EMOTIONALLY FOCUSED MARITAL THERAPY: AN OVERVIEW

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The purpose of this article is to present a recently articulated approach to marital therapy in terms of theory, clinical strategies, and outcome research. The treatment assumes that the most appropriate model for adult intimacy is that of an emotional bond and integrates systemic and experiential change strategies, focusing particularly on resynthesizing the emotions underlying interactional positions.

Marital therapy has become a major treatment modality as an end in itself, as a means to restructure in a family system and as a method of facilitating change in individual symptom patterns (Beach & O'Leary, 1986; Rounsaville & Chevron, 1982). Up to this point behavioral researchers have been considerably more effective than those of other orientations in specifically outlining change techniques and strategies and in testing the outcomes of these strategies (Jacobson, 1978). In fact, there has been a dearth of controlled outcome research in the dynamic approaches (Beach & O'Leary, 1985). One experimental approach which has specified strategies and interventions and has been recently empirically validated is emotionally focused marital therapy (EFT) (Greenberg & Johnson, 1986*a*; Johnson & Greenberg, 1985*a*). This article presents a basic outline of the theory, change strategies, and outcome research associated with EFT.

Theoretical Perspectives

EFT is a synthesis of experiential and systemic perspectives and interventions. Intrapsychic and interpersonal perspectives are combined in that interactional positions adopted by the partners are assumed to be maintained by both individual emotional experience and by the way interactions are organized, that is, by intrapsychic realities and the interactional patterns or rules of the relationship. The goal of therapy is then to access, express, and reprocess the emotional responses underlying each partner's interactional positions and thereby facilitate a shift in these interactional positions toward accessiblity and responsiveness. This then results in a more secure and satisfying bond. Such a shift in position might occur, for example, when a blaming hostile spouse accesses an underlying sense of isolation and a need for reassurance and is able to ask for such reassurance in a manner that evokes acceptance and caring from the other spouse. The therapist using EFT constantly moves between a focus on intrapsychic experience and interpersonal context and uses each to expand on and redefine the other.

EFT is experiential in that it views partners as being active perceivers constantly constructing the meaning of their experience, including their perception of self and the other partner, on the basis of their current emotional state. Emotional experience is considered to override other cues and provide a framework for the creation of meaning.

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

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into the client's sense of self.

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

The EFT approach is systemic in that each partner's response is constantly framed in terms of the other's behavior and in terms of the reaction a particular response is likely to evoke in the other. There is a constant focus on the structure and process of interaction. The degrees of closeness/distance and dominance/submission are monitored as is the unfolding of automatic negative cycles such as "I attack because you withdraw"; "No, I withdraw because you attack." The position each partner takes in the interaction is made explicit, expanded on and linked to underlying emotions. A blaming position might then be framed in terms of a desperate seeking for contact, and in terms of how the other spouse's behavior maintains this desperation. Such a frame allows for a new interaction to be structured around desperation rather than hostility. Certain emotional responses tend to be associated with particular positions; for example, when underlying feelings are attended to, blamers typically speak of being isolated, unloved, and deprived, withdrawers on the other hand often speak of feeling helpless, inadequate, unaccepted, and intruded upon.

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

The primary theoretical assumptions that form the basis for practice of EFT are as follows:

1. The repetitive, rigid, negative interactions found in distressed couples are simultaneously maintained by self-reinforcing complimentary responses, that is, by the organization of the couple system, and the dominant emotional experience of each partner in the relationship. It is necessary, therefore, to deal with both the intrapsychic and the interpersonal in marital therapy.
2. The problematic responses of a distressed couple represent the best attempts that that couple can make to protect themselves from pain while struggling to redefine the relationship in terms of a more secure bond. The needs and desires partners have are best viewed as essentially healthy and potentially adaptive and can be dealt with clearly when recognized and owned. Therefore, emotional responses are validated and legitimized by the therapist.
3. Present rather than past experience provides the richest material for therapy and, in the area of intimate relationships, emotion is primary and overrides other cues. Many responses associated with intimacy, such as affection, are emotional in nature. Such responses cannot be taught or commanded. Emotional experience motivates attachment behaviors, guides perception, and provides a framework for meaning. If a partner's dominant intrapsychic experience is rejection, that partner looks for, sees, and responds to rejection constantly even if it is only minimally present. Discrepant responses, that is, nonrejecting responses, made by the other spouse in fact tend to be discounted. Emotional responses must then be dealt with in marital therapy; they are the main target of change. Primary emotion is seen in EFT as a source of potentially adaptive responses and as a key agent in relationship definition. The distinction between primary and secondary or reactive emotional responses in therapy has been dealt with elsewhere (Greenberg & Johnson, 1986*b*). Secondary emotional responses are usually readily available to consciousness and often take the form of defensive coping strategies, whereas primary emotion is often not attended to, for example, the sense of threat that leads to an aggressive coping response. Primary emotions are used in EFT to create new perceptions, responses, and interactional patterns.

4. The process of change involves the synthesizing of new emotional responses and the enacting of new interactions rather than the learning of new skills or the attainment of insight. New communication patterns arise from new experiences of the self and the other. When partners view the other as accessible and responsive, they are motivated to communicate in a more open and congruent fashion.
5. The most appropriate paradigm for adult sexual intimacy is that of an emotional bond (Johnson, 1986). Such a bond encompasses attachment behaviors such as proximity seeking and affectional aspects such as a sense of security and closeness. The key issue of marital conflict is then the security of the interpersonal bond, and the cornerstones of such a bond in marriage are considered to be accessibility and responsiveness (Ainsworth, 1973). This assumption suggests that change strategies such as the teaching of negotiation skills that are based on a social exchange paradigm of close relationships (Thibaut & Kelley, 1959), where giving is initiated to obtain a reward, may be less effective and appropriate than strategies that focus on affect and each partner's ability to respond to the other's emotional needs. This point is elaborated further elsewhere (Johnson, 1986).

Clinical Strategies and Interventions

Treatment usually involves 8–15 sessions, the first two of which constitute assessment. The last two sessions are generally spread over 4 or 5 weeks. EFT consists of a sequence of steps which the partners progress through and repeat at deeper and more relevant levels as therapy progresses. These steps are:

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

Systemic and experiential perspectives and interventions are meshed, and they interlock in most of the steps of therapy; however, occasionally system or experience becomes a more primary focus; for example, in step 2 the sequence of interactional responses is the primary focus, whereas in step 3 of therapy intraphysic experience and how it is processed is the primary focus.

The first two steps of therapy are primarily concerned with assessment, the clarification of how each partner experiences the relationship and views the process of interaction, and the positions each takes in the negative interactional cycle. Assessment involves two conjoint sessions and one individual session for each spouse. The aim of the individual sessions is to explore issues such as the level of commitment to the relationship and the perception of the spouse, which are easier to assess in the absence of the partner. Individual sessions can also help to establish a therapeutic alliance. Such sessions also allow the therapist to probe and formulate hypotheses as to the emotional experience underlying interactional positions. The conjoint assessment sessions focus on the history of the relationship and relationship problems, on problematic events and responses, and on the observation of interactional patterns. EFT is designed to be a brief form of psychotherapy, that is, it is designed to be implemented in approximately 15 sessions. Positive indicators of suitability for EFT are presenting problems such as general marital dissatisfaction and alienation, lack of intimacy, and power struggles, and interactional patterns such as blame and withdrawal. Contraindications include any condition under which the experience or expression of vulnerability is not likely to be adaptive or respected. Such conditions are found in violent relationships or in situations of emotional divorce, where one partner's agenda for therapy is to facilitate leaving the relationship. In the case of violent relationships, once the violent behavior has been brought under control and a minimum of trust established with the partner, then EFT may become appropriate.

