A COMPARATIVE TREATMENT STUDY OF
EXPERIENTIAL AND BEHAVIORAL APPROACHES
TO MARITAL THERAPY

By

SUSAN M. JOHNSON

B.A. University of Hull, 1968
M.A. University of British Columbia, 1980

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to the required standard

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Department of Counselling Psychology

The University of British Columbia
1956 Main Mall
Vancouver, Canada
V6T 1Y3

Date 10 June 1984
All our actions take
Their hues from the complexion of the heart
As landscapes their variety from light

W.T. Bacon

Emotion is a transformation of the world.

J.P. Satre
ABSTRACT

The present study compared the relative effectiveness of two interventions in the treatment of marital discord, a cognitive behavioral intervention, teaching problem solving skills, and an experiential intervention, focusing on emotional experiences underlying interaction patterns.

Forty-five couples seeking therapy were randomly assigned to one of these two treatments or a wait list control group. Each treatment was administered in eight sessions by six experienced therapists whose interventions were monitored and rated to ensure treatment fidelity. Results indicated that the perceived strength of the working alliance between couples and therapist and general therapist effectiveness were equivalent across treatment groups, and that both treatment groups made significant gains over untreated controls on measures of goal attainment, marital adjustment, intimacy levels and target complaint reduction. Further, the effects of the experiential treatment were superior to those of the cognitive behavioral treatment on marital adjustment, intimacy, and target complaint level. At follow-up, marital adjustment scores in the experiential group were still significantly higher than in the cognitive behavioral group.
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CHAPTER I
INTRODUCTION

Background

Interpersonal conflict appears to be an inevitable part of all human relationships. Blake and Mouton (1978) have suggested that the most pressing task facing modern society is that of educating its citizens to resolve interpersonal conflict without reference to solutions such as the law. One sub-set of such conflict which seems particularly disruptive in the everyday life of people in North America is the conflict which arises between spouses. In Canada and the U.S.A. one marriage in three currently ends in divorce (U.S. Bureau of the Census, 1976, Adams & Nagnur, Statistics Canada, 1981). There is also evidence that marital disruption is a significant stressor with a greater incidence of psychiatric admission, motor vehicle accidents, physical illness and alcoholism occurring during or after marital separation (Bloom, Asher & White, 1978). The negative consequences of marital disruption for children is well documented (Wallerstein & Kelly, 1974), and Renne (1971) has suggested that in terms of physical health, marital distress can be as damaging as marital separation.

On the other hand there is now evidence to suggest that positive close relationships seem to help innoculate those involved against the stresses of life. Myers, Lindenthal, Pepper and Ostrander (1975) have shown that intact marital status appears to make it easier for persons undergoing life stress events to avoid increased psychiatric impairment. Lowenthall and Haven (1968) in their analysis of adaption
in the later years of the lifespan were "struck by the fact that the happiest and healthiest among them often seemed to be the people who were or had been involved in one or more close relationships" (p. 20). Other researchers such as Rosow (1967) have found support for the assertion that the depth of intimacy experienced with others is a key correlate in a person's ability to adapt over the lifespan; in fact Lowenthal and Weiss (1976) suggest that men and women find the motivation to live autonomous satisfying lives only through the presence of one or more mutually supportive and intimate dyadic relationships. The main vehicle for such intimacy in our society would appear to be through the institution of marriage.

Given the significance of intimate dyadic relationships and the fact stated above that one in three marriages currently ends in divorce it would seem to be no accident that marital therapy as a field has grown substantially in the last decade (Gurman & Kniskern, 1981). The growth of marital therapy may also be viewed as being part of a shift towards a concern with human transactions rather than just the behaviour of individuals. The influence of Sullivan (1953), who viewed personality as the enduring pattern of recurrent interpersonal situations characterizing a human life, of Leary (1957) and of Carson (1969) can be seen in the present flowering of marital and family therapy approaches. Duke and Nowicki (1982) point out that effective treatment outcomes in all theoretical orientations are linked to changes in the client's customary ways of interacting with others, the attitudes he or she maintains towards others, and the beliefs he or she holds about him or herself.
Sullivan (1953) stressed that such beliefs about the self are, above all interpersonal in both their development and current evolving contents. This view is echoed by Kiesler (1982) who suggests that the self is social, interpersonal and transactional in its development and functioning throughout life.

Marital therapy has grown not only as a separate entity but as a component or general mode of intervention for a wide variety of problems traditionally treated by individual psychotherapy including affective disorders, alcoholism, sexual dysfunction, childhood behaviour problems and obsessive compulsive disorders such as agoraphobia. In fact in the last decade marital therapy may be viewed as having evolved into one of the most significant psychotherapeutic interventions in the mental health field (Gurman, 1978). Also as Lewis, Beavers, Gosset and Austin Phillips (1976) point out in their study of psychological health in family systems, interventions at the level of the marital relationship have considerable potential for creating change at other levels, and that if only one level could be approached (individual, marital or family) the marital level would seem to have potentially the greatest impact upon both the individual and the total family.

As the field of marital therapy has grown research into the effects of such therapy has also grown (Gurman & Kniskern, 1981). By 1978 Gurman and Kniskern (1981) were able to state that in general non-behavioural marital therapy appeared to produce beneficial effects in 65% of cases, which is essentially the same gross improvement rates noted for non-marital individual therapy by Bergin (1971). Jacobson and Weiss (1978) were also able to document the effectiveness of the
behavioural approach to marital therapy. However studies examining the comparative efficacy of behavioral approaches as opposed to other treatment methods are nearly non-existent (Gurman & Kniskern, 1981). Jacobson (1978) has commented upon the need for comparative outcome studies to evaluate treatment approaches hitherto unexamined by empirical methods, such as the more psychodynamic interventions. The need for comparative studies of behavioral and treatment methods is then well recognized in the literature.

The completion of such comparative studies has been hampered by the fact that considerable homogeneity of interventions exists across different theoretical models. This homogeneity of interventions is reflected for example by the fact that Sager, a psychodynamic practitioner (1981) and Weiss, a behavioral practitioner, (1978), both use operations such as behavioral contracting. Particular models have also become more encompassing. O'Leary and Turkewitz (1978) point out that even behavior therapy has tended to become ambiguous as a result of the cognitive trend in psychology.

A comparison of different kinds of interventions from different models addressing specific problems would then address the need for an investigation into what kinds of interventions are most effective in the marital context. A specification of the target of change would also be a desirable refinement in any study comparing interventions taken from different models of therapy. In marital therapy one of the most logical targets would appear to be the conflict engaged in by distressed couples. There is agreement in the literature that effective conflict resolution interactions between spouses is crucial for the maintenance
of marital satisfaction (Glick & Gross, 1975), and that distressed couples have greater numbers of unresolved problems and conflict episodes than do non-distressed couples (Birchler & Webb, 1977). Since one of the main goals, if not the sine qua non of marital therapy, is to facilitate the resolution of conflict between spouses, the effect of different kinds of interventions on marital conflict resolution would appear to be a fruitful area of investigation.

Although it is often difficult to distinguish different types of interventions encompassed within contrasting models, there does seem to be a clear distinction between the rational problem solving operations typically employed by cognitive behaviorists (Jacobson, 1981; Jacobson & Margolin, 1979; O'Leary & Turkewitz, 1981) and the emotional exploration operations of the more experiential and dynamic approaches (Feldman, 1982; Wile, 1981; Perls, 1973). Experientially oriented treatments have emphasized the importance of assisting clients to explore and experience previously disavowed emotional material in order to help resolve their problems, whereas approaches based upon classic learning theory have viewed such a process as far less relevant to the process of change, and have focussed upon changing environment response relationships (Borkovec & Grayson, 1981). A comparison of interventions taken from these two approaches would then address the comparative efficacy of two intervention modes currently operating in the field of marital therapy and would also add to the knowledge in the field in other ways. For example, considerable interest has been recently shown in the role of affect in behavior therapy (Rachman, 1981) and in marital therapy in particular (Margolin & Weinstein, 1983); however therapeutic
operations geared towards working with emotion have been associated with psychodynamic or humanistic formulations, which do not readily lend themselves to empirical study. To stipulate specific emotionally oriented operations and describe their effectiveness would then seem to be valuable in itself.

The role of emotional experience in the resolution of interpersonal conflict and in the facilitation of conflict resolution or other changes in therapy is then a controversial issue requiring further exploration. Emotional experience has ranged from being considered irrelevant, detrimental, or incidental to necessary and even crucial to therapeutic change. Recently therapists such as Epstein and Bishop (1981) have proposed that human emotions function as facilitating factors in problem solving since different emotions tend to stimulate different solutions (for example anger facilitates an aggressive/defensive solution), and theorists such as Zajonc (1980) have argued for the dominance and primacy of affect in human experience. Mahoney (1980) has suggested that the role of affect in psychotherapy is a key issue with theorists of different persuasions biased either towards the control or expression of affect. As a consequence there has been a lack of studies which examine situations in which affective expression may facilitate therapeutic change. The stipulation and evaluation of interventions focussing upon and using emotion thus has general significance outside the context of marital therapy.

In summary this study is concerned with the specification of an affectively based treatment for marital discord followed by a preliminary evaluation of the efficacy of this treatment when compared
with a wait list control group and with a problem solving
cognitive-behavioral treatment. As suggested above such a study would
appear to have considerable current social, clinical and theoretical
relevance; addressing the need for the specification and evaluation of
approaches to marital therapy other than the well-documented behavioral
approach and the more general question of the relevance of affective
experience in the treatment of relationships.

**Definition of Terms**

Operational definitions of the key concepts used in this study are
as follows:

**Marital Therapy:** Gurman (1978) defines marital therapy as therapy
in which the marital relationship is the patient. Gurman and Kniskern
(1978) view marital therapy as a subtype of family therapy, and comment
that some family therapists focus on and conceive of the spouse dyad as
being the core family sub-system requiring change (Satir, 1967).
However, in their article they evaluate marital and family therapy
semi-independently since this is in keeping with the current labelling
practice in the field. Marital therapy involves the modification of an
intimate relationship between two partners, in such a way as to reduce
pain and discomfort and increase satisfaction and a sense of
well-being. Such modification may involve facilitating a renewal of the
relationship on a more acceptable basis or facilitating a separation of
the spouses. The process may be viewed in molecular terms as the
creation of a more acceptable contract, in the sense of behaviors
exchanged, or in molar terms as a redefinition of the relationship in the sense of the positions taken by each partner in the relationship.

Marital Conflict: Different extensive conceptualizations of this phenomenon are summarized in Chapter II. Fink (1968) defines social conflict in terms of antagonistic psychological relations or antagonistic interaction. Koren, Carlton and Shaw (1980) state that "Marital conflict is an adversary event within the context of an ongoing intimate relationship. Thus in the process of influencing each other toward opposing content spouses also affirm or redefine the character of their marriage" (p. 461). This definition was employed in this study. Altman and Taylor (1973) suggest that continued unresolved interpersonal conflict acts to create "depenetration" or loss of intimacy and rewards in a relationship so that the process moves to "successively more superficial areas of the relationship" (p. 173). Waller and Hill (1951) distinguished between acute progressive and habituated conflict in marriage and suggest that the deeper the investment and ego-involvement in a relationship the more conflict tends to be viewed as a threat to the self.

Conflict Resolution: Koren et al. (1980) suggest that conflict outcomes can be evaluated from two major perspectives, one that focuses on mutual satisfaction and another that focuses on the attainment of objective resolutions. This study will attempt to address both viewpoints by assessing outcome satisfaction and by an observational assessment of agreement or resolution, as well as an assessment of specific goal attainment.

Problem Solving Treatment: This treatment is defined as the problem solving interventions described in Appendix A, which focus upon
the teaching of new skills and rules for resolving conflictual interaction. Problem solving is defined by Jacobson and Margolin (1979) as "a structured interaction between two people designed to resolve a particular dispute between them," concentrating upon "manifest observable complaints" (p. 117).

**Emotionally Focussed Treatment:** The emotionally focussed treatment in this study is defined as the interventions described in Appendix A, which are designed to bring to awareness and develop rather than suppress or dispose of emotional experiences. The exploration of underlying emotional issues is the focus of therapy.

**Marital Distress:** Distress in this study was operationalized as at least one partner scoring below 100 on the Dyadic Adjustment Scale (Spanier, 1976). Couple scores were obtained by taking the mean of the individual scores for each couple. This study considers distress level on an individual basis rather than requiring both partners to score below 100, since one distressed partner is adequate to constitute a distressed relationship and in fact in couples who request therapy one partner usually presents as significantly more distressed than the other. The pre-treatment couple scores in this study ranged from 71 to 105, the mean being 92. The overall mean DAS scores was 93.8 for husbands and 90.5 for wives.

The following hypotheses are under investigation in this study: that both an affectively oriented treatment and a cognitive behavioral skill oriented treatment will be more effective in helping couples reach relationship goals, reduce target complaints, increase marital
adjustment and levels of intimacy than a wait list control condition, and that these two treatments will have differential effects on the above variables as measured at post assessment and at follow-up.
CHAPTER II

LITERATURE REVIEW

The following review will focus on the outcome literature in marital therapy, conceptual models of interpersonal conflict and marital distress, interventions in marital therapy, and the role of emotion in psychotherapy and in marital therapy in particular. A description of the treatments used in this study then follows.

Outcome Research in Marital Therapy

In the last decade the rate of growth of research in the outcomes of marital and family therapy has been astounding. Recent extensive reviews of the family and marital therapy research have been completed by Gurman and Kniskern (1978, 1981), Jacobson (1978), and Williams and Miller (1981). Gurman and Kniskern (1981) in their review state that the evidence suggests that both behavioral and non-behavioral treatments are effective beyond chance and more specifically conclude that, in the marital therapy reviewed 65% of cases improved. They note that conjoint treatment is clearly the treatment of choice, since individual psychotherapy for the treatment of marital problems has a poor record when it comes to positive outcomes and also a high rate of negative outcomes.

Williams and Miller (1981) state that, although there seems to have been little change in quality, the quantity of outcome research in this area has recently tripled, and the question of general therapeutic effectiveness seems to have been answered in the affirmative. However
the question of the differential effectiveness of the key approaches to marital therapy does not seem to have been addressed.

Comparative studies in the marital area have been confined to a comparison of the treatment components within one model. Margolin and Weiss (1978) for example, compared behavioral communications skills training with that training plus a cognitive restructuring component and a non-specific intervention (finding that the communication skills plus cognitive restructuring component was the most effective); and O'Leary and Turkewitz (1981) conducted a comparative outcome study of "good faith" contracting plus communication enhancement and communication skills training involving empathy training, finding that both were effective compared to a no-treatment control.

There is in the literature only one non-analogue study that compares behavioral interventions with a form of nonbehavioral marital therapy, and that is the study conducted by Liberman, Levine, Wheeler, Sanders and Wallace (1976) who compared communications skills training plus contingency contracting group intervention with an approach consisting of the ventilation and discussion of feelings. Here couples in both groups improved on self-report measures but only the behavioral group showed improvement on problem solving methods. Methodological problems such as the lack of a control group, non-random assignment and a small therapist sample qualify any conclusions based on these data. There are four analogue studies which compare behavioral and nonbehavioral approaches in existence. The first of these studies is by Fisher (1973), who compared behavioral group therapy with an Adlerian group format involving non-distressed couples and found that both
interventions increased perceptual congruence or agreement between husband and wife. The second study by Wieman (1973) which compared groups that taught behavior exchange skills to groups involved in a conjugal relationship enhancement program, found no significant post-treatment differences on various measures of marital adjustment. Venema (1975) compared a form of communication training with a contingency contracting procedure given in the form of seven weekly workshops; however, none of the groups made significant changes. Lastly, Cotton (1976) found no differences between communication training (Carkhuff, 1969) and a behavior exchange treatment on self report measures of marital satisfaction.

This shortage of across-model comparative studies is surprising when one considers the large volume of literature (for example practically the whole June 1978 issue of the journal *Family Process*) concerned with the relative merits of behavioral versus more dynamically oriented approaches. The shortage of such studies may be due not only to the homogeneity of treatment components across models but also to the lack of identity among the non-behavioral treatments (Williams & Miller, 1981). This lack of identity is reflected by the fact that in reviews of outcome research such treatments have been categorized by a characteristic they lack, that is by not being behavioral, rather than by an easily recognizable characteristic they share. In his review (1978) Jacobson states that

"few would deny the popularity of either the psychoanalytic or the systems theory approaches to marital therapy. However neither perspective can claim even a single outcome experiment investigating its effectiveness. The absence of studies investigating systems approaches is partially explained by the emphasis of these theorists on family as opposed to marital therapy" (p. 397).
The behaviorists, on the other hand, have been characterized by their rigorous methodological stance. He also stated that a most welcome research development would be a number of well controlled comparative outcome studies examining approaches that have not been empirically validated.

The experiential/dynamic approach which has produced a great deal of theory and practice but little research is then one of the approaches that is relatively uninvestigated. It would seem that the time is ripe for a controlled study comparing a behavioral and a more experiential/dynamic approach to marital therapy. Since treatment operations tend to be homogeneous across models, it is necessary to specify different interventions taken from differing theoretical perspectives and examine their efficacy in the treatment of dysfunctional marital conflict. Despite the similarity in the interventions used by therapists of different schools, there does appear to be a clear distinction between the rational problem solving operations typically employed by behaviorists (Jacobson & Margolin, 1979; O'Leary & Turkewitz, 1981) to change the environment response relationships, and the emotional exploration operations of the more experiential and dynamic approaches (Perls, 1973; Feldman, 1982; Satir, 1973), to change perception and experience. A comparison of these two types of interventions is then possible and pertinent.

Conceptual Models of Interpersonal Conflict and Marital Distress

In order to understand the process and goals of marital therapy it is necessary to consider the phenomenon of interpersonal conflict, and
the various conceptual models underlying the practice of marital therapy.

Conflict may be viewed as a process in which incompatible demands or behaviors result in negative interaction (Deutsch, 1969). It is an inevitable but not necessarily a destructive phenomena. Conflict for example may stimulate interest and curiosity, provide an impetus for the ventilation of problems or the generation of solutions and help to create new adaptive norms. However problems in marital relations are usually defined as the presence of dysfunctional conflict and discord. Deutsch (1969) suggests that the process of dysfunctional conflict is one that leads to escalation and an expansion of issues rather than resolution and effective problem solving, and usually involves components of threat and coercion, tactics which tend to elicit reciprocation in kind. All theorists seem to concur that destructive conflict often arises when conflictual issues are ignored and suppressed (Jacobson & Margolin, 1979; Rausch, Barry, Hertel & Swain, 1974), since "the effects of unattended conflict are irrepresible and satisfaction will be cumulatively impaired" (Jacobson & Margolin, 1979, p. 23). Rausch et al. (1974) suggest that the suppression of interpersonal differences and of the feelings attached to them results in less of each person's self being communicated and this often leads to an erosion of trust.

Conflictual marital interaction may also be viewed as an exercise in interpersonal control whereby spouses attempt to sway each other toward incompatible goals (Morton, Alexander & Altman, 1976); for example one spouse attempts to persuade the other to adopt a point of
view or problem solution while the other argues or resists. Koren, Carlton and Shaw (1980) state that marital conflict is an adversary event within the context of an ongoing intimate relationship taking place on a content level and also serving to affirm or redefine the character of the relationship. This viewpoint is consistent with that of Watzlawick, Beavin and Jackson (1967), who view all communications as containing a content or digital component and a relationship defining or analogic component. Gurman (1978) also points out that while there are many ways to define conflict, as a demand for immediate change, as the escalation of reciprocal aversiveness, as ineffective problem solving, or as the frustration of inappropriate needs all models of dyadic conflict see this phenomena as a result of attempts to define the relationship between spouses in a certain way. Effective conflict resolution interactions which Koren et al. (1980) suggest consists of two factors, mutual satisfaction with outcomes and the attainment of objective resolutions, would appear to be essential for a marriage to remain viable and satisfying (Glick & Gross, 1975; Birchler, Weiss & Vincent, 1975; Birchler & Webb, 1977).

Dysfunctional conflict has also been associated with particular interactional patterns, such as the frequent occurrence of criticism and derogatory blaming (Koren et al., 1980, Bernal & Baker, 1979); more frequent negative affect reciprocity in general; specific responses such as cross complaining (Gottman, 1979); high reactivity, that is functioning on the basis of immediate contingencies (Jacobson, Follette & Waggoner Mcdonald, 1982); and selective focussing upon negative behavior (Robinson & Price, 1980). These patterns tend to be
self-reinforcing and result in a decline in general marital satisfac-
tion, the alienation of the partners from each other and ineffective
problem solving. These kinds of behaviors are particularly potent since
negative behaviors account in general for a larger proportion of the
variance in the spouses ratings of marital satisfaction than do pleasing
behaviors (Patterson, Hops & Weiss, 1975).

The approaches towards marital conflict and distress vary according
to theoretical orientation. Gurman (1978) identifies three major
theoretical approaches to marital therapy: the psychoanalytic, the
behavioral and the systems approach.

The Systems Approach: This approach emphasises the interconnected-
ness of interactions and is a perspective that, although focussing more
on family rather than on specifically marital interactions, has
influenced all other approaches to marital therapy. Dynamic therapists
such as Wile (1981) and behaviorists such as Weiss (1980) both
acknowledge their debt to the systems transactional model and have
incorporated this perspective into their approaches.

The systems approach to marital conflict is one which stresses
.circular causality (Bateson, 1971; Jackson, 1967), so that each partners
behavior is viewed as a reaction or adjustment to the behavior of the
other. The individuals behavior is caused then not by personal problems
or "neurotic" reactions but by the present operating transactional
system. Systems theory contains a number of differing approaches, from
Bowen (1976) who views conflict in marriage in basically psychoanalytic
and monadic terms as arising when individuals are poorly internally
differentiated, to authors such as Haley, who focus on the partners
struggle for control within the interdependent web of interpersonal transactions which constitute a "system". Haley (1963) views the major conflicts in a marriage as centering on the problem of who is to tell whom what to do under what circumstances. Individual symptoms may then arise as a means of gaining control in a relationship. The Palo Alto group (Watzlawick, Weakland & Fish, 1974) who view themselves as "interactional" therapists also subscribe to the systems model. Both Haley and the Palo Alto group suggest that conflict is created by paradoxical communication when report or digital and command or analogic/relationship defining levels of communication are contradictory. Such paradoxical communication is purposeful in that it avoids the open expression of ambivalence and the clear definition of an "I" position, and thus defends the individual from the anxiety attendant upon self and relationship definition.

Watzlawick et al. (1974) also focus on problematic cognitions. He states that often the solution to the problem becomes the problem, in that what is problematic is the meaning attributed to the situation and therefore its consequences, rather than its concrete facts (Watzlawick, 1976). These theorists suggest that it is how individuals "punctuate" a communication sequence that is of primary importance in understanding conflicts, that is how a series of events is grouped to produce cause and effect labels. Gurman (1978) has pointed out the similarity between this approach and cognitive behavioral therapists such as Beck (1976), Meichenbaum (1977) and Ellis (1973). In this model habitual modes of operating are maintained, and conflict resolution opposed by an inherent homeostatic or balancing mechanism, which is presumed to operate in any
system to maintain stability and equilibrium. This, by implication, places the therapist in a position where it is necessary to strategically manipulate clients often with paradoxical instructions since direct intervention will be resisted.

The major contribution of the systems theory orientation has been its emphasis on present couple interactions, and on the cyclical and self-reinforcing nature of conflictual interactions (Wile, 1981). However, this perspective on the process and organization of communication is maintained at the expense of a considering individual orientated motivational explanations for behavior. As Gurman (1978) suggests, this approach seems to emphasise input and output or "between effects" and to largely ignore "within effects"; the problem is identified as the patterns of interaction which constitute the relationship rather than the individual partners. Systems theorists such as Haley (1976) like the behavioural therapists tend to regard feelings and other internal experience as epiphenomena of overt behavior change. He suggests that main goal of therapy is to get people to behave differently and so to have different subjective experiences. The difficulty here is that feelings of well-being, particularly crucial where a relationship such as marriage is concerned, do not always show a high correlation with behavioral changes (Strupp & Hadley, 1977). Interventions used in this approach such as paradoxical directions teach the partners nothing about their relationship so that they are left with no tools to prevent future problems.

Interventions stipulated by this model, such as paradoxical instructions are difficult to test empirically relying as they do upon a
complex context of interactions and meanings. Comparative research is also difficult since the systems perspective has become so incorporated into other approaches.

**The Psychoanalytic/Psychodynamic Approach:** The psychodynamic tradition focuses on conflict as an expression of intrapsychic needs, expectations and construals that arise in the context of an intimate relationship. Barry (1970) states that

"in any interpersonal situation behavior is at least partly determined by the internal reference system (of each of the actors) of self to others and others to self, which is the product of each one's experience with significant others up to that point in time" (p. 41).

Conflicts then may be projected intrapersonal polarities or the result of the inevitable frustration of inappropriate needs (Dicks, 1967) or a change in needs as a result of developmental changes and crises.

Object relations theory (Dicks, 1967; Meissner, 1978) forms the foundation of this approach. Meissner (1978) suggests that the success of the marital relationship is determined to a large extent by the "residues of internalized objects and the organization of introjects which form the core of the sense of self" (p. 27). In this model conflict is generally viewed as the result of narcissistic needs or infantile dependence projected onto the partner, or as arising from rigid and relatively undifferentiated object relations schemata (Rausch et al., 1974). Schemata refer to the organized structures of images of the self and others and the needs and affects characterizing the relationships between these images in one or both partners which then constrain the ways interpersonal messages will be perceived and
responded to. Rigid schemata then render the partners unable to change roles in response to the others needs and this loss of emotional flexibility results in marital conflict and distress. In this model marital difficulties are then often viewed as symptoms of unresolved childhood conflicts (Meissner, 1978; Nadelson, 1978), or infantile impulses and failures in the separation-individuation process (Ables & Brandsma, 1977). In the latter case, Mahler's (1968) notion of separation-individuation is applied to the partners in the marital relationship. Failure to separate from one's primary care-givers is hypothesized to be the source of marital conflict since dependency and vulnerability are increased by this failure and the undifferentiated partner or partners come to depend on the responses of the other to define his or her selfhood. As Skynner (1976) states conflictual couples "are usually attracted by shared developmental failures" (p. 43). Sager (1981), perhaps the most well known practising psychoanalytically orientated marital therapist, speaks of unexpressed and often unconscious expectations based upon introjected childhood influences that form the basis for dysfunctional marital contracts.

