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Facilitating intimacy: Interventions and effects

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Abstract (Abstract): A study examined the effects of two sets of marital interventions taken from Emotionally Focused Therapy and Cognitive Marital Therapy on levels of marital intimacy, dyadic trust and dyadic adjustment. Both test group scores were significantly higher than controls on the self-report measures of intimacy.

Full text: There is considerable empirical evidence that positive interpersonal relationships promote mental and physical health and that intimacy in particular is an important predictor of psychological and physiological well-being (Costello, 1982; Mitchell &Tricket, 1980). Survey data indicate that married individuals have substantially better psychological well-being than the unmarried (Gove, Hughes, &Style, 1983; Gove &Shin, 1989). Reis (1984) reviewed 10 recent studies of mortality and psychological health and concluded that "well-being is most likely to stem from contact with affectively close or intimate partners" (p. 34). This review also suggests that quality of contacts is of greater consequence than their sheer existence or breadth. It is also interesting to note that the most frequent interpersonal concerns presented to psychotherapists are problems related to intimacy (Horowitz, 1979), and apart from general marital dissatisfaction, intimacy has been recognized as an important issue in marital therapy (Berman &Lief, 1975).

The need for a better understanding of the nature of intimacy and for increased research investigating means to enhance intimacy has been increasingly noted by professionals working in the field (Hinde, 1978). There is a clear lack of studies investigating different interventions used to facilitate intimacy (Stauffer, 1987). This may be due to the lack of a clear operational definition of this variable (Sexton &Sexton, 1982). Although intimacy is mentioned with some frequency in the research literature, psychology has yet to clearly conceptualize and validate the nature of intimacy (Schaefer &Olson, 1981). Several attempts have been made to articulate a model of intimacy. However, these models include so many different variables that it becomes difficult to distinguish between intimacy and general marital satisfaction (Schaefer &Olson, 1981; Waring, 1988). The result is blurred conceptual boundaries which fail clearly to delineate intimacy as a unique concept. In addition, the majority of relationship enhancement studies tend to use general marital satisfaction as their outcome variable and therefore have failed to examine the effect of their interventions on intimacy per se.

The present study investigates the effectiveness of specific interventions aimed at facilitating intimacy taken from two approaches to marital therapy. In this study intimacy, not general relationship satisfaction, is used as the specific outcome criterion. The operational definition of intimacy used here was taken from Wynne and Wynne (1986), who define intimacy as a relational event in which trusting self-disclosure is responded to with communicated empathy.

The effects of two sets of interventions taken from two marital therapies, Emotionally Focused Therapy (EFT) (Greenberg &Johnson, 1988; Johnson &Greenberg, 1987) and Cognitive Marital Therapy (CMT) (Waring, 1988) were compared to each other and to a wait-list control group. Both of the approaches from which the two interventions were taken have been manualized and tested empirically (Johnson &Greenberg, 1985a; Waring, 1988). Nondistressed couples who desired greater intimacy in their relationship were randomly assigned to intervention and therapist or to the wait-list control group. Treated couples received six sessions of conjoint marital therapy and were measured at posttreatment and again at a 10-week follow-up. A brief description of the approaches from which the intimacy interventions were taken and the interventions themselves follows.

INTERVENTIONS

CMT is a short-term psychotherapy aimed at helping spouses improve their marital satisfaction and develop intimacy through cognitive self-disclosure. Cognitive self-disclosure refers to the verbal expression of thoughts, beliefs, attitudes, and assumptions (Waring, 1988; Waring &Russell, 1980). Spouses are therefore encouraged to disclose their thoughts, beliefs, attitudes, and assumptions regarding their marital problems and the influence of their parents' relationship on their own. Cognition is seen as a primary determinant of affective variables such as feelings associated with closeness.

Using personal construct theory (Kelley, 1955), Waring (1988) suggests that partners develop cognitive schemas to understand the relationships they observe and experience while growing up. These personal constructs are then transferred onto present marriages. Partners then confirm these beliefs by means of selective attention and ignore evidence that may be discrepant. Both spouses must therefore be helped to see how the other differs from their cognitive schema in order to become truly intimate with one another. Spouses are therefore encouraged to disclose key personal constructs and explore how they were developed. The mechanism of change here is insight, or an intellectual understanding of why the relationship is the way it is, achieved by rendering the unconscious conscious.

