A randomized trial of emotion-focused therapy for couples in a training clinic
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Abstract (Document Summary)
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Full Text (7139 words)

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[Headnote]
Forty married couples participated in a randomized trial comparing 8 weekly sessions of emotion-focused therapy (EFT) for couples to a group of couples who were placed on an 8-week waiting list. A composite marital satisfaction score was created from scores on the Dyadic Adjustment Scale, Positive Feelings Questionnaire, and Personal Assessment of Intimacy in Relationships scale. Controlling for pretest scores, participants in the treatment group had significantly higher levels of marital satisfaction after 8 weeks than wait-list participants. Supplementary analyses identified variables associated with gains in therapy and with dropping out (7139 words).

Emotion-focused therapy (EFT) for couples is a synthesis of experiential and family systems approaches to psychotherapy (Johnson, 1996). Several outcome studies have been conducted on EFT, and after behavioral approaches, emotion-focused therapy is now the most empirically validated approach to the treatment of relationship discord (Alexander, Holtzworth-Munroe, & Jameson, 1994). In a recent review, only EFT and behavioral couples therapy were judged as having scientifically demonstrated efficacy for the treatment of relationship distress (Baumcom, Shoham, Mueser, & Daito, & Stickle, 1998). Research on EFT is reviewed in a meta-analysis (Johnson, Hunsley, Greenberg, & Schindler, 1999). Previous EFT outcome research has been conducted in Canada, primarily by its originators and their students. This article reports what is, to our knowledge, the first randomized trial of the effectiveness of EFT conducted in the United States and one of the first outcome investigations conducted by researchers unconnected with the originators of the EFT model. Finally, the study reported here is only the second known attempt to assess outcomes of EFT when therapy is conducted by novice couples therapists.

In EFT, cycles of interaction are identified and tracked (the systemic component), while the underlying emotional experience of each partner is identified for each step of the cycle (the experiential component). The therapist reframes the problem and facilitates each member of the couple's acceptance of both their own and their partner's emotional response. Through this process, the couple begins to make new requests of each other and to generate new solutions to their presenting problem, which results in the old cycle being disrupted and a new, more adaptive cycle initiated. This process occurs through time (see Greenberg & Johnson- 1989: Johnson- 1996).

Eight sessions of EFT administered by experienced therapists produced significant gains, relative to a wait-listed control group, with respect to target complaints and measures of goal attainment, marital adjustment, and marital intimacy (Johnson & Greenberg, 1985a). In addition, Johnson and Greenberg (1985a) found that the EFT intervention in their study produced greater gains than a cognitive behavioral problem-solving intervention with respect to marital adjustment, intimacy, and improvement on the target complaint.
EFF has performed well in comparison to other models of couples therapy. Ten sessions of EFe produced results equivalent to those of a strategic systemic intervention at posttreatment and 12-month assessments (both were superior to a wait-list control group; Goldman & Greenberg, 1992). James (1991) compared standard EFe with communication training (12 sessions in both conditions). While both interventions resulted in higher posttreatment marital adjustment scores than a waitlist control group (James, 1991), by 4-month follow-up the standard EFT group had superior gains with respect to improving the target complaint.

To date, only one EFT outcome study has utilized novice therapists (Johnson & Greenberg, 1985b). In that study, eight sessions of EFe were administered to participants on the waiting list for another study (Johnson & Greenberg, 1986a). Their posttreatment scores were compared to their scores at entry into the study and after the 8-week waiting period (Johnson & Greenberg, 1986a). Following treatment, the participants reported higher levels of marital adjustment, greater intimacy, better goal attainment, and greater improvement with respect to the target complaint. These changes were maintained at an 8-week follow-up.

