

Differential Effects of Experiential and Problem-Solving Interventions in Resolving Marital Conflict

Susan M. Johnson and Leslie S. Greenberg
University of British Columbia, Vancouver, British Columbia

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 treatments or to 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 therapists 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. Furthermore, the effects of the emotionally focused treatment were superior to those of the problem-solving treatment on marital adjustment, intimacy, and target complaint level. At follow-up, marital adjustment scores in the emotionally focused group were still significantly higher than those in the problem-solving group.

The more dynamic approaches to marital therapy seem to have produced much practice but little research and have made unique contributions to the understanding of relationship processes but not to the technology of treatment interventions (Gurman, 1978). These approaches have tended in practice to be eclectic and pragmatic rather than rigorous in the specification of interventions designed to modify marital interactions. Jacobson (1978a) suggested that it is crucial for other approaches to follow the example set by their behavioral colleagues and to specify and empirically validate their interventions.

Considerable attention has recently been given to the role of affect in psychotherapy in general (Greenberg & Safran, in press; Mahoney, in press; Rachman, in press) and

in marital therapy in particular (Finchman & O'Leary, 1982; Margolin & Weinstein, 1983). It is becoming increasingly clear that a complete approach to therapy needs to deal not only with cognitive and behavioral processes but also with affective processes. The experiential and dynamic approaches focus extensively on affective processes but have not always clearly specified the interventions used. This is particularly true in experiential marital therapy. A set of affective interventions was therefore specified in order to test the efficacy of an integrated affective systemic approach to marital therapy (Greenberg & Johnson, in press).

Most of the comparative research in marital therapy has been concerned with comparing the effectiveness of different components of the behavioral approach. The one nonanalogue study comparing behavioral interventions with another form of therapy is that of Liberman, Levine, Wheeler, Sanders, and Wallace (1976), who compared the effects of communication training plus contingency contracting group interventions and an insight approach. Results were inconclusive; both groups improved on self-report measures, but only the behavioral group improved on problem-solving skills. Methodological problems

Preparation of this article was supported in part by Social Sciences and Humanities Research Council Grants 410830726 and 410840135 to the second author and represented the first author's doctoral dissertation.

We gratefully acknowledge the assistance of Bob Prosser with data analysis and Gisella Theurer with data collection.

Requests for reprints should be sent to Susan M. Johnson, who is now at the Department of Psychology, University of Ottawa, 651 Cumberland Street, Ottawa, Ontario, K1N 6N5, Canada.

such as the lack of a control group, no random assignment, and a small therapist sample biased in favor of the behavioral treatment makes even these inconclusive results tentative.

The present study was implemented to evaluate an emotionally focused treatment (EF) according to a treatment manual (Greenberg & Johnson, in press) and to compare the effectiveness of this treatment with an untreated wait-list control (C) and the problem-solving (PS) intervention outlined by Jacobson and Margolin (1979). This PS treatment seems to epitomize the present behavioral approach to marital therapy, which includes cognitive components, and has been extensively and rigorously researched during the last decade (Jacobson, 1977, 1978b, 1979).

Thus, couples seeking assistance for problems in conflictual relationships were randomly assigned to one of the two treatment groups (EF or PS) and to one of the six therapists implementing each treatment or to the wait-list control group. Treated couples received eight sessions of conjoint marital therapy and were measured at assessment, after treatment, and at 2-month follow-up. Control groups were assessed after a 2-month waiting period and then were treated.

Method

Subjects

Couples requesting counseling in response to a newspaper article were screened by phone and in an assessment interview. The article described the research project as one that provided counseling for couples to help them resolve problems and gave a phone number to call. To be included, couples had to be presently living together and to have been cohabiting for a minimum of 1 year, to have no immediate plans for divorce, to have received no psychiatric treatment within the last 2 years, to be free of alcohol or drug problems and primary sexual dysfunction, not to be presently involved in other psychologically oriented treatment, and at least one partner had to score in the distressed range (under 100) on the Dyadic Adjustment Scale (DAS; Spanier, 1976).

Two couples were excluded because they had been living together less than a year; five couples were excluded because they had already separated and were living apart; seven couples were excluded because they had recently been or were currently receiving psychiatric treatment for problems such as depression; two couples were excluded because one of the partners was reportedly alcoholic; three couples were excluded because they reported their marital problem as primarily involving sexual dysfunction; six couples were excluded during the assessment

interview because their scores on the DAS were above the criteria set for distress; 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.

Forty-five couples entered the study, 15 in each treatment group and 15 in the control group. The mean length of partnerships was 8.6 years (range = 1–24 years), and the average educational level of spouses was 15 years. There was an average of 1.75 children per family (range = 0–7 children), and 22% of the spouses had been married previously. Seven couples had received previous marital therapy. When these demographic variables were analyzed, no significant differences were found among the three groups.