Marital conflict in this model is related to the "identity adequate ego strength" (Dicks, 1967, p. 31) of the partners, that is their relative freedom from neurosis or intrapsychic conflict around such issues as fears of intimacy or abandonment (Feldman, 1979).

The goal of traditional psychoanalytically oriented marital therapy is to restructure those aspects of personality functioning in both spouses that create distress and conflict in the marital relationship
and facilitate each spouse's encountering his or her mate as a safe real person.

Gurman (1978) suggests that the psychoanalytic approach offers a model that bridges the gap between private inner experience and public outer behavior, and thus allows an understanding of both the function and meaning of marital behavior. He stresses that this model also focuses upon the adaptive potential of marital conflict, for as Rausch et al. (1974) state

"of all human relationships marriage has the greatest potential for reintegrating the schemata associated with anxieties of childhood,—schemata concerned with trust, giving and receiving love, autonomy, expression and inhibition of anger and other feelings, concepts of maleness and femaleness, closeness and distance" (p. 47).

This perspective on marital conflict must confront two issues: 1) it fails to take account of the current patterns of interaction that maintain marital conflict beyond any perceptual distortions engendered by phenomenon such as marital transference, and 2) there are no existing operational definitions of central constructs such as individuation. Gurman (1978) also suggests that while it may have added to our understanding of the subtleties of the marital relationship this model has yielded few significant technical innovations in the treatment of dysfunctional intimate relationships. This approach has also tended to limit the therapist to activities designed to create insight as to the unconscious origins of conflict in each partner (Taylor Segraves, 1982).

One variation of, or perhaps more accurately deviation from, the psychoanalytic perspective that is significant to this study is the
experiential approach which is an outgrowth of the humanistic existential tradition. Whereas in the psychoanalytic tradition problems are attributed to uncontrollable impulses, in the experiential approach problems are attributed to defenses that result in impulses being subdued and re-emerging in distorted or exaggerated forms. Clients are assumed to have healthy feelings and needs, which will emerge into awareness with the help of the therapist. Conflict, intrapsychic or interpersonal, is viewed then as the result of the disowning or denial of experience resulting in distorted expression and a lack of need fulfillment.

From the experiential perspective (Rogers, 1951; Perls, Hefferline & Goodman, 1951), people are regarded as active perceivers, who construct meanings and organize what they see or hear on the basis of their current emotional state and experiential organization. Kaplan and Kaplan (1981) state that internal experience may be viewed as determined by intrapsychic factors and by context factors, in that relationship rules and definitions as well as intrapsychic blocks or splits determine what people attend to in themselves and their partner.

The experiential approach then differs from the psychoanalytic tradition in that present experience and interactions with others are the focus of therapy rather than past experiences, and the impulses of the client are viewed as healthy rather than signs of developmental failure or neurosis. Insight, the usual goal of the psychodynamic therapy, is not the aim of this approach which regards new emotionally meaningful experience as necessary for the creation of change. Specific applications of this model to couple therapy has been limited and no
outcome studies of an experiential approach to therapy have been completed.

The Behavioral Approach: The behavioral approach which in this field is more accurately termed applied social learning theory views conflict as a demand for immediate change (Weiss & Margolin, 1977). This demand involves the initiation of coercive interaction patterns where one partner seeks to gain positive reinforcement in exchange for negative reinforcement resulting in the escalation of reciprocal aversiveness. More specifically it is assumed that marital conflicts result from faulty behavior change operations (Patterson & Hops, 1972). Thus Jacobson (1981) suggests that distressed couples control the behavior of the other through "the presentation of negative communication and the withholding of positive communication" (p. 562). The logical antidote to such behavior would seem to be to teach people how to be effective behavior modifiers (Jacobson, 1978). On a more general level, Jacobson et al. (1982) suggest that the basic social learning hypothesis underlying this model of marital therapy is that marital distress is associated with low rates of rewarding exchanges and high rates of punishing exchanges. Each spouse's behavior is viewed as largely a function of the consequences provided for that behavior by the partner. Thus if a partner is rewarded for coercive behavior by compliance from his spouse this behavior will tend to increase, often to the long-term detriment of the relationship.

The behavioral approach is based on behavioral exchange theory (Thibaut & Kelly, 1959) which suggests that a relationship may be viewed as a market place in which two people exchange a set of behaviors from
their repertoire and that these behaviors are exchanged with certain rewards and costs to each of the partners. Social behavior is maintained by a high ratio of rewards to costs and by the perception that alternative relationships offer comparatively fewer rewards and more costs. When reinforcement is not dispensed at an equitable rate or not judged to be adequate then the situation fosters conflictual interaction. Theorists such as Stuart (1969) suggest that a quid pro quo or a "something for something" arrangement underlies successful marriages and that distressed marriages are ones in which there is a scarcity of positive outcomes available for each partner. According to exchange theory then partners in a satisfying relationship should reinforce each other at an equitable rate, with exchanges following a norm of reciprocity over time so that parity is established.

The issue of reciprocity is an important one in this model since recent proponents point out that it is not only rates of behavior but the sequence that is important if behavior is to be viewed largely as a function of its consequences. Gottman, Markman and Notarius (1977, 1979), and Margolin and Wampold (1981) have tested this notion of reciprocity and found that there is a greater tendency towards negative reciprocity in distressed marriages. Gottman (1979) found however that in non-distressed couples positive responses were not contingent upon the spouses antecedent code whereas Margolin and Wampold found evidence for positive reciprocity in non-distressed couples.

Gottman (1979) noted that partners who were able to resolve conflicts were more flexible and less rigid in the structure of their interactions and were able to "unlatch" (p. 122) at any stage in an
interaction and so break negative chains with agreement or some kind of editing process. Research on reciprocity seems to suggest then that exchange theory operates in distressed relationships rather than in non-distressed relationships. Jacobson and Margolin (1979) note that freedom from control by a partner's immediate consequences is perhaps an operational definition of "trust". They point out that distressed couples seem relatively dependent on immediate as opposed to delayed punishments and rewards, whereas day to day satisfaction in happily married couples is relatively independent of daily fluctuations in the frequency of rewarding and punishing behaviors (Jacobson et al, 1982).

The inability to resolve conflict in this model is the result of negative habitual behaviors resulting from a deficit in negotiation and problem solving skills. Weiss (1978) suggests that in marriage satisfaction is an accomplishment and "accomplishment is related to skillfulness as well as effort" (p. 192), and that such skill involves using rules rather than the specific responses of the partner to dictate one's own next response. The traditional behavioral model of a theorist such as Stuart (1969), is based on the assumption that the impression which each spouse forms of the other is based on the behavior of the other. Thus when one changes behavior there are corresponding changes in each partner's impressions and perceptions of the other. This viewpoint gives rise to treatment based upon techniques such as contingency contracting. Stuart's approach contrasts somewhat with that of therapists such as Jacobson and Margolin (1979) whose approach includes the modification of cognitive constructs such as the way in which spouses appraise the relationship in order to judge its adequacy.
Jacobson & Margolin then acknowledge the role of cognition in the creation and maintenance of marital conflict, and support the view of theorists such as Bernal and Baker (1979) who point out that distressed couples tend to attribute relationship problems almost exclusively to the disposition of their partner (example: the problem is that you are stupid) rather than viewing problems in terms of shared responsibility. Jacobson et al. (1982) in their study on couples reactivity found that their data suggests that negative behaviors have

"a different meaning for distressed couples than they do for non-distressed couples. These differences in meaning seem to implicate cognitive and perceptual differences between distressed and non-distressed couples in the way they process and interpret relationship events" (p. 713).

These behavioral therapists then follow in the path of theorists such as Bandura (1977) who argued that behavior is mediated by cognitive symbolic mechanisms and set the stage for the evolution of the coping skills paradigm and the focus upon attributional theory (Mahoney & Arnkoff, 1978). The teaching of negotiation skills as put forward by Jacobson & Margolin (1979) has come to epitomize this cognitive behavioral approach to marital distress.

Comparison of Approaches

Gurman (1978) points out that each theoretical perspective offers very different explanations of the forces operating in relationship definition and relationship conflict and indeed each of the conceptualizations of dysfunctional conflict/distress, would seem to imply a different basis for intervention. However there are many similarities
across models in terms of the therapeutic operations actually used. It is possible to see the different models as geared towards different levels of the complex dynamics between spouses. The behaviorists consider overt behavior and conscious contracts, with feelings and experience to a certain extent being seen as epiphenomena, while the psychodynamic theorists are more concerned with the motives and intentions behind overt behavior and how intimate relationships reflect and help to construct the nature of the self.

Many ultimate goals, process goals, and therapeutic activities seem to be commonly found across all models of marital therapy. Gurman (1978) suggests that all models seem to value increased role flexibility and adaptability, the resolution of presenting problems and decreased symptomatology, a more equitable balance of power, open and clear communication and increased self-esteem. He points out a particular confluence between psychoanalytic and Bowenian goals, and between the systems based communicationists and behaviorists goals. The mediating goals which seem to be of major importance across models are: (1) the specification of problems, (2) the clarification of each spouses' individual desires and needs in the relationship, (3) redefining the nature of the couples' difficulties, (4) encouraging each partner's recognition of his/her mutual contribution to the marital discord, (5) the modification of communication patterns, (6) increasing positive reciprocity, and (7) decreasing the use of coercion and blame.

All approaches also attach importance to four therapist activities: (1) directing and structuring the flow of therapy sessions, and guiding the sequencing of treatment goals, (2) challenging assumptions about
marriage, and providing alternative world views, (3) clarifying the communication process and (4) assigning out-of-therapy homework of various sorts. All approaches, except the communications-oriented systems theorists, also believe that it is important for the therapist to provide an explicit rationale for the couple's difficulties and the treatment proposed. Many approaches also advocate the teaching of concrete interpersonal skills, imparting expert knowledge and modelling new more adaptive behaviors.

So how do the interventions based upon different conceptualizations of marital distress/conflict differ? Some therapeutic goals will differ, psychodynamic therapists being more oriented towards personal growth than the behaviorists, who focus primarily upon skills. Techniques guided by different conceptualizations will also be implemented with a differing focus, intent, and within a different context. For example, Jacobson (1981) points out that in the more behavioral approaches, communication skills are "problem" not "expression" oriented. The view of the couple-therapist relationship, and how it is used to achieve treatment goals, also differs in various models, technique being the key to success in the behavioral models, and an intense therapeutic relationship being seen as crucial in the more psychodynamic approaches.

The differences between the main theoretical models may be clarified by considering how each approaches the modification of communication patterns in marital therapy.

The modification of communication patterns is the most common key element found in all marital therapies. Communication here is the
interactional content and the means by which the relationship is defined; that is the medium of relationship definition and change, and a target for specific intervention in itself. As Jacobson and Dallas (1981) point out communication is "the primary vehicle for the exchange of rewards and punishments in a relationship" (p. 392).

Koren et al. (1980) found that low criticalness and high responsiveness predicted conflict resolution and satisfaction with that resolution. He suggests that couples use their communication behaviors to convey relationship attitude, whereas other theorists such as Gottman (1978) suggest that a lack of skill resulting in a contrast between the intended and received message is the root of marital dissatisfaction. This would seem to be a key distinction. Marital therapists who are behaviorally oriented tend to concentrate on increasing communication skills especially the skills involved in verbal expression. Jacobson and Margolin (1979) write that teaching couples communication "resembles instruction in other kind of technical skills such as learning to operate an automobile" (p. 192). More psychodynamically oriented therapists tend to focus upon intentions of the sender and the reception of a message as well as expression and to see communication patterns as a reflection of the motivations and personal construals of the partners. Interventions will reflect this difference in viewpoint; one therapist will teach skills another will explore needs and fears experienced by the spouse's. The behavioral therapist acts from the premise that if one spouse's behavior changes then changes in the others perceptions of, and reactions to, that partner will follow. The psychodynamic therapist will tend to try to reorient the spouse's
perceptions of each other so that behavior may be viewed differently. Thus Jacobson (1981) suggests that behaviorists are likely to use "descriptive" feedback when modifying couples communication whereas psychodynamic therapists would use interpretation.

The approach of an ego-oriented dynamic therapist, such as Wile (1981), to the modification of communication patterns provides an effective contrast to the more behavioral approach. Wile states that he helps couples to construct "the dialogue or conversation they might have had" if they had been able to be open and trusting and the effect is "in vivo communication training ... without the rules and without the training" (p. 157). Clear communication is then the means by which such a therapist attempts to clarify partners' positions in a relationship and develop a shared perspective. In Wile's model, to state feelings fully and have them validated rather than interrupted or disqualified enables partners to feel more in contact with each other and in greater control of the relationship.

In the dynamic and experiential approaches poor social skills are seen not as samples of inadequacies in expertise or performance to be remedied by practice but as signs of deprivation and alienation, often reflecting norms of minimal self-disclosure and self-exposure. As the research of Birchler, Weiss and Vincent (1975) suggests distressed couples show normal communication skills levels when not involved in an encounter with their spouse.

The more dynamic models assume that insight into the motivations and needs of the self and the other, which maintain the positions each partner takes in interactions, will create change. In the case of the
experiential therapies, it is assumed that new emotional experiences that clarify underlying feelings and needs will create new and more positive patterns of communication. If communication patterns are a reflection of inner experience then to change the ways the couple experience the relationship will change how they communicate.

The behavioral approach attempts to facilitate the control of negative communication patterns and to substitute positive rule based practices; the dynamic approach is to explore such patterns in terms of the experience of the relationship which they reflect and to create new insight or new experiences.

Woolfolk (1976) states that,

"By and large one finds that the kinds of techniques employed in each approach to therapy are quite consistent with its theory of affect. Similarly the technical narrowness of each school can be viewed as reflecting a corresponding limited understanding of emotion" (P. 49).

The differing role of emotion in therapy seems to best reflect the differences between the behavioral and experiential models. In the behavioral interventions the expression of emotion is relegated to clarification of the impact of one partner's behavior upon the other and is taught as a skill. In ego-oriented dynamic approaches such as Wile's (1981) or the experiential treatment used in this study the exploration of emotion is seen as a key method for altering the salience of private events and facilitating new learning. The time would seem to be right for the delineation of an emotionally focussed treatment taken from an experiential model, which specifically addresses and uses emotional experience in the creation of change and a comparison of that treatment
with an already tested cognitive-behavioral intervention such as problem solving (Jacobson & Margolin, 1979).

Whereas the coping skills paradigm and the teaching of problem solving has been specified and tested empirically in the area of marital therapy (Jacobson, 1977, 1978b, 1979; Orvis, Kelley & Butler, 1976) the general area of emotion and therapeutic interventions centered upon the use of emotion are lacking in corresponding clarity and direction. It is essential at this point to discuss the role of emotion in therapy and in marital therapy in particular.

The Role of Emotion in Therapy

Authors such as Mahoney (1980) and Fincham and O'Leary (1982) suggest that the role of affect in therapeutic change is the issue of the current decade, as the role of cognition tended to be the issue of the 70s. The role of affect in change would seem to be particularly important in the context of a therapy that attempts to change relationships in the direction of increased satisfaction and a sense of well-being and even to encourage the creation of affection and intimacy where possible. In the marital therapy literature, in the psychotherapy literature and in the psychology literature in general the role of emotional experience in human functioning has been unclear.

At the turn of the decade Zajonc (1980) published a provocative position paper entitled "Thinking and Feeling: Preferences need no Inferences", arguing that affective and cognitive systems are relatively independent and that affective responses actually precede cognitive responses and even stimulus recognition. This article has prompted
theorists, even the behaviorists to consider the place of affect in therapy. Rachman (1981) has commented on the Zajonc article and has suggested that behaviorists should aim to expand behavior modification to include affect modification. The research of Fincham and O'Leary (in press) suggests that causal attributions in close relationships do not seem to affect behavioral responses to the extent that might be expected and if they do have an effect this effect is mediated by affective or feeling response especially in the case of negative behavior. This result might help to explain Williams (1979) finding that couples at the extremes of the happy-distressed continuum reported rewarding and punishing behaviors, respectively in response to the partners presence regardless of the behaviors emitted.

Mahoney (1980) has commented on the need to review the role of factors such as unconscious processing and the experience of affect in therapy rather than placing an excessive emphasis on the role of rationality in adaptation. He also discusses various theories as to how the experience or expression of affect may facilitate therapeutic change. For example, he discusses the theory that human learning may be state dependent (Bower, 1981), that is that an angry client may be able to learn to deal more effectively with anger if anger is present.

Greenberg and Safran (1982) state that:

"therapists who construe affect as a dependent variable in human functioning tend to regard emotion as disruptive to the therapeutic process, and this leads them to either bypass emotion in the process of therapy or to restrict their focus to looking for ways to control client's emotion. Although it is true that certain emotional reactions such as angry outbursts and panic reactions or more chronic states are by
definition reactions to situational events and are disruptive to problem solving in therapy this is not true of all emotion" (p. 2).

Greenberg and Safran (1984) differentiate between primary, reactive and instrumental affect; primary affect being that which needs to be sought after and clarified in therapy in order to aid problem solving. Theorists such as Arnold (1960), Plutchik (1980), and Izard (1977) stress that emotions, not just rationality and cognitive processes, function so as to enhance human adaptation, providing a motivating force for adaptive behaviors. Epstein and Bishop (1981) in their approach to family therapy also stress that emotions function as facilitating factors in problem solving.

The role of affect in therapy is then recognized as an important issue in current psychotherapy literature. Behaviorally orientated therapists now recognize that this issue of it must be addressed but generally see affect as a disruptive phenomena which should be modified. Dynamic and experiential therapists on the other hand view affect as a key variable in therapy and as something which should be experienced by the client and used in the therapeutic process. It would seem appropriate at this point to consider some of the theoretical perspectives from which emotional experience has been considered and the implications of these perspectives for treatment.

Strongman (1978) describes twenty theories of emotion. Emotion has been viewed as essentially a motivational concept (Arnold, 1960; Leeper, 1970), as primarily a state of physiological arousal (James, 1907), as an essentially cognitive phenomenon and a source of meaning and values (Solomon, 1977), as a response to cognition (Lazarus, 1982; Schatcher,
1971) as simply a learned conditioned response (Millenson, 1967) and as a form of psychic energy (Rapaport, 1970). Other authors have viewed emotion as a complex experience consisting of many elements. Lang (1977) for example views emotion as consisting of subjective, behavioral and physiological elements. Arnold's approach is also actually a mixture of cognitive, physiological and motivational approaches since she views emotion as a response to an "intuitive appraisal" of a stimulus, and involving a felt tendency to action. In her model correct appraisals and appropriate actions require memories of sensory and motor events, memories of previous positive and negative attitudes and the rehearsal in imagination of the appropriate actions.

Zajonc (1980) views emotion as precognitive, and independent of cognitive processing and states that affective reactions are "primary" and irrevocable, whereas Lazarus (1982) argues that Zajonc confuses cognition with conscious awareness, and that appraisal is crucial to the emotional response, and can happen as automatic discrimination without awareness. However, both of these stances view experience in terms of a linear causal model; the debate is simply which element comes first, emotional response or cognition.

Greenberg and Safran (1982) drawing on Leventhal's (1979) model suggest that emotion is appropriately considered as an integration of a number of different information processing components which operate simultaneously. They state, "information from the conceptual level, schematic level and the perceptual motor level may be thought of as constantly feeding into the emotion process simultaneously rather than being linearly or unidirectionally related" (p. 14). As Greenberg and
Safron point out, Leventhal maintains that three distinct mechanisms operate in emotional processing. These are, a predominantly facial expressive motor mechanisms, a schematic or emotional memory and a conceptual system which stores rules and beliefs about emotional experiences. In this model schematic memory mechanisms direct attention in the perceptual field and store automatic reactions. Schemas are representations of prior emotional experience and can generate as well as be generated by expressive motor responses. The conceptual system is concerned with conscious and volitional processing and can analyze and evaluate concrete experience, storing the situational antecedents and consequences of feelings. Experienced emotion is then a preattentive synthesis of perceptual motor information, implicit motor schemas and conceptual cognition. In this model Leventhal integrates affect, cognition, physiology and behavior into a comprehensive model of human emotion.

What significance do these different theories of emotion have in terms of therapeutic interventions? Rachman (1981) suggests that if affect is primary and independent then therapists should attempt to modify mood directly and focus upon that single dysfunctional system. Schachter's (1971) model of emotion, which is that emotion basically consists of the labelling or explanation of physiological arousal, implies that the therapist might help clients re-label such arousal or become desensitised to such arousal. Cognitive behaviorists such as Aaron Beck (1976) or Meichenbaum (1977) who view cognition as primary and emotional response as the product of cognition focus their therapeutic interventions upon the modification of thoughts and belief struc-
tures. Therapy consists then of altering beliefs and dysfunctional cognitive processing styles.

For the more traditional behaviorist emotion is either a conditioned response to be deconditioned (Millenson, 1967) or modified by techniques such as the use of images (since affect is associated with non-verbal channels) or music, as suggested by Rachman (1981). Other psychoanalytic theorists have viewed emotion in therapy generally as a component of the "corrective emotional experience" (Applebaum, 1982) experienced by the client in relation to the therapist. Emotion has also been considered as being repressed and experienced in the process of making the unconscious conscious, or as a signal that unconscious material is about to emerge into awareness.

Some theorists view emotion as a form of psychic energy, and so have focused upon ventilation and catharsis in the sense of purging as the primary way to use emotional experience to facilitate change. (Nichols & Zax, 1977) However, if emotion is viewed according to Leventhal's (1979) synthesis model then obscure concepts such as the release of psychic energy in catharsis are not necessary to justify the expression of intense emotion as a useful element in therapy. Rather the expression of emotion is understood as a complex aspect of information processing. It is interesting to note that in the Liberman et al. comparative study (1976) the non-behavioral treatment seems to have as its base the ventilation of emotion, that is, it was a catharsis based intervention.

Berger and Luckmann (1966) suggest that language is an ongoing objectification of experience which helps to crystallize and stabilize
subjective experience; it is thus possible to see a link between emotional expression and emotional synthesis. If as Leventhal (1979) suggests emotion is an integration of concepts, schemas and perceptual motor responses, it would seem to be a rich source of information relevant for therapy. As Greenberg and Safran (1982) point out, accessing and acknowledging affect can help to motivate change, and also to access "hot" cognitions which themselves require change. These authors and clinicians such as Wile (1981) suggest that previously avoided or unacknowledged affective experience forms the basis for new perspectives and meaning sets.

Therapists such as Epstein and Bishop (1981) view the experience of emotion as adaptive since it tends to stimulate different problem solutions. These authors teach their clients to identify and use emotions that will facilitate the resolution of their presenting problems, for example teaching non-assertive clients to access and use anger.

What are the therapeutic implications of a model such as Leventhal's (1979)? This question has been addressed by Greenberg and Safran (1981), who suggest that "clinical problems can result both from the repetitive synthesis of maladaptive emotions and the absence of adaptive emotional synthesis" (p. 18). The focus of therapeutic work is then modifying the synthesis of maladaptive emotions or facilitating the synthesis of new adaptive emotions. Synthesizing adaptive emotional experience can be facilitated by helping people get in touch with affect that is not normally attended to, or encoding affective information more accurately (Arnkoff, 1980; Davison, 1980; Gendlin, 1980; Wexler, 1974).
To achieve this the therapist could suggest at a conceptual level that certain affective experiences are acceptable and direct attention to various perceptual motor cues. Greenberg and Safran suggest that

"once the new information is attended to the therapist asks the client to verbalize his or her experience and explores emotional memories and images and discusses the rules and meanings surrounding the feelings in order to help synthesize new affective experience ... Once new adaptive emotional experiences have been generated the therapist can help the client learn to translate them into appropriate actions" (p. 21).

Bower (1981) has suggested that many maladaptive cognitions can only be accessed in the presence of the state in which they were acquired, that is in states of affective arousal. The experience and amplification of emotion may then be a prerequisite to the modification of "hot cognitions" (Abelson, 1963), and to the creation of the motivation to deal more effectively with problem responses. Green and Murray (1975) did indeed find that the expression of feelings facilitated the attainment of insight. Greenberg and Safran also suggest general interventions such as the use of vivid and metaphorical language, the reflection of feeling and heightening the awareness of non-verbal expression.

Jacobson and Margolin (1979) present another view; they state that since change is largely a matter of effort and practice and there is a correlation between feelings and behavior, the causal sequence is irrelevant. The decision regarding intervention can then be made on the basis of efficiency, and since the therapeutic technology for changing behavior is considerably more developed than the technology for changing feelings and attitudes, the most efficient intervention is one which focuses on changing behavior.
Affect in Marital Therapy

The field of marital therapy reflects the general controversy concerning the role of affect as opposed to more rational and behavioral approaches in therapeutic interventions. As Mahoney (in press) suggests "our tacit notions about emotional processes exert a persuasive influence on how we approach and conduct therapy." Gurman and Knudson (1978) in their critical review of the more behavioral approaches note the behavioral focus upon the "rational observing ego" and the assumed client openness to reason and ability to see that change is in their rational self-interest. They criticize this approach for a lack of focus upon "the power and salience of private events" (p. 128) and the assumption that if behavior changes then changes in feelings will follow. In fact in recent years cognitive private events have been included even in models of behavioral marital therapy (Jacobson & Margolin, 1979), behaviorists tending to become cognitive-behaviorists. The private events which now appear to be at issue in therapy, are emotional in nature.

In the more behavioral therapies couples are encouraged to separate problem solving from emotional expressiveness and learn to control the latter in favor of problem solving. As Margolin and Weinstein (1983) state a skill oriented stance places a "value on rational as opposed to emotional processes" (p. 334). However these authors now suggest that affective experience and expression seem essential to the aims of marital therapy, and that emotional expression may be conceptualized as a skill, for example spouses can be taught "to assign labels to physiological cues" (p. 349). The more dynamic experiential therapies
focusing as they do more upon intrapsychic phenomena and upon the relationship not as a reciprocal offering of behaviors but as a bargain about the definition of self have tended to be more concerned with the exploration of emotional experience. As Solomon (1977) notes emotional experience is essentially self-referring and concerned with self-concept. Gurman, Knudson and Kniskern (1978) suggest that the expression of feeling serves to define relationships, and attempts to define relationships represent fundamental attempts to define one's self. Gurman and Knudson (1978) go on to suggest that the emotional vulnerability which typifies distressed marital partners disrupts the partners ability to recognize, respond to or learn from new experiences. It is also not possible to teach responses such as respect which may be key in a relationship and do not always follow from a spouse learning to behave in a more pleasing fashion. Responses such as love, which for most people is the sine qua non of marriage (Broderick, 1981), seem by their very nature difficult if not impossible to bring under cognitive control. It may be that the more behavioral approaches actually encourage repression with their focus on compromise and pleasing behaviors (Gurman & Knudson, 1978).