CMT facilitates cognitive self-disclosure by asking only "why" or "theory" questions and avoids and suppresses affective interchange and/or behavioral interpretation or confrontation (Waring &Stalker, 1991). The spouses may talk only to the therapist and take turns bringing up any biographical material they think is relevant to answering the "why" question. When one spouse cannot answer, the therapist systematically asks the other spouse, "What were you thinking while your spouse was talking?" When the couple understands one "why" question, the therapist asks a more sophisticated "why" question to facilitate cognitive self-disclosure and thus increase the couple's understanding and level of intimacy. Empirical evidence for the general effectiveness of CMT as a treatment for marital discord is inconsistent with some positive (Waring, 1981, 1988) and some negative results (Waring &Stalker, 1991). It is also unclear if this approach facilitates intimacy per se since the outcome measures used in the above research reflect general relationship satisfaction.

Emotionally focused marital therapy is an integration of experiential and systemic traditions in psychotherapy (Greenberg &Johnson, 1986b). The experiential tradition emphasizes the role of affect and intrapsychic experience in changing relationships whereas the systemic tradition emphasizes the role of communication and interactional cycles in the maintenance of a given system. In EFT, partners are therefore encouraged to interact directly with each other in the sessions and particularly to explore and to disclose the underlying feelings and needs which arise at the current moment. These feelings are heightened and reprocessed with the help of the therapist to enable distressed couples to change their interactional positions and become more accessible and responsive to each other (Johnson &Greenberg, in press).

Emotion is considered to be of prime importance here and is viewed as organizing attachment behaviors (Bowlby, 1969), orienting partners to each other in terms of influencing perceptions and evoking responses, and biasing the creation of meaning (Greenberg &Johnson, 1990). The expression of emotion is seen as a powerful regulator of social interaction and is used in EFT to restructure interactional cycles and to create a closer and more secure bond between partners (Johnson, 1986).

Most of the techniques used to access previously unacknowledged feelings are taken from Gestalt and client-centered therapy. The techniques used to reframe and restructure interactions reflect the influence of systemic therapists such as Minuchin (1974). The therapist focuses on, reflects, and validates client responses, particularly emotional responses, and uses evocative responding 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. 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 the use of images

and metaphors.

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 enhances engagement and intimacy. 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. EFT has been found to be generally effective in alleviating marital distress (James, 1991; Johnson &Greenberg, 1987), and some findings have suggested that EFT may enhance certain kinds of intimacy (Johnson &Greenberg, 1985a, 1985b).

The essential contrast between CMT and EFT is that CMT assumes the primacy of cognition as a determinant of emotion whereas EFT assumes the primacy of affect as a basis for organizing experience and constructing meanings in intimate relationships. CMT interventions aim at accessing underlying thoughts and theories in order to gain greater understanding of the relationship; EFT interventions access underlying emotions and use emotional expression to evoke new responses from the partner. This study was designed to examine the differential effectiveness of two interventions which approach the creation of intimacy in very different ways and are associated with different mechanisms of change. CMT focuses upon the attainment of insight and understanding of self and other, and EFT focuses upon emotional experience and interaction. Both of these have been considered essential to the creation of intimacy (L'Abate &Sloan, 1984; Solomon, 1989).

METHOD

SUBJECTS

The sample consisted of couples who responded to newspaper advertisements and an article describing a research project for basically happy couples wishing to enhance their relationship. Couples were screened through telephone and assessment interviews using the following inclusion criteria: couples had to be presently living together and to have cohabited for a minimum of 2 years, with no incidents of separation in the last 2 years. They were also free of alcohol or drug related problems, had received no psychiatric treatment or medication in the past year, were not presently receiving other psychological treatment, and scored a minimum of 95 on the Dyadic Adjustment Scale (Spanier, 1976; the formal cutoff point for distress on this measure is 97; the norm for happily married couples is 114).