Therapists

Twelve therapists participated. Six therapists (two men and four women) administered each treatment. Therapists in both groups possessed an average of 4 years clinical experience that included marital therapy implemented within the framework of the model they used in this study. All therapists were trained in and professed an orientation congruent with the model of therapy they were asked to implement. All therapists had at least a master's degree in clinical or counseling psychology or in social work. Each group of therapists was given 12 hr of additional training by an experienced trainer in the implementation of the therapy manual describing the approach they were using. Therapists were also given brief telephone consultations and 2 hr of group supervision during the study; both groups received the same amount of assistance.

Measures

The Test of Emotional Styles (ES; Allen & Hamsher, 1974). This test measures three factors of emotional style, Orientation, Expressiveness, and Responsiveness, and was used to check for group equivalence on these three factors in order to ensure that treatment effects would not be confounded with a group bias toward emotional experience. Allen and Hamsher reported convergent and divergent validity and internal consistency data; reliability for the three factors just listed were .92, .90, and .85, respectively.

The Couples Therapy Alliance Scale (AS; Pinsof & Catherall, 1983). This instrument was completed by each client in private after the third therapy session and is a measure of the client's view of the therapeutic relationship, based on the work of Bordin (1979). The measure contains three components: bond between therapist and client, agreement as to therapeutic goals, and engagement in tasks relevant to the process of therapy. These three components are viewed in relation to Self, Other, and the Relationship in three separate subscales. The client responds to the 28 items on a Likert-type 5-point scale. This instrument was intended to control for the relationship factors that have been shown to be important in predicting therapeutic outcomes. Because it is still in the process of revision, item analyses were

conducted, and the reliability (internal consistency) for this sample was .96 for the total test and .88, .92, and .85, respectively, for each of the subtests (Self, Other, and Relationship).

Dyadic Adjustment Scale (Spanier, 1976). This widely used self-report questionnaire can be scored as an index of global marital adjustment (total score) or can be broken down into four subscales, Consensus (13 items), Satisfaction (10 items), Cohesion (5 items), and Affectional Expression (4 items). It is at present the instrument of choice for the assessment of marital adjustment in terms of reliability and validity. Spanier reports a reliability of .96 (Cronbach's alpha). Most items involve a 5- or 6-point Likert-type scale defining the amount of agreement or frequency of an event. When subjected to an item analysis the reliability (internal consistency) for the total test for this sample ($N = 45$) was .84, and the subtest reliabilities were .73, .78, .79, and .58, respectively.

Target Complaints (TC; Battle et al., 1966). This measure was recommended by Waskow and Parloff (1975) as a core battery instrument for use in outcome research and consists of a 5-point scale on which each client is asked to rate the amount of change on the presenting problem. Battle et al. gave evidence as to the validity and reliability of this measure and reported a reliability (test-retest) of .68.

Goal Attainment Scaling (GAS; Kiresuk & Sherman, 1968). This procedure is a means of obtaining from clients specific, observable, and qualifiable individual goals for therapy and of measuring the attainment of these goals. Five levels of attainment—worse than expected results, less than expected results, expected results, somewhat better than expected results, and much better than expected results—were specified during assessment in terms of three specific behaviors and one emotional response.

The Personal Assessment of Intimacy in Relationships Inventory (PAIR; Schaefer & Olson, 1981). This instrument consists of 36 items arranged in six subscales, Emotional, Social, Sexual, Intellectual, and Recreational Intimacy, and Conventional; this last subscale was designed to measure social desirability factors. The test was constructed so that a difference score is obtained between perceived and expected levels of intimacy, but only the perceived scores were used in this study. Couples indicate agreement or disagreement on a 5-point Likert-type scale. Schaefer and Olson (1981) reported reliabilities for all subtests in the .70 range. The reliabilities for this sample were .69, .64, .79, .57, .72, and .67, respectively. As suggested by Clayton (1975), the Conventional subscale was viewed in this study as a measure of functional relationship idealization.

A posttreatment interview was conducted to gather descriptive data as to how couples experienced the process of therapy. Control couples completed an Activities While Waiting Questionnaire to check for other possible therapeutic factors that might have occurred during the waiting period.

Manipulation Checks

To ensure treatment validity, the interventions used by the therapists in the treatment sessions were monitored and rated by two trained graduate student raters who

viewed the videotapes of selected sessions and who were not informed as to which treatment they were observing. The raters categorized the therapist interventions into the categories of the implementation checklist that was devised for this study.