Jacobson and Weiss (1978) in their reply to the above authors suggest that couples are "quite skillful at expressing negative feelings that an encouragement of this practice would be counterproductive" (p. 151). They state that they encourage a focus upon the positive, and attempt to provide couples with a new armamentarium of skills with which to manage conflict. Couples have then to become accomplished at tasks such as problem solving "over a wide range of resources, including love,
affection and the use of finances" (p. 152), and are thus guided by the therapist in the creation of a positive control system, and the rational restructuring of contingencies in the relationship.

Jacobson and Margolin (1979) suggest that the most difficult client behavior to change in marital therapy is the tendency of the spouse to blame each other for marital problems. Most dynamic and experiential theorists agree. However, where cognitive behaviorists would tend to attempt to replace such behavior with problem solving, following a set of rules rather than emotional cues, dynamic and experiential therapists tend to explore the underlying anxiety occurring within the partners which acts as a stimulus for and response to defensive interpersonal behavior. In the more dynamic therapies it is not the skill level but the context which is considered the issue.

Authors who consider emotional experience to be crucial in the modification of relationships have then considered defensive behavior, motivated by emotional vulnerability, to be a block to new learning, problem solving, and positive intimacy experiences. The intrapsychic experience of vulnerability becomes a relationship event in that it can foster emotional reactivity and defensiveness, or under positive circumstances, intimacy and bonding.

The disclosure of emotional experience is also generally viewed as intimacy enhancing, and thus related closely to marital satisfaction (Margolin & Weinstein, 1983). L'Abate (1977) focuses upon the necessity for the sharing of feelings such as vulnerability and hurt for the creation of intimacy and true conflict resolution. He suggests that to be aware of and express hurt is a healing process in itself. Knudson,
Sommers and Golding (1980) found in fact that couples who resolved conflict by 'engagement' rather than avoidance had greater access to one another's interpersonal perceptions and construals of reality, suggesting greater intimacy.

However authors who believe in the importance of the exploration of affect in marital therapy, may employ very different interventions. Margolin and Weinstein (1983) focus on the skill of emotional expression whereas Bockus (1980) focuses upon the displacement of family of origin patterns onto present relationships and uses gestalt techniques to enact past emotional experiences in the present.

What then is the role of emotional experience in changing relationships?

If Zajonc is correct that emotion is primary and somewhat independent then it is not surprising that Fincham and O'Leary (in press) found that behavioral responses in marriage seemed to be primarily mediated by affective responses rather than casual attributions. It would seem that strong emotional experience, such as fear or vulnerability, which has become associated with a particular situation (for example, closeness with ones spouse) tends to provide a powerful framework which gives meaning to experience. If we are afraid we see our spouse's actions as threatening. Emotion experience tends to dominate, to override other cognitive and behavioral cues. Weiss (1980) suggests that adult intimate relationships are "based largely upon sentiment, the love, regard and fulfillment promised by relatedness" (p.243) and that the meaning given to interaction patterns is not just a function of the "outcome" of events but a function of sentiment. He speaks of "senti-
merit override", which enables people to give to each other noncontingently in positive relationships. Kaplan and Kaplan (1982) also point out that when interacting, people will organise what they "see" and "hear" according to their current emotional state and experiential organization. Thus couples tend to focus on negatives and overlook positive behavior changes on the part of their spouse unless each partner's emotional experience of the relationship is attended to. Arnold (1960) also suggests that emotions bias the appraisal of new situations and intensifies reactions to them. If emotional experience is primary and overrides other cues it would seem to be an essential target for change in marital therapy.

There is also the point that such experience may block new learning. Couples may not use problem solving skills if competing behaviors are more salient in the relationship (Mead, 1981). The experience of emotional vulnerability and resulting defensive reactions would certainly seem to be one such set of competing responses that would tend to block the learning of new skills and perspectives or the use of existing skills. If this is the case it may be that no new learning can take place until the automatic synthesis of pain, fear and vulnerability has been accessed, validated and confronted. As Kinston and Bentovim (1981) suggest the therapist might interpret the depth meaning behind the surface pattern of interactions which are generally repetitious responses aimed at protection of the self from the spouse. The accessing of underlying emotional experience is facilitated in marital therapy by the fact that the stimulus for such an experience, namely the partner, is present. The therapist however, offers a certain
safety to each of the partners, as well as guiding them with probes and interpretations.

To avoid emotional experience in marital therapy or regulate it to a confined and secondary role would not, in light of the above remarks seem functional. Rather strong emotional experience may be used to evoke and access key cognitions, of which the client has hitherto been unaware. Dyfunctional cognitions can then be clarified and modified. The modification of cognitions concerning the nature of the self in relation to the other would seem to be particularly pertinent here. Bower (1981) suggests that cognitions may be more easily evoked if the client is experiencing the state during which those cognitions were first aroused and were most salient. Also positive and useful cognitions may arise out of emotional experience both in terms of clarifying needs and wants and evoking new responses and solutions to problems. The behaviorists have suggested that one problem with contingency contracting is that people do not know what they want, or perhaps, are unwilling to communicate their wants to their spouse. The experience of previously unacknowledged emotion and the synthesis of new emotion gives rise to action dispositions which provide a sense of direction and aid problem solving. Newly formulated wants and needs arise out of emotional experience, and suggest new adaptive responses (Greenberg, 1984). For example if a partner realizes that she is afraid of close contact with her spouse and needs reassurance, she is then able to communicate her feelings and needs. This allows her partner to recognize that to comfort may be a better solution than his usual response of withdrawal or rational lecturing.
The communication of deeply felt emotion also tends to increase the acceptance and sense of intimacy in a relationship especially if the partners are accustomed to receiving reactive emotional responses, such as outbursts of anger. High levels of intimacy seem to correlate negatively with conflict in a relationship and tend to be very closely related to marital satisfaction (Waring, McElrath, Lefcoe & Weisz, 1981). Waring et al. found expressiveness or self-disclosure to be the key ingredient of intimacy. Tolstedt and Stokes (1983) differentiate between verbal intimacy (self-disclosure), physical intimacy and affective intimacy or feelings of closeness which include "emotional bonding, including intensity of liking, moral support, and ability to tolerate flaws in the significant other," (p. 574). These authors found all three kinds of intimacy especially affective intimacy, were significantly related to marital satisfaction. Altman and Taylor (1973) in their social penetration theory differentiate the concept of intimacy into verbal exchanges which may vary in breadth, (range of topics about which an individual discloses), depth (closeness to the innermost core of the person) and valence (positive or negative quality). The communication of relatively "deep" personal needs fear and emotional vulnerabilities would seem to facilitate the building of emotional bonds through reciprocal self-disclosure. This kind of process would seem to be naturally antithetical to the distance, alienation and polarisation normally found in recurring dyadic conflict. The disclosure of unacknowledged feelings especially those of vulnerability also tends to lower the other partners tendency to protect themselves and encourages responsiveness. A new view of the partner, for example one which
recognizes the need for contact underlying a blaming stance in a relationship, evokes different responses and encourages the formation of new bonds. As this process continues, the overriding emotional climate may become less threatening and goodwill between partners may expand allowing the relationship to be defined differently.

The expression of feeling is then not, as Jacobson suggests, only to make the impact of one partner's behavior on the other clear, but 1) to defuse blocks to new learning; 2) to help couples explore and formulate previously unacknowledged feelings, needs and wants; 3) to access important dysfunctional unconscious cognitions; 4) to facilitate new perceptions of the other which evoke new responses and opportunities for intimacy. The end result of this process is that the relationship is experienced in new and more intimate ways and defined in a less rigid and defensive manner.

The Emotionally Focussed therapy used in this study attempts to help clients access, explore and express key underlying emotional responses to their spouse to change the way partners perceive each other and respond to each other, and thus to create new opportunities for intimacy.

A Description of Interventions Used in This Study

This study will then attempt to address the need for a comparative study of an effective cognitive-behavioral intervention, problem solving, and experiential emotionally focused intervention for the resolution of marital conflict.
Problem Solving (PS)

The rational problem solving treatment is taken from Jacobson and Margolin (1979) and is outlined in Appendix A. The affective treatment (Greenberg & Johnson, in press) is based on the experiential tradition in psychotherapy which emphasises the role of affect in change (Greenberg & Safran, 1984; Perls, Hefferline & Goodman, 1951; Satir, 1973) and the systemic tradition which emphasises the role of communication and interactional cycles in maintaining problem states (Sluzki, 1978; Watlawick, Beavin & Jackson, 1967). This treatment is also outlined in Appendix A.

The Problem Solving Intervention seems at present to epitomize the cognitive behavioral approach to marital therapy and to be the most empirically validated intervention specific to this model (Jacobson, 1977, 1978, 1979, in press). This intervention focuses upon the teaching of problem solving (or positive control) and communication skills. Feelings although not ignored are generally regarded as epiphenomenal in the context of overt behavior change. As Gurman and Knudson (1978) point out

"The general goals of behavioral marriage therapy are to increase the rate of rewarding interactions based on positive behavior change operations and decrease the rate of aversive interactions and coercive control, and teach concrete conflict resolution and problem solving strategies and skills", (p.123).

Weiss (1978) defines problem solving as the application of reason, intelligence or experience, to the production of some outcome such as decision making about children. Problem solving may be applied to situations and the communication process itself. Mahoney (1977) notes
that practitioners using problem solving training in their treatment packages employ a basic sequence of skill building; that is specifying the problem, collecting information, identifying causes and patterns, examining options, narrowing options, experimenting, comparing results and revising solutions. The client develops cognitive skills such as means ends thinking, the evaluation of probable consequences, and the rehearsal of possible options.

Jacobson and Margolin (1979) include the components outlined by Mahoney but add refinements such as pinpointing specific problem behaviors in the problem definition stage and the brainstorming of possible solutions leading to a reasonable compromise and the specification of an agreement in the resolution phase. Rules for effective communication are also taught as part of the problem solving sequence. The problem solving components used here are attempts to teach couples new rules and a new cognitive set for approaching marital conflict. The Margolin and Weiss study (1978) emphasises the importance of the cognitive restructuring factors in this approach particularly the creation of a collaborative set and the reattribution of problems in terms of lack of skill rather than negative intent on the part of the spouse. Such interventions are geared to help couples abandon blaming and accept more personal responsibility for the relationship failure. In general the therapist role is mainly that of a teacher and coach, the therapist states rules, models new behaviors and provides feedback on behavioral rehearsal. These rules might consist of such commands as: be specific, phrase requests in terms of positive changes, respond directly to a criticism (no cross-complaining), or wait for your spouse
to complete a thought before giving your reactions. These rules are usually stated positively since it is easier to reinforce the occurrence of a behavior than its non-occurrence. Negative feedback may be given in the form of pointing out non-productive behavior, and explaining the negative consequences that ensued. Behavioral therapists also teach stimulus control strategies, that is, the couple is instructed to bring their problem solving attempts under the control of particular times and settings; for example, Margolin, Christensen and Weiss (1975) suggest helping couples to label whether they are involved in emotional expression or problem solving. The focus is upon the control of bad habits and conscious rational problem orientated behavior. The effectiveness of this treatment as opposed to other behavioral treatments, such as simple contingency contracting, has been demonstrated (Jacobson, 1977).

Jacobson and Margolin (1979) state that problem solving is first "an expeditious way of teaching behavior management" and second provides "stimulus control over couples conflict related interactions, thus altering the quality as well as the connotations of such interactions" (p.213). These authors suggest that problem solving skills training serves a preventative function since it helps couples to acquire self-management skills. The expression of feelings is part of communication training in this model. Couples are encouraged to label incidents in terms of feelings and validate their partner's feelings. The focus here is the enhancement of positive exchanges rather than the expression of negative feelings.

The problem solving process begins with a discussion of manifest
observable complaints in terms of mutuality in order to create a collaborative set. Problems are then defined in terms of specific behaviors and derogatory labels are discouraged in favor of descriptions of problem behaviors. Partners are encouraged to admit to their part in the problem, be brief and present-orientated in their presentation of problems, discuss only one problem at a time (no side tracking), paraphrase each other's remarks, and avoid making inferences or mind reading. Jacobson (1981) defines steps towards the definition of a problem as: Always begin with something positive (since distressed couples seem to selectively track displeasing behaviors), be specific using pinpointing skills, encourage feeling expressions especially concerning the negative impact of behaviors, help partners to acknowledge their part in the problem, and keep definitions brief. After definition, Jacobson suggests that the remaining discussions should be solution focused, using brainstorming to generate solutions. Behavior change, then, is based upon "mutuality and compromise". He also points out (Jacobson & Margolin, 1979) that the tendency of the spouses to defend themselves and their transgressions is the most difficult response class to modify. Spouses will deny the legitimacy of the others complaint, deny responsibility for actions, or enumerate circumstances which render the behavior beyond their control. Jacobson suggests that the therapist deal with this by setting the ground rule that legitimacy is assumed, since one partner is upset.

The line between communication training, problem solving and contingency contracting in behavioral marital therapy is often difficult to draw. Tasks such as the appropriate expression of feeling, or
pinpointing behaviors (discrimination training) and operationalizing one's expectations could be seen as communication tasks or components of problem solving. As may be seen in Appendix A the Problem Solving Treatment in this study consisted of the teaching of communication skills, followed by the teaching of problem definition and solution skills and ending in good faith contracting. Good faith contracts are structured so that each spouse's rewards and penalties are independently determined in terms of his or her own contractual obligation to change.

**Emotional Focussed Therapy**

Experiential models of therapy based on the work of authors such as Perls (1973) and Rogers (1951) have consistently emphasised the role of affect in changing perception (Greenberg & Safran, 1982, 1984) and the Emotionally Focused therapy used in this study focuses on present affective experience in an interactional framework in order to change perception. The therapist in this approach attempts to enter each person's frame of reference and explore the reality of the relationship as it appears to this person, and as it translates into relationship events. Partners are regarded as active perceivers who construct meanings and organise perceptions and responses on the basis of current emotional states, and who tend to disown aspects of their experience because of internal blocks or splits or because of perceived requirements of the relationship as presently defined.

Change in this perspective can then occur by changing one person's experience and perceptions of self in relation to other, or by changing the other partner's position and pattern of responses, or most likely by
changing both simultaneously and in a reciprocally determining fashion. Insight in this approach is not enough to bring about change in the relationship. Rather partners must experience, on an emotionally meaningful level, new aspects of themselves and new interactions. Thus partners encounter each other in the session and participate in a "corrective emotional experience". The use of effective communication skills is seen as emerging more as a result of change rather than bringing it about. The experiencing of new feelings motivates problem solving and good communication as does the perception of the partner as more accessible and responsive.

Change occurs then in this approach by a deepening of experience which brings new aspects of self into focal awareness and into the interaction. Specific interactional behaviours are reframed in a positive manner in terms of these underlying emotional states, in order to change the sequence of interactions. At least five processes of change appear to occur in the emotionally focused treatment of couples. (Greenberg & Johnson, in press).

1. An individual perceives him or herself differently by bringing into focal awareness experiences not previously dominant in this person's view of self; for example, "I see and accept my vulnerability."

2. The spouse on witnessing the partner's new affective expression, perceives the partner in a new way; for example, "I see your need for caring and contact rather than your hostility."
3. The individual's personal reorganization leads to different behaviour in the interaction between the spouses; for example, "I now ask you for reassurance from a position of vulnerability."

4. The spouse's new perceptions of the partner lead to different responses; for example, "I comfort you rather than withdraw."

5. As a function of their partner's new behaviours, the individuals come to see themselves in new ways; for example, "since I can fulfill your needs, I see myself as valuable and necessary to you."

The combination of the above processes leads to a redefinition of the self in the relationship for both partners. Different aspects of the self are expressed and accepted in the relationship and this leads to a change in interactional patterns. The partners' perceptions of each other are framed in new terms which facilitate the creation of a new responsiveness to the other partners' needs. Spouses then are more able to accept certain behaviours from their partners, that might previously have been unacceptable and offensive. This whole process, due to its high demand for disclosure, is in itself conducive to the building of intimacy and emotional bonds, both of which are key aspects of marital satisfaction (Tolstedt & Stokes, 1982). The treatment manual for training in this approach contains the nine steps outlined below:

1. Delineate conflict issues in the core struggle.

2. Identify the negative interaction cycle, for example pursue and withdraw.

3. Access unacknowledged feelings inherent in the position each partner takes in the interaction cycle.
4. Reframe the problem in terms of underlying feelings.
5. Promote identification with disowned needs.
6. Promote acceptance of partner's experience.
7. Facilitate expression of needs and wants.
8. Establish the mergence of new solutions.

The therapist in this approach must establish the kind of therapeutic alliance which allows new experience to be explored with confidence, particularly experiences of vulnerability, fear and unexpressed resentment. The therapist also strives to legitimise the responses of each partner as reflections of universal human needs. In order to access and heighten emotional responses the therapist uses the methods of Gestalt therapy (Perls, et al, 1951) and innovations from client centered therapy (Rice, 1974). The therapist also guides the formulation of meanings as new experiences occur, for example, reframing hostility as desperation or distance as fear in such a way that this reconstruction remains true to the clients present experience, evokes acceptance from both the experiencing and observing spouse, and promotes contact between the partners.
CHAPTER III
THE METHODOLOGY OF THE STUDY

This chapter begins with a description of the client population and therapists, followed by a delineation of the instruments used and the research procedures. The hypotheses of the study are then outlined, followed by a description of data analysis procedures.

Client Population

The subjects for this study requested counselling after reading a newspaper article (Long, 1983) describing the Couples Problem Solving Project. Couples were offered eight marital therapy sessions designed to help them resolve marital conflict. The clients after screening and an assessment interview then attended the Education Clinic at The University of British Columbia for therapy.

Client couples were screened on the telephone and again in the assessment interview according to the following criteria:

1. Clients had to have been cohabiting for a minimum of twelve months.
2. Clients had to have no immediate plans for divorce or separation.
3. Individual clients had to have received no psychiatric treatment or hospitalization within the last two years.
4. Individual clients had to report having no problems with alcohol or drugs.
5. Individual clients had to report experiencing no primary sexual dysfunction.
6. Clients had to score in the distressed range on the Dyadic Adjustment Scale (Spanier, 1976); in this study that is defined as at least one partner scoring below 100 on this scale.

7. Clients had to be willing to consent to research procedures, testing and video-taping.

8. Clients had to be currently uninvolved in any other psychologically oriented treatment either on an individual or couple basis.

There were 45 couples included in the study, 15 in each of the two treatment groups and 15 in the wait list control. The following demographic data was collected from these 45 couples. The mean for the number of years couples had been living together was 8.6 years (range: 1-24). There was an average of 1.75 children per family (range: 0-7). Seven couples had been involved in previous marital counselling (15% of the total), and 20 individuals (22% of the total) had been previously married before engaging upon their present relationship. The mean age of the partners involved in the study was 35.3 years (range: 25 - 55). The median range of family income was reported to be $35,000 -45,000 Canadian dollars per year. The mean number of years of education completed by spouses was 15; this was defined on the questionnaire as having completed a community college program or part of a degree. The occupations of the spouses were categorised on the Blishen Scale (1971). Typically the male spouses fell into the semi-professional category, while the female spouses fell into the trades catagory on this scale. The variables, number of years together, family income, male and female occupation, educational level and age were examined for
differences using an analysis of variance and no statistically significant differences were found between the three groups (two treatment groups and the control). Thus the randomisation process seemed to successfully select groups that were equivalent on these demographic variables. For details of this analysis please turn to Table E-1, Appendix E. These subjects were predominantly members of the dominant caucasian cultural group not from distinct ethnic backgrounds where particular cultural values may influence expectations concerning marriage.

The assignment of subjects to group was completed using the sequence of one, two and three found in a random number table. Couples designated as ones were assigned to the EF group, two's to the PS group and three's to the Control. As a couple was accepted into the study after assessment they were given the first number on the list. There was one exception to this procedure. If a couple scored under 80 on the DAS they were set aside until three such couples were collected and then assigned as above. This was to ensure that any one treatment group did not contain a disproportional number of very low scoring couples. After assignment to group, treatment couples were placed with therapists (one to six) according to a random number table.

The subjects were also administered the Test of Emotional Style (Allen & Hamsher, 1974), which measures Orientation towards emotion, Expressiveness, and Responsiveness to emotional stimuli, and no significant differences were found between the three subject groups. Details of this analysis may also be found in Table E-2, Appendix E.
Therapists

There were 12 therapists involved in this study; six (two males and four females) administering each treatment. The therapists ranged in age from 28 to 43. Five of the therapists administering the Problem Solving Treatment were senior or recently graduated clinical psychology doctoral students. The mean number of years of academic training for this group was 4.6 (range: 2-6).

The therapists administering the Emotionally Focussed Treatment were social workers or counselling psychologists, all possessing a masters degree. The mean number of years of academic training for this group was 3 (range: 2-5) This difference in years of academic training between therapist groups was not statistically significant, and was not taken to be operationally significant.

All PS therapists were trained primarily in a behavioral approach to psychotherapy and their professed orientation was Behavioral or Cognitive - Behavioral. All EF therapists were trained in systemic and humanistic approaches to psychotherapy, and their professed orientations were Experiential and Systemic.

In terms of clinical experience the mean for both the EF and PS therapists was 4 years. The distribution of years of experience across therapists in each group was also very similar (range: 2-7).

In general the therapists conducting the two treatments were as far as possible balanced as to training and experience, however the PS therapists did possess slightly more years of academic training on average.

In each group four therapists saw two couples, one therapist saw three couples and one therapist saw four couples. The therapists had
been trained in a group setting (approximately 12 hours of training) to implement the two therapy manuals. The EF therapists were trained by Dr. L. Greenberg of The University of British Columbia and the PS therapists were trained by Ms. Lisa Wood who collaborates with Dr. N. Jacobson of the University of Washington. Two group supervision meetings were conducted during the study, one for each therapist group. All therapists were also given a minimal amount of telephone consultation and feedback during the study (not exceeding 15 minutes per couple).

An analysis of variance treating therapists as a fixed variable and post-test measures as dependent variables found no significant differential therapist effects. Details of this analysis may be found in Tables E5 and E6, Appendix E.

Instruments

All constructed instruments, questionnaires and instructions for their completion are to be found in Appendix B.

Subject Variables

1. Demographic Questionnaire

This questionnaire addressed the following questions: the number of years spent together as a cohabiting couple, the number of children living in the home, whether spouses has been previously married or had been involved in previous marital therapy, the approximate amount of the family income, the age of the spouses as well as their educational level and present occupations. This last variable was categorised according to the Blishen Scale (Blishen & McRoberts, 1976). The purpose of this
questionnaire was to provide an accurate description of the sample population. Couples completed relevant parts of this measure together and individually focused parts separately. All other measures were completed separately by both spouses.


This test was given to ascertain if the treatment groups were initially equivalent on scores indexing the three factors of emotional style, Orientation, Expressiveness and Responsiveness. This was necessary since a high level of these factors in the couples assigned to the EF treatment might positively bias the treatment effects. The three dimensions of emotionality addressed in the test may be defined thus; responsiveness, as intensity of experienced affect, expressiveness, as the predisposition to communicate affect interpersonally, and orientation as attitude towards emotion. The test consists of 75 items (25 per subscale) in the form of forced choices. Subjects are requested to choose between two statements marking the one that is most true as a description of themselves. Allen and Hamsher report validity and reliability data. On their sample (N = 173) they indicate that internal consistency levels (coefficient alpha) were, Orientation .92, Expressiveness .90, and Responsiveness .85, and found these subscales to be unconfounded with independent measures of adjustment or social desirability. Females scored significantly higher than males on all dimensions.

An analysis of variance revealed no statistically significant differences between the three subject groups in this study on this
measure. The details of this analysis may be found in Table E-2, Appendix E.

Therapy Process Variables

3. The Couples Therapy Alliance Scale (AS) (Pinsoff & Catherall, 1983)

This instrument was completed by each client after the third therapy session as a measure of the client's view of the therapeutic relationship. The measure has three components, agreement between client and therapist on therapeutic goals, the existence of personal bonds between therapist and client and the development of tasks that are perceived by the client as relevant to his/her concerns. These components are identified by Bordin (1979) as the key elements in the concept of therapeutic relationship. These three components are also viewed in relationship to the self, the other partner and the couple's relationship as a whole. The measure consists of 28 items (11 relate to self, 11 to other partner, and 6 to the couple relationship) which the subject responds to on a Likert type five point scale.

This instrument was intended to control for the general or relationship factors which have been shown to be important in predicting therapeutic outcomes. The task dimension which measures engagement in the tasks of therapy would also appear to be particularly relevant in this study to show that clients were equivalently engaged in both types of therapy and perceived them as equally relevant.

Since this instrument is still in the process of being revised an item analysis was conducted to determine reliability for this sample
population. The results of this analysis are presented in the results chapter.

4. The Implementation Checklist

This checklist of therapist interventions was devised by the researcher for the purposes of this study. The purpose of the checklist was to enable trained raters (three hours of training) to ascertain whether the interventions stipulated in the treatment manuals occurred. These raters examined two ten minute samples of therapy taken from the second and final third of randomly selected sessions. The checklist consists of 20 categories of therapist interventions taken from the treatment manuals. As well as ten categories of interventions from each treatment three additional categories not assignable to either treatment were included, namely, information gathering, refocus on topic, and non-codable. The implementation checklist was pilot-tested first on four couples and judged to be satisfactory, in the sense that the process of treatment was easily codable into the given categories.

5. Therapist Intervention Report

Therapists were required to complete a checklist at the end of each session. This checklist consisted of the same categories of interventions as the Implementation Checklist and therapists were requested to check off the interventions they had used in the session and report an estimate of the frequency of use. Therapists also recorded how "resolved" they considered the couple to be at the end of each session. These reports were simply monitored by the researcher and
the research assistant and also served to remind therapists of the interventions required in the treatment manuals.

Outcome Variables

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

This instrument was used as a screening and pre-treatment measure and as a general measure of outcome at termination and follow-up. The DAS consists of 32 items arranged into four subscales measuring dyadic consensus (13 items), satisfaction (10 items), cohesion (5 items) and affectional expression (4 items). It is at present considered to be the instrument of choice for the assessment of marital adjustment in terms of reliability (coefficient alpha in Spanier's sample, .96) and validity. Spanier presents validity data such as a correlation between the DAS and the Locke Wallace Marital Adjustment Scale (1959) of .86. In the Koren et al. study (1980) distress level measured on this instrument correlated with satisfaction concerning conflict outcomes and objective conflict resolution.