It has been said that the greatest single need in research that assesses couple and family therapy is replication studies (Lebow & Gurman, 1985). Lebow and Gurman note that such studies are “difficult to execute, time-consuming, and costly” (1995, p. 50). The present study was designed as a partial replication of the Johnson and Greenberg (1985a, 1985b) studies. In order to reduce costs, we conducted the study in a family therapy training clinic. Our hypothesis was that couples treated by novice therapists would have greater marital satisfaction after eight sessions of EFT than couples on an 8-week waiting list. We also expected that participants who were initially randomly assigned to the wait-listed control group would, after completing eight sessions of EFT, report significantly higher levels of marital satisfaction than at the outset of the study. Additional concerns pursued in the current study included: (1) determining whether certain demographic and personality variables moderated the effects of the EFT treatment, (2) identifying factors associated with client gain during the course of treatment, and (3) assessing client satisfaction with the therapy program. We were also interested in the feasibility of conducting outcome studies in a family therapy training clinic.

METHOD

Participants

Couples participating in the study were referred by clinicians or responded to newspaper advertisements. The announcements were placed in the bulletin board section of the local newspaper’s classified advertisements and read: “Married Couples Needed: Couples experiencing problems in their marriage needed for research study on marital therapy at location. Call (clinic number) for info.” Individuals calling in were told that this was a research study evaluating the effectiveness of an approach to marital therapy and that participants would either be randomized to 8 weeks of therapy or assigned to an 8-week waiting list followed by 8 weeks of therapy. To be eligible, couples had to be married and living together. Exclusionary criteria included the presence of physical or emotional abuse, substance abuse problems, and primary sexual problems. Interested couples were mailed printed information about the study and copies of the Dyadic Adjustment Scale (Spanier, 1976) for each of them to complete and return. A score below 97 on the returned DAS forms for at least one of the spouses was required for participation in the study. This score represents one standard deviation below the mean for a group of married participants in the original validation study of the DAS (Spanier, 1976) and has generally been accepted as a definition of marital distress. All couples who mailed back the DAS had at least one spouse scoring below 97. For two couples, both partners were African American; all other participants were Caucasian.

Procedure

Couples were invited to come for a pretest session where informed consent was obtained. Participants completed a questionnaire regarding demographic and individual information, the Positive Feelings Questionnaire (PFQ; O’Leary, Fincham, & Turkewitz, 1983), the Personal Assessment of Intimacy in Relationships scale (PAIR; Schaefer & Olson, 1981), and the Role Category Questionnaire (RCQ; Crockett, 1965) measure of cognitive complexity. At the conclusion of this session, they were told to which of the two groups they had been randomly assigned. A total of 40 couples entered the study and completed the pretest assessment. Twenty-two couples were randomly assigned to the treatment group, while 18 were assigned to the wait-list group.

Participants in the therapy group began sessions the week after the baseline assessment session. Eight 50-min sessions were conducted. There was no fee charged for the therapy sessions, which were held in therapy rooms equipped with a one-way mirror, microphone and video camera, and intercom phone system. Sessions were held weekly; when either the couple or therapist were not able to meet the next week, the session was delayed but the number of sessions remained at eight. Fifteen-min pre- and posttherapy supervision sessions were conducted. All sessions were videotaped and supervised live. Phone-in supervision was utilized via the intercom phone system, and the therapist would come out of the session to consult with the supervisor about 10 min before the conclusion of the session. There was a weekly 1-hr group supervision...
session employing videotape supervision.

Therapy followed the nine steps of EFt as described in Greenberg and Johnson (1988). In brief, the nine steps are: (1) delineate the conflict issues in the struggle between the partners, (2) identify the negative interaction cycle, (3) access unacknowledged feelings underlying interactional positions, (4) reframe the problem(s) in terms of underlying feelings, (5) promote identification with disowned needs and aspects of self, (6) promote acceptance by each partner of the other partner's experience, (7) facilitate the expression of needs and wants to restructure the interaction based on the new understandings, (8) establish the emergence of new solutions (cycles), and (9) consolidate new positions (Greenberg & Johnson, 1988).

Posttherapy testing was held I week after the last session. At this time, participants repeated the instruments they had completed at the baseline session and also completed the Purdue Family Therapy Satisfaction Scale (PFTSS; Paddock, 1990) and the Client Satisfaction Questionnaire (CSQ; Nguyen, Attkisson, & Stegner, 1983).