This checklist comprises six categories of interventions. One category contains 3 general interventions that were common to both treatments, such as information gathering. The five other categories were problem definition, dealing with attacking behavior, facilitating listening, directing the process of therapy, and facilitating problem resolution. In these five categories, 10 differential interventions taken from each of the two treatment manuals were described; for example, contrasting interventions in the problem-definition category might be (a) the therapist defines the problem in terms of emotions underlying interactional positions (EF) or (b) the therapist defines the problem in terms of manifest behaviors and lack of skill (PS).

Two 10-min segments from the middle and final third of 120 sessions were observed and rated. These sessions were selected randomly from the total 240 sessions. Each couple was thus observed for 80 min during therapy. An intervention was defined as a complete therapist statement; in all, 1,866 interventions were coded. Of these, only 47 (2.5%) were coded in categories that were inappropriate to the treatment condition being observed. Interrater reliability was calculated on 406 observations (20.8%) taken from 25 randomly chosen sessions. The two raters agreed on 93% of the interventions observed. Cohen's kappa (1960), which considers the proportion of agreement after chance agreement has been removed from consideration, was .99 for cross-treatment agreements and .95 for interventions within treatments. These statistics suggest that the treatments were implemented according to the treatment manuals and were able to be differentiated easily and reliably.

Procedure

After telephone screening and assessment interviews, couples were informed of research requirements and were given pretests. Treatment couples were randomly assigned to treatment and therapist and were seen weekly for eight 1-hr sessions. All sessions were videotaped and audiotaped. Couples completed the Alliance Scale after the third session. At the end of treatment or the waiting period, couples were reassessed; treatment couples were informed of the follow-up procedures, and wait-list couples were assigned to a therapist for treatment. Treatment couples were contacted by phone 8 weeks after termination, and follow-up questionnaires were sent to them in the mail. There were no dropouts from this study. This unusual lack of attrition may be due to the excellent quality of the therapists in this study and the alliance ($M = 117.45$, maximum possible = 140) they were able to create with their clients.

Experimental Conditions

The problem-solving treatment used in this study is based on the concept that couples may be taught to become more skilled at negotiation and positive control strategies so that coercive tactics will be unnecessary and

also may be taught to control the negative communication practices that have become habits in their relationship. Although this approach is concerned with teaching behavior management, there is also a focus on the enhancement of positive exchanges. As Margolin and Weinstein (1983) pointed out, such a skill-oriented stance places a value on rational rather than emotional processes, the expression of feeling being confined in therapy mostly to the clarification of the impact of one partner's behavior on the other. Rules for effective communication, problem definition, and problem solution, including the making of contractual agreements, are taught, modeled, and rehearsed. Problems are defined in terms of specific manifest behaviors, and couples are taught communication skills, such as paraphrasing, that help them to manage conflict in their relationship. The therapist's role is mainly that of teacher and coach. The treatment manual for this intervention may be found in Jacobson and Margolin (1979). The effectiveness of this treatment as opposed to other components of the behavioral approach, such as contingency contracting, has been demonstrated (Jacobson, 1977).

The emotionally focused treatment represents an integrated affective systemic approach to marital therapy (Greenberg & Johnson, in press) and is based on the experiential tradition of psychotherapy, which emphasizes the role of affect and intrapsychic experience in change (Gendlin, 1974; Greenberg & Safran, in press; Perls, Hefferline, & Goodman, 1951; Rogers, 1951), and the systemic tradition, which emphasizes the role of communication and interactional cycles in the maintenance of problem states (Sluzki, 1978; Watzlawick, Beavin, & Jackson, 1967). In this model, clients are viewed as active perceivers constructing meanings on the basis of their current emotional state and experiential organization and are seen as having healthy needs and wants that can emerge in the safety of the therapeutic environment. It is not partner's feelings and wants that are considered the problem, but rather the disowning, or disallowing, of these experiences that leads to ineffective communication and escalating interactional cycles.

From this perspective, problems are seen as being maintained by self-sustaining, reciprocal, negative interaction patterns, the most basic of which appears to be a pursuer-distancer or attack-withdraw pattern that springs from and sustains each partner's distress and negative perceptions of the other.

The therapist in this approach therefore identifies the negative interaction cycles and guides the couple in accessing the unacknowledged feelings underlying each person's position in this cycle. Particular attention is paid to underlying vulnerabilities, fears, and unexpressed resentments. This process of accessing and expressing previously unacknowledged feelings is to be distinguished from the ventilation of superficial or defensive reactions and from talking about feelings on a rational level; it is a synthesis of new emotional experience in the present (Greenberg & Safran, in press). The therapist uses the methods of Gestalt therapy and innovations from client-centered therapy (Rice, 1974) to access and heighten specific underlying responses. The therapist then reframes the problem in terms of these emotional responses and encourages clients to identify with their disowned feelings and needs and to accept and respond to their partner's needs. Finally, the therapist helps the couple to consolidate

their new positions in relation to their partner and focuses on the strengthening of trust and intimacy that arises from this process. The treatment goal here is the creation of a new emotional experience to promote new interactional positions.