Certain interaction patterns, such as when both partners are highly withdrawn from each other, may be more difficult to deal with in therapy. In the case of couples who present a withdraw–withdraw pattern in therapy, there is often a lack of willingness to become engaged in the relationship on an emotional level, as well as a reluctance to separate. The process of therapy is then to clarify if the couple wishes to separate, accept the status

quo, or reengage. In the latter case EFT is then implemented as usual. In the case of the withdraw–withdraw pattern, as in other patterns, the therapist legitimizes emotional responses in terms of the interactional dance that the partners have with the best of intentions constructed, and of which they are now the victims. Negative perceptions of the self and the partner are particularly noted. During the assessment process the therapist also begins to frame the partner's problems in terms of deprivation of normal adult needs. There is a particular focus on bonding needs such as the need for security, comfort and support, and reassurance of worth.

In steps 3 and 4 the therapist begins to use experiential techniques to access unacknowledged feelings and uses these feelings to further explore and clarify relationship positions. Critical or attacking responses, for example, may be explored and probed for underlying feelings such as a sense of having been abandoned, or fears concerning isolation. Such underlying feelings then place the critical partner's hostile position in a different context; a context that facilitates deescalation of the negative cycle. The reframing of presenting problems in terms of underlying feelings sets the stage for the choreographing of new interactions. A presenting problem of alienating extreme jealousy in one spouse, responded to by indignant anger and distancing by the other, is framed in terms of the fears that prevent the jealous spouse from asking for reassurance and caring, and the helplessness of the other at being constantly mistrusted. The original negative cycle of accusation and distance here allowed both partners to protect themselves and avoid the experience of vulnerability but at the cost of offending and alienating the other.

In step 5 the focus is on the exploration and acceptance of disowned needs and aspects of self. The needs of the partners are viewed in terms of the provisions supplied by intimate bonds (Weiss, 1982). These provisions include such elements as the reassurance of worth, confirmation of identity, a shared reality, and a desire for nurturance and secure support. Aspects of self that are not normally attended to or experienced are probed, heightened, and clarified. The powerful immediacy of the process of interaction, in the context of the safety of therapy, helps the client to access these new aspects of self. In a withdrawn and passive-aggressive husband, for example, the emotion accessed may be extreme fear of being alone, and the fear that if he demands anything from his wife she will abandon him to total isolation. Once such fear is accepted as legitimate and owned, this spouse can then present himself differently to his wife and begin to take some initiative to define the relationship in terms of his own needs.

Steps 6 and 7 involve the communication of newly experienced aspects of self to the spouse in such a way as to evoke acceptance from that spouse. Such communication is in itself an analogical redefinition of the relationship. It defines the relationship as one in which one partner can ask for key emotional responses from the other. Such communication also evokes new affiliative responses in the other spouse and begins a positive interaction cycle. If one spouse cannot accept the other's needs or respond in a positive manner, then this is explored using experiential techniques. This may involve the exploration of any catastrophic fears blocking the partner's ability to respond. The strong emotional experiencing of new aspects of self in step 5 gives rise naturally to a clear sense of what is desired; a desire for reassurance is inherent in the experience of fear of abandonment. The partners now create a new set of interactions that encompass their personal vulnerabilities, making further avoidance and self-protection unnecessary.

The final steps of therapy involve the consolidation and integration of the changes made in the therapy process. New interaction patterns are established, and in the context of a climate of accessibility and responsiveness, chronic contentious issues can be resolved; for example, if one partner no longer sees the country cottage as a symbol of her spouse's withdrawal from her but experiences a secure bond with her spouse, then the issue of what to do with the cottage becomes easy to negotiate. The therapist highlights the new interaction patterns that have replaced the old problematic and escalating negative cycles. The couple at this point often share new perceptions of their spouse and a new metaperspective on their relationship. Explicit planning for the protection and consolidation of the new intimacy and trust which has evolved as a result of therapy is also encouraged. A more complete account of the therapy process may be found elsewhere (Greenberg & Johnson, 1986; Greenberg & Johnson, in press).

