whereas the
IS group had remained stable over this period. Rempel (1987), who conducted a one-year follow-up of Goldman’s (1987) study, reports that at this follow-up the two groups were again indistinguishable. The EFT group had improved from four-month follow-up levels back to levels comparable with its scores at termination.

**RELATIONSHIP ENHANCEMENT (RE) COMMUNICATION SKILL TRAINING**

**Background**

Couples communication training is part of an emerging new phenomenon in the mental health field, namely, the psychological skills training movement (Larson, 1984; Goldstein, 1981). This movement began to emerge in the early 1970s in response to the public’s increasing interest in and demand for psychological knowledge, and in response to the recognition in the mental health field that traditional strategies were insufficient to meet the demands for psychological services (Larson, 1984). Drawing adherents from a wide range of theoretical orientations (e.g., behavioral to humanistic), this movement has the common goal of giving psychology away to both helpers and clients by converting psychological principles into teachable skills, and disseminating these skills by means of systematic methods and programs. When the target population of skills training interventions is clients, the goal may be either remedial or preventive. The dominant emphasis is on prevention.

According to Larson (1984), the basic ingredients of the skills training
movement are skills, methods, and programs. Skills are the competencies that are necessary for effective living. Skills may be categorized as either interpersonal (i.e., communication skills) or as psychosocial (i.e., basic life skills). The teaching/learning methods derive from both education and psychology. From the field of education come programmed texts, structured discussion, simulation and gaming; from the field of psychology come methods based on social learning theory such as modeling, behavioral rehearsal, and feedback. Skills training programs tend to be systematic and highly structured.

Because the skills training movement emerged in the early 1970s, it is not surprising that communication skills training programs were developed for couples. As Navran (1967) writes, "common sense observation, newspaper reports, the work of novelists and playwrights, the statements of individuals receiving psychotherapy and research findings all converge to emphasize the positive relationship between communication and a good marital relationship" (p. 173).

Two distinct traditions of couples communication skills training emerged, the nonbehavioral and the behavioral (Beach and O'Leary, 1985). The nonbehavioral tradition is heavily influenced by Rogerian ideas and emphasizes the role of affect in the teaching of listening and empathic responding skills. In contrast, according to Baucom and Hoffman (1986), the communication skills taught typically in behavioral marital therapy have been oriented toward assisting the partners to become more efficient problem solvers.

It appears that a convergence between the nonbehavioral and the behavioral traditions of communication skills training is occurring. N. S. Jacobson (Jacobson & Holtzworth-Munroe, 1986), one of the leading proponents of the
behavioral tradition, indicates that whereas historically he and his colleagues taught listening and expressing skills as preludes to problem solving, now they are focusing on these skills as important targets for change in their own right. Their approach is now to help couples acquire a mastery of basic listening and expressive skills before teaching problem-solving skills. B. G. Guerney (Guerney, Brock, & Coufal, 1986), one of the leading representatives of the nonbehavioral tradition, has increasingly expanded the number of communication training skills that he teaches to include skills that focus on implementing cognitive and behavioral change. For example, in his most recent article (Guerney et al., 1986), Guerney has added three new skills, two of which focus on initiating cognitive and behavioral change (called the skill of self-change and the skill of helping others change).

The convergence between the two communication skills training traditions is an interesting development in the field. However, because an Emotionally Focused therapy (EFT) stands within the nonbehavioral tradition, this review will focus on couples communication skills training approaches within the nonbehavioral tradition.

In the nonbehavioral couples communication skills training tradition, there are three main approaches that have received some systematic evaluation: The Minnesota Couples Communication Program (MCCP) (Miller, Nunnally, & Wackman, 1976), communication training programs that are based on Carkhuff's (1971) model of interpersonal skills training (e.g., Pierce, 1973; Wells, Figurel, & McNamee, 1975), and Relationship Enhancement (RE) (Guerney, 1977).

Of these three approaches, RE has received the most empirical validation. N. S. Jacobson (Jacobson & Holtzworth-Munroe, 1986), one of the leading
authorities in the field of marital therapy research, states that RE is the only other model of marital therapy besides cognitive-behavioral marital therapy (CBMT) that has documented its effectiveness in a series of controlled outcome studies including independent replications.

In his review of marital enrichment programs, Chartier (1986) concludes that RE and MCCP are the two most effective approaches to couples communication skills training, and that RE is more effective than MCCP. The superiority of RE over MCCP is based primarily on two sources. In their meta-analysis of outcome studies of marital enrichment programs, Giblin, Sprenkle, and Sheehan (1985) report that RE studies have an average effect size of .96 compared to an average effect size of .42 for MCCP. An outcome investigation by Brock and Joanning (1983), which directly compares MCCP and RE, reports results that are consistent with this meta-analysis (the Brock and Joanning study will be reviewed in the section treating the effectiveness of RE).

Because the purpose of most interest in this investigation was to test whether or not the addition of a communication skills training (CT) component would enhance the effectiveness of EFT, it made sense to construct the CT component in this study in part from RE, which appears to be the most effective nonbehavioral approach to couples communication skills training currently available (Chartier, 1986). The more effective the approach from which in part the CT component was constructed, the more likely that this component would enhance EFT.
Description of RE

RE is a communication skills training approach developed by B. Guerney (1977), which seeks to foster personal and interpersonal growth. RE assumes that the basic problem underlying personal maladjustment and relationship conflict is the lack of understanding of self and other. Its goal is to overcome this lack of understanding by building empathic relationships through the teaching of specific communication skills.

Guerney, Brock, and Coufal (1986) consider that RE is best described as an integrated approach, in which components from four major psychotherapeutic traditions have been "selected as fitting very well with one another, indeed, building on one another, instead of merely being an eclectic hodgepodge" (p. 154). These orientations are the humanistic, the interpersonal, the behavioral, and the psychodynamic.

From the humanistic tradition, Guerney et al. (1986) draw exclusively on the Rogerian approach (Rogers, 1951). More specifically, RE borrows the construct of the self-concept, and the construct of the defence system operating to protect the self-concept. RE also borrows the Rogerian therapeutic attitudes of empathy, acceptance, respect, and understanding, incorporating these attitudes into one of the central skills (i.e., empathic responding) taught to clients in RE therapy.

From the interpersonal tradition of H. Sullivan (1953), but particularly the elaboration of Sullivanian theory by T. Leary (1957), RE borrows the notion that individuals elicit interpersonal responses (largely on an unconscious level) that are reciprocal in nature. It trains individuals in the behavioral skills necessary to
emit the interpersonal behaviors necessary to further their conscious goals so as to replace the automatic, anxiety-reducing reactions that would otherwise determine their interactions (Guerney et al., 1986).

From the behavioral tradition, RE draws on the social learning principles of Bandura (1977) and the operant reinforcement principles of Skinner (1971) for the techniques of modeling and reinforcement respectively that are used to facilitate the acquisition of communication skills (Guerney et al., 1986). These techniques are practiced liberally by therapists as they teach RE skills.

From the psychodynamic tradition (the Freudians in particular), RE draws a number of constructs: the importance of the unconscious, the power of defense mechanisms, the value of self-understanding (insight), and the positive power of catharsis (Guerney et al., 1986). The guidelines of the second central communication skill in the RE approach (i.e., the Expressive skill) were designed to incorporate these important constructs.

As a communication skills training approach, RE assumes an educational rather than a medical/clinical model of psychotherapy (Guerney, 1977). This means that it views clients' interpersonal problems as learning deficits rather than as illnesses, and perceives clients as capable of directing their own learning rather than passively receiving treatment. This also means that RE views therapists as educators or teachers.

According to Guerney (1977), the RE approach has broad applicability. It is applicable to a variety of helper and client populations. Client populations include not only adults, but also adults with children and/or adolescents. RE
programs are available in different modalities (i.e., individual, one-couple conjoint, and conjoint group), and are offered in a wide variety of settings (e.g., educational institutions, hospitals, and industry).

RE is designed to serve remedial and/or preventative functions. Because the acquisition of communication skills gives people the skills with which to build stronger relationships and to resolve future problems, the primary goal of RE is prevention (Guerney, 1977).

In his major work on RE, *Relationship Enhancement* (Guerney, 1977), Guerney describes four communication skills (also called modes): (1) the expressive skill, (2) the empathic responding skill, (3) the skill of mode switching, and (4) the skill of facilitation. Of these four skills, only the expressive and responding skills are communication skills per se. The other two skills enable couples to use the expressive and responding communication skills effectively. The skill of mode switching instructs clients how to alternate effectively between the two basic communication skills; the skill of facilitation teaches clients how to correct others’ violations of the expressive and responding communication skills.

In his later writings, Guerney expands the number of skills that are taught in RE. In an article published in 1984, Guerney adds two skills that are implicit in *Relationship Enhancement*: interpersonal conflict/problem resolution and generalization/maintenance. The former provides direction to people in the specific task of problem solving; the latter advises people how to ensure that their communication skills become a permanent part of their behavioral repertoire.

In his most recent article concerning RE (Guerney et al., 1986), Guerney
adds three more skills, bringing to nine the number of skills which he believes are necessary and sufficient in order for RE to be effective. Two of these skills (i.e., self-change and helping others change), are intended to complement the interpersonal conflict/problem resolution skill by teaching clients how to implement successfully agreements reached through problem solving. The third skill results from the division of generalization/maintenance into two separate skills.

The description of RE will be limited to a discussion of RE's two communication skills (i.e., expression and empathic responding) and mode switching. The rationale for limiting the discussion in this way is two-fold: first, the communication skills and mode switching lie at the heart of RE; second, it is impractical to fit additional RE skills into a four-session CT component.

According to Guerney et al. (1986), the purpose of the expressive skill is to equip partners (a) to understand their emotional-psychological-interpersonal wants and needs better; (b) to express such wants and needs to each other in ways that do not incite unnecessary anxiety, defensiveness, conflict and hostility, but instead tend to engender respect, understanding, and cooperation; and (c) to deal with conflicts and problems with less anxiety, promptly, assertively, positively, and in terms of their own specific goals and needs.

As delineated in Guerney (1977, 1984), the six subskills or guidelines of the expressive skill are:

1. Before you express your own point of view, show understanding--try to let the other person see that you appreciate his or her feelings, views, and
circumstances.

This subskill directs partners who are about to assume the expresser mode to convey empathy for their partners' viewpoint before expressing their own feelings and/or interpersonal messages. The rationale of this subskill is that it "pulls" an understanding response from partners.

2. Be the world's leading authority on everything you say.

This subskill directs partners to state their views in a way that acknowledges the subjectivity of their perceptions and judgements. That is, whenever partners are discussing a significant topic and there is even the remotest possibility that the other partner might disagree with their views, they are to state their views subjectively (e.g., "I think," "I believe," "In my view," "It seems to me"), rather than presenting them as objective, factual, morally valid, or normatively correct. The rationale of this subskill is that stating one's views in subjective terms reduces argumentativeness and allows the partner to respond to one's position as such. It also allows one's partner to respond to one's needs rather than to his or her own perceptions of reality.

3. State your past, present, or anticipated feelings if they are important to the issue.

This subskill directs partners to bring to awareness and to express the feelings that they have about relationship issues. The rationale of this
subskill is that by expressing one's feelings the other partner has more information to respond to, which increases the probability that the other's response will be more understanding and compassionate.

4. Be specific.

This subskill directs partners to describe the particular events and behaviors that cause them to think and feel as they do. The rationale of this subskill is that specifying observable, concrete behaviors and pinpointing time, place, and circumstances, minimizes overgeneralizing (e.g., "You always," "You never"). Overgeneralizing makes it difficult for one's partner not to react defensively. This is particularly the case with overgeneralizations about the other partner's motives and character (e.g., "You don't care about me," "You're lazy"). Because being specific presents evidence in a way that helps one's partner to see how one arrived at one's position, it also increases understanding and facilitates problem solving.

5. When you want another to change his or her views or behaviors, at the earliest feasible time state your positive assumptions, attitudes, expectations, and feelings about the other that are related to the issue.

This subskill directs partners to bring to awareness and state their implicit positive attitudes or feelings (e.g., affection) toward their partners. These are often more basic than, and may even have given rise to, negative feelings (e.g., anger, because of feeling neglected). That partners request change from each other implies certain positive attitudes and
feelings, which should be placed in a clear focus at some point in the discussion. The rationale for this subskill is that stating one’s implicit positive attitudes/feelings makes it likely that one’s partner will be more compassionate and more willing to change in accordance with one’s request.

6. When you want your partner to change, state your "interpersonal message" at an appropriate time.

This subskill directs partners to state their wants and needs in terms of requests for new, more satisfying attitudes and behaviors from the other partner. The rationale for this subskill is that it allows the other partner to understand precisely what the partner wishes of him or her. It increases the probability that the other partner will consider the partner's request realistically. As such, this subskill is a good starting point for problem solving.

The empathic responding skill is based in large measure on the behaviors (and their underlying attitudes) of the traditional Rogerian psychotherapist. This skill involves understanding one's partner from his or her internal frame of reference and conveying this understanding to the partner.

Guerney et al. (1986) indicate that the purpose of the empathic responding skill is to equip partners (a) to understand the
emotional-psychological-interpersonal needs of each other better, and (b) to elicit from each other more prompt, frequent, honest, relevant, open, trusting, and intimate behaviors.

Guerney (1977) indicates that the notion of acceptance is central to empathic responding:

All aspects of the empathic responder mode are directed toward one end: complete acceptance of the other as a valued person. Each of the components of this mode (including clarification of feelings) is important mainly not in itself, but rather as it contributes toward this end. (p. 325)

Guerney (1977) states why the notion of acceptance is so vital to empathic responding:

It is almost impossible to train a person to speak openly, honestly, and constructively of his innermost interpersonal wishes, needs, and feelings, unless he has acquired faith that such expressions will meet with acceptance rather than with coolness or rejection. Until he has a measure of such faith, he will hardly be aware himself of what these needs and wishes are, in the midst of a dialog, let alone be capable of communicating them. (p. 29)

Guerney (1984) indicates that the subskills of empathic responding are:

1. Listen intently.
2. Show interest and understanding while the partner is
talking.

3. Absorb your partner's mood.

4. Concentrate on your partner's internal world.

5. Put yourself in your partner's place by asking yourself the following questions: "If I were my partner, (a) what would I be thinking pro and/or con about myself as a person, (b) what would I be feeling; (c) what would I be wishing; (d) what would I be thinking about doing; (e) what conflicts would I be experiencing about any of the above?"

6. Consider possible differences between your reactions (your answers to the above questions) and the reactions of the other.

7. Formulate a tentative statement that incorporates answers to one or more of the questions outlined above.

8. Put yourself in the other's place again to hear your own tentative statement.

9. Screen out potentially threatening words or phrases.

10. Make your statement declaratively and without use of the first person pronoun.

11. Monitor the length of your statement in accordance with the other's reactions.

12. Accept corrections readily. (pp. 180-181)

Guerney (1977) suggests a number of responses that partners should avoid when they are in the empathic mode:

1. Avoid asking your partner questions (the rationale for this guideline is
that asking questions interrupts the partner's flow of communication).

2. Avoid presenting your own opinion, perception, and viewpoint about what your partner is saying (the rationale for this is that the empathic responder will have the opportunity to express his or her position when in the expressive mode).

3. Avoid interpreting things for your partner (i.e., partners must not add their own reasoning as to causality or make connections between different events in a way that alters their partner's perspective).

4. Avoid making suggestions about how your partner might alter the situation in a favorable way or solve a problem.

5. Avoid making judgements about what your partner has said (i.e., judgements about the validity, correctness, or morality of your partner's statements).

The skill of mode switching is designed to give partners the ability (a) to keep in mind which of the communication modes (i.e., expressive or empathic) is being used at any given time, (b) to use each of these modes at the appropriate time, (c) to change from one mode to the other in a manner that is coordinated with the needs of the other partner, and (d) to understand when and how to switch from one mode to the other (Guerney, 1984).

Guerney (1984) indicates that the subskills of mode switching are:
1. As the expresser, switch modes (a) when you have already expressed your most important thoughts, feelings, and suggestions on the topic under discussion, or (b) when you want to know your partner's views, feelings, or suggestions.

2. As an empathic responder, switch modes (a) when you have already repeated your partner's deepest thoughts and feelings on an issue twice, or (b) when your thoughts and feelings begin to impair your ability to be empathic, or (c) when you have something to say that might favorably influence the other's perceptions to help your partner to resolve a conflict or problem or reach a goal of your own, or (d) when you have something to say that might help to resolve a problem or conflict between yourself and your partner.

Effectiveness of RE

In this section, seven outcome studies of RE with couples are reviewed. Three of these studies compare conjoint group RE as a treatment package against a control group (Collins, 1971; Ely, Guerney, & Stover, 1973; Rappaport, 1976). Another three studies compare conjoint group RE with other treatment approaches (Wieman, 1973; Jessee & Guerney, 1981; Brock & Joanning, 1983). One study compares one-couple conjoint RE with therapists' preferred approaches (Ross, Baker, & Guerney, 1985).

In the first of three studies conducted by Guerney and his associates to establish the effectiveness of RE as a treatment package, Collins (1971; also reported in Guerney, 1977) solicited a sample of 54 distressed couples from
Pennsylvania State University. Collins assigned this sample randomly to either an experimental group or a no-treatment control. The experimental group was subdivided into four RE groups, each receiving one-and-one-half hours of communication skills training per week over a six month period. Outcome was assessed using (a) two self-report measures of marital adjustment, the Marital Adjustment Test (MAT) (Locke & Williamson, 1958) and the Conjugal Life Questionnaire (CLQ) (Guerney, 1977), and (b) two self-report measures of communication, the Primary Communication Inventory (PCI) (Navran, 1967), and the Marital Communication Inventory (MCI) (Bienvenu, 1970).

Results indicate that the experimental group showed significant gains over the control group on one self-report measure of communication (MCI) and on one self-report measure of marital adjustment (MAT), but failed to reach significance on the other two measures. These findings are mixed, providing partial support for the effectiveness of conjoint group RE.

A second conjoint group study (conducted in 1971 but reported in Rappaport, 1976) used an intensive format (two four-hour sessions and two eight-hour sessions spread over two months) rather than the weekly format used by Collins (1971). Rappaport also modified the RE program in order to increase its intensity (e.g., emphasis on homework assignments). Couples in this study were primarily student volunteers (no indication of their level of distress is given). Couples served as their own controls by waiting for a two month period before receiving treatment. Of the 39 couples selected for inclusion in the study, 13 dropped out prior to treatment, and an additional six failed to complete the post-treatment measures.
Outcome was assessed using two direct observation measures and seven self-report measures. The former are: the Self-Feeling Awareness Scale (SFAS) (Guerney, 1977), and the Acceptance of Other Scale (AOS) (Guerney, 1977). The latter are: the Marital Communication Inventory (MCI) (Bienvenu, 1970), the Interpersonal Relationship Scale (IRS) (Guerney, 1977), the Marital Adjustment Test (MAT) (Locke & Williamson, 1958), the Conjugal Life Questionnaire (CLQ) (Guerney, 1977), the Relationship Change Scale (RCS) (Guerney, 1977), the Satisfaction Change Scale (SCS) (Guerney, 1977), and the Handling Problems Change Scale (HPCS) (Guerney, 1977).

Rappaport reports that couples showed significant improvement at post-treatment compared to post-wait on all the measures employed. Although these findings are more impressive than those in the Collin's (1971) study, their conclusiveness is constrained by limitations related to the design. The own-control design, as discussed by Rappaport (1976), does not control for the passage of time, and increases the potential for reactivity to the assessment measures. What most constrains the conclusiveness of these findings is the high attrition rate of 33% following the pre-waiting assessment interview. Because the author does not compare the couples who dropped out with those that remained, it may well be that attrition was selective (e.g., that couples who were less motivated dropped out of treatment).

In a third conjoint group study evaluating RE as a treatment package, Ely, Guerney, and Stover (1973) solicited a sample of 23 clinically distressed student couples. The authors assigned this sample randomly to either an experimental condition which received brief group treatment (eight to ten two-hour
weekly sessions of RE), or to a wait-list control condition (couples in this condition later received treatment, which allowed for a quasi-replication study).

Outcome was assessed using trained observers’ ratings of (1) two categories of communication behavior (feeling expression and feeling clarification) during role-play conditions (no reference given), and (2) four categories of communication behavior (feeling expression and feeling clarification under two sets of instructions) in response to situations presented in the Ely feeling questionnaire (no reference given). Two self-report measures, the Primary Communication Inventory (PCI) (Navran, 1967) and the Conjugal Life Questionnaire (CLQ) (Guerney, 1977) were used.

Using analysis of covariance, the experimental condition showed significant gains over the control condition on five of the six observational variables and on the PCI, but not on the CLQ. The own-control quasi-replication produced similar results except that all six of the observational variables showed significant increases. The most salient weakness of this study is that the senior author was the only therapist.

The studies by Collins (1971), Rappaport (1976), and Ely, Guerney, and Stover (1973), although not without methodological limitations, provide initial support for the effectiveness of RE as a treatment package within a conjoint group modality. These investigations indicate that conjoint group packages of differing format and duration are effective in increasing communication skills and general relationship adjustment. Because the couples in these studies are primarily student volunteers, the findings of these studies are generalizable primarily to similar populations of married student volunteers whose marriages range from
nondistressed to distressed. A limitation of these studies is that it is impossible to determine how well change at post-treatment is maintained because no follow-up assessments were conducted.

In the first of three conjoint group studies using a comparative treatment strategy, Wieman (1973) solicited 36 couples and assigned them randomly to one of three conditions: (1) RE, (2) Reciprocal Reinforcement therapy (RR), which is patterned after the Operant-Interpersonal approach of Stuart (1969), and (3) a wait-list control. Couples in both treatment conditions received a brief treatment of eight weekly sessions. Outcome was assessed using self-report measures of marital adjustment, marital communication, and cooperativeness. In-session process measures were also used (in RE, ratings of Speaker and Listener roles; in RR, ratings of positive statements).

The results of this study indicate that both treatments showed significant increases over the control condition on all the dependent variables. There were no significant differences on any of the dependent variables between the two treatments. The mean gains achieved by both treatments were maintained at ten week follow-up.

Jessee and Guerney (1981) conducted a conjoint group comparative study in which they assigned randomly 45 unsolicited clinical couples to a RE condition or to a Gestalt Relationship Facilitation (GRF) condition (18 couples remained in each treatment after attrition). Each condition received 12 weekly sessions of two and one-half hours each. The dependent variables were six self-report measures: the Marital Adjustment Test (MAT) (Locke & Williamson, 1958), the Marital Communication Inventory (MCI) (Bienvenu, 1970), the Interpersonal Relationship
Scale (IRS) (Guerney, 1977), the Relationship Change Scale (RCS) (Guerney, 1977), the Satisfaction Change Scale (SCS) (Guerney, 1977), and the Handling Problems Change Scale (HPCS) (Guerney, 1977).

Using a t-test analysis of pre to post-test differences, Jessee and Guerney (1981) report that both treatments showed significant gains on all measures. Although they did not employ a control group, they argue for the validity of these gains on the basis of the stability of couples' performances in the absence of treatment in other studies. Using a repeated measures analysis, the authors report the differential effectiveness of RE on the MCI, HPCS, and SCS.

In this study group leaders were nested within treatments, making it impossible to assess the group leader-by-treatment interaction. Because RE clients perceived their leaders as more enthusiastic than GRR clients did, it is possible that the differential effectiveness of RE on the MCI, HPCS, and SCS is attributable to differences in enthusiasm between group leaders in the two treatments. No follow-up was conducted precluding any statement about how differential gains were maintained beyond the post-test.

Brock and Joanning (1983) conducted a conjoint group comparative study in which they assigned randomly a sample of mildly distressed couples to three conditions: (1) an experimental RE condition, (2) an experimental Minnesota Couples Communication Program condition (MCCP), and a no-treatment control condition. Each of the experimental conditions received ten weekly sessions of two hours each.

Outcome was assessed using two self-report measures: the Dyadic
Adjustment Scale (DAS) (Spanier, 1976), and the Marital Communication Inventory (MCI) (Bienvenu, 1970). On the DAS, the total score and each of the four subscales were treated as dependent variables. The subscales are: DAS-Cohesion, DAS-Satisfaction, DAS-Affectional Expression, and DAS-Consensus. A newly developed communication rating scale, the Communication Rapid Assessment Scale (CRAS) (Joanning, Koval & Brewster, 1982) was also used. The data were analyzed using analysis of covariance with pretest scores as the covariate. The unit of analysis for all variables except CRAS was the individual spouse (CRAS yields only a couple score).

At post-test, the RE condition showed significantly greater gains than the control condition on all seven dependent measures except for DAS-Cohesion. The MCCP condition showed no significant gains compared to the control condition. RE showed differential treatment effects on DAS-Total, DAS-Affectional Expression, DAS-Consensus, and MCI.

At three month follow-up, RE reported significantly greater gains than the control condition on DAS-Consensus, DAS-satisfaction, and CRAS, while MCCP reported no significantly greater gains than the control condition. RE showed differential treatment effects on DAS-Consensus, DAS-satisfaction, and CRAS.

Two main conclusions may be drawn from this study: (1) that RE appears to be a more effective communication training program than MCCP, and (2) that RE was partially successful in maintaining post-treatment gains at follow-up (RE's superiority over the control condition was eroded on DAS-Total, DAS-Affectional Expression, and CRAS).
The comparative studies by Wieman (1973), Jessee and Guerney (1981), and Brock and Joanning (1983) add considerable weight to the preliminary evidence of the effectiveness of conjoint group RE established by the earlier studies that compared RE as a treatment package to a control group. Both the Wieman study and the Brock and Joanning study demonstrate the superiority of RE compared to the control conditions (no such comparison is possible in the Jessee and Guerney study because it lacks a control condition). In terms of the differential effectiveness of conjoint group RE, results range from no differential effectiveness (Wieman) to moderate differential effectiveness (Jessee and Guerney) to considerable differential effectiveness (Brock & Joanning). As Guerney et al. (1986) note, in none of these studies has RE been found to be less potent than an alternative approach on any dependent variables.

Although Wieman (1973) and Brock and Joanning (1983) improve on earlier studies by reporting follow-up findings, these results are ambiguous. Wieman reports that post-treatment gains were maintained at a ten week follow-up; Brock and Joanning report a substantial loss of post-treatment gains at three month follow-up.

Ross, Baker, and Guerney (1985) report the only one-couple conjoint study of RE to date. This is also the first study of RE with a client and therapist population not housed in a university. These authors assigned randomly 24 unsolicited clinic couples to a RE condition or to a Therapists' Preferred Therapy (TPT) condition in which experienced marital therapists employed their preferred approaches. The five therapists, who were given three days of training in RE, were fully crossed with treatments. Outcome was assessed using three self-report
measures: the Marital Adjustment Scale (MAS) (Locke & Williamson, 1958), the Interpersonal Relationship Scale (IRS) (Guerney, 1977), and the Marital Communication Inventory (MCI) (Bienvenu, 1970).

Results indicate highly significant differences in favour of RE on all three dependent measures. The gains in this study are much more impressive than in previous studies of RE, a finding which Ross et al. (1985) attribute to the greater severity of distress of couples in this study relative to previous studies. The authors hypothesize that RE may be more effective with more severely distressed couples than with less severely distressed couples. No follow-up data is reported making it impossible to determine how well the differential effectiveness of RE was maintained.

To conclude, this review of conjoint group and one-couple conjoint RE studies indicates that group RE is effective in increasing general relationship functioning and communication in nonclinic couples ranging from the nondistressed to the distressed. The comparative studies suggest that RE is the preferred nonbehavioral approach to conjoint group communication skills training. The comparative study of Ross et al. (1985) provides preliminary evidence for the effectiveness of one-couple conjoint RE with distressed clinic couples.

Given that RE is prevention-oriented, it is surprising that follow-up data were collected in only two of the seven studies reviewed. While in Wieman (1973) post-treatment gains were maintained, in Brock and Joanning (1983) they were only partially maintained. Brock and Joanning suggest that post-treatment gains may be maintained better in future studies of conjoint group RE than in their study because their version of RE (i.e., Guerney, 1977) did not include the
skill of generalization/maintenance which Guerney (1984) has since incorporated into his approach. The effectiveness of RE in maintaining post-treatment gains requires further replication.

There is mixed evidence that one-couple conjoint communication skills training is more effective than conjoint group communication skills training. That Ross et al. (1985) found much larger gains using the one-couple conjoint modality than any of the previous conjoint group RE studies suggests that the one-couple conjoint modality may be the more effective of the two modalities. Schindler, Hahlweg, and Revenstorf (1982) report that one-couple conjoint communication skills training is more effective than conjoint group communication skills training at post-test, but not at six month or one year follow-ups. Bennun (1984) found no differences between these treatment formats. The question of which treatment modality is most effective requires further investigation.

**COMMUNICATION TRAINING (CT) COMPONENT**

Before presenting a summary of the communication training (CT) component developed for this study, a number of relevant issues require discussion: (1) the construction of an EFT-Compatible CT component, (2) the sequencing of the CT component in relation to the EFT treatment package, (3) the duration of the CT component, and (4) the complementarity of the EFT treatment package and the CT component.
Construction of an EFT-Compatible CT component

The decision was made to construct an EFT-Compatible CT component. The rationale for constructing an EFT-Compatible component was that the better the fit between the CT component and the EFT treatment package, the greater the likelihood that couples would make a smooth transition to the CT component and respond positively to it.

The EFT-Compatible CT component was constructed in part from elements of EFT and in part from elements of RE. From RE were borrowed the basic communication skills of expression and responding (plus mode switching, a coordinating skill) and the therapist activities used to teach these skills.

From EFT was borrowed the theoretical/clinical understanding of primary emotion in therapeutic change. The primary mechanism of therapeutic change in EFT is the expression of primary emotion underlying couples' negative interactional cycles. Although RE (Guerney, 1977) addresses the expression of underlying feelings (called positive feelings), it has not developed a theory of primary emotion nor has it articulated how to work with primary emotion clinically.

From EFT was also borrowed the expression of wants and needs as these emerge into awareness from the expression of primary feelings. RE's sixth expressive subskill (Guerney, 1984) includes the expression of wants and needs (called interpersonal messages), but the notion of wants and needs emerging into awareness from the expression of primary feelings is absent in RE.

The rationale for selecting these elements was that it seemed important
initially to introduce couples to the communication skills which are fundamental to communication skills training approaches, and then to teach as a skill an element of EFT (i.e., the expression of primary emotion) that is central to the EFT theory of change. Jacobson and Holtzworth-Munroe (1986) appear to have been guided by a similar rationale in the construction of their Communication/Problem-Solving component. Initially, these authors teach basic communication skills derived from Guerney (1977) and then teach a behavioral element (problem-solving) that is central to the social learning-cognitive perspective.

In light of constructing an EFT-Compatible CT component, certain modifications of the elements derived from RE were required in order to render them compatible with the CT component. First, whereas in RE responders are taught to reflect implicit positive feelings (Guerney, 1977), in the CT component the skill of empathic responding was limited to responders reflecting explicitly stated primary feelings in order to discourage mind reading. Second, whereas in RE expressers are taught to express positive feelings and interpersonal messages (Guerney, 1977 and 1984), in the CT component the skill of expression was expanded to include the EFT notion of expressing primary feelings and felt-needs. Third, whereas the idea of an audio tape demonstration was borrowed from RE, in the CT component this tape demonstration reflected the focus in EFT of expressing primary emotion underlying negative interactional cycles.

Sequencing of the CT component

Adding a CT component to EFT raises the issue of the sequencing of this component in relation to EFT. Guerney (1977) recommends that if RE is
combined with another skills training program or therapy approach, it be
administered first. He takes this position because he thinks that RE provides a
base for helping couples to make the most effective use of other training
programs or therapy.

In this study, it was decided to have the CT component follow rather
than precede the EFT treatment package. This decision was made for a number
of reasons. First, because EFT is designed to alter negative interactional cycles
and to increase intimacy, it was thought that following the EFT treatment
package partners would feel more motivated to learn skills that could enhance
their relationships than at the beginning of therapy. In other words, it seemed
unlikely that partners who were feeling alienated and perhaps in relationship
crisis would be as amenable to learning communication skills in the first four
sessions of therapy as they would be after the EFT treatment package.

A second reason for placing the CT component after the EFT treatment
package is that it was thought that over the course of the EFT treatment
couples would have formed a therapeutic alliance which would dispose partners to
be more trusting of the therapist and each other, and more responsive to the
goal of communication training (i.e., the acquisition of skills) and the tasks of
communication training (i.e., the rehearsal of specific skills). In other words, it
seemed reasonable that an established therapeutic alliance would facilitate the
acquisition of communication skills.

Finally, because communication skills are prevention-oriented, it seemed
reasonable to provide couples with communication skills after the EFT treatment
when these skills would be most useful. In this way couples would have their
recently acquired skills readily at hand to support themselves in the post-therapy period.