The wait-list control group was told that a therapist could not be assigned to them at present and that there would be a maximum required wait of 8 weeks before the treatment could begin. At the end of 7 weeks clients in the group were contacted, and a time was set for a reassessment of the present status of the relationships and the first therapy session. The Activities While Waiting Questionnaire was given to monitor other possible therapeutic activities during this period, such as reading self-help books, and a minimal amount of such potentially therapeutic activity was reported.

Results

Preliminary analyses consisted of item and test analyses as well as tests for group equivalence on demographic variables and the Test of Emotional Styles. No significant group differences were found on the three subscales of this test for male or female spouses. Also, no significant differences were found between the means of the two treatment groups on any of the subscales or on the total score for the alliance measure ($p < .20$). These results suggest that both groups had therapeutic alliances of a similar quality and found the treatments equally relevant to their concerns. Differential therapist effects were also tested by a series of one-way analyses of variance (ANOVAS; Therapist \times Individual Score on Each Postmeasure) in which therapists were treated as a fixed factor. The critical significance level corrected by the Bonferroni procedure (Hays, 1981) would be .0027, however these results were not significant even at the .01 level. Thus, there was no evidence of differential therapist performance.

Pretreatment Measures

Preliminary univariate analyses on all DAS and PAIR subscales and an overall multivariate test found no significant differences between groups, $F(20, 68) = .83, p < .66$. Total adjustment scores (DAS) for couples, not included in the multivariate analysis of variance (MANOVA) because of lack of independence, were not significantly different in the three experimental groups, $F(2, 42) = .06, p < .94$. The mean on this variable for the couples in the EF group was 92.8 ($SD = 8.8$);

for PS couples the mean was 91.7 ($SD = 8.1$) and for the controls, 91.9 ($SD = 10.7$). Couples' distress level was then consistent across groups.

Treatment Effects

Because the total DAS score could not be included in a multivariate analysis, an ANOVA was conducted, $F(2, 42) = 16.79, p < .001$, and post hoc comparisons using Tukey's procedure found that all groups were significantly different from each other.

The results of a MANOVA conducted on treatment outcome variables are presented in Table 1. The overall F statistic was as follows: $F(24, 64) = 1.24, p < .001$. To guard against the problem of escalating Type I error rate, the Bonferroni procedure was used to calculate the critical significance level for each univariate test. After post hoc Tukey statistics were calculated on each variable with a significant F ratio, the results were as follows:

1. Both treatment group means were sig-

nificantly higher than controls on the DAS subscale, Consensus; on TC and GAS; and on the PAIR subscale, Intellectual Intimacy.

2. Only the EF treatment group means were significantly different from controls on the DAS subscales, Satisfaction and Cohesion, and on the PAIR subscale, Conventionality.

3. The EF treatment group scored significantly higher than did the PS group on the total DAS score and on the DAS subscales, Satisfaction and Cohesion; on the PAIR subscales, Intellectual Intimacy and Conventionality (here interpreted as Idealization); and on TC improvement. Thus, the EF and PS groups did not differ significantly on the DAS subscale, Consensus, or on GAS, although both differed from controls on these measures.

Although the subscales Affectional Expression ($p < .01$) and Emotional Intimacy ($p < .015$) did not reach the .004 level of significance, the trend here was in favor of the EF treatment. The results at termination show both treatments are more effective than a wait-list control and also show differential effects consistently in favor of the EF treatment.

Table 1
Multivariate Analysis of Variance: Means for Treatment Outcome Variables

Variable	Group			$F(2, 42)$
	EF	PS	C	
DAS				
Consensus	48.13	47.53	40.8	8.25*
Satisfaction	38.43	34.10	31.70	8.60*
Cohesion	17.27	13.80	11.90	13.91*
Affectional Expression	8.87	7.0	7.13	5.12
PAIR				
Emotional	64.13	51.33	45.60	4.68
Social	65.33	56.40	52.26	2.74
Sexual	69.33	62.80	59.06	0.92
Intellectual	70.26	58.66	43.33	20.29*
Recreational	72.0	64.67	57.27	3.98
Conventionality	64.80	45.07	38.40	7.74*
TC	3.70	3.07	1.17	69.89*
GAS	60.0	57.33	42.33	31.11*

Note. EF = emotionally focused, PS = problem solving, C = wait-list control, DAS = Dyadic Adjustment Scale, PAIR = Personal Assessment of Intimacy in Relationships Inventory, TC = Target Complaints, GAS = Goal Attainment Scaling.