Conceptually, Spanier suggests that the scale can be considered to be a measure of the adjustment of the dyad as a functioning group rather than a measure of individual adjustment to the relationship. The scale has a maximum possible range of 0 to 151. The mean total score in Spanier's sample for married and divorced couples was 114.8 (S.D. 17.8) and 70.7 respectively. Spanier reports the reliability of the subscales as Consensus .90, Satisfaction .94, Cohesion .86 and Affectional Expression .73. Most of the items involve a six or five point Likert
scale defining the amount of agreement or the frequency of an event. Included in the satisfaction subscale is also a global happiness rating and a rating of commitment.

An item analysis was conducted on this instrument for the purposes of this study, the results of which are presented in the results chapter.


A description of the main complaint arising in the relationship was articulated by each spouse to the assessor during the initial interview and rated as to improvement or deterioration at the termination of the sessions and at follow-up. The measure is recommended by Waskow and Parloff (1975) as a core battery instrument for use in psychotherapy outcome research. It consists of three five point scales on which each client in this study was asked to rate the amount of change on three different complaints related to the core conflict in the relationship. In this study one score (TC) was computed based on the client's rating of the status of the primary target complaint.

Battle et al. (1966), give evidence as to the validity of this measure in terms of significant correlations with other outcome measures particularly the correspondence of target complaints to the complaints obtained in an intensive psychiatric interview. These authors state that they found this measure to be "informative, and it made good clinical sense and seemed to respond differentially to experimental manipulation" (p. 187). The authors report the correlation between the
rankings of problems by patients on two different occasions as .68. The severity ratings of the target complaints did not change. A final study by the above authors also found that the content of target complaints did not differ significantly when these ratings were reported to different interviewers. The type of Target Complaints articulated by clients in this study are described in Appendix B.

Jacobson, Follette and Elwood (in press) suggest that measures which tap the couples presenting problems most directly such as problem checklists like this instrument and goal attainment scales are the instruments of choice in marital therapy.

8. **Goal Attainment Scaling (GAS)** (Kiresuk & Sherman, 1968)

The GAS measurement procedure is a method of goal definition and goal measurement. It is a method of obtaining from clients specific observable and quantifiable individual goals. The procedure includes a means of formally specifying the actual goals undertaken by a client in relation to his/her presenting concerns. With this procedure it is possible to determine the extent to which the client's goals have been attained.

The GAS scores are based on a standard score system (T scores) having a mean of 50 and a standard deviation of 10. The goal outcomes range from "much worse than expected" (-2) through "expected" (0) to "much better than expected" (+2), with each outcome level defined by a particular observable behavior or group of behaviors. A scale must have at least two points that are sufficiently precise and objective in their description so that an unfamiliar observer would have no trouble in
determining whether the client's position lies above or below the chosen point. The scale thus becomes an evaluative transformation of the treatment outcome into an approximate random variable with a mean of zero and a variance of one (before transformation to the standard T score having a mean of 50 and standard deviation of 10).

One purpose in the development of the GAS system was to allow outcome data to be grouped for easy analysis without losing the import of individual client goals. A standard score may be generated for each client to evaluate his/her position before and after therapy. Kiresuk and Sherman point out that essentially the GAS has the following characteristics: 1) a set of statements of goals for an individual; 2) a system of weights for these goals; 3) a set of expected outcomes for these goals ranging from "most unfavorable" to "most favorable"; 4) a follow-up scoring of these outcomes; and 5) a score summarizing the outcome across all goals.

In this study the clients were asked to focus upon the main goal in relation to their marital issues and to define 5 levels of attainment of that goal in terms of three observable and quantifiable behaviors and one subjective emotional reaction. One level of attainment was described as "worse", that is the instrument, like the TC instrument allows for deterioration. An example of the way in which a level of attainment might be defined may be clarifying. A spouse might describe the "somewhat better than expected" level of goal attainment in terms of, 1) being able to reach consensus on decisions 75% of the time, 2) being able to talk calmly about issues when consensus was not immediately attainable, and as a result, 3) only encountering one
escalating distressing fight a month. As a result the spouse might expect to feel generally calmer and more secure in the relationship.

In the assessment interview clients formulated their goals and rated their present level of attainment on an individual independent basis. At termination and follow-up the level of attainment was measured again.

9. **The Personal Assessment of Intimacy in Relationships Inventory (PAIR)** (Schaefer & Olson, 1981)

This instrument consists of 36 items arranged into 6 subscales, Emotional Intimacy, Social Intimacy, Sexual Intimacy, Intellectual Intimacy, Recreational Intimacy, and Conventionality. Definitions for these subscales may be found in Appendix B. Each subscale is a separate entity; there is no total score. The instrument attempts to operationalise different kinds of intimacy. Intimacy is presumed to be a key dimension of the marital relationship and one which may be expected to correlate positively with the resolution of relationship conflicts.

The inventory measures the perceived versus the expected degree of intimacy, so that a difference score may be computed in each of the five areas of intimacy mentioned above. The conventionality subscale was designed to measure social desirability factors and is scored only as perceived. Each partner responds to each item "as it is now" (perceived) and then "how he/she would like it to be", (expected) indicating agreement or disagreement on a five point Likert scale.

Olson and Schaefer (1982) report in the manual that in their sample (N = 384), the PAIR subscales correlated positively with the Locke
Wallace Marital Adjustment Scale (1959) and negatively with the Conflict Scale on the Moos Family Environment Scale (1976). The authors report the reliability (Cronbach's alpha) of each of the subscales as .75 for the Emotional (EM) subscale, .71 for the Social (SO), .77 for the Sexual (SX), .70 for the Intellectual (IN), and .70 for the Recreational (RC) subscales. They also state that scores on the subscales were found to have a fairly normal distribution (range = 0 - 96). They found that except for Social Intimacy and Conventionality (CON) the mean perceived score fell between 42 and 58 for each scale. The average score for Social Intimacy was somewhat higher (x = 61) and for Conventionality was somewhat lower x = 38). They report that large discrepancies between male and female perceived scores were common (0 - 70 points on each scale), however the mean discrepancy was 14 - 20 points. Means for expected subscales ranged between 80 - 86.

The authors suggest that a high score on the Conventionality subscale is the result of the couple "faking good" and a tendency to idealize the relationship (PAIR Manual, 1982). These two formulations would seem to present alternative interpretations of this subscale. Clayton (1975) suggests that the meaning of conventionality as it relates to the measurement of marital adjustment may in fact be idealisation of the spouse and of the relationship, and that this idealisation may in fact be a positive marital adjustment technique. The process of idealisation has been considered by many theorists as essential to the experience of romantic attachment (Csikszentmihalyi, 1980). Clayton also criticizes Edmonds (1967) original work on social desirability factors in the measurement of marital adjustment since
Edmonds only recorded one of his sample spouses responses and did not describe his sample's demographics. In fact Clayton and other authors such as Dean and Lucas (1974) suggest in general that the issue of social desirability in this area has been overstated. In the light of the above the conventionality subscale on the PAIR will be considered as a measure of functional idealisation of the spouse and the relationship.

An item analysis was conducted on this instrument for the purposes of this study and the results are presented in the results chapter.

10. The Post Treatment Standardised Interview

This standardised interview was constructed for this study to explore the subjects experience of the process of therapy. Questions concerned the perceived changes in the relationship, the factors each spouse perceived as facilitating treatment, or hindering treatment, critical incidents during therapy which seemed to contribute to change, and whether spouses would have preferred more sessions. The interview was used by the assessor after administering the post-tests to obtain the couples impressions on the above areas. Subjects gave their answers orally and they were noted by the assessor.

11. The Activities While Waiting Inquiry

The questionnaire was administered by the assessor to the control group at the pre-treatment interview. The questionnaire was given to attempt to monitor possible therapeutic factors or activities experienced by the couple during the waiting period.
12. The Rating of Conflict Resolution

Observers rated the attainment of specific resolution behaviors during a task set by the therapist in the last session (see Appendix B for a description of the task). The raters used a simple outcome coding system suggested by Koren (1978) to rate the in therapy performance. According to this measure a resolution can then take the form of one spouse capitulating to the other or both spouses reaching some kind of compromise. In either case at least one solution proposal and a subsequent statement of acceptance or agreement is required for a resolution classification. Unfortunately the performance of the required task was not successful. It seems in this study to have been influenced by the demand characteristics of the situation, that is couples seemed to do what their therapist asked them to do regardless of the state of their relationship. The measure did not seem to be valid as an assessment of conflict resolution in this study and so was not rated in the analysis.

Data Collection Procedures

Data collection took place from April to November, 1983. All couples except two requested counselling after reading a newspaper article describing the Couple Problem Solving Project and offering distressed couples eight sessions of marital therapy. The other two couples heard of the project from participants.

The couples were screened on the telephone and were scheduled either for an assessment interview or referred elsewhere in the locality for treatment or assistance.
The couples screened out of the study were as follows: two couples were screened out because they had been living together less than a year; five couples were screened out because they had already separated and were living apart; seven couples were screened out because they had recently been or were currently receiving psychiatric treatment for problems such as depression; two couples were screened out because one of the partners reported that one of them was alcoholic; three couples were screened out because they reported their marital problem as primarily involving sexual dysfunction; six couples were screened out during the assessment interview because they scored too high on the DAS; three couples were excluded because of their extremely low DAS scores, that is a couple score of 65 and below (Spanier (1976) reports 70 as the mean for divorced couples); two couples objected to the taping of sessions, and one couple was excluded because of extensive upcoming vacations.

The assessment interviews were conducted by the researcher plus two assistants and consisted of giving information concerning the Project and what was expected of participants, addressing issues such as confidentiality of information, signing consent forms, and completing the DAS, PAIR, TC, GAS, and Emotional Style questionnaires. An example of the Consent Form may be found in Appendix C. The couples were then assigned randomly to treatment and therapist.

The treatment couples then completed eight hours of marital therapy, completing the Alliance scale after session three. This scale was completed after the therapist had left the room and placed in a sealed envelope which was the left in the clinic. The couple also
completed a process oriented questionnaire after every session. This data was collected for use in a future study on the process of change. After the eighth session an assessor, other than the researcher, administered the post tests (DAS, PAIR, TC, GAS) and the Post Treatment Questionnaire. All therapy sessions were audio and video taped and randomly selected sessions were checked by raters for treatment fidelity. The control group couples were told that it was necessary for them to wait until a therapist could be assigned to them. After eight weeks they were contacted, given a post wait assessment interview consisting of the pre-tests (DAS, PAIR, TC, GAS) and the Activities While Waiting Questionnaire, and began therapy. The therapists treating the control group were graduate students in the Counselling Psychology Department of The University of British Columbia who were then supervised by Dr. Greenberg and the researcher. An analysis of the outcome data for the control group is not included in this study.

Once treatment had begun there were no drop outs from the study. This unusual phenomena the researcher believes may be attributable to the thorough assessment procedures and the quality of the therapists who were able to create a strong therapeutic alliance with their clients. A total of 45 couples (n = 15) were included in the study.

Couples came into therapy every week for eight weeks unless summer holidays intervened. A limit of one break between sessions of no longer than 12 days was arranged in the assessment interview. Approximately one quarter of the couples from both treatment groups did take this kind of a break.
Eight weeks after treatment couples were contacted on the phone and asked standardised questions as to the present level on their Target Complaint and Goal Attainment. A description of the questions may be found in Appendix C. The DAS and PAIR questionnaires were then sent in the mail to the couples who completed and returned them.

All test scoring and key punching was verified. Two errors of recording were found and corrected.

**Hypothesis**

The assumptions and outcome hypotheses of the study were as follows:

**Assumptions**

1. That observers blind to the treatment being implemented would reliably differentiate between treatments on an implementation checklist instrument applied to random samples of audio-taped interventions. Thus treatments would be different as implemented and the interventions used would be appropriate to the designated treatment.

2. The treatment groups were not expected to differ significantly on a measure of therapeutic alliance.

**Outcome hypotheses**

1. The following means of the treatment groups were expected to be significantly different at the end of treatment from the means of a wait list control group:
a. The total score and subscales of the Dyadic Adjustment Scale, a measure of marital adjustment.
b. The six subscales of the PAIR, a measure of intimacy levels in different areas of the relationship.
c. The Goal Attainment measure.
d. The Target Complaint measure.

2. The treatment groups were expected to show differential effects at the termination of treatment on:
   a. The total scores and subscales of the DAS.
   b. The six subscales of the PAIR.
   c. The Goal Attainment measure.
   d. The Target Complaint measure.
   e. An observed measure of conflict resolution.

3. The treatment groups were also expected to retain any differential effects found at the termination of treatment when assessed at follow-up.

**Data Analysis Procedures**

The computer programs used in this analysis were, S.P.S.S.:X (SPSS Inc., 1983) and S.P.S.S.:9 (Nie et al., 1975), LERTAP (Nelson, 1974) and BMDP (Dixon, 1981).

The data analysis was divided into three stages. The preliminary analysis consisted of an item analysis of the DAS, the PAIR, and the Alliance Scale to ascertain the reliability of the above instruments. The second stage involved the testing of assumptions concerning group equivalence on instruments such as the Alliance Scale, the Test of
Emotional Style and Demographics and the examination of Implementation Checks. The third stage consisted of testing for pre-treatment differences and the multivariate analysis of treatment outcome measures. Variables found to differentiate between the two treatment groups at termination of treatment were also analysed at follow-up by means of a repeated measures multivariate analysis of variance. In addition, variables found not to differentiate between treatment groups at termination were analysed to check for "sleeper" effects. Some additional analyses of individual post-treatment scores and follow-up scores were also completed.

Hypotheses were tested allowing a Type 1 error probability of .05 (two tail). However when multiple analyses were conducted in order to control the experiment-wise error rate the critical significance level was computed as .05 divided by the number of variables in the analysis (Hays, 1981). Differences among levels for a particular factor were examined using Tukey's procedure (Glass & Stanley, 1970).

In all multivariate analyses the test statistic used was the Pillai-Bartlett, recommended by Olson (1976) as being the most generally powerful and robust statistic available. In all analyses the homogeneity of variance assumptions were checked and no significant differences found, except on the Couples Alliance Scale (Table 5) and on the pre-test scores of the PAIR Perceived, subscale 6 (Table 7). Although in these analyses the assumption of homogeneity of variance is violated since the n's are equal, in which case the influence of this violation is very small, and the effects of non-normality on the nominal level of significance of the F-test are extremely slight (Glass & Stanley, 1970), the ANOVA procedure was considered to be valid.
In the pretest posttest and follow-up analyses of DAS scores the total DAS score, often used as a main outcome variable in other marital therapy outcome studies (Jacobson, in press) could not be included in the multivariate analyses which involve the subtests on this scale since such inclusion would then violate the assumption of independence. Additional analyses of the total DAS score are then reported separately.

Follow-up scores were analysed using a repeated measures analysis to account for the dependency between posttest and follow-up scores.

Limitations of the Study

Since therapists are nested within treatments in this study the issue of differential therapist skills has to be addressed. Both sets of therapists were trained in and oriented towards the treatment they were asked to implement. Therapists were all experienced and from the point of view of their training and amount of experience would appear to be similar. The therapists were also monitored during the study by two raters during implementation checks; (120 out of 240 sessions were monitored). These raters found only 2.5% of the therapist interventions observed to be inappropriate to their designated treatment. When therapist effects were tested as a fixed variable in an ANOVA analysis (dependent variables being the post-test measures) no evidence for differential effects was found. There were also no significant differences found between treatment groups on the Alliance measure, and mean scores were relatively high which suggests that couples in both groups found their therapists relevant, effective and easy to relate to. O'Leary and Turkewitz (1978) discuss the issues concerning the
crossing versus the nesting of therapists and treatment. They point out that crossing therapists and treatment can create systematic bias unless therapists are as effective in and equally committed to both treatments. In fact in the cross model study by Liberman et al. (1976) the researchers state that their results were confounded by the fact that therapists biased towards the behavioral model conducted both treatments. Jacobson, Follette and Elwood (in press) also point out that the crossing of therapists and treatments tends to increase the common elements among treatments, diluting the ability of researchers to detect treatment differences. The fact that therapists are nested under treatment in this study ensures a "pure" sample of each therapy in that each treatment was conducted by therapists committed to the treatment and trained in just that treatment before the project. The relatively large number of therapists used (n = 12) also helps to protect against differential therapist effects and increases external validity.

The short duration of treatment can also be regarded as a limitation in this study. Eight sessions were chosen as the minimum number of sessions in which therapists could facilitate change in marital therapy. Matarazzo (1965) suggests that most clients do not continue therapy for more than 10 sessions, and the trend in psychotherapy and especially in marital therapy seems to be towards short term therapy in which the therapist actively structures his interventions toward clearly formulated goals (Malan, 1976, Mann, 1973); nevertheless a longer treatment period of, for example 12 sessions, would have given time to address issues such as the maintenance of changes made during treatment. There was also some concern that the
short time frame in fact favored the skill teaching process and placed
the emotionally focussed treatment at a disadvantage.

Another issue in the implementation of the present study was the
use of the principal investigator as one of the therapists. There is no
evidence to suggest differential therapist effects however, either on
the Alliance Scale, the analysis of therapist effects, or the
implementation checks. The principal investigator also did not
administer any of the post tests to any couples involved in the study,
nor assess any of the couples assigned to her as clients. Nevertheless
it would have been preferable to have kept the therapist and
investigator roles separate. Also, although every attempt was made to
operationalise both treatments in a parallel and equitable fashion, the
researcher was not in the position of valuing the treatments equally,
being biased towards the Emotionally Focussed treatment. To insure
external validity the study should then be replicated by other
investigators.

The mean level of distress (a score of 92.1 on the DAS) in this
study suggests that this sample is most accurately considered as
moderately rather than severely distressed; the mean score for Spanier's
normative sample being 114.8 and 70.7 for divorced couples. Some
couples scoring as severely distressed were included in this sample,
each group containing couples with couple scores under 80 on the DAS.
Also the means indicate that couples are in the distressed range with
scores that range from mildly to severely distressed. Jacobson et al.
(in press) make the point that even though the inclusion of some mildly
distressed couples may appear to ease the task of therapy in fact the
inclusion of such couples increases the difficulty of demonstrating treatment effects.

As a result of the fact that couples who participated in the study were solicited a question arises as to how representative this sample is of a clinical population who voluntarily seek treatment. However, Last, Thase, Hersen, Bellack and Himmelhoch (1984) found no differences between solicited and non-solicited depressed patients on treatment outcome measures, thus supporting the inclusion of solicited clients in clinical studies. In this study there certainly were couples who had considered or who were considering separation included in the study, and some had separated previously. All couples were concerned about their relationship to the point that they were willing to commit themselves to the assessment sessions, therapy sessions and follow-up procedure. All couples completed the eight sessions, there were no drop-outs. However to address this question properly data on the average DAS scores for clinical couples would seem to be necessary.

The study would perhaps be enhanced by objective behavior ratings, for example a measure of problem solving behavior in the last session. The attempt to set out a task reflecting conflict resolution did not differentiate between couples; all couples were able to complete it. The study could be viewed as being limited by the fact that all measures except the rating of conflict resolution were essentially self-report measures. However this kind of measurement seems to be particularly appropriate in the sense that marital satisfaction or well-being is by nature a qualitative subjective factor rather than an externally quantifiable phenomena, and this is perhaps one of the reasons
researchers in this area have focussed upon self-report measures. Also objective phenomena and subjective factors do not always correspond. Margolin (1978) found that trained observers coding of positive and negative communication behaviors did not in fact correlate with marital satisfaction whereas spouse reports of pleasing behaviors did. Also in recent studies Jacobson et al. (in press) have suggested that observational coding systems are relatively insensitive to relationship changes produced during behavioral marital therapy. The Goal Attainment measure could be viewed as more objective in that it was specifically tied to observable behaviors, although the individual still subjectively judged, as to whether those behaviors did in fact occur in the relationship. It is arguable that it is the perception of behaviors that is salient to marital adjustment rather than their objective occurrence. The difficulty of attaining relevant objective measures is also an issue in this field, and it has been suggested that use of these measures will be justified only when it has been demonstrated that such systems measure constructs that are not adequately measured by less expensive means (Jacobson et al., in press).

The issue of social desirability factors on measures such as the PAIR and the DAS has been addressed in this chapter. It would also appear logical to presume that any demand characteristics were randomly distributed across both groups and therefore not confounded with differences between groups. As suggested by O'Leary and Turkewitz (1978) research procedures were set up in such a way as to minimise clients investment in impression management, for example ensuring that therapists were absent when questionnaires were completed.
CHAPTER IV
RESULTS AND DATA ANALYSIS

Stage 1. Preliminary Item and Test Analysis

The first part of the preliminary analysis consisted of an item analysis of the Dyadic Adjustment Scale or DAS (Spanier, 1976) using the LERTAP computer program (Nelson, 1974). The means, standard deviations and reliabilities calculated for the pre-treatment DAS couple scores are presented in Table 1. Reliabilities were calculated using Hoyt's ANOVA (internal consistency) method; the reliability for the DAS as a whole was calculated at .84.

Table 1
DAS: Test Statistics

<table>
<thead>
<tr>
<th>Subtests (N = 90)</th>
<th>Con.</th>
<th>Satis.</th>
<th>Coh.</th>
<th>A. Ex.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>41.46</td>
<td>31.63</td>
<td>12.18</td>
<td>6.71</td>
<td>91.98</td>
</tr>
<tr>
<td>S.D.</td>
<td>5.96</td>
<td>5.11</td>
<td>3.55</td>
<td>1.96</td>
<td>11.71</td>
</tr>
<tr>
<td>Reliability (Hoyt)</td>
<td>.73</td>
<td>.78</td>
<td>.79</td>
<td>.58</td>
<td>.84</td>
</tr>
<tr>
<td>Cronbach's (Alpha)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>.57</td>
</tr>
</tbody>
</table>

Note: Consensus contains 13 items
Satisfaction contains 10 items
Cohesion contains 5 times
Affectional expression contains 4 items
The relatively low reliability of the Affectional Expression subscale would appear to be a reflection of the lack of variance on this scale. Most of the items on the test correlated at a positive and adequate level with other test items and the overall reliability of the subscales appears to be satisfactory. The Cronbach's Alpha level for the total test (.57) suggests that four separate but related aspects of marital adjustments are being measured by this test. The Hoyt reliability for the total (.84) reflects the intercorrelation of all test items (32); the Cronbach's alpha coefficient reflects the intercorrelation of the four subscales. Some items correlated at less than a .30 level with the other subscale items particularly on the Consensus subscale (5 items out of the 13). This suggests that consensus concerning subjects such as ways of dealing with inlaws or parents and philosophy of life may not be as related to the concept of marital adjustments as consensus regarding other more dyadically focussed issues such as the amount of time spent together. Subtest correlations are given in Table D-1, Appendix D.

Reliabilities were also calculated for the scores of males and females independently. The reliability for the males on the total test being .86 and for the females .80; these data are presented in Tables D-2 and D-3 in Appendix D.

The subscales of the Personal Assessment of Intimacy in Relationships Inventory or PAIR which was constructed by Schaeffer and Olson (1981) were also subjected to an item analysis. The Perceived part of this test contains six subscales and the Expected part only five since the subscale Conventionality is not included in the second part of the test. The means, standard deviations and reliabilities for the PAIR
Perceived and for the PAIR Expected subscales are presented in Tables 2 and 3 respectively.

Table 2
PAIR Perceived: Test Statistics

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>10.60</td>
<td>13.89</td>
<td>14.09</td>
<td>12.18</td>
<td>15.06</td>
<td>11.38</td>
</tr>
<tr>
<td>S.D.</td>
<td>4.56</td>
<td>4.48</td>
<td>5.47</td>
<td>4.22</td>
<td>4.13</td>
<td>3.92</td>
</tr>
<tr>
<td>Reliability (Hoyt)</td>
<td>0.69</td>
<td>0.64</td>
<td>0.79</td>
<td>0.57</td>
<td>0.72</td>
<td>0.67</td>
</tr>
</tbody>
</table>

Note: Possible range = 0 to 24
All subscales contain 6 items.

Although this test was not constructed to yield a total score the Hoyt reliability for the perceived form of the total test was computed as 0.87 and the Cronbach's Alpha for the composite as 0.77. The reliability for the Intellectual subscale is relatively low, and may be the result of items one and four correlating at below the .30 level with the rest of the subscale items. This suggests that experiencing a partner as helping to clarify one's thoughts (item one) or finding that it is useless to discuss some issues together (item four) may not be of the same relevance to a distressed couple as the experience of relating to a partner who frequently tries to change one's ideas or frequently "puts down" their partner in a serious discussion. Items such as the last two mentioned would seem to relate to the coercive patterns of interaction found more frequently in distressed couples than items one
and four. The .57 reliability of this subscale however still seems adequate given the small number of items (6). The subtest correlations for the PAIR Perceived are given in Table D-4, Appendix D. The means, standard deviations and reliabilities for males and females scored independently are to be found in Table D-5, Appendix D. The reliabilities for the female scores seem to be somewhat lower however the standard deviations are also smaller suggesting a lowered reliability due to lack of variance. The interpretation of the Conventionality subscale as Idealisation is supported somewhat by the fact that this subscale was found to correlate with the DAS subscale Satisfaction at the .78 level for male subjects and the .60 level for female subjects in this sample.

The PAIR Expected scores represent the couple’s ideal of how the relationship should be in the five areas of intimacy included in the test. The means, standard deviations and reliabilities for the PAIR Expected are presented in Table 3.

Table 3
PAIR Expected: Test Statistics

<table>
<thead>
<tr>
<th>Subtests (N = 90)</th>
<th>Em.</th>
<th>Soc.</th>
<th>S</th>
<th>Int.</th>
<th>Rec.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>22.03</td>
<td>18.62</td>
<td>22.48</td>
<td>21.13</td>
<td>21.12</td>
</tr>
<tr>
<td>S.D.</td>
<td>1.97</td>
<td>2.99</td>
<td>2.08</td>
<td>2.48</td>
<td>2.42</td>
</tr>
<tr>
<td>Reliability (Hoyt)</td>
<td>.60</td>
<td>.52</td>
<td>.62</td>
<td>.52</td>
<td>.50</td>
</tr>
</tbody>
</table>

Note: Hoyt for total = .78  
Cronbach's Alpha = .70  
All subtests contain 6 items
These reliabilities are lower than those of the PAIR Perceived subscales. Once again however standard deviations are also low; couples tended to answer many of the items in a similar fashion. This suggests that on these scales and in this sample people's ideals as to what constitutes a good relationship did not differ to any great extent. The subtest correlations for the PAIR Expected are given in Table D-6, Appendix D. The means, standard deviations and reliabilities for males and females scored independently are to be found in Table D-7, Appendix D.