A total of 36 couples were admitted into the study. This allowed for the constitution of three groups of 12, which is the mean for treatment groups in enrichment outcome research (Giblin, Sprenkle, &Sheehan, 1985). The mean age for the entire sample (N=72) was 40.9 (SD=11.03), and ages ranged from 24 to 77 years old. The number of years couples had been together ranged from 3 to 43; the mean was 15.7 (SD=10.7). One CMT couple chose to withdraw from the study after two counseling sessions. They were replaced by another couple with similar pretest scores in order to maintain equally numbered groups.

THERAPISTS

Ten therapists participated in this study. Therapists were nested within treatment and matched the treatment they implemented in orientation and general training (cognitive or emotional orientation). Five therapists administered each intervention. Therapists were doctoral interns in clinical psychology and were all experienced in couples interventions. Both groups of therapists were matched for level of experience. Specific training was given by the originators of each intervention and was based on a manual describing the intervention to be used. During the study, group supervision was given once a week to each group of therapists by the trainers. Both groups received the same amount of assistance.

MEASURES

THE MILLER SOCIAL INTIMACY SCALE (MSIS) (Miller &Lefcourt, 1982). The MSIS is a 17-item self-report measure of the level of intimacy currently experienced in a given relationship. The MSIS items were judged as

reflecting the definition of intimacy used in this study and were considered to be free of bias in favor of either intervention. Cronbach alpha coefficients of .86 and .91 for two different samples have been reported, and test-retest reliability was calculated at .96 (Miller &Lefcourt, 1982). A reliability analysis (internal consistency) using this sample yielded a coefficient of .89. Items are rated on 10-point scales and summed to obtain a total score. The theoretical range is 17-170. In the original sample the mean score for the unmarried sample was 137.5; for the married sample, 154.3; and for a clinic sample, 126.3.

DYADIC TRUST SCALE (DTS) (Larzelere &Huston, 1980). The DTS contains eight items and measures the degree to which a person believes another person to be benevolent and honest. The scale is applicable for both dating and marriage relationships. A reliability coefficient of .93 was reported by the originators. The coefficient of internal consistency using this sample was calculated at .85.

DYADIC ADJUSTMENT SCALE (DAS) (Spanier, 1976). The DAS is a widely used self-report questionnaire which yields an index of global couple adjustment. Most items involve a 5-or 6-point Likert-type scale defining the amount of agreement or frequency of an event. Spanier reports a reliability coefficient of .96 (Cronbach's alpha). The reliability for this sample was .89.

TARGET CONCERNS QUESTIONNAIRE (TC). The TC was adapted from the Target Complaints instrument (Battle et al., 1966). Spouses were asked to describe the two main blocks to intimacy that they hoped to resolve during the counseling sessions. After treatment and again at follow-up, couples are asked to rate on two 5-point scales the amount of change on the two concerns identified at the outset of the study. This was used as an additional measure of perceived change in intimacy. Battle et al. give evidence as to the validity and reliability of the Target Complaints Questionnaire and report a test-retest reliability of .68.

VERBAL INTERACTION TASK (VIT) (Guerney, 1977). The VIT was adapted from Guerney (1977) and is designed to stimulate meaningful dialogue between intimate partners. It was used in this study for the purpose of generating interactions which were then rated by observers using the two Carkhuff scales described below. Various studies (Guerney, 1977) have successfully used the material generated by the VIT to verify experimental hypotheses.

COUPLES THERAPY ALLIANCE SCALE (CTAS) (Pinsof &Catherall, 1986). The CTAS is a 29-item measure; each item is responded to on a 5-point Likert scale and designed to assess the couple's perception of the therapeutic alliance. This instrument contains three components: bond between therapist and client, agreement on therapeutic goals, and engagement in tasks relevant to the process of therapy. It was used in this study to control for therapeutic relationship variables which might influence therapeutic outcome. It was completed by each spouse in private after the second session. Reliability (internal consistency) for this sample was .94.

