



National Library
of Canada

Bibliothèque nationale
du Canada

Canadian Theses Service Service des thèses canadiennes

Ottawa, Canada
K1A 0N4

NOTICE

The quality of this microform is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

If pages are missing, contact the university which granted the degree.

Some pages may have indistinct print especially if the original pages were typed with a poor typewriter ribbon or if the university sent us an inferior photocopy.

Reproduction in full or in part of this microform is governed by the Canadian Copyright Act, R.S.C. 1970, c. C-30, and subsequent amendments.

AVIS

La qualité de cette microforme dépend grandement de la qualité de la thèse soumise au microfilmage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

S'il manque des pages, veuillez communiquer avec l'université qui a conféré le grade.

La qualité d'impression de certaines pages peut laisser à désirer, surtout si les pages originales ont été dactylographiées à l'aide d'un ruban usé ou si l'université nous a fait parvenir une photocopie de qualité inférieure.

La reproduction, même partielle, de cette microforme est soumise à la Loi canadienne sur le droit d'auteur, SRC 1970, c. C-30, et ses amendements subséquents.

**FACILITATING INTIMACY:
A COMPARATIVE OUTCOME STUDY OF
EMOTIONALLY FOCUSED AND
COGNITIVE INTERVENTIONS**

Michel L. Dandeneau

**Thesis presented to the School of Graduate Studies
of the University of Ottawa
as partial fulfillment of the requirements
for the degree of Doctor of Philosophy
(Clinical Psychology)**



Michel L. Dandeneau, Ottawa, Canada, 1990



National Library
of Canada

Bibliothèque nationale
du Canada

Canadian Theses Service Service des thèses canadiennes

Ottawa, Canada
K1A 0N4

The author has granted an irrevocable non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of his/her thesis by any means and in any form or format, making this thesis available to interested persons.

The author retains ownership of the copyright in his/her thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without his/her permission.

L'auteur a accordé une licence irrévocable et non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de sa thèse de quelque manière et sous quelque forme que ce soit pour mettre des exemplaires de cette thèse à la disposition des personnes intéressées.

L'auteur conserve la propriété du droit d'auteur qui protège sa thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

ISBN 0-315-62329-2

Canada



UNIVERSITÉ D'OTTAWA
UNIVERSITY OF OTTAWA

ABSTRACT

The present study delineated intimacy from other confounding concepts in the literature and investigated the differential effects of two types of marital interventions taken from Emotionally Focused Therapy (EFT) and Cognitive Marital Therapy (CMT), on levels of marital intimacy, dyadic trust and dyadic adjustment. It was hypothesized that both EFT and CMT would have a positive effect on levels of intimacy, trust and adjustment as compared to a wait-list control group, and that there would be a differential effect in favor of EFT as compared to CMT. Thirty-six couples free of distress and seeking to enhance their intimate relationship were randomly assigned to EFT, CMT or a wait-list control group. Therapists' interventions were monitored and found to be faithfully implemented. Groups were equivalent on demographic variables and quality of therapeutic alliance. Results indicated that both EFT and CMT group means were higher than controls on the self-report measures of intimacy. Observational measures of intimacy revealed differential effects in favor of EFT as compared to CMT at posttest. At a ten-week follow-up, EFT group means were higher than CMT on self-reported intimacy and adjustment.

ACKNOWLEDGEMENTS

I wish to express my warmest gratitude and appreciation to Dr. Sue Johnson-Douglas, my thesis advisor. With skill, sensitivity, and patience she guided me, supported me, and challenged me to extend my limits. For all this, Sue, I am indebted to you.

I would also like to thank the members of my thesis committee for their helpful comments in bringing this project to an end: Dr. Pierre Baron, Dr. Henry Edwards, and Dr. Michael McCarrey.

A research project such as this one could not be completed without the help of many. I feel indebted to each and every couple who accepted to participate in this study, as well as to all the research assistants and therapists for their impeccable collaboration.

Special thanks go to Dr. Dwayne Schindler and Dr. Ken Welburn for their patient help with the statistical analyses, and to Lee Stethem for proofreading and printing.

I would like to express a very personal thank-you to Claudette Dubé-Socqué for helping me access my personal strength and deepen my understanding of intimacy.

Most of all, I would like to express my deepest appreciation to Francine, my beloved companion, who was

there throughout all those years, sharing the labor pains and giving me relentless support. She was part of my darkest moments as well as my greatest highs. A true companion. Thank-you, Francine.

CURRICULUM STUDIORUM

Michel Dandeneau was born in Fisher Branch, Manitoba, Canada in 1954. He studied at the Collège Universitaire de Saint- Boniface (University of Manitoba) where he obtained a Bachelor's Degree in Philosophy in 1976. In 1981 he received a Diploma in Theology and a Master's Degree in Pastoral Family Studies from St. Paul's University in Ottawa. In the same year he also received a Bachelor of Arts Degree (summa cum laude) with concentration in Psychology from the University of Ottawa. The following year he was awarded an Honours Degree in Psychology (magna cum laude) from the same university.