Couples randomly assigned to the wait-list were given an appointment for the post-wait-list assessment session, held 8 weeks after the baseline testing, where they completed the same instruments as at the first session. Following this, they received eight therapy sessions and then completed a third testing session. At this final session, they repeated the baseline instruments again as well as completed the Purdue Family Therapy Satisfaction Scale and the Client Satisfaction Questionnaire.

Among the 22 couples assigned to the treatment group, 13 completed the study and nine dropped out. Of the 14 couples assigned to the wait-listed group, four dropped out before the end of the wait-list period and nine went on to complete eight therapy sessions. On average, participants were 36 years old (range 23-59), rated themselves as slightly to moderately religious, had been married 1.2 times (range 1-3), had been divorced 2 times (range 0-2), had been married 10.5 years (range < 1-36), had a yearly family income from $30,000 to $49,999, and had one child living in the home (range 0-2). The average participant had a baseline DAS score of 66 (range 51-113, SD = 12.2), a baseline PFQ score of 80 (range 53-112, SD = 16.6), and a baseline PAIR score of 100 (range 71-131, SD = 13.3). There were no initial differences between participants assigned to the treatment and those assigned to the control groups on the demographic variables or assessments of marital satisfaction.

Therapists

The therapists were eight residents in psychiatry who volunteered to serve as study therapists in return for clinical supervision. There were six women and two men (seven Caucasians and one Asian), who were in at least their second year of residency training. None had any prior experience conducting couples therapy. Consistent with other studies (e.g., Johnson & Greenberg, 1985a), therapists were provided with 12 hr of training in emotion-focused therapy that covered the theory and techniques of the approach. Each therapist was provided with a copy of the Greenberg and Johnson (1988) text, which was used as a treatment manual. Emphasis was given to chapter 5 ("The Process of Therapy"), which details the nine steps of the therapy. Videotapes were shown of the first author conducting EFF sessions to demonstrate the techniques. Because of the limited time that the therapists could devote to the study before they had to move to other clinical assignments, there were no practice cases before the therapists began seeing study couples.

Instruments

Dyadic Adjustment Scale (DAS). The DAS is a 32-item self-report inventory to assess marital adjustment and is one of the most commonly used measures for this purpose (Spanier, 1976). Spanier (1976) reports an internal consistency for the 32-item DAS of .96. Validity has been demonstrated by the ability of the DAS to discriminate married from divorced couples and by its high correlation with other measures of marital adjustment (Spanier & Filsinger, 1983).

Positive Feelings Questionnaire. The PFQ was designed to assess the amount of positive affect towards a spouse (O'Leary et al., 1983). It is a 17-item self-response inventory with responses made on a 7-point scale. All items discriminated between clinic and nonclinic couples, and the PFQ was also internally consistent (cc = .94; O'Leary et al., 1983). The PFQ has been found to be responsive to changes occurring from marital therapy (O'Leary & Arias, 1983, Turkewitz & O'Leary, 1981).

Personal Assessment of Intimacy in Relationships. The PAIR consists of 36 items designed to assess emotional, social, sexual, intellectual, and recreational intimacy (Schafer & Olson, 1981). Items are answered on a 5-point scale, and evidence has been presented for its internal reliability and for convergent validity with similar measures (Schafer & Olson, 1981).
Role Category Questionnaire. The Role Category Questionnaire (Crockett, 1965) is a measure of interpersonal cognitive complexity that is theoretically derived from the personal construct psychology of Kelly (1955). Those constructs used for thinking about other people form the subsystem of "interpersonal constructs."

Participants provided written descriptions of two peers, one liked and one disliked, and were given 10 min to complete the two descriptions. The descriptions were scored for differentiation by counting the number of interpersonal constructs they contained. Interpersonal constructs "are operationally defined as any characteristic, quality, trait, motivation, belief, habit, mannerism, or behavior attributed by the subject to the described person" (Burleson & Waltman, 1988, p. 7). Two coders were utilized in the present study and were trained according to the instructions in Burleson and Waltman (1988). An interrater reliability of .98 was achieved for independent scorings of a subsample of 25 RCQs.