EMPATHIC UNDERSTANDING IN INTERPERSONAL PROCESSES SCALE (EMP) (Carkhuff, 1969). The EMP scale is derived from empathy scales which have been validated extensively in process and outcome research on counseling and psychotherapy (Carkuff &Berenson, 1967). It is devised to apply to all interpersonal processes and outlines five different levels of empathic understanding which are used to rate units of interaction taken from conversation material such as those generated by the VIT.

This measure was used in conjunction with the self-disclosure scale described below to yield an observed measure of intimacy. Three trained raters blind to the purposes of this study used this scale to rate statements uttered by couples during the VIT.

FACILITATIVE SELF-DISCLOSURE IN INTERPERSONAL PROCESSES SCALE (SD) (Carkhuff, 1969). The SD scale was derived originally from a scale measuring therapist self-disclosure which has been validated in psychotherapy process and outcome research. This form of the SD was designed by Carkhuff to apply to all interpersonal processes. It was used in this study in conjunction with the EMP scale to constitute an observed measure of intimacy.

IMPLEMENTATION CHECKS

To confirm that the treatments were implemented faithfully in accordance with the treatment manuals, a number

of verification procedures were carried out. First, tapes of sessions picked at random were audited by the researcher during the course of the study and implementation was judged to be more than adequate. Second, sections of interviews were listened to in group supervision and neither supervisor reported improper implementation. Third, when given a brief description of both treatments at follow-up, all couples were immediately able to identify correctly which group they were in. In addition to this, an implementation check was conducted by two trained independent raters.

A checklist of therapist interventions was adapted for the purposes of this study from a similar checklist used in a previous study (Johnson &Greenberg, 1985a). The checklist consists of 22 operations selected from both treatment manuals (11 from each of the two interventions).

Seventy-two of the total 144 sessions were randomly selected to be coded on the Implementation Checklist. One 10-minute segment was taken from the middle third of each of these 72 sessions. A total of 925 therapist interventions were coded by two trained raters who were blind to the treatment condition they were observing. 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. Of the 925 coded interventions, only 16 (1.7%) were found to be inappropriate to the treatment condition being observed. This small percentage of inappropriate interventions suggests that both approaches could be easily distinguished and implemented according to treatment manuals. Interrater reliability was calculated on 15 randomly chosen sessions yielding a total of 287 observations (31% of total observations). The overall percentage of agreement between raters was 88%.

PROCEDURE

After telephone screening and assessment interviews, couples were given pretests and were randomly assigned to one of three groups, CMT interventions, EFT interventions, or control. Couples in both experimental groups were seen for six 1-1/2-hour sessions, 1 week apart. All sessions were audiotaped. Couples were asked to complete the Couples' Therapy Alli-ance Scale after the second session. At the end of the six sessions, couples were given post-treatment measures and the wait-list couples were called in for reassessment followed by treatment. A 10-week follow-up was conducted by personally contacting couples and asking them to come in and complete the follow-up questionnaires. All treated couples completed the follow-up procedures. Debriefing on the study was offered at that time.

As stated previously, the two sets of interventions used in this study were taken from two treatment approaches, CMT and EFT. In both approaches subjects were asked to identify a problematic event concerning intimacy to help focus the sessions. Typical interventions from each of these two approaches, one which focuses upon cognitive processes and considers insight as the active ingredient of therapy (CMT) and one which focuses upon emotion and considers the emotional reprocessing of experience as the active ingredient of therapy (EFT), were synthesized to create two brief treatment programs aimed at increasing intimacy between partners.

RESULTS

Preliminary analyses of variance indicated that there were no significant differences between groups on demographic variables (age, years together, income, education, occupation), on all pretreatment measures, and on the Couples Therapy Alliance Scale. The group mean on this measure was 5.5 for EFT couples and 5.7 for CMT couples. The maximum possible score is 7 (Completely Agree) and all couples scored above 4 (Neutral). This suggests a high degree of mutual collaboration between therapists and couples in both groups on the tasks and goals of treatment.