Therapist Interventions

The EFT therapist has to be able to move quickly and easily between intrapsychic and interpersonal

realities and to grasp and use one to reframe and influence the other. Specifically the therapist has to be able to use experiential techniques to access, expand, and reprocess emotional experience, thereby activating different aspects of self and reconstructing the process of interaction.

Experiential techniques used consist of interventions adapted predominantly from Gestalt and client-centered approaches. The client's experience is the essential reference point for the therapy process; the therapist then has to look for opportunities to focus and guide that experience in a way that remains essentially true to the reality of the client. The therapist focuses on, reflects, and validates client responses, particularly emotional responses, and uses evocative responding (Rice, 1974) to help the client reprocess experience in the present. This is done in such a way as to facilitate the construction of previously disallowed emotions or to restructure maladaptive emotional experience (Greenberg & Safran, 1986). Questions such as, "What is happening for you as you say this?" or "What is it about her tone of voice that makes you feel so uncomfortable?" might be typical.

The therapist also activates, heightens, and expands emotional experience by techniques such as the repetition of key sequences or sentences, or by using images and metaphors. For example, a therapist might encapsulate a partner's experience by using an image such as being "shut out" and then encourage the client to focus on and expand this further. The therapist may also interpret experience if it is necessary; for example, by speaking for some aspect of the client's experience that the client does not yet own or by helping the clients to frame their responses in terms of underlying emotions and vulnerabilities. For example, hostile attacking behavior might be framed in terms of a desperate need to have an impact on the other spouse, to obtain a response and to end the panic the client experiences when the other is seen as inaccessible. A full account of the techniques used to access aspects of experience that are normally not attended to is not possible in the context of this article but is elaborated elsewhere (Greenberg & Johnson, in press).

From a systemic perspective the task of the EFT therapist is to use the emotional experience of the spouses, to change interactions by evoking new responses which motivate reciprocal positive behavior in the partner. The experience of vulnerability, for example, leading to a new response such as a request for reassurance, evokes compassion and contact. The assertive expression of anger, on the other hand, tends to be boundary defining and facilitates the taking of initiative and control in the relationship. The therapist continuously helps the partners to frame their experience in such a way as to undermine rigid positions and facilitate contact and acceptance. The therapist then heightens interactional patterns and makes interactional messages explicit, engouraging the couple to enact and replay problematic events.

As therapy progresses the therapist also helps the partners to interact in new ways. These new interactions are evoked by new intrapsychic experience and new perceptions of the partner. For example, a withdrawn spouse may be encouraged to reach out and comfort his now obviously vulnerable partner; the therapist will then focus on and heighten the significance of this new response and facilitate the other spouse's positive response to such comfort. Such an interaction may be the beginning of a new positive cycle in the relationship which then replaces the problematic escalating cycle of distress and distance. The focus is on the process of interaction and the therapist plays the role of director or choreographer, refocusing and redirecting the interaction as it occurs.

Clinical Issues

One of the issues most crucial to the successful implementation of EFT is the differentiation of the level or type of emotional experience that may be usefully explored in therapy. It is possible to differentiate emotion into primary, reactive, and instrumental aspects, and this distinction is discussed in detail elsewhere (Greenberg & Safran, 1986). In EFT, instrumental emotion, which is expressed in order to influence another, is bypassed. Secondary reactive emotion, which is easily accessible, is validated and explored so that more primary underlying emotions will become the focus of attention. In the abstract these distinctions seem complex; however, in therapy it is not difficult to differentiate these aspects of emotional experience. The model of emotion used in the EFT is a constructionist information-processing model in which primary emotions are newly synthesized from subsidiary components such as expressive motor responses and schematic memories and images (Leventhal, 1979). When a client reprocesses experience in therapy and begins to feel the panic and aloneness which fuels the reactive anger directed at the partner, these primary emotional ex-

periences have a sense of discovery inherent in them. Such primary emotion is then a motivator, an action tendency which may translate into new responses toward the spouse (Greenberg & Johnson, 1986*a*).