The RCQ has had demonstrated test-retest reliability of .84-.86 over a 4-week period (O'Keefe, Shepherd, & Streeter, 1982). RCQ scores have been found to have relevance to couples' communication (Burleson & Denton, 1992; Denton, Burleson, & Sprenkle, 1995), while other evidence supporting the validity of the RCQ is summarized elsewhere (Burleson & Waltman, 1988; O'Keefe & Sypher, 1981).

Religiosity Measure. There was one item on the demographic/individual information questionnaire regarding religiosity that read: "Do you consider yourself: antireligious, not religious, slightly religious, moderately religious, strongly religious." Participants marked the applicable response.

Client Satisfaction Questionnaire. The CSQ is an 8-item self-report instrument to assess client satisfaction with mental health services (Nguyen et al., 1983). Evidence has been presented for its validity and reliability (Attkisson & Zwick, 1982). Respondents mark one of four responses that vary according to the item. For example, to the question that asked "To what extent has our program met your needs?" participants may mark that "Almost all," "Most," "Only a few," or "None" of their needs have been met.

Purdue Family Therapy Satisfaction Scale. The PFTSS was initially developed by faculty of the Marriage and Family Therapy Program at Purdue University Q. Constantine, W. Denton, F. Piercy, and D. Sprenkle; R Piercy, personal communication, May 29, 1998). The current 18-item version of the scale has a Cronbach's (x of .91 (Paddock, 1990).

For the purposes of this study, four of the items were reworded to reflect couples, rather than family, therapy (i.e., the words "marital" or "spouse" replaced "family"). Items are rated on a 5-point Likert-type scale. Eleven items are worded in the positive direction (e.g., "I feel more confident about managing our marital difficulties as a result of marital therapy"), and seven are worded in the negative direction (e.g., "Overall, I am dissatisfied with how I got along with the therapist").

RESULTS

Preliminary Analyses

A set of preliminary analyses was undertaken to assess the structure of the three measures of marital satisfaction employed in the study: the Dyadic Adjustment Scale, the Personal Assessment of Intimacy in Relationships scale, and the Positive Feelings Questionnaire. Intercorrelations among these three measures were computed for all participants who completed the pretest (N = 80) and the posttest (N = 54). As can be seen in Table 1, the three measures of marital satisfaction were significantly and strongly intercorrelated at both pretest (average r = .60) and posttest (average r = .73).

Second, to assess the dimensionality of the assessments of marital satisfaction, principal components factor analyses were conducted on scores for the three measures at both pretest and posttest. The results of these analyses are summarized in Table 2. Unidimensional solutions were observed for the three measures at both pretest (eigenvalue = 2.20) and posttest (eigenvalue = 2.46). All three measures loaded strongly on the single factor at both pretest and posttest.

Given that the DAS, PAIR, and PFQ all assess aspects of marital satisfaction, that all three measures were highly intercorrelated, and that the three measures exhibited a clear unidimensional structure, we decided to create a composite measure of marital satisfaction. The composite scores were created by weighting each individual's standardized score on each measure by the factor loading for that measure; these scores were then summed and restandardized. The composite was created by summing and standardizing factor scores on the three measures. These procedures were applied to the data at both pretest and posttest. The internal consistency coefficient (i.e., Cronbach's 0-0) for the 3-item marital satisfaction score was .81 at pretest and .89 at posttest.

Tests of Hypotheses: Assessing the Effects of Emotion-Focused Therapy on Marital Satisfaction
The major study hypothesis, that EFr would prove effective at enhancing marital satisfaction, was assessed through a 2 by 2 analysis of covariance (ANCOVA). The between-group factors in this analysis were treatment status (treatment group vs. wait-list control group) and gender, the covariate was pretest marital satisfaction score, and the dependent variable was marital satisfaction at posttest. (Husbands’ and wives’ marital satisfaction scores were uncorrelated, so the data for both were included in analyses, and gender was treated as a between-group factor.)