TABLE OF CONTENTS

Abstract	i
Acknowledgements	ii
Curriculum studiorum	iii
Table of contents	v
List of Appendices	x
List of Tables in the text	xii
Introduction	1
Review of the Literature	3
The Relevency of Intimacy	3
Historical background	3
Intimacy and well-being	5
Intimacy and psychotherapy	9
The Concept of Intimacy	12
Conceptual perspectives on intimacy	13
Psychodynamic/developmental viewpoints	13
Social psychological approaches	16
Humanistic Viewpoints	21
Definition models of intimacy	25
An operational definition of intimacy	33
Why self-disclosure?	36
Why trust?	38

Why empathy?	39
Delineation of intimacy from other related concepts	41
Attachment	41
Dependence	44
Cohesion and commitment	44
Love	46
Marital satisfaction	48
Interventions for improving Intimate Relationships	50
Couple based programs	51
Interventions used in this Study to enhance Intimacy	59
Cognitive Marital Therapy (CMT)	60
Emotionally Focused Therapy (EFT)	67
Hypotheses	78
Significance of this Study	79
 Methodology	 81
Research design	81
Setting	82
Subjects	82
Therapists	84
Instruments	85
Standardized Telephone Screening Procedure	85
Information and Consent Form	86
Demographic Data Questionnaire	86

Hypothesized treatment effects	109
Hypothesis 1	109
Hypothesis 2	113
Hypothesis 3	115
Hypothesis 4	116
Hypothesis 5	118
Hypothesis 6	119
Effect sizes	120
Discussion	123
Summary of results	124
Relationships between dependent variables	126
Treatment effects	128
Dyadic Trust	130
Dyadic Adjustment	133
Intimacy	134
Why was EFT more effective than CMT at follow-up and not at posttest	135
Why was EFT more effective?	138
How emotion is used in EFT	139
Expression of primary emotion evokes empathic responsiveness	141
Core interpersonal beliefs	143
Change in interactional cycle	145
Limitations of this study	147

Target problems	148
Population	148
Manner of recruitment	149
Therapists	149
Selection and setting of treatment	150
Variation of treatment	150
Assessment methods	150
Suggestions for future research	151
References	153

Appendix E - Tables	227
E1 Pearson Correlation Coefficients	228
E2 Analysis of Variance: Demographics	229
E3 Analysis of Variance: Couples Therapy Alliance Scale	230
E3a Analysis of Covariance for MSIS at Posttest with Pretest Score as Covariate	231
E3b Analysis of Covariance for SD at Posttest with Pretest Score as Covariate	232
E3c Analysis of Covariance for EMP at Posttest with Pretest Score as Covariate	233
E4 Planned Comparison Tests: EFT, CMT and Control Group Means at Posttest	234
E5 Analysis of Covariance for MSIS at Follow-up with Pretest Score as Covariate ..	235
E6 Planned Comparison Tests: EFT and CMT Groups at Posttest and Follow-up	236
E7 Analysis of Covariance for DTS at Posttest with Pretest Score as Covariate	237
E8 Analysis of Covariance for DTS at Follow-up with Pretest Score as Covariate	238
E9 Analysis of Covariance for DAS at Posttest with Pretest Score as Covariate	239
E10 Analysis of Covariance for DAS at Follow-up with Pretest Score as Covariate	240

LIST OF TABLES IN TEXT

No.	Title	Page
1	Reliability Statistics for Self-Report Measures	104
2	Pretest, Posttest and Adjusted Group Means on MSIS, SD, and EMP	111
3	Pretest, Follow-up and Adjusted Group Means on MSIS.	114
4	Pretest, Posttest and Adjusted Group Means on DTS ..	116
5	Pretest, Follow-up and Adjusted Group Means on DTS .	117
6	Pretest, Posttest and Adjusted Group Means on DAS ..	118
7	Pretest, Follow-up and Adjusted Group Means on DAS .	120

Facilitating Intimacy: A Comparative Outcome Study
of Emotionally Focused and Cognitive Interventions

INTRODUCTION

The general area of concern in this study is the enhancement of intimate relationships. Intimacy is seen by all as being of central importance in our lives and more and more people are turning to their intimate relationships to provide them with meaning and personal security. Yet, divorce and separation statistics reveal how more and more of these relationships fail to endure. Perhaps one of the biggest challenges in life is to get close to someone and stay there.

Intimacy is a complex concept which has generated a variety of theories, definitions, and philosophies over the years. The latter half of the twentieth century is witnessing an increasing demand placed on intimate relationships for general personal fulfillment (Brehm, 1985). In the last two decades, empirical studies have multiplied and have demonstrated the significant association between close relationships and general physical and psychological well-being (Fehr & Perlman, 1985). Support for the importance of intimacy also comes from evidence on the negative consequences of a lack of intimate bonds. The lack of intimate bonds has been related to various psychological difficulties ranging from depression to

nonpsychotic emotional illness (Perlman, Fehr, & Duck, in press). Other research shows that divorce and loneliness are psychologically transmitted between generations, which means that deficiencies in intimacy experienced today may be perpetuated in the following generation (Lobdell & Perlman, 1985).