Analyses of covariance using pretreatment scores as covariates were performed on the outcome variables. This analysis was conducted to obtain the error term used in the planned comparisons, as suggested by Tabachnick and Fidell (1989). Planned comparisons using t ratios (Kirk, 1968) were conducted on the adjusted group means for each hypothesis at posttreatment and at follow-up. Group means at pretest, posttest, and follow-up for all outcome variables may be found in Table 1. (Table 1 omitted). The potential problem of an inflated Type 1

error rate was corrected for by using a Bonferroni-type adjustment to set the critical level of significance for each t ratio. The conventional alpha level of .05 was therefore split by the total number of outcome variables. This adjusted the alpha level at .05/6=.008. All analyses were done using couple mean scores (male plus female scores divided by 2).

MAIN TREATMENT EFFECTS

Both CMT and EFT were expected to have a positive effect on levels of intimacy as compared to a wait-list control group. Both CMT and EFT posttest adjusted group means on the MSIS (EFT mean 136.6, plus CMT mean 139.6) were compared to the post-wait adjusted control group mean (mean 129.2) which yielded a t ratio ($t(66)=3.33$, $p<.001$). The degrees of freedom were computed using the formula: $df=pq(n-1)$ where p is the number of groups and q is the number of time periods (Kirk, 1968). Separate t-tests on the MSIS and TC scores of each treatment versus control group scores were not conducted, first because the posttreatment CMT and EFT means on these variables were either identical (TC mean, 3.8) or extremely close (MSIS means 136.3, and 138.0), and second in the interests of limiting the number of planned comparisons. On the Target Concerns questionnaire planned comparison tests between treatment and control group means (EFT mean, 3.8, CMT 3.8, control group 2.2) also yielded a significant t ratio ($t(33)=6.8$, $p<.0005$). Thus both treatments significantly increased intimacy as measured by the MSIS and TC instruments when compared to a wait-list control.

A nonsignificant t ratio was found on the SD measure (EFT mean 2.7, CMT 2.0, control 2.3; $t(30)=.06$, $p>.008$), as well as on the EMP measure (EFT mean 2.1, CMT 1.6, control 1.6; $t(30)=1.32$, $p>.008$). Thus, no significant differences were found between treatment and control groups on observational measures of intimacy.

Both CMT and EFT interventions were expected to have a positive effect on levels of dyadic trust as compared to the wait-list control group. However, no significant differences were found between the adjusted treatment and control group means (EFT mean 44.7, CMT 48.3, control, 46.0) on the DTS at posttest ($t(66)=.27$, $p>.008$). There were also no significant differences found between the two treatment groups on this variable at posttest or at follow-up.

In brief, main treatment effects were found on both self-report measures of intimacy; however, no treatment effects were found in the analysis of observational data or on the measure of trust.

DIFFERENTIAL EFFECTS

The question of whether one treatment would be more effective than the other in facilitating intimacy was then examined. At posttest, no significant difference was found between EFT and CMT group means either on the MSIS or on the TC measure. However, EFT group means were significantly higher than CMT at posttest for both SD and EMP observational measures ($p<.005$).

At follow-up, the EFT group mean on the MSIS was found to be significantly larger ($t(66)=4.29$, $p<.0005$). The large difference at follow-up was due to a decrease in CMT group scores back toward pretest levels and a continued increase in EFT group scores beyond the posttreatment level. These results are summarized in Figure 1. (Figure 1 omitted). A similar pattern is observed in the TC scores at follow-up where the EFT group mean was significantly higher than CMT ($t(33)=2.96$, $p<.005$).

In summary, a differential effect in favor of the EFT intervention was found at posttest on the observational measures and at follow-up on the self-report measures of intimacy. No observational data were collected at follow-up. A summary of these comparisons may be found in Table 2. (Table 2 omitted).