Replication Study: Effects of EFT for Wait-Listed Participants

The design of the study included a wait-listed control group that received the EFr treatment program only after the experimental group had completed the study. This feature of the study’s design provided an opportunity to carry out a replication of the main investigation within subjects. As noted previously, participants randomly assigned to the waiting list completed the initial pretest assessments of marital satisfaction and then completed these assessments a second time 8 weeks later. (For purposes of this replication study, these second assessments will be referred to as the “secondary pretest.”) Participants then received the eight therapy sessions and completed the marital satisfaction questionnaires a third and final time (posttest). Of the 18 couples initially assigned to the wait-listed condition, 14 completed the first phase of the study and were invited to undergo the EFT program; nine of these couples (N = 18) actually completed the eight therapy sessions and responded to the third set of marital satisfaction questionnaires.

Because the replication study did not include a between-groups factor for experimental condition, it was not feasible to employ the standardized index of marital satisfaction as a dependent variable. Thus, the replication study retained the three separate assessments of marital satisfaction (the DAS, PAIR, and PFQ) in their original units and employed a doubly multivariate approach in analyses (i.e., assessments of multiple dependent measures at multiple time points). Specifically, the effects of the EFT intervention on participants in the replication study were assessed through a 2 by 3 doubly multivariate mixed-model MANOVA (multivariate analysis of variance) with repeated measures on the last factor. Since husbands’ and wives’ scores on the three dependent variables were not significantly correlated, the data for both were included in analyses and gender was treated as a between-group factor. The within-subjects factor was time at which the assessments of marital satisfaction were completed (initial pretest, secondary pretest 8 weeks later, and posttest at completion of eight therapy sessions). The dependent variables were scores on the DAS, PAIR, and PFQ. Single degree-of-freedom contrasts were employed to compare scores on the dependent variables at posttest with scores on these variables at each of the two pretests.

Supplemental Analyses

Three sets of supplemental analyses were undertaken to examine (1) whether certain variables moderated the effects of the marital therapy, (2) which participants gained the most from the therapy, and (3) the extent of client satisfaction with the therapy.

Assessments of potential moderating variables. It is important to determine whether the effects of the therapeutic program used in the present study were qualified by individual characteristics of the participants. This was already done in previously reported analyses for the categorical variable of gender; no significant moderating effects were observed. We also examined whether six continuous variables, four of them demographic (participant age, participant educational level, family income, years married) and two of them psychological (religiosity and interpersonal cognitive complexity) qualified the effects of the therapy program.
Regression methods were used to assess the potentially moderating effects for these six variables. None of the six approached statistical significance. (Details of these analyses are available from the authors.) Thus, the effects of EFr in this study were not qualified by the variables of gender, age, education, income, length of marriage, cognitive complexity, or religiosity.

A 2 by 2 multivariate analysis of variance was employed to assess whether gender and initial assignment to treatment or control group affected client satisfaction. The between-groups factors in this analysis were participant gender (male vs. female) and the group to which participants had been assigned initially (experimental versus wait-listed control); the dependent variables were responses to the CSQ and PFTSS. (Recall that at the point client satisfaction was assessed, all study participants had completed EFT treatments.) No significant effects were detected by the analysis. Thus, client satisfaction did not vary as a function of either gender or the group to which participants had been assigned initially.

Correlational analyses were employed to assess the extent to which demographic factors and interpersonal cognitive complexity were associated with clients' satisfaction with the EFT program. Scores on the CSQ and PFTSS were correlated with age, educational level, yearly family income, number of years married, cognitive complexity, and religiosity. The results of these correlational analyses are displayed in Table 4. Age, years married, and cognitive complexity were not associated with the assessments of client satisfaction. However, educational level and income were significantly negatively correlated with both measures of client satisfaction, and religiosity was positively associated with both measures of client satisfaction (see Table 4). Thus, the clients most satisfied with the therapy program tended to be less educated, less affluent, and more religious.