The most frequent interpersonal concerns presented to psychotherapists are problems related to intimacy (Horowitz, 1979). Intimacy has been recognized as an important dimension to be worked with in marital therapy (Berman & Lief, 1975). Yet, there is a lack of studies investigating different interventions used in marital therapy to facilitate intimacy. (Stauffer, 1987). Studies on relationship enhancement have used general marital satisfaction as their outcome variable and have failed to examine the effect of their interventions on intimacy per se.

The present study addresses the particular need to investigate specific interventions used in marital therapy which are aimed at facilitating intimacy, using intimacy as the specific outcome criterion. Two sets of interventions taken from two marital therapies (EFT and CMT) were compared to each other and to a wait-list control group for differential effects on intimacy.

The following sections provide an overview of the literature and a description of the methodological aspects of the study.

Review of the Literature

Relevancy of Intimacy

Historical Background

The nature of intimate relationships changed in various ways as sociocultural patterns evolved in different societies. For the purposes of this study a brief historical overview will focus on the evolution of intimate relationships in American society from the colonial era to the present.

According to Gadlin (1977), the current nature of intimate relationships originated in the early nineteenth century with the advent of rapid industrialization and urbanization that separated the work world from the home. Prior to this, during the colonial period in the mid 1600's, intimate relationships were rooted in a formal social order characterized by a strict sense of duty and authority in the family and in the community. People were always together, be it in the family or at work or at leisure. People were literally close to each other and intimacy meant "physical proximity". The home was the center of social existence and served as the foundation of social stability.

As industrialization and urbanization increased in the first half of the nineteenth century, employment and the business world took people out of their homes. The move from farms to cities generated a crisis in personal identity

and interpersonal relations. Home life and intimate relationships started to be modeled according to occupational demands. Men spent less time at home and gained more power in the work force. This trend continued well into the twentieth century. The family structure was no longer the primary source of socioeconomic survival. The post second world war period saw a steady and definite decline in the extended family model in favor of the nuclear family.

As the socioeconomic importance of intimate relationships declined over time, their personal psychological significance increased. In contemporary life intimate relationships have become a refuge from alienation in a competitive work world and from social anonymity and isolation (Levinger & Raush, 1977). Toffler (1979) argues that as society becomes more transient and meaningless in some ways, humans will turn towards their personal relationships in search of meaning, fulfillment and stability. Close personal relationships become one's "portable roots, anchoring one against the storm of change" (Toffler, 1979, p. 239).

Veroff, Douvan and Kulka (1981) have analyzed survey data from Americans on different aspects of their lives over the years 1957 to 1976 and found that "intimacy has become a vehicle for personal fulfillment much more in 1976 than it was in 1957" (p.537). In 1957, Americans sought happiness primarily through fulfillment of their role in society (i.e.

being a good lawyer, a good homemaker, a good teacher, etc.). By 1976, Americans were placing greater importance on fulfilling personally defined goals (e.g. satisfaction with one's work, having good friends, being close to one's children etc.). Veroff et al. (1981) also discovered that with the decline of normal structured institutionalized ways of dealing with problems, more people were turning to intimate relationships to deal with personal problems.

This evidence is also consistent with increased rates of divorce and cohabitation, decrease in religious practice, decline of confidence in government, increased demands for women's equal rights along with a gradual diminution of the influence of traditional institutions (churches, marriage) on the lives of many Americans (Brehm, 1985).

Intimacy and Well-being

Researchers investigating the psychological significance of marriage, close relationships with others, and bereavement have copiously supplied the scientific literature with empirical evidence suggesting that positive interpersonal relationships in general promote mental and physical health and that intimacy in particular is an important predictor of psychological and physiological well-being (Cobb, 1976; Mitchell & Trickett, 1980; Fehr & Perlman, 1985; Gove, Style & Hughes, 1990). Survey data have consistently indicated that married individuals have substantially better psychological well-being than the

unmarried (Andrews & Withey, 1976; Campbell, 1981; Gove, Hughes, & Style, 1983; Gove & Shin, 1989).

Reis (1984) reviewed 10 studies of mortality and psychological health published in a 6 year span from 1976 to 1982 and concluded that "well-being is most likely to stem from contact with affectively close or intimate partners" (p.34). Reis also examined several other studies which point out that quality of contacts is of greater consequence than their sheer existence or breadth. Others have found that the depth of intimacy proved to be a key factor in one's ability to adapt over the life span (cf. Schaefer & Olson, 1981). It has been argued that most men and women live autonomous, self-generating and satisfying lives only through one or more mutually supportive intimate relationships (Lowenthal & Weiss, 1976).