**Duration of the CT component**

The duration of the CT component constructed for this study was four one-hour sessions. This is considerably shorter than the 16-20 hours duration of the most abbreviate studies of RE (Brock & Joanning, 1983; Ely, Guerney & Stover, 1973; Wieman, 1973). The abbreviate nature of the CT component compared to these studies of RE is attributable to the intent in this study to construct a component in order to add this to an existing treatment package rather than to construct a complete communication training treatment package such as RE.

Given that Johnson and Greenberg (1984) had demonstrated eight sessions of EFT to be a sufficient number of sessions to constitute an effective EFT treatment package, the constructive research design in this study required that the CT component be less than eight sessions. Had a communication training of eight or more sessions been combined with an eight session EFT treatment package, the design would have become the combination of two treatment packages rather than the addition of a component to a primary, existing treatment package.

Four sessions seemed a reasonable duration for the CT component in light of a number of factors that were hypothesized to increase its intensity. First, it was hypothesized that the intensity of the CT component would be increased because as a one-couple modality it is more individually focused than the group
communication training modality. To date, there has been only one study of RE using the one-couple modality (i.e., Ross, Baker, & Guerney, 1985). In accounting for the impressive gains of couples in this study in relation to earlier studies using the group modality, these authors hypothesize that one-couple RE would be more effective than group RE, if both were of equal duration, because of the increased time that couples in the one-couple modality would have to focus on their own issues (there are typically three couples in group RE).

Second, a number of factors were hypothesized to increase the intensity of the CT component that pertain to the sequencing of the CT component in relation to EFT. The CT component was placed after the EFT treatment package because it was thought that (1) couples would have an increased readiness to learn communication skills after their negative interactional cycles had been reduced, (2) the existence of an established therapeutic alliance would enhance the acquisition of communication skills in the CT component, and (3) the implicit modeling of communication skills in EFT (i.e., therapists' empathic responses and partners' expressions of primary feelings) would facilitate the learning of communication skills in the CT component in a structured, explicit manner.

A final rationale for the four-session CT component was the precedent of CT components of brief duration in the behavioral communication training literature. Baucom (1982) conducted a treatment of ten sessions, the first half of which was a problem-solving/communication training component and the last half a behavioral contracting component. Schindler, Hahlweg and Revenstorf (1983) conducted a 15-session treatment of which sessions 1-4 and 15 were assessment, sessions 5-8 were communication training, and sessions 9-14 were
problem-solution. These studies suggested that a CT component of four sessions was a reasonable duration when added to an existing treatment package.

Complementarity of EFT and the CT component

In EFT, communication problems are considered to be the result of motivational problems. Couples are considered to not so much lack good communication skills as to be blocked in their use of these skills by negative interactional cycles. For example, partners may demonstrate satisfactory communication skills when they are feeling close, but when they are caught in a pursue-withdrawal pattern, with one partner criticizing and the other partner defending, partners lack the motivation to use these skills.

Change in communication problems in EFT is considered to be effected by new affective experiences:

Affectively oriented encounters create change in communication style as partners experience themselves and their partners differently. The experiencing of new feelings helps motivate problem solving and good communication practices. The perception of the partner as more accessible and responsive also motivates and facilitates open communication. (p. 258)

In communication skills training approaches such as the CT component, communication problems are viewed as the result of deficits in communication skills. Couples who communicate poorly are considered to lack the communication skills which are necessary for effective communication. From this perspective,
change in communication problems is effected by the teaching and learning of new skills that overcome communication skill deficits.

Although EFT and the CT component have different explanations of and solutions for communication problems, these approaches are complementary to each other. EFT unblocks communication by changing negative interactional cycles. In this way, communication skills that couples possess but may not be motivated to use become available in the relationship. The CT component enhances communication by teaching new communication skills to couples who may be motivated to communicate but who lack specific skills. Because EFT unblocks communication by changing negative interactional cycles and the CT component enhances communication by teaching new communication skills, these two approaches have a complementary relationship.

Description of the CT component

The CT component consists of four one-hour sessions of communication skills training. A summary of each of these sessions is presented here. For a full explication of the CT component and therapist activities, see the CT component manual in Appendix A.

Each of the four sessions follow the same sequence of essential elements: homework review, didactic skill presentation, behavioral rehearsal, debriefing, and homework assignment. In session one, the homework assignment of reading the Communication Training Manual For Couples is reviewed. An audio tape demonstration of a couple discussing a relationship issue with and without the use of communication skills is listened to and discussed (for a transcript of this
tape, see the CT Component manual in Appendix A). Couples are introduced to the two basic communication skills, expression and empathic responding, and to the coordinating skill of mode switching, a technique that enables partners to move back and forth smoothly between the two communication modes as they discuss issues. The communication skills are practiced (i.e., behavioral rehearsal) and debriefed. A homework assignment is given to practice the skills at home before the next session.

In session two, the homework assignment from session one is reviewed. Couples are introduced to the concept of primary, underlying feelings, and the value of expressing these feelings in the relationship. Couples are also introduced to the concept of "felt-needs" (i.e., needs that emerge from an awareness of underlying feelings), and the value of expressing these needs in the relationship. The communication skills are practiced with particular attention to the expression of underlying feelings and felt-needs, and debriefed. A homework assignment of practicing the communication skills is given.

In session three, the homework assignment from session two is reviewed. Couples are introduced to the distinction between secondary or reactive anger and primary or underlying anger, and to guidelines for the constructive expression of the latter. The communication skills are practiced with an emphasis on the expression of underlying anger/resentment. A homework assignment of practicing the communication skills is given.

In session four, no new skills are presented. Couples are given the opportunity to practice and consolidate their skills. In order to facilitate the generalization and maintenance of the communication skills after therapy
terminates, the importance of regular practice and the application of communication skills to every day life is discussed. Closure is brought to the therapy by couples and therapists expressing their appreciations and saying goodbye.

**CONCEPTUAL HYPOTHESES**

This review has examined the outcome research pertaining to both the EFT treatment package and the RE approach to couples communication training from which the CT component in this study was derived in part. The EFT treatment has been demonstrated to be more effective than no treatment in three outcome studies (Goldman, 1987; Johnson & Greenberg, 1985a; Johnson & Greenberg, 1985b) and to be superior to alternate treatments on certain outcomes in one study (Johnson & Greenberg, 1985a) but not in another (Goldman, 1987). The conjoint group RE approach has been demonstrated to be more effective than no treatment in five outcome studies (Brock & Joanning, 1983; Collins, 1971; Ely et al., 1973; Rappaport, 1976; Wieman, 1973) and to be superior to alternate treatments on certain outcomes in two studies (Brock & Joanning, 1983; Jessee & Guerney, 1981) but not in a third (Wieman, 1973). The comparative study of Ross et al. (1985) has provided preliminary evidence for the effectiveness of one-couple conjoint RE.

In light of the demonstrated effectiveness of both EFT and RE compared to no treatment in previous research, the first hypothesis was stated in the directional form as follows:

1. An Emotionally Focused therapy alone and in combination with the
communication training (CT) component will be more effective than no treatment.

Because there was no previous research on which to base the superiority of the EFT+CT condition compared to the EFT condition, there was some question about which form, the directional or the null, was appropriate for stating the second hypothesis. It seemed that an EFT treatment plus a CT component constructed in part from RE and in part from EFT, which provided couples with skills that they could use after termination, would be more effective (in particular at four-month follow-up) than an EFT treatment plus an additional four EFT sessions. For this reason, it was decided to state the second hypothesis in the directional form as follows:

2. The addition to EFT of a communication training (CT) component will enhance the effectiveness of EFT.
CHAPTER III: METHODOLOGY OF THE STUDY

This chapter describes the research design, subjects, therapists, instruments, and data analysis procedures.

DESIGN OF THE STUDY

In keeping with previous outcome studies of EFT, and marital therapy outcome research in general, the main unit of analysis was the couple (i.e., the summed scores of the male and female within a dyad, divided by two). Given this unit of analysis, the basic design was a three factor, $3 \times 7 \times 3$ (treatment-by-therapist-by-occasion) mixed model, with therapist nested within treatment, treatment fully crossed with occasion, and repeated measures over three occasions as the third factor. In this design, the three levels of the experimental independent variable, treatment, were two active treatment conditions (i.e., EFT; EFT+CT), and a null treatment group (i.e., the wait-list control). The seven levels of the nested factor, therapist, were seven different therapists assigned randomly to each treatment. The three levels of the repeated factor, occasion, were pre-test, post-test, and four-month follow-up. On one measure, the Dyadic Adjustment Scale, there was an additional occasion after the eighth session of treatment; the wait-list control group was not evaluated at follow-up. Within this design, treatment and occasion were treated as fixed factors; therapist and subjects were treated as random factors. The random nuisance factor, therapist, was included in the analysis to ensure that it was not confounded with the other factors in the design and not because of an interest in this factor per se (Kirk, 1982).
Because of the possibility of differential effects of treatment for males and females, analyses pertaining to the first research hypothesis were repeated with the individual as the unit of analysis. With this unit of analysis, the design became a four-factor, 3x7x2x3 (treatment-by-therapist-by-gender-by-occasion) mixed model, with therapist nested within treatment, treatment fully crossed with gender and occasion, and repeated measures over three occasions.

SUBJECTS

The couples in this study were not randomly selected but were solicited by means of articles in three newspapers: the Vancouver Sun, the Province, and the Vancouver Courier. These articles described the Couples Counselling Project as a research study offering free counselling to couples wishing to resolve communication problems. Of the couples who responded by telephone to these articles, only those who met specific criteria, both at an initial telephone screening and at a subsequent assessment interview, were included in the study. These criteria were:

1. Partners must have been cohabiting for a minimum of twelve months, and currently living together.
2. Partners must not have had any immediate plans for divorce or separation.
3. Partners must not have received psychiatric treatment or psychiatric hospitalization within the last two years.
4. Partners must not have reported problems with alcohol or drugs.
5. Partners must not have reported experiencing primary sexual dysfunction.
6. Partners must have scored in the distressed range on the Dyadic Adjustment Scale (Spanier, 1976), but must not have scored in the severely
distressed range. Following Burger and Jacobson (1979), the distressed range was defined as at least one partner scoring below 100; following Spanier's (1976) norm of 70 for divorced couples, the severely distressed range was defined as a couple score of less than 70.

7. Partners must have consented to research procedures, testing, and video-taping.

8. Partners must not have been involved currently in any other psychologically oriented treatment, on either an individual or a couple basis.

Fifty-six assessment interviews were required in order to select 42 couples who met these criteria. Of the 14 couples who were interviewed but who did not meet the criteria, seven couples were too well-adjusted (i.e., neither partner scored less than 100 on the DAS), and three couples were too severely distressed (i.e., a couple score of less than 70). Both of these groups were given appropriate referrals to resources in the community. Three couples separated before the study commenced, and one couple decided not to participate (no reason given).

Following the completion of pre-test measures at the assessment interview, 42 couples were assigned randomly using a random number table to the three levels of treatment (i.e., 14 couples to each of the two active treatment conditions, and 14 couples to the wait-list control group). Couples who had been assigned to the two active treatments were then assigned randomly to therapists.

Following random assignment to the control group, all control couples were contacted by the investigator and informed that there would be a three month delay before they would receive treatment (all couples had been informed in the
initial telephone screening that there was a one-third possibility that there would be a three month delay). Control couples were told at this time that if they required assistance before three months elapsed, that this would be available.

Of the 42 couples who began the study, one couple in the EFT+CT group dropped out at session seven. This unmarried couple had come into counselling hoping to clarify their commitment to each other, and in the process of doing so decided to separate. This couple was replaced by a couple that was selected randomly from a short wait-list (not the wait-list control).

Demographic data descriptive of the final sample of 42 couples were collected. The mean for the number of years couples had been living together was 9.64 (range: 2-31). There were an average of 1.57 children per family (range: 0-4). Eleven couples (26 percent of the total) had been involved in previous marital counselling of a very brief nature (mean .5 months). Twenty-three individuals (27 percent of the total) had been previously married before entering their present relationship. The mean age of the partners was 36.96 years (range: 24-59). The median family income was approximately 35,000-45,000 dollars per year. The mean number of years of education completed by spouses was 15 (this was defined as having completed two years of post secondary education or a community college program).

TREATMENTS

There were two active treatment conditions, EFT and EFT+CT. The EFT+CT condition received an EFT treatment package of eight one-hour sessions followed by the CT component of four one-hour sessions. An EFT treatment
package of eight one-hour sessions was selected because Johnson and Greenberg (1984) had demonstrated this to be a sufficient number of sessions to constitute an effective EFT treatment. A CT component of four one-hour sessions was constructed because this seemed a reasonable duration in order to enhance the primary, existing EFT treatment package (for a fuller explanation of the duration of the CT component, see chapter two).

The EFT condition received an EFT treatment package of eight one-hour sessions plus an additional four EFT sessions that were added to control for the variable of time. Had these sessions not been added and significant between group differences found, the interpretation of treatment effects would have been confounded.

The Emotionally Focused therapy used in this study is described in detail in chapter two. Its treatment manual, which delineates the steps of treatment and corresponding therapists’ interventions, is in Appendix A. The communication training (CT) component used in this study is described in chapter two, as is the Relationship Enhancement approach to communication skills training from which in part it is constructed. The CT component manual, which delineates the four treatment sessions and therapists’ interventions, is in Appendix A.

Each couple received twelve one-hour sessions. For couples in the EFT condition, all 12 sessions were administered according to the EFT manual (see Appendix A). For couples in the EFT+CT condition, the first eight sessions were administered according to the EFT manual, and the last four sessions according to the CT component manual (see Appendix A). All sessions were conducted at the Education Clinic or at the Department of Counselling Psychology on the
campus of the University of British Columbia.

**THERAPISTS**

There were 14 therapists in this study, all graduate students in the Department of Counselling Psychology who volunteered to participate in the study because of their desire to receive further clinical training in marital counselling. Therapist is considered a random factor in this investigation because these 14 therapists did not exhaust the pool of potential therapists who could have been trained for this study and because the intent is to generalize to the treatment of comparable couples by graduate level therapists.

Therapists were nested within either the EFT or the EFT+CT treatment by random assignment. Nesting therapists within treatments was necessary on pragmatic grounds. Because therapists volunteered to treat no more than two couples each, had the therapist factor been crossed with the treatment factor, it would have been impossible to conduct a multivariate analysis. The reason for this is that when there is only one observation per cell (in this case, the couple), the degrees of freedom for the within error term would have been zero, making it impossible to calculate an F statistic.

The following descriptive data were collected from the therapists in this study. There were two males and five females assigned randomly to the EFT treatment and three males and four females assigned randomly to the EFT+CT treatment. There was one doctoral candidate in the EFT treatment and two doctoral candidates in the EFT+CT treatment. All the rest of the therapists were magistral students who had completed at least one year in the M.A.
program of the Department of Counselling Psychology. Therapists in the EFT treatment had a mean of 7.43 years of experience in general counselling (range: 3-14); EFT+CT therapists had a mean of 6.50 years (range: 2.5-10). Therapists in the EFT treatment had a mean of 1.93 years of experience in conducting couples counselling (range: .5-5.0); EFT+CT therapists had a mean of 2.33 years experience (range: 0-9). Therapists in the EFT treatment had completed a mean of 3.43 courses in marital/family counselling (range: 2-7); EFT+CT therapists had completed a mean of 2.36 courses (range .5-5.0).

All therapists were trained to administer the EFT treatment according to the EFT treatment manual (see Appendix A). In addition, therapists administering the CT component were trained to implement the CT manual (see Appendix A). Training methods in both EFT and the CT component consisted of instruction, modeling and/or tape presentations of interventions, followed by the behavioral rehearsal of these interventions and feedback. All training was conducted by the investigator of this study under the supervision of his supervisor, Dr. J. Friesen.

Therapists in both treatment conditions received approximately 12 hours of training in EFT as a group. Therapists in the EFT+CT condition received an additional 11 hours of training in the CT component. This training was given while EFT+CT therapists were conducting sessions numbered four through eight of the EFT therapy. All therapists in the EFT condition except one received training in the CT component during the post-treatment period. Four of seven EFT therapists chose to practice implementing the CT component under supervision with wait-list control couples during the post-treatment period.

Therapists from both treatment conditions received four biweekly two and
one-half hour sessions of group supervision together. These sessions pertained to the first eight sessions of EFT. Thereafter, therapists in both conditions received two biweekly two and one-half hour sessions of supervision separately. Supervision consisted of video tape analysis of treatment sessions and discussion. The investigator provided this supervision under the direction of his supervisor, Dr. J. Friesen. Therapists also received approximately one hour of individual supervision.

**IMPLEMENTATION CHECKS OF TREATMENT INTEGRITY**

The extent to which treatment has been carried out as intended is referred to as treatment integrity (Kazdin, 1986b). Kazdin identifies a number of steps that are required to ensure treatment integrity. The first step is to train therapists to carry out the therapeutic procedures. In this study, therapists in both treatment conditions received 12 hours of training in administering the EFT therapy as defined in its treatment manual; therapists in the EFT + CT condition received an additional 11 hours of training in the CT component (for copies of both treatment manuals, see Appendix A). Training procedures, which were specified in writing and checked by this investigator’s supervisor, consisted of instruction, modeling and/or tape presentations of interventions, followed by behavioral rehearsal and feedback.

Kazdin’s (1986b) second step for ensuring treatment integrity is that once treatment begins, procedures must be implemented to prevent therapists from drifting from the treatment procedures. In this study, therapists from both treatment conditions met jointly for four bi-weekly two and one-half hour sessions of group supervision during the first eight sessions of EFT. Thereafter, therapists
in both conditions received two bi-weekly two and one-half hour sessions of supervision separately. Supervision procedures consisted of video tape analysis of treatment sessions. Each therapist also received approximately one hour of individual supervision.

Kazdin’s (1986b) third step for ensuring treatment integrity is an assessment of the extent to which the treatment procedures were carried out correctly. This requires coding therapist and/or client behavior and identifying ways in which adherence to and departures from the treatment manual are evident. In this study, a separate implementation checklist was used to determine the extent to which EFT and the CT component were implemented according to their respective treatment manuals. These checklists will be described briefly here. For a full description, see Appendix B.

1. EFT implementation checklist.

This checklist is comprised of two parts. The first part, which was developed by Johnson (1984), pertains to EFT interventions. It has ten categories of therapist interventions drawn from the EFT manual, plus three nonspecific categories: information gathering, refocus on topic, and noncodeable EFT interventions.

The second part of the EFT checklist pertains to nonEFT therapist interventions. In order to develop a representative but manageable checklist of nonEFT interventions, this investigator selected randomly (a) five cognitive-behavioral therapist interventions from the checklist used in Johnson and Greenberg’s (1985) study, and (b) five integrated systemic therapist interventions from the checklist used in Goldman’s (1987) study. Four
additional therapist interventions were selected from the CT component implementation checklist for a total of 14 nonEFT interventions.

The purpose of the first part of this checklist was to assess the extent to which independent raters could agree on the specific EFT interventions used. The purpose of the first and second parts of the checklist combined was to assess the extent to which therapists adhered to the EFT manual or failed to adhere to it. Because treatment integrity refers to the extent to which treatment has been carried out as intended, both parts of the checklist were crucial to treatment integrity. For raters to determine that departures from EFT fell within an acceptable range would demonstrate treatment integrity. Whether or not raters were able to reach a high percentage of agreement concerning specific EFT interventions is important but not central to the issue of treatment integrity.

Two magistral students in Counselling Psychology were trained (10 hours) to implement the two-part EFT checklist. Training procedures consisted of instruction, and practice on trial segments with feedback.

Implementation checks of the EFT therapy were conducted in two phases. In the first phase, sessions two through eight of both the EFT and the EFT+CT treatments were assessed (session one was excluded because it was an assessment session). These seven sessions were used to form blocks for the analysis, and two different couples from both EFT and EFT+CT were assigned randomly to each of these blocks. In this way, a total of 28 sessions (one session per couple) representative of sessions two through eight were assessed by both raters.
In each session, one ten minute segment was selected from either the first half or the last half of the session. Ratings were made from audio tapes, with the unit of analysis being a "meaningful" therapist statement. The qualifier "meaningful" excluded therapist statements that did not convey an intelligible meaning (e.g., utterances that were interrupted). Raters noted the beginning and end of each therapist statement in order to ensure that both were evaluating the same unit.

In the second phase, sessions 9 through 11 of the EFT treatment were assessed (session 12 was excluded because it was the termination session). These three sessions were used to form blocks for the analysis, and three different couples from EFT were assigned randomly to each of these blocks. In this way a total of nine sessions representative of sessions 9 through 11 were evaluated by both raters.

2. CT Component Implementation Checklist

This checklist, which was derived primarily from Guerney (1977), has two parts. In the first part, seven CT therapist interventions are defined: social reinforcement, structuring, modeling, encouraging-prompting, encouraging a mode switch, trouble-shooting (client reaction), and other (interventions that are consistent with the CT component but not codeable). In the second part, eight nonCT interventions are defined: directive lead, interpretation, suggestion/explanation, encouragement/approval, personal criticism, inappropriately directed therapist responses, and failure to correct.

The purpose of the first part of the CT checklist was to assess the extent to which two independent magistral students in Counselling
Psychology agreed on the specific CT interventions being used. The purpose of the first and second parts of the checklist combined was to assess the extent to which therapists adhered to the CT manual or failed to adhere to it. As was the case with the EFT checklist, both parts of the CT component checklist were crucial to the assessment of treatment integrity.

Two additional magistral students in Counselling Psychology were trained (four hours) to implement this two-part CT checklist. Training procedures consisted of instruction and practice on trial segments with feedback. Both raters also received ten hours of therapist training in the CT component before being trained as raters.

Tapes were selected for rating in the following manner. First, the CT component sessions (i.e., sessions 9 through 12) were used to form blocks for the analysis. Second, four different couples were assigned randomly to blocks 9 through 11, and two different couples to block 12. In this way, a total of 14 sessions (one per couple) representative of the four sessions of the CT component were evaluated by both raters. In each session, ten minute segments of the behavioral rehearsal exercise were rated. Each segment commenced five minutes into the exercise. Ratings were made from audio tapes, with the unit of analysis being a "meaningful" therapist statement. Following Guerney (1977), the qualifier "meaningful" was included to eliminate those instances in which the therapist's statement was not an intelligible expression (e.g., when the therapist was interrupted).
INSTRUMENTS

Outcome instruments

Following Jacobson, Follette, and Elwood's (1984a) recommendation, primary dependent measures were distinguished from secondary or exploratory measures. The four primary dependent measures in this study are described first, and then the one secondary measure is described.

1. The Dyadic Adjustment Scale (DAS) (Spanier, 1976)

The DAS is a widely used summary measure of marital adjustment. It is a measure of the individual's adjustment to the relationship, but has also been used to study the adjustment of the couple to the relationship (Spanier & Filsinger, 1983). Spanier and Filsinger (1983) report that the total score reliability of the DAS is .96 (Cronbach's coefficient alpha), and that the DAS has the following types of validity: first, content validity (judges determined content validity based on theoretical dimensions); second, criterion-related validity (the scale discriminated married and divorced samples); third, construct validity (the DAS has the construct validity of conforming to a theoretical structure).

Factor analysis indicates that the DAS has four components or subscales (Spanier, 1976). These subscales are: Dyadic Consensus (the degree to which the couple agrees on matters of importance to the relationship, Dyadic Cohesion (the degree to which the couple engages in activities together), Dyadic Satisfaction (the degree to which the couple is satisfied with the present state of the relationship and is committed to its
continuance), and Affectional Expression (the degree to which the couple is satisfied with the expression of affection and sex in the relationship). Spanier and Thompson (1982) add support to this four-component structure of the DAS through a replication of this structure using a new data set (n = 205 couples).

The reliability of the subscales, and the number of items per subscale are: Consensus (.90) (13 items), Satisfaction (.94) (10 items), Cohesion (.86) (5 items), and Affectional Expression (.73) (4 items). The total scale has 32 items and a theoretical range of 0 to 151 (Spanier, 1976).

Spanier’s (1976) norms for married and divorced couples based on mean total couple scores are 114.8 (S.D. 17.8) and 70.7 (S.D. 23.8) respectively. Spanier and Filsinger (1983) report that although the former norm for married couples is fairly representative, the latter norm for divorced couples may be low. They indicate that insufficient studies have compared currently distressed and nondistressed couples to suggest a cutoff point for marital distress on the DAS. They cite Burger and Jacobson’s (1979) diagnostic guideline that a couple is distressed when one partner has a score under 100, suggesting that this cutoff is arbitrary pending further investigation.

In this study, the DAS was used as a screening and pre-treatment measure, and as a general measure of outcome at termination and follow-up. In order to assess in greater detail the effect of the CT component on the dependent variable of marital adjustment, this measure
was also administered at the end of session eight before the CT component was introduced. In order to conduct a more refined analysis, the four subscales of the DAS were analyzed as well as the total scale score.

2. Communication Scale (CS) (Olson, Fournier, & Druckman, 1985)

   The CS is a ten-item subscale in a marital inventory called ENRICH (Evaluating and Nurturing Relationship Issues, Communication, and Happiness). The CS assesses individual’s feelings, beliefs, and attitudes about marital communication. This scale was originally developed for a premarital inventory, PREPARE (Fournier, 1979), and with minor revisions (one new item and one revised item) was incorporated in 1981 into ENRICH.

   Based on a nation-wide probability sample of 672 couples, the authors report an internal consistency (Cronbach’s alpha) of .68; based on a four-week interval testing occasion and a sample of 115 individuals, they report a test-retest reliability of .90. The CS has a five-point Likert-type scale ranging from one (strongly agree) to five (strongly disagree) with a theoretical range of 0-50.

   The validity of the CS derives from the PREPARE inventory. Fournier (1979) reports that the CS is correlated significantly with the Marital Adjustment Scale (Locke & Williamson, 1985).

3. Psychosocial Intimacy Questionnaire (PIQ) (Tesch, 1985).

   This measure was designed to assess the construct of psychosocial intimacy in the relationships of adolescents and adults. It may be used to evaluate this construct in friendship, dating, or marital relationships (Tesch,
Tesch (1985) establishes the psychometric properties of this measure on the basis of three studies, all of which used college-age samples. In terms of construct validity, the author reports that the PIQ correlates positively and negatively with scores on measures of similar and dissimilar constructs respectively. In terms of reliability for opposite-sex relationships, the author reports an internal consistency of .98 and test-retest reliability (three week interval) of .84.

On the basis of a factor analysis, Tesch (1985) suggests that psychosocial intimacy is a function of three major factors. The author describes these factors as (1) romantic love (items pertaining to love and emotional expression, physical intimacy, and interdependence), (2) supportiveness (items pertaining to respect, helpfulness, and acceptance), and (3) communication ease (items pertaining to "being oneself", communicating, and lack of ambivalence about the relationship).

Although this measure has 60 items, in this study three items were excluded that seemed inappropriate to the couples in this study (#25, #34, #60). The PIQ has a six-point Likert-type scale ranging from one (strongly disagree) to six (strongly agree) with a theoretical range in this study of 0-342.

4. Target Complaints (TC) (Battle, Imber, Hoehn-Saric, Stone, Nash, & Frank, 1966)

The rationale for including this instrument as a primary dependent
measure was the importance of having a measure that evaluates the effectiveness of treatment in relation to presenting problems in therapy. Although there is a range of opinion among marital/family researchers regarding the degree of centrality to be assigned to the assessment of the resolution of presenting problems (Gurman, Kniskern, & Pinsof, 1986), there is a consensus that change in presenting problems should be assessed in outcome studies.

The TC is an individualized measure that assesses individual's spontaneously expressed presenting complaints or target complaints. It is recommended by Waskow and Parloff (1975) as a core battery instrument for use in psychotherapy outcome research. In their review of this measure, Mintz and Kiesler (1982) conclude that ratings of improvement on TC have been shown to be effective outcome measures in diverse therapy studies.

Battle et al. (1966) report reliability data from two studies. In the first study, a correlation of .68 was found between rankings of complaints by clients before and after an assessment interview, and no significant change was found in the severity ratings of complaints by clients from before to after an assessment interview. In the second study, the content of target complaints did not differ significantly when these ratings were reported to different interviewers.

In terms of validity, Battle et al. (1966) report that the TC correlates significantly with other outcome measures. They also report that complaints elicited from clients were congruent with presenting complaints assessed in an independent psychiatric evaluation. Mintz and Kiesler (1982)
note that although many researchers have had the data to calculate the concurrent validity of TC with other outcome measures, very few have done so. They indicate that what data do exist suggests that improvement ratings on the TC tap a broad improvement factor. Mintz and Kiesler (1982) also state that the TC has substantial face validity by virtue of target complaint items being spontaneous reports from clients in their own words.

In this study, couples were asked at the assessment interview to write down in order of priority three relationship issues that they wished to resolve in therapy. At post-treatment and follow-up, they were asked to rate the degree of improvement on these three complaints on a five-point Likert-type scale ranging from one (worse) to five (a lot better). Mintz and Kiesler (1982) note that variation in the severity of the primary initial problem is likely to be smaller than the variation in the severity of the second and third complaints. The implication of this is that a total score is likely to be more highly related to the severity of the secondary problems than to the severity of the primary problem. In order to avoid this, the data analysis was based on the client’s improvement rating of the primary target complaint.

5. Passionate Love Scale (PLS) (Hatfield & Sprecher, 1986)

This instrument was developed because of the desire to research systematically the construct of passionate love. This construct, which has been labelled puppy love, a crush, infatuation, or obsessive love by theorists, is defined by the authors as an intense longing for union with
another. Although passionate love is essentially an adolescent phenomenon, and has been commonly understood to change into companionate love as couple relationships mature, there is some evidence that passionate love recurs throughout the life cycle (Hatfield & Sprecher, 1986).

There are two forms of the PLS: a regular version (30 items), and a shorter version (15 items). Both versions have high reliability, as calculated by the coefficient alpha (regular form, .94; shorter version, .91). Both versions have construct validity as demonstrated by their correlating highly with other measures of intimacy, and by their correlating to a significantly greater degree with those variables that are most similar conceptually to the construct of passionate love. These psychometric data are based on a sample of undergraduate adolescents (n=164). The PLS has a nine-point Likert-type scale ranging from one (not at all true) to nine (definitely true) with a theoretical range of 0-135.

The PLS had the status of a secondary measure in this study. It was included because of an interest in exploring the effectiveness of treatment in relation to this construct. Because the authors note that the shorter version is adequate for most investigations of passionate love, the shorter version was used.

Therapy Process Variables

1. Integrative Psychotherapy Couples Alliance Scale (Pinsof & Catherall, 1986)

This instrument measures the construct of the therapeutic alliance from the perspective of the individual partner. Pinsof and Catheral (1986)
define the therapeutic alliance as "that aspect of the relationship between the therapist system and the patient system that pertains to their capacity to mutually invest in, and collaborate on, the therapy" (p. 139).

The Couples Alliance Scale has two theoretical dimensions, called the content dimension and the interpersonal system dimension. The content dimension, which refers to the "what" of the alliance, has three categories (i.e., bonds, tasks, and goals) derived from Bordin's (1979) integrative conceptualization of the working alliance in individual psychotherapy. This conceptualization overcomes the traditional dichotomy between general relationship factors and specific technical factors by viewing the technical factors as requiring a particular type of relationship bond (Greenberg & Pinsof, 1986). The system dimension, which refers to the "who" of the alliance, also has three categories: self-therapist, other-therapist, and group-therapist.

These two dimensions form a 3x3 matrix. Each of the 29 items of the Couples Alliance Scale fit into one of the cells of the matrix. This measure has a Likert-type seven point scale that yields an overall alliance score, plus a separate score for each of the six variables in the matrix.

Using a small pilot study, the authors report a rate-rerate reliability of .79. They attribute minimal predictive validity to the measure on the basis of a significant positive correlation reported by Catherall (1984) between the Couples Alliance Scale and partner progress as measured by a therapist report instrument developed by Storrow (1960) and modified by Catherall (1984).
Because the therapeutic alliance seems to be related positively to various outcome indices (Greenberg & Pinsof, 1986), the Couples Alliance Scale was included in this study to control for possible between-group differences in the quality of the therapeutic alliance that could confound treatment effects. This measure was administered at the end of the third session.

Subject Variables

1. Demographic Questionnaire (Johnson, 1984)

The purpose of this questionnaire was to provide an accurate description of the client sample. The following data were collected: the number of years spent together as a cohabiting couple, the number of children from the current marriage, whether or not partners had been married previously, whether partners had received marital therapy previously (and if so, of what duration), the approximate amount of family income, and the age and educational levels of both partners.

Other measurement procedures

1. Post-treatment structured interview

A structured interview was constructed for this study to explore (a) clients' reactions in both treatment conditions to EFT, and (b) the clients' reactions in the EFT+CT treatment to the CT component. In order to accomplish this, the interview was divided into two parts.