Qualitative Client Evaluations of the Therapy

An additional source of data regarding client reactions to the therapeutic intervention came from their comments in two open-ended questions at the bottom of the CSQ. The first item read "The thing I like best about the center is" and the second read "If I could change one thing about the center, it would be." Forty-three individuals provided comments, including those participants who had been in the treatment group as well as those who had initially been in the wait-list group and had subsequently completed the therapy. Many participants wrote more than one comment under each heading. Comments were divided into component concepts and then grouped under categories of similar content.

Positive comments related to the EFT program mentioned the role of the therapist as a facilitator of discussion. One participant wrote that what she liked best was that "we were encouraged to speak to one another about our feelings-it really helped my husband to open up to me. I enjoyed it." Another participant noted that she liked the "positive and kind approach in dealing with the problem by understanding where my spouse is and his understanding where I am-no blame, just discovery." Another participant responded: "The experience was a great one. The therapist made my husband comfortable to communicate with me there. The guidance and selection of questions were most helpful." Positive comments from men included appreciating that "the therapist didn't try to tell us certain things, like what to think, how to feel or what to say. He let
us be ourselves and just tried to stimulate conversation" and that the therapist "encouraged communication between us." Another participant wrote that he liked "the interaction and interruption of the therapist to point out things and the stimulation for self thought to find solutions to conflicts."

Some of the positive comments referred to aspects of couples therapy that might be shared by any model. These included statements such as "coming to the center I felt safe and felt that I was not wrong or right in my feelings," "the consideration of the both of us as individuals," "nonjudgmental personnel," and "the counselor remains neutral and doesn't allow you to brnt ul] east flAts in detail."

Not all participants appreciated that the therapist tried to facilitate their finding their own solutions. Among those who made suggestions for change in the therapy itself, it was usually for more specific direction from the therapist. Some wanted the therapist to take a more active role in solving their problems. These participants made comments such as I would have liked to have been told more professional opinions of our problems instead of mostly focusing on how we felt," "more help changing actual situations or solving differences of opinion, help changing major problems in our relationship-such as total lack of intimacy." Other participants felt more explicit homework or reading assignments would have been beneficial: "more active intervention by the therapist, concrete suggestions such as books, pamphlets, videos, etc." I would have liked to have focused more on exact steps to turn things around. I would've liked to have been given more homework," "offer literature or recommend relevant reading material to give better direction and guidance in following through with therapists' suggestions," "offer more solutions to our problems." Other similar suggestions included "To offer activities, projects, or other to help couple resolve differences. Or perhaps use role playing and evaluating the scenarios played out" and "perhaps could try role playing during the sessions so that the therapist could see what happens between my wife and L."

One participant did not seem to value that the therapy focused on present experience, as he commented "The therapy seemed superficial, dwelling on daily interactions, rather than trying to discover the sources of problems. I would suggest trying to focus on the causes, rather than the symptoms of an unhappy marriage." Another participant wished for more guidance on how to proceed after the conclusion of the sessions: "give resources indicated for the couple for future therapy or self help support groups as deemed appropriate by the group."

A number of comments related to the research and training aspects of the therapy. Comments about having a team were generally positive (e.g., that a best part was "the team viewpoint, where several may evaluate our problems at once. Not just one person's perspective"), but there were a number of negative comments about the mirror making participants feel uncomfortable.

The largest category of comments were positive remarks about the therapist's concern and caring. In particular, many participants valued that the therapist seemed to care about them. Comments were registered that a best part of the experience was "the therapist seemed open, honest, and caring about our situation," "they seem to really care about helping you with your problems!" "genuine caring attitude, ability to remember detail and focus in on our unique situation," "the people were friendly," "the therapist was very nice and seemed truly concerned. By the end she seemed like a concerned friend." No negative personal comments were made about the therapists.