Lowenthal and Haven (1968) have documented the importance of intimate relations in supporting and protecting older adults in times of crises such as widowhood and retirement. They were "struck by the fact that the happiest and healthiest among them often seemed to be the people who were, or had been, involved in one or more close relationships" (p. 20). Widowed, divorced and never married persons ranging from 15 to 64 years of age incur a significantly higher risk for most causes of mortality (Lynch, 1977). Lynch also found along with Jacobs and Charles (1980) that widows and widowers who maintained only superficial relationships with friends and relatives had a

significantly higher risk of illness and mortality than those who had or developed close relationships after the loss.

Women (ages 18 to 65) who have experienced stressful life events and who lack a confidant are in fact ten times more likely to be depressed than those with a confidant (Brown & Harris, 1978). It is also noted that superficial friendships fail to provide even relative protection to these women.

The lack of intimacy has also been found to be a factor in male depression (Roy, 1981). Goldberg (1976) maintains that the lack of close relationships with other males is strongly associated to the significantly higher rate of suicide among men.

In a 5-year prospective study of the development of new angina pectoris cases among 10,000 married men, Medalie and Goldbourt (1976) found that if the subject felt he had a loving and supporting wife the risk of angina pectoris was reduced from 93 to 52 per 1,000 despite the presence of electrograph abnormality, high levels of anxiety and serum cholesterol.

The importance of intimacy has also been shown through investigations of the experience of loneliness. Weiss (1974) distinguishes between loneliness of emotional isolation due to an absence of attachment relationships and loneliness of social isolation resulting from an absence of social integration. Of the two forms emotional isolation

would be the most severe.

The absence of significant close relationships is seen as predisposing the individual to emotional difficulties and psychiatric disturbance. Freedman (1978) found that 90% of the people who reported being very happily in love also claimed to be very happy in general. However, unhappy people in his sample mentioned love as the one ingredient over anything else that would make them happy. In his review Gove (1973) found that the rate of psychiatric disorders was higher among unmarried individuals than among married individuals. He also found that the incidence of death due to various causes such as suicide, accidents, diabetes, lung cancer, tuberculosis, and even homicide was higher for unmarried persons. Diener (1984) reports a strong correlation between satisfaction with one's marriage and family life and people's overall sense of subjective well-being.

The prevalence of nonpsychotic emotional illness in the general population has been significantly associated to deficiencies of marital intimacy (Waring, McElrath, Mitchell, & Derry 1981; Waring, Patton, Neron, & Linker, 1986). An association between neurosis and lack of close attachments has been demonstrated by Henderson, Bryne, & Duncan-Jones (1981). Hames and Waring (1979) have shown a significant correlation between a lack of marital intimacy defined in general terms reported by psychiatric patients and the severity of nonpsychotic emotional illness. More

specifically, deficiencies of marital intimacy have been found to be significantly associated with the severity of depression (Waring & Patton, 1984).

Several authors claim that reconnecting deficient social bonds should, at least in part, be the focus of therapy for nonpsychotic emotional difficulties (Speck and Rueveni, 1969; Weissman and Paykel, 1974; Pattison, 1977).

Intimacy and Psychotherapy

Horowitz (1979) found that problems with intimacy constituted the single largest cluster of complaints by clients seeking psychotherapy for interpersonal problems. According to an earlier study by Gurin, Veroff, and Feld, (1960), marital concerns ranked first among the reasons why people sought help for emotional problems. In another study, it was found that 50% of individuals seeking psychotherapy wanted help specifically for marital difficulties, while an additional 25% presented problems related to their marriages (Sager, Gundlach, Kremer, Lenz, & Royce, 1968).

The relationship between marriage and intimacy has been recognized by theorists and researchers alike (Brehm, 1985). Anthropologists agree that, insofar as we know, human beings have always called upon a form of one to one relationship (even in polygamy) to fulfill their profound developmental and psychological needs for intimacy, trust and affection (Briffault & Malinowski, 1956). Research indicates that

marriage still remains by far the preferred way of life for the vast majority of people in our society (Burgess, 1981). People enter marriage because they believe it will meet their needs for "intimacy and enduring commitment" (Skolnick, 1978, p.387) and that the marriage bond will become the "closest, deepest, most important and most enduring relationship of one's life " (Slater, 1968, p.99). Thus, marriage continues to be the main source of intimacy in our society.

As mental health professionals were confronted with marriage related difficulties, the field of psychotherapy gradually developed new approaches dealing more specifically with marital problems. Marital therapy thus became firmly established in the 1970's as a rapidly growing discipline with an increasing number of practitioners, professional organizations, and research journals. The need to better understand the nature of intimacy has been increasingly felt by professionals working in the field and a call has been made for increased research investigating means to enhance intimacy (Hinde, 1978).

In their discussion on marital therapy, Berman and Lief (1975) identify three important dimensions of marital psychodynamics: boundary (Who else is considered to be part of the marital system?), power (Who is in charge?), and intimacy (How near, how far?). Pertaining to the last dimension, Berman and Lief claim that "the vacillations in emotional and geographic distance, as partners struggle with

their need for and fear of closeness, are significant data for the marital therapist" (p.585). Yet no studies have been conducted in order to specifically explore the effects of different marital therapy interventions on couples' intimacy levels.