Part A, which pertains to the Emotionally Focused treatment, was
administered to partners in both treatments. Questions concern the factors each spouse perceives as facilitating treatment, and partners' perceptions of change processes identified by Greenberg, James, and Conry (in press).

Part B was administered only to partners in the EFT+CT treatment. The questions assess partners' reactions to the CT component, including their perceptions of the CT component in relation to the Emotionally Focused phase of treatment.

The interview was conducted by the investigator after the dependent measures were administered at post-test. Partners' oral responses were recorded in writing.

**ADMINISTRATION OF OUTCOME MEASURES**

All five outcome measures were administered to both active treatment groups at pre-test, post-test, and four-month follow-up. In addition, the Dyadic Adjustment Scale was given to both active treatment groups after eight sessions of therapy. All five outcome measures were completed by the control group at pre-test and post-test, but not at four-month follow-up.

**OPERATIONAL HYPOTHESES**

Two research hypotheses were investigated in this study. The first hypothesis was:

Couples in both treatment conditions would achieve greater gains than the wait-list control group at post-test on the Dyadic Adjustment Scale
The second hypothesis was:

Couples in the EFT+CT treatment condition would achieve greater gains than the EFT treatment condition at post-test and four-month follow-up on measures of four components of the Dyadic Adjustment Scale (DAS-Consensus, DAS-Affectional Expression, DAS-Cohesion, DAS-Satisfaction) (Spanier, 1976), the Communication Scale (CS) (Olson, Fournier, & Druckman, 1985), the Psychosocial Intimacy Questionnaire (PIQ) (Tesch, 1985), Target Complaints (TC) (Battle et al., 1966), and the Passionate Love Scale (PLS) (Hatfield & Sprecher, 1986).

**DATA ANALYSIS PROCEDURES**

The data analysis was performed in three stages: a preliminary analysis, an analysis of treatment effects, and an analysis of descriptive data.

**Preliminary analysis**

Because initial demographic and pre-test differences among the three treatment groups could confound the interpretation of treatment effects, assumptions of group equivalence were tested on these variables. In addition,
because differences between the two active treatment levels of the independent variable in therapist characteristics and the quality of the therapeutic alliance could confound the interpretation of treatment effects, assumptions of group equivalence were also tested on these variables.

Because the integrity of the independent variable, treatment, is vital to drawing conclusions about treatment effects, implementation checks of therapists' interventions were conducted using checklists (see Appendix B). The crucial analysis in terms of treatment integrity pertains to the first and second part of both checklists. If it could be demonstrated that therapists' departures from the EFT treatment (i.e., nonEFT interventions) and therapists' departures from the CT component (i.e., nonCT interventions) fell within an acceptable range of variation, then it could be concluded that both treatments possessed treatment integrity.

As Kazdin (1986b) notes, because some departures from prescribed treatment are likely to occur, the issue is whether or not the treatment was carried out within some acceptable range of variation. In this study, it was decided that if five percent or less than five percent of therapists' interventions were nonEFT (or nonCT), this would constitute an acceptable range of variation. If therapists' nonEFT and nonCT interventions fell within this range, the EFT treatment and the CT component would be considered to possess treatment integrity. Although arbitrary, the criterion of five percent was selected because it seemed that both treatments would continue to be reasonably representative of their treatment manuals if five percent or less than five percent of therapists' interventions departed from the EFT and the CT component treatment manuals.
The first part of each checklist was analyzed by calculating a percentage agreement between the two independent raters. This statistic was calculated by dividing the total number of agreements by the total agreements and disagreements (Borg & Gall, 1983). Although a high percentage of inter-rater agreement would show that raters were capable of agreeing consistently on specific therapist interventions, this analysis was not central to the issue of treatment integrity.

**Analysis of treatment effects**

The data analysis of treatment effects was conducted in two parts corresponding to the two research hypotheses (this was necessary because there were no four-month follow-up data for the wait-list control group).

The first part of the analysis, which corresponds to the first research hypothesis, involved two separate analyses:

1. **Analysis 1A**
   A three group (EFT vs. Con and EFT+CT vs. Con) by two times (pre, post) repeated measures experiment on the DAS (total score), CS, PIQ, and PLS.

2. **Analysis 1B**
   A three group (EFT vs. Con and EFT+CT vs. Con) experiment on the post-test scores of TC.

   Analysis 1B was required because there was no measurement of pre, post change scores on TC.
The second part of the analysis, which corresponds to the second research hypothesis, involved three separate analyses:

3. Analysis 2A
A two group (EFT vs. EFT+CT) by three times (pre, post, four-month follow-up) repeated measures experiment on the DAS (total score), CS, PIQ, and PLS.

4. Analysis 2B
A two group (EFT vs. EFT+CT) by four times (pre, eight week, post, four-month follow-up) repeated measures experiment on the four subscales of the DAS (DAS-Consensus, DAS-Affectional Expression, DAS-Cohesion, DAS-Satisfaction).

5. Analysis 2C
A two group (EFT vs. EFT+CT) by two times (post, four-month follow-up) repeated measures experiment on TC.

Analysis 2B was conducted because the subscales of the DAS could have differing patterns of significance which when combined might appear as a nonsignificant result for the total score of the DAS. Analysis 2C was required because there was no measurement of pre to post change scores on TC (this measure is a post-therapy report).

Multivariate and univariate analyses were performed on the dependent variables using the P:4V and P:8V programs of the BMDP statistical package (Dixon, 1985). The GLM program of SAS (Helwig & Council, 1985) was used for multivariate analyses pertaining to the second research hypothesis, because P:4V could not accommodate the random nested factor, therapist.
In all multivariate analyses the test statistic used was Wilks' Lambda (Wilks, 1962). Approximate multivariate F ratios are reported in the next chapter based on this statistic.

Hypotheses were tested allowing a Type 1 error probability of .05. In order to guard against the problem of an escalating Type I error rate, when univariate analyses were conducted following a significant MANOVA, the Bonferroni procedure was used to calculate the critical significance level for each univariate test (Hays, 1981). In this procedure, the significance probability, p, of a univariate test must be less than $\lambda = \alpha / n$ in order to be significant at level $\alpha$. For example, if there were four dependent variables in the multivariate analysis, only those univariate analyses with a significance probability of less than $.05/4 = .013$ would be considered statistically significant.

Because the hypotheses of interest in this study pertain to differences among groups over time, the crucial statistic in all multivariate and univariate analyses using the couple as the unit of analysis was the group-by-occasion interaction. Other significant sources of variance were also reported.

Significant univariate treatment-by-occasion interactions were followed by Dunn's procedure of planned nonorthogonal contrasts (Kirk, 1982). In this procedure, each contrast is tested at $\alpha/C$ level of significance (where C denotes the number of planned contrasts) in order that the familywise error rate can not exceed the sum of C per contrast error rates. For example, if an investigator was testing $C=2$ contrasts and wanted the familywise error rate to be less than or equal to .05, each contrast would be tested at the $.05/2 = .025$ level of significance.
In keeping with previous studies of EFT and marital therapy outcome research in general, the main unit of analysis in this study was the couple (i.e., the combined score of the male and female within the dyad, divided by two). Because of the possibility of differential effects of treatment for males and females, analyses pertaining to the first hypothesis were repeated with the individual as the unit of analysis. In these analyses, the crucial test statistic was the group x gender x occasion interaction.

Analysis of descriptive data

Clinical significance of treatment effects

Authors such as Kazdin (1986a), Jacobson (1985), and Lambert, Shapiro, and Bergin (1986) advocate the importance of data analysis that addresses the issue of clinical significance. Kazdin (1980) defines clinical significance as "the practical value of the effect of an intervention; that is, whether it makes any "real" difference to the subjects" (p. 365). In other words, it is important that findings be not only statistically significant but also clinically meaningful. This is illustrated by Jacobson et al.'s (1986) conclusion that, although the statistical significance of the cognitive-behavioral marital therapy has been established convincingly, when criteria of clinical significance are applied, a substantial proportion of couples do not benefit substantially from treatment, particularly at 12-month follow-up.

Jacobson, Follette, and Revenstorf (1984b) caution that in the absence of significant treatment effects using conventional parametric statistics, significant
tests of differential proportions between groups (i.e., clinical significance) must be interpreted cautiously because the latter are less powerful than the former.

Jacobson et al. (1984b) propose criteria that may be used to convey the clinical significance of outcome research, and have applied these criteria to current marital therapy outcome research (Jacobson & Follette, 1985) as well as to previous marital therapy outcome studies (Jacobson et al., 1984c). In order for a couple to be improved to a clinically significant degree, the couple must meet two criteria (Jacobson & Follette, 1985). First, their couple score must place them closer to the mean of the functional population than to the mean of the dysfunctional population on the variable of interest. Second, because it makes little sense to infer clinically significant treatment effects when no change has occurred (even if the level of post-test functioning falls within the limits of the functional population), the change must be of sufficient magnitude to rule out measurement error as a potential explanation for the change. The former criterion addresses the issue of whether a couple's status subsequent to treatment is distressed or nondistressed; the latter criterion addresses the issue of whether or not the magnitude of the change is reliable statistically.

Jacobson and Follette (1985) operationalize the first criterion by establishing a cutoff score. Using Spanier's (1976) norms for the DAS, they determine the cutoff couple score for the DAS to be 97. In terms of this cutoff, couples with total DAS scores greater than 97 are considered nondistressed; couples with total DAS scores less than 97 are considered distressed.

Following Christen and Mendoza's (1986) suggested alterations, Jacobson, Follette, and Revenstorf (1986) operationalize the second criterion through the use
of the reliable change index (RC). This index is the difference between pre-test and post-test scores divided by the standard error of difference (the standard error of difference represents the amount of difference which one could expect between two scores, obtained on the same test by the same individual, as a function of measurement error alone). Under normality an RC equal to or greater than 1.96 indicates that the difference in two test scores occurs as a function of measurement error roughly five or less times in 100. When RC is equal to or greater than 1.96, one may conclude that the pre- to post-test change is (probably) not due to measurement error alone but is a real change in the true score due to the experimental treatment (Christen & Mendoza, 1986).

The reliable change index (RC) is calculated by subtracting the pre-test score of a hypothetical couple from their post-test score, and dividing the resulting difference score by the standard error of difference between the two test scores. The standard error of difference may be computed by taking the square root of the product of two x the standard error of measurement (SE) squared (SE is the product of the standard deviation of the dependent variable and the square root of one minus the reliability of the measure of the dependent variable).

In this study, the standard error of measurement was calculated to be 1.864. This calculation assumed the standard deviation of the DAS to be 9.32 (the average of the standard deviations of the three levels of the grouping factor at pre-test) and the reliability of the DAS (as reported by Spanier, 1976) to be .96. The standard error of difference was then calculated to be 2.64 in this study.
When RC is equal to or greater than 1.96, one may conclude that the pre- to post-test change is (probably) not due to measurement error alone but is a real change in the true score due to the experimental treatment. In this study a difference score (post-test minus pre-test) of 5.2 points was required to calculate an RC index of equal to or greater than 1.96. When rounded to the nearest integer, a difference score of five points or more on the DAS was required in this study to conclude that a couple's change score was (probably) reliable statistically.

Jacobson and Follette (1985) recommend that the RC index be applied alone and in combination with the cut-off score. They consider the former to reflect the percentage of couples "improved" in therapy, and the latter, which represents a conservative estimate of clinically significant change, to reflect the percentage of couples "no longer distressed". Jacobson, Follette, and Elwood (1984a) regard the percentage of couples "no longer distressed" to be of particular importance because typically couples enter therapy defining "success" to mean that they will be happy together by the time therapy is over. In their view, it is questionable whether anything less than couples leaving therapy nondistressed is clinically meaningful.

In this study, the RC index was applied alone and in combination with the cut-off score on the total couple DAS scores at post-test and four-month follow-up.
Structured interview

In order to explore clients' reactions in both treatment conditions to EFT, and clients' reactions in the EFT+CT condition to the CT component, a structured interview was constructed (see Appendix B). The data from this interview were summarized and reported descriptively.
CHAPTER IV: RESULTS AND DATA ANALYSIS

In this chapter the results of the data analysis are reported. There are three main sections: first, the results of preliminary analyses pertaining to assumptions of group equivalence and the integrity of treatments; second, the results of analyses pertaining to outcome effects of the main experiment; third, the results of analyses pertaining to descriptive data.

RESULTS OF PRELIMINARY ANALYSES

Testing assumptions of group equivalence

Assumptions of group equivalence were tested by comparing the two treatment groups and the control group with respect to demographic data and pre-test scores. The multivariate analysis of pre-test scores (DAS, CS, PIQ, and PLS) did not indicate significant differences: approx. F (8,72) = .77, p = .626. Similarly, the univariate analysis of demographic variables (number of years spent together as a cohabiting couple, number of children from the current marriage, previous therapy and duration of previous therapy if any, family income, age of each partner, educational level of each partner, previous marriage(s) if any of each partner) did not indicate significant differences, with p values ranging from .11 to .86 (see Table C-16).

With respect to therapist characteristics, assumptions of group equivalence were tested by comparing the therapists of the two treatment groups on gender, level of graduate study (magistral or doctoral), years of experience in general counselling, years of experience in couples counselling, and number of courses
completed in marital/family therapy. The univariate analysis of these five therapist characteristics indicated that there were no significant differences between groups of therapists, with p values ranging from .30 to .77 (see Table C-17).

Assumptions of group equivalence were tested also with respect to the Couples Therapy Alliance Scale (Pinsof & Catherall, 1983). In this analysis, the scores of the two treatment groups taken after the third session were analyzed in order to test the assumption that there were no significant group differences in the quality of therapeutic alliances between therapists and their couples. If a significant difference had been found, alliance potency would have been confounded with the treatment factor in the interpretation of effects. The EFT couples' mean score was 167.71 (SD = 18.81) and the EFT+CT couples' mean score was 171.29 (SD = 15.50). No significant difference was found between treatment groups when using the couple as the unit of analysis: F (1,12) = .34, p = .579. The results of this univariate analysis are presented in Table C-18 (see Appendix C). Similarly, no significant differences were found when using the individual as the unit of analysis. The univariate F statistic for the group x gender interaction was F (1,12) = 1.17, p = .301. The results of this analysis are presented in Table C-19 (see Appendix C). On the basis of these analyses, it would appear that group differences in the quality of therapeutic alliances were not a confounding factor in this experiment.
Testing the integrity of treatments: Implementation checks

The EFT implementation check was conducted in two phases. In the first phase, sessions two through eight of both the EFT and the EFT+CT treatments were assessed. Of the 514 therapist interventions rated, five were categorized as nonEFT. Of the 128 interventions rated in the second phase (sessions nine through eleven of the EFT treatment), three interventions were categorized as nonEFT. Out of the 642 interventions rated in the two phases combined, eight interventions (1.2 percent) were categorized as nonEFT and 98.8 percent as EFT. All of these were CT interventions as opposed to cognitive-behavioral or integrated systemic interventions. The CT intervention most often used was modelling (number 13), where the therapist instructs one partner to make a specific statement to the other partner (e.g., Tell him, "I'm upset with how you are responding to me"). The occurrence of modelling statements in EFT would seem to be an extension of the technique used in EFT where the therapist tells one partner to say directly to the other partner what this partner has just said to the therapist.

The proportion of interventions rated as nonEFT (1.2 percent) was well below the criterion of treatment integrity specified for this study (it was decided that treatment integrity would be assumed if five percent or less than five percent of the interventions were nonEFT). This suggests that therapists in both active treatments adhered closely to the EFT manual.

The percentage of inter-rater agreement concerning EFT therapist interventions in the first phase (i.e., sessions two through eight of both EFT and EFT+CT) was 53.9 percent. The percentage of agreement in the second phase
(i.e., sessions nine through 11 of the EFT condition) was 61.7 percent. Both of these percentage agreements are quite low. Because the investigator was required to make numerous decision rules about the implementation of Part A of the EFT checklist, it would appear that this part of the checklist was not well enough specified by its originator (Johnson, 1984) to be used effectively by an independent researcher.

A total of 403 interventions were rated by CT raters. Of this total, two interventions (one-half of one percent) were categorized as nonCT and 99.5 percent as CT. This proportion of nonCT interventions is very small, and suggests that CT therapists adhered very closely to the CT component manual.

The percentage of inter-rater agreement concerning CT therapist interventions was 79.65 percent. This percentage of agreement is satisfactory (Borg & Gall, 1983), and indicates that both raters were able to achieve a reasonable level of agreement in categorizing CT interventions.

**RESULTS OF ANALYSES OF TREATMENT EFFECTS**

**Analyses with the couple as the unit of analysis**

Analyses of treatment effects were conducted first with the couple as the unit of analysis. The means and standard deviations on each of the dependent variables assuming this unit of analysis are presented in Table C-20 (see Appendix C). The results of five analyses are described below, two corresponding to the first research hypothesis (i.e., Analysis 1A, 1B), and three corresponding to the second research hypothesis (i.e., Analysis 2A, 2B, 2C).
Analysis 1A: Comparison of EFT vs. Control and EFT+CT vs. Control at pre-test and post-test on the Dyadic Adjustment Scale (DAS) (total score), Communication Scale (CS), Psychosocial Intimacy Questionnaire (PIQ), and Passionate Love Scale (PLS)

The repeated measures MANOVA indicated a statistically significant group x time interaction: approx. F (8,72) = 2.34, p = .027 (see Table 1). Univariate analyses, corrected by the Bonferroni procedure (λ = .05/4), showed significant group x time interaction effects on the Dyadic Adjustment Scale (total score) and Communication Scale, but not on the Psychosocial Intimacy Questionnaire or the Passionate Love Scale (see Table 2). Two planned nonorthogonal contrasts were
Table 2

Summary ANOVA of Analysis 1A: EFT vs. Control and EFT+CT vs. Control at Pre-Test and Post-Test on the Dyadic Adjustment Scale (DAS) (Total Score), Communication Scale (CS), Psychosocial Intimacy Questionnaire (PIQ), and Passionate Love Scale (PLS) (N = 42)

<table>
<thead>
<tr>
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<th>Source</th>
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<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>DAS</td>
<td>Between Group [G]</td>
<td>397.72</td>
<td>2</td>
<td>198.86</td>
<td>.93</td>
<td>.405</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>8381.84</td>
<td>39</td>
<td>214.92</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Within Occasion [0]</td>
<td>3420.19</td>
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<td>3420.19</td>
<td>56.25</td>
<td>&lt;.001*</td>
</tr>
<tr>
<td></td>
<td>O x G</td>
<td>691.19</td>
<td>2</td>
<td>345.59</td>
<td>5.68</td>
<td>.007*</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>2371.13</td>
<td>39</td>
<td>60.79</td>
<td></td>
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</tr>
<tr>
<td>PIQ</td>
<td>Between Group [G]</td>
<td>1178.43</td>
<td>2</td>
<td>589.22</td>
<td>.51</td>
<td>.607</td>
</tr>
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<td></td>
<td>Error</td>
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<td>39</td>
<td>1164.67</td>
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</tr>
<tr>
<td></td>
<td>Within Occasion [0]</td>
<td>10109.10</td>
<td>1</td>
<td>10109.10</td>
<td>29.39</td>
<td>&lt;.001*</td>
</tr>
<tr>
<td></td>
<td>O x G</td>
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<td>2</td>
<td>787.77</td>
<td>2.29</td>
<td>.115</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>13414.76</td>
<td>39</td>
<td>343.97</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CS</td>
<td>Between Group [G]</td>
<td>34.13</td>
<td>2</td>
<td>17.06</td>
<td>.33</td>
<td>.718</td>
</tr>
<tr>
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<td>Error</td>
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<td>39</td>
<td>51.02</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Within Occasion [0]</td>
<td>665.86</td>
<td>1</td>
<td>665.86</td>
<td>36.41</td>
<td>&lt;.001*</td>
</tr>
<tr>
<td></td>
<td>O x G</td>
<td>214.54</td>
<td>2</td>
<td>107.27</td>
<td>5.87</td>
<td>.006*</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>713.22</td>
<td>39</td>
<td>18.29</td>
<td></td>
<td></td>
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<tr>
<td>PLS</td>
<td>Between Group [G]</td>
<td>386.73</td>
<td>2</td>
<td>193.37</td>
<td>.49</td>
<td>.616</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>15385.84</td>
<td>39</td>
<td>394.51</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Within Occasion [0]</td>
<td>535.05</td>
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<td>535.05</td>
<td>9.85</td>
<td>.003*</td>
</tr>
<tr>
<td></td>
<td>O x G</td>
<td>214.90</td>
<td>2</td>
<td>107.45</td>
<td>1.98</td>
<td>.152</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>2199.30</td>
<td>39</td>
<td>54.34</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Significant at $\alpha = .05/4 = .013$. 
conducted using Dunn's procedure of multiple comparisons (Kirk, 1982) on the post-test scores of both the Dyadic Adjustment Scale and Communication Scale. As is shown in Table 3, both treatment groups were significantly higher than the control group on the Dyadic Adjustment Scale. Only the EFT + CT condition achieved significantly higher gains than the control group on the Communication Scale.

Table 3
Summary of Planned Nonorthogonal Contrasts of Analysis 1A: EFT vs. Control and EFT + CT vs. Control at Post-Test on the Dyadic Adjustment Scale (DAS) (Total Score) and Communication Scale (CS)

<table>
<thead>
<tr>
<th>Measures</th>
<th>Group Means</th>
<th>Contrasts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EFT</td>
<td>EFT + CT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DAS</td>
<td>103.30</td>
<td>105.60</td>
</tr>
<tr>
<td>CS</td>
<td>31.71</td>
<td>34.50</td>
</tr>
</tbody>
</table>

Note. tD represents the t statistic used with Dunn's procedure.

* Significant at α = .05.

In this analysis, the multivariate F statistic for the main time effect (times averaged over groups) was significant, as were the univariate F statistics for the main time effects on all the dependent measures (see Table 1 and 2). Because the research hypothesis under consideration in this analysis pertains to significant differences among occasions between groups (not averaged over groups), this main time effect is not relevant.
Analysis 1B: Comparison of EFT vs. Control and EFT+CT vs. Control at post-test on Target Complaints (TC)

The univariate analysis indicated a significant group effect: approx. $F(2,39) = 13.72, p < .001$ (see Table 4). Two planned nonorthogonal contrasts indicated that both treatment groups achieved significant gains over the control group (see Table 5).

Table 4
Summary ANOVA of Analysis 1B: EFT vs. Control and EFT+CT vs. Control at Post-Test on Target Complaints (TC)

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>17.33</td>
<td>2</td>
<td>8.67</td>
<td>13.72</td>
<td>&lt;.001*</td>
</tr>
<tr>
<td>Error</td>
<td>24.64</td>
<td>39</td>
<td>.63</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Significant at $a = .05$.

Table 5
Summary of Planned Nonorthogonal Contrasts of Analysis 1B: EFT vs. Control and EFT+CT vs. Control at Post-Test on Target Complaints (TC)

<table>
<thead>
<tr>
<th>Measures</th>
<th>Group Means</th>
<th>Contrasts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EFT</td>
<td>EFT+CT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TC</td>
<td>4.36</td>
<td>4.50</td>
</tr>
</tbody>
</table>

* Significant at $a = .05$. 

...
Analysis 2A: Comparison of EFT vs. EFT+CT at pre-test, post-test, and follow-up on the Dyadic Adjustment Scale (DAS) (total score), Communication Scale (CS), Psychosocial Intimacy Questionnaire (PIQ), and Passionate Love Scale (PLS)

The group x occasion interaction of the repeated measures MANOVA was not statistically significant: approx. F (8,42) = 1.12, p = .369 (see Table 6). Because this is the interaction that is relevant to the research hypothesis under consideration, no follow-up analyses were conducted.

Table 6
Summary MANOVA of Analysis 2A: EFT vs. EFT+CT at Pre-Test, Post-Test, and Follow-Up on the Dyadic Adjustment Scale (DAS) (Total Score), Communication Scale (CS), Psychosocial Intimacy Questionnaire (PIQ), and Passionate Love Scale (PLS)

N = 28

<table>
<thead>
<tr>
<th>Source</th>
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<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
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<tr>
<td>Group [G]</td>
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<td>.992</td>
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<tr>
<td>Therapist [T(G)]</td>
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<td>48,44.41</td>
<td>.224</td>
</tr>
<tr>
<td>Within</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occasion [0]</td>
<td>6.28</td>
<td>8,42</td>
<td>&lt;.001*</td>
</tr>
<tr>
<td>0 x G</td>
<td>1.12</td>
<td>8,42</td>
<td>.369</td>
</tr>
<tr>
<td>0 x T(G)</td>
<td>1.22</td>
<td>96,101.56</td>
<td>.161</td>
</tr>
</tbody>
</table>

Note. Parentheses indicate a nesting relationship.

* Significant at α=.05.

Analysis 2A did reveal a significant main time effect (see Table 6). This effect indicates that there were significant differences among occasions averaged
over groups. Because the research hypothesis under consideration in this analysis pertains to significant differences among occasions between groups (not averaged over groups), this main time effect is not relevant.

Analysis 2B: Comparison of EFT vs. EFT+CT at pre-test, eight weeks, post-test, and follow-up on the Dyadic Adjustment Scale (DAS) subscales (DAS-Consensus, DAS-Affectional Expression, DAS-Cohesion, DAS-Satisfaction)

The group x occasion interaction of the repeated measures MANOVA was not statistically significant: approx. F (12,84.96) = 1.06, p = .404 (see Table 7). Given this finding, no follow-up analyses were conducted.

Table 7
Summary MANOVA of Analysis 2B: EFT vs. EFT+CT at Pre-Test, Eight Weeks, Post-Test, and Follow-Up on the Dyadic Adjustment Scale Subscales (DAS-Consensus, DAS-Affectional Expression, DAS-Cohesion, DAS-Satisfaction)

<table>
<thead>
<tr>
<th>Source</th>
<th>Approx. F</th>
<th>Approx. df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups [G]</td>
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<td>.907</td>
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<tr>
<td>Therapist [T(G)]</td>
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<td>48,44.41</td>
<td>.567</td>
</tr>
<tr>
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<td>12,84.96</td>
<td>&lt;.001*</td>
</tr>
<tr>
<td>0 x G</td>
<td>1.06</td>
<td>12,84.96</td>
<td>.404</td>
</tr>
<tr>
<td>0 x T(G)</td>
<td>.95</td>
<td>140,161.9</td>
<td>.610</td>
</tr>
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</table>

* Significant at α=.05.
The repeated measures MANOVA indicated a statistically significant main time effect (see Table 7). Because the research hypothesis under consideration in this analysis pertains to significant differences among occasions between groups (not averaged over groups), this main time effect is not relevant.

Analysis 2C: Comparison of EFT vs. EFT+CT at post-test and follow-up on Target Complaints (TC)

The repeated measures ANOVA on the individualized dependent variable, Target Complaints, indicated a statistically significant group x occasion interaction: F(1,12) = 4.89, p = .047 (see Table 8). Two planned nonorthogonal contrasts were conducted, one on the post-test scores and the other on the follow-up scores. As is shown in Table 9, there were no significant differences between EFT and EFT+CT at post-treatment. At follow-up, the EFT group was superior to the EFT+CT group.

The repeated measures ANOVA indicated a statistically significant main time effect (see Table 8). An inspection of the group means (EFT: 4.36 at post-test and 4.00 at follow-up; EFT+CT: 4.50 at post-test and 3.61 at follow-up) indicates that while couples in both treatments experienced post-treatment regression, EFT+CT couples did so to a greater degree than EFT couples did.
Table 8
Summary ANOVA of Analysis 2C: EFT vs. EFT+CT at Post-Test and Follow-Up on Target Complaints (TC)

N = 28

<table>
<thead>
<tr>
<th>Source</th>
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<td>Between</td>
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<td></td>
<td></td>
</tr>
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<td>Group [G]</td>
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<td>.22</td>
<td>.39</td>
<td>.544</td>
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<td>Therapist [T(G)]</td>
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<td>.56</td>
<td>.90</td>
<td>.567</td>
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<td>Within</td>
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<td>5.47</td>
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<tr>
<td>O x G</td>
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<td>1.00</td>
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* Significant at $a = .05$.

Table 9
Summary of Planned Nonorthogonal Contrasts of Analysis 2C: EFT vs. EFT+CT at Post-Test and Follow-Up on Target Complaints (TC)

N = 42

<table>
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<td></td>
<td>Post tD</td>
<td>Follow-up tD</td>
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<tr>
<td>TC</td>
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<td></td>
<td>4.00</td>
<td>3.61</td>
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* Significant at $a = .05$. 
Summary of analyses with the couple as the unit of analysis

In the first part of the data analysis corresponding to the first research hypothesis, both EFT and EFT+CT achieved significantly higher gains than the control group at post-test on the Dyadic Adjustment Scale (total score) and Target Complaints. Group means on the total Dyadic Adjustment Scale for both treatment conditions and the control group are presented graphically in Figure 1. On a third measure, the Communication Scale, only the EFT+CT condition achieved significantly higher gains at post-test than the control group. Although there were trends in the hypothesized direction on the Psychosocial Intimacy Questionnaire and Passionate Love Scale, differences on these measures were not significant.

In the second part of the data analysis corresponding to the second research hypothesis, no significant differences were found between EFT and EFT+CT at post-test and follow-up on the Dyadic Adjustment Scale (total score) and its four subscales (DAS-Consensus, DAS-Affectional Expression, DAS-Cohesion, DAS-Satisfaction), nor on the Communication Scale, Psychosocial Intimacy Questionnaire, and Passionate Love Scale. Significant between group differences were found on only the individualized measure, Target Complaints. Contrary to the directional hypothesis, EFT was superior to EFT+CT on this measure at the four-month follow-up.
Note. EFT = ● EFT + CT = ◆ C = ▲

Control group was not assessed at eight weeks or follow-up.

Figure 1. Group means on total DAS couple scores.
Analyses with the individual as the unit of analysis

Because of the possibility of differential effects of treatment for males and females, the analyses pertaining to the second hypothesis of this study (i.e., Analysis 2A, 2B, 2C) were repeated with the individual as the unit of analysis. The crucial test statistic in these analyses was the group x gender x occasion interaction. The significance of this interaction would indicate differential treatment effects between males in EFT and males in EFT + CT on different occasions and/or between females in EFT and females in EFT + CT on different occasions. The means and standard deviations on each of the dependent variables assuming the individual as the unit of analysis are presented in Table C-21 (see Appendix C).

Analysis 2A: Comparison of EFT vs. EFT + CT at pre-test, post-test, and follow-up on the Dyadic Adjustment Scale (DAS) (total score), Communication Scale (CS), Psychosocial Intimacy Questionnaire (PIQ), and Passionate Love Scale (PLS) with the individual as the unit of analysis

The group x gender x time interaction of the repeated measures MANOVA was not significant: F(8, 42) = 1.07, p = .404 (see Table 10). This indicates that there were no differential treatment effects between males in EFT and males in EFT + CT on different occasions or between females in EFT and females in EFT + CT on different occasions. Given this finding, no follow-up analyses were conducted.

In this analysis, there was a main gender effect (see Table 10). This indicates that there were differential effects between men and woman averaged
Table 10

Summary MANOVA of Analysis 2A: EFT vs. EFT + CT at Pre-Test, Post-Test, and Follow-Up on the Dyadic Adjustment Scale (DAS) (Total Score), Communication Scale (CS), Psychosocial Intimacy Questionnaire (PIQ), and Passionate Love Scale (PLS) With the Individual as the Unit of Analysis

N = 28

<table>
<thead>
<tr>
<th>Source</th>
<th>Approx. F</th>
<th>Approx. df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
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<td>48,98.34</td>
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<td>Gender [Ge]</td>
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<td>.003 *</td>
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<td>.621</td>
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<td><strong>Within</strong></td>
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<tr>
<td>Occasion [0]</td>
<td>6.53</td>
<td>8,42</td>
<td>&lt;.001 *</td>
</tr>
<tr>
<td>0 x Gr</td>
<td>1.17</td>
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<td>.340</td>
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<tr>
<td>0 x T(Gr)</td>
<td>1.31</td>
<td>96,212.48</td>
<td>.056</td>
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<td>O x Ge</td>
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<td>.080</td>
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<td>O x Ge x Gr</td>
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<td>O x Ge x T(Gr)</td>
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<td>96,212.48</td>
<td>.943</td>
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</tbody>
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Note: Parentheses indicate a nesting relationship.

* Significant at α = .05.

over groups and occasions. An inspection of the group means on these measures (see Appendix C-19) indicates that men achieved higher scores on average than women. Because this main effect is not relevant to the hypothesis under consideration, it was not investigated further.

The main effect of therapist nested within group was also significant (see
Table 10). The differential effectiveness of therapists nested within treatments is not an unexpected finding given individual differences in efficacy among therapists. This finding was not examined further because the random nuisance factor, therapist, was not the focus of this study.