* $p < .001$.

Follow-Up Measures

All treatment couples except one returned the follow-up data ($n = 29$). The focus of the follow-up was to determine whether differential effects found at treatment termination would also be found 8 weeks later. Because the total DAS score could not be included in a MANOVA, a repeated measures ANOVA was conducted, and a significant difference was found between groups, $F(1, 27) = 9.4, p < .005$. The mean for the EF group was 112.4 ($SD = 11.2$) and for the PS group, 101.1 ($SD = 8.9$). No significant time effect or Time \times Group interaction was found.

The results of a repeated measures MANOVA conducted on the variables that differentiated between groups at the end of treatment, that is, on Satisfaction, Cohesion, Intellectual Intimacy, Conventionality, and TC, are shown in Table 2; the overall multivariate $F(5, 23) = 3.67, p < .014$. Thus, the general difference between groups found at treatment termination held at follow-up. The critical significance level for univariate statistics was set at .01

(Bonferroni correction). No significant time effect or Time \times Group interaction was found. The Conventuality variable failed to differentiate between the two groups; the EF group appeared to regress on this variable ($p < .03$). The Intellectual Intimacy and TC variables just failed to reach significance at the .01 level ($p < .014$, for both). However, the EF group means on the Satisfaction and Cohesion variables continued to be significantly higher ($p < .007$ and $p < .001$). This analysis was repeated after treatment with the variables that did not differentiate between treatments in order to check for sleeper effects; however, the multivariate F statistic was not significant. The group means at pretest, posttest, and follow-up assessment are presented in Figure 1.

Individual Analyses

Additional analyses were conducted on individual scores, and these are briefly reported

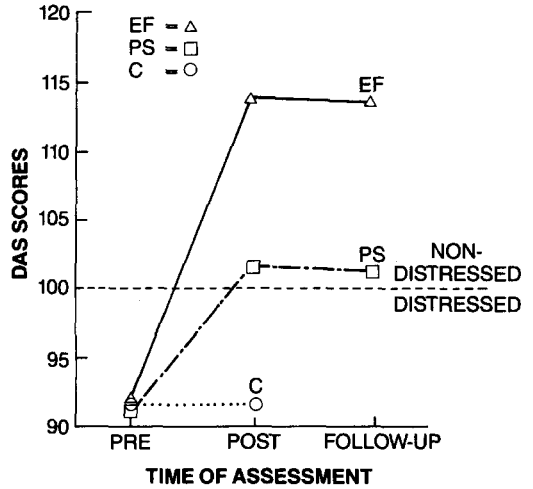


Figure 1. Group means on total Dyadic Adjustment Scale (DAS) scores at pretest, posttest, and follow-up. (EF = emotionally focused, PS = problem solving, C = wait-list control.)

Table 2
Repeated Measures Analysis: Follow-up Mean Scores on Differentiating Variables

Variable	Time	Group		F(1, 127)
		EF (n = 15)	PS (n = 14)	
DAS				
Satisfaction	1	38.6	34.0	8.48 ^{a*}
	2	38.3	34.1	0.03 ^b
Cohesion	1	17.6	13.9	15.89 ^{a*}
	2	16.9	13.6	2.11 ^b
TC	1	3.8	3.3	6.87 ^{a*}
	2	3.7	3.1	0.97 ^b
PAIR				
Intellectual	1	70.3	58.3	6.87 ^{a*}
	2	68.7	58.6	0.06 ^b
Conventuality	1	64.8	45.0	5.38 ^{a*}
	2	55.5	44.6	2.47 ^b

Note. EF = emotionally focused, PS = problem solving, DAS = Dyadic Adjustment Scale, TC = Target Complaints, PAIR = Personal Assessment of Intimacy in Relationships Inventory.

^a Group F statistic. ^b Time F statistic. ^c Time \times Group interaction.
^{*} $p < .01$.

here. No significant differences between groups were found on any of the pretreatment variables when male and female scores were considered separately. The additional information of interest given by these analyses is as follows: If posttreatment total DAS scores are considered individually, only means for men were significantly different in all three groups; the EF mean was the highest and the control mean, the lowest; for women, both treatment group means were significantly higher than that for controls, but the difference among them was not significant. Significant differences between treatment groups for the variable Conventuality (interpreted as Idealization), which was significant in the analysis of couple scores, were found on male means only. For female partners only, Emotional Intimacy and Affectional Expression were significantly higher in the EF group; these variables did not reach significance in the couples analysis. Intellectual Intimacy did not differentiate between treatment groups in individual analyses, although significant differences were found between C and EF groups when female scores were considered and between both treatment groups and controls when male scores were considered. At follow-up, significant differences between groups were found on the DAS total scores when

men and women were considered separately ($p < .006$ and $p < .011$, respectively); in both cases EF individual scores were higher. When female scores were considered, Satisfaction and Cohesion failed to reach the critical level for significance, whereas the means for men were significantly different at the .01 level.