This section has highlighted the increasing importance of intimacy and has discussed its positive relationship to physical and psychological well-being, as well as its gradual recognition as a central concern in the field of psychotherapy. The literature reviewed so far does not offer a clear definition of intimacy. Intimacy is referred to in a general and vague manner encompassing a number of undefined variables or as an interchangeable synonym to such concepts as marriage and love. When a researcher claims that intimacy is positively associated with well-being, we yet have to determine what is meant by "intimacy". The following section will focus more on the concept of intimacy itself and how it has been viewed by different thinkers and researchers in the psychological literature.

The Concept of Intimacy

The formal study of intimacy can be traced back to the sociological work of Georg Simmel at the turn of the century (Perlman et al., in press). In the 40's and 50's neo-freudians such as Sullivan, Fromm, and Erikson emphasized the need of some form of intimacy as being critical to one's development and to one's functional adjustment. Angyal (1965), in explicating the basic tenets of his theory, affirms that "to be is to mean something to someone else" (p. 18). He further asserts the need to live in the "love and affection and thought of the other person. To be received in this way into the life of another seems to be one of the most important issues for human beings" (p.24).

This section will look at intimacy from the perspective of three major general approaches in psychology: Psychodynamic/Developmental viewpoints, Social Psychological approaches, and Existential/Humanistic approaches. We will then turn to different definition models used in the literature to conceptualize and elucidate the phenomenon of intimacy. Finally an attempt will be made to further clarify the concept of intimacy and an operational definition will be offered.

Conceptual Perspectives on Intimacy

Psychodynamic/Developmental Viewpoints

Sullivan (1953) views intimacy as intrinsically tied in to one's development. The need for intimacy becomes a powerful integrating tendency, i. e. a motivating system in human life which gets us involved with others. It begins in infancy with a need for contact, a need for tenderness and for protective care. It continues in childhood with the added need for the participation of a significant adult in the child's play activities and in the juvenile era with the need to be in an accepted and significant group of playmates similar to oneself.

In the preadolescent stage one develops an interest in a particular member of the same sex who becomes a "chum" or a close friend. Until this stage, the child was virtually incapable of what is known as empathy, i. e. "a real sensitivity to what matters to another person" (p. 245). The other becomes of practically equal importance as oneself in all fields of value, which marks a significant change from the juvenile era and represents the beginning of love. This "chumship" will become the basis on which intimate relationships will subsequently be built throughout adolescence and adulthood. As individuals move on to late adolescence, they consolidate their need for intimate loving relationships, a need which will be with them for the rest of their lives.

According to Sullivan, our recurrent need for intimacy

is experienced through the very powerful motivating force of loneliness. He suggested that a lack of intimacy would result in the painful experience of loneliness which would then motivate the person to seek contact despite fear and anxiety. This has been only partially supported by empirical evidence. A factor analysis of the reasons for loneliness, conducted by Rubenstein and Shaver (1982), revealed that "Being unattached" accounted for the largest percentage of the common variance, thus supporting the idea that lack of intimacy results in loneliness. However the converse --loneliness motivates people to seek contact-- was not confirmed. On the contrary, "social contact" was the least common response to loneliness. This suggests that although the lack of intimacy may produce loneliness, the quest for intimacy is not a result of loneliness, rather intimacy is a need and a value in and of itself.

Erikson (1963, 1980) too spoke of intimacy within a developmental context but contrary to Sullivan, who saw the need for intimacy as an integrating force throughout life, Erikson made it the nucleus of only one of his developmental stages. He sees intimacy (vs isolation) as part of a critical developmental task to be negotiated in the passage from late adolescence to early adulthood. For Erikson, real intimacy is possible only after a reasonable sense of identity has been established. "The condition of a true twoness is that one must first become oneself" (1980, p. 101). The young adult must first develop a sufficient level

of self-confidence and self-definition to be able to express his true feelings to others.

The idea that identity is a precursor to intimacy has been challenged by Matteson (1975) who argues that people may grow and discover themselves through experiences of intimate sharing. "There is no clear pattern to suggest that identity must precede intimacy; intimacy also alters identity" (p. 161). Hodgson and Fischer (1979) studied sex differences in the processes of identity and intimacy development among college youth. They found that "a certain level of identity development must precede a readiness for intimacy among males, whereas such 'readiness' in females either precedes or coexists with the first gropings toward identity" (pp. 47-48).

Although Erikson's theory in general is clear about identity preceding intimacy, he does however suggest that intimate encounters are important in the development of identity: "... nobody can quite 'know' who he or she 'is' until promising partners in work and love have been encountered and tested" (1982, p. 72). He also suggests the importance of self-disclosure in the formation of one's identity when he describes a kind of adolescent attachment often devoted to "an attempt at arriving at a definition of one's identity by talking things over endlessly, by confessing what one feels like and what the other seems like, and by discussing plans, wishes, and expectations" (1980, p. 101). The idea that self-disclosure is a way to

discover one's identity was strongly asserted by Jourard: "... no man can come to know himself except as an outcome of disclosing himself to another person" (1971, p. 6). The relationship between self-disclosure and intimacy will be discussed later under the section "An operational definition of intimacy".