**Analysis 2B:** Comparison of EFT vs. EFT+CT at pre-test, eight weeks, post-test, and follow-up on the Dyadic Adjustment Scale (DAS) subscales (DAS-Consensus, DAS-Affectional Expression, DAS-Cohesion, DAS-Satisfaction) with the individual as the unit of analysis

The group x gender x time interaction of the repeated measures MANOVA was not significant: $F(12, 87.60) = 1.35, p = .205$ (see Table 11). Because this indicates that there were no differential treatment effects for males and females on different occasions, no follow-up analyses were conducted.

The main effect of the therapist nested within group factor was significant (see Table 11). This factor was not examined further because the random nuisance factor, therapist, was not the focus of this study. The main time effect was also significant (see Table 11). This effect is identical to and echoes the significant main time effect in Analysis 2B, where the couple was the unit of analysis (see Table 7).

**Analysis 2C:** Comparison of EFT vs. EFT+CT at post-test and follow-up on Target Complaints (TC) with the individual as the unit of analysis

The group x gender x time interaction of the repeated measures ANOVA was not significant: $F(1,12) = .35, p = .563$ (see Table 12). Given this finding,
Table 11

Summary MANOVA of Analysis 2B: EFT vs. EFT+CT at Pre-Test, Eight Weeks, Post-Test and Follow-Up on the Dyadic Adjustment Scale (DAS) Subscales (DAS-Consensus, DAS-Affectional Expression, DAS-Cohesion, DAS-Satisfaction) With the Individual as the Unit of Analysis

N = 28

<table>
<thead>
<tr>
<th>Source</th>
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<th>Approx. df</th>
<th>p</th>
</tr>
</thead>
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<td>Therapist [T(Gr)]</td>
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<td>Gender [Ge]</td>
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<td>.999</td>
</tr>
<tr>
<td>Within Occasion</td>
<td>6.53</td>
<td>12,87.60</td>
<td>&lt;.001*</td>
</tr>
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<td>0 x Gr</td>
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<td>0 x T(G)</td>
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<td>.077</td>
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<td>.032*</td>
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<td>144,325.28</td>
<td>.999</td>
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</tbody>
</table>

* Significant at $a = .05$.

no follow-up analyses were conducted.

The group x time interaction was significant (see Table 12). This effect is identical to and echoes the significant group x time interaction in Analysis 1C, where the couple was the unit of analysis (see Table 8).

In this analysis the main effect of therapist nested within group was significant, as was the gender x therapist nested within group interaction (see Table 12). These significant sources of variance were not examined further.
Table 12

Summary ANOVA of Analysis 2C: EFT vs. EFT+CT at Post-Test and Follow-Up on Target Complaints (TC) With the Individual as the Unit of Analysis

N = 28

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<tr>
<th>Source</th>
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<th>MS</th>
<th>F</th>
<th>p</th>
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<td>.44</td>
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<td>.544</td>
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<td>&lt;.001*</td>
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<td>Gender [Ge]</td>
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<td>1.08</td>
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<td>.22</td>
<td>.17</td>
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<tr>
<td>Ge x T(Gr)</td>
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<tr>
<td>Error</td>
<td>6.75</td>
<td>28</td>
<td>.24</td>
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Within Occasion

<table>
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<tr>
<th>Source</th>
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<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
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<tr>
<td>Occasion [0]</td>
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<td>10.94</td>
<td>26.63</td>
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<td>0 x Gr</td>
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<td>2.01</td>
<td>4.89</td>
<td>.047*</td>
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<tr>
<td>0 x T(G)</td>
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<td>1.07</td>
<td>.420</td>
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<tr>
<td>O x Ge</td>
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<td>1.08</td>
<td>1.71</td>
<td>.215</td>
</tr>
<tr>
<td>O x Ge x Gr</td>
<td>.22</td>
<td>1</td>
<td>.22</td>
<td>.35</td>
<td>.563</td>
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<td>O x Ge x T(Gr)</td>
<td>7.57</td>
<td>12</td>
<td>.63</td>
<td>1.64</td>
<td>.136</td>
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<tr>
<td>Error</td>
<td>10.75</td>
<td>28</td>
<td>.38</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Significant at $a = .05$.

because the random nuisance factor, therapist, was not the focus of this study.

Summary of analyses with the individual as the unit of analysis

When the data of the three analyses pertaining to the second hypothesis (i.e., Analysis 2A, 2B, 2C) were reanalyzed using the individual as the unit of analysis, no significant group x gender x occasion interactions were found. This indicates that neither EFT nor EFT+CT were differentially effective with males or females on different occasions.
Clinical significance of treatment effects

The clinical significance of treatment effects on the Dyadic Adjustment Scale (DAS) was determined using the two criteria proposed by Jacobson and Follette (1985). These authors define the first criterion as whether or not the couple's score places them closer to the mean of the functional population than to the mean of the dysfunctional population on the variable of interest. This criterion is operationalized by establishing a cut-off score based on norms for the variable of interest.

Jacobson and Follette's (1985) second criterion is that the change in a couple's score must be of sufficient magnitude to rule out measurement error as a potential explanation for the change. Jacobson, Follette and Revenstorf (1986) operationalize this criterion as the reliable change index (RC), which is the difference between pre-test and post-test scores divided by the standard error of difference (for a complete explanation of this criterion and its operationalization, see chapter three).

In this study, the standard error of difference was computed to be 2.64. This required a difference score (post score minus pre score) of at least five points in order to calculate a RC index of equal to or greater than 1.96 and to conclude that the change score on the DAS was (probably) statistically reliable (for a detailed explanation, see chapter three). Following Jacobson and Follette (1985), in this study the cut-off score on the DAS was set at 97.
Percentages of couples improved and no longer distressed

Following Jacobson & Follette (1985), the RC index, when applied alone, was considered to reflect the percentage of couples who were "improved". In order to be deemed "improved" in this study, a couple's score had to have an increase of five points or more from pre-test to post-test (or pre-test to follow-up). As Table 13 shows, while the majority of couples in both active treatment groups were improved at post-test, only half of the wait-list control couples were improved. At follow-up the percentages of couples improved had dropped somewhat such that approximately three quarters of the couples in both treatment groups were improved.

Table 13
Percentages of Couples Improved and No Longer Distressed

Post-test N = 42

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>Improved</th>
<th>No longer distressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>EFT</td>
<td>14</td>
<td>86%</td>
<td>79%</td>
</tr>
<tr>
<td>EFT+CT</td>
<td>14</td>
<td>93%</td>
<td>71%</td>
</tr>
<tr>
<td>C</td>
<td>14</td>
<td>50%</td>
<td>21%</td>
</tr>
</tbody>
</table>

Follow-up N = 28

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>Improved</th>
<th>No longer distressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>EFT</td>
<td>14</td>
<td>71%</td>
<td>50%</td>
</tr>
<tr>
<td>EFT+CT</td>
<td>14</td>
<td>79%</td>
<td>57%</td>
</tr>
</tbody>
</table>

Note. The "improved" column is based on the RC index; the "no longer distressed" column is based on the RC index and the cut-off score of 97 on the DAS.
Following Jacobson & Follette (1985), the RC index was applied in combination with the cut-off score on the DAS. This combination, which is considered a conservative estimate of clinical significance, reflects couples who were "no longer distressed". In order to be deemed "no longer distressed" in this study, couples had to have experienced a rise of five points or more in their couple score from pre-test to post-test (or pre-test to follow-up) and had to have a couple score of 97 or more at post-test (or follow-up).

As Table 13 shows, while approximately three-quarters of the couples in both active treatment groups were "no longer distressed" at post-test, slightly less than one-quarter of the couples in the wait-list control were no long distressed. Relative to pre-test scores, at follow-up 50 percent of the couples in EFT and 57 percent of the couples in EFT+CT were no longer distressed. In other words, approximately one-half of the couples appeared to be benefiting from therapy at follow-up in terms of the criteria employed.

Percentages of couples deteriorated

The phenomenon of deterioration has been well documented in the field of marital and family therapy (Gurman & Kniskern, 1981). Jacobson, Follette, and Elwood (1984a) suggest that approximately five percent of couples receiving cognitive-behavioral marital therapy actually deteriorate during the course of therapy. It was important to determine in this study the percentage of couples
that deteriorated over the course of therapy.

Jacobson and Follette (1985) note that because there exists no standardized criteria of clinically significant deterioration, the only available criteria for determining deterioration rates are those relying exclusively on statistical decision rules. Following these authors, deterioration rates were calculated using the RC index. In this study, couples were considered deteriorated if their couple score on the DAS dropped by five points or more from pre-test to post-test (or pre-test to follow-up).

As Table 14 shows, while no couples had deteriorated in the EFT+CT group at post-test, two couples (14 percent) had deteriorated in the EFT group. Relative to pre-test, at follow-up one couple (seven percent) had deteriorated in each treatment condition.

Table 14
Percentages of Couples Deteriorated

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>Post</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>EFT</td>
<td>14</td>
<td>14%</td>
<td>7%</td>
</tr>
<tr>
<td>EFT+CT</td>
<td>14</td>
<td>0%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Note. Deterioration percentages are based on the RC index.
Structured interview

A two-part structured interview was conducted at post-test in order to elicit clients’ reactions to the EFT treatment and the CT component. The results of this interview are summarized in a descriptive fashion.

Part A: Clients’ reactions in EFT and EFT+CT to the EFT treatment

In response to the question of what they found most helpful about the Emotionally Focused approach, couples in both active treatment groups (n=28) identified the following general areas: (1) increased awareness and expression of feelings and needs, (2) increased understanding of the partner, (3) the role of the therapist in facilitating the expression of feelings and validating feelings, remaining neutral/objective, focusing on issues, providing emotional support, (4) the definition and discussion of issues, (5) improved communication, (6) having a regular, scheduled time to focus on the relationship, (7) having a "safe" environment in which to discuss difficult issues, (8) increased understanding of one’s self, particularly feelings and needs, (9) increased closeness and commitment, and (10) increased awareness of problematic interactions.

In a previous study (Greenberg, James, & Conry, 1988), five categories of change processes in EFT were identified from clients’ self-reports. In this study, individuals (n=56) were asked to choose which category had been most important in helping them change their relationships. The categories, and the percentages of partners who selected each were: (a) seeing my partner experience feelings (often
with real intensity) that he or she does not show typically in our relationship (25 percent), (b) coming to new understandings or realizations (often deeply felt) about myself, my partner, or the relationship (50 percent), (c) taking responsibility for my part of the problem (3.5 percent), (d) sharing feelings and thoughts that I would not share normally with my partner (12.5 percent), and (e) having the therapist validate the legitimacy of my feelings or way of looking at things (9 percent).

Part B: Clients' reactions in EFT+CT to the CT component

In response to the question of what they found most helpful about the CT component, couples in the EFT+CT group identified the following general areas: (1) improved listening, (2) increased awareness and expression of underlying feelings and needs, (3) the provision of a structure which facilitated the discussion of difficult issues, (4) the role of the therapist in modeling and providing feedback, (5) learning basic communication skills of expression and responding, (6) defining and resolving issues, (7) the opportunity to make a complete, clear expression of one's position, (8) practicing the communication skills in the sessions and at home, (9) learning that it is possible to understand one's partner without agreeing.

In response to the question of what it was like to learn communication skills after eight sessions of EFT, approximately one-half of the clients (n=28) indicated that initially they felt some degree of discomfort learning the communication skills because they experienced these skills as unnatural,
nonspontaneous, and restrictive after the free-flowing, spontaneous character of the EFT sessions. By the second session of the CT component, these individuals expressed that they were beginning to feel comfortable with and to appreciate the CT communication skills.

Individuals in the EFT+CT group (n = 28) were asked whether they would have preferred to receive more communication training sessions, more of the Emotionally Focused sessions, or the same proportion as in this study (i.e., eight sessions of EFT plus four sessions of CT). This question presupposed the same limit of 12 sessions as couples received in this study. Fifty-seven percent of the individuals expressed a preference for more CT sessions. Thirty-nine percent preferred the same proportion of EFT and CT sessions as in this study. Only one individual expressed a preference for more EFT sessions.

Of the individuals who expressed a preference for more CT sessions, these individuals would have preferred an additional one or two sessions. The rationale of approximately three-quarters of these individuals for wanting a few more communication training sessions was that they lacked confidence in their ability to use the skills and wanted more practice.

In the final question of the structured interview, individuals were asked, "If you were to recommend couples counselling to a friend, would you recommend the communication training approach, the Emotionally Focused approach, or the combination you experienced in this project?" All but one individual (96 percent) stated that they would recommend the combined approach. The general explanation given by individuals for preferring the combined approach seemed to be that they perceived both approaches to make a valuable contribution, and to
fit together well. Expressions that are typical of how individual clients perceived EFT's contribution were: "opening each other up to how they felt", "building trust with the therapist and one's partner", "helping to understand one's partner and one's self", and "exploring what's going on in the relationship". Expressions that are typical of how individual clients perceived the contribution of the CT component were: "teaching a new way to communicate", and "providing a tool that can be used in the future to resolve problems".

Individuals perceived that the two approaches fit together well, and expressed this notion in different ways. Several clients spoke of EFT raising issues and feelings that could later be talked about in the CT component. A few clients mentioned that once the emotional issues had been aired in EFT, it was easier to go on to learning skills. Another client stated that EFT laid the groundwork for talking directly to the partner in the CT component by establishing trust with the partner and therapist.
CHAPTER V: DISCUSSION OF RESULTS

FIRST RESEARCH HYPOTHESIS: EFFECTIVENESS OF BOTH TREATMENTS COMPARED TO THE WAIT-LIST CONTROL

The first hypothesis of this investigation was that both treatment groups would achieve higher gains than the wait-list control group at post-test. This hypothesis was supported partially by both the statistical and clinical analyses.

The statistical analysis indicated that both EFT and EFT+CT achieved significantly higher gains than the wait-list control group at post-test on the Dyadic Adjustment Scale (DAS) (total score) and Target Complaints (TC). On the Communication Scale (CS), only the EFT+CT condition achieved significantly higher gains than the wait-list control group. Although there were trends in the direction of significance on the Psychosocial Intimacy Questionnaire (PIQ) and Passionate Love Scale (PLS), no significant differences were found on these measures.

Before proceeding to the discussion of these mixed results, it is appropriate to note the results of the analysis of clinical significance. At post-test on the DAS (total score), the percentages of couples "no longer distressed" in EFT and EFT+CT were 79 percent and 71 percent respectively, while the percentage of couples "no longer distressed" in the wait-list control group was 21 percent. Although this analysis is much less powerful than the statistical analysis, it is consistent with the latter in that it shows that both treatments were partially effective compared to the wait-list control.
It is important to account for the mixed results of the first hypothesis. That the EFT+CT group achieved significantly higher gains on the Communication Scale compared to the wait-list control group than the EFT group did, suggests that couples in therapy are more likely to experience superior immediate gains in communication compared to couples who are not in therapy if the therapeutic approach used specifically targets communication as an area of change.

Given that the stated goal of EFT is to repair intimate emotional bonds (Johnson & Greenberg, 1987), the failure of either treatment to achieve significant gains on the Psychosocial Intimacy Questionnaire compared to the wait-list control requires discussion. An explanation of this finding is that the attenuation of adult intimate emotional bonds is best construed as a process that takes place gradually over time in the life of the relationship. Just as it takes time for relationship bonds to be eroded, so also it takes time for these bonds to be repaired. In other words, once a sense of security, trust, and closeness is eroded, these affectional components are not restored immediately. If this view is correct, perhaps it is naive to expect significant gains in intimacy with a brief time-limited application of EFT. Perhaps researchers would be advised to have more modest expectations concerning the extent to which the damaged emotional bonds of distressed couples may be repaired in brief applications of EFT.

In the context of this discussion, it should be noted that the Passionate Love Scale was included in this study as a secondary measure. The reason for its inclusion was to explore a construct that is typically identified as an adolescent phenomenon but that appears to span the life cycle (Hatfield &
Sprecher, 1986) in the context of marital therapy. The findings in this study suggest that the construct of passionate love is not easily changed therapeutically. An inspection of EFT and EFT+CT mean couple scores reinforces this (see Table C-20). The mean couple score of the EFT group actually dropped below pre-treatment levels at follow-up while the EFT+CT group remained above pre-treatment levels at follow-up. While these exploratory findings do not appear promising with respect to the construct of passionate love as a target of change in couples therapy, further investigation is warranted.

To conclude this discussion of the mixed results of the first hypothesis, both treatment conditions were superior to the wait-list control on the Dyadic Adjustment Scale (total score) and Target Complaints, but not on the Psychosocial Intimacy Questionnaire and Passionate Love Scale (these measures showed trends toward significance but failed to reach significance). This suggests that it may be easier to effect therapeutic change in marital therapy on certain dimensions of relationship functioning than others. It would appear that the constructs of marital adjustment and target complaints are more responsive to therapeutic intervention than constructs that share in common the general dimension of intimacy/passionate love.

An explanation of this phenomenon may be that constructs in which the notion of the emotional bond (Johnson & Greenberg, 1987) is central are less responsive to therapeutic change because repairing the emotional bonds of moderately distressed couples is a difficult process that requires considerably more time than is typical of brief therapy.
SECOND RESEARCH HYPOTHESIS: DIFFERENTIAL EFFECTIVENESS OF EFT COMPARED TO EFT+CT

The second research hypothesis of this investigation was that the addition of the CT component would enhance the effectiveness of EFT at post-test and four-month follow-up on the four subscales of the Dyadic Adjustment Scale (DAS) (i.e., DAS-Consensus, DAS-Affectional Expression, DAS-Cohesion, DAS-Satisfaction), the Communication Scale (CS), the Psychosocial Intimacy Questionnaire (PIQ), and Passionate Love Scale (PLS). The statistical analysis did not support this hypothesis. On seven of eight dependent variables (i.e., DAS-Consensus, DAS-Affectional Expression, DAS-Cohesion, DAS-Satisfaction, CS, PIQ, and PLS) there were no differential treatment effects at post-treatment or at follow-up with either the couple or the individual as the unit of analysis. In addition, no differential treatment effects were found when the total score of the DAS was analyzed as a global measurement of marital adjustment.

On one dependent variable, Target Complaints (TC), differential treatment effects were found in favour of EFT at follow-up with the couple as the unit of analysis. An inspection of the group means (EFT: 4.36 at post-test and 4.00 at follow-up; EFT+CT: 4.50 at post-test and 3.61 at follow-up) indicates that couples in the EFT+CT group were continuing to achieve their goals to a moderate degree at follow-up but that they experienced much more post-treatment regression than the EFT group did.

The magnitude of the post-treatment regression experienced by the EFT+CT group on this measure compared to the EFT group is interesting. An
inspection of the group means of the other measures (see Table C-20) indicates, that with the exception of DAS-Consensus, on which the EFT+CT group dropped below the EFT group to a negligible degree (44.11 vs. 44.54 respectively), on none of the other measures did the EFT+CT group fall below the EFT group. The EFT+CT group’s slippage on Target Complaints may be attributed to client expectations. Perhaps the couples in this group had high expectations at termination that they would continue to achieve their goals by applying the communication skills they had recently been introduced to and subsequently experienced disillusionment when they had difficulty doing so.

The second hypothesis was unsupported not only by the statistical analysis but also by the analysis of clinical significance. At post-test and follow-up, the percentages of couples "no longer distressed" on the DAS (total score) were essentially equivalent in both groups. More specifically, at post-test 79 percent of the couples in EFT and 71 percent of the couples in EFT+CT were no longer distressed, while at follow-up 50 percent of the couples in EFT and 57 percent of the couples in EFT+CT were no longer distressed.

That neither statistical nor clinical analyses support the second hypothesis is an interesting finding. This is particularly true of the four-month follow-up. Because of the maintenance function of communication skills, it is on this occasion that differential treatment effects would have been hypothetically most likely to occur. Jacobson and Holtzman (1986), for example, note that without the skills orientation of cognitive-behavioral marital therapy, many couples who receive this therapeutic approach relapse after termination routinely and quickly, and with it more couples maintain their treatment gains.
In this experiment, couples in both treatments regressed from post-test to follow-up by approximately equivalent amounts on all measures (except as was mentioned above, on Target Complaints). For example, on the DAS (mean total couple score), the EFT group slipped back from 103.30 at post-test to 98.11 at follow-up, while the EFT+CT group slipped back from 105.6 at post-test to 100 at follow-up.

Several explanations of the null findings pertaining to the second hypothesis, and more specifically, of the CT component's failure to prevent post-treatment regression, are possible. One possible explanation is that the CT component failed to enhance EFT because it targeted the wrong issues. According to this explanation, the fundamental issues of distressed couples are issues of bonding and emotional commitment to the relationship rather than communication skill deficits. This explanation appears plausible when one considers that the level of functioning of the EFT+CT group immediately prior to the introduction of the CT component was in the distressed range (the EFT+CT mean total DAS score at the end of the eighth session was 93.64). In other words, perhaps the CT component failed to enhance EFT at both post-test and follow-up because the fundamental issues of couples at this level of functioning pertained to bonding and emotional commitment rather than to skill deficits.

What mitigates against this explanation is that the EFT group, which was at a comparable level of functioning at the end of the eighth session (mean of 93.75), and which received four additional sessions targeted at the issues of bonding and emotional commitment, failed to achieve gains that were superior to EFT+CT (except on Target Complaints at follow-up). Were this explanation
compelling, one would have expected the EFT group to have achieved gains that were consistently superior to EFT+CT at both post-test and follow-up. What also mitigates against this explanation is that the CT component did address emotional issues (e.g., the expression of underlying feelings) within a skills training framework.

A second explanation of the failure of the CT component to enhance EFT (particularly at follow-up) is that the CT component was not sufficiently powerful to ensure that couples learned the new communication skills well enough for these skills to "take hold". This view is supported by individuals' self-reports in the structured interview at termination. When asked whether they would have preferred to receive more communication training sessions, more of the EFT sessions, or the same proportion as in this study (i.e., eight sessions of EFT plus four sessions of CT), 57 percent of the individuals in the EFT+CT group (n=28) expressed a preference for one or two more CT sessions, while 39 percent expressed a preference for the same proportion. Of the 57 percent who expressed a preference for a few more CT sessions, approximately three quarters cited their lack of confidence and need for more practice in using the skills as the reason. These client perceptions suggest that the CT component failed to enhance EFT at post-test and in particular at follow-up because this component was not sufficiently potent in helping spouses incorporate the communication skills into their daily interactions.

This explanation raises the question of why the CT component lacked potency. One possible reason is that it was not delivered adequately. This explanation is unlikely because (a) therapists received a clearly specified training
program that used standard training procedures (i.e., instruction, modeling, behavioral rehearsal and feedback), (b) therapists were closely supervised as they administered the CT component, and (c) implementation checks indicated that therapists adhered to the CT component manual.

Another possible reason is that the CT component was not designed adequately. This explanation is unconvincing because the component was constructed in part from the basic communication skills of RE and in part from the primary mechanism of therapeutic change in EFT (i.e., teaching the expression of primary feelings and felt-needs as a skill).

The most likely reason for the CT component's lack of potency is that it was not of sufficient duration to have its intended effects. This position is supported by clients' self-reports in the structured interview at termination. Fifty-seven percent of individuals indicated that they would have wanted a few more CT sessions. The rationale cited by most of these individuals was that they did not feel confident about incorporating the communication skills into their daily interactions with their spouses.

A third explanation of the failure of the CT component to enhance EFT is that there may have been insufficient power to detect a difference between groups when differences existed. Kazdin (1986b) notes that if both treatments produce some change, the investigation must be sufficiently powerful to detect what may prove to be relatively small differences. Given mean differences between the active treatment groups of 2.30 raw score points at post-test and 1.89 points at follow-up on the DAS, and following Cohen's (1988) procedure for estimating the power of an interaction effect, the effect size of the group x
occasion interaction effect on the main dependent variable, the DAS, was .028. With rounding, this effect size is less than Cohen’s small effect size, which is set by convention at .10. The power corresponding to this effect size is less than .05. This is extremely low power for detecting a true difference between treatments.

Although the lack of statistical power is problematic, the difference in mean raw scores on the DAS between treatment groups at post-test and follow-up would seem to be so small as to be trivial regardless of whether or not there had been increased power. Applying the criterion of the Reliable Change index (Jacobson et al., 1984b), this study assumed that a change of five or more raw score points on the DAS was required in order for this change to be considered statistically reliable (i.e., not likely attributable to measurement error). Against this criterion, neither the difference in mean scores on the DAS between the active treatment groups at post-test (2.30 raw score points) or follow-up (1.89 raw score points) is statistically reliable. Without a larger treatment effect, increasing the sample size in order to increase power would appear pointless.

To conclude, the failure of the CT component to enhance the effectiveness of EFT may be attributed to both insufficient power and lack of treatment potency. Increasing the sample size and the potency of treatment might have counteracted these limitations and increased the probability of a significant result.
EFFECTIVENESS OF THIS STUDY AS A REPLICATION OF EFT

It is important to examine how this investigation qua replication of EFT compares to Johnson and Greenberg's (1985a) original study and Goldman's (1987) replication. When the effectiveness of the EFT treatment versus the wait-list control in this study is compared to the effectiveness of the EFT treatments versus the wait-list controls in these previous studies, it appears that this study may not be as effective as either of these studies. While the previous studies demonstrated EFT to be more effective than the wait-list controls on all the dependent variables, this study demonstrated the EFT treatment to be more effective on the Dyadic Adjustment Scale and Target Complaints, but not on the Communication Scale (except the EFT+CT condition at post-test), the Psychosocial Intimacy Questionnaire, and the Passionate Love Scale.

That this replication study of EFT appears to be less effective than the earlier studies may be related to three factors. The first factor is the specific dependent variables used. On the two measures which this study used in common with the earlier studies, the DAS and TC, this study showed that the EFT treatment achieved superior gains to the wait-list control. It is possible that the EFT treatment in this study would have appeared to be more effective if another variable that had been found to be significant in the earlier studies, the Goal Attainment Scaling (GAS) (Kiresuk & Sherman, 1968), had been used instead of the exploratory measure, PLS.

Another factor that may be related to this replication of EFT being less effective than the earlier studies is therapists' level of academic achievement and clinical experience. In the Johnson and Greenberg (1985a) study and the Goldman
In the (1987) study, all therapists had the minimum of a masters degree. In this study, six of the seven EFT therapists were magistral students. The six EFT therapists in the Johnson and Greenberg investigation were all experienced clinicians working in the field. The seven EFT therapists in the Goldman investigation were also experienced, with a minimum of two year’s experience in couples counselling. The EFT therapists in this study were experienced in general counselling (mean of 6.5 years), but less experienced in working with couples. Three therapists had had less than one year’s experience with couples, with the mean of all seven therapists being 1.93. That the EFT therapists in this study were somewhat less advanced than therapists in the earlier studies in terms of level of academic achievement and degree of clinical experience with couples may be related to this study appearing to be a less effective replication than the Goldman replication or the original study.

A third factor that may relate to the effectiveness of this replication of EFT compared to the earlier studies pertains to who conducted the training and supervision of therapists. This is the first outcome study of EFT in which the principal investigator of EFT, L. S. Greenberg, was not responsible for the training and supervision of therapists. In this study, this task was carried out by the writer. This writer’s clinical experience includes (a) participation as a therapist in the Johnson and Greenberg (1985b) partial replication study and the Goldman (1987) study, (b) three years in a Gestalt-Experiential training program conducted by Dr. Greenberg and Deloris Bate, and (c) four supervised clinics with couples/families through the Department of Counselling Psychology. That this replication of EFT appears to be less effective than Goldman’s replication and the Johnson and Greenberg’s (1985a) original study may be related to differential
levels of clinical and pedagogical experience between this investigator and Dr. Greenberg as well as to other individual differences.

It is of interest to compare this study to earlier studies in other areas besides effectiveness. One such area is the distress level of couples in each study prior to treatment as measured by the Dyadic Adjustment Scale (Spanier, 1976). While the level of distress of the total couple sample in the Johnson and Greenberg (1985a) study (mean of 92.35) was considered moderately distressed, the level of distress in the Goldman (1987) study (mean of 84.2) was considered severely distressed. In the current study, the total couple sample's level of distress (mean of 88.5) falls midway between these previous studies (see Table 15). While Goldman's criterion of severely distressed (defined as a DAS score of less than 85) is somewhat arbitrary, using this cut-off would place the level of distress of this study's sample in the moderately distressed range. It is interesting to note that when only the level of distress of the EFT condition is considered, the level of distress of Goldman's EFT condition (mean of 86.3) and the current investigation's EFT condition (mean of 87.61) are almost equivalent.

Another area in which the outcome studies of EFT may be compared is the status of the wait-list control group at post-wait relative to pre-wait. While in this study the wait-list control group improved from pre-wait to post-wait on all measures, this was not the case in the previous studies. For example, with respect to mean couple DAS scores (see Table C-15), the wait-list group in this study improved from pre-wait to post-wait (a rise of 4.5 score points). In the Johnson and Greenberg (1985a) and Goldman (1987) studies, the wait-list groups dropped slightly (.4 and 1.6 score points respectively) over the corresponding
Table 15
Results of EFT Outcome Studies: Mean Couple Total DAS Scores

<table>
<thead>
<tr>
<th>Investigation Group</th>
<th>Pre</th>
<th>Post</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johnson &amp; Greenberg (1985)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td>92.8</td>
<td>112.7</td>
<td>112.12</td>
</tr>
<tr>
<td>Control</td>
<td>91.9</td>
<td>91.5</td>
<td></td>
</tr>
<tr>
<td>Goldman (1987)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td>86.3</td>
<td>100.1</td>
<td>92.05</td>
</tr>
<tr>
<td>Control</td>
<td>82.5</td>
<td>80.9</td>
<td></td>
</tr>
<tr>
<td>James (1989)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td>87.61</td>
<td>103.3</td>
<td>98.11</td>
</tr>
<tr>
<td>Control</td>
<td>89.57</td>
<td>94.07</td>
<td></td>
</tr>
</tbody>
</table>

period. Pending further replications, the improvement of the wait-list control group in this study is best understood as a random effect.

It is also important to compare the EFT outcome studies with respect to post-treatment regression. As is shown by an inspection of group mean couple scores on the DAS in Table 15, post-treatment regression of the EFT condition was negligible in the Johnson and Greenberg (1985a) study (a drop of .56 score points). Post-treatment regression of the EFT condition in the Goldman (1987) study was considerable (a drop of 8.05 points) and in the current study slightly less but still appreciable (a drop of 5.19 points). Given the presence of post-treatment regression at the four-month follow-up in the latter two replication studies of EFT, the absence of regression in the Johnson and Greenberg study
may be attributed to the brevity of its follow-up period (two months) and/or to the higher level of functioning of its couples (it may be that higher functioning couples maintain post-treatment gains more effectively, but this is an empirical question).

Goldman (1987) proffers two possible explanations for the post-treatment regression of the EFT group in her study: first, that because the couples in her sample were more distressed than Johnson and Greenberg’s (1985a) sample, her couples may not have developed sufficient intimacy and resolution of relationship problems for change to hold; second, that because of the evocative nature of EFT, couples may have had idealistic expectations of how their relationships would be following therapy, making them more susceptible to feelings of disillusionment after therapy ended.

This investigator finds the first explanation more plausible. It would seem that couples in this investigation experienced gains in relationship adjustment (as reflected by the DAS), but that there was insufficient development of emotional bonding and intimacy for these gains to be self-sustaining in the absence of ongoing therapeutic support. That couples in EFT failed to experience gains in intimacy compared to wait-list controls at post-test as reflected by the Psychosocial Intimacy Questionnaire is consistent with this explanation.

**ADDITIONAL CONSIDERATIONS IN EVALUATING TREATMENT**

The results of the statistical analysis corresponding to the first research hypothesis showed that both treatments were more effective than the wait-list control for certain outcomes but not for all. The results of the statistical analysis
corresponding to the second research hypothesis indicated that there were essentially no differential treatment effects between EFT and EFT+CT. This finding was corroborated by the application of criteria of clinical significance.

That both treatments appear to be about equally effective in relation to each other and to the wait-list group raises the question of whether or not there are other grounds besides treatment effectiveness that might be considered in preferring one treatment package over the other. Kazdin (1986a) notes that even if the outcome of two treatments is identical, the treatment of choice might be determined on the grounds of differing client reactions to treatment (e.g., attrition, untoward side effects, consumer satisfaction, and acceptance of treatment).

In this experiment client reactions to treatment were assessed in a structured interview at termination. The final question of this interview is particularly relevant to this discussion. When individuals (n=28) in the EFT+CT group were asked, "If you were to recommend couples counselling to a friend, would you recommend the communication training approach, the Emotionally Focused approach, or the combination you experienced in this project?", they selected the combined approach almost unanimously (96 percent). The general explanation given for this preference was that individuals perceived both approaches to make a valuable contribution and to fit together well. Because these data are impressionistic, extremely limited (based on one question in the structured interview), and subject to possible demand characteristics, it is best considered an interesting, exploratory finding that warrants further investigation.