Descriptive Data

The main results of the posttreatment interview, which probed couples' experience of therapy, were that couples' experience of therapy was consistent with the two therapy manuals; clients in the PS group spoke of having more skills and engaging in negotiations more often, and those in the EF group spoke of experiencing underlying feelings and perceiving each other differently. The Activities While Waiting Questionnaire results for the control group suggested that the waiting period was uncontaminated by other significant therapeutic events. As to deterioration, there were no significant decreases of total DAS scores in the treatment groups; the largest drop from earlier scores was a drop of 7.5 computed on an EF couple at follow-up. One separation was reported after follow-up by a couple in the PS group, but this was by mutual consent and was amicable. If couples' posttreatment total DAS scores are viewed in terms of effect size (Smith & Glass, 1977), this statistic computes at 2.19 for the EF group and 1.12 for the PS group. The mean effect of the EF treatment in this sample is more than two standard deviations from the mean of the control group after the waiting period. Were couples nondistressed at the end of therapy? The mean total DAS score for the EF treatment couples after treatment ($M = 112.7$) is within 2 points of Spanier's norm for married couples ($M = 114.8$), and this level was the same at follow-up; also, seven of the EF couples scored above this norm at termination and follow-up. The mean for PS couples after treatment was 102.4, and for controls after the waiting period, 91.5.

Discussion

In this study, both treatments significantly improved the quality of dyadic relationships. The study therefore replicates the past re-

search on the effectiveness of the PS treatment, which in this study increased the total DAS level, as well as the amount of Consensus and Intellectual Intimacy between partners, and facilitated improvement in the Target Complaint that brought couples to therapy and the attainment of relationship goals, as measured by the GAS.

The results of this study demonstrate the effectiveness of the affective systemic emotionally focused treatment, which increased total DAS level and the Consensus, Satisfaction, and Cohesion elements of this scale, as well as the amount of Intellectual Intimacy and Conventionality (Idealization) between partners and facilitated improvement in TC and GAS. This suggests that focusing on inner experience as it is translated into relationship events during interaction may be a powerful tool for changing the nature of relationships.

Differential outcome effects for the two treatments were found. The results and the trends in these results were consistently in favor of the EF group. The EF group means were significantly higher on total DAS score, on the Satisfaction and Cohesion aspects of this score, on Intellectual Intimacy and Conventionality, and on TC improvement. At follow-up, the first three measures just mentioned continued to differentiate between groups.

It is interesting to note that the EF couples' improvement on Consensus and GAS was consistent with that made by PS couples even though these are variables that may be expected to be especially responsive to the PS treatment. This would seem to suggest that the EF treatment also had an effect on a couple's ability to negotiate and change specific behaviors in spite of the fact that these areas were not focused on in terms of skill training or contracting. It may be that the increase in trust and responsiveness, which is the goal of the EF treatment, has an effect in these areas. The clarification of positions taken in relation to each other may be as useful as training in negotiating rules. As Gurman suggested (1981), poor social skills in a relationship often reflect relationship rules of minimal disclosure and self-exposure.

The differential increase in Satisfaction and Cohesion attained by EF couples may

reflect the fact that this treatment attempts to address what Gurman (1978) referred to as the felt needs of the couple directly, especially if positive affect is considered the most important characteristic of a good marriage, as Broderick (1981) suggested. Hahlweg, Schindler, Revenstorf, & Brengelmann (1984) found that the emotional-affective quality of the relationship predicted successful outcome in therapy and suggested that whereas a behavioral approach facilitates the improvement of manifest behaviors such as problem solving, it is perhaps less well suited to deal with the internal experiences affecting the emotional qualities of a marriage. The increased idealization of spouse and relationship found in the EF group seems in light of individual scores to be mainly a reflection of idealization on the part of the male spouses. It may be that because a man is generally less oriented toward emotion, the opportunity to access and express emotion results in a more positive and romantic estimation of his spouse. This effect would seem to be short lived because it was not found to be significant at follow-up. Intellectual Intimacy was also higher in the EF group, implying that the generation of openness and trust perhaps generalizes to the discussion of rational issues. The increased reduction of the TC in the EF group may be considered evidence for the importance of emotional experience in therapeutic change. If such experience provides a framework for the creation of meaning in a relationship and overrides other cues, then the modification of such experience directly addresses the sense of deprivation and pain that is reflected in the target complaint or core struggle.