In summary, psychodynamic approaches view intimacy as an important element in one's development, whether it be an integrating force throughout life or a particular developmental task intrinsically linked to self identity. Sullivan's concept of "chumship" and Erikson's allusion to self-disclosure both presage a definition of intimacy based on empathy and self-disclosure.

Social Psychological Approaches

From a social psychological perspective, intimacy has been seen as an equilibrium of approach and avoidance forces (Argyle & Dean, 1965; Coutts & Schneider, 1976; Aiello & Thompson, 1980). According to equilibrium theory, if one component of intimacy changes, one or more of the others will also change but in the opposite direction in order to maintain the balance. Such a view would seemingly make intimacy practically impossible or stagnant at best. This hypothesis was not supported by research done by Jourard (1971) and by Cozby (1973) who studied the relationship between self-disclosure and distance. They found that as distance decreased, disclosure time increased when there was

increasing trust and positive feelings toward the person coming close.

Perhaps the most widely adopted social psychological perspective of relationships is that of social exchange (Thibaut and Kelley, 1959). According to this approach, intimate relationships are determined by the same principles as those governing the economic marketplace: rewards, costs, alternatives. Rewards refer to the pleasures, satisfactions, and gratifications provided by a given relationship. The costs refer to factors that inhibit or deter a desired sequence of behavior or reward. Costs are higher when great physical or mental effort are required in order to obtain a reward, or when embarrassment or anxiety accompany the action.

Social exchange theory views relationships as bargains or trade-offs and is based on the assumption that "every individual voluntarily enters and stays in any relationship only as long as it is adequately satisfactory in terms of his rewards and costs" (Thibaut & Kelley, 1959, p. 37). Individuals are believed to compare the outcome (i. e. rewards/costs ratio) of any current relationship to the outcome they think they would receive in some other alternative relationship. These comparison levels for alternatives determine the level of satisfaction experienced in a given relationship.

The effect of exchange attitudes on the quality of interpersonal relationships have been investigated by

Murstein, Cerreto, and MacDonald (1977). These authors defined two personal orientations according to the degree to which people believe equity of exchange should characterize their relationships. An exchange-oriented individual would expect perfect reciprocity, i. e. "every positive or negative action by one individual should be met by a similarly weighted action by the recipient" (p. 543). The nonexchange-oriented people are not concerned with reciprocity and do not keep records of what they have done for others or what others have done for them. They endorse an unconditional acceptance of others and forgive transgressions. Murstein et al. (1977) found that exchange orientation was negatively associated with marital adjustment whereas in friendship pairs exchange and friendship intensity were positively related. The authors propose that exchange orientation may be adverse to longstanding relationships.

Clark and Mills (1979) found that *quid pro quo* exchanges reduced liking when people were involved in a "communal" relationship, i. e. a relationship in which people respond to another person's needs. Other studies have also supported the notion that a nonexchange orientation is positively associated with intimate relationships (Milardo & Murstein, 1979; Seligman, Fazio, & Zanna, 1980), and that treating a communal relationship in terms of exchange compromises the relationship (Mills & Clark, 1982). Although for most people communal or

nonexchange relationships are most important, past research has been concentrated mostly on exchange (Mills & Clark, 1982).

Social penetration theory as developed by Altman and Taylor (1973) provides perhaps the most extensive work on the development of intimacy in relationships. Social penetration theory views personality as a series of (onion skin) layers which differ along a central-peripheral dimension or "depth dimension" which convey several key properties:

- * At the peripheral layers are superficial and more accessible information such as biographical characteristics. As one progresses toward more intermediate layers, there are more fundamental characteristics such as opinions and attitudes. The central core layers contain fears, self-concepts, and basic values.

- * More central areas have a greater impact on peripheral areas and are linked to a greater number of other aspects of personality. Thus shifts at more central layers are expected to have a greater impact on the whole personality than changes at peripheral layers. The deeper the characteristic, the more it involves the total personality.

- * As one moves to deeper layers, there are more unique and idiosyncratic characteristics which are not usually made readily accessible to others.

- * The greater the depth of a characteristic, the

greater the probability that it represents a vulnerable zone of the personality, such as a real or perceived weakness.

* The deeper layers also contain "socially undesirable" aspects of the personality.

According to social penetration theory, intimacy between two individuals consists of a gradual process of moving from the periphery to the core of their mutual personalities. Self-disclosure then becomes a privileged access route to the layers that lie closest to the innermost core of the person. At first people will disclose only superficial data that are relatively impersonal. If this initial exchange is rewarding they may deepen their intimacy by increasing both breadth (disclosing more information on a given layer), and depth of exchange (sharing more and more on topics closer to the core of the personality). This type of interaction can be diagrammed as a wedge profile with relatively more exchange at peripheral layers and relatively fewer exchanges at deeper central layers of personality. At the beginning of a relationship the wedge is both narrow (few areas disclosed) and shallow (impersonal topics). As intimacy progresses, the wedge broadens (more topics discussed) and deepens (topics closer to the core).