The level of experience is also crucial here. It is not the discussion of feelings, or the ventilation of already formulated emotional responses, or the facilitation of insight that is sought after in EFT, but the evocation and synthesis of new emotional experience in the present with total involvement. It is not the ventilation of the blamer's anger that is heightened but, after such anger has been legitimized and differentiated, the vulnerability and helplessness underlying the blaming. This vulnerability plus the need for support and comfort then become the focus of therapy.

The timing of interventions is also a key issue in EFT. The therapist has to be continuously involved in process diagnosis (Greenberg & Johnson, 1986*c*) to determine if the context is safe enough to evoke emotional responses such as vulnerability. Part of the process of learning to implement EFT is to begin to know what emotion should be accessed, at what points in therapy, in what type of interactions, and what effects such expression will have. The goal is not the experience of emotion itself, but the evocation and experience of primary emotions that can then be used to create change in the relationship structure.

In terms of using marital therapy to address individual symptomatologies such as depression, phobias, or chronic pain disorders, such symptoms are viewed in EFT as partly a function of the individual's position in the relationship and partly a function of the definition of self which at once creates and is a result of the relational process. Individual symptomatology can then be addressed in the process of EFT.

EFT appears to be most successful with couples who wish to restructure their relationship in terms of a close bond, but have become alienated by negative interaction cycles often of a blame–withdraw nature. From clinical experience it appears that the existence of some basic trust and desire to respect the other's vulnerability, even if more evident in the past, is a prerequisite for successful outcome. The capacity for a therapeutic alliance is also assumed.

Outcome Research

At present two outcome studies of EFT have been completed. The first (Johnson & Greenberg, 1985*a*) compared the relative effectiveness of two marital therapies, EFT and a cognitive behavioral problem-solving approach (PS). Forty-five distressed couples were randomly assigned to one of these treatments or a wait list control. Eight sessions of each treatment were implemented by six experienced therapists, committed to the particular approach they were using. Adherence to treatment manuals was monitored and maintained with a high degree of consistency. The perceived quality of the therapeutic alliance was also measured and checked for equivalence across treatment groups. Results indicated that both treatment groups made significant gains over untreated controls on measures of goal attainment, marital asjustment, intimacy levels, and target complaint reduction. The effects of the EFT were also superior in this study to the PS intervention on marital adjustment level as measured by the Dyadic Adjustment Scale (DAS) (Spanier, 1976) on intellectual intimacy (as measured by the PAIR; Schaefer & Olson, 1981), and on target complaint level. These results were generally maintained at follow-up. It has been suggested recently that there are more meaningful ways of summarizing the effects of treatment than simply reporting group means (Jacobson et al., 1984). If couples' posttreatment DAS scores are assessed in terms of effect size (Smith & Glass, 1977), the obtained effect size for the EFT group was 2.19, and the PS group was 1.12. The mean effect of EFT here was more than two standard deviations from the postwait mean of the control group. Another way to view the results is to compare the treated couples' marital adjustment to that of normal, happy couples. The posttreatment and follow-up mean DAS score for EFT couples was within two points of Spanier's (1976) norm for married couples ($M = 114.8$), and 47% of the EFT couples scored above this norm. This study constitutes one of the first controlled comparative studies of a conjoint dynamic and a conjoint behavioral treatment for marital distress and indeed one of few controlled outcome studies of a dynamic marital therapy. The EFT approach seems to have a positive effect on the couple's ability to negotiate and change specific behaviors as well as on variables that were more directly addressed by the treatment interventions. Such variables include marital satisfaction which is usually viewed by marital partners as being highly related to positive affect (Broderick, 1981). The main limitations of the study were that all measures were self-report and that the couple sample is

most accurately described as moderately rather than severely distressed.