The fact that assignment to treatment was random, that implementation was monitored, and that therapeutic alliance was consistent across groups adds credibility to the claim that differential effects in outcome 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, consistent across treatment groups, suggest that both treatments were equally credible and relevant to participants.

One potential limitation of this study was the use of the first author as one of the EF therapists. This author did not administer

any posttests, however, and there are no data to suggest differential therapist effects or differential therapist-client alliances. Nevertheless, it would have been preferable to have kept these roles separate. Also, although every attempt was made to operationalize both treatments in a parallel and equitable fashion, the researchers were possibly biased toward the EF treatment because they had developed this treatment. To ensure external validity, this study should therefore be replicated by other investigators.

The mean level of distress for the couples in this study ($M = 92.1$, $SD = 9.1$, range = 71–105) on the pretest total DAS score suggests that this sample is most accurately considered as moderately distressed rather than severely distressed. However, as Jacobson, Follette, and Elwood (1984) pointed out, even though the inclusion of some mildly distressed couples may appear to ease the task of therapy, it also increases the difficulty of demonstrating treatment effects. The fact that couples were solicited also prompts a question as to how representative this sample was of a clinical population. However, most of the couples involved had considered or were considering separation, and all were willing to engage in tedious and demanding research procedures to obtain and complete treatment.

The fact that therapists are nested under treatment has disadvantages and advantages (O'Leary & Turkewitz, 1978). In light of the fact that no evidence exists for differential therapist effectiveness and the large number of therapists used (12), the advantages (the fact that all therapists were committed to and were trained in the approach they implemented and thus were more able to produce a pure sample of each therapy) appear to outweigh the disadvantages. No significant differences were found between the two groups of therapists on variables such as years of clinical experience or training or the quality of the relationship they were able to create with their clients as measured by the Alliance Scale (Pinsof & Catherall, 1983). However, because of the limited statistical power present in the analysis of differential therapist effects it is possible that treatment differences were in some way a reflection of the different sets of therapists.

The study could be viewed as being limited by the fact that all measures were self-report. However, this kind of measurement seems to be particularly appropriate in the sense that marital satisfaction or well-being is a qualitative, subjective factor rather than an externally quantifiable phenomena, and thus it is the perception of behaviors that is salient to marital satisfaction. Also, in recent studies, Jacobson et al. (1984) 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 whether those behaviors did in fact occur in the relationship. The difficulty of attaining relevant objective measures is also an issue in this field, and it has been suggested that use of coding 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., 1984).

Concerning the issue of social desirability factors on measures such as the PAIR and the DAS, it is logical to presume that any demand characteristics were randomly distributed across both groups and therefore were not confounded with differences between groups. As suggested by O'Leary and Turke-witz (1978), research procedures were set up in such a way as to minimize the client's investment in impression management, for example, ensuring that therapists were absent when questionnaires were completed.

Future research should be conducted to examine in depth the process of conflict resolution in the emotionally focused therapy. This will shed light on how change occurs in this treatment and on the role of affect in the creation of more positive relationships in marital therapy.