The phenomenon of post-treatment regression raises the question of how many couples who enter brief therapy are well off in the long term. This
question is not easily answered because it presupposes a standard of success. The standard adopted by Jacobson, Follette, and Elwood (1984a) is that couples must remain "no longer distressed" as defined by statistical and clinical criteria (see chapter three) in order to be considered treatment successes. In applying this standard to their most recent outcome study, Jacobson and Follette (1985a) report that 48.9 percent of their total sample was no longer distressed at the six-month follow-up. This figure is comparable to the finding in the current investigation using their criteria. At four-month follow-up, 50 percent of the couples in EFT and 57 percent of the couples in EFT+CT were no longer distressed.

Approximately one-half of the couples in this investigation were "no longer distressed" at the four-month follow-up: how should this be interpreted? It is important to interpret this finding in light of the standard of success that it presupposes. This standard is a conservative estimate of clinically significant improvement (Jacobson, Follette, & Revenstorf, 1984). As a conservative estimate, it disregards those couples who were highly distressed at the outset of therapy and who made substantial gains but not enough to be considered "no longer distressed". It also disregards those couples who entered therapy functioning above the "no longer distressed" cut-off score and who remained above this score, but who were excluded from the "no longer distressed" category because they did not show statistically reliable change (a rise of five or more points in the couple DAS score in this study).

What Jacobson et al.'s (1984a) standard of success does highlight is the importance of developing new procedures that will enable higher percentages of
couples to maintain their treatment gains after therapy ends. Currently, Jacobson, Schmaling, and Holtzworth-Munroe (1987) are investigating the effects of booster sessions as one possible intervention to accomplish this end.

Another issue which is important to discuss in this context is the phenomenon of deterioration. This phenomenon has been well-documented in the field of marital and family therapy (Gurman & Kniskern, 1981). At follow-up in this study, one couple (seven percent) had deteriorated in each treatment condition, where deterioration was defined as a drop of five points or more on the couple score of the DAS (see chapter three). This figure is comparable to the deterioration rate observed in studies of cognitive-behavioral marital therapy. Jacobson, Follette, and Revenstorf (1984) suggest that approximately five percent of couples receiving cognitive-behavioral marital therapy deteriorate while in therapy. It would seem that deterioration is a phenomenon that extends to diverse therapy approaches, but, fortunately, is experienced by only a small percentage of couples. In this study, the deteriorated couples seemed to be those whose emotional bonds were so precarious that these bonds were not able to be rejuvenated by brief therapy.

LIMITATIONS OF THE STUDY

Because it is impossible to separate the effects of therapists from the effects of treatment unless therapists are crossed with treatments, the preferred design would have been to cross therapists with treatments (Jacobson, 1985; Kazdin, 1986a). The decision to nest therapists within treatments is a limitation that was dictated by practical constraints. It was impossible to recruit therapists
who were willing to see more than two couples each in exchange for training and supervision. Crossing therapists with treatments would have required that therapists see a minimum of four couples each in order to make the multivariate analysis possible. When therapists see only two couples each and are fully crossed with treatment (i.e., therapists counsel one couple in each treatment condition), the degrees of freedom of the within error term become zero, making it impossible to calculate the mean square within and subsequent F ratios.

The limitation of nesting therapists within treatments is mitigated by the relatively large number of therapists per group (n=7) in this study. Randomly assigning this number of therapists minimizes the likelihood of mean differential therapist skills between treatment conditions. That there were no significant differences between groups of therapists on five therapist characteristics (see Table C-17) suggests that there was no confounding between therapist characteristics and treatments and supports the view that randomization eliminated mean differential therapist skills between treatments.

Although nesting therapists within treatments is a limitation, this design avoids the risk of contamination of treatments at the therapist level. Nesting therapists in this study avoided the possible "bleedthrough" of CT techniques to EFT-only couples. Such contamination would have made it difficult to evaluate the effectiveness of treatments.

Another possible limitation is the use of only self-report measures in this study. Researchers in the marital/family field such as O'Leary and Turkewitz (1978) and Gurman and Kniskern (1981) advocate the use of both self-report and direct observation in data collection. Their view is that both access strategies
provide important albeit different information about treatment effects.

Although acknowledging their bias as behavior researchers for direct observation measures, Jacobson et al. (1984a) justify the sole use of self-report measures in outcome research. Because direct observation measures (a) have no more direct correspondence to target problems than do self-report measures, (b) lack construct validity, (c) seem to be relatively insensitive to relationship changes, and (d) are costly to use, they believe it is difficult to justify their use in outcome studies when cheaper and more efficient self-report measures that correlate significantly with observation coding systems are available. Although it would have been preferred to have included an observational measure, on the basis of these arguments the sole reliance on self-report measures need not be considered a serious limitation of this study.

**GENERALIZATION OF THE STUDY**

The couples in this study were moderately distressed volunteers who were solicited from Vancouver and the Lower Mainland via newspapers. Although the couples in this study shared in common with clinic couples the target problem of marital distress, because data on the average DAS scores of clinic couples was unavailable, it was impossible to determine how closely the couples in this study resembled clinic couples in terms of severity of marital distress. Apropos of this, Kazdin (1986b) notes that even when volunteer and clinical samples share the same presenting problems, generality from the former to the latter is still an open question which must be determined empirically because of other differences between the samples. The findings of this study, therefore, may be generalized to
the population of moderately distressed volunteer couples in Vancouver and the Lower Mainland.

One component of the context of generalization is that of therapist. Unlike the Johnson and Greenberg (1985a) and Goldman (1987) studies in which therapists were treated as a fixed factor, the therapists in this study were treated as a random factor. This means that the findings of this study are not limited to the 14 specific therapists who participated in this study, but may be generalized to the treatment of comparable couples by other graduate student therapists, either in the doctoral program or nearing the completion of the magistral program in the Department of Counselling Psychology.

Another component of the context of generalization is the clinical experience of the trainer/supervisor of therapists. In this study, the training/supervision of therapists were conducted by the investigator who has moderate clinical experience (viz., participation as a therapist in the Johnson and Greenberg (1985b) study and the Goldman (1987) study, three years in a Gestalt-Experiential training program conducted by Dr. Greenberg and Deloris Bate, and four supervised clinics with couples/families through the Department of Counselling Psychology). This means that the findings of this study may be generalized to the population of moderately distressed volunteer couples in Vancouver and the Lower Mainland who are treated by therapists trained and supervised by an investigator with moderate clinical experience.

To conclude, this study may be generalized to moderately distressed volunteer couples in Vancouver and the Lower Mainland who are treated by graduate students either in the doctoral program or nearing the completion of the
magistral program in the Department of Counselling Psychology at the University of British Columbia, who are trained/supervised by an investigator of moderate clinical experience.

CONCLUSION

The first conclusion of this study is that both treatments appear to be more effective than a wait-list control for certain outcomes but not for all. While couples in both active treatment conditions experienced significantly higher gains on measures of marital adjustment and target complaint improvement than couples who waited for treatment, couples in both conditions failed to experience higher gains on measures of intimacy and passionate love. In addition, neither treatment was successful in enhancing communication except the EFT+CT condition at post-test.

The second conclusion is the null finding that the addition of a four-session communication skills training component was not effective in enhancing the effectiveness of an Emotionally Focused couples therapy at either post-test or four-month follow-up. Moderately distressed couples in the EFT+CT condition did not achieve significantly higher gains than couples in the EFT condition on a summary measure of marital adjustment or its four components (i.e., consensus, affectional expression, cohesion, satisfaction), nor on measures of communication, intimacy, and passionate love. With the exception of the EFT treatment maintaining its post-test gains on target complaint improvement more effectively than the EFT+CT condition, there were no differential treatment effects.
One of the main recommendations for future research is that an outcome study be conducted in which the duration of the CT component is increased. Given a CT component of longer duration, it is likely that couples would feel more confident about the acquisition and use of communication skills than couples in the present study. Such enhanced confidence could be expected to result in stronger treatment effects, particularly long term effects.

Another recommendation for enhancing the effectiveness of the CT component would be to change the timing of this intervention within the EFT treatment. Assuming the same 12-session format, one suggestion would be to initiate the CT component after four sessions of EFT and to conclude with four sessions of EFT. In this format, couples would continue to practice their CT skills as homework exercises and to report on their practice throughout the final four sessions, even though the focus of these sessions would be EFT. Perhaps in this way couples would have sufficient practice to feel confident about incorporating the CT skills into their daily spousal interactions.

A third recommendation for enhancing the effectiveness of EFT would be to provide booster sessions comprised of communication skills training after the regular therapy ended. The treatment package of EFT + CT + CT booster sessions could be compared with the existing EFT package to see if the former package was more effective than the latter.

regressed on the DAS from 100.1 at post-test to 92.05 at the four-month follow-up, Rempel reports that this same group had recovered to post-treatment levels at the one-year follow-up. Because EFT couples in this study also regressed, albeit to a lesser extent than in Goldman’s study, it would be interesting to do a one-year follow-up of EFT couples in this study. If Rempel’s finding that couples recovered their losses at one year was replicated, this would suggest that EFT has long-term self-generating effects.

In the structured interview individuals in the EFT+CT treatment stated almost unanimously that they would recommend the combined approach of EFT+CT to a friend seeking couples counselling as opposed to either EFT or CT. One recommendation for investigating this exploratory finding further would be to assess client reactions to EFT and EFT+CT by means of an objective semantic differential scale. Significant differences might be found between individuals’ experience of the EFT treatment and the EFT+CT treatment. For example, if in the absence of differential treatment effects on other measures, EFT+CT was experienced as being significantly more "worthwhile", "fair", "important" etc., a case could be made that EFT+CT is the treatment of choice based on differential client reactions to treatment.

In addition to recommendations concerning future outcome research, it is also important to undertake process research. In this study, one question in the structured interview explored change processes that had been identified in an earlier study of EFT (Greenberg, James, & Conry, 1988). The two main categories of change processes selected by 56 individuals in this study were (a) coming to new understandings or realizations (often deeply felt) about myself, my
partner, or the relationship (50 percent), and (b) seeing my partner experience feelings (often with real intensity) that he or she does not show typically in the relationship (25 percent). These findings suggest that episodes involving the emergence of affective-cognitions and episodes involving the vivid expression of primary feelings warrant intensive study. In addition, these change episodes could be related to intermediate and final outcomes (Greenberg, 1986).
REFERENCES


definition of clinically significant change. In letters to the Editor, Behavior
 Therapy, 17, 308-311.

learning-cognitive perspective. In N. S. Jacobson & A. S. Gurman (Eds.),
Clinical handbook of marital therapy (pp. 29-70). New York: Guilford.

analysis of Behavioral Marital therapy: 2-year follow-up and prediction of

social learning and behavior exchange principles. New York: Brunner/Mazel.

Johnson, S. M. (1984). The comparative efficacy of an Emotionally Focused and

and problem-solving interventions in resolving marital conflict. Journal of

therapy: An outcome study. Journal of Marital and Family Therapy, 11,
313-317.


Format:

Framework

Assessment

Therapy steps and therapist activities

Termination

Operational definitions

Therapist interventions, descriptions

© Greenberg and Johnson
Emotionally focused treatment framework

L. Greenberg and S. Johnson

1. Define issues as presented.

2. Identify negative interactional cycle.

3. Facilitate clients in accessing and accepting previously unacknowledged emotions underlying the cycle.

4. Redefine the problem cycle in terms of these new emotions and the client’s interacting sensitivities.

5. Encourage identification with previously unacknowledged aspects of experience by enactment of redefined cycle.

6. Facilitate acceptance of partner’s position.

7. Encourage clients to state needs and wants arising from their new emotional synthesis.

8. Facilitate new solutions.

9. Help clients to integrate new perspectives of the self and the other, solidify new relationship positions and ways of achieving intimacy.
Session one: Assessment

Therapist tasks

1. Delineate conflict issues more precisely and attempted solutions.
   Identify themes in core struggle.

2. Discuss each partner's perception of the problem.
   Observable behaviours are noted but the focus is upon how each partner sees the self and the other in this relationship and the stances or positions each takes in the relationship.

3. Note and explore patterns in the process of interaction.
   Identify sequences of problematic reactions as the couples narrate or enact them. How do this couple connect, maintain distance, attempt to influence and protect themselves against each other and the therapist? Allow a 10 minute discussion of the presenting problem for research purposes.

4. Enquire regarding the history of the relationship.
   Key events are noted. The strengths of the relationship when it is functioning well are assessed. The couples' expectations of the relationship are explored. Norms as to power/control, dependence/independence, and closeness/distance are noted. The therapist also considers the developmental stage of the relationship and the level of commitment.

5. Enquire about the family of origin and life history of the partners.
   Note partners' views of male and female roles and the norms
mentioned above. Hypothesize vulnerabilities and sources of anxiety stemming from life experiences which may be reflected in the present relationship. How do interaction patterns impact the individual’s self-concept and self-esteem?

6. Present Treatment Rationale.

The therapist frames problems in terms of deprivation, unmet needs, and interacting sensitivities in the relationship. The problem is framed in terms of stuck emotional chain reactions which have become automatic and which both partners have participated in building and now are imprisoned by.

Process note: The goal of the therapist throughout the session is to establish a working alliance, to create rapport and trust with both partners and give them hope for positive outcomes. Since this is an information gathering in nature than in the following sessions where client-client interaction will increase. The therapist by his/her behaviour also creates expectations for the process of the sessions, for example by encouraging clients to speak for themselves not for the other and discouraging disruptive interruptions.

Typical therapist activities.

Empathic Responding
Direction Questions and Probes as to issues, interaction patterns and intrapersonal anxieties.
Observe/Hypothesize regarding the central struggle in the relationship.
Framing of problem in terms of treatment perspective.
Steps of treatment

Because this therapy tends to occur in a circular rather than a linear sequence, this manual will focus upon the steps of the process rather than attempt a session by session account. The steps in the process and the key interventions follow below. These steps are elaborations of the framework stated above.

1. Define issue as presented.

Define problems as seen by the clients. Establish each person’s view of the problem, and how they perceive their own and their partner’s role in the problem. Establish shared goals. Each person is encouraged to make a full and complete statement of his/her position.

Therapist Activities: Direct questions and probes; Empathic responding; Summarizing and integrating information; Validate opposing reality claims and positions, and each partner’s need to be right and innocent of blame.

2. Identify negative interaction cycles.

An example of such a cycle might be, "when you demand attention, he withdraws by leaving the room. You become more upset as he refuses to talk to you. You finally give up and also withdraw. Finally after a day or so, he initiates superficial contact." In such cycles each of the partner’s solutions to the problem intensifies the problem for the other. The therapist explores behaviours, feelings and perceptions involved in the cycle in order
to clarify each partner's position in the "dance." Behaviour towards the partner is linked to underlying feelings. Such cycles may be talked about and reconstructed or they may occur in the therapy session where the therapist identifies and comments upon them as they happen. For example, the therapist comments "I notice that when you start to express your views on this topic, your partner asks you why you see things that way, and then you seem to get confused and start to explain ... etc.

Negative messages such as blaming the partner are explored in terms of underlying needs. The framing of behaviour in terms of an interactional cycle fosters a perspective of mutual responsibility. The partners are encouraged to develop their positions more fully and their positions are validated.

Therapist Activities: The therapist identifies and connects elements in the cycle by means of questioning, exploring, clarifying and interpreting each partner's perceptions, feelings and reactions to the other. Negative alienating reactions occurring in the session are pointed out and discussed, for example, mind reading of the other partner or making negative dispositional attributions. Blaming behaviour is not ruled out as unhelpful but used by the therapist to search for the feeling underlying specific accusations. It is developed further rather than challenged as unacceptable. The therapist uses open ended explorations and only interprets if clients are unable to discover their own experience.

Examples:

a) To clarify cycle and positions the therapist says:

What did you do then? or
When your partner does ---- what do you do?

You criticize Jack for never holding you and for being cold to you.

When he does this, how do you feel?

b) To draw attention to interactional patterns the therapist says:

It seems that when your partner talks, you interrupt--I'm wondering what is happening for you, what is it that you are experiencing when you do this?

3. Access and accept unacknowledged feelings underlying problematic interactions.

Emotional responses at the periphery of awareness are attended to, heightened and linked to self-perceptions. Particular attention is paid to vulnerabilities, fears and unexpressed resentments. Significant events arousing strong emotion are at times reconstructed, or enacted in the session and are focused upon to reveal underlying emotion. Clients are thus exposed to aspects of self and the other not previously acknowledged. This is to be distinguished from the ventilation of superficial and/or defensive reactions; it is a new synthesis of emotional experience. An example of such a superficial reaction would be an angry reaction expressed with no awareness of a sense of threat or underlying fear. These reactions are explored for the underlying experience of fear.

*Therapist Activities:* Evocative responding (see the end of the manual for a detailed description of the modified form of this intervention). This intervention involves focused reflection, probing and interpretation by the therapist. The therapist may attempt to supply missing feelings, or supply sentences for a client
to finish. The therapist may also attend to bodily sensations the client is
experiencing and to non-verbal behaviour in general. Images and metaphors may
also be created to heighten and clarify emotional responses. The focus is upon
looking at inner experience and the owning of such experience. This experience is
then validated by the therapist. There is a continuing focus on the emotional
experience occurring in the present.

4. The problem is redefined in terms of newly synthesized emotional
experiences.

The problem is now construed in terms of adult unmet needs and
sense of deprivation and alienation. Interacting sensitivities are explored and
interpreted and individual experience is translated into the meaning carried
for the other spouse and the relationship. Such interpretations integrate the
clients' affective, cognitive and behavioural experiences.

Fears and coping reactions are validated and related back to the
responses taught in the family of origin and to key self-images. The
current need for these responses is explored.

New perspectives on the relationship and the partners' behaviour
created by the new emotional synthesis are now integrated. For example, a
blaming response may be seen as an expression of a need for love or a
withdrawal seen as a fear response instead of as an attempt to punish or
hurt. Attempts are made to capture these new feelings as they are
occurring in interactions during the session. The clients are encouraged to
interact with each other in the sessions and to share their underlying
feelings as they emerge in the session in reaction to their partners. There
is a strong focus on what is occurring in the present between the partners. These feelings are explored fully, both in terms of their personal meanings and their meaning to the partner.

Therapist Activities: The impact on the relationship of the personal vulnerabilities explored in step three is now clarified. The therapist interprets elements in the interactional sequence in terms of underlying needs and fears which stem from interacting sensitivities. For example, Jim is vigilant regarding actions of Jill that he perceives as rejecting and responds by bullying; Jill is sensitive to bullying and responds by rejecting. This cycle prevents contact and the meeting of the partners' needs in the relationship. Evocative responding may also be used as well as interpretations of issues and defensive reactions in terms of family of origin schemata. A present-centered focus is maintained and partners are regularly asked what they feel right now in response to what their partners just said.

5. Identifying with disowned aspects of experience in the redefined cycle.

The cycle, redefined in terms of underlying emotional experience and needs, is enacted deliberately in order for the partners to become more aware of their underlying needs and to gain a sense of control of these automatic responses. The clients are instructed to become more fully "who they are" by engaging deliberately in their part of the cycle rather than trying not to engage in this behaviour. For example, the withdrawer and the pursuer are both encouraged to experience more fully their underlying feelings and needs which were previously disowned. Aspects of experience such as the withdrawer's fear of being overwhelmed and need to protect
and the blamer's feelings of being unloved and need for support are fully discussed and then prescribed. Partner are asked to identify with disowned aspects of their experience, to develop their positions fully and to engage deliberately in some of the behaviours associated with their previously disowned feelings and needs. This is an intrapsychically oriented intervention focusing on enacting disowned parts rather than enacting the negative interactional cycle as occurs in some paradoxical interventions. Distancing partners, for example, may be asked either in the session or for homework to protect themselves deliberately or practice putting up a wall as a way of becoming more aware of and gaining control over this sometimes problematic aspect of their own behaviour. Pursuers are asked to engage deliberately in support seeking behaviours and to become aware of their need to be nurtured and the feelings associated with this. If one partner feels too dependent or feels anxious about being intimate, he or she is asked to identify with the dependent or fearful aspect of his/her experience rather than to deny these parts or try to disown them. Both partners are reassured at this point that even though it might seem strange or be difficult to act in a manner that they construe as problematic (such as dependent or afraid), that these are the feelings they are actually feeling and that to carry out these instructions will help them to be more congruent. It is emphasized that it is important in resolving marital conflict to take responsibility for one's feelings, and that accepting these feelings and deliberately behaving in ways associated with these feelings will give each of them more control and choice with respect to these feelings and behaviours. Once partners have identified with disowned aspects of their
experience, it is possible to integrate these aspects both intrapsychically and also into the relationship. Identifying with disowned aspects of experience is worked on in the session and given as homework. Partners are asked to identify with disowned aspects of experience deliberately if possible, or to "go with" their experience when they begin to feel their previously disowned experience rather than fighting against this aspect of themselves.

*Therapist Activities:* The therapist suggests that people identify fully with previously disowned aspects of their experience. The therapist conveys an ultimate acceptance of each person's position, feelings and needs by suggesting that partners do what they are doing rather than try not to. Although there is a "prescription" of certain behaviours and experiences, the focus is on having people do what they do with full awareness and responsibility (in order to make previously automatic responses deliberate) rather than to prescribe a paradox to gain therapeutic control of the interactional cycle.

6. Acceptance of the partner's position.

The focus is now upon the communication to the spouse of the newly experienced emotional responses, and the partner's acceptance of these responses. The therapist facilitates acceptance of the other's needs on the part of each spouse, primarily by tracking interactions and blocking or exploring nonaccepting responses. The therapist helps the couple construct the conversation they might have had if they had been in touch with and able to report their feelings and vulnerabilities. The phobic avoidance of the expression of vulnerability in the relationship is usually confronted in this process. This session is not directed towards the teaching of the specific
skill of empathic listening but toward helping partners reveal new aspects of themselves to their mates and facilitating a new intimacy and contact between the partners. Blocks to one partner's ability to hear and accept the other's experience are examined and interpreted in terms of that partner's view of self, past learning in family of origin and catastrophic fears. The therapist facilitates acceptance of self and others in contrast to the usual pattern of reciprocal disqualification which occurs in distressed relationships.

**Therapist Activities:** Evocative responding; interpretation and labelling to clarify relationship events; drawing attention to the nature of responses to the partner and the impact of these responses, and suggesting alternatives.

Example:

A) I feel alone (experience of abandonment and helplessness integrated in previous steps) because you never show yourself, your feelings; never really show me how you feel.

B) I don't show you my feelings, well I suppose I don't. I'm afraid to show you. When I have, I get attacked. Therapist: (to A). How can B show you his feelings in a way that you can hear them?

7. Expression of needs and wants.

The emotional synthesis of the issue in terms of intra-individual and interpersonal experience leads to a clarification of needs and wants in the relationship. One partner can now directly ask for what he or she wants
or needs from the other, and the implications of these desires for the individuals and the relationship can be examined. Key attitudes underlying the positions each partner has taken in the relationship begin to be explored.

*Therapist Activities:* Focus interaction upon the expression of needs and wants. Clarify and interpret such needs if necessary.

8. New solutions.

The statement of needs and wants, when accessed, integrated and accepted by the spouse, leads to the creation of new alternative solutions to the couple's struggle and the presenting problem which is symptomatic of this struggle. The therapist clarifies and explores aspects of the solution with the couple and again helps them to confront blocks to positive responding. The therapist also draws attention to and highlights new positive patterns of interaction. New solutions constitute a redefinition of the relationship, for example, a relationship may become one in which one person can state needs and the other can give support, rather than a relationship in which one has to coerce and bully the other into seeing and responding in a certain way. New solutions are assessed in terms of the needs of both partners and their general feasibility, and if possible enacted in the session.

*Therapist Activities:* Clarify and explore new solutions, for example, how can a partner help his spouse trust him and feel safe in the relationship? Perhaps by engaging in activities that he knows reassure her that she is important to him.
This sense of safety will then enable her to respond to him in ways that he finds satisfying.


The therapist helps the couple develop a shared perspective, a detailed picture of the relationship, and engage in metacommunication as to the past and present nature of the relationship. The therapist clarifies new positions and positive sequences of emotional response and the new interactional cycles. The past relationship positions taken by the partners and the negative cycle are discussed. New goals for future relationship development as well as new ways of creating and maintaining intimacy are discussed.

*Therapist Activities:* Summarizing. Termination issues.

Process note: These nine steps tend to be cyclical; the therapist may circle back to previous steps if necessary, or begin the cycle of steps focusing upon some new aspect of the couples' core struggle. In the sessions, the couple continue to expand their awareness of their stances in the relationship and the needs and fears underlying these positions. As positions, interaction patterns, and key underlying emotional responses become clearer, the couple's manner of interacting becomes less reactive and automatic, alternative behaviours, feelings and thoughts, are experienced and experimented with. The couple develop a shared perspective of the relationship and begin to "woo" each other back into intimacy. Since previously unaccepted aspects of the self have been accessed, validated, expressed and integrated into the relationship, anxiety reducing defences are less and less
evident. As therapy continues, ideally the therapist does less and the partners interact more and more, helping each other through the therapeutic process.

**Termination session**

This session, like the assessment session, will always follow a certain format: the treatment process is reviewed, new interaction patterns highlighted, and the present state of the relationship in terms of goodwill, trust, open contact, closeness and positive affect, assessed and summarized. The original presenting problem is discussed and post-treatment measures completed.

**Operational definitions**

Need: Awareness of an urgent lack of nurturance, safety, or basic relatedness necessary for survival and a sense of well-being. Boszormenyi-Nagi suggests that the other is the object, the "ground" for an individual's identity delineation and security needs, and labels this "ontic dependence."

Interactional cycles: Sequences of behaviours where the response of one partner becomes the automatic stimulus for an automatic reaction in the other, (e.g. I nag because you ignore me. No, I ignore you because you nag). Such cycles are alienating and usually spiral into more intense conflict.

Interacting sensitivities: The strategies designed to cope with the special sensitivity or vulnerability of one partner which elicits the special vulnerability of
the other, resulting in an alienating emotional chain reaction. The issue to which
the partner is sensitive often has historic significance. This term, then, refers to
the sensitivity which underlies core feeling reactions, which leads to negative
interactional cycles.

Position: A point of view, perspective or orientation in a relationship. A view of
the self in relation to the other which creates a set of expectations which guide
perceptions, feelings and behaviour. Positions tend to become rigid and polarized
in a context of threat to self-esteem or well-being.

Contact: To meet or come together, to touch, to connect or experience reciprocal
openness, allowing the other to impact you. To communicate openly on an
intense personal level. To touch—to permit part of the body/self to come in
contact with, so as to feel.

Interpret: To clarify meaning by connecting or relating one element in a situation
to another, for example, by connecting relationship behaviours to intrapsychic
perceptions of the self. It is also a process of imposing meaning upon events, or
creating a new frame of reference. Can be more or less confrontational.

Clarify: To make the implicit explicit--deals with what is just beyond awareness.
Symbolize more completely. Can be a mild form of interpretation.
Therapist intervention of evocative responding

This intervention consists of probes or statements which attempt to clarify and heighten the client's emotional experience in therapy and make the automatic a focus of conscious awareness.

The elements of experience focused upon are:

Stimulus (cue and appraisal)
Arousal
Response.

The therapist's focus depends upon the process of therapy:

Situation 1: If Stimulus, Arousal and Response (S.A.R.) are all clearly experienced in awareness, that is, if the stimulus is clear and differentiated, arousal is present and acknowledged, and response is expressed with ownership and inner awareness, then the therapist pushes for a more differentiated inner awareness and a clearer expression of experience and needs. Thus, spouses are exposed to aspects of themselves and each other that is beyond awareness.

Examples:

Client -
When you yell at me, I feel hot, shaky, and afraid. I just have to get away, so I leave the room.

Therapist -
How do you experience the fear, as shakiness?
Client -

When you look concerned and sit close to me like that, I feel very uncomfortable. I feel smothered, hemmed in, so I turn away, close off and ignore you till you go away.

Therapist -

Smothered, you feel like you don’t have room to breathe. That’s scary, you feel anxious? (Client nods) What will happen if you don’t turn away?

Client -

She will expect me to be a certain way, warm, and I can’t feel a certain way. I know that I’m not the husband she wanted.

Situation 2: If Arousal is missing, the therapist heightens using images, probes and interpretations.

Example: Therapist -

Is that painful for you?

Client -

Yes, very.

Therapist -

It almost sounds like you're in a cave and shouting help, help, and all you feel you get is the echo of your own voice.

Client -

I have to deal with it, not burden him with my jealousy, he's struggling too.

Therapist -
Sounds like you want to hold his hand and help him while he makes love to his lover.

**Situation 3:** If the Stimulus is not clear, specific and alive the therapist focuses upon cues and the meaning of the cues to the individual so as to differentiate the impact of a particular stimulus.

**Example:** *Therapist -*

What is it that sparks off your cynicism and makes it hard for you to listen to him?

*Client -*

He’s so condescending, I get hostile.

*Therapist -*

What about the way he does this gets to you?

*Client -*

He is so logical, never lets go, and that look on his face of I know better.

*Therapist -*

He seems cold and superior.

**Situation 4:** If the Response is unclear the therapist differentiates the Stimulus or helps the couple enact the sequence so that they may unfold and dismantle their interactions in terms of emotion, cognition and behaviour.

**Example:** *Therapist -*

So what happens when Pat tells you that she doesn’t want to make love, and turns away?
Client -

Nothing, I accept it, might ask her why.

Therapist -

I'm wondering if you don't feel hurt or feel that need to get back at her?
COMMUNICATION TRAINING (CT) COMPONENT MANUAL

P. S. James and L. S. Greenberg (1987)
Introduction to the CT component

In session one, in the context of providing couples with an overview of the EFT approach and its rationale, therapists introduce couples to the communication skills training component. Couples are informed that the final four sessions of treatment (i.e., sessions nine through twelve) will be dedicated to couples’ learning the basic communication skills of expression and of empathic responding. The former is described as the clear, open communication of one’s feelings, needs, and thoughts in such a way as to maximize the partner’s ability to respond in a positive manner; the latter is described as responding to the partner’s expressions with understanding and acceptance so as to promote further expression.

Therapists provide a three-fold rationale for the communication skills training component (Guerney, 1977). First, therapists indicate that research with couples has shown that communication training is effective in enhancing couples general relationship satisfaction and their ability to communicate (Beach & O’Leary, 1985). Therapists also mention that the communication training they will receive is constructed in part from B. Guerney’s (1977) Relationship Enhancement approach, which appears to be the most effective nonbehavioral approach to communication training to date (Chartier, 1986). Second, therapists indicate that communication skills are an effective preparation for problem solving. Through partners understanding each other’s feelings and thoughts, the true nature of the problem comes into focus. Once the true problem is clearly defined through the use of communication skills, couples are in a good position to problem solve. Third, therapists indicate that communication skills are prevention-oriented. By
learning to use communication skills effectively, couples acquire the tools with which to work through misunderstandings and interpersonal difficulties in the future.

In order that couples are prepared for the transition from EFT to the CT component, therapists remind couples at the end of session six, and seven, that in session nine they will be beginning four sessions of communication training. At the end of session seven, therapists request that couples stay an additional 15 minutes immediately following session eight in order to be introduced to the CT component.

At the end of session eight, therapists administer the DAS, and then introduce partners to the communication skills training component. First, they reiterate the three-fold rationale for communication skills training that was presented in session one.

Second, therapists provide a homework assignment that is designed to prepare couples for the communication training sessions. Couples are given a copy of the Communication Training Manual For Couples (see Appendix A), and are asked to read this manual carefully in order to develop a conceptual understanding of communication training. In order to enhance partners' compliance with this assignment, therapists provide a brief overview of the contents of the manual, and ask each partner to specify when in the upcoming week each intends to read the manual.
Session one of the CT component

1. Homework review (10 minutes)

Therapists begin the session by assessing partners’ progress in reading the Couples Manual. Therapists explore partners’ responses to the manual by asking questions such as what partners find helpful about the communication skills and what stands out for them. Therapists elicit and respond to questions that partners may have. Therapists are careful to reassure partners that they are not expected to have a full grasp of the contents of the manual, but merely a preliminary exposure to the material. Therapists reinforce partners amply for completing this assignment.

If either or both partners have not completed this assignment, therapists indicate that this jeopardizes their ability to learn the communication skills, and renegotiates with them to complete it before the next session. Therapists make it clear that all the assignments are an integral part of the CT component, and that couples are expected to complete them.