An item analysis was conducted on the Couples Therapy Alliance Scale (Pinsoff & Catherall, 1983) and the means, standard deviations and reliabilities are presented in Table 4.

Table 4
Couples Therapy Alliance Scale: Test Statistics

<table>
<thead>
<tr>
<th>Subtests (N = 60)</th>
<th>Self</th>
<th>Other</th>
<th>Relationship</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>46.12</td>
<td>44.55</td>
<td>25.17</td>
<td>115.83</td>
</tr>
<tr>
<td>S.D.</td>
<td>5.58</td>
<td>5.95</td>
<td>3.30</td>
<td>14.04</td>
</tr>
<tr>
<td>Reliability (Hoyt)</td>
<td>.88</td>
<td>.92</td>
<td>.85</td>
<td>.96</td>
</tr>
<tr>
<td>Cronbach's (Alpha)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>.91</td>
</tr>
</tbody>
</table>

Note: Total observed range = 81-140
Total possible range = 0 - 140, 28 items
Each item in this instrument correlated at a positive and adequate level with the other test items. Thus each item can be said to be performing correctly. The overall reliability of the test for this sample of subjects seems to be very satisfactory. The Cronbach's Alpha level for the total test (.91) suggests that the subtests are correlated to the point that they may be considered as a unit rather than as separate factors. The means on all the subtests are relatively high which implies that the alliance of couples and therapists in this sample was in general positive; that is that couples were able to bond with their therapist, perceived the therapist as working with them towards the same goals and viewed the therapist as skilled and able to help change their relationship.

Stage II: Testing Assumptions of Group Equivalence

An analysis of variance was conducted on each of 8 demographic variables (group by demographic variable). Number of Years Together, Family Income, Level of Occupation of both spouses, Age of both spouses, and Level of Education of both spouses. No significant differences were found on these factors when tested at the .05 level of significance corrected by the Bonferroni procedure (Hays, 1981). Details of this analysis may be found in Table E-1, Appendix E.

Individual responses on the subscales of the Test of Emotional Style (Allen & Hamsher, 1974), namely Orientation, Expressiveness were also analysed using an analysis of variance (group by male and female subscales). In this analysis no significant differences were found between groups on any of the three subscales. The critical significance
level was set at .05, corrected by Bonferroni (.05/6 = .008). The means, standard deviations and p values are presented in Table E-2, Appendix E.

The scores of the two treatment groups on the Couples Therapy Alliance Scale (Pinsof & Catherall, 1983), were analysed in order to test the assumption that there was no significant group differences in the quality of the alliance between therapist and couple. If a significant difference existed it would present a confounding factor in the interpretation of treatment effects. The means on this scale for both groups were relatively high (maximum possible is 140), the EF couples mean score being 121.3 (SD = 19.8) and the PS couples mean score being 113.6 (SD = 10.9). The higher mean in the EF group might be expected in a treatment in which the therapist focusses upon emotional experience rather than the teaching of skills since the former tends to create bonds between therapist and client. The results of the analysis of the couples alliance scores are presented in Table 5. No significant differences were found in this analysis or in an analysis of male and female alliance scores considered seperately, (Table E-3, Appendix E), or in an analysis of the individual subtests of the Alliance Scale.

Since the Task dimension of this scale was considered particularly relevant in that it reflects how relevant and engaging couples found the therapeutic interventions to be; an additional analysis was conducted on the items pertaining to this dimension. The means of both groups on this dimension were high; the maximum possible score was 50, and the mean of the EF couples was 42.6 (SD = 4.6), while the PS couples mean was 41.7 (SD = 4.2). No significant differences were found between
Table 5

Summary Anova: Couple Therapy Alliance Scale

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>SS</th>
<th>MS</th>
<th>DF</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
<td>433.2</td>
<td>433.2</td>
<td>1</td>
<td>1.69</td>
<td>.204</td>
</tr>
<tr>
<td>Within (N = 30)</td>
<td>7,178.2</td>
<td>256.4</td>
<td>28</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

treatment groups on this variable. Details of the results may be found in Table E-4, Appendix E. These results suggest that both groups had similar expectations as to the effectiveness of the treatment they were offered and found both treatments relevant to their concerns.

Differential therapist effects were tested by a series of oneway analyses of variance (Therapist (N = 12) by each post-measure) in which therapists were treated as a fixed factor. Although 18 analyses on male and female post-treatment scores were conducted and a Bonferroni procedure would then result on a critical significance level of \( .05/18 = .0027 \), these analyses were not significant even at the .01 level. The details of these analyses are to be found in Tables E-5 and E-6, Appendix E.

Before analysing treatment outcome data it was necessary to confirm that the treatments were implemented in accordance with the manuals. For the purpose of this implementation check a total number of 120 out of the 240 sessions were observed. The sessions to be observed were chosen at random. Two segments of 10 minutes duration were taken from
the middle and final third of these 120 sessions. Each couple was thus observed during therapy for a total of 80 minutes. These segments were rated from video and audio tapes by two trained independent raters and coded on the Implementation Checklist. This Checklist consists of 23 coding categories, 3 of which were general categories, the remaining categories describing 10 interventions characteristic of each of the treatments. An intervention was defined as a complete therapist statement, the beginning and end of which was noted by the raters to ensure that they were both coding the same units. In all 1866 interventions were coded by the raters who were blind as to the treatment condition they were observing.

Out of the 1866 interventions coded 47 were categorised in such a way as to be inappropriate to the treatment condition being observed. Thus in total 2.5% of the total interventions observed were rated as belonging to inappropriate categories. Of these 47 inappropriate interventions 15 occurred in the Problem Solving condition and 32 in the Emotionally Focussed condition. This may reflect the fact that the former treatment is by nature somewhat more structured and easily delineated. In the Problem Solving treatment the emotionally focused intervention most often used was intervention number 7, where the therapist probes for emotional experience, for example by asking one spouse "how do you feel when he does that". In the Emotionally Focussed treatment the problem solving intervention most often used was number 8 where the therapist helps the couple pinpoint specific behaviors, for example by asking, "and when he does this what do you do, how you react". These kinds of questions would seem to be necessary no matter what kind of therapeutic model the therapist is using.
The small proportion of interventions appropriate to the other treatment suggests that the treatments were very easily distinguishable and able to be implemented according to the therapy manuals.

Inter-rater reliability was calculated on 406 observations taken from 25 randomly chosen sessions (20.8% of the total sessions observed). The two raters agreed on 379 of the interventions observed (93% agreement). The 27 disagreements which occurred between raters consisted of 2 cross treatment $(n = 2)$ disagreements, and 25 cross intervention $(n = 20)$ disagreements. Inter-rater reliability was calculated using Cohen's (1960) statistic Kappa. This statistic is a conservative estimate of reliability corrected for the proportion of agreement to be expected by chance alone. The Kappa statistic for between treatment agreement was then computed as .99. The Kappa statistic for inter-rater agreement as to interventions (within treatments) was computed as .95. These statistics suggest that treatments and interventions were able to be reliably differentiated.

At the end of Stage 2 of the analysis it was then possible to assert that no statistically significant differences were found between experimental groups on Demographic variables or the Test of Emotional Style, and that treatment groups were not significantly different in terms of therapeutic alliance. Therapist effects were tested for and found to be non-significant; also Implementation Checks and the inter-rater reliability on these checks were found to be satisfactory, for the purposes of this investigation.
Stage III: Analysis of Treatment Effects: Pre-Test Post-Test and Follow-Up Measures

Pre-Treatment Measures

The final stage of the analysis began with an examination of pre-treatment DAS and PAIR scores to assess whether there were any important initial differences between the three experimental groups. Analyses of variance were computed on these measures and no significant differences were found (the significance level being set at .05). The multivariate F statistic being $F_{(20,68)} = .83, p < .665$. The couples' pre-test scores on the total DAS are presented in Table 6. The mean for couples scores (male plus female scores divided by 2) was calculated as 92.1. The mean for the EF group being 92.8 (SD = 8.8), for the PS group 91.7 (SD = 8.1) and for the Control group 91.9 (SD = 10.7). Scores for all three groups ranged from 71 to 105. The homogeneity of variance assumption was checked and no significant differences found; Bartlett Box $F = .59, p < .555$.

Table 6

Summary Anova: Pretest DAS Couple Scores

(N = 45)

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>SS</th>
<th>MS</th>
<th>DF</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
<td>10.8</td>
<td>5.4</td>
<td>2</td>
<td>.06</td>
<td>.940</td>
</tr>
<tr>
<td>Within</td>
<td>3,645.8</td>
<td>86.8</td>
<td>42</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
The means, standard deviations, F ratios and P values for the pre-treatment PAIR Perceived scores are presented in Table 7. There were no significant differences between groups on these six subscales. The subscale means here are comparable to those of Schaefer and Olson's original sample referred to in Chapter 3.

Couples appeared to experience great difficulty completing the Expected subscales on the PAIR during both assessment and termination procedures. This was perhaps because of the double negatives involved in the wording of the Expected part of this instrument. For example, agreeing or disagreeing with whether "when it comes to having a serious discussion it seems we have little in common" is the ideal for a relationship. The assessors assisted the couples in completing these scales whenever possible but the relatively low reliability reported for these sub-tests may be not only a result of the homogeneity of responses but the result of a large amount of error variance. The Expected subscales were included originally in the PAIR to provide a reference point for the Perceived subscales. Since these subscales were administered three times it was decided that the three sets of Perceived scores served as valid reference points for each other and that it might be preferable to use only the Perceived scales as an outcome instrument rather than the differences between Perceived and Expected scores.

First it was necessary to test for differences in pre-test and post-test Expected scores.

No statistically significant differences were found between groups on the pre-test PAIR Expected subscales ($\alpha = .05$). The means, standard deviations, F ratios and P values for these subtests are presented in
# Table 7

Pre-Test PAIR Perceived Couple Scores

<table>
<thead>
<tr>
<th>Variables</th>
<th>ET</th>
<th>PS</th>
<th>C</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M/SD</td>
<td>M/SD</td>
<td>M/SD</td>
<td>(2,42)</td>
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</tr>
<tr>
<td>(N = 45)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP1 (Em)</td>
<td>52.3</td>
<td>53.1</td>
<td>52.5</td>
<td>.01</td>
<td>.990</td>
</tr>
<tr>
<td></td>
<td>13.7</td>
<td>15.2</td>
<td>18.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP2 (Soc)</td>
<td>57.5</td>
<td>56.1</td>
<td>53.1</td>
<td>.32</td>
<td>.732</td>
</tr>
<tr>
<td></td>
<td>14.4</td>
<td>16.6</td>
<td>15.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP3 (Sx)</td>
<td>54.5</td>
<td>57.2</td>
<td>57.1</td>
<td>.09</td>
<td>.917</td>
</tr>
<tr>
<td></td>
<td>22.7</td>
<td>18.8</td>
<td>17.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP4 (Int)</td>
<td>52.0</td>
<td>48.1</td>
<td>46.0</td>
<td>.89</td>
<td>.419</td>
</tr>
<tr>
<td></td>
<td>9.4</td>
<td>11.3</td>
<td>15.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP5 (Rec)</td>
<td>61.2</td>
<td>61.1</td>
<td>57.7</td>
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</tr>
<tr>
<td></td>
<td>11.9</td>
<td>15.5</td>
<td>14.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP6 (Con)</td>
<td>37.3</td>
<td>37.1</td>
<td>38.7</td>
<td>.06</td>
<td>.939</td>
</tr>
<tr>
<td></td>
<td>10.0</td>
<td>8.8</td>
<td>17.8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table E-7, Appendix E. The multivariate $F$ statistic $(10, 78)$ on these subscales was calculated at $0.62$, $p < 0.794$. There were also no significant differences found on any of the post-test PAIR Expected subscales; the multivariate $F$ statistic $(10, 78)$ being computed at $0.42$, $p < 0.930$. The means, standard deviations, $F$ ratios and $P$ values of these subscales are presented in Table E-8, Appendix E. In addition a repeated measures analysis of variance (BMDP version, Dixon, 1981) was conducted on the pre-test and post-test treatment PAIR Expected scores to ascertain if couples changed their ideals as a result of treatment. No significant changes or group by time interactions were found on any of the subscales ($\alpha = 0.05/5 = 0.01$, corrected by the Bonferroni procedure). The details of this analysis are reported in Table E-9, Appendix E. All these non-significant results suggested that any significant variation between groups would be found in the Perceived scores. In light of the above concerns and analyses it was then decided to set aside the Expected subscales and take the Perceived subscales as the outcome variable. All subsequent analyses then considered only the PAIR Perceived subscales.

On the Target Complaints measure couples described their major concern in their relationship which was then designated as the focus for therapeutic change. None of the spouses presented complaints which were incompatible with each other and all appeared to be relevant to the couples at termination and follow-up.

Couples also described in behavioral terms five levels of treatment goals. The level designated as "less than expected results" described three observable behaviors and one feeling reaction characterizing the relationship at the time of assessment.
Post Treatment Measures

The total DAS couples score could not be included in the multivariate analysis since this score was not independent of the DAS subscales. A separate univariate analysis was then conducted on this measure and is presented in Table 8. These scores are post-treatment for the ET and PS groups and post-wait for the Control group. The mean for the EF group was computed as 112.7 (SD = 10.8), for the PS group the mean was 102.4 (SD = 9.5), and for the Control group the mean was 91.5 (SD = 9.7). Post hoc comparisons using the Tukey procedure (Glass & Stanley, 1970) found all three groups to significantly differ from each other at the .05 level of significance.

Table 8
Summary Anova: Post-test DAS Total Scores

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>SS</th>
<th>MS</th>
<th>DF</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
<td>3,371.9</td>
<td>1,685.9</td>
<td>2</td>
<td>16.80</td>
<td>.001</td>
</tr>
<tr>
<td>Within</td>
<td>4,215.8</td>
<td>100.4</td>
<td>42</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A MANOVA (SPSS:9 version) was conducted between the three groups over all 12 treatment outcome variables, that is on DAS subscales, Consensus, Satisfaction, Cohesion and Affectional Expression, on PAIR Perceived subscales, Emotional, Social, Sexual, Intellectual and Recreational Intimacy and Conventionality, on Target Complaints and Goal Attainment.
The results of this multivariate analysis of treatment outcome variables are presented in Table 9. The multivariate $F$ statistic (24, 64) was calculated at 4.33, $p < .001$.

In order to guard against the problem of escalating Type 1 error rate, the Bonferroni procedure was used to calculate the critical significance level for each univariate test ($0.05/12 = .004$). At this level of significance differences were found on DAS subscales 1, 2, and 3, PAIR subscales 4 and 6 (DAS subscale 4 and PAIR subscale 1 narrowly missing significance), Target Complaint, and the Goal Attainment Scale.

Post hoc comparisons were conducted on the variables showing significant $F$ ratios using Tukey's procedure to ascertain if mean differences were between treatment groups and Controls or between the two treatment groups or both. These comparisons yielded the following results:

1. Both treatment groups were significantly higher than controls on the variables DAS 1 (Consensus), PAIR 4 (Intellectual Intimacy), Target Complaint, and Goal Attainment.

2. The PS treatment group did not differ significantly from controls on the variables DAS 2 (Satisfaction), DAS 3 (Cohesion), and PAIR 6 (Conventionality), whereas the EF treatment group did differ significantly from controls on these variables.

3. The EF treatment group scored significantly higher than the PS treatment group on the variables DAS 2 (Satisfaction), DAS 3 (Cohesion), PAIR 4 (Intellectual Intimacy), PAIR 6 (Conventionality, here interpreted as idealisation) and Target Complaint improvement.
# Table 9

## Multivariate Analysis of Variance: Treatment Outcome Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Groups</th>
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<tr>
<td></td>
<td>EF</td>
<td>PS</td>
<td>C</td>
<td>F</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>M/SD</td>
<td>M/SD</td>
<td>M/SD</td>
<td>(2,42)</td>
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<td><strong>DAS</strong></td>
<td></td>
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<td></td>
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<tr>
<td>Consensus</td>
<td>48.13</td>
<td>47.53</td>
<td>40.8</td>
<td>8.25</td>
<td>.001*</td>
</tr>
<tr>
<td></td>
<td>3.27</td>
<td>7.42</td>
<td>4.97</td>
<td></td>
<td></td>
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<tr>
<td>Satisfaction</td>
<td>38.43</td>
<td>34.10</td>
<td>31.70</td>
<td>8.60</td>
<td>.001*</td>
</tr>
<tr>
<td></td>
<td>4.86</td>
<td>4.29</td>
<td>4.34</td>
<td></td>
<td></td>
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<tr>
<td>Cohesion</td>
<td>17.27</td>
<td>13.80</td>
<td>11.90</td>
<td>13.91</td>
<td>.001*</td>
</tr>
<tr>
<td></td>
<td>3.18</td>
<td>1.49</td>
<td>3.41</td>
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<tr>
<td>Affectional Expression</td>
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<td>5.12</td>
<td>.010</td>
</tr>
<tr>
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<td>1.55</td>
<td>1.89</td>
<td>1.88</td>
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<td></td>
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<tr>
<td><strong>PAIR</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Emotional</td>
<td>64.13</td>
<td>51.33</td>
<td>45.60</td>
<td>4.68</td>
<td>.015</td>
</tr>
<tr>
<td></td>
<td>17.19</td>
<td>17.49</td>
<td>16.26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social</td>
<td>65.33</td>
<td>56.40</td>
<td>52.26</td>
<td>2.74</td>
<td>.076</td>
</tr>
<tr>
<td></td>
<td>13.52</td>
<td>15.82</td>
<td>17.33</td>
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<tr>
<td>Sexual</td>
<td>69.33</td>
<td>62.80</td>
<td>59.06</td>
<td>.92</td>
<td>.405</td>
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<tr>
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<td>21.59</td>
<td>21.48</td>
<td>19.74</td>
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<tr>
<td>Intellectual</td>
<td>70.26</td>
<td>58.66</td>
<td>43.33</td>
<td>20.29</td>
<td>.001*</td>
</tr>
<tr>
<td>A</td>
<td>11.73</td>
<td>10.52</td>
<td>12.51</td>
<td></td>
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</tr>
<tr>
<td>Recreational</td>
<td>72.0</td>
<td>64.67</td>
<td>57.27</td>
<td>3.98</td>
<td>.026</td>
</tr>
<tr>
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<td>13.46</td>
<td>13.06</td>
<td>16.19</td>
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</tr>
<tr>
<td>Conventionality</td>
<td>64.80</td>
<td>45.07</td>
<td>38.40</td>
<td>7.74</td>
<td>.001*</td>
</tr>
<tr>
<td>B</td>
<td>18.53</td>
<td>17.59</td>
<td>21.05</td>
<td></td>
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</tr>
<tr>
<td><strong>TC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target Complaint</td>
<td>3.70</td>
<td>3.07</td>
<td>1.74</td>
<td>69.89</td>
<td>.001*</td>
</tr>
<tr>
<td>A</td>
<td>.46</td>
<td>.84</td>
<td>.45</td>
<td></td>
<td></td>
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<td><strong>GAS</strong></td>
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</tr>
<tr>
<td>Goal Attainment</td>
<td>60.0</td>
<td>57.33</td>
<td>42.33</td>
<td>31.11</td>
<td>.001*</td>
</tr>
<tr>
<td>C</td>
<td>7.51</td>
<td>8.34</td>
<td>2.29</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: 
- \( p = 0.5/12 = .004 \)
- \( * = p < .004 \)
- A = EF > PS > C on Post Hoc (Tukey)
- B = EF > PS, C on Post Hoc (Tukey)
- C = EF, PS > C on Post Hoc (Tukey)
4. The EF and PS treatment groups did not differ significantly on the variables DAS 1 (Consensus) and Goal Attainment.

Although group differences on the variables DAS 4 (Affectional Expression) and PAIR 1 (Emotional Intimacy) did not reach the level of statistical significance set by the Bonferroni procedure (.004) the trend here was for the EF treatment group mean to be higher; on the DAS 4 subscale the EF mean was higher than both PS and Control groups and on the PAIR 1 subscale the EF treatment mean was higher than the Control. All of these results are summarised in Table 9.

To summarise, both treatment group means were higher than controls on Consensus (DAS), Intellectual Intimacy (PAIR), TC and GAS. Only the EF treatment means were higher than controls on Satisfaction, Cohesion (DAS) and Conventionality (PAIR). After treatment the EF group scored significantly higher than the PS group on the variables Satisfaction and Cohesion (DAS), Conventionality and Intellectual Intimacy (PAIR) and on TC improvement. Results show both treatment and differential treatment effects in favor of the EF treatment.

At the termination of treatment a Post Treatment Standardised Interview was given to the treatment groups, and after the waiting period an Activities While Waiting Questionnaire was administered to the control group.

On the Activities While Waiting Questionnaire the results were as follows. Of the 15 control couples four stated that they had attempted to improve their relationship during the eight week waiting period. Of these couples three had been on some kind of vacation, and stated that this time together had helped somewhat. Two of these couples had also
read self help books during this time. One partner had received advice from a friend concerning his relationship. The couples who were actively seeking to improve their relationship before coming to therapy seemed to try more than one activity, talking to a friend, reading a book, and using holiday time to be together.

In general the responses seem to suggest that the waiting period was not contaminated with other powerful therapeutic variables. The holiday variable would seem to be the most significant and the effect of this was balanced by the treatment couples who also took vacations. In fact the control group mean total DAS scores did not change appreciably during the waiting period; the pre-assessment mean on the DAS scale for this group was 91.9 (SD = 10.9) and the post-wait score was 91.5 (SD = 9.7). The Pearson Product Correlation Coefficient between pre-assessment and post-wait DAS scores was computed as .87 (p < .001). No follow-up was possible with couples in this group since they were placed in treatment after the waiting period.

The results of the Post Treatment Standardised Interview were as follows. All treated couples stated that their relationship had improved as a result of therapy. The couples appeared to characterize the perceived relationship changes in terms of three categories: 1) emotional climate, here couples talked of communication becoming more open and less defensive and the level of trust and sense of safety increasing; 2) awareness of each other and relationship dynamics; 3) new responsiveness to each others needs and a new sense of closeness. The PS group talked more in terms of avoiding issues less and having more skills and tools with which to confront issues. The E.F. group talked
more in terms of perceiving each other differently, for example, "we see how we are acting and reacting to each other." They also spoke of being less blaming and of conflicts becoming less intense. The demand characteristics of this situation for the couple were obvious and to attempt to minimise these as much as possible the assessor attempted to write down exactly what the spouses said and to maintain a distant and neutral stance during the interview.

In response to a question as to what was helpful about therapy both groups spoke of the therapist as creating a safe place to work out issues, fulfilling a mediator role and contributing an objective perspective. The E.F. couples also talked of the therapist helping them to clarify issues and patterns in the relationship; the P.S. couples spoke of the specific discipline and structured techniques the therapist had shown them.

The question concerning critical incidents in therapy elicited more responses from the couples involved in the E.F. therapy than from those involved in the P.S. treatment, as might be expected since the E.F. treatment is based upon the creation of intense emotional experiences. The P.S. couples stated that the therapy process was a gradual process of teaching. One P.S. couple spoke of "dramatic revelations" at home between therapy sessions, another stated that the impact of dealing with his anger successfully was critical for him. Another couple stated that an incident occurred which made it clear that they both felt very committed to the relationship and that this seemed to change the process between them. The E.F. couples described critical incidents in terms of times when vulnerabilities were exposed which resulted in partners
seeing their spouse in a different way and being able to respond positively to this new view of each other. One partner spoke of realising that her spouse needed help from her in knowing how to be close, another of talking of his hurt and his spouse responding to him so that he could decide not to withdraw, another of incidents where he felt emotional rather than "staying logical" and "understanding the pain that our patterns create".

In response to a question concerning factors which hindered progress in therapy or were unpleasant couples spoke of the T.V. cameras, small counselling rooms and the questionnaires. One E.F. spouse spoke of the counsellor expressing feelings in a stronger manner than that spouse was comfortable with, and one spoke of too much focus being placed on the other partners problems. Of the P.S. couples 2 spoke of paraphrasing practice being tedious, one of the couples spoke of not dealing with the main issue, one of emotional issues not being adequately addressed, and one of skill teaching getting in the way of emotional discussions which the couple then had at home.

In response to the question of whether more sessions were needed in the E.F. group two couples said they would have "liked" a few more to resolve issues completely, only one couple stated that they definitely needed more sessions. In the P.S. group eight couples and two individual partners stated that they needed more sessions. This was a surprising finding in that the researcher considered the P.S. treatment to be more easily accomplished in the 8 sessions than the E.F. treatment. It may be perhaps explained in terms of the skill training at times appearing less relevant to couples than the exploration of immediate emotional issues.
These data are impressionistic. They do seem to suggest that the couples indeed experienced the two treatments in ways that are congruent with the intended nature of those treatments. The E.F. treatment was experienced as delving into emotional vulnerabilities and clarifying patterns and the P.S. treatment was experienced by the couples as communication and problem solving skill training.

The Rating of Conflict Resolution

All treatment couples succeeded in attaining agreement concerning the specific request each partner made of their spouse in the last session. The task did not discriminate between couples or treatments. First this may be because of the nature of the task; the requests although relating to the core conflict were often very specific and small, for example, "Can you hug me if I ask you to when I come home at night?" and thus likely to evoke verbal agreement even if the relationship had not changed significantly. Second this task was given by the therapist in the last session and the desire to comply with and please the therapist might be expected to be a key factor in this situation and result in couple agreement. The difficulties of attaining relevant interactional data which can be coded by raters into simple categories is demonstrated by this measure. The Structural Analysis of Social Behavior (Benjamin, 1977) a measure which indexes quality of interaction rather than verbal agreement to a request might be preferable.
Additional Individual Analyses

Although the main unit of analysis in this study was the couple, the researcher decided to also examine individual male and female scores in particular domains such as the DAS and the PAIR Perceived at the termination of treatment.

Preliminary analysis of variance on male and female pre treatment PAIR scores had found no significant differences between groups when the critical level for significance was set at .05. These results may be found in Table E-10, Appendix E. Individual spouses post-test PAIR scores were analysed using a MANOVA (SPSS: 9, Nie, 1975).

In the analysis of post-test scores (Table E-11) for males the multivariate $F (12, 76)$ was computed at $2.38, p < .011$. The only significant univariate $F$ ratios ($\alpha = .05/6 = .008$) were found on subscales 4 and 6, that is Intellectual Intimacy ($F (2, 42) = 11.8, p < .001$) and Conventionality ($F (2, 42) = 7.7, p < .001$). Post-hoc analyses using Tukey's procedure found the mean of the EF group to be significantly higher than PS and Control groups on subscale six, and the mean of the Control group to be significantly lower than PS and EF groups on subscale four. For male spouses the EF treatment seemed then to increase significantly the idealisation of the spouse and the relationship, but no differential treatment effect was found on the variable Intellectual Intimacy.