The measure of general dyadic adjustment was used primarily in this study to screen out distressed couples and to minimize the impact of general relationship satisfaction on intimacy per se. It is of course not possible to isolate these two variables since one, marital satisfaction, provides the context for the other, intimacy. However, by restricting the range on the DAS, an attempt was made to focus on intimacy specifically and minimize the role of marital distress/satisfaction, Thus couples scoring below 95 on the DAS were referred elsewhere. However, test analyses were conducted at post and follow-up on DAS scores. Neither CMT nor EFT intervention group scores were significantly different from controls (EFT mean 111.2, CMT 111.0, control, 108.4;

t=1.06, p>.008) or from each other (t=.06, p>.008) at posttest. At follow-up, however, there were significant differences between CMT and EFT group means in favor of EFT (t=3.44, p<.001).
An analysis of statistical power (Cohen, 1977) was also conducted for all nonsignificant results. The estimated statistical power coefficients were weak, ranging from .02 to .17. This suggests that it may be possible to find significant treatment effects with a larger sample. A repeated measures analysis of variance was conducted for each group across time to investigate the possibility of a significant difference between posttest and follow-up scores within each of the experimental groups. It was found that intimacy (MSIS) for the EFT group increased significantly from post to follow-up (p=.003) and decreased significantly for the CMT group (p=.028). Trust (DTS) and adjustment (DAS) both increased significantly for EFT (DAS, p=.006; DTS, p=.024). No difference was found for CMT. For the TC measure no difference was found between post and follow-up in the EFT group whereas a significant decrease was observed within CMT (p=.002).
In summary, results indicate that both CMT and EFT increased self-reported intimacy as compared to a control group. Furthermore, differential effects in favor of EFT were found at posttest on observational measures of intimacy and also at follow-up on self-report measures of intimacy and dyadic adjustment. Trust, adjustment, and self-reported intimacy all continued to improve from posttest to follow-up in the EFT group. No data were collected from the control group at follow-up.

DISCUSSION

In this study both treatment interventions improved the self-reported level of intimacy in nondistressed couples. These results are consistent with studies on various marital enrichment programs which focus on the enhancement of communication skills closely related to self-disclosure and empathy (Giblin et al., 1985; Gurman &Kniskern, 1977). These results suggest that focusing upon a couple's relationship and helping them either calmly to discuss the topic of closeness/distance with the therapist or emotionally to reprocess the experience of closeness/distance enhances partners' experience of intimacy, at least in the short term.
The strengths of the study are that two specific interventions aimed at enhancing intimacy, which was clearly defined, were stipulated in therapy manuals, implemented according to these manuals, and monitored during implementation. There was random assignment to treatment intervention and therapist, and possible confounding variables such as therapeutic alliance were measured. Nondistressed couples were used to minimize the impact of general marital satisfaction, and intimacy was used as a specific outcome variable. In contrast, virtually all relationship enhancement studies have used overall marital satisfaction and various relationship skills as their outcome criteria (Giblin et al., 1985) or have generally failed to separate the concept of intimacy from general marital satisfaction or other related concepts (Margolin, 1982; Waring, 1981). In this study, the concept of intimacy is clearly operationalized as a relationship event involving both partners.
Since intimacy was the main focus of this study, most of the discussion will center on this variable. However, the results concerning two other variables, trust and dyadic adjustment, will be discussed first.
No significant differences on the Dyadic Trust Scale (DTS) were found between treatment and control groups at posttest or between treatment groups at follow-up. This result might be seen as contrary to expectations based on research demonstrating a positive correlation between dyadic trust and depth of self-disclosure (Larzelere &Huston, 1980).
Since intimacy was increased by treatment in this study, it might be expected that trust would also increase. However, despite a small but significant positive correlation between MSIS and DTS scores in this study (r=.28), it appears that treatment had a positive effect on intimacy but not on trust. A closer examination of the results on both the MSIS and the DTS indicates very similar trends across time periods. Trends for both MSIS and DTS scores increased from pre to posttest for both treatment groups but decreased slightly for the control group. On both the MSIS and the DTS measures, trends increased from post to follow-up for the EFT group but decreased for the CMT group, thus displaying the same pattern for both intimacy and trust; however, results on the DTS did not reach significance. This may be a reflection of a lack of variance in the DTS scale due to its smaller

number of items (8) compared to the 17 items in the MSIS. It may also be that the DTS is less sensitive to change than the MSIS measure.

Trust has been viewed as a prerequisite for intimacy, as necessary but not sufficient (Larzelere &Huston, 1980). It may be that since scores on this variable were high in this sample (M=46.2), the prerequisite level of trust was present and thus any changes on this variable would be minimal and difficult to detect.