DISCUSSION

This study tested emotion-focused therapy for couples under demanding conditions. The therapists were novice couples therapists, and the study participants included the first couples they had ever treated. Only eight sessions of therapy were provided. Although this was the number used in earliest tests of EFT (e.g., Johnson & Greenberg, 1985a, 1985b), more recent investigations have used 10 (e.g., Goldman & Greenberg, 1992) or 12 sessions (James, 1991). Further, sessions in this study were 50 min (the traditional length of therapy sessions in the United States), rather than 75 min (e.g., Johnson & Greenberg, 1985a, 1985b). Thus, this study essentially provided one-third less treatment than had ever been utilized in an EFT effectiveness study.

Despite these disadvantages, the therapy remained effective in improving marital satisfaction. The EFT program proved effective at enhancing marital satisfaction in both our between-groups experimental study and our within-subjects replication study. Moreover, effects of the therapeutic intervention were not qualified by any of the individual or demographic factors we assessed.

EFT is a therapy that encourages people to identify and discuss their emotions. On the surface, it may seem that this type of therapy would be most beneficial for couples who are affluent, highly educated, and psychologically minded. However, we found that the people who gained the most from therapy were those who had lower income, lower educational levels, and lower levels of cognitive complexity. Consistent with these findings, Johnson and Talisman (1997) found that men who gained the most from EFT were rated as less expressive by their partner at intake. They conclude that "EFT may be more appropriate ... for less expressive and withdrawn males." (Johnson & Talisman, 1997, p. 149). Less expressive individuals would have room to grow from a therapy that aids them in learning how to identify and discuss their emotions and feelings. In contrast, individuals who already freely discuss their emotions may have less to gain.

It is interesting that we found that our therapists tended to be most optimistic when they received verbal, articulate clients who readily discussed their feelings. In contrast, therapists often despaired when trying to aid some of the taciturn participants in describing their emotional experience and feelings. However, in terms of producing change, therapists may have the most beneficial effect on those clients who are less "fun" to work with. It may be useful to remind novice therapists of this potential during the training process.

Another interesting finding was that the participants who dropped out of the study also had lower educational levels, lower incomes, and lower levels of cognitive complexity than those who completed the study. Thus, the couples who were most likely to benefit from the therapy were also those most likely to drop out. It is of note that those who dropped out had significantly lower family incomes and more children at home. It may have been harder for these couples to make child care
arrangements, even though therapy sessions were conducted in the late afternoon and evening in an attempt to make them as convenient as possible. Consideration could be given to the provision of child care to increase follow-through with therapy.

It is possible that people with lower levels of interpersonal cognitive complexity, lower socioeconomic levels, and so on, might feel anxious about initiating couples psychotherapy. However, if they persevere, they may achieve greater benefit from therapy than the couples who were initially more comfortable. It is also possible that EFr in particular might be more anxiety producing for such individuals because of its focus on the discussion of emotions. It might be that special strategies are necessary to engage the people who are most likely to drop out (as well as benefit from) EFr.

There were a number of dropout couples in this study, while previous outcome studies have not experienced any dropouts (Goldman & Greenberg, 1992; James, 1991; Johnson & Greenberg, 1985a, 1985b). We do not know how to explain this discrepancy. Of course, it is possible that the quality of the therapy, the strength of the therapeutic alliance, and so on, were lower in the present study. Unfortunately, the data do not address these variables. It does appear that one distinction of the present study was the utilization of live supervision, with a one-way mirror, therapy team, supervisory phone-ins, and intrasession consultation between therapist and supervisor. Previous EFT studies utilized audio or videotaped sessions without live supervision (e.g., Johnson & Greenberg, 1985a, 1985b). Although there is some evidence that clients are generally satisfied with live supervision (Piercy, Spreenke, & Constantine, 1988), several participants who completed our study made comments about feeling uncomfortable with the one-way mirror/videotaping or that they would have liked to have met the team. Although all participants agreed to live supervision before entering the study, perhaps participants who dropped out experienced more discomfort with the process than they had anticipated. EFT specifically seeks to elicit vulnerable emotions, so perhaps having an observing team may be particularly inhibiting with this approach. Unfortunately, those who dropped out of the study did not provide their reasons, so we can do no more than speculate. Contact of study dropouts would be a valuable addition to future research protocols.