2. Communication skills demonstration (10 minutes)

Therapists play a standardized audio cassette recording of two scenarios which shows the difference that the use of expressive and responding skills make in the discussion of a conflictual relationship issue (see the end of this manual for a transcript of this recording). Following Guerney (1977), the primary purpose of playing the tape is to increase partners’ motivation to learn the communication skills.
In the first scenario, without the use of communication skills, a couple discusses the issue of time spent together. In the second scenario, the same couple discusses the identical issue using the communication skills that will be acquired in the course. Whereas in the first scenario the couple's communication degenerates into a negative interactional cycle, in the second scenario the partners develop an understanding of each other's feelings and avoid such a cycle.

After playing the tape, therapists ask partners for their responses to the tape, and reinforce them for their perceptions about how the two scenarios differ. Therapists point out any salient differences in the two scenarios that couples may not have detected (Guerney, 1977).

3. Emphasizing difficulty, support, and eventual success.

Therapists indicate that although the expressive and responding skills are conceptually straightforward, and the audio tape demonstration suggests they are easily applied, these skills are difficult to learn and apply, particularly in real life situations where skills are easily forgotten in the heat of emotional issues. Therapists suggest that it is normal for couples to experience disappointment and frustration in the early stages of learning and applying communication skills, and that it is likely they will experience this (Guerney, 1977).

Couples are told that even though learning communication skills will be difficult, that in four sessions they may expect to develop a basic level of competence. The key to success is practice, which is why practice homework assignments are taken seriously (Guerney, 1977).
In order for couples to develop a basic level of competence, therapists indicate they will model responses and make suggestions for improvements in a direct manner that couples may find somewhat off-putting at first. Couples are told that therapists’ direct style is a function of the teaching approach and not a function of how well they are learning the skills (Guerney, 1977).

4. Skills of expression, empathic responding, and mode switching.
   a. Didactic presentation (10 minutes)

   Couples are given a brief didactic introduction to the two communication skills of expression and empathic responding, and to the coordinating skill of mode switching. This introduction is kept brief because of the assumption that couples learn new skills most effectively by receiving instructive feedback as they practice and by reflecting retrospectively upon their practice. In keeping with this assumption, the subskills of the two communication skills, which are described in the Couples Manual, are taught as couples practice by means of therapists’ structuring, modeling, and encouraging-prompting interventions (a description of therapist activities is included in this manual).

   The skill of expression is described as the clear, direct expression of one’s feelings, thoughts, and needs. Therapists indicate that clear, direct expression increases the responding partner’s ability to understand and respond to the expresser in a helpful, cooperative manner. As guidelines to expression, therapists instruct partners to
speak from the "I" position, to include their feelings if relevant, and to be as specific as possible (Guerney, 1977).

Therapists then indicate that the counterpart of the skill of expression is the skill of responding. This skill is described as a particular type of listening and responding to one's partner (called empathic responding), such that one's partner knows that whatever he or she expresses will be accepted fully. Therapists stress that the notion of acceptance is vital to empathic responding. It is only when partners know that whatever they express will be accepted that they feel free to express the deepest parts of themselves (Guerney, 1977).

Therapists outline two guidelines that are central to empathic responding: first, listen intently, attempting to understand your partner from his or her perspective; second, reflect back your partner's expression in such a way that your partner feels understood and supported.

Once couples have a basic conceptual understanding of the communication skills of expression and empathic responding, therapists introduce the skill of mode switching. This skill is described as a coordinating skill that enables them to move back and forth smoothly between the expressing and responding skills as they discuss issues (Guerney, 1977).

Therapists indicate that expressers switch modes (i.e., become responders) (a) when they have already expressed their most important
feelings and thoughts on the issue under discussion, or (b) when they want to know their partner’s feelings and thoughts. Therapists indicate that empathic responders switch modes (a) when they have already repeated the partner’s deepest feelings and thoughts on an issue twice, or (b) when their feelings and thoughts begin to impair their ability to be empathic (Guerney, 1977).

Therapists state that whenever either partner wishes a mode switch, it is important to indicate this to the other partner verbally, and to check out whether the other partner is ready to make a switch or would like to say a bit more. Therapists establish the guideline that responders reflect the last expressers’ statement before assuming the expressive mode. When responders do assume the expressive mode, therapists indicate that they are free to choose to respond to the partners’ last statement or to go in a new direction (Guerney, 1977).

b. Behavioral rehearsal (25 minutes).

The couple chooses a mild relationship issue that is current in their relationship. Therapists indicate that the focus of the exercise is primarily on learning the communication skills rather than on resolving their issue because these skills must be acquired before they can be used effectively. Partners are instructed to assume an attentive physical posture (i.e., to face each other squarely, to maintain an open stance, to lean slightly forward, and to maintain good eye contact), and to decide in which communication mode each wishes to
begin the discussion. In order to teach couples the subskills of expression and empathic responding, therapists use all the therapist interventions delineated in this manual. Therapists supervise partner’s practice of these skills word by word.

c. Debriefing.

The practice exercise is debriefed by asking both partners to reflect on their use of the communication skills. Therapists indicate that the focus of the debriefing is their use of the skills rather than the topic discussed. Specifically, therapists encourage partners to comment on their difficulties and learnings with respect to the skills, and to ask questions. Therapists use partners’ reflections on their experience as an opportunity to teach and to consolidate their learnings.

Therapists reassure partners who experience the communication skills as slow and awkward that their experience is typical of couples initially, and indicate that with practice they will become more facile with the skills. Therapists validate partners for their hard work and affirm their potential with respect to mastering the skills (Guerney, 1977).

5. Homework assignment (10 minutes)

Each couple selects a mild issue that is current in their relationship. In selecting an issue, therapists indicate that it is important that they choose an issue with which they are likely to have the experience of succeeding in using the skills. Specifically, this means that they avoid
relationship issues that are too emotionally charged to discuss without the therapist's assistance. Partners choose a specific time and place during the week when they agree to discuss this issue for 20 minutes, followed by a debriefing in which each partner describes what the experience was like for him or her with the other partner in the empathic mode. If couples run into difficulty doing the exercise, they are advised to stop and to discuss their experiences at the next session. Couples are encouraged to limit the total assignment to one-half hour in order to avoid becoming tired or discouraged by continuing on too long. Whether couples complete the exercise or not, they are asked to fill in the Practice Home Session Report (see the end of this manual) and to bring it to the next session (Guerney, 1977).

Therapists instruct partners that during the homework assignment they will notice failures to follow the CT methodology in themselves and in each other. Therapists indicate that the primary way of dealing with violations of the methodology is for partners to assume responsibility for correcting their own mistakes. Partners' corrections of each other's violations are limited to maintaining two distinct communication modes and switching appropriately between these modes. When making such a correction, partners are instructed to make their comments behavioral and descriptive rather than evaluative by using the formula, "I notice that ... " (e.g., "I notice that as you were reflecting, you started to share your own point of view").

Because couples may tend not to do the homework assignments,
therapists enhance the salience of homework in a number of ways. First, therapists present the rationale for the assignment by indicating that practice is essential if they are to acquire the communication skills in four sessions. Second, therapists elicit an explicit commitment for compliance from both partners. This involves the specifics of when and where they will do the assignment. If therapists sense that one or both of the partners is resistant to doing the assignment, therapists make this the focus of discussion using troubleshooting skills (see therapist activities). Third, therapists anticipate and exaggerate the aversiveness of the practice sessions by predicting that couples will find them difficult and frustrating. By doing this, therapists increase the likelihood that couples will find the experience less aversive than they were expecting. Fourth, therapists anticipate potential excuses for noncompliance by predicting that couples will find numerous reasons not to do the assignment, and by asking partners what these reasons might be. In doing so, therapists draw attention to partners underlying fears with respect to the homework (e.g., fear of risking, fear of failure).

Session two of the CT component

1. Homework review (10 minutes)

    Using the Practice Home Session Report (Guerney, 1977) as a springboard for discussion, therapists ask for each partner's response to the homework assignment and respond to any questions or difficulties the partners experienced. If couples failed to do the assignment (as opposed to not completing it because of difficulties), therapists are careful not to
support and/or sympathize with couples' explanations. Therapists take the position that it is too bad that they are jeopardizing the likelihood of their learning important skills that they would find useful after therapy ends, and stress that there is still hope for their acquiring the skills if they complete the remaining homework assignments (therapists take this approach whenever couples do not complete homework assignments).

2. Expression of underlying feelings and felt-needs

   a. Didactic presentation (10 minutes).

   Therapists introduce couples to the concept of primary, underlying feelings. Couples are apprized that these are deeper feelings, which are experienced in response to specific situations (e.g., primary fear is experienced in response to a situation of threat).

   Therapists state that there are two reasons why it is important to become aware of and express primary, underlying feelings. The first is that doing so may help them to discover new aspects of themselves. This may lead them to see themselves differently as individuals, or their partner to see them differently. These changes in self-perception and interpersonal perception may lead to new ways of interacting, and in turn, to new perceptions.

   The second reason for becoming aware of and expressing underlying feelings is that an awareness of these feelings may inform partners of what their felt-needs are. Partners are informed that becoming aware of and expressing underlying feelings leads to an awareness of their wants and needs (the term "felt-needs" expresses
the close connection between underlying feelings and needs). Therapists state that felt-needs, when expressed in the expressive mode, lead to problem solving and conflict resolution. Therapists stress the importance of partners not assuming to know what each other's needs are, but rather expressing their needs directly while in the expressive mode. As with the expression of underlying feelings, therapists stress that it is not constructive for partners while in the responding mode to guess what the expresser's felt-needs are.

Therapists illustrate the concepts of underlying feelings and felt-needs with the example of a husband who reacted to a relationship issue in an angry, defensive manner, and realized later on that he had reacted this way because he was afraid on a deeper level. Coming to this awareness helped the husband to see himself as having a legitimate fear rather than being immature, and enabled the husband to express this awareness to his partner rather than staying angry and withdrawn. In turn, the wife saw her husband in a new light, as needy rather than hostile, which enabled the wife to respond more supportively. The awareness of feeling afraid underneath also enabled the husband to identify his felt-need for reassurance, which he was able to ask his wife for.

As well as explaining and illustrating the concepts of primary, underlying feelings and felt-needs, therapists help couples to understand these concepts by reflecting on the tape demonstration earlier in the session or experiences they may have had in previous therapy
sessions.

Therapists indicate that they will assist both partners while they are in the expressive mode to express any underlying feelings and felt-needs that they may become aware of. While in the responsive mode, partners are instructed that they are not to guess what the other partner is feeling on a deeper level because it is not constructive for couples to engage in mind reading.

b. Behavioral rehearsal.

The couple chooses a current relationship issue for discussion. Therapists use their full repertoire of interventions, with a particular emphasis on listening for underlying feelings and felt-needs in expressers and prompting and/or modeling expressive responses that disclose these feelings and needs.

c. Debriefing (10 minutes)

The practice exercise is debriefed following the same procedures as identified in session one.

3. Homework assignment (10 minutes)

A practice session is arranged following the same procedures as identified in session one.
Session three of the CT component

1. Homework review (10 minutes)

Using the Practice Home Session Report (Guerney, 1977) to stimulate discussion, therapists ask for each partner's response to the homework assignment and respond to any difficulties the partners experienced. Therapists deal with noncompliance with respect to homework in the same manner as in earlier sessions.

2. Expression of primary anger/resentment
   a. Didactic presentation (10 minutes)

Therapists make the distinction between primary or underlying anger/resentment and secondary or reactive anger. Secondary anger is described as the defensive anger that one feels when one is responding to a more basic feeling of hurt or fear. Primary anger is described as the anger one experiences in response to a specific situation in which one is not respected or is wronged in some way.

Therapists indicate that it is important to deal with these two types of anger differently. With secondary anger, it is important for partners to become aware of and express the underlying feelings; with primary anger/resentments, it is important that both partners accept and express these feelings in the relationship. Therapists reassure partners that they will help them to learn to distinguish between primary and secondary anger, and to deal with each appropriately.

Therapists indicate that it is important to accept and express
primary feelings in the relationship because (a) the suppression of primary anger leads to increased distance and feelings of hopelessness between partners, and is often ineffective either because partners sense each other's anger or their anger erupts in spite of their best attempts to suppress it, and (b) an acceptance of primary anger and its appropriate expression enables partners to make contact with each other, including helping partners to become clear about what they want (there is often an implicit request in resentment that needs to be made explicit).

Therapists indicate that partners may have difficulty accepting and expressing their primary anger because they fear their anger will be damaging or uncontrollable, or because they learned in their childhood that it was unacceptable to express their anger. Therapists reassure partners that with practice they will learn to overcome these blocks to accepting and expressing anger.

Therapists outline three guidelines that are central to the constructive acceptance and expression of primary anger/resentment: first, because your partner may not feel comfortable with the expression of anger, give your partner some reassurance (e.g., "Even though I'm angry, I still care", or "I don't want to be angry, but I am"); second, speak from the "I" position and state the specific cause of your anger (e.g., "I'm angry because you didn't keep your promise"); third, ask yourself what your anger tells you that you want from your partner, and make a specific request (e.g., "I want
you to arrange tickets to the theatre this weekend").

b. Behavioral rehearsal (25 minutes)

Couples discuss a current relationship issue. Therapists use their full repertoire of interventions, with a particular emphasis on listening for primary anger/resentment and modeling/prompting expressive responses that disclose these feelings.

c. Debriefing (10 minutes)

The practice exercise is debriefed following the same procedures as in earlier sessions.

3. Homework assignment (10 minutes)

A practice session is arranged following the same procedures as identified in session one.

Session four of the CT component

1. Homework review (10 minutes)

The same procedures are followed in this review as in earlier sessions.

2. Behavioral rehearsal (25 minutes)

Couples discuss a current relationship issue. Therapists continue to intervene directly, but do so only when necessary in order to reinforce the couple's sense of their increasing competence and self-sufficiency in the use of communication skills.

3. Debriefing (10 minutes)
Therapists debrief the exercise following the same procedures as in earlier sessions, with an emphasis on reinforcing the couple for their progress.

4. Generalization and maintenance (10 minutes)

The importance of regular practice in order to consolidate the communication skills that have been acquired is discussed. Couples are reminded that in order for the communication skills to become part of their behavioral repertoire, it is important for them to set aside regular times to practice. It is recommended that they set up a regular time each week during which to discuss relationship issues using their new skills. They are advised that there will be many potential obstacles to their maintaining a regular practice time, but that there are numerous benefits to doing so.

In addition to regular practice times, the importance of using communication skills in everyday situations is stressed. Therapists indicate that the communication skills they have acquired are effective in relationships with children, adolescents, friends, and colleagues. Couples are encouraged to use their skills in a variety of relationships beyond their primary relationship (Guerney, 1977).

The use of communication skills is stressed as a way of recovering from relationship quarrels or fights. Couples are told that it is inevitable that they will have quarrels. What is important is that as soon after a quarrel as partners are prepared to talk, that they do so using their communication skills. By doing so they will have the ability to create closeness much more quickly than before they acquired their communication
In using their communication skills, partners are instructed to take a self-focus with respect to subskill violations. The rationale given is that whereas pointing out the other partner's communication violations tends to lead to defensiveness, taking responsibility for correcting one's own violations leads to improved communication.

5. Closure

Therapists and couples express appreciations and say goodbye.

Therapist activities

Although the therapist activities corresponding to the CT component were drawn largely from RE (Guerney, 1977), in keeping with the construction of an EFT-Compatible CT component, minor modifications of RE's therapist activities were made in order for them to be compatible with EFT. These modifications will be noted in this section.

Part A: Interventions appropriate to the CT component.

1. Social reinforcement

This intervention describes both verbal and nonverbal reinforcing statements addressed to either the expresser or the responder whenever a partner in either of these modes (a) responds well, (b) responds at a level better than his/her general level has been, (c) corrects or improves his/her own response, or (d) follows an appropriate suggestion made by the therapist. Reinforcement is the single most frequent therapist response, and
is intended as much to produce a general feeling of success and encouragement as to reinforce and shape particular behaviors contingently (Guerney, 1977). Neither verbal nor nonverbal reinforcement is directed to the perceptions or ideas being expressed, but rather to the process (i.e., how well the CT component guidelines are being followed in expressing ideas and perceptions).

One type of verbal reinforcement is brief phrases that are delivered in as close proximity to the partner's statement as possible. Such phrases may be offered while partners are in mid sentence, or at the end of sentences. Examples of brief words or phrases are: fine, good, right, very good, excellent, great, terrific, wonderful, beautiful, you're doing well (Guerney, 1977).

Another type of verbal reinforcement is lengthier statements that specify what either the responder or the expresser did that is praiseworthy. This type of reinforcement is appropriate when partners switch modes. An example of a longer statement to the expresser is: "That was a rough thing to state subjectively; you corrected yourself beautifully". An example of a longer statement to the responder is: "That was a very supportive reflection; you reflected the feeling very well" (Guerney, 1977).

Nonverbal reinforcement is also important because nonverbal responses can be inserted quickly, without interrupting the flow of the dialogue, to reinforce subcomponents of a client's ongoing statement. Most often, nonverbal responses take the form of head nodding, facial expressions, and manual signs interpreted in this culture as indicating approval (Guerney,
Therapists maintain as equal a balance of verbal reinforcement between the two partners as possible. When therapists are aware that they are reinforcing one partner more than the other, they increase the amount of reinforcement to the latter. Therapists are also careful to reinforce partners in both the expressive and responding modes. In other words, partners in the expressive mode should be reinforced equally to partners in the responding mode (Guerney, 1977).

2. Structuring

This intervention describes responses used to explicitly explain guidelines for CT component modes and procedures, or to remind partners of the guidelines. Structuring responses to expressers include asking the expresser (a) to speak subjectively or from an "I" position, (b) to state feelings (including underlying feelings) and felt-needs, (c) to state the specific cause of feelings, (d) to talk directly to the responder, (e) to use specific language (e.g., nouns rather than pronouns lacking clear antecedants), (f) to state specific behaviors/events rather than generalizations, (g) to rephrase questions as statements (usually questions convey implicit statements), and (h) to limit expressions to a length that the responder may reflect without becoming confused/overloaded. All of the above subskills except (b), (e), and (g), which are EFT-based, are drawn from Guerney (1977). Examples of each of these structuring responses respectively are:

a. Bob, it is important that you present your ideas as your own subjective viewpoint rather than as objective fact. This will make it
easier for Linda to hear what you are saying.

b. Daren, you've indicated that you're angry when Paul isn't willing to spend time with you. What you said implies how important he is to you, and that at times you feel unloved and uncared for. It's important to share these underlying feelings too.

c. Bill, you stated very well that you are afraid. Tell her specifically what you are afraid of.

d. Bruce, what you said was very open. You expressed your feelings subjectively and very well. I notice that you were looking at me as you spoke. Say these things to her now.

e. George, you mentioned you dislike that about Mary. Tell her what that is.

f. Mary, instead of saying that Jim is lazy, it's best to be specific by mentioning one or two of the behaviors you have in mind and telling him how you feel about them. Do this now.

g. Shirlie, in the question you just asked, I think there is an implicit statement. Try making a statement out of your question by telling him how you feel about that.

h. Henry, I'd like to stop you because it's important that you not say so much that Jodie gets confused and isn't able to reflect what you've said.

Structuring responses to responders include reminding responders (a) to reflect feelings that have been explicitly stated and the specific cause of these feelings, (b) to not ask questions, (c) to not give advice or suggest solutions, (d) to not make interpretations, (e) to direct their statements to
the partner, (f) to use the verb "to feel" if they are reflecting a feeling and the verb "to think" if they are reflecting a thought, (g) to refrain from adding to what the expresser has said or leading the expresser, (h) to include important content that may not have been reflected, and (i) to understand that to reflect what one's partner is saying does not mean to agree with it. All of the above subskills except (f) and (i), which are EFT-based, are drawn from Guerney (1977). Examples of each of these structuring responses respectively are:

a. Mary just said she is feeling anxious. Try reflecting this feeling and why specifically she is feeling this way.

b. I want to remind you to avoid asking the expresser to give you more information.

c. You're giving her what you think is the solution to the problem. You can do that as the expresser, but as the responder, it's best to not give solutions. Just concentrate on showing your understanding of what she is feeling and needing now.

d. I think you're trying to tell him why he feels as he does in this situation. This is an interpretation rather than an empathic reflection. Concentrate on showing understanding of what he is feeling.

e. You picked up on his ambivalence, but seemed to be so absorbed in thinking about your response that you didn't make contact with her as you spoke. Say this again, directly to her.

f. I notice that you said "You feel that my parents shouldn't visit"; the phrase "that my parents shouldn't visit" is a thought rather than a feeling. It's best to use the verb "to think" when you express a
reflective thought.

g. Reflecting is such a difficult task that at times you may go a bit beyond what your partner has said. I think you did this in the last part of your statement.

h. It is important to reflect all the main ideas your partner is expressing. You reflected the first reason your partner is annoyed with you. Try reflecting her second reason also.

i. It is important to realize that to reflect back what your partner is saying does not mean to agree with your partner. To understand your partner does not necessarily mean to agree because you are both individuals with your own opinions.

Unlike in RE in which therapists structure responders to reflect expressers' implicit feelings (Guerney, 1977), in the CT component therapists direct structuring responses that remind partners of underlying feelings only to expressers and not to responders. This is because structuring responders to reflect the expresser's underlying feelings that have not been stated previously contributes to mind reading. Each partner is encouraged to take a self-focus with respect to underlying feelings, which finds expression only in the expressive mode.

3. Modeling

This intervention describes therapist responses that provide expressers and responders with examples of statements or sentences to repeat to their partners. Therapists model responses to responders if the latters' reflection (a) misses a clearly expressed feeling or need, (b) misses important content,
and (c) misses either side of an inner conflict. All of the above subskills except (c), which is EFT-based, are drawn from Guerney (1977). Examples of modeling responses in each of these situations respectively are:

a. Try, "I understand that you're ticked off with me because I ask you to be responsible for making dinner and then step in and tell you how to do it".

b. Try, "I see that you are upset with me because I said I would stay within our budget and then didn't".

c. Try, "You feel torn. One part of you feels hopeful about the possibility of greater closeness; the other part of you is cynical about this change happening".

Modeled responses for responders are always directed to responders because the goal of communication training is to teach partners to respond to each other in new ways. If the therapist thinks that the responder's response will be inadequate, in order to protect the responder's self-esteem, the therapist will often model responses in anticipation of the responder's reflection. Therapists also use modeling responses when responders hesitate or look to them for help (Guerney, 1977).

Therapists model any of the following expressive subskills to expressers: (a) stating things in subjective terms, (b) labeling feelings (including underlying feelings) and felt-needs, (c) stating the specific cause of feelings, (d) using specific language rather than vague impersonal terms, and (e) rephrasing questions as statements. Unlike in modeling empathic responses where therapists may model a response before the responder
speaks, in modeling expressive responses therapists can model only after the expresser has spoken because otherwise the therapist has no way of knowing what to model. All of the above subskills except (b), (d), and (e), which are EFT-based, are drawn from Guerney (1977). Examples of modeling responses for each of the expressive subskills respectively are:

a. Try, "My viewpoint on this is that birth control is a mutual responsibility that belongs to both of us".

b. Try, "I feel upset and annoyed when you withdraw from me".

c. Try, "I resent your not telling me about overdrawing our account when we spoke about our finances last night".

d. Try, "I dislike you saying this rather than I dislike people saying this".

e. Instead of asking, "Can you give me an example of something you've initiated on your own?", try "I'm angry because I think you are procrastinating needlessly".

It is important to highlight that therapists direct modeling responses that bring to awareness underlying feelings only to expressers and not to responders. This is because feeding a sentence to the responder that models the expresser's underlying feelings contributes to mind reading.

Although therapists initially model entire sentences, as responders become more adept at responding empathically, therapists model key words or phrases (Guerney, 1977). An example of such a modeling response to a responder is: Try, "I hear that you're unhappy".

When therapists model a response to either the expresser or the
responder, it is important that partners repeat the entire response rather than agreeing with the response and then continuing to talk. The reason for this is that the purpose of the modeled response is to assist partners to address each other directly. Much of the intensity of modeled responses is lost if recipients of such responses do not repeat these responses to their partners. Recipients may put modeled responses in their own words as long as the intent of the modeled statement is not lost. Therapists may have to be firm in requesting that recipients of modeled responses actually reiterate these responses.

Modeling responses are often combined with structuring responses; that is, after reminding a partner of a subskill (i.e., a structuring response), the therapist may model a statement that demonstrates the appropriate use of the particular subskill (Guerney, 1977). An example of a structuring-modeling response to a responder is: You’re telling her why she behaves in certain ways. Remember that in order to keep the discussion constructive, it’s best not to do that. Try, "I understand that you feel frustrated by your tendency to procrastinate ".

In keeping with the focus in EFT of therapists defining and validating partners' positions, when therapists provide structuring-modeling responses for the expresser, their task is to help the expresser make clear, direct statements that the responder is able to reflect successfully. This may require that the therapist make a number of interventions that refine and clarify the expresser's statements until a statement is reached that is sufficiently clear and direct for the responder to reflect. This is particularly
the case if the therapist detects an underlying feeling that the expresser is not stating. The therapist will provide structuring-modeling responses until this underlying feeling is expressed clearly.

4. Encouraging a mode switch.

This intervention describes responses designed to teach partners when and how to switch from the expresser to the responder mode and vice versa.

Therapists suggest a mode switch to the expresser when (a) the expresser wants to know his or her partner's thoughts concerning the issue being discussed, and (b) when the expresser seems to be repeating him or herself. Before suggesting a mode switch in the latter instance, therapists must be satisfied that the expresser has stated any underlying feelings and needs that could be expressed given additional exploration (Guerney, 1977). Examples of therapist mode switching responses in each of these instances respectively are:

a. In what you're saying now, and in what you've said in your last comment as well, you're implying that you wonder whether your husband really cares whether or not you succeed in your job. Is that something that you would like him to reply to now, or would you rather develop your own feelings about this further?

b. You sound a little bit like you're beginning to run dry on this point. If this is the case, this would be an appropriate time to suggest a mode switch.

Therapists suggest a mode switch to responders when (a) responders
are having difficulty being empathic and feel the strong urge to present
their own viewpoints, and (b) responders have already reflected their
partner's deepest feelings and thoughts on an issue twice. With respect to
the former, an important cue to therapists is when they detect that
responders are trying to get their own point of view across while
maintaining the formal aspects of an empathic response (Guerney, 1977).
Examples of mode switching responses to responders in each of these
instances respectively are:

a. That was a good empathic statement, but I think his remarks are
getting to you. You seem to be tightening up. Would you like to
request a change in mode?

b. You seem to be reflecting the same feeling in this response as in
your previous response. Perhaps this would be a good time to switch
modes. Check out whether your partner is ready to switch.

Therapists establish the ground rule that responders always make an
empathic response to the expresser's last comment before assuming the
expressive mode. Therapists also establish that the partner wanting a mode
switch checks out the readiness of the other partner before making this
switch (Guerney, 1977).

In keeping with the focus in EFT of therapists defining and
validating partners' positions, before allowing a mode switch, therapists
make a clinical judgement regarding whether or not expressers have stated
their positions fully and whether or not responders have reflected these
positions adequately. If therapists think that expressers have not expressed
their positions fully (in particular, underlying feelings and felt-needs), they check out this perception with the expresser. For example, a therapist might say to an expresser: "I'm not sure if you have expressed yourself fully on this issue. Is there something more you're wanting to say or are you ready for a mode switch?" If therapists think that responders have not adequately reflected their partner's positions, they check out this perception with the expresser. For example, a therapist might say to an expresser: "I'm not sure whether you are feeling understood fully or whether you are ready for a mode switch. If you are not feeling understood fully, state your view again in order that your partner may reflect what you are saying again."

5. Encouraging-Prompting

Encouraging-prompting responses are intended (a) to encourage partners to give a response, and (b) to add to or refine an existing response. Unlike structuring, encouraging-prompting responses are not intended to correct an outright error or remind the client about a particular rationale or principle. Rather, encouraging-prompting responses serve to stimulate the client to make a particular kind of response or to refine one just made. Unlike modeling responses, which feed particular sentences or phrases that are intended to be repeated, encouraging-prompting responses are open-ended (Guerney, 1977). Examples of encouraging-prompting responses to expressers are:

- What are you feeling?
- I agree that you're feeling disappointed. But I think that underneath the disappointment you're also feeling something else.
Tell her specifically what causes you to feel this way.

Now that you’ve identified what you’re feeling, maybe this feeling will help you to know what you’re needing.

Examples of prompting responses to responders are:

How is she feeling right now?

You reflected her anger well. Reflect also why she is feeling this way.

I think he’s feeling ambivalent. What’s the other side of his feelings?

Just as modeling responses are combined with structuring responses, so also are prompts. Therapists frequently prompt partners after making structuring responses (Guerney, 1977). An example of a therapist structuring-prompting response to a responder is: "I think that you missed the feeling that your partner expressed. What is she feeling?"

6. Troubleshooting-client reaction

Troubleshooting in response to a client reaction occurs whenever a partner is either unwilling or unable to follow standard CT component procedures. If it is an instance of the partner’s being unwilling to follow the procedures, therapists respond empathically to the doubts and difficulties being expressed in order to draw out the partner’s resistant feelings and thoughts fully. After this, therapists use structuring (e.g., presenting the underlying rationale for communication skills training such as empirical evidence) to try to persuade the resistant partner to return to CT component procedures. Therapists then solicit the partner’s view and return to empathic responses to make certain that the partner’s doubts have been assuaged. If the partner is now comfortable with going back to CT
component procedures, troubleshooting is over. If the partner still has doubts, the process is repeated. As a last resort in dealing with client resistance, therapists ask partners to try communication skills training and to see if this is helpful (Guerney, 1986).

Another type of troubleshooting-client reaction response occurs when a partner is unable to follow CT component procedures because he or she is emotionally overwhelmed (for example, by anger or sorrow). Here, the therapist responds empathically to help the partner deal with those feelings (Guerney, 1986).

7. Monitoring functions

Therapists monitor the amount of time that partners spend in the responsive and expressive modes in order that both partners spend approximately the same amount of time in both modes. Because, depending on the nature of the issue under discussion, one partner may spend more time in the responsive mode than in the expressive mode in a particular session, therapists compensate for this by requesting that the other partner spend more time in the responsive mode in the next session (Guerney, 1977).

Therapists monitor individual differences in the rate of learning. If one partner is learning more slowly than the other, the therapist supports this partner's efforts and acknowledges the difficulty of learning new behaviors that are contrary to life-long behavioral patterns (Guerney, 1977).

Because partners may not consider discussing certain issues that are
fundamental to their relationship (e.g., issues of closeness/distance, dominance/submission), therapists direct couples to discuss these issues. Therapists follow each issue being discussed through to its resolution in the session. If the issue is not resolved fully during the session, therapists instruct couples concerning whether or not they should continue to work toward a solution at home or to wait until the next supervised session.

PART B: Interventions inappropriate to the CT component.

1. Directive lead

This describes responses in which the therapist steers the conversation. This occurs when the therapist responds to the content of what is being said rather than to the skills or process. Examples of this are (a) steering a couple toward a solution to a problem, and (b) guiding a partner toward an insight without explicitly stating a specific insight (Guerney, 1977). Examples of these two types of directive lead respectively are:

a. You mentioned a moment ago that how you are attempting to solve the problem isn't working. Perhaps you might try this...
b. Do you often have this kind of an argument before you make love?

2. Interpretation

This describes responses in which the therapist points out a fairly specific item of knowledge about a participant. Interpretive responses usually (a) imply causality, (b) highlight contradictions, or (c) point out connections or relationships between events (Guerney, 1977). Examples of these types of interpretive responses respectively are:
a. It seems as though it's easier for you to make passionate love after you've had an argument.

b. It seems that when he does something that is distressing to you, that you end up feeling guilty; somehow, it never seems to make you mad.

c. You've talked the same way earlier about how your mother made you feel when she constantly made suggestions to you. It sounds very much like the feelings you have when your wife asks you to do things. Do you think there is a relationship here between your feelings toward your mother and your wife?

3. Suggestion/advice, explanation:

   This describes responses in which therapists (a) offer suggestions to partners about how to look at things or give advice about how to behave, and (b) explain psychological or interpersonal phenomena beyond those pertinent to the concepts and skills of the CT component (Guerney, 1977). Examples of each of these responses respectively are:

   a. Try going out together more. Find something you both like to do, and do it together.

   b. Sometimes behavior like that is really a cry for help.

4. Encouragement/reassurance, approval:

   This describes responses in which therapists attempt to make partners feel good, or more frequently, less bad. Such responses are usually elicited by a client's complaint, expression of anxiety, or self-belittling statement; they differ from reinforcing responses regarding the CT program
and skills in that they are reactions to the content of the problems partners are dealing with in their relationship (Guerney, 1977). Examples of encouragement/reassurance, and approval respectively are:

a. I know you're both feeling distant and lonely, but things are bound to get better soon if you continue to give each other the space you need.

b. I think it's just great that you've made the decision to go away for the weekend. That kind of thing can really be a revitalizing experience.