Neither CMT nor EFT significantly increased dyadic adjustment as compared to the control group at posttest. However, at follow-up a significant difference was found between treatment groups in favor of EFT. These follow-up results are consistent with those of other studies which have demonstrated the effectiveness of EFT in increasing marital adjustment (James, 1991; Johnson &Greenberg, 1985a, 1985b). Again, trend patterns for adjustment were similar to the trend patterns observed for the intimacy and trust variables. This consistency in patterns confirms that intimacy, trust, and adjustment are related components in an intimate relationship. It may be that adjustment scores were not significantly increased by treatment at posttest because only relatively distress-free couples were admitted into the study, thus making it more difficult to increase their satisfaction level in only six sessions. Adjustment may also be a more stable component in basically positive relationships and therefore less susceptible to change under treatment conditions. However, as intimacy in the EFT group continued to increase from post to follow-up, general marital satisfaction also increased, suggesting that over time increasing intimacy positively affects general marital satisfaction.

On the intimacy variable, results at posttest indicated that initially CMT was as effective as EFT in terms of increasing intimacy, but on a longer term basis, as evidenced by the followup scores, the initial improvements in the CMT group were lost. The EFT group on the other hand apparently continued to improve even after termination, resulting in increased intimacy and satisfaction levels at follow-up. This suggests that EFT spouses were relating to each other in a more satisfying and closer manner, and continuing to increase their intimacy even when the therapist was no longer present.

How may these phenomena, that the CMT group failed to maintain their treatment gains and that the EFT group continued to improve over time, be explained, and what are the implications for treatments which attempt to enhance intimacy? Disclosing underlying feelings to a responsive partner seemed to increase intimacy at the time it occurred, but the effect of such events also increased over time, perhaps because time allows for the integration of such changes on an intrapsychic and interpersonal level. Couples may need some time to trust these patterns before intimacy is fully experienced and enhanced. On the other hand, cognitively discussing intimacy issues in a calm manner seemed to help couples understand each other and feel closer in the moment but may not be powerful enough to facilitate a close sense of connection over time. It is also possible that because of the short number of sessions, core conflicts were revealed but not resolved resulting in a reduced level of intimacy at followup.

Both interventions focused upon self-disclosure; however, the nature of the self-disclosure differed. First, disclosure in the CMT intervention consisted of rational explanation and discussion whereas disclosure in the EFT intervention involved the discovery and disclosure of aspects of self not usually included in awareness or in the interaction with the partner. Accessing emotions that underlie responses to one's spouse as the partners struggle with closeness may constitute a more involving, "lived," and encompassing process than sharing cognitive material such as thoughts and theories. It is perhaps the difference between "hot" experience and "cool" reflection. Emotional responses to intimate others also tend to be closely associated with core aspects of self and the reprocessing of these can be a privileged access route to the innermost core of the person, where he/she is most vulnerable and most unique, or as social penetration theory would frame it (Altman &Taylor, 1973), the deeper levels of personality. The level of self-disclosure may then have been different in the two interventions. It may also be difficult to access core beliefs about the nature of self and other without emotional arousal. The central change strategy of CMT, disconfirming personal constructs about marriage that block intimacy, may then be more difficult if such arousal is avoided in therapy.

Second, the empathic response element of intimacy may have been more powerful in the EFT intervention. The experience and expression of powerful emotions that arise when interacting with one's spouse tend to evoke empathy and a sense of connection in the partner and to facilitate sensitive responsiveness. The responses that intimates desire from each other, such as love, compassion, or reassurance, cannot be negotiated or rationally decided upon, but can be evoked by the other's emotional expression. Emotional expression may be construed as a primary signaling system in, and powerful regulator of, interpersonal interaction (Buck, 1984; Greenberg &Johnson, 1990). Nonverbal cues such as facial expression, so crucial in emotional expression, convey one partner's internal state to the other and tend to define the relationship in terms of closeness/distance and dominance/submission. The intense level of self-discovery and disclosure fostered in the EFT interventions tends to motivate the other spouse to respond, and the therapist also actively choreographs this contact, creating the context for emotional engagement. This engagement has recently been identified as a key variable in long-term marital satisfaction (Gottman &Krokoff, 1989).