For Females the multivariate $F (12, 76)$ was computed as $1.98, p < .038$. The only significant univariate $F$ ratios ($\alpha = .05/6 = .008$) were found on Intellectual Intimacy, subscale 4 ($F (2, 42) = 10.9, p < .001$), and Emotional Intimacy subscale I ($F (2, 42) = 6.22, p < .004$).
Post-hoc analyses found the mean of the EF group to be significantly higher than PS and Control groups on subscale 1, and the mean of the EF group to be significantly higher than that of the Controls on subscale 4. For female spouses the EF treatment seemed to increase the Emotional Intimacy in the relationship; this result is lost in the analysis based on the couple unit. There is no significant differential treatment effect on the variable Intellectual Intimacy when female scores are considered separately. When both spouses are considered however this variable is significantly effected by the EF treatment. Details of these analyses may be found in Table E-11, Appendix E.

Individual spouses post-test DAS scores were analysed using a MANOVA (SPSS: 9, Nie, 1975). For Males the multivariate $F$ (8, 80) was computed as 3.35, $p < .002$. The only significant univariate $F$ ratios ($\alpha = .05/4 = .0125$), were found on the subscales 2, Satisfaction ($F (2, 42) = 8.39, p < .001$) and 3, Cohesion ($F (2, 42) = 11.85, p < .001$). Subscale 1, Consensus, narrowly missed reaching the critical level for significance ($p < .015$). Post-hoc analyses using Tukey's procedure found the mean of the EF group to be significantly higher than PS and Control groups on subscales 2 and 3.

For Females the multivariate $F$ (8, 80) was computed as 3.61, $p < .001$. All univariate $F$ ratios ($\alpha = .05/4 = .0125$) were found to be significant. Post-hoc analyses using Tukey's procedure found the control group mean to be lower than both treatment means on subscale 1, Consensus. Only EF and Control group means differed significantly on the subscale Satisfaction. On subscale 3 - Cohesion, and 4 - Affectional Expression, the mean of the EF group was found to be
significantly higher than those of the PS and Control group. The only additional information added by this individual analysis would seem to be that subscale 4, Affectional Expression while not reaching the required level of significance in the couples analysis appears to have been significantly affected by the EF treatment when female spouses are considered separately. The details of these analyses are presented in Table E-12, Appendix E.

The male and female scores on Target Complaints were consistently similar across groups and were similar to the results of the analysis of couples scores. The male mean score for the EF group was 3.7 (SD = .62) and the female mean score was 3.7 (SD = .46); the male mean score for the PS group was 3.1 (SD = .88) and the female mean score was 3.1 (SD = 1.2). The wait list male and female means were also very close, 1.4 (SD = .63) and .93 (SD = .46) respectively at the post-wait assessment.

The Goal Attainment means showed a similar pattern. The male and female means in the EF group being computed as 60 (male SD = 8.6, female SD = 7.7); in the PS group the male mean was 56.7 (SD = 9.2) and the female mean was 58.0 (SD = 9.1). The wait list group male mean after the waiting period was 42 (SD = 3.8) and the female mean was 42.7 (SD = 2.6).

**Follow-Up Measures**

Eight weeks after termination of treatment couples completed follow-up measures. All couples except one returned the follow-up data (n = 29). The hypotheses of the study concerned possible differential effects of the two treatments EF and PS. The main focus of the
follow-up was then to examine whether the differential effects found at treatment termination would also be found at follow-up.

On a preliminary repeated measures analysis of variance of total DAS scores for the two treatment groups significant differences were found; \( F(1, 27) = 9.4, p < .0049 \). The mean for the EF group (\( n = 15 \)) at follow-up was 112.4 (SD = 11.2) and for the PS group was 101.1 (SD = 8.9). No significant effects were found for Time, or Time by Group Interactions. These results are summarised in Table 10.

Table 10

Summary Repeated Measures Anova: Total DAS Follow-Up Scores

(\( N = 30 \))

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>SS</th>
<th>MS</th>
<th>DF</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>1,762.7</td>
<td>1,762.7</td>
<td>1</td>
<td>9.38</td>
<td>.005</td>
</tr>
<tr>
<td>Error</td>
<td>5,076.4</td>
<td>188.0</td>
<td>27</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Time</td>
<td>5.2</td>
<td>5.2</td>
<td>1</td>
<td>.25</td>
<td>.620</td>
</tr>
<tr>
<td>Time by Group</td>
<td>1.3</td>
<td>1.3</td>
<td>1</td>
<td>.06</td>
<td>.805</td>
</tr>
<tr>
<td>Interaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Error</td>
<td>554.2</td>
<td>20.5</td>
<td>27</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

A multivariate repeated measures analysis of variance (2 times, that is termination and follow-up, by 2 groups, and the 5 differentiating outcome variables) was then conducted on the variables, Satisfaction and Cohesion (DAS 2 and 3), Intellectual Intimacy and Conventionality (PAIR 4 and 6) and Target Complaints. These variables had differentiated between treatment groups at termination. At follow-up the
multivariate F statistic was significant, $F(5, 23) = 3.67$, $p < .014$. Thus when all five differentiating variables were considered together there was an overall statistically significant difference in favor of the EF treatment between the treatment groups at follow-up. This analysis was conducted using the SPSS:X program (SPSS, 1983). The results may be found in Table 11. Once again to avoid escalating Type I error the critical significance level was corrected using Bonferroni's procedure ($0.05/5 = 0.01$). In this analysis no significant time effects or time by group interactions were found; this suggests that the means of the groups did not change significantly from post-treatment to follow-up. The variable Conventionality failed to differentiate between the two groups at follow-up. An examination of means revealed that the EF group appeared to regress on this variable during the eight weeks after treatment. The variables Intellectual Intimacy and Target Complaint just failed to reach significance ($p > .014$) in this analysis. The consistency of the trend in results and the narrow margin by which these means missed the critical level for significance suggests that with a larger sample or more powerful instruments these variables might have been found to be significantly different. The variables Satisfaction, $F(1, 27) = 8.48$, $p < .007$, and Cohesion, $F(1, 27) = 15.89$, $p < .005$, remained significantly higher in the EF group. The EF group then maintained significantly higher levels of Satisfaction and Cohesion as well as higher total DAS scores (which included the Satisfaction and Cohesion subscales) over the eight weeks following treatment than did the PS group.
Table 11
Repeated Measures Analysis: Follow-Up Scores on Differentiating Variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>EF</th>
<th>PS</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M/SD</td>
<td>M/SD</td>
<td>(1,27)</td>
<td></td>
</tr>
<tr>
<td>Satisfaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(DAS) I</td>
<td>38.6 (4.8)</td>
<td>34.0 (4.2)</td>
<td>G 8.48</td>
<td>.007*</td>
</tr>
<tr>
<td>(DAS) II</td>
<td>38.3 (4.8)</td>
<td>34.1 (3.0)</td>
<td>T .03</td>
<td>.855</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cohesion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(DAS) I</td>
<td>17.6 (3.3)</td>
<td>13.9 (1.3)</td>
<td>G 15.89</td>
<td>.001*</td>
</tr>
<tr>
<td>(DAS) II</td>
<td>16.9 (3.2)</td>
<td>13.6 (1.8)</td>
<td>T 2.11</td>
<td>.158</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>3.8 (.35)</td>
<td>3.3 (.99)</td>
<td>G 6.87</td>
<td>.014</td>
</tr>
<tr>
<td>II</td>
<td>3.7 (.46)</td>
<td>3.1 (.86)</td>
<td>T .97</td>
<td>.335</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intellectual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Int. (PAIR) I</td>
<td>70.3 (11.7)</td>
<td>58.3 (10.8)</td>
<td>G 6.87</td>
<td>.014</td>
</tr>
<tr>
<td>Int. (PAIR) II</td>
<td>68.7 (16.3)</td>
<td>58.6 (14.2)</td>
<td>T .06</td>
<td>.809</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conventionality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(PAIR) I</td>
<td>64.8 (18.5)</td>
<td>45.0 (18.2)</td>
<td>G 5.38</td>
<td>.028</td>
</tr>
<tr>
<td>(PAIR) II</td>
<td>55.5 (22.3)</td>
<td>44.6 (19.3)</td>
<td>T 2.47</td>
<td>.128</td>
</tr>
</tbody>
</table>

Note: EF, n = 15; PS, n = 14
α = .05/5 = .01
G = Group F statistic
T = Time F statistic
TG = Interaction, Time and Group
* = p < .01
The variables which did not differentiate between treatment groups at termination of treatments were also analysed to assess whether treatment had created effects that were not immediately apparent at post assessment, so called "sleeper effects". These variables were Consensus and Affectional Expression (DAS 1 and 4), Emotional, Social, Sexual and Recreational Intimacy (PAIR 1, 2, 3 and 5), and Goal Attainment. The multivariate F statistic was not significant, \( F(7, 21) = 1.26, p < .315 \), and none of the univariate F ratios on these variables reached the critical level for significance \((.05/7 = .007)\). Thus there was no statistically significant evidence found for any treatment "sleeper" effects. The results of this analysis may be found in Table E-13, Appendix E. There were no significant Time or Time by Group Interactions found in this analysis.

**Additional Individual Analysis on Follow-Up Data**

As with post-treatment data additional individual analyses were conducted on follow-up data.

A preliminary repeated measures analysis of variance on both male and female total DAS scores found significant differences between groups; the F ratios being computed at \( F(1, 27) = 9.08, p < .006 \), and \( F(1, 27) = 7.48, p < .011 \) respectively. The mean for the EF males was 113.0 (SD = 11.4) and for the PS males was 102.2 (SD = 10.0). The means for the EF females was 111.8 (SD = 12.0) and for the PS females was 100 (SD = 10.0). No significant Time effects or Time by Group Interactions were found. Results are shown in Table E-14, Appendix E.
A repeated measures analysis of the variables which differentiated between the treatment groups at termination and the variables which did not differentiate between the groups was conducted for males and females using the BMPD program (Dixon, 1981). The results for the individual analysis of differentiating variables that is for Satisfaction and Cohesion (DAS 2 and 3), Intellectual Intimacy (PAIR 4 and 6), and Target Complaints are found in Table E-15, Appendix E. The results for the non-differentiating variables may be found in Table E-16, Appendix E. No significant Time or Time by Group Interaction effects were found in either of these analyses.

As can be seen in Table E-15 when scores on the differentiating variables are analysed individually the female means miss the critical significance level (.01) except for Cohesion; this significant result however is best considered as a Type 1 error, since the overall multivariate F is not significant, \( F(5, 23) = 2.31, p < .077 \); the male means however were found to be significantly different in the EF and PS groups on the variables Satisfaction, and Cohesion, with Target Complaints just missing the critical level for significance; the overall multivariate F was computed at, \( F(5, 23) = 5.75, p < .001 \). The EF treatment appears then to have shown a differential effect on the level of male satisfaction and cohesion at follow-up whereas effects on female Satisfaction and Cohesion were not statistically significant.

As Table E-16 shows none of the non-differentiating variables were found to be significantly different for males (multivariate F (7, 21) = 1.16, p < .37) or females (multivariate F (7, 21) = 1.09, p < .40) in the treatment groups at follow-up.
Descriptive Data

Authors such as Gurman and Kniskern (1978) have emphasised that outcome studies must include information on deterioration as well as on improvement. All the instruments used in this study except observed conflict resolution allowed for deterioration of the relationship during the process of therapy. Jacobson Follette and Elwood (in press) stated that in research in behavioral marital therapy approximately 5% of treated couples actually deteriorate, in this study that would mean 1-2 couples would show scores deteriorating to the point of statistical significance. In fact none of the treated couples total adjustment scores decreased to this point. The post-treatment scores of 2 couples dipped below pre-treatment scores by 5 and 4 points (both couples were in the PS group) and 2 couples follow-up scores dipped below their pre-treatment scores, an EF couple by 7.5 and a PS couple by 2 points. One decision to separate was reported by a couple in the PS group after treatment termination but this separation was amicable and by mutual consent.

Another way of viewing the data is in terms of effect size (Cohen, 1977). Here the difference in means between treatment groups and controls is divided by the standard deviation of the control group; this provides an estimate of the magnitude of change. In this study if the couples post-treatment total dyadic adjustment score for each treatment group (112.7 for the EF group, 102.4 for the PS group) is subtracted from the mean of the control group (91.5) and divided by the standard deviation for that group (9.7) the effect sizes are 2.19 for the EF group and 1.12 for the PS group. The mean effect of the affectively
focussed treatment, EF, is then over two standard deviations from the mean of the control measured after the waiting period. This would seem to be a sizable treatment effect. However this statistic does not address the issue of variability in outcome across a sample of subjects. The eta statistic for the total post DAS couples scores was computed at .67; that is 45% of the variance in the total DAS score after treatment was able to be explained by group membership. Thus a significant amount of the variance in this variable was attributable to group membership.

Another way of viewing the data suggested by Jacobson et al. (in press) is to report the proportion of treated couples who improve. Jacobson et al. (in press) suggest as a criteria for improvement that a couple change from pre-test to post-test by at least 1.96 SE. However since control group couples changed very little in this sample (SD. for change scores in the control group = 5.38, $\bar{X} = 1.07$) the statistic suggested above is equal to 4.22 in this sample. Since this seems small as a criterion for improvement the standard deviation of the DAS (SD, 17.8) reported by Spanier (1976) is used here as the basis for criterion for improvement. If then the criterion established for improvement is a rise in total adjustment score of 17 - 18 points, then 10 EF couples (66%) and 6 PS couples (40%) met this criterion at post-assessment. At follow-up 9 EF couples (60%), (2 couples just failing to reach the criterion with a 16 point improvement) and 4 PS couples (26%) met the criterion. These data are displayed in Table 12.
Table 12
Percentages of Couples Improved on Total DAS

<table>
<thead>
<tr>
<th>Group</th>
<th>Post-Test n</th>
<th>Improved</th>
<th>Unimproved</th>
<th>Follow-Up n</th>
<th>Improved</th>
<th>Unimproved</th>
</tr>
</thead>
<tbody>
<tr>
<td>EF</td>
<td>15</td>
<td>66</td>
<td>34</td>
<td>15</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td>PS</td>
<td>15</td>
<td>40</td>
<td>60</td>
<td>14</td>
<td>26</td>
<td>74</td>
</tr>
<tr>
<td>C</td>
<td>15</td>
<td>0</td>
<td>100</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Improvement = 17 points on total DAS.

Another way of viewing the data is to consider not the amount of change but the point at which couples finish. Do couples come out of therapy non-distressed? If the criteria for non-distressed is a score of 114 or over on the total post-treatment adjustment score (114.8 being Spanier's mean for married couples) then 7 of the EF couples qualified as non-distressed at post-test and follow-up assessment (46%), and 2 of the PS couples qualified at post-assessment and follow-up (13%). The mean of the EF group, 112.7, is however very close to Spanier's norm. If the criteria for marital happiness are made a little less stringent and taken as 114.8 means half of a standard deviation (17.8/2 = 8.9) then couples scoring above 106 would be considered non-distressed. In this case 13 of the EF couples (86%) and 6 of the PS couples (40%) would be considered non-distressed at post-assessment and 11 EF couples (73%) and 4 PS couples (27%) would be considered non-distressed at follow-up.
The same kind of analyses can be applied to other outcome measures such as Target Complaint. In the EF group 14 couples scored 3 or above (somewhat improved) at post-assessment and at follow-up, in the PS group 11 couples scored 3 or above at post-assessment and 7 reached this level at follow-up (n = 14). In the EF group nine couples scored four (very much improved) at post assessment and seven at follow-up. In the PS group four couples scored at this level at post assessment and one reached this level at follow-up. The differences in group means at pretest post-test and follow-up assessment on total adjustment scores are shown in Figure I.
Figure 1. Group Means on Total DAS Couple Scores at Pretest, Posttest and Follow-up Assessment.

DAS SCORES

TIME OF ASSESSMENT

NOTE:  
EF = ▲
PS = ■
C = ●

No F measures were possible on the C group.  
Spaniers (1976) sample mean for non-distressed couples = 114  
At F the PS group mean is based on n = 14
CHAPTER V
DISCUSSION OF RESULTS

Summary

The purpose of this study was to delineate an emotionally focussed experiential treatment for marital conflict in distressed relationships, to test this treatment empirically and to compare its effectiveness with a problem solving skill oriented behavioural treatment which had already received extensive empirical validation. The forty-five couples who participated in the study were recruited from a newspaper article and randomly assigned to one of the two treatment groups or the wait list control group. Each couple in the treatment groups received eight sessions of conjoint marital therapy implemented according to the two treatment manuals. Implementation checks found that treatments were able to be reliably differentiated and were implemented in accordance with the manuals. No significant differences were found between couples in the three groups on demographic variables, a measure of emotional style, or pre-measures of marital adjustment and intimacy. There were also no differences found between the two treatment groups on a measure of the quality of the couples alliance with their therapist. The twelve therapists (six implementing each treatment) were balanced as to experience and education and no evidence was found to suggest differential therapist effects. A multivariate analysis of post-measures of marital adjustment, intimacy, reduction in target complaint, and goal attainment found that couples in both treatments reported significantly more therapeutic gains than those in the control group. Both treatment
groups were superior on the measure of total marital adjustment, on the consensus aspect of this adjustment, on the measure of intellectual intimacy, improvement in the target complaint and goal attainment. A differential treatment effect was also found. There were significant differences between treatments in favor of the emotionally focussed treatment on the total adjustment score, satisfaction and cohesion aspects of marital adjustment, on a measure of intellectual intimacy, idealisation of the spouse and the relationship and on the amount of improvement in the target complaint. Thus significant evidence was found to substantiate both research hypotheses concerning the overall effectiveness of both treatments and the existence of differential treatment effects. At follow-up the emotionally focused treatment continued to show significantly greater overall effects compared to the Problem Solving treatment, and significantly greater specific effects on the total DAS score and on the Satisfaction and Cohesion aspects of this score. Differences between treatment groups on the variables Target Complaint Improvement and Intellectual Intimacy just failed to reach the critical significance level; the trend however remained consistently in favor of the Emotionally Focused treatment.

Discussion

The primary significance of these results is that a treatment for marital distress which does not focus upon changing behaviour has been tested empirically and found to be effective. Gurman has suggested (1978) that the psychodynamic model has tended to offer ways of understanding intimate relationships rather than a clear set of
interventions or a technology for the process of therapy. In this study specific interventions directed towards alleviating marital conflict were stipulated in a therapy manual, implemented according to that manual, monitored during implementation, and tested as to their effectiveness. This would seem to represent an advance in the field of marital therapy and suggests that focusing upon inner experience as it is translated into relationship events during interaction, may be a powerful tool for changing the nature of relationships.

The finding that the Problem Solving (PS) treatment implemented in the manner of Jacobson and Margolin (1979) was effective is consistent with all the previous research on the Problem Solving treatment (Jacobson, 1977, 1978, 1979, Jacobson & Anderson, 1980) and further supports the assumption that skill training of this type does help couples learn to negotiate and change target behaviours. The PS treatment increased the total adjustment level (DAS) and the amount of consensus between partners as well as, their ability to share ideas and talk about issues with understanding (intellectual intimacy). It also facilitated the attainment of treatment goals formulated in terms of reaching a predetermined level on three specific behaviours, as well as an improvement in target complaint.

However as Jacobson (1983) suggests teaching couples positive control strategies may change behaviour without improving either the cognitive or affective components of marital satisfaction, especially since trust would seem to be constituted by independence from immediate contingencies and it is this independence which characterises positive marital relationships. Murstein et al. (1977) found that a quid pro quo
conception of a relationship where spouses negotiate for reciprocal exchanges was inversely related to marital satisfaction and only worked well in rather distant relationships. In this study there is evidence that the PS treatment did impact the couples' behaviours as reported on the goal attainment measure: it did increase their ability to talk to each other in a rational manner and to problem solve on pragmatic issues and reach consensus with the result that there was an improvement in the target complaint, however it did not seem to affect couples sense of satisfaction, cohesion or affectional expressssion (DAS subscales) or levels of intimacy except for the intellectual intimacy; Margolin (1983) has suggested that increasing intimacy has not up to this point been part of the process of behavioural marital therapy. An increase in satisfaction has been found in other outcome studies using problem solving training (Jacobson, 1977, 1978), although Teichert (1978) found that problem solving training increased the marital satisfaction in his study only for female spouses and not for the males. The fact that an increase in satisfaction was found in other behavioral outcome studies but not here would seem to be a reflection of how this variable is defined. Jacobson (in press) defines satisfaction as the total DAS score and if it is so defined, then the P.S. treatment when compared with controls was found to have a significant effect on satisfaction in this study. However when the subscales of the DAS are analysed separately and satisfaction is separated from other elements of marital adjustment then the PS treatment did not seem to significantly affect couples satisfaction within their relationship.
Weiss, Hops and Patterson (1973) have also suggested in general that it may be that training in behaviour change can appear "far removed from the kinds of hurts brought to us by clients" (p. 339) and that the issue is how to relate skill building and marital satisfaction.

It is interesting to note that Emotionally Focussed (EF) couples did not differ significantly from the PS couples after treatment on the Consensus variable or on Goal Attainment. This would seem to suggest that the EF treatment as well as the PS treatment had an effect on couples ability to negotiate and change specific behaviours although these areas were not focussed upon in terms of skill training. It may be that the increased ability to negotiate in the EF couples is a consequence of an increase in trust occurring as a result of the sharing of emotional experience. As trust increases in a relationship spouses may be more able to formulate their needs and ask for them to be met in a way that evokes a caring response. Responses based on caring tend to lead to effective negotiations for they are blame free and are motivated by a sincere desire to reach agreement.

These results suggest that distressed couples do not necessarily require skill training in order to be able to negotiate differences effectively and change their performance towards their spouse. This interpretation would concur with the research of Birchler et al. (1975) who found that distressed couples show normal problem solving skills when interacting with opposite sex strangers. As Gurman (1981) suggests poor social skills in a marital relationship often reflect basic rules of minimal intimacy, self-disclosure and self-exposure. The EF couples spoke in the Post Treatment Questionaire of seeing each other
differently; perhaps a new and less threatening perception of one's spouse and a clarification of the positions spouses take in relation to each other can aid the negotiation process as much as a set of negotiating rules. It would certainly appear logical that trust and goodwill are helpful prerequisites to the attainment of conflict resolution. These results imply that the performance of behaviours which enhance relationship quality through effective negotiation can be facilitated by focusing upon the emotional reality of the relationship for both the spouses as well as by direct training in negotiation.

The effectiveness of the EF treatment indicates that focusing upon unacknowledged feelings and vulnerabilities evoked by the marital interaction patterns is a valuable and powerful intervention in marital therapy. The EF treatment as well as increasing consensus and goal attainment also was found to influence couples sense of satisfaction and cohesion in the relationship, and their tendency to idealise the relationship, as well as improving spouses Intellectual Intimacy and Target Complaint above the level attained by the couples involved in the PS treatment.

The increase in satisfaction and cohesion attained by the EF couples may reflect the fact that the EF treatment attempts to address directly what Gurman (1978) refers to as the "felt needs" of the couple. If as Broderick (1981) suggests "positive affect" is considered by most to be the goal of a good relationship an intervention which works directly with affect might be expected, if effective, to influence marital satisfaction more immediately than a growth in negotiation skills. Hahlweg, Schindler, Revenstorff and Brengelmann (in press) found
in their study that the emotional-affective quality of the relationship predicted successful outcome in therapy, and they suggest that whereas a behavioural approach facilitates the improvement of manifest behaviours such as problem solving it is less well suited to "deal with the internal events affecting the emotional qualities of a relationship." If it is possible to explore and address the felt needs of couples and facilitate spouses responding to each other's needs then the couples' experience of satisfaction with the relationship would be expected to change. It may also be that if the emotional experience of the relationship overrides other cues spouses may be more open to perceiving and accepting new and more cooperative behaviours and attitudes in their spouse after the emotional climate has changed.

The increase in satisfaction and cohesion may also be understood in terms of intimacy and the enhancement of bonds. In the description of couples in healthy families given by Lewis et al. (1976) they note three characteristics of these healthy relationships; first, the presence of profound emotional bonds, second, opportunities for intimacy, and third the use of respectful negotiation. The increase in satisfaction and cohesion in the EF treatment group may be regarded as a reflection of the fact that this treatment directly addresses the first two issues. This is supported by the fact that the Affectional Expression aspect of the Dyadic Adjustment Scale and the Emotional Intimacy subscale on the Intimacy Inventory showed a trend in favor of the EF treatment. Both factors were actually found to be significant for the female spouses on an analysis of individual data; the reason for the differential response by females may be that they are more sensitive to these aspects of a
relationship or that they were more affected by the elements of treatment. These factors are the kinds of elements one would expect to increase as intimacy and bonding progressed. If as Waring et al. (1981) suggests satisfaction for most couples is closely related to intimacy level and intimacy is enhanced by the disclosure of relatively "deep" personal needs and fears then an increase in satisfaction and cohesion would appear to be the natural outcome of an effective implementation of the EF treatment.

The increased idealisation of spouse and relationship found in the EF treatment seems as a result of the analysis of individual scores to be mainly a reflection of increased idealisation on the part of the male spouses. One interpretation of this result is that the male spouses were faking positive responses on the Intimacy Scale. However, this result is consistent with the trend of the results as a whole and in the light of the discussion of this subscale in Chapter 3 it seems more likely that males began to see their spouses in a more positive and romantic light. The Post-Therapy Questionnaire results where couples spoke of seeing their partner differently and perceiving their partner's vulnerability would seem to support this interpretation. It may be that since men are generally less responsive to, oriented towards and expressive of emotional experience, when males are able openly and safely to express emotions to their spouse this results in a more positive estimation of their spouse. This result may also be a generalisation of the overall increase in satisfaction experienced by couples in the EF group.
Intellectual Intimacy also changed to a significantly higher level in the EF couples compared to the PS couples. It may be that openness and trust evoked by the EF therapy generalized from the expression of emotional issues to cognitive rational discussion. In an emotional climate of hostility and defensiveness issues considered at the level of rational discussion can quickly escalate into heated struggles and so intellectual discussion may be stifled or avoided.