5. Personal criticism

These are responses in which the therapist tends to belittle either or both partners or to put them down in any way (Guerney, 1977). An example is: "You're not really trying very hard."

6. Other diversions:

These are responses that divert the partners from the educational purpose of the CT component. Responses include the sharing of (a) opinions, (b) experiences or anecdotes, and (c) self-disclosures. These responses are to be distinguished from social conversation that characterizes the opening moments of the session, and humour, which when interspersed through the session, facilitates the learning experience (Guerney, 1977). Examples of each of the above diversions respectively are:

a. I think that mothers should stay in the home when children are young.

b. I saw a man blow up at his wife in a restaurant today. It was
quite a scene. They could sure use this training.

c. I like to watch Miami Vice on TV too; it's one of my favourites.

7. Inappropriately directed responses:

These are responses in which therapists (a) direct empathic responses to the expresser, and (b) direct reformulated expressive responses to the responder. These responses are correct in terms of what is said, but not in terms of to whom they are said (Guerney, 1977). Examples of these responses respectively are:

a. Expresser (to husband): I don't see us changing, so what hope is there? I can't take it much longer the way it is.

    Therapist (to wife): You're feeling very discouraged about the relationship right now; you're almost ready to give up on it.

b. Expresser (wife to husband): You're very inconsiderate of me at parties. You pay so little attention to me that I might as well not be there.

    Therapist (to responder): She's saying that she feels neglected and hurt at those parties at those times when you seem to her to be ignoring her.

8. Failure to correct

Failure to correct the expresser.

Expressive statements that are serious deviations (in the sense of being psychologically threatening) and that the therapist does not correct are coded "failure to correct". Serious deviations include the expresser speaking (a) in objective rather than subjective terms, (b) in general, blanket terms
rather than in specific behaviors, and (c) in terms of the other person's motivations, thoughts, and feelings rather than in terms of the expresser's own reactions to specified behavior of the other (Guerney, 1977). Examples of each of these responses respectively (without the therapist's correction) are:

a. You don't have a clue about how to love. As a husband, your a wipeout.

b. You're a depressed person. You do nothing to help yourself and like to wallow in self-pity.

c. You wouldn't come home late if you weren't disinterested in our marriage.

Failure to correct the responder.

Failure to correct the responder occurs only when there are extreme content deviations from the responder's role that go uncorrected by the therapist. These are when the responder (a) makes no effort even to restate what has been said to him by the expresser, and (b) enters into a clear statement of his own point of view without going through mode-switching procedures (Guerney, 1977).
Audio tape demonstration of CT communication skills

Instructions to couples

In this recording, you will hear two role play scenarios. In both scenarios, a couple discusses the issue of time spent together in their relationship. In the first scenario, the couple lacks communication skills; in the second scenario they use the communication skills that you will acquire in this training. Listen carefully, and notice the differences between these scenarios.

Scenario A

H1: I got an invitation to go golfing this weekend with some representatives of a company that may be doing business with our firm. Good employees don't miss opportunities like this.

W1: You never spend time with me on the weekend anymore. You're always doing business.

H2: What do you mean? We go out together. Anyhow, I'll be out on Saturday. You don't get ahead unless you do things like this.

W2: And, where does that leave me? Stuck at home, doing more of the endless work that you never notice needs to be done.

H3: Look you take the work around home too seriously. Why not go spend the day with your parents. They would probably like that.

W3: I don't want to see my parents. I see them enough as it is.
H4: Well, then, see one of your friends.

W4: Oh, they're all busy this weekend, doing things with their partners. Barbara said that she and Mike are going camping. Jane and Dana are going to the island to a lovely little place. She showed me pictures of the last time they were there. You never take me away like that.

H5: If I were to take you everywhere you want to go, we'd be broke. The only way to get ahead these days is to work hard and save.

W5: But when is there any fun for just the two of us? You're either preoccupied thinking about your work or about making money. There are no treats in this relationship!

H6: You're impossible. Never satisfied. Always wanting more from me.

W6: Yes? Well, you're impossible too. Never willing to give or even be available to me.

H7: If you weren't so bitchy, maybe I would be.

W7: Who wouldn't be bitchy married to a compulsive workaholic like you.

H8: See, I can't even talk with you. What's the point. I'm going out.

Scenario B

H1: Honey, I know how difficult it is for you when I take weekend work commitments, and I appreciate how flexible you are in accommodating my work. I
got an invitation to go golfing from one to six this Saturday with some representatives that our company may be doing business with, and I think it's important that I attend.

W1: I hear that you want to attend this function on Saturday, but am disappointed because we had already made plans to go shopping. I was really counting on having your company. Besides, you have had work commitments on three out of four Saturdays this month. I'm beginning to feel pushed aside, as if in the last month I'm less important than your work is.

H2: You're right. In the last month I really have been preoccupied with my work. I can understand how you're feeling disappointed with my telling you I have an engagement I want to attend.

W2: I know how your boss is a demanding person. I certainly wouldn't want you to be in his bad books. But at the same time, I have been feeling a bit neglected, and would resent you if you went.

H3: It's important to me that you not feel neglected. I feel so stuck. On the one hand, if I go to the function, I leave you feeling neglected; on the other hand, if I don't go, I risk my boss' disapproval.

W3: I hear that you're in a difficult position. I also appreciate your expressing your concern for me, your not wanting me to feel uncared for. I do want to say, though, that I feel in a bind too. If you do go, I will feel resentful, and underneath that, probably hurt. If you don't go, I will feel responsible for any problems that may arise with your boss, and I will also feel responsible if our
shopping doesn't go well.

H4: It sounds like we are both in a difficult position of sorts. I'm not sure how to resolve this issue, but somehow talking has helped me to understand your position more clearly. I'm glad you shared your feelings with me, otherwise I wouldn't have known.

W4: I'm pleased that we've had this talk too. Now that we understand each other's feelings and needs, I'm confident that we can come up with a solution that is reasonably satisfying to both of us. How comfortable are you with setting this issue aside until after dinner?

H5: I'm okay with your suggestion. In fact, I think that is a good idea.
Practice home session report (Guerney, 1977)

Couple No.:__ Gender:__ Date:__

We completed this assignment fully: Yes___ No___

If you answered no above, indicate whether this was because you did not get started the exercise or started the exercise but stopped because of difficulties.

Did not start:___ Started but stopped:___

1. Topics we discussed in this practice session are:

2. Please indicate your perceptions of:
   
a. Feelings expressed by my partner.

   b. Feelings I expressed.

   c. I feel my partner understood me: (a) very well ___; (b) pretty well ___; (c) rather poorly ___.

   d. I feel that, as the result of this conversation, I understand myself: (a) no more ___; (b) somewhat more ___; (c) much more ___.

   e. I feel that, as the result of this conversation, I understand my partner: (a) no more ___; (b) somewhat more ___; (c) much more ___.
It is widely recognized that couples who communicate well are more satisfied in their relationships than couples who do not communicate well. You may have heard partners say, "We just don't seem to be able to communicate". At times, you may think this of your own relationship, and wish for better communication between you and your partner.

This manual describes the basic skills of good communication. These skills are drawn in part from Bernard Guerney's (1977) Relationship Enhancement approach to couple's communication skills training and in part from the Emotionally Focused approach to couples counselling that you have been experiencing up until now.

This manual introduces you to two basic communication skills or modes, the expressive skill and the empathic responding skill, plus a skill called mode switching that coordinates the use of the expressive and empathic responding communication skills. Each of these skills will be explained in detail later with examples.

As you read, you may be struck by how simple the skills are. This simplicity is deceiving. Good communication skills are difficult to learn well enough that they become part of how you interact with your partner regularly. For this reason, you will no doubt experience some discouragement and frustration in learning the communication skills.

The key to success in learning the communication skills is not brilliance, but practice. By working hard in the sessions and completing the homework
assignments, you will acquire a basic competence in the use of communication skills.

Your counsellor will assist you in developing this competence by offering lots of support and direction. Because your counsellor will be using a more direct style of giving support and making suggestions than in the previous sessions, you may be surprised by how much teaching he or she does. The reason for your counsellor's teaching style is that research shows this is the best way to assist couples in learning the communication skills in a brief period.

Because a careful reading of this manual will assist you in the upcoming sessions, it is suggested that you underline as you read, or do whatever you do when you read information carefully. You may also want to reflect on your own experiences in communicating with your partner as you read.

Skill of expression

Good communication requires that you learn how to express your feelings, needs, and thoughts clearly. The purpose of the expressive skill is to equip you (a) to understand your feelings, needs and/or wants better; (b) to express your wants and needs to your partner in ways that do not incite unnecessary anxiety, defensiveness, conflict and hostility, but instead tend to engender respect, understanding, and cooperation; and (c) to deal with conflicts and problems with less anxiety, promptly, assertively, positively, and in terms of your own specific goals and needs (Guerney, 1986).

The subskills of the expressive skill are:
1. Be the world's leading authority on everything you say.

You probably have had the experience of people expressing what clearly are their own ideas or opinions as if their ideas were factual or correct. You may have felt uncomfortable in such situations, and wished that they had expressed these ideas as their own subjective opinions. Whenever you are discussing your ideas with your partner, it is important to state your views subjectively (e.g., "I think", "I believe", "In my view", "It seems to me"). This is because your partner will be more likely to hear your views without countering defensively with his or her perceptions of reality (Guerney, 1977).

Consider an example of this subskill. The same statement is expressed in an objective manner in A1 and in a subjective manner in A2:

A1: Both parents should not work outside the home because the children suffer.

A2: I think it is better that both parents do not work outside the home because in my view the children suffer when they do.

2. State your past, present, or anticipated feelings if they are important to the issue.

Because your feelings about an issue often convey important information to your partner, expressing these feelings facilitates
communication. It is easier for your partner to respond to you empathically when you state your feelings because what you are feeling is clear (Guerney, 1977).

Consider statement A1 in which the expresser does not state his or her feelings and A2 in which the expresser does:

A1: You said you would meet me at 6 p.m. What happened?

A2: I'm upset by your being late. You said you would meet me at 6 p.m. What happened?

3. Be specific.

You are probably aware of times when you make statements to your partner like, "you always ... " or "You never ... ". These are overgeneralizations about relationship events that could be prevented by being more specific (e.g., pinpointing time, place, and circumstances). You are probably also aware of times when you make statements like "You don't care about me" or "You're lazy". These are generalizations about your partner's motives and character that also could be prevented by being more specific (Guerney, 1977).

Consider an example of overgeneralizing about relationship events (A1) and a more specific alternative (A2):
A1: You never help me with the cleaning any more.

A2: For the last three weekends you have not helped me with the cleaning.

Consider an example of overgeneralizing about the other partner's character (A1) and a more specific alternative (A2):

A1: You're no good for anything but what you want to do. You won't even spend time with your stepson.

A2: I've noticed that in the last two weeks you haven't chosen to spend time with your stepson.

Another way of being specific is to state the complete word or phrase that you have in your mind rather than using pronouns like 'it' and 'that'. When you use these pronouns, you are clear in your own mind what these pronouns refer to, but your partner likely is not.

Consider an example (A1) in which pronouns are used, and an alternative expression (A2) in which they are not used.

A1: I feel frustrated. I think you have done this three times already.
A2: I feel frustrated by the way you left the dinner dishes undone. I think you have left the kitchen untidy three times this week.

You may want to notice how often you use pronouns rather than complete words or phrases when you express yourself in the coming week.

4. Become aware of and express your deeper, underlying feelings regarding relationship issues.

Perhaps you are aware of incidents with your partner when you expressed a certain feeling, and realized later on that you were feeling something else on a deeper level. For example, perhaps you reacted in an angry, defensive manner and realized later on that you had reacted that way because you were hurt or afraid on a deeper level.

It is important to become aware of and to express underlying feelings (e.g., fear, sadness, resentment) for two reasons. First, if your partner becomes aware of your underlying feelings, your partner may see you in a different light. This may lead your partner to respond to you in a more supportive manner. For example, if your partner learns that underneath your anger you are feeling hurt or afraid, your partner may see you as needy rather than as hostile and respond to you with compassion. Second, because an awareness of our deeper feelings tells us what our needs are, becoming aware that on a deeper level you feel afraid will help you to identify your need for reassurance, and perhaps to ask your partner for this.
Consider an example in which the expresser is unaware of underlying hurt (A1), and an alternative in which the expresser is not only aware of feeling hurt but also expresses this (A2):

A1: I'm furious with you. You had no reason to go to the party without asking if I wanted to go.

A2: I feel really hurt and angry because you went to the party without asking if I wanted to go.

5. When you have stated your underlying feelings, state the want or need that is related to your feelings.

Becoming aware of your deeper feelings will often help you to identify your wants and needs. This is because there is a close connection between what we feel deeply and what our wants and needs are. The expression "felt-needs" captures this close connection. Consider this example:

A: I feel afraid that you will reject me when I am feeling depressed. I think what I need from you is to know that you care for me even when I am depressed. Do you?

In this example, A expresses his or her underlying fear of rejection, becomes aware of his or her need for reassurance, and asks the partner for this. Although this example is highly condensed, it does illustrate how
the expression of underlying feelings leads to the awareness and expression of needs.

**Skill of empathic responding**

Just as good communication requires that you express your feelings, needs, and thoughts clearly, it also requires that you learn to listen effectively. You probably have had the experience of someone listening to you, and then reflecting back to you what you were saying to them in such a way that you felt genuinely understood and accepted. Listening carefully, and then reflecting back to your partner what he or she is saying such that he or she feels understood and accepted is what is meant by empathic responding.

The purpose of the empathic responding skill is to equip you (a) to understand the feelings and needs of each other better, and (b) to elicit from each other more prompt, frequent, honest, relevant, open, trusting, and intimate behaviors (Guerney, 1986). Empathic responding is such an important skill that it will be explained in some detail.

The skill of empathic responding has two aspects: understanding and acceptance. The understanding aspect means to understand your partner’s experience (i.e., feelings, wants and/or needs, and thoughts) from his or her frame of reference or perspective. Another way of saying this is to imagine yourself in your partner’s place, to understand his or her experience from inside his or her skin.

The acceptance aspect of empathic responding means to regard your
partner's experience as valid and legitimate. It is an attitude which says, "I view as valid and legitimate whatever you feel, want and/or need, and think." Acceptance is the context in which understanding occurs; it lies at the very heart of empathic responding.

Understanding and acceptance are important because it is only if you can be sure that your partner will respond to whatever you say in an understanding/accepting manner that you are likely to feel safe enough to express your deepest feelings and needs. You will likely appreciate the importance of understanding/acceptance more fully when the expression of underlying feelings is discussed later on.

Although you may feel okay about understanding/accepting your partner's feelings and needs, you may feel uneasy about understanding/accepting your partner's thoughts or opinions because you may think that to do so suggests you are agreeing. It is possible for you to understand/accept your partner's thoughts and opinions, and also to disagree. While the attitude of acceptance means that both your thoughts and your partner's thoughts are valid and legitimate, because you are different people with your own thoughts and opinions, you will inevitably disagree with each other's thoughts and opinions from time to time.

The ideas discussed above will be illustrated by the alternate responses of one partner (B) to the following statement by the other partner (A):

A: I never see you any more. Even when you are home, you're tired and unresponsive. I've been thinking about this. I think you should quit your job so
we can spend some time together.

B’s possible responses are:

B1: That’s a ridiculous idea, and you’re ignorant even suggesting it.
This response is nonempathic and nonaccepting. It is not only critical of A’s idea, but puts A down as a person.

B2: I hear that you’re upset because we spend little quality time together on account of my work.
This response is empathic because B conveys an understanding/acceptance of how A feels, including the specific cause of A’s feeling.

B3: I hear that you’re upset because we spend little quality time together on account of my work. However, I think that your solution is not the best way to deal with the problem, and we should explore some alternatives.
This response is both understanding/accepting of A’s feelings, and at the same time expresses disagreement with A’s solution. This is an example of how understanding/accepting responses allow for disagreement with the partner’s thoughts and opinions.

There are seven subskills of empathic responding. Each will be listed and discussed in turn:

1. Listen intently, showing interest and understanding while your partner is talking (Guerney, 1984).

Listening intently means to give your partner your full attention. It
means to attend to not only his or her words, but also to his or her nonverbal behavior (e.g., tone of voice, gestures, facial expressions). This is because your partner's nonverbal behavior often conveys his or her experience (particularly feelings) more clearly than his or her words.

How you position yourself physically will have a lot to do with whether or not your partner perceives you to be listening intently and showing interest while he or she is talking. By facing your partner squarely, adopting an open posture, leaning forward at times, and maintaining good eye contact, you will convey to your partner that you are listening intently. By adopting this physical posture you will also help yourself to remain alert and interested in what your partner is saying.

2. Concentrate on your partner's internal world, particularly to his or her mood (Guerney, 1984).

It is important early in an interaction with your partner that you get some sense of his or her mood (this is a term that describes a person's predominant or general feeling state). By determining early on what your partner's mood is (e.g., sadness, happiness, anger), you will be in a better position to respond empathically.

3. Put yourself in your partner's place by asking, "If I were my partner, (a) what would I be feeling, (b) what would I be wanting and/or needing, (c) what would I be thinking (about doing and/or about myself as a person), and (d) what conflicts would I be experiencing about any of the above (Guerney, 1984).

The goal of empathic responding is to make a response that is
interchangeable with what your partner is expressing. An interchangeable response captures the essential aspects of what your partner is saying. Three essential aspects of experience are what your partner feels, wants and/or needs, and thinks. The above questions are useful because they will help you to focus on and to reflect important aspects of your partner's experience.

Feelings are particularly important in empathic responding. This is because feelings convey the emotional meaning of what your partner is saying. When you reflect your partner's feelings, your partner will feel more deeply understood than had you not reflected his or her feelings.

Feelings may be stated directly in what your partner says, but more frequently are expressed indirectly in your partner's nonverbal behavior (e.g., facial expressions, tone of voice, and gestures). For this reason, it is important in asking yourself what your partner is feeling to observe closely his or her nonverbal behavior.

4. Formulate a statement that incorporates answers to one or more of the questions outlined above (Guerney, 1984).

There is no set way to make an empathic statement. What is important is that your statement convey understanding and support to your partner.

The following examples of expressions (A) and empathic responses to these expressions (B) demonstrate responses that are both understanding and supportive:
a. The reflection of a feeling plus the specific cause of the feeling.

A: What do you mean that you're not interested in making love? Last night when I asked, you said that tomorrow would be a better time.
B: I hear that you're frustrated because I had suggested that we make love tonight, and now I'm not wanting to.

Even though A's expression does not indicate that A is feeling angry directly, B infers from A's nonverbal behavior (e.g., tone of voice) that A is angry, and reflects this. B also reflects the specific cause of A's feeling, or why A is feeling frustrated.

When reflecting your partner's feelings, it is important to make a distinction between feelings and thoughts. This is because in every day language, people use the verb 'feel' and then express a thought or an opinion rather than a feeling. The distinction is this: a feeling describes an emotion (e.g., sad, happy, angry), while a thought describes an idea or an opinion. Consider this example:

A: The only way we can meet our financial obligations is to budget.
B: You feel that budgeting is necessary

In this example, even though B responds using the verb 'feel', there is no feeling word present in B's statement. Because A has expressed
an opinion regarding the importance of budgeting, the response "you think that budgeting is necessary" is appropriate. As you formulate your empathic responses, be sure that if you use the verb 'feel', that you actually use a feeling word.

b. The reflection of a want and/or need plus its specific content.

Consider this example in which B reflects A's want and the specific content of what A wants:

A: It's no fair that you expect me to work fulltime and to do most of the work around here too.
B: I hear that what you're wanting is for me to pull more of the load at home.

Because there is a close relationship between feelings and wants and/or needs (i.e., an awareness of our feelings often tells us what our wants and needs are), it is useful to reflect both a feeling and the want that is related to the feeling. This is illustrated using the previous example:

B: You resent that I leave the work around here mostly to you, and you want more help from me.

c. The reflection of a thought.
Consider this example:

A: Managing the kids is much more difficult when often you fail to stand behind the decisions I make.
B: You think that the kids are more difficult to deal with when I don't back up your decisions.

In this response B reflects A's thought or opinion about parenting. Often when your partner expresses a thought, you will sense by observing your partner's tone of voice or facial expression that he or she has a feeling about what he or she is thinking. For example, while A is expressing what he or she thinks about parenting, perhaps B notices a worried look on A's face or detects some anxiety in A's voice. If this is the case, B would reflect both what A thinks and the feeling that A has about this thought. In the following example, B reflects both A's thought and the feeling that A has about this thought.

B: I see that you're frustrated when I fail to back you up with the kids.

Whenever your partner expresses thoughts, you can be pretty sure that he or she will have a feeling about what he or she is thinking. This is because we tend to express thoughts only if they
have some meaning for us, and we generally have feelings about what has meaning for us. It is important that you listen for the feelings that are implicit in what your partner thinks, and reflect both feelings and thoughts.

d. The reflection of conflicts.

At times you will sense that your partner feels conflicted, as if there are two parts of himself or herself at odds with each other. Consider these examples:

A: I’m upset with my father because he said he would lend me some money and he hasn’t come through. But he’s done so much for me.
B: One part of you feels annoyed with your dad because you were counting on the loan; another part of you thinks that you shouldn’t be annoyed with him because he has given you so much.

In this example, B reflects the inner conflict between what A feels and thinks. Using the formula "One part ... another part ..." helps to clarify that A is experiencing an inner conflict.

5. Put yourself in your partner’s place to hear your own tentative statement, screening out potentially threatening words and phrases (Guerney, 1984).

You know from your own experience how sensitive you are to the way your partner responds to you. For this reason, it is important to screen out any words and phrases that you think your partner would react to.
6. Make your statement brief, being as specific and particular as possible with respect to content.

Consider this example:

A: We have been invited to a wedding in three months time. Mary Jane and Ted are getting married. Although I haven’t known Mary Jane for long, I really like her and am glad that she has invited us. I think the wedding should be fun, a chance to meet new people. I’m telling you about it now because I know how you get booked up.

B: You’re happy that she has invited us. You like her even though you haven’t known her for long and think it should be fun in terms of meeting some new people. You want to make sure that I book the time off now because experience tells you that I book up fast.

Here, B’s reflection is adequate but could be improved if it were briefer and more specific in content. The drawback of lengthier responses is that they tend to shift the focus from the expresser to the responder; the drawback with content that is general or vague is that your partner will not feel as understood as he or she would had you used specific content. Consider this example:

B: You’re pleased to be invited to Mary Jane and Ted’s wedding because you like Mary Jane and you think the wedding will be interesting socially. It’s important to you that I book the time off.
In this response, B is briefer and more specific in terms of content. Note, for example, that B specifies that the invitation is to Mary Jane and Ted's wedding. In this example, B is also more specific because the noun 'wedding' rather than the impersonal pronoun 'it' is used. It is best to use words or phrases rather than to use impersonal pronouns like 'it' or 'that', because the latter are vague and cause confusion.

7. Accept corrections readily because your partner is the expert on how he or she thinks and feels (Guerney, 1984).

When responding empathically to your partner, it is important that you accept how your partner qualifies or corrects your reflection. This is because your partner is the expert on how he or she thinks and feels, just as you are the expert on how you think and feel. Consider this example:

A: I don't quite know how I feel when you say that you want to do more activities without me.
B: You must be feeling upset.
A: Right now, it's more like I'm afraid that your wanting more independence will cause us to drift apart.
B: I understand that you're worried about our moving apart.

Here, B's assumption about what A is feeling is incorrect, but B is open to being corrected by A.

There are a number of responses that are to be avoided in empathic responding. These responses are:
1. Avoid asking your partner questions because this interrupts his or her flow of communication. If you think it is important to ask a question (e.g., for clarification), ask an open question rather than a closed question (Guerney, 1977).

Whereas a closed question elicits a 'yes' or a 'no' answer from your partner, an open question elicits a fuller response. Because of this, when you think it is important to ask a question, it is more effective to ask an open question than a closed question. Consider this example of a closed question (B1) and an open question (B2):

B1: Did you have a good day at work?
B2: How was work for you today?

Here, B2's question would be more helpful in eliciting information from A than B1's question.

2. Avoid presenting your own opinion, perception, or viewpoint about what your partner is saying. As the expresser, you will have the opportunity to express yourself (Guerney, 1977).

At times when you are responding empathically to your partner, you will feel the urge to present your own viewpoint. Out of your concern to be a good listener in relation to your partner, you may want to slip in your own point of view even while you attempt to respond empathically. Unfortunately, this does not work well for either of you. You will not be satisfied because you will not have expressed your viewpoint fully; your
partner will not be satisfied because he or she will not feel understood fully. For this reason, it is better that you indicate directly that you want to switch from the responding mode to the expressive mode. You will be taught the skill of mode switching later.

3. Avoid making suggestions about how your partner might solve the problem (Guerney, 1977).

When responding empathically to an issue that distresses your partner but that does not involve you directly, you will probably feel the urge to suggest solutions. Although it is natural for you to want to help your partner in this way, often your partner is not wanting you to suggest solutions but is merely wanting to be heard and understood in an empathic manner. Unless your partner asks for solutions, in situations such as this it is best to simply be empathic.

Another time you will probably feel the urge to suggest solutions is when you are dealing with a relationship issue that does involve you directly. In situations such as this, the appropriate time to problem-solve is when you both agree to work on reaching a solution, after you have explored your feelings and thoughts about the issue fully. This is because the real problems that need to be solved come into focus only through considerable exploration of each other's thoughts and feelings about the issue (Guerney, 1984).

4. Avoid making judgements about what your partner has said, because the latter are contrary to the accepting aspect of empathy (Guerney, 1977).

It is important that you avoid making judgements about what your
partner has said because the latter tend to "pull" defensive reactions from your partner which can quickly spiral into arguments and bad feelings. Consider this example in which B responds by judging A's experience:

A: I had a dream last night about Bob (a boyfriend whom A has not had contact with for many years). Since then, I've been thinking about him a lot.
B1: You shouldn't be thinking about him. You should just forget about him.
A: Who says I shouldn't think about him?
B: I did, that's who!

Consider this example in which B responds empathically:

B: You're feeling preoccupied with Bob because of your dream.
A: Yes, I am. I find it strange that I would dream about him after all this time.
B: Yes, it does seem unusual to have such a dream now.
A: Oh well, thanks for hearing this. Maybe I won't be quite so preoccupied now.
Mode switching

You will no doubt be curious about how and when you are to switch from being the responder to the expresser and vice versa. There are a number of guidelines for both the expresser and the responder that will help you (a) to keep in mind which communication mode you are using at any given time, (b) to use each of the modes at the appropriate time, and (c) to change from one mode to the other in a manner that satisfies both you and your partner (Guerney, 1984).

As the expresser, switch modes when: (1) you have already expressed your most important feelings and thoughts on the issue under discussion, and (2) you want to know your partner's feelings and thoughts (Guerney, 1984).

As the empathic responder, switch modes when (1) you have already repeated your partner's deepest feelings and thoughts on an issue twice, (2) your own feelings and thought begin to impair your ability to be empathic, and (3) you have something to say that might contribute to resolving an interpersonal conflict (Guerney, 1984). Do not worry if these guidelines are hard to keep straight. For now, it is enough to have a basic understanding of mode switching.

The procedure to follow in mode switching is this. In keeping with the above guidelines, whenever you become aware as either the expresser or the responder of wanting to mode switch, indicate this to your partner by asking if this is an appropriate time to switch (it may be that your partner wants to say a bit more before switching). When the timing is appropriate to your partner, switch modes. When you are the responder, it is important that you reflect your
partner's last statement before assuming the expressive mode in order that your partner feels understood before becoming the responder (Guerney, 1977).

**Maintaining your communication skills**

In this program you will work hard to acquire new ways of communicating. Like most things that you learn, practice is required to maintain your skills. It is recommended that you set up a regular time each week during which to discuss relationship issues using your new skills. There will be many potential obstacles to your maintaining a regular practice time, but there are numerous benefits to your doing so.

In addition to practicing your communication skills at regularly scheduled times, you will also find it useful to practice your skills in everyday situations. Studies have shown that the communication skills you are learning are effective with children and adolescents, friends, and colleagues. One of the added benefits of communication training is that the skills you learn may be used in a wide variety of relationships beyond your primary relationship with your partner.

You will also find your communication skills very helpful in recovering from quarrels or fights. It is inevitable that you will continue to have quarrels. What is important is that you have the ability to recover quickly from your quarrels. Your communication skills provide you with this ability. As soon after a quarrel as you and your partner are prepared to talk, it is important to sit down and discuss the unresolved relationship issues using your communication skills. By doing so, you will be able to create closeness much more quickly than before you acquired your skills.
In discussions with your partner, you will undoubtedly be aware of instances in which your partner fails to use the communication skills you have been taught. Although it will be tempting to correct your partner in such instances, it is more constructive to take responsibility for how you use the communication skills. In other words, focus on correcting your own violations of the communication skills. This will be appreciated by your partner and will enhance your communication as a couple.
EFT IMPLEMENTATION CHECKLIST

Part A: EFT interventions (Johnson, 1984)

Problem definition

1. The problem is defined/redefined in terms of the emotions underlying the positions taken in the relationship and the sense of deprivation experienced by the couple.
   
   Example: So the problem for you in this relationship is that you basically feel alone and isolated from Jim.

2. The therapist clarifies and elaborates the basic positions taken by the partners in the relationship.
   
   Example: So your basic approach to this relationship is that you need to manage it, to take control so that your wife will be able to overcome what you see as her problems. Your approach on the other hand is to resist his taking control, not by confronting him but by withholding yourself from him?

Attacking Behavior

3. 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.

   Example: You're feeling pretty angry right now, Penny? Yes, he is always so logical, and that makes me feel ..., powerless perhaps? Like you can't get through to him?
Process focus

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

Example: What happens to you when Linda turns her head like that as you talk?

or

So as Cary tries to take control of the situation you feel more and more afraid, like a little child is afraid?

(see Evocative Responding sheet in the EFT manual)

5. Emotional meanings are discovered, differentiated and elaborated upon.

Example: So although you feel hostile and overwhelmed when he does this, you are too unsure of yourself and afraid of his disapproval to tell him so?

(see Evocative Responding sheet in the EFT manual)

6. 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.

Example: Tom, when you experience Sue withdrawing from you, it seems like you become afraid that you are not important to her and you demand reassurance; but then, Sue, you panic, when people demand responses from you, you tend to feel that you are being taken over, and so you withdraw more.

Listening
7. Blocks/resistance to accepting a partners experience are explored in terms of underlying feelings, self-concept or experience in family of origin (the awareness of inner experience is the focus).

Example: It seems like you find it hard to accept that Linda is sometimes afraid of you, that you might create that kind of response in her?

or

What happens to you when Mary gets mad like this ... you know I had the image of your mother attacking you, the way you described earlier.

Problem Solving

8. The therapist facilitates affectively based needs and wants being accessed and expressed to the partner.

Example: Brenda, can you tell Cory what it is that you really want from him right now? How can he reassure you?

9. The therapist helps the clients crystalize their new view of their partner, and to explore their new feeling response to this perspective.

Example: So, Cory, this is a new view for you, to understand that Brenda is truly afraid to have sex with you, to let you in. How do you respond to that? Client, "I feel softer, not so angry."

10. Shared perspectives on the relationship are clarified. Metacommunication regarding the relationship is facilitated.

Example: So, John, it seems that you are able to help Anne feel more secure in the relationship now and that she is therefore more accessible to you, and you are feeling more accepted.

Additional categories
11. Information gathering.
12. Refocus on topic.
13. EFT but not codable (example: therapist assigning homework).

Part B: nonEFT interventions

Instructions to raters: listed below are 14 therapist interventions representative of three alternative approaches to EFT. Place a check on the rating form whenever you encounter one of these nonEFT therapist interventions. An intervention is defined as a therapist statement.

Cognitive-Behavioral interventions

Listed below are five cognitive-behavioral marital therapy interventions drawn randomly from Johnson's (1984) implementation check of Cognitive-Behavioral and Emotionally Focused therapist interventions.

1. The problem is defined in terms of manifest observable complaints and lack of skills on the part of the couple.
   Example: So these problems, managing the kids and Pam's overinvolvement in activities outside the home ... right now it seems that you need to learn some new ways to solve these problems.

2. The therapist frames the problem in terms of mutual bad habits that will need work to overcome, and teaches behavior change concepts.
   Example: Both of you have some habits that prevent you from enjoying this relationship, but the easiest way to get your partner to change is to reward them for changing; to reward them by changing your own behavior.

3. Negative behavior such as name calling is labelled as unhelpful and related
to lack of skill. A substitute is usually suggested. Rules are set and
rehearsed.

Example: Jane, do you know why I am interrupting you right now?
(Client) "Yes, I guess I was calling him names. Right, and that is not
helpful. Can you describe to him the behavior that you find so offensive?

4. The therapist facilitates the identification of specific behaviors expected from
the partner, without basing them in feelings.