The basic wedgelike progression of social penetration with greater disclosure in superficial versus intimate areas along with a more rapid rate of growth of exchange in peripheral areas compared with central intimate layers has been consistently confirmed through research (Taylor, 1968;

Altman & Haythorn, 1965; Frankfurt, 1965).

In summary, equilibrium theory lacks solid research support and is weak in terms of theoretical accountability for intimate relationships. Exchange theory has generated considerable research, much of which indicates an aversive relationship between exchange orientation and intimacy. It also fails to explain the process of intimacy, focusing more on why people stay in or leave relationships. Social penetration theory accounts well for the process of intimacy and is supported by consistent confirmation through research. It also uses self-disclosure as a keystone in the definition of intimacy which is seen as a gradual process of disclosure and penetration to the core layers of a person.

Humanistic Viewpoints

Fromm (1956) defines genuine love as "an expression of productiveness and implies care, respect, responsibility and knowledge" (p. 50). Productiveness, in Fromm's theory, is the sign of a mature personality who has outgrown the stage of an exploitative and hoarding orientation where one is virtually unable to give for fear of deprivation. The "productive character" experiences giving as the expression of potency and of aliveness. In a loving relationship mature people give of themselves, of that which is alive in them for the joy of giving and not in order to receive (as contended by exchange theorists). By "care" Fromm means "the active concern for the life and the growth" of the one

we love. Respect is the ability to see the other as a unique individual and responsibility is one's response to the needs of another.

According to Fromm, care, respect and responsibility are not possible without "knowing" the other person. Such knowledge in a loving relationship is possible "only when I can transcend the concern for myself and see the other person in his own terms" (p. 24). One who knows another in this way is able to respond empathetically to what is deeper, e.g. to the unexpressed anxiety and suffering beneath the expression of anger. Knowledge also refers to what Fromm sees as a basic yearning in all human beings -- the desire to "penetrate into the secret of man's soul, into the innermost nucleus which is 'he'" (p. 25). Loving knowledge transcends objective knowledge gained through thought, although objective psychological knowledge of another is a "necessary condition for full knowledge in the act of love" (p. 26). Knowledge could also be seen as revealing oneself to another, making oneself known in the process of self-disclosure. Thus revealing one's deeper needs, feelings and thoughts would be expected to help evoke care, respect and responsibility in the other.

Rogers (1972) emphasizes a growth oriented here and now process when speaking of an intimate partnership. He believes that getting in touch with and disclosing any persisting feeling, positive or negative, to the intimate partner, and trying to understand empathetically his or her

response constitutes a basic element of an enriching intimacy. Rogers also stresses the importance, in a living relationship, of becoming a separate self by getting closer to and being one's feelings experienced in one's own organism. One can then be the complexity of personal feelings, meanings and values with one's intimate partner and "be free enough to give of love and anger and tenderness as they exist in me. Possibly then...I can encourage my partner to follow his or her own road to a unique personhood, which I would love to share" (p. 209).

In Gestalt literature the term "contact" (Perls, Hefferline & Goodman, 1951) refers essentially to the same phenomenon as the term "intimacy" in Transactional Analysis (Berne, 1961). Both terms refer to two individuals risking themselves in a game-free coming-together where the outcome is unpredictable and where both are open and ready to receive what the other has to offer (Moursund, 1985). Each is willing to touch and affect the other as well as be touched and be affected in a mutually vulnerable process. This process not only requires that we give to and receive from each other, but that we adjust our openness to the other's being. True contact changes a person: "I not only take in something new, but my very ability to take in must change" (Moursund, 1985, p. 118).

In summary, Fromm's concept of full knowledge through love suggests that self-disclosure of one's deeper life facilitates empathy and evokes responsiveness in an intimate

partner. Rogers describes one's deeper life as including personal feelings, meanings and values and emphasizes the importance of sharing any persistent phenomena in this area and empathizing with the partner's response. The Gestalt and Transactional Analysis literature speak of intimacy in terms of a game-free contact characterized by mutual openness and vulnerability which presuppose a safe, trusting and empathic context. Thus, the humanistic/existential literature relative to love and intimacy in general suggests a conceptualization of intimacy based on trusting self-disclosure and empathy.

Having summarized how representatives from different schools of thought in psychology have viewed intimacy in general, we will now bring into focus particular models and variables used in the literature to define intimacy.

Definition Models of Intimacy

Although the concept of intimacy has been directly or indirectly alluded to by writers and thinkers since the beginning of written history, it has only recently become a separate topic of investigation. Until the early 1970's intimacy was not a formal entry in the index of the Psychological Abstracts. Between 1973 and 1979 an average of 46 entries per year were reported with a peak of 70 reached in 1978. In the first half of the 1980's, the average number of entries rose to 60 per year peaking at 77 in 1984. The tardiness of psychological research on intimacy may be due to its complexity and multidimensional nature along with the difficulty in operational specification (Sexton & Sexton, 1982).