Although most participants seemed to enjoy the therapist's role in guiding and facilitating conversation, some wished for more directive involvement (e.g., homework, reading assignments). James (1991) did just this by adding four sessions of communication-skills training to eight sessions of EFT. He found that 96% of his participants endorsed exposure to both approaches rather than having had only EFT or only communication skills training (even though there were no significant differences in outcome).

The current study has several limitations that should be noted. For one, there was no long-term followup of the participants. Previous studies have found that effects of EFr endure at follow-ups of 2-4 months (Goldman & Greenberg, 1992; James, 1991; Johnson & Greenberg, 1985a, 1985b). However, others have found that many couples eventually relapse after therapy and that one course of couples therapy is probably not a lifetime remedy for relationship problems (Bray & Jouriles, 1995; Jacobson & Addis, 1993). Bray and Jouriles question whether it is not "reasonable to assume that couples may need therapy at different points in time?" (1995, p. 466) and point out that some therapists (e.g., Cummings, 1986) advocate repeated periods of brief psychotherapy across the life cycle rather than one course of sessions that is intended to be curative. We assumed that the effects of treatment delivered in this study would not be permanent and advised couples that we would not consider them to be a "failure" as a couple should they find themselves needing to pursue further couples therapy in the future. For us, the question is not "do the effects of therapy endure?" but, rather, "how long do the effects of therapy endure?" Unfortunately, we are unable to address that question from the available data.

Another study limitation is that there was no objective assessment of the fidelity of delivery of the intervention. From our direct observation of all sessions, we would say that the treatment delivered generally followed the instructions in Greenberg and Johnson (1988). Specifically, the sessions did not consist of giving advice, teaching communication skills, or delivering paradoxical directives. We were impressed with the quality of our therapists/trainees; many showed outstanding abilities, but none had done this type of therapy before. Not surprisingly, we observed that the steps of EFr were not always followed with the highest precision.

Greenberg and Johnson (1988) state that the two main tasks in EFr are accessing emotional experience and changing interactional positions. This was consistent with our own experiences in supervision. We observed that, lacking experience with and confidence in this model (or any other couples therapy model), therapists would tend to give up too early when participants did not quickly provide the information requested. This was evident in the two areas mentioned above. Identifying a cycle of interaction was a new concept for the couples as well as our therapists and it seemed, at times, that both groups questioned the importance of this task. One point of supervision was encouraging therapists to persist in tracking cycles of interaction when participants implicitly or explicitly resisted this. Similarly, when more reticent participants did not seem able to identify and put words to their emotions, encouragement was sometimes needed to inspire the therapists to persevere in their efforts. (We often found that when participants realized that the therapist was not going to resist in this line of questioning they would, then, become more verbal about their emotional experience.) A third general area of supervision was encouraging the therapists to guide the participants to interact with each other rather than only with the therapist. Thus, our general impression is that the therapy delivered was EFT even if it was not always exemplary EFT.
This may actually heighten the significance of our findings, as it could indicate that the intervention might not have to be delivered flawlessly to be effective. These results provide further evidence to support the efficacy of emotion-focused couples therapy as a treatment of relationship discord and the value of considering affect within couples treatment (Denton, 1991). Additional validation studies conducted by different investigators in different sites will further help to delineate the merits of emotion-focused therapy. Moreover, given the proven effectiveness of EFV in treating marital distress, it may now be time to conduct more focused studies of this therapy. What can be done to enhance the magnitude and duration of the effects produced by EFV? What are the most effective ways of training therapists in the practice of EFV? What is the role of EFV in the treatment of other conditions? Explorations of these questions may facilitate the continued development and evolution of EFV.

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