Third, the disclosure of vulnerability, minimized in the CMT process, is an essential element of the EFT interventions. It has been argued that it is impossible to have intimacy without risking revealing vulnerabilities (Descutner &Thelen, 1991; L'Abate &Sloan, 1984), and certainly, in attachment contexts, the communication of vulnerability evokes protection and contact (Bowlby, 1969). The prototypical bonding event between infant and caregiver or adult lovers is that one partner discloses vulnerability, risking hurt and acting in trust, and the other responds sensitively, draws closer, and comforts the discloser. Revealing vulnerability also defuses fear in the other and makes reciprocal disclosure more likely. In EFT this vulnerability is experienced and enacted in the therapy session, so each partner experiences needing the other and having the other respond.

The arguments made above all point to a more general conclusion, that whether one focuses upon the level of self-disclosure and the modification of core beliefs, the facilitation of empathic responsiveness, or the expression of vulnerability and its intrapsychic and interpersonal consequences, the change factor that is essentially missing in CMT is affect (Denton, 1991). It is beyond the scope of this article to discuss affect in general, but it is significant that in CMT affect is viewed as a negative disorganizing factor and in EFT it is viewed as an orienting, motivating factor which can be used to create positive contact between partners (Greenberg &Johnson, 1986b).

The differential results may also be a reflection of other differences in the two treatment packages, such as the use of more couple interaction in ET as opposed to more therapist-partner interaction in CMT, and the specific kinds of cognitive interventions used in CMT. Would the effect of the CMT interventions have been more stable if the couple had been instructed to discuss with each other the essential perceptions and understandings of the other partner arrived at with the therapist? Certainly discussing emotions, or even reprocessing them with the therapist while the partner observes, is not considered effective practice in EFT. It is necessary to turn the experience of emotion into a relationship event. Process research in EFT (Johnson &Greenberg, 1988) suggests that both deep levels of emotional experiencing and the translation of this experiencing into new interaction sequences are necessary elements in change events associated with positive outcomes. If the insight that may be created by CMT were developed into new interactions, would this add to CMT's effectiveness? This may, however, be difficult to reconcile with the nature of CMT since once the couple is directed to interact, the door is opened to affective expression, and the essence of CMT is that affect is controlled and a rational calm is maintained. Although some discussion and the teaching of listening skills are also part of CMT (Waring, Carver, Stalker, &Gitta, 1991), the lack of focus on partners practicing these skills together may inhibit the generalizability of such skills to interactions outside of the session, particularly since there is evidence that the ability to communicate effectively with an outsider does not necessarily transfer to the marital relationship (Birchler, Weiss, &Vincent, 1975).

These results suggest that when the goal is to facilitate intimacy, understanding enhances closeness, but unless affect is also addressed and new interactions created in the sessions, this closeness may be short-lived.

If couples discover and express the affect that underlies their interactional stances, particularly vulnerabilities, and thus encounter each other in a new way in the session, intimacy levels will tend to increase and continue to improve after therapy has ended.

These results may only be generalized to those couples who report that they have a basically positive relationship, and it is also important to note that the subjects involved responded to advertisements for free counseling sessions and therefore may differ from clinical couples requesting therapy and couples seeking therapy to enhance their relationship. Therapists in this study were nested under treatment. This may be seen as a strength since these therapists, like therapists in clinical practice, were committed to the treatment they implemented; it may also be seen as a limitation since there is a possibility that any differences in treatment effects are attributable to differences between the groups of therapists.

Future research might be conducted to examine in depth the processes involved in creating intimacy as well as the relationship between these processes and outcome. Peak moments of intimacy experienced by partners within a session could be identified and intensively analyzed using task analytic methods (Greenberg, 1984). Such moments could be identified by using interpersonal process recall (Elliot, 1986) or by using third-party rating scales such as the experiencing scale (Klein, Mathieu, Gendlin, &Kiesler, 1969). Such research would facilitate the building of a model of intimacy enhancement, may help to explain the cognitive and emotional processes involved in intimacy, and specifically link in-session events to treatment outcomes.

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