Other facets of intimacy measured by the PAIR appeared unaffected by either treatment, namely Social, Sexual and Recreational Intimacy. Social Intimacy as a factor correlated at a noticeably and uniquely low level with all other outcome subscales, which suggests that issues such as whether couples have many friends in common are not related to marital adjustment in the same manner as the other outcome variables. Recreational Intimacy seemed to be unaffected by higher levels of satisfaction and general adjustment; perhaps common activities become part of life style and remain relatively resilient in the face of changing relationship happiness or distress. Sexual Intimacy was also unaffected by treatment this may be due to the screening procedures which screened out sexual dysfunction, or perhaps because the treatment procedures specifically did not focus upon this area. This results also suggest that sexual aspects of a marriage are in some sense a distinct if related area within the relationship.

The increased reduction of the Target Complaint in the EF group may be seen as part of the general effect of EF on satisfaction and intimacy, or it can be interpreted as a reflection of the importance of emotional experience. Fincham and O'Leary (in press) have suggested
that behavioural responses in close relationships seem to be mediated by affective response rather than casual attributions, and Zajonc (1980) has argued for the primacy of affect in general. If emotional experience provides a framework for the creation of meaning in a relationship and overrides other cues, when that emotional response is modified, then interaction patterns between spouses can become more flexible and open and any complaint may be able to be dealt with more effectively. Complaints also tended to be emotional in content so that exploring and disclosing vulnerabilities and emotional needs would address the "hurt" and sense of deprivation which Wile (1981) suggests is the basis for marital distress.

The main significance of the research results seems to be that a treatment intervention which focuses on the emotional experience underlying the interactional patterns in relationships can be specified and in this study was found to be a powerful tool to change the manner in which couples experienced their relationship and to facilitate the resolution of marital conflict. The fact that assignment to treatment was random and that the therapeutic alliance was monitored and no significant differences found between treatment groups adds credibility to the claim that the differential differences in outcome between the treatment groups were due to the interventions used rather than confounding factors such as client motivation or therapist and client relationship factors. The responses on the Task dimension of the Alliance Scale also suggest that both treatments were equally credible and relevant to participants, and the fact that there were no drop-outs from either treatment further supports this view.
This study does not specifically show a causal link between the occurrence of emotional processes and outcomes in marital therapy, however it is possible to postulate the mechanisms of change involved in the EF treatment. The key mechanisms of change in the EF treatment are proposed to be the modifying of spouses' perceptions of themselves and each other. This process creates a new reciprocal responsiveness and undermines the automatic evocation of reciprocal self-protective stances, and facilitates the growth of intimacy and trust which results from the exploration and disclosure of personal meanings and needs. Solomon (1977) has noted that emotional experience is essentially self-referring and concerned with self-concept. The exploration and heightening of primary emotional experience helps to access the self schema and make available key cognitions regarding the nature of self as defined in relation to the other spouse. Such cognitions would seem to be logically related to the positions taken by the partners in a relationship and thus how the relationship is defined. Also, spouses' responsiveness to the others' needs and affirmation of the others' reality tie the partners together, and enhances the development of creusive bonds (Turner, 1970). These bonds are formed in the process of continued interaction. The ability to abandon ordinary defence patterns and image management and disclose with safety, Turner (1970) suggests, not only enhances spontaneity but quickly creates ties between people.

Conclusions

The main implications of this study are then that a treatment which focuses upon the accessing and expression of underlying emotional
experience can modify marital adjustment and intimacy levels and facilitate the attainment of relationship goals and the reduction of target complaints leading to an alleviation of marital conflict and distress. These results suggest that this experiential approach is a viable alternative to the skill oriented behavioral approach to marital therapy and attest to the significance of emotional experience in the process of modifying the nature of intimate relationships.

On a theoretical level the most important issues arising from this study would seem to be the salience of emotional experience in relationship definition and the question of the appropriateness of a skill orientation to intimate relationships. Both issues are complex in nature and cannot be adequately addressed by any single study. The question of how emotional processes relate to and can be used to create change must be addressed by research which specifically focuses upon the process of change. This study however at least delineates specific therapist activities designed to evoke and modify emotional responses. The issue of the relevance of skills and the teaching of skills in marital therapy is also a multifaceted one. The process of learning alternative behavior patterns would seem to be an inherent part of any therapy, however how the learning of skills relates to the creation of love and respect is a difficult question. As Weiss (1978) points out behavioral marital therapy offers a technology for changing relationships rather than a theory of adult intimacy. It may be useful to place the modification of intimate relationship in the context of intimate emotional bonds rather than viewing such relationships in terms of exchange theory.
On the level of clinical practice this study poses questions as to how best to delineate even more specifically the appropriate therapist interventions at particular points in the client's change process, and how to train therapists to implement emotionally focused interventions. The issue of the possible integration of behavioral and experiential interventions is also an interesting one. The most effective marital therapy may be, for example, a series of emotionally focused interventions to change the positions taken by the spouses in relation to each other, followed by the teaching of problem solving skills to help the couple maintain and strengthen these new positions.

From the point of view of the clinician the results of this study attest to the efficacy of a clinical intervention in which the therapist, 1) identifies themes in a core struggle, 2) identifies negative interaction cycles and the positions each partner takes in these cycles, 3) redefines the problem in terms of newly synthesized emotional experiences, 4) encourages partners to identify with disowned aspects of their experience, 5) helps each partner to accept the other's position and, 6) facilitates the expression of needs and wants and the creation of new solutions. The focus on inner experience as it translates into relationship events appears to be a fruitful one in marital therapy.

**Future Research**

The first task implied by the results of this study is the replication of the study, perhaps by a behaviorally oriented researcher. The results of the treatment of those couples assigned to
the control group in this study will also be analysed and should provide additional evidence as to the efficacy of the EF treatment. The study involving the control group differs from the study presented in this dissertation in that the therapists used to treat the control couples were inexperienced; the effect of therapist experience level on the efficacy of the EF treatment should then be able to be documented. This is a particularly relevant issue since one hypothesis concerning the EF treatment is that a relatively high level of therapist expertise and experience is necessary to successfully implement this treatment. Inexperienced therapists seem to find it difficult to focus on the process of interaction rather than the content and to evoke and heighten emotional experience rather than rationally discuss such experience (Greenberg & Johnson, in press).

Possible future research might also examine the process of conflict resolution comparing the in therapy performance of couples who resolve conflicts with that of non-resolvers and relating process oriented indices such as the level of experiencing on the Experiencing Scale (Klein, Mathieu, Keisler, Gendlin (1969) or the quality of interactions recorded on the Structural Analysis of Social Behaviour (Benjamin, 1977) to outcome variables. As suggested by Rice and Greenberg (1983) change events in therapy may be identified and successful performance in a particular change event documented and related to successful eventual outcomes. Such research would facilitate the building of a model of conflict resolution and the detailed descriptive analysis involved would hopefully begin to explain how change occurs in the emotionally focused
treatment, and specifically link in-therapy events to treatment outcomes.

Continued outcome research perhaps with more severely distressed couples using a longer treatment program might also elucidate the factors which predict future success or failure in the Emotionally Focused treatment and so help to delineate the strengths and limitations of this approach.
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APPENDIX A

TREATMENT MANUALS
RATIONALE: PROBLEM SOLVING INTERVENTION

These counselling sessions are based upon the idea that couples get into habitual ways of relating to and trying to change each other that tend to make the relationship more distressing for both partners rather than enabling them to work out their problems together. The sessions will focus upon teaching you both some new communication skills and some new structured ways of defining and solving problems in your relationship so that you can both learn to negotiate effectively for the changes you would like to see in each other's behavior.

Since all problems in a relationship have implications and consequences for both partners every problem is a mutual problem and collaboration is in the interest of both of the partners. This counselling process involves teaching couples how to negotiate with each other for change in a structured rational way and how to find compromises that will be satisfying to both parties.

We will be working on modifying communication patterns that interfere with problem solving through the use of feedback and by demonstrating different ways of communicating which we can then practise together. You will learn a supportive style of communication which may not be the way you want to interact with each other all the time, but can help you when specific issues come up in the relationship that you need to resolve in order to keep the relationship satisfying and involving for you both.
This manual is brief since the process of therapy is also delineated in Jacobson and Margolin (1979), pages 215-258.

General Principles: All new skills are first taught using positive or relatively neutral content. Each session begins with the therapist setting the agenda for the session, than reviewing the homework, troubleshooting if necessary (especially in sessions 2 and 3), and teaching new skills.

**FRAMEWORK**

<table>
<thead>
<tr>
<th>Session</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1</td>
<td>Assessment. Presentation of treatment rationale.</td>
</tr>
<tr>
<td>Session 2</td>
<td>Troubleshoot if necessary. Teach communication skills, model, rehearse and coach using positive content as much as possible.</td>
</tr>
<tr>
<td>Session 3</td>
<td>Troubleshoot if necessary. Teach problem definition and analysis skills, model rehearse and coach using hypothetical or very minor real issues, using communication skills.</td>
</tr>
<tr>
<td>Session 4</td>
<td>Troubleshoot only if essential. Review problem definition skills, apply these skills to an issue in the couple's relationship.</td>
</tr>
<tr>
<td>Session 5</td>
<td>Teach problem solution skills, apply these skills to a hypothetical or minor issue first, then to the issue defined in Session 4.</td>
</tr>
<tr>
<td>Session 6</td>
<td>Teach contracting skills, apply to a hypothetical or small issue first and then to the solutions to the issue brainstormed in Session 5.</td>
</tr>
<tr>
<td>Session 7</td>
<td>Revise the contract implemented for homework. Revise the complete process of problem definition, analysis, solution, and contracting.</td>
</tr>
<tr>
<td>Session 8</td>
<td>Summarize processes and rules. Deal with transfer and generalisation issues.</td>
</tr>
</tbody>
</table>
PROBLEM SOLVING TREATMENT

SESSION 1 - ASSESSMENT

Therapist Tasks:

1. Amplify strengths, probe for and reinforce the functional aspects of the relationship.

2. The therapist enquires as to the history of the relationship. How did the couple meet, what attracted them to each other, how did courtship proceed, what was it that they found rewarding about each other. Focus on positives.

3. Encapsulate problems as presented, and attempted solutions. The therapist frames the problem as a mutual one, collaboration being in the interests of both partners.

4. The therapist observes the couple interact for 8 minutes as they discuss their problem and notes their communication patterns.

5. The therapist presents the treatment rationale. The problem is framed in terms of lack of skills necessary to create positive change in the relationship. The therapist emphasises that hard work and collaboration are necessary and homework assignments are an essential part of the counselling.

Homework: Give the couple the problem solving manual to read, encouraging them to set a time in the week to do this and any future homework.
SESSION 2

The therapist gives the rationale for learning to listen to each other, sharing and clarifying communication. The therapist models positive non-verbal behavior and paraphrasing and shapes communication skills through a process of feedback instruction and rehearsal. Feedback is descriptive, e.g. you interrupted him, as opposed to interpretive or evaluative. Later in the sessions when the couple are familiar with the structure the therapist may simply stop the couple's interaction and ask "Why I am stopping you" and encouraging the couple to identify and rectify their mistake. The therapist focuses upon the effect of communication patterns, that is the responses certain behaviors elicit from the partner. The couple are encouraged to label feelings and to validate those of their spouses. The therapist focuses particularly upon enhancing positive exchanges. The therapist's main activities consist of giving feedback, modelling, structuring behavioral rehearsal of effective communication and reinforcing positive exchanges.

These skills should first be practised using positive content, for example talking about a pleasant memory.

If necessary the Troubleshooting procedure can be used in this session. Here the therapist listens to a problem situation from both points of view, summarizes the problem which occurred and asks both partners at each play by play step what they could have done differently to prevent the situation becoming as negative. The therapist looks for general principles emerging from this particular incident and writes a contract to help the couple avoid a reoccurrence of the conflict.
Homework: Five minutes each of paraphrasing the partner as they talk about a positive issue.

SESSION 3

The therapist explains the rationale for learning problem definition skills and environmental contingencies which support the process (e.g. set an agenda, set a time frame, do not problem solve in the heat of the battle). The couple are now encouraged to use the communication skills taught in the last session to define issues more clearly. The therapist sets out rules for the problem definition process and gives rationales for these rules:

1. When stating a problem begin with relevant positives to maximise the partners ability to listen and to keep issues in perspective.

2. Be specific. Focus on behavior, situation, and consequence. The therapist insists upon behavior description rather than trait labels and discourages the use of inferences, suggesting couples speak only of what they can observe. Different ways to view problems may also be summarized here. Each problem may be viewed in terms of excess, deficit, environmental contingencies, differing expectations, or lack of reward for desired behavior. This structure may be used again when teaching brainstorming.

3. Avoid overgeneralisations.

4. Label your feelings, that is the impact your partner's behavior has upon you.
5. Admit to your part in the problem, e.g., I should have brought it up sooner.

6. Be brief. Side-tracking and cross-complaining are discouraged, as in any discussion of causes. The skills are first modelled by the therapist and tried out using hypothetical or very minor real problems. Having taught the rules the therapist then stops the interaction when they are not observed and helps the couple to modify their behavior. A good problem definition consists of a description of behavior, a specification of the situation, and consequences.

Homework: Practise paraphrasing, and take a very minor issue in the relationship and use the above process to come up with a clear problem definition. The therapist also uses Troubleshooting in this session if necessary.

SESSION 4

In this session the skills of Sessions 2 and 3 continue to be reinforced and practised. If possible the couple should now use these skills to define an issue that is of concern to them in their relationship. Legitimacy of the problem is assumed if it is distressing to one of the partners. The partners commitment to negotiation is stressed as essential to problem solving. Homework: Write a problem definition on a small problem in their relationship, and put the problem in the perspectives of excess, deficit, etc.
SESSION 5

The procedures for problem solving are now taught. The therapist teaches the brainstorming process using a hypothetical or very minor problem. Alternative solutions are considered in terms of costs and benefits to each partner. Possible options are narrowed and refined. The focus here is upon negotiation, partners are encouraged to differentiate between what they want ideally and what they are willing to settle for. Having practised once the partners then brainstorm solutions to the problem they defined in Session 4. After listing 5-6 feasible solutions a cost benefit analysis should whittle the list down to 2-3. The therapist helps the couple consider the difficulties inherent in the implementation of solutions, and the rewards they can provide to reinforce such implementation.

Homework: Brainstorming solutions for one of the small issues used as problem definition homework in the last sessions.

SESSION 6

In this session contracting is taught and a contract is written up for the issue brainstormed in Session 5. The contract is a good faith contract, and is written up in specific behavioral terms. The therapist helps the couple to consider ways to ensure that the contract is implemented.

Homework: To implement the above contract. To write up a contract for the small issue they brainstormed for homework.
SESSION 7

In this session the specific contract made in Session 6 is evaluated and revisions are made if necessary. Communication, problem definition and problem solving skills are then reviewed. If possible the couple then take a small issue and rehearse a problem solving session to deal with that issue with the therapist coaching them.

Homework: Conduct a problem solving session at home on a minor issue.

SESSION 8

Processes and rules are summarised. The therapist structures an eight minute interaction where the couple discuss the problem they discussed during the eight minute interaction in session one. The therapist also prepares the couple for relapse and teaches them how to initiate a problem solving session; they then rehearse this initiation. The therapist helps the couple identify cues which might suggest that such a session is necessary, and how the environment can be made conducive to problem solving, as well as ways the couple might increase the probability of this process occurring in the future.

If necessary Session 3 may be divided into two sessions and Sessions 6 and 7 collapsed.

Please inform the assessor for your couple as to the date and time of your last session since post measures will be given at the end of this session.
PROBLEM ANALYSIS

Problems may be viewed in terms of

1. Too much of a certain behavior
2. Too little of a behavior
3. Circumstances in the situation which contribute to the problem
4. Partners having different expectations
5. Partners not rewarding each other for desired behaviors.

Each of these views may lead to different solutions.

EXAMPLE - Paul not spending enough time with Mary at the party may be viewed as:

1. Paul talking too much to other people.
   Mary sitting too much on her own and not socializing.

2. Paul not talking to Mary enough.
   Mary not responding to people's approaches enough.

3. The fact that both Paul and Mary were tired of attending parties, having attended three the week before.

4. Mary assumed that Paul and she would be together all evening since the party was small.
   Paul assumed that they would be separate since there were business people at the party he wanted to meet.

5. Mary did not respond to Paul when he did talk to her.
   Paul did not include her in the conversation when she did approach him.
RATIONALE: EMOTIONALITY FOCUSED INTERVENTION

These counselling sessions are based upon the idea that the more you understand and can accept the positions you and your partner take in the relationship, that is the way you see and react to each other, the more choice you can have over what happens in the relationship. It is often underlying concerns or feelings that we are not quite aware of or cannot quite express which color the way we react to each other. Emotional chain reactions seem to get set up and then take on a life of their own, so that both partners end up feeling misunderstood and frustrated and that they are somehow not really getting what they want from each other. Feelings towards each other which are not understood often get in the way of couples being able to discuss things openly and resolve concrete issues.

So these sessions will be geared towards each of you having a clearer picture of what happens in your relationship, how each of you experience the relationship, and helping you to be aware of and communicate your needs to each other in a way that your partner can hear and accept. Both of you will then hopefully feel more accepted and closer to each other and as a result be able to resolve issues openly and find new and positive ways to respond to each other.
THERAPY MANUAL: EMOTIONALLY FOCUSED THERAPY

FORMAT:

FRAMEWORK

ASSESSMENT

THERAPY STEPS AND THERAPIST ACTIVITIES

TERMINATION

OPERATIONAL DEFINITIONS

THERAPIST INTERVENTIONS, DESCRIPTIONS

©/Greenberg and Johnson
SESSION 1 - ASSESSMENT

THERAPIST TASKS

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

2. Discuss each partners perception of the problem. Observable behaviors 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 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 given them hope for positive outcomes. Since this is an information gathering and diagnostic session much more of the interaction will be therapist-client 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

Direct 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

This therapy tends to occur in a circular rather than a linear sequence therefore this manual will focus on 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 below.

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 their position.

Therapist Activities: Direct questions and probes; Empathic responding; Sumarizing 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 partners 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 position 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?

2. Access and accept unacknowledged feelings underlying problematic interreacts.

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 focussed 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 3 are now clarified. The therapist interprets elements in the interactional sequence in terms of underlying needs and fear which stem from interacting sensitivities, for example, Jim is vigilant regarding actions of Jill's 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 more fully experience
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. Each person is
asked to identify with disowned aspects of their experience, to develop
their position fully and to deliberately engage 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
deliberately protect themselves 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
deliberately engage 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 anxiety about being intimate, he or
she is asked to identify with the dependent or fearful aspect of their
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 this is only being 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 them more control and choice of these feelings and behaviours. Once partners have identified with disowned aspects of their experience it is possible to integrate these aspects both intraphysically and also into the relationship. Identifying with disowned aspects of experience is worked on in the session and given as homework and people are asked to do it deliberately if possible, or to "go with" their experience when they begin to feel their previously disowned experience rather than fighting against that aspect of themselves.

**Therapist Activities:** Suggests 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 people 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 partners 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 non-accepting 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 relationship.

**Therapist Activities:** Evocative responding; interpretation and labeling 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, 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.

9. Integrate new perspectives

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 focussing upon some new aspects 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 couples' 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 partner interact more and more helping each other through the therapeutic process.

TERMINATION SESSION:

This session like assessment will always follow a certain format. The treatment process will be 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 lead 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 confrontive.

 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. EVOCATIVE RESPONDING

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

The elements of experience focussed 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 (SAR) 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 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 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.

**Examples:**

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
Examples: Therapist - What is 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?
APPENDIX B

INSTRUMENTS USED IN THE STUDY
DEMOGRAPHIC DATA QUESTIONNAIRE

COUPLE NUMBER ____________

1. How many years have you lived together as a couple? _______

2. How many children do you have? _______

3. Have the two of you had any marital counselling before taking part in this project? Yes_______ No_______

4. Please tick the category within which you gross family income falls:
   ___ Under $15,000
   ___ $15,000 - 25,000
   ___ $25,000 - 35,000
   ___ $35,000 - 45,000
   ___ $45,000 - 55,000
   ___ Above $55,000

This section should be completed by the male partner only

5. Please state your age (in years) _______

6. What is your present occupation? __________________________
   If you are currently unemployed please state reasons why
   _______________________________________________________

7. Have you had a previous marriage? Yes_______ No_______

8. Please tick the category which best describes your educational level:
   ___ Grade 10 or less
   ___ Grade 12 or less
   ___ 2 years of post secondary education
   ___ Community college program completed
   ___ University degree completed
   ___ Graduate program completed
   ___ Ph.D. or equivalent completed

This section should be completed by the female partner only

9. Please state your age (in years). _______

10. What is your present occupation? __________________________
    If you are currently unemployed please state reasons why
    ______________________________________________________
11. Have you had a previous marriage? Yes________ No________

12. Please tick the category which best describes your educational level:

____ Grade 10 or less
____ Grade 12 or less
____ 2 years of post secondary education
____ Community college program completed
____ University degree completed
____ Graduate program completed
____ Ph.D. or equivalent completed
The kinds of stated concerns couples brought into the research project seemed to fit into the following categories:

1. Lack of intimacy, that is physical (affection and sexual closeness) and communication.

2. Lack of communication in the sense of recurring power struggles and seemingly unresolvable fights resulting in distance between partners and a lack of cooperation in decision making.

3. Situational conflicts which were not resolved and became the source of recurring disagreements, for example extra-marital affairs or the birth of a handicapped child.

4. Conflicts concerning role definitions and responsibilities.

Most couples spoke of wanting more open communication, more affection and a greater responsiveness to each other's needs. The first two catagories were mentioned by the majority of couples. There appeared to be a balance of complaints across groups; for example each group contained one couple where the male spouse had a particular problem with outbursts of uncontrollable anger, and all groups also contained one couple resolving issues concerning past extra-marital affairs. The issue most often mentioned was a lack of open communication however this is a vague and general term which then had to be differentiated by the couple and assessor. In general couples' concerns appeared more expression oriented rather than instrumentally oriented.
TARGET COMPLAINTS QUESTIONNAIRE C

We are interested at this time in the two or three main concerns that you hope to resolve during counselling. Please list them below:

(a)

(b)

(c)
QUESTIONNAIRE D
(at termination)

We are interested in how much the following issues in your relationship has (have) changed since you started the program. Please circle the words that describe your position.

a. ____________________________________________________________
   ____________________________________________________________
   worse... same... slightly better... somewhat better... a lot better

b. ____________________________________________________________
   ____________________________________________________________
   worse... same... slightly better... somewhat better... a lot better

c. ____________________________________________________________
   ____________________________________________________________
   worse... same... slightly better... somewhat better... a lot better
GOAL ATTAINMENT QUESTIONNAIRE A

Couple No. ______________
Date: ______________

Description of the issue you will be working on. ________________________

____________________________________________________________________

Much worse than expected results: ________________________________

____________________________________________________________________

Somewhat less than expected results: _____________________________

____________________________________________________________________

Expected or most likely results: ________________________________

____________________________________________________________________

Somewhat better than expected results: _____________________________

____________________________________________________________________

Much better than expected results: ________________________________

____________________________________________________________________

(Place asterisk (*) next to level where you are now).
THE PAIR INVENTORY

The following are the definitions of intimacy implicit in the PAIR.

**Emotional Intimacy:**

The experiencing of closeness of feeling; the ability and freedom to share openly, in a nondefensive atmosphere when there is supportiveness and genuine understanding.

**Social Intimacy:**

The experience of having common friends and a similar social network.

**Sexual Intimacy:**

The experience of showing general affection, touching, physical closeness, and/or sexual activity.

**Intellectual Intimacy:**

The experience of sharing ideas, talking about events in one's life, or discussing job-related issues, current affairs, etc.

**Recreational Intimacy:**

Shared experiences of interests in past-times or hobbies; mutual participation in sporting events; mutual involvement in any general recreational or leisure activity.
POST TREATMENT STANDARIZED INTERVIEW

C.P.S.P. 
Couple No. 

Please place M or F after recorded statements.

1. Has your relationship improved as a result of this counselling?

   M. Yes ______ No ______
   F. Yes ______ No ______

   If so how would you describe the change?

2. What did you find most helpful about this treatment?

3. Can you remember any critical moments which you consider important in terms of helping you or your partner change your relationship?

4. What was least helpful or hindering for you about this treatment?

5. Would you have preferred more sessions?

   M. Yes ______ No ______
   F. Yes ______ No ______
ACTIVITIES WHILE WAITING INQUIRY

Assessor: ___________________________  Couple No. ________

Have you and your partner taken any action to try and improve your relationship since the first assessment? For example have you received any other outside help, read any books which you found useful, or taken any other action to help yourselves while you were waiting for counselling?

Yes ___  No ___

Document reply:

Reading books _______

Talking with friends _______

Speaking to any "expert", e.g. a minister _______

Improving the context of the relationship _______ for example buying a car if this was an issue, taking a vacation.

Other ____________________________

What was it about this activity that you feel helped your relationship.
CONFLICT RESOLUTION TASK

Instructions for Therapists:

In the last fifteen minutes of the session please ask your couples to take a few minutes to talk about the issue they have addressed in therapy. Recap the issue for them in general terms. Suggest to them that you would like to see what it is like for them to make a specific solution proposal to their partner that addresses some part of their issue, which seems relevant to them at the moment. You would like them to keep it as short and as simple as possible, and the way you would like them to do it is – they each make a statement as to one thing they are willing to do to help create harmony in the relationship, and then make a request of their partner as to one thing they would like their partner to do. The partner then responds, disagreeing or agreeing to their request. If they find that they cannot agree to their partners request, that is fine. The purpose of this is to help the researchers and the therapist gauge how resolved, if at all, they feel about their issue.

The therapist intervenes in this procedure only to structure the sequence (e.g. to prompt someone to begin, cut someone off who is just rambling or to explain the next step).

Example:

I will initiate us spending an evening together once a week, suggesting the time and activity, and I'd like you to respond to me when I ask you for a hug when I come home in the evening.

Individuals responses to their partners requests were then rated by observers as falling into four categories, Acceptance, Agreement (Resolution), or Rejection, Disagreement.
COUPLES PROBLEM SOLVING PROJECT - IMPLEMENTATION CHECKLIST

Couple No. _____ Session No. _____ Rater _____

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

Intervention Checklist

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.
2. The problem is defined in terms of manifest observable complaints and lack of skills on the part of the couple.
3. The therapist clarifies and elaborates the basic positions taken by the partners in the relationship.
4. The therapist frames the problem in terms of mutual bad habits that will need work to overcome, and teaches behavior change concepts.