The second outcome study (Johnson & Greenberg, 1985*b*) involved a within-subject design in which control subjects placed on the waiting list in the first study were treated and postwait, posttreatment, and follow-up outcomes assessed. The therapists in this second study, however, were novice therapists who received 12 hours of training in EFT plus ongoing weekly supervision. No significant changes on dependent measures (the same as used in the first study) were found at the postwait assessment, adding to the evidence that marital distress is not a phenomenon prone to spontaneous remission. Positive results on all outcome measures were found after treatment. The results were generally consistent with the previous study. However the effect size (.94) was smaller. The most likely explanation for the smaller effect size would seem to be the inexperience of the therapists who were learning how to practice marital therapy in this project. One of the positive findings of this study is that EFT has been delineated with sufficient specificity that it may be successfully taught to novice therapists.

A third outcome study is also nearing completion (Goldman, 1986). In this study 42 couples were randomly assigned to EFT, to an integrated systemic treatment group, or to a wait list control. Preliminary analysis found that at the termination of treatment both treatments significantly improved the quality of marital relationships when compared with the wait list condition. No differential outcome effects were found. However, the analysis of a 4-month and 1-year follow-up has yet to be completed. A summary of the DAS pre- and posttreatment means and standard deviations together with effect sizes (Cohen, 1977) for all three outcome studies is given in Table 1.

Future directions for research would appear to be the testing of EFT with more severely distressed couples, and with specific populations such as couples where one partner is depressed, as well as the initiation of research relating process to outcome.

Some initial projects in the area of relating process to outcome have begun and have focused on issues such as whether deep experiencing in key therapy sessions may be related to change, that is, to extratherapy outcome, or whether the occurrence of certain in-therapy events can be used to predict change. An example of one in-therapy event that is being studied, since it is hypothesized in the theory of EFT to lead to change, is a "softening." A softening event is one in which a blamer asks a withdrawer for a caring response from a position of vulnerability. Preliminary data suggest that depth of experiencing as measured by the Experiencing Scale (Klein et al., 1969). and the occurrence of a softening event can be

TABLE 1. Results of Treatment Outcome Studies: DAS Scores and Effect Sizes

	DAS Scores				
	Pretreatment		Posttreatment		
Investigation Group	M	SD	M	SD	Effect Size
Johnson & Greenberg (1985)					
Treatment	92.8	8.8	112.7*	10.8	2.19
Control	91.9	10.7	91.5	9.7	
Johnson & Greenberg (1986)					
Treatment	93.5	11.1	103.9*	12.4	.94
Control	93.9	9.4	[a]	[a]	
Goldman (1986)					
Treatment	86.3	8.25	100.1*	14.2	1.92
Control	82.5	7.1	80.9	9.9	

[a] In this study subjects acted as their own controls.

$$\text{effect size} = \frac{\text{posttreatment mean} - \text{control group mean}}{\text{SD of control group}}$$

* = $p < .01$.

used to predict significant improvement in DAS scores at treatment termination. In addition, client perceptions of change processes and the type of interactional changes that occur in therapy have been studied. Such projects are part of the attempt to describe and explain the process of change from the point of view of client process (Greenberg, 1984). Initial results on these projects relating process to outcome appear to be promising, and suggest that the expression and acceptance of underlying feelings is important in the change process. There is also evidence that a change in the perception of the spouse as a function of emotional experience is part of the change process.

Summary

The strength of this approach would appear to be that it is specifically delineated and thus provides a technology for change, something that many dynamic therapies may have lacked in the past (Gurman, 1981). Also, this approach has been empirically validated. It is also an integrated approach that addresses both intrapsychic and interpersonal issues and processes, and is based on a formulated paradigm of adult intimacy, the bonding paradigm. EFT also addresses the issue of the importance and function of emotion in marital therapy. This is an issue that has received considerable attention in the last few years (Fincham & O'Leary, 1983; Margolin & Weinstein, 1983), in light of increasing recognition that emotional response is the main target of change in marital therapy.

The task is now to become clearer on the limits of EFT, to explore where therapy fails and whether there are patterns in such failures. Are there perhaps certain presenting problems or interactional patterns that are contraindications for EFT? In addition, as the process of change becomes clearer through studies relating process to outcome, it should also be possible to refine and improve the therapist interventions and strategies that create such change.

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