Example: The therapist helps the client frame, "I want you to give me a
hug and a kiss every morning before getting out of bed".

5. A solution is chosen and a contract is negotiated stressing reciprocity and
compromise. Costs and benefits of solutions are weighed.

Example: So the agreement is that Jerry will be home every day by
six-thirty, and Marlene will ask five questions about Jerry's day at the
dinner table.

Integrated Systemic interventions

Listed below are five integrated-systemic interventions drawn randomly
from Goldman's (1987) implementation check of Integrated Systemic and
Emotionally Focused therapist interventions.

6. The problem is defined in terms of goals for therapy, stated in specific
behavioural terms.

Example: Your problem is that your discussions escalate into damaging
fights. You would know that this had changed if you could discuss things
calmly that previously you were unable to.

7. The therapist positively connotes negative behaviours (i.e., blaming) in terms
of the function of the behavior in the cycle.

Example: You begin picking at him because you want to reestablish some contact with him. Picking at him doesn’t feel very good but is helpful in overcoming periods when you avoid talking to each other.

8. The therapist reframes the couple’s negative cycle in positive terms, emphasizing the protective function of each person’s position.

Example: As I’ve said, I think you’re both very perceptive and sensitive, which is a measure of the caring between you. (To the blamer, A) A, you’re particularly sensitive to how B responds to you--and that sensitivity is very important and helpful to B--because it’s your way of letting B know how much you care about him. (To the controller, B) B, your attentiveness and forcefulness is part of how you show your caring and closeness. If you didn’t care, you wouldn’t invest so much energy in telling her what you think about her.

9. The therapist acknowledges improvement but restrains the couple by suggesting that partners "go slow" and that too much change too quickly might be dangerous.

Example: I credit you with working hard to be responsive to each other and with avoiding conflict. It is important that you gradually quarrel less because stopping your quarrels all at once may leave your relationship without passion. It is better to lessen your quarrelling gradually as you find new ways to express your passion.

10. The therapist prescribes the negative interactional cycle.

Example: Because your attacking John helps to reduce the tension that builds between the two of you, and your withdrawing from Helen protects
you both by not allowing the fight to become too damaging, for the time
being you should continue to attack John whenever you feel the tension
building, and you should leave the scene of the fight before things get out
of hand. In this way you will be able to maintain the delicate balance
between you.

Communication training interventions

Listed below are four communication skills training interventions selected
from the CT component manual.

11. Social reinforcement (SR)

This intervention describes verbal reinforcing statements addressed to
either the expresser or the responder whenever a partner in either of these
modes: (a) responds well, (b) responds at a level better than his/her general
level has been, (c) corrects or improves his/her own response, or (d) follows
an appropriate suggestion made by the therapist (Guerney, 1977).

There are two types of verbal reinforcement, brief words or phrases,
and lengthier statements. Examples of brief words or phrases are: fine,
good, right, very good, excellent, great, terrific, wonderful, beautiful, you're
doing well. An example of a longer statement to the expresser is: "That
was a rough thing to state subjectively; you corrected yourself beautifully".
An example of a longer statement to the responder is: "That was a very
supportive reflection; you reflected the feeling very well" (Guerney, 1977).

12. Structuring (S)
This intervention describes responses used to explicitly explain guidelines for CT component modes and procedures, or to remind partners of the guidelines. Structuring responses to expressers include asking the expresser (a) to speak subjectively or from an "I" position, (b) to state feelings (including underlying feelings) and felt-needs, (c) to state the specific cause of feelings, (d) to talk directly to the responder, (e) to use specific language (e.g., nouns rather than pronouns lacking clear antecedents), (f) to state specific behaviors/events rather than generalizations, (g) to rephrase questions as statements (usually questions convey implicit statements), and (h) to limit expressions to a length that the responder may reflect without becoming confused/overloaded. All of the above subskills except (b), (e), and (g), which are EFT-based, are drawn from Guerney (1977). Examples of each of these structuring responses respectively are:

a. Bob, it is important that you present your ideas as your own subjective viewpoint rather than as objective fact. This will make it easier for Linda to hear what you are saying.

b. Daren, you’ve indicated that you’re angry when Paul isn’t willing to spend time with you. What you said implies how important he is to you, and that at times you feel unloved and uncared for. It’s important to share these underlying feelings too.

c. Bill, you stated very well that you are afraid. Tell her specifically what you are afraid of.

d. Bruce, what you said was very open. You expressed your feelings subjectively and very well. I notice that you were looking at me as you spoke. Say these things to her now.
e. George, you mentioned you dislike *that* about Mary. Tell her what *that* is.

f. Mary, instead of saying that Jim is lazy, it's best to be specific by mentioning one or two of the behaviors you have in mind and telling him how you feel about them. Do this now.

g. Shirlie, in the question you just asked, I think there is an implicit statement. Try making a statement out of your question by telling him how you feel about that.

h. Henry, I'd like to stop you because it's important that you not say so much that Jodie gets confused and isn't able to reflect what you've said.

Structuring responses to responders include reminding responders (a) to reflect feelings that have been explicitly stated and the specific cause of these feelings, (b) to not ask questions, (c) to not give advice or suggest solutions, (d) to not make interpretations, (e) to direct their statements to the partner, (f) to use the verb "to feel" if they are reflecting a feeling and the verb "to think" if they are reflecting a thought, (g) to refrain from adding to what the expresser has said or expressing one's own viewpoint, (h) to include important content that may not have been reflected, and (i) to understand that to reflect what one's partner is saying does not mean to agree with it. All of the above subskills except (f) and (i), which are EFT-based, are drawn from Guerney (1977). Examples of each of these structuring responses respectively are:

a. Mary just said she is feeling anxious. Try reflecting this feeling and why specifically she is feeling this way.
b. I want to remind you to avoid asking the expresser to give you more information.

c. You're giving her what you think is the solution to the problem. You can do that as the expresser, but as the responder, it's best to not give solutions. Just concentrate on showing your understanding of what she is feeling and needing now.

d. I think you're trying to tell him why he feels as he does in this situation. This is an interpretation rather than an empathic reflection. Concentrate on showing understanding of what he is feeling.

e. You picked up on his ambivalence, but seemed to be so absorbed in thinking about your response that you didn't make contact with her as you spoke. Say this again, directly to her.

f. I notice that you said "You feel that my parents shouldn't visit"; the phrase "that my parents shouldn't visit" is a thought rather than a feeling. It's best to use the verb "to think" when you express a thought.

g. You will have a chance to express your own view soon when you become the expresser. As the responder, your task is to reflect back what your partner said.

h. It is important to reflect all the main ideas your partner is expressing. You reflected the first reason your partner is annoyed with you. Try reflecting her second reason also.

i. It is important to realize that to reflect back what your partner is saying does not mean to agree with your partner. To understand your partner does not necessarily mean to agree because you are both
individuals with your own opinions.

Unlike in RE in which therapists structure responders to reflect expressers' implicit feelings (Guerney, 1977), in the CT component therapists direct structuring responses that remind partners of underlying feelings only to expressers and not to responders. This is because directing responders to reflect the expressers' underlying feelings that have not been stated previously contributes to mind reading. Each partner is encouraged to take a self-focus with respect to underlying feelings, which finds expression only in the expressive mode.

13. Modeling (M)

This intervention describes therapist responses that provide expressers and responders with examples of statements or sentences to repeat to their partners. Therapists model responses to responders if the latters' reflection (a) misses a clearly expressed feeling or need, (b) misses important content, and (c) misses either side of an inner conflict. Examples of modeling responses in each of these situations respectively are:

a. Try, "I understand that you're ticked off with me because I ask you to be responsible for making dinner and then step in and tell you how to do it".

b. Try, "I see that you are upset with me because I said I would stay within our budget and then didn't".

c. Try, "You feel torn. One part of you feels hopeful about the possibility of greater closeness; the other part of you is cynical about this change happening".

Modeled responses for responders are always directed to responders because the goal of communication training is to teach partners to respond to each other in new ways. If the therapist thinks that the responder's response will be inadequate, in order to protect the responder's self-esteem, the therapist will often model responses in anticipation of the responder's reflection. Therapists also use modeling responses when responders hesitate or look to them for help (Guerney, 1977).

Therapists model any of the following expressive subskills to expressers: (a) stating things in subjective terms, (b) labeling feelings (including underlying feelings) and felt-needs, (c) stating the specific cause of feelings, (d) using specific language rather than vague impersonal terms, and (e) rephrasing questions as statements. Unlike in modeling empathic responses where therapists may model a response before the responder speaks, in modeling expressive responses therapists can model only after the expresser has spoken because otherwise the therapist has no way of knowing what to model. All of the above subskills except (b), (d), and (e), which are EFT-based, are drawn from Guerney (1977). Examples of modeling responses for each of the expressive subskills respectively are:

a. Try, "My viewpoint on this is that birth control is a mutual responsibility that belongs to both of us".

b. Try, "I feel upset and annoyed when you withdraw from me".

c. Try, "I resent your not telling me about overdrawing our account when we spoke about our finances last night".

d. Try, "I dislike you saying this rather than I dislike people saying this".

e. Instead of asking, "Can you give me an example of something you've initiated on your own?", try "I'm angry because I think you are procrastinating needlessly".

It is important to highlight that therapists direct modeling responses that bring to awareness underlying feelings only to expressers and not to responders. This is because feeding a sentence to the responder that models the expresser's underlying feelings contributes to mind reading.

Although therapists initially model entire sentences, as responders become more adept at responding empathically, therapists model key words or phrases (Guerney, 1977). An example of such a modeling response to a responder is: Try, "I hear that you're unhappy".

When therapists model a response to either the expresser or the responder, it is important that partners repeat the entire response rather than agreeing with the response and then continuing to talk. The reason for this is that the purpose of the modeled response is to assist partners to address each other directly. Much of the intensity of modeled responses is lost if recipients of such responses do not repeat these responses to their partners. Recipients may put modeled responses in their own words as long as the intent of the modeled statement is not lost. Therapists may have to be firm in requesting that recipients of modeled responses actually reiterate these responses.

Modeling responses are often combined with structuring responses; that is, after reminding a partner of a subskill (i.e., a structuring
response), the therapist may model a statement that demonstrates the appropriate use of the particular subskill. An example of a structuring-modeling response to a responder is: You’re telling her why she behaves in certain ways. Remember that in order to keep the discussion constructive, it’s best not to do that. Try, "I understand that you feel frustrated by your tendency to procrastinate".

In keeping with the focus in EFT of therapists defining and validating partners’ positions, when therapists provide structuring-modeling responses for the expresser, their task is to help the expresser make clear, direct statements that the responder is able to reflect successfully. This may require that the therapist make a number of interventions that refine and clarify the expresser’s statements until a statement is reached that is sufficiently clear and direct for the responder to reflect.

14. Encouraging a mode switch (EMS)

This intervention describes responses designed to teach partners when and how to switch from the expresser to the responder mode and vice versa.

Therapists suggest a mode switch to the expresser when (a) the expresser wants to know his or her partner’s thoughts concerning the issue being discussed, and (b) when the expresser seems to be repeating him or herself. Before suggesting a mode switch in the latter instance, therapists must be satisfied that the expresser has stated any underlying feelings and needs that could be expressed given additional exploration (Guerney, 1977). Examples of therapist mode switching responses in each of these instances
respectively are:

a. In what you’re saying now, and in what you’ve said in your last comment as well, you’re implying that you wonder whether your husband really cares whether or not you succeed in your job. Is that something that you would like him to reply to now, or would you rather develop your own feelings about this further?

b. You sound a little bit like you’re beginning to run dry on this point. If this is the case, this would be an appropriate time to suggest a mode switch.

Therapists suggest a mode switch to responders when (a) responders are having difficulty being empathic and feel the strong urge to present their own viewpoints, and (b) responders have already reflected their partner’s deepest feelings and thoughts on an issue twice. With respect to the former, an important cue to therapists is when they detect that responders are trying to get their own point of view across while maintaining the formal aspects of an empathic response (Guerney, 1977). Examples of mode switching responses to responders in each of these instances respectively are:

a. That was a good empathic statement, but I think his remarks are getting to you. You seem to be tightening up. Would you like to request a change in mode?

b. You seem to be reflecting the same feeling in this response as in your previous response. Perhaps this would be a good time to switch modes. Check out whether your partner is ready to switch.
Therapists establish the ground rule that responders always make an empathic response to the expresser's last comment before assuming the expressive mode. Therapists also establish that the partner wanting a mode switch checks out the readiness of the other partner before making this switch (Guerney, 1977).
Instructions to raters: listen to a meaningful therapist statement (this excludes instances where the therapist says a few words and is cut off) and place a check mark on the rating form under an intervention each time that intervention is used. There may be more than one intervention in a meaningful therapist statement.

Part A: CT interventions

Therapist interventions that are appropriate to the CT component are:

1. Social reinforcement (SR)

   This intervention describes verbal reinforcing statements addressed to either the expresser or the responder whenever a partner in either of these modes (a) responds well, (b) responds at a level better than his/her general level has been, (c) corrects or improves his/her own response, or (d) follows an appropriate suggestion made by the therapist (Guerney, 1977).

   There are two types of verbal reinforcement, brief words or phrases, and lengthier statements. Examples of brief words or phrases are: fine, good, right, very good, excellent, great, terrific, wonderful, beautiful, you're doing well. An example of a longer statement to the expresser is: "That was a rough thing to state subjectively; you corrected yourself beautifully". An example of a longer statement to the responder is: "That was a very supportive reflection; you reflected the feeling very well" (Guerney, 1977).
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c. Bill, you stated very well that you are afraid. Tell her specifically what you are afraid of.

d. Bruce, what you said was very open. You expressed your feelings subjectively and very well. I notice that you were looking at me as
you spoke. Say these things to her now.

e. George, you mentioned you dislike *that* about Mary. Tell her what *that* is.

f. Mary, instead of saying that Jim is lazy, it's best to be specific by mentioning one or two of the behaviors you have in mind and telling him how you feel about them. Do this now.

g. Shirlie, in the question you just asked, I think there is an implicit statement. Try making a statement out of your question by telling him how you feel about that.

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Structuring responses to responders include reminding responders (a) to reflect feelings that have been explicitly stated and the specific cause of these feelings, (b) to not ask questions, (c) to not give advice or suggest solutions, (d) to not make interpretations, (e) to direct their statements to the partner, (f) to use the verb "to feel" if they are reflecting a feeling and the verb "to think" if they are reflecting a thought, (g) to refrain from adding to what the expresser has said or expressing one's own viewpoint, (h) to include important content that may not have been reflected, and (i) to understand that to reflect what one's partner is saying does not mean to agree with it. All of the above subskills except (f) and (i), which are EFT-based, are drawn from Guerney (1977). Examples of each of these structuring responses respectively are:

a. Mary just said she is feeling anxious. Try reflecting this feeling and
why specifically she is feeling this way.

b. I want to remind you to avoid asking the expresser to give you more information.

c. You’re giving her what you think is the solution to the problem. You can do that as the expresser, but as the responder, it’s best to not give solutions. Just concentrate on showing your understanding of what she is feeling and needing now.

d. I think you’re trying to tell him why he feels as he does in this situation. This is an interpretation rather than an empathic reflection. Concentrate on showing understanding of what he is feeling.

e. You picked up on his ambivalence, but seemed to be so absorbed in thinking about your response that you didn’t make contact with her as you spoke. Say this again, directly to her.

f. I notice that you said "You feel that my parents shouldn’t visit"; the phrase "that my parents shouldn’t visit" is a thought rather than a feeling. It’s best to use the verb "to think" when you express a thought.

g. You will have a chance to express your own view soon when you become the expresser. As the responder, your task is to reflect back what your partner said.

h. It is important to reflect all the main ideas your partner is expressing. You reflected the first reason your partner is annoyed with you. Try reflecting her second reason also.

i. It is important to realize that to reflect back what your partner is saying does not mean to agree with your partner. To understand your
partner does not necessarily mean to agree because you are both individuals with your own opinions.

Unlike in RE in which therapists structure responders to reflect expressers' implicit feelings (Guerney, 1977), in the CT component therapists direct structuring responses that remind partners of underlying feelings only to expressers and not to responders. This is because directing responders to reflect the expressers' underlying feelings that have not been stated previously contributes to mind reading. Each partner is encouraged to take a self-focus with respect to underlying feelings, which finds expression only in the expressive mode.

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This intervention describes therapist responses that provide expressers and responders with examples of statements or sentences to repeat to their partners. Therapists model responses to responders if the latters' reflection (a) misses a clearly expressed feeling or need, (b) misses important content, and (c) misses either side of an inner conflict. Examples of modeling responses in each of these situations respectively are:

a. Try, "I understand that you're ticked off with me because I ask you to be responsible for making dinner and then step in and tell you how to do it".

b. Try, "I see that you are upset with me because I said I would stay within our budget and then didn't".

c. Try, "You feel torn. One part of you feels hopeful about the possibility of greater closeness; the other part of you is cynical about
this change happening".

Modeled responses for responders are always directed to responders because the goal of communication training is to teach partners to respond to each other in new ways. If the therapist thinks that the responder's response will be inadequate, in order to protect the responder's self-esteem, the therapist will often model responses in anticipation of the responder's reflection. Therapists also use modeling responses when responders hesitate or look to them for help (Guerney, 1977).

Therapists model any of the following expressive subskills to expressers: (a) stating things in subjective terms, (b) labeling feelings (including underlying feelings) and felt-needs, (c) stating the specific cause of feelings, (d) using specific language rather than vague impersonal terms, and (e) rephrasing questions as statements. Unlike in modeling empathic responses where therapists may model a response before the responder speaks, in modeling expressive responses therapists can model only after the expresser has spoken because otherwise the therapist has no way of knowing what to model. All of the above subskills except (b), (d), and (e), which are EFT-based, are drawn from Guerney (1977). Examples of modeling responses for each of the expressive subskills respectively are:

a. Try, "My viewpoint on this is that birth control is a mutual responsibility that belongs to both of us".

b. Try, "I feel upset and annoyed when you withdraw from me".

c. Try, "I resent your not telling me about overdrawing our account when we spoke about our finances last night".
d. Try, "I dislike you saying this rather than I dislike people saying this".

e. Instead of asking, "Can you give me an example of something you've initiated on your own?", try "I'm angry because I think you are procrastinating needlessly".

It is important to highlight that therapists direct modeling responses that bring to awareness underlying feelings only to expressers and not to responders. This is because feeding a sentence to the responder that models the expresser's underlying feelings contributes to mind reading.

Although therapists initially model entire sentences, as responders become more adept at responding empathically, therapists model key words or phrases (Guerney, 1977). An example of such a modeling response to a responder is: Try, "I hear that you're unhappy".

When therapists model a response to either the expresser or the responder, it is important that partners repeat the entire response rather than agreeing with the response and then continuing to talk. The reason for this is that the purpose of the modeled response is to assist partners to address each other directly. Much of the intensity of modeled responses is lost if recipients of such responses do not repeat these responses to their partners. Recipients may put modeled responses in their own words as long as the intent of the modeled statement is not lost. Therapists may have to be firm in requesting that recipients of modeled responses actually reiterate these responses.
Modeling responses are often combined with structuring responses; that is, after reminding a partner of a subskill (i.e., a structuring response), the therapist may model a statement that demonstrates the appropriate use of the particular subskill. An example of a structuring-modeling response to a responder is: You’re telling her why she behaves in certain ways. Remember that in order to keep the discussion constructive, it’s best not to do that. Try, "I understand that you feel frustrated by your tendency to procrastinate".

In keeping with the focus in EFT of therapists defining and validating partners’ positions, when therapists provide structuring-modeling responses for the expresser, their task is to help the expresser make clear, direct statements that the responder is able to reflect successfully. This may require that the therapist make a number of interventions that refine and clarify the expresser’s statements until a statement is reached that is sufficiently clear and direct for the responder to reflect.

4. Encouraging a mode switch (EMS)

This intervention describes responses designed to teach partners when and how to switch from the expresser to the responder mode and vice versa.

Therapists suggest a mode switch to the expresser when (a) the expresser wants to know his or her partner’s thoughts concerning the issue being discussed, and (b) when the expresser seems to be repeating him or herself. Before suggesting a mode switch in the latter instance, therapists must be satisfied that the expresser has stated any underlying feelings and
needs that could be expressed given additional exploration (Guerney, 1977).
Examples of therapist mode switching responses in each of these instances respectively are:

a. In what you're saying now, and in what you've said in your last comment as well, you're implying that you wonder whether your husband really cares whether or not you succeed in your job. Is that something that you would like him to reply to now, or would you rather develop your own feelings about this further?

b. You sound a little bit like you're beginning to run dry on this point. If this is the case, this would be an appropriate time to suggest a mode switch.

Therapists suggest a mode switch to responders when (a) responders are having difficulty being empathic and feel the strong urge to present their own viewpoints, and (b) responders have already reflected their partner's deepest feelings and thoughts on an issue twice. With respect to the former, an important cue to therapists is when they detect that responders are trying to get their own point of view across while maintaining the formal aspects of an empathic response (Guerney, 1977).

Examples of mode switching responses to responders in each of these instances respectively are:

a. That was a good empathic statement, but I think his remarks are getting to you. You seem to be tightening up. Would you like to request a change in mode?

b. You seem to be reflecting the same feeling in this response as in your previous response. Perhaps this would be a good time to switch
modes. Check out whether your partner is ready to switch.

Therapists establish the ground rule that responders always make an empathic response to the expresser's last comment before assuming the expressive mode. Therapists also establish that the partner wanting a mode switch checks out the readiness of the other partner before making this switch (Guerney, 1977).

5. Encouraging-prompting

Encouraging-prompting responses are intended (a) to encourage partners to give a response, and (b) to add to or refine an existing response. Unlike structuring, encouraging-prompting responses are not intended to correct an outright error or remind the client about a particular rationale or principle. Rather, encouraging-prompting responses serve to stimulate the client to make a particular kind of response or to refine one just made. Unlike modeling responses, which feed particular sentences or phrases that are intended to be repeated, encouraging-prompting responses are open-ended (Guerney, 1977). Examples of encouraging-prompting responses to expressers are:

- What are you feeling?
- I agree that you're feeling disappointed. But I think that underneath the disappointment you're also feeling something else.
- Tell her specifically what causes you to feel this way.
- Now that you've identified what you're feeling, maybe this feeling will help you to know what you're needing.

Examples of prompting responses to responders are:
How is she feeling right now?

You reflected her anger well. Reflect also why she is feeling this way.

I think he's feeling ambivalent. What's the other side of his feelings?

Just as modeling responses are combined with structuring responses, so also are prompts. Therapists frequently prompt partners after making structuring responses (Guerney, 1977). An example of a therapist structuring-prompting response to a responder is: "I think that you missed the feeling that your partner expressed. What is she feeling?"

6. Troubleshooting-client reaction (T)

Troubleshooting in response to a client reaction occurs whenever a partner is either unwilling or unable to follow standard CT component procedures. If it is an instance of the partner's being unwilling to follow the procedures, therapists respond empathically to the doubts and difficulties being expressed in order to draw out the partner's resistant feelings and thoughts fully. After this, therapists use structuring (e.g., presenting the underlying rationale for communication skills training such as empirical evidence) to try to persuade the resistant partner to return to CT component procedures. Therapists then solicit the partner's view and return to empathic responses to make certain that the partner's doubts have been assuaged. If the partner is now comfortable with going back to CT component procedures, troubleshooting is over. If the partner still has doubts, the process is repeated. As a last resort in dealing with client resistance, therapists ask partners to try communication skills training and to see if this is helpful (Guerney, 1986).
Another type of troubleshooting-client reaction response occurs when a partner is unable to follow CT component procedures because he or she is emotionally overwhelmed (for example, by anger or sorrow). Here, the therapist responds empathically to help the partner deal with those feelings (Guerney, 1986).

7. Other (O)

This category designates responses that are consistent with the CT component but which do not fit under any of the specified therapist interventions (e.g., focusing on a new issue, directing one partner to respond to the other).

Part B: nonCT interventions

Therapist responses that are inappropriate to the CT component are:

1. Directive lead

This describes responses in which the therapist steers the conversation. This occurs when the therapist responds to the content of what is being said rather than to the skills or process. Examples of this are (a) steering a couple toward a solution to a problem, and (b) guiding a partner toward an insight without explicitly stating a specific insight (Guerney, 1977). Examples of these two types of directive lead respectively are:

a. You mentioned a moment ago that how you are attempting to solve the problem isn't working. Perhaps you might try this...

b. Do you often have this kind of an argument before you make love?
2. **Interpretation**

   This describes responses in which the therapist points out a fairly specific item of knowledge about a participant. Interpretive responses usually (a) imply causality, (b) highlight contradictions, or (c) point out connections or relationships between events (Guerney, 1977). Examples of these types of interpretive responses respectively are:
   a. It seems as though it’s easier for you to make passionate love after you’ve had an argument.
   b. It seems that when he does something that is distressing to you, that you end up feeling guilty; somehow, it never seems to make you mad.
   c. You’ve talked the same way earlier about how your mother made you feel when she constantly made suggestions to you. It sounds very much like the feelings you have when your wife asks you to do things. Do you think there is a relationship here between your feelings toward your mother and your wife?

3. **Suggestion/advice, explanation**

   This describes responses in which therapists (a) offer suggestions to partners about how to look at things or give advice about how to behave, and (b) explain psychological or interpersonal phenomena beyond those pertinent to the concepts and skills of the CT component (Guerney, 1977). Examples of each of these responses respectively are:
   a. Try going out together more. Find something you both like to do, and do it together.
b. Sometimes behavior like that is really a cry for help.

4. Encouragement/reassurance, approval

This describes responses in which therapists attempt to make partners feel good, or more frequently, less bad. Such responses are usually elicited by a client's complaint, expression of anxiety, or self-belittling statement; they differ from reinforcing responses regarding the CT program and skills in that they are reactions to the content of the problems partners are dealing with in their relationship (Guerney, 1977). Examples of encouragement/reassurance, and approval respectively are:

a. I know you're both feeling distant and lonely, but things are bound to get better soon if you continue to give each other the space you need.

b. I think it's just great that you've made the decision to go away for the weekend. That kind of thing can really be a revitalizing experience.

5. Personal criticism

These are responses in which the therapist tends to belittle either or both partners or to put them down in any way (Guerney, 1977). An example is: "You're not really trying very hard."

6. Other diversions

These are responses that divert the partners from the educational purpose of the CT component. Responses include the sharing of (a) opinions, (b) experiences or anecdotes, and (c) self-disclosures. These responses are to be distinguished from social conversation that characterizes the opening
moments of the session, and humour, which when interspersed through the
session, facilitates the learning experience (Guerney, 1977). Examples of
each of the above diversions respectively are:
a. I think that mothers should stay in the home when children are young.
b. I saw a man blow up at his wife in a restaurant today. It was quite a scene. They could sure use this training.
c. I like to watch Miami Vice on TV too; its one of my favourites.

7. Inappropriately directed therapist responses

These are responses in which therapists (a) direct empathic responses to the expresser, and (b) direct reformulated expressive responses to the responder. These responses are correct in terms of what is said, but not in terms of to whom they are said (Guerney, 1977). Examples of these responses respectively are:
a. Expresser (to husband): I don’t see us changing, so what hope is there? I can’t take it much longer the way it is.
   Therapist (to wife): You’re feeling very discouraged about the relationship right now; you’re almost ready to give up on it.
b. Expresser (wife to husband): You’re very inconsiderate of me at parties. You pay so little attention to me that I might as well not be there.
   Therapist (to responder): She’s saying that she feels neglected and hurt at those parties at those times when you seem to her to be ignoring her.

8. Failure to correct
Failure to correct the expresser.

Expressive statements that are serious deviations (in the sense of being psychologically threatening) and that the therapist does not correct are coded "failure to correct". Serious deviations include the expresser speaking (a) in objective rather than subjective terms, (b) in general, blanket terms rather than in specific behaviors, and (c) in terms of the other person's motivations, thoughts, and feelings rather than in terms of the expresser's own reactions to specified behavior of the other. Examples of each of these responses respectively (without the therapist's correction) are:

a. You don't have a clue about how to love. As a husband, your a wipeout.
b. You're a depressed person. You do nothing to help yourself and like to wallow in self-pity.
c. You wouldn't come home late if you weren't disinterested in our marriage.

Failure to correct the responder.

Failure to correct the responder occurs only when there are extreme content deviations from the responder's role that go uncorrected by the therapist. These are when the responder (a) makes no effort even to restate what has been said to him by the expresser, and (b) enters into a clear statement of his own point of view without going through mode-switching procedures (Guerney, 1977).
STANDARDIZED FOLLOW-UP PROCEDURE (JOHNSON, 1984)

Each couple was called four months after the termination of treatment. Each partner was spoken to separately and reminded of the Target Complaints measure. The TC scale anchors were read to each partner twice, followed by the description of their target complaint which they each had given in the assessment interview. They were then asked to place this complaint on the scale so as to reflect its present status in the relationship. They were then told of the other questionnaires in the mail and asked to complete them.

The process of the call was: Do you remember the target complaint you identified as the main issue in your relationship and rated on a scale after your last therapy session? The levels of the scale were, Worse, Same, Slightly Better, Somewhat Better, Much Better. I am going to ask you to place your complaint as you experience it now on this scale, so I will read the levels to you again. You might even like to write them down. The levels were Worse, Same, Slightly Better, Somewhat Better, Much Better. Your issue was ..... (the client’s short description of his or her complaint is read). Now, I would like you to place that issue on the scale. Do you experience it as Worse, the Same, Slightly Better, Somewhat Better, or Much Better? Thank you.
POST-TREATMENT STRUCTURED INTERVIEW

PART A: Client reactions to the EFT treatment (to be administered to couples in both active treatments)

1. What did you find most helpful about the Emotionally Focused approach?

2. There are a number of things that individuals who have received the Emotionally Focused approach report have helped them or their partners to change their relationships. Which do you think was the most important for you?
   a. Seeing my partner experience feelings (often with real intensity) that he or she does not show typically in our relationship.
      M: ___ F: ___
   b. Coming to new understandings or realizations (often deeply felt) about myself, my partner, or the relationship.
      M: ___ F: ___
   c. Taking responsibility for my part of the problem.
      M: ___ F: ___
   d. Sharing feelings and thoughts that I would normally not share with
my partner.

M: ___ F: ___

e. Having the therapist validate the legitimacy of my feelings or way of looking at things.

M: ___ F: ___

Part B: Client reactions to the CT component (to be administered to only couples in the EFT+CT treatment)

1. What did you find most helpful about the communication training sessions?

2. What was it like to learn communication skills after eight sessions of the Emotionally Focused approach?
3. Would you have preferred to receive more communication training sessions, or more of the Emotionally Focused sessions?
M:___
F:___
Please indicate the reason for your preference.

4. If you were to recommend couples counselling to a friend, would you recommend the communication training approach, the Emotionally Focused approach, or a combination such as you experienced in this project?
M:___
F:___
Please indicate the reason for your preference.
APPENDIX C

ANOVA TABLES OF DEMOGRAPHIC AND THERAPIST VARIABLES

Table C-16
ANOVA of Demographic Variables

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<td>No. of children</td>
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Note. N=42; DF (2,39)
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Note. N=14; DF (1,12)
Table C-18

Summary ANOVA: EFT vs. EFT+CT on the Couples Therapy Alliance Scale
Using Post Third-Session Couple Scores

N = 28

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<th>MS</th>
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### Table C-19

Summary ANOVA: EFT vs. EFT+CT on the Couples Therapy Alliance Scale

Using Post Third-Session Individual Scores

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TABLES OF MEANS AND STANDARD DEVIATIONS OF DEPENDENT MEASURES

Table C-20

Table of Means and Standard Deviations for Dependent Measures With the Couple Score as the Unit of Analysis

DAS (total score) N = 42

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CONSENSUS N = 28

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### Table C-20 continued

**AFFECTIONAL EXPRESSION N = 28**

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### Table C-21

Table of Means and Standard Deviations for Dependent Measures With the Individual as the Unit of Analysis

**DAS** (total score) N = 42

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Table C-21 continued

**PIQ**  
**N = 42**

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|                 |        | Post | 39.76 | 26.00 | 32.66 |
|                 |        | FU   | 36.01 | 31.92 | ----  |
|                 | Female | Pre  | 24.88 | 33.13 | 39.54 |
|                 |        | Post | 32.79 | 41.16 | 37.18 |
|                 |        | FU   | 31.86 | 33.28 | ----  |

**CS**  
**N = 42**

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|                 |        | Post | 7.50 | 7.49  | 7.02 |
|                 |        | FU   | 5.17 | 6.29  | ----|
|                 | Female | Pre  | 5.21 | 4.89  | 6.78 |
|                 |        | Post | 6.52 | 9.19  | 8.18 |
|                 |        | FU   | 5.62 | 5.88  | ----|
### Table C-21 continued

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