Attacking Behavior

5. The therapist validates or develops the positions implied by negative behavior such as name calling; such behavior is interpreted in terms of underlying needs and feelings.
6. Negative behavior such as name calling is labelled as unhelpful and related to lack of skill. A substitute is usually suggested. Rules are set and rehearsed.

Process Focus

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

8. The therapist focusses upon and helps the couple pinpoint specific behaviors. Observable antecedents and consequences of problem behaviors are noted.

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

10. Feelings are labelled in a problem/goal oriented context to communicate the impact one partners behavior has upon the other.

11. 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.

12. Problem defining and solving sequences skills and rules are taught and used to structure interactions.

LISTENING

13. Blocks/resistance to accepting a partners experience are explored in terms of underlying feelings, self-concept or experience in family of origin. (Awareness of inner experience is focus).
14. Communication ground rules are set up and practised. Paraphrasing is taught (not reflection), responses are directed by the therapist and rehearsed (skill focus).

PROBLEM SOLVING

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

16. The therapist facilitates the identification of specific behaviors expected from the partner, without basing them in feelings.

17. The therapist helps the clients crystallise their new view of their partner, and to explore their new feeling response to this perspective.

18. Brainstorming of alternative solutions if facilitated. Menus of possible solutions are constructed.

19. Shared perspectives on the relationship are clarified.

Metacommunication regarding the relationship is facilitated.

20. A solution is chosen and a contract is negotiated stressing reciprocity and comprise. Costs and benefits of solutions are weighed.

ADDITIONAL CATEGORIES


22. Refocus on topic.

23. Not codable (example: therapist assigning homework).
EXAMPLES: EXPLICATION OF IMPLEMENTATION CHECKLIST CATEGORIES

1. So the problem for you in this relationship is that you basically feel alone and isolated from Jim.

2. 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.

3. 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?

4. 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 you own behavior.

5. 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?

6. 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?

7. 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.
8. What is it exactly that your partner does that disturbs you? ..... when does this occur? ..... what happens then?

   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?

10. So when he leaves his clothes on the floor you feel angry? ..... and even less willing to co-operate with his desires?

11. 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.

12. The therapist models for the client the rule - Admitting your part in the problem. You could say, I know I can make it difficult for you to work because I step in and interrupt but it would be nice if ....

13. 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.

14. Sally please repeat back the core of what Tom said before responding to him.
15. Brenda can you tell Cory what it is that you really want from him right now? How can he reassure you?

16. The therapist helps the client frame.
   I want you to give me a hug and a kiss every morning before getting out of bed.

17. 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."
   So you feel closer to her? Perhaps you would like to comfort her right now?


19. 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.

20. 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.
Add Frequency of Use:

1 ______ 2 ______ 3 ______ 4 ______ 5 ______
Minimally modestly often moderately often very often

THERAPIST INTERVENTION CHECKLIST

Couple No. _______ Session No. _______ Therapist _______

Please place a tick beside interventions you recall using in this session.

-----------------------------------------------

Problem Definition
1. _____ Defining the problem in terms of underlying emotions.
2. _____ Defining the problem in terms of lack of skill, observable behaviors.
3. _____ Clarifying/Elaborating basic positions taken by the couple.
4. _____ Teaching behavior change concepts.

Management of Attacking Behavior
5. _____ Validating/Interpreting blame in terms of underlying emotions.
6. _____ Labelling blaming as unhelpful, suggesting substitutes - pinpointing.

Process Focus
7. _____ Probing for, heightening emotional experience, especially fears, clarifying triggers and responses experienced.
8. _____ Pinpointing specific behaviors, observable antecedents and consequences.
9. _____ Interpreting/Elaborating upon emotional meanings.
10. _____ Labelling feeling to make impact consequences of behavior clear.
11. Clarifying interacting sensitivities, the meaning of individual behavior for the relationship. Enacting negative cycles.


**Listening**

13. Exploring blocks to acceptance of others' communication in terms of feelings, self-concept, or family of origin.

14. Teaching communication skills directly, rehearsing skills such as paraphrasing.

**Problem Solving**

15. Facilitating the expression of affectively based needs and wants.

16. Identifying behaviors expected from partner.

17. Facilitating crystallisation of new view of, response to partner.


THERAPIST SESSION REPORT

Therapist ____________ Couple No. _______ Session No. _______

1. How much progress do you feel your clients made in dealing with their issues in this session?
   a. A great deal of progress
   b. Considerable progress
   c. Moderate progress
   d. Some progress
   e. No progress

2. How resolved do you think your clients are right now in regard to their issues?
   a. Totally resolved
   b. Considerably resolved
   c. Moderately resolved
   d. Somewhat resolved
   e. Not at all resolved
APPENDIX C

FORMS: CONSENT AND FOLLOW-UP
CONSENT FORM: THE COUPLES PROBLEM SOLVING PROJECT

We ___________________________ understand that this research project is concerned with examining methods of helping couples resolve problems and marital conflict. We consent to the use of video-tape recording of our marital therapy sessions, and the release of these video-tapes to the research team supervised by Dr. L. Greenberg. We also give our consent to the use of our written response to the questionnaires for the purposes of this research.

We understand that we will receive eight one hour counselling sessions and that all recordings and written responses will have our names deleted and be coded to protect our privacy before they are given to research assistants for scoring. We also understand that we have the right to withdraw from this project at any time and/or to request that tapes be erased. We understand that withdrawal or tape erasure would not in any way jeopardize access to further therapy. We further acknowledge that neither of us have received psychiatric treatment during the last two years.
STANDARDIZED FOLLOW-UP PROCEDURE

Each couple were called eight weeks after the termination of treatment. Each partner was spoken to separately and reminded of the Target Complaints and Goal Attainment measures. The T.C. scale anchors were read to each partner twice, followed by the description of their T.C. which they each had given in the assessment interview. They were then asked to place that complaint on the scale so as to reflect its present status in the relationship. The Goal Attainment levels were then presented and each partner was asked to identify the level most descriptive of their relationship at present as the descriptions of the levels they had each given at assessment were read out to them. They were then told of the other questionnaires in the mail and asked to complete them.

The process of the call was as follows:

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 that 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. Now I have one more question to ask you and then I would like to speak to your partner. Do you remember the Goal Attainment levels you described for us and rated after your last therapy session? The levels were Worse, Less than Expected Results, Expected Results, Better than Expected and Much Better than Expected. I will read out the level to you and then your description of that level. I will read it twice and then I would like you to tell me which level describes your relationship now. Do you understand? The worse level you described as ________, the Less than Expected level you described as ________, the Expected level you described as ________, the Better than expected level as ________, and the Much Better than Expected level as ________. I will read these again and I would like you to tell me the level which describes your relationship now. Thank you.
FOLLOW-UP LETTER TO COUPLES

Thank you for participating in our follow-up for the Couples Problem Solving Project.

There are two questionnaires for each of you to complete. The OAS and the PAIR. When you have completed them please place them in the stamped addressed envelope provided and mail. It will help us if you could complete the questionnaires within a week of receiving them.

The results of the study will be available early in 1984 and can be mailed to you upon request.

The research team and I would like to thank you for making this study possible and sincerely hope that you found it a rewarding experience.

Sue Johnson, Coordinator
The Couples Problem Solving Project
APPENDIX D

ITEM ANALYSIS
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<td>Coh.</td>
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<td>Aff. Ex.</td>
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<td>32.82</td>
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Table D-3

DAS: Females: Test Statistics

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<td>Mean</td>
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<td>3.29</td>
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</tr>
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<td>Reliability (Hoyt)</td>
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<td>.71</td>
<td>.71</td>
<td>.56</td>
<td>.80</td>
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<tr>
<td>Cronbach's Alpha</td>
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Table D-4
PAIR Perceived: Subtest Correlations

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<th>Total</th>
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<tbody>
<tr>
<td>Em</td>
<td>.291</td>
<td>.267</td>
<td>.559</td>
<td>.378</td>
<td>.617</td>
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</tr>
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<td>Soc</td>
<td></td>
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<td>.329</td>
<td>.409</td>
<td>.238</td>
<td>.638</td>
<td></td>
</tr>
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<td>Sa</td>
<td></td>
<td></td>
<td>.213</td>
<td>.323</td>
<td>.292</td>
<td>.632</td>
<td></td>
</tr>
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<td>Int</td>
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<td></td>
<td>.511</td>
<td>.482</td>
<td>.726</td>
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</tr>
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<td></td>
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<td>.714</td>
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<td></td>
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<td>(N = 90)</td>
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Note: Emotional Intimacy correlates with Conventionality (idealisation) at the .617 level.
Table D-5
PAIR Perceived: Individual Scores

<table>
<thead>
<tr>
<th>Subtests (N = 45)</th>
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<th>Soc</th>
<th>Sx</th>
<th>Int</th>
<th>Rec</th>
<th>Con</th>
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</thead>
<tbody>
<tr>
<td><strong>Males: Test Statistics</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>12.04</td>
<td>13.56</td>
<td>13.80</td>
<td>12.29</td>
<td>15</td>
<td>10.16</td>
</tr>
<tr>
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<td>3.96</td>
<td>5.57</td>
<td>4.35</td>
<td>4.24</td>
<td>4.10</td>
</tr>
<tr>
<td>Reliability (Hoyt)</td>
<td>.75</td>
<td>.49</td>
<td>.79</td>
<td>.60</td>
<td>.76</td>
<td>.71</td>
</tr>
</tbody>
</table>

| **Females: Test Statistics** |    |     |     |     |     |     |
| Mean             | 9.16  | 14.22 | 14.38 | 12.07 | 15.11 | 8.60 |
| S.D.             | 3.93  | 4.97  | 5.42  | 4.13  | 4.07  | 3.62 |
| Reliability (Hoyt) | .53  | .73   | .79   | .55   | .68   | .61  |

**Note:**
Males: Reliability for Total (Hoyt) = .88
Cronbach's Alpha = .77

Females: Reliability for Total (Hoyt) = .87
Cronbach's Alpha = .79
Table D-6
PAIR Expected: Subtest Correlations

<table>
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<tr>
<th></th>
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<th>5</th>
<th>Total</th>
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<tbody>
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<td>Em</td>
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<td>.276</td>
<td>.501</td>
<td>.423</td>
<td>.420</td>
<td>.726</td>
</tr>
<tr>
<td>Soc</td>
<td>-</td>
<td>.060</td>
<td>.294</td>
<td>.275</td>
<td>.621</td>
<td></td>
</tr>
<tr>
<td>Sx</td>
<td>-</td>
<td>.396</td>
<td></td>
<td>.418</td>
<td></td>
<td>.644</td>
</tr>
<tr>
<td>Int</td>
<td>-</td>
<td></td>
<td>.345</td>
<td></td>
<td></td>
<td>.719</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td>.712</td>
<td></td>
</tr>
<tr>
<td>Total</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>(N = 90)</td>
</tr>
</tbody>
</table>

Note: The minimal correlations occur here mainly on the Social Intimacy subscale. When a correlation matrix for post scores on all dependent variables was constructed this scale stood out in that it correlated only very minimally with any other measure. This suggests that spending time with other couples or having friends in common is not of the same significance to couples as other kinds of intimacy or facets of marital adjustment.
Table D-7
PAIR Expected: Individual Scores

<table>
<thead>
<tr>
<th>Subtests (N = 45)</th>
<th>Em</th>
<th>Soc</th>
<th>Sx</th>
<th>Int</th>
<th>Rec</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Males: Test Statistics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>21.89</td>
<td>18.13</td>
<td>22.36</td>
<td>20.58</td>
<td>21.07</td>
</tr>
<tr>
<td>S.D.</td>
<td>2.12</td>
<td>2.94</td>
<td>2.14</td>
<td>2.88</td>
<td>2.39</td>
</tr>
<tr>
<td>Reliability (Hoyt)</td>
<td>.68</td>
<td>.43</td>
<td>.63</td>
<td>.53</td>
<td>.46</td>
</tr>
<tr>
<td><strong>Females: Test Statistics</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
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<td>19.11</td>
<td>22.60</td>
<td>21.69</td>
<td>21.18</td>
</tr>
<tr>
<td>S.D.</td>
<td>1.83</td>
<td>3</td>
<td>2.05</td>
<td>1.88</td>
<td>2.48</td>
</tr>
<tr>
<td>Reliability (Hoyt)</td>
<td>.51</td>
<td>.60</td>
<td>.62</td>
<td>.42</td>
<td>.54</td>
</tr>
</tbody>
</table>

**Note:**
- Males: Reliability for Total (Hoyt) = .78
  Cronbach's Alpha = .71
- Females: Reliability for Total (Hoyt) = .78
  Cronbach's Alpha = .68
APPENDIX E

DATA ANALYSIS
<table>
<thead>
<tr>
<th>Variables</th>
<th>ET</th>
<th>PS</th>
<th>C</th>
<th>F</th>
<th>p</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>M/SD</td>
<td>M/SD</td>
<td>M/SD</td>
<td>(2,42)</td>
<td></td>
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<tr>
<td>(N = 45)</td>
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<td>No. of Years Together</td>
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<td>10.2</td>
<td>6.7</td>
<td>1.8</td>
<td>.1778</td>
</tr>
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<td>5.7</td>
<td>5.8</td>
<td>3.9</td>
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<tr>
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<td>3.8</td>
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<td>1.6</td>
<td>1.4</td>
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<tr>
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<td>37.8</td>
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<td>.5774</td>
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<td>7.3</td>
<td>5.8</td>
<td>8.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female Age</td>
<td>34.3</td>
<td>34.4</td>
<td>34.5</td>
<td>.006</td>
<td>.9945</td>
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<td>6.2</td>
<td>8.7</td>
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<tr>
<td>Male Occupation</td>
<td>59.6</td>
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<td>52.8</td>
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<td>9.9</td>
<td>14.4</td>
<td>13.0</td>
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<tr>
<td>Female Occupation</td>
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<td>43.9</td>
<td>41.1</td>
<td>1.202</td>
<td>.3106</td>
</tr>
<tr>
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<td>12.7</td>
<td>16.7</td>
<td>8.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male Educational Level</td>
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<td>4.5</td>
<td>4.1</td>
<td>.290</td>
<td>.7499</td>
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<td>1.7</td>
<td>1.4</td>
<td>1.5</td>
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<td></td>
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<tr>
<td>Female Educational Level</td>
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<td>3.6</td>
<td>3.3</td>
<td>3.54</td>
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<td>1.1</td>
<td>1.5</td>
<td>1.2</td>
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</tr>
</tbody>
</table>

Note: α = .006 (.05/8)

Occupational Categories and Numbers are taken from the Blishen Scale.

Family Income and Educational Level numerals represent nominal categories.
Table E-2

Test of Emotional Style: Analysis of Variance

<table>
<thead>
<tr>
<th>Variables</th>
<th>ET (M/SD)</th>
<th>PS (M/SD)</th>
<th>C (M/SD)</th>
<th>F (2,42)</th>
<th>p</th>
</tr>
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<tbody>
<tr>
<td>Male Orientation</td>
<td>17.2/7.5</td>
<td>13.7/8.3</td>
<td>13.5/6.2</td>
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<td>.322</td>
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<tr>
<td>Male Expressiveness</td>
<td>9.7/7.2</td>
<td>10.5/5.0</td>
<td>10.3/4.9</td>
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<td>.938</td>
</tr>
<tr>
<td>Male Responsiveness</td>
<td>9.4/4.2</td>
<td>8.5/4.8</td>
<td>10.9/4.9</td>
<td>.96</td>
<td>.390</td>
</tr>
<tr>
<td>Female Orientation</td>
<td>19.5/5.5</td>
<td>20.3/5.8</td>
<td>18.0/8.2</td>
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<td>.624</td>
</tr>
<tr>
<td>Female Expressiveness</td>
<td>14.0/6.9</td>
<td>18.4/4.3</td>
<td>12.8/6.8</td>
<td>3.46</td>
<td>.041</td>
</tr>
<tr>
<td>Female Responsiveness</td>
<td>14.1/4.0</td>
<td>15.1/4.5</td>
<td>12.9/5.0</td>
<td>.89</td>
<td>.417</td>
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</tbody>
</table>

Note: \( \alpha = .008 (\ .05/6) \)
Table E-3

Couples Therapy Alliance Scale: Individual Scores

<table>
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<tr>
<th>Variables</th>
<th>Groups</th>
<th>EF</th>
<th>PS</th>
<th>F</th>
<th>p</th>
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<td>(N = 45)</td>
<td>M/SD</td>
<td>M/SD</td>
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<tr>
<td>Male</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>118.0</td>
<td>114.6</td>
<td>.23</td>
<td>.636</td>
<td></td>
</tr>
<tr>
<td></td>
<td>23.5</td>
<td>13.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>124.5</td>
<td>112.6</td>
<td>3.53</td>
<td>.071</td>
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<td>20.9</td>
<td>12.8</td>
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</table>

Note: α = .05/3 = .016
Table E-4

Summary Anova: Task Dimension of Alliance Scale

(N = 30)

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>SS</th>
<th>MS</th>
<th>DF</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
<td>6.1</td>
<td>6.1</td>
<td>1</td>
<td>.31</td>
<td>.583</td>
</tr>
<tr>
<td>Within</td>
<td>552.6</td>
<td>19.7</td>
<td>28</td>
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</tbody>
</table>
Table E-5
Therapist Effect on Posttest Total DAS Scores

<table>
<thead>
<tr>
<th>No. of Therapists Couples</th>
<th>Males</th>
<th></th>
<th></th>
<th></th>
<th>Females</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>M/SD</td>
<td>F(11,18)</td>
<td>p</td>
<td>M/SD</td>
<td>F(11,18)</td>
<td>p</td>
<td></td>
</tr>
<tr>
<td>1</td>
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<tr>
<td>3</td>
<td>2</td>
<td>110.5</td>
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<td>107.5</td>
<td>12.0</td>
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<td>4</td>
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<td>16.9</td>
<td>115.0</td>
<td>15.6</td>
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<tr>
<td>6</td>
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<td>91.3</td>
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<td>7</td>
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<td>117.5</td>
<td>9.2</td>
<td>120.0</td>
<td>11.3</td>
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<td></td>
</tr>
<tr>
<td>8</td>
<td>2</td>
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<td>115.5</td>
<td>2.1</td>
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<td></td>
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<tr>
<td>9</td>
<td>2</td>
<td>111.0</td>
<td>1.4</td>
<td>108.0</td>
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<td>2</td>
<td>114.0</td>
<td>9.9</td>
<td>118.5</td>
<td>9.2</td>
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<td></td>
</tr>
<tr>
<td>11</td>
<td>3</td>
<td>109.7</td>
<td>12.7</td>
<td>106.7</td>
<td>13.0</td>
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</tr>
<tr>
<td>12</td>
<td>4</td>
<td>113.3</td>
<td>12.4</td>
<td>105.5</td>
<td>20.01</td>
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</tbody>
</table>

Note: N = 60, α = .01

Bartlett Homogeneity of Variance: Males = F = .78, p = .659
Females = F = .73, p = .709
Table E-6
Therapist Effect on Post Treatment Variables
PAIR Subscales, GAS, TC: F Values

<table>
<thead>
<tr>
<th>Variables</th>
<th>Males</th>
<th>F/p</th>
<th>Females</th>
<th>F/p</th>
</tr>
</thead>
<tbody>
<tr>
<td>PP1</td>
<td>1.97</td>
<td>.096</td>
<td>1.92</td>
<td>.105</td>
</tr>
<tr>
<td>PP2</td>
<td>1.18</td>
<td>3.66</td>
<td>1.36</td>
<td>.273</td>
</tr>
<tr>
<td>PP3</td>
<td>.82</td>
<td>.820</td>
<td>.83</td>
<td>.614</td>
</tr>
<tr>
<td>PP4</td>
<td>1.33</td>
<td>.287</td>
<td>1.39</td>
<td>.257</td>
</tr>
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Note: d.f. = 11,18
Set α = .01, corrected α = .05/18 = .0027

All Bartlett Box F values were non-significant
### Table E-7

**Pretest Pair Expected Couple Scores**

<table>
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**Note:** α = .05
Table E-8

Post-test PAIR Expected Scores

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<td>p</td>
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<td>M/SD</td>
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<tr>
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Note: set $\alpha = .05$
corrected $\alpha = .01$
Table E-9

Summary Anova: Pre and Post-test PAIR Expected Scores

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<td>86.9 (6.4)</td>
<td>89.3 (5.9)</td>
<td>.06</td>
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<tr>
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<td>87.4 (12.5)</td>
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<td>74.1 (5.8)</td>
<td>72.0 (8.18)</td>
<td>4.16</td>
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<tr>
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<td>75.2 (9.3)</td>
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<td>88.9 (6.9)</td>
<td>90.5 (7.9)</td>
<td>4.2</td>
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<td>89.2 (6.2)</td>
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<td>.519</td>
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<tr>
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<td>Pre</td>
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<td>83.5 (7.4)</td>
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<tr>
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<tr>
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<td>85.2 (4.1)</td>
<td>83.1 (6.5)</td>
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Note: set α = .01 (.05/5)
### Table E-10

**Individual Pretest PAIR Perceived Scores**

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<th>C (M/SD)</th>
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<th>p</th>
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<td>(N = 45)</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Male: PP1</strong></td>
<td>46.4/15.2</td>
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<td>0.498</td>
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<tr>
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<td>56.8/16.5</td>
<td>51.7/17.8</td>
<td>54.1/13.8</td>
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<td>0.693</td>
</tr>
<tr>
<td>PP3</td>
<td>52.8/24.3</td>
<td>56.5/21.7</td>
<td>56.3/21.9</td>
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<td>0.882</td>
</tr>
<tr>
<td>PP4</td>
<td>54.1/12.5</td>
<td>48.7/16.6</td>
<td>44.5/21.7</td>
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<td>PP5</td>
<td>62.4/14.3</td>
<td>60.0/13.8</td>
<td>56.3/21.3</td>
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<td>41.9/15.8</td>
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<tr>
<td><strong>Female: PP1</strong></td>
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<tr>
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<td>58.1/20.7</td>
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<td>52.0/19.7</td>
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<td>0.490</td>
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<td>56.3/27.4</td>
<td>57.9/22.2</td>
<td>57.9/16.3</td>
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<tr>
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<td>36.5/11.1</td>
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<td>0.775</td>
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</table>

Note: Set $\alpha = 0.05$
| Variables | Groups | \[
\begin{array}{lllll}
 & \text{EF} & \text{PS} & \text{C} & \text{F} & \text{p} \\
\hline
\text{(N = 45)} & \text{M/SD} & \text{M/SD} & \text{M/SD} & (2,42) & \\
\hline
\text{Male: PP1 (Em)} & 66.9 & 58.7 & 52.0 & 2.09 & .136 \\
& & 17.0 & 20.2 & 22.5 & \\
\text{PP2 (Soc)} & 62.9 & 55.4 & 51.2 & 1.62 & .209 \\
& & 15.4 & 18.2 & 20.2 & \\
\text{PP3 (Sa)} & 66.9 & 63.5 & 54.9 & 1.06 & .355 \\
& & 24.5 & 19.9 & 24.9 & \\
\text{PP4 (Int)} & 73.6 & 61.9 & 43.2 & 11.83 & .001* \\
& & 16.6 & 13.3 & 20.9 & \\
\text{PP5 (Rec)} & 72.3 & 63.2 & 55.7 & 4.16 & .022 \\
& & 14.6 & 12.5 & 19.3 & \\
\text{PP6 (Con)} & 64.8 & 45.1 & 38.4 & 7.74 & .001* \\
& & 18.5 & 17.6 & 21.0 & \\
\text{Female: PP1 (B)} & 61.3 & 44.0 & 39.2 & 6.22 & .004* \\
& & 20.3 & 18.1 & 15.4 & \\
\text{PP2} & 67.7 & 57.3 & 53.3 & 2.54 & .091 \\
& & 16.6 & 18.7 & 18.8 & \\
\text{PP3} & 71.7 & 62.1 & 63.2 & .80 & .456 \\
& & 22.0 & 27.3 & 18.0 & \\
\text{PP4 (D)} & 66.9 & 55.5 & 43.5 & 10.92 & .001* \\
& & 12.2 & 15.5 & 13.3 & \\
\text{PP5} & 71.7 & 66.1 & 58.8 & 2.26 & .116 \\
& & 16.2 & 17.1 & 16.7 & \\
\text{PP6} & 53.1 & 35.7 & 32.0 & 4.92 & .012 \\
& & 22.9 & 21.5 & 12.9 & \\
\end{array}
\]

Note: $\alpha = .05/6 = .008$

$\alpha = p < .008$

$B = \text{EF} > \text{PS, C}$

$C = \text{EF, PS} > \text{C}$

$D = \text{EF, PS} > \text{PS, C, Therefore, EF} > \text{C}$
Table E-12

Individual Post-test DAS Scores

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<td>C</td>
<td>F</td>
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<td>M/SD</td>
<td>M/SD</td>
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Note: \( \alpha = .05/4 = .0125 \)

* \( p < .0125 \)

B = EF > PS, C
C = EF, PS > C
D = EF, PS > PS, C. Therefore, EF > C
Table E-13

Repeated Measures Analysis: Follow-up Scores on Non-Differentiating Variables

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<td></td>
<td></td>
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<tr>
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<td>7.6 ( 1.7)</td>
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<td>49.8 (17.2)</td>
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<td>II</td>
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<td></td>
<td></td>
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</tr>
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<td>55.7 (16.2)</td>
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<td>TG</td>
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Note: EF, n = 15; PS, n = 14
a = .05/7 = .007
G = Group F Statistic
T = Time F Statistic
TG = Interaction, Time by Group
Table E-14

Summary Anovas: Individual Total DAS Scores at Follow-up

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<th>Source of Variation</th>
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<th>DF</th>
<th>F</th>
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<td><strong>Female:</strong></td>
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Note: $\alpha = .05$  \* = $p < .05$. 
### Table E-15

Individual Follow-Up Scores on Variables Differentiating Groups at Post-Assessment

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<tr>
<th>Variables</th>
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<th>PS</th>
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<th>p</th>
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<td>34.9 (4.4)</td>
<td>G 8.51</td>
<td>.007*</td>
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<tr>
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<td>.577 .454</td>
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<tr>
<td>TC</td>
<td>I</td>
<td>3.7 (.62)</td>
<td>3.1 (.92)</td>
<td>G 7.31</td>
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<td>3.0 (.73)</td>
<td>T .787</td>
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<td>.039</td>
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**Note:**
- α = .05/5 = .01
- * = p < .01
- EF, n = 15; PS, n = 14
### Table E-16

**Individual Follow-Up Scores on Variables Not Differentiating Groups at Post-Assessment**

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**Note:** \( \alpha = .05/7 = .007 \)  
EF, n = 15; PS, n = 14