References

- Allen, J. G., & Hamsher, J. H. (1974). The development and validation of a test of emotional styles. *Journal of Consulting and Clinical Psychology, 42*, 663-668.
- Battle, C. C., Imber, S. D., Hoehn-Saric, R., Stone, A. R., Nash, E. R., & Frank, J. D. (1966). Target complaints as criteria of improvement. *American Journal of Psychotherapy, 20*, 184-192.
- Bordin, E. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice, 16*, 222-229.
- Broderick, J. (1981). A method for deviation of areas for assessment in marital relationships. *The American Journal of Family Therapy, 9*, 25-34.
- Clayton, R. R. (1975). *The family, marriage and social change*. Lexington, MA: Heath.
- Cohen, J. (1960). A coefficient of agreement for nominal scales. *Educational Psychological Measurement, 20*, 37-46.
- Finchman, F., & O'Leary, D. K. (1982). *Affect in the eighties: A new direction in behavioral marital therapy*. Paper presented at the 90th Annual Convention of the American Psychological Association, Washington, DC.
- Gendlin, E. T. (1974). Client-centered and experiential psychotherapy. In D. A. Wexler & L. North Rice (Eds.), *Innovations in client-centered therapy* (pp. 211-246). New York: Wiley.
- Greenberg, L., & Johnson, S. M. (in press). Emotionally focused couples therapy: An integrated affective systemic approach. In N. S. Jacobson & A. S. Gurman (Eds.), *The clinical handbook of marital therapy*. New York: Guilford Press.
- Greenberg, L., & Safran, J. (in press). Integrating affect and cognition: A perspective on the process of therapeutic change. *Cognitive Therapy and Research*.
- Gurman, A. S. (1978). Contemporary marital therapies: A critique and comparative analysis of psychoanalytic, behavioral and systems theory approaches. In T. J. Paolino & B. S. McCrady (Eds.), *Marriage and marital therapy* (pp. 445-566). New York: Brunner/Mazel.
- Gurman, A. S. (1981). Integrative marital therapy. Toward the development of an interpersonal approach. In S. H. Budman (Ed.), *Forms of brief therapy* (pp. 415-453). New York: Guilford Press.
- Hahlweg, K., Schindler, L., Revenstorf, D., & Brengelmann, J. C. (1984). The Munich marital therapy study. In K. Hahlweg & N. S. Jacobson (Eds.), *Marital interaction: Analysis and modification* (pp. 3-26). New York: Guilford Press.
- Hays, W. L. (1981). *Statistics*. New York: Holt Rinehart & Winston.
- Jacobson, N. S. (1977). Problem solving and contingency contracting in the treatment of marital discord. *Journal of Consulting and Clinical Psychology, 45*, 92-100.
- Jacobson, N. S. (1978a). A review of the research on the effectiveness of marital therapy. In T. J. Paolino & B. S. McCrady (Eds.), *Marriage and marital therapy* (pp. 395-444). New York: Brunner/Mazel.
- Jacobson, N. S. (1978b). Specific and nonspecific factors in the effectiveness of a behavioral approach to the treatment of marital discord. *Journal of Consulting and Clinical Psychology, 46*, 442-452.
- Jacobson, N. (1979). Increasing positive behavior in severely distressed marital relationships: The effects of problem solving training. *Behavior Therapy, 10*, 311-326.
- Jacobson, N. S., Follette, W. C., & Elwood, R. W. (1984). Outcome research in behavioral marital therapy: A methodological and conceptual reappraisal. In K. Hahlweg & N. S. Jacobson (Eds.), *Marital interaction: Analysis and modification* (pp. 113-129). New York: Guilford Press.

- Jacobson, N. S., & Margolin, G. (1979). *Marital therapy: Strategies based on social learning and behavior exchange principles*. New York: Brunner/Mazel.
- Kiresuk, T. J., & Sherman, R. E. (1968). Goal attainment scaling: General method for evaluating comprehensive community mental health programs. *Community Mental Health Journal*, 4, 443-453.
- Lieberman, R. P., Levine, J., Wheeler, E., Sanders, N., & Wallace, L. J. (1976). Marital therapy in groups: A comparative evaluation of behavioral and interactional formats. *Acta Psychiatrica Scandinavica Monograph, Supplement 226*, 1-34.
- Mahoney, M. (in press). Integrating cognition, affect and action: A comment. *Cognitive Therapy and Research*.
- Margolin, G., & Weinstein, C. D. (1983). The role of affect in behavioral marital therapy. In L. R. Wolberg & M. C. Aronson (Eds.), *Group and family therapy* (pp. 334-355). New York: Brunner/Mazel.
- O'Leary, D. K., & Turkewitz, H. (1978). Methodological errors in marital and child treatment research. *Journal of Consulting and Clinical Psychology*, 46, 747-758.
- Perls, F., Hefferline, R., & Goodman, P. (1951). *Gestalt therapy*. New York: Julian Press.
- Pinsof, W., & Catherall, D. (1983). *The Couples Therapy Alliance Scale manual*. Chicago, IL: The Chicago Center for Family Studies, Northwestern University.
- Rachman, S. (in press). A re-assessment of the "Primacy of Affect." *Cognitive Therapy and Research*.
- Rice, L. (1974). The evocative function of the therapist. In D. Wexler & L. Rice (Eds.), *Innovations in client centered therapy* (pp. 289-312). New York: Wiley-Interscience.
- Rogers, C. R. (1951). *Client-centered therapy*. Boston: Houghton & Mifflin.
- Schaefer, M. T., & Olson, D. H. (1981). Assessing intimacy: The PAIR inventory. *Journal of Marital and Family Therapy*, 1, 47-60.
- Sluzki, C. (1978). Marital therapy from a systems theory perspective. In T. J. Paolino & B. S. McCrady (Eds.), *Marriage and marital therapy* (pp. 366-394). New York: Brunner/Mazel.
- Smith, M. L., & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist*, 32, 752-760.
- Spanier, G. (1976). Measuring dyadic adjustment. *Journal of Marriage and the Family*, 38, 15-28.
- Waskow, I. E., & Parloff, M. B. (Eds.). (1975). *Psychotherapy change measures*. Rochville, MD: National Institutes of Mental Health.
- Watzlawick, P., Beavin, J. H., & Jackson, D. D. (1967). *Pragmatics of human communication: A study of interactional patterns, pathologies, and paradoxes*. New York: Norton.

Received February 28, 1984

Revision received October 1, 1984 ■