Although intimacy is mentioned with some frequency in the research literature, psychology has yet to clearly conceptualize, define and validate the nature of intimacy (Schaefer & Olson, 1981). All too often attempts at defining it have resulted in vague statements such as "Intimacy means the degree of closeness two people achieve" (Hendrick & Hendrick, 1983, p.18) or "Intimate relationships. Relationships between loving persons whose lives are deeply intertwined" (Walster, Walster, & Berscheid, 1978, p. 146). Intimacy is often blurred and used synonymously with related concepts such as marriage, marital satisfaction, self-disclosure (Hinde, 1979), bodily contact (Morris, 1971), and love (Rubin, 1973).

Weiss and Lowenthal (1975) identified similarity, reciprocity, and compatibility as essential aspects of an intimate relationship and argued that such a relationship was a major resource in facing life transitions. Others have discussed whether the experience of intimacy is basically intrapsychic (Maslow, 1970), interpersonal (Sullivan, 1953), or a mixture of dynamic personal and non-personal (collective unconscious) components (Jung, 1928). In what may seem to be an attempt to integrate these three views, Wilner (1975) states that intimacy derives from intrapsychic exploration which is in turn derived from an interpersonal exchange. Wilner (1982) also views intimacy "as generating fresh experience in that it brings each individual into a new relationship with himself/herself" by extending personal boundaries through intimate contact with the essential (unconscious) nature of another person (p. 23).

Rubenstein and Shaver (1982) have listed features that psychologists use in defining intimacy: openness, honesty, mutual self-disclosure; caring, warmth, protecting, helping; being devoted to each other, mutually attentive, mutually committed; surrendering control, dropping defenses; becoming emotionally attached, feeling distressed when separation occurs (p. 21).

Intimacy has also been defined by what it provides to the partners in terms of fulfillment of psychological needs (Brehm, 1985). Weiss (1974) identified six categories

of relational provisions, each ordinarily associated with a particular type of relationship: attachment; social integration; opportunity for nurturance; reassurance of worth; a sense of reliable alliance; the obtaining of guidance. It is suggested that in a satisfying intimate relationship all of these needs are met at least to some extent. Intimate partners would ideally provide a sense of security and accessibility to one another, share feelings, help and take care of each other, discuss practical concerns, be a source of companionship for one another, and provide mutual reassurance (Brehm, 1985).

Several authors resort to a "horizontal" / breadth model looking for different types or different factors of intimacy. Clinebell and Clinebell (1970) have distinguished twelve different types of marital intimacy including: sexual, emotional, intellectual, aesthetic, recreational, creative, work, crisis, conflict, commitment, spiritual, and communication intimacy. Waring (1988) has identified eight different facets to intimacy which include: affection, expressiveness, compatibility, cohesion, sexuality, conflict resolution, autonomy, and identity. Schaefer and Olson (1981) have come up with a five factor model of intimacy including: emotional, social, intellectual, sexual, and recreational intimacy. All of these horizontal models leave much to be desired in that they include so many different variables that it becomes difficult to distinguish between intimacy and general marital satisfaction. These models

therefore fail to clearly delineate and establish intimacy as a unique concept.

In contrast to a horizontal conceptualisation of intimacy Dahms (1972) proposes a three tiered hierarchical model including: 1) Intellectual, based on superficial selling of one's self-ideal rather than the real self; 2) Physical, which includes touching and sexuality; 3) Emotional, characterized by mutual accessibility, naturalness (authenticity), nonpossessiveness, and process (the state of emotional intimacy is one that is never attained once and for all). In this model, the third level of intimacy is of the highest order. In the process of a breakdown in a relationship, emotional intimacy is the first to disappear, then follows physical intimacy, and "soon only the chatter about daily routine (intellectual intimacy) remains" (p.49). This model suggests that all intimate overtures of an intellectual or cognitive nature will be of a lesser depth and value than emotional sharing. However, this may not be the case. A partner may use emotion instrumentally, eg., by crying in order to manipulate and control the other. Such "emotional sharing" may not in fact be any deeper or authentic than sharing one's very personal self concept.

Frey, Halley, and L'Abate (1979) and L'Abate and Sloan (1984) also propose a "vertical" model rather than a "horizontal" concept. Their model proposes three levels: Self-presentational -- superficial efforts at being intimate

-- efforts aimed at enhancing one's image; Phenotypic -- efforts aimed at resolving conflict and dealing with anger; Genotypic -- deepest level, involves the risk and vulnerability of sharing our hurts and fears. At the genotypic level, intimacy is an emotional process which involves the sharing of hurt feelings and fears of being hurt. It means being there when the going gets tough, when difficult events and experiences in our lives lead us to feeling fallible, needy, and vulnerable. The essence of intimacy "can be found mostly in the ability to Be with someone who hurts, either ourselves or someone we love and who loves us. Our ability to Be is based on the ability to be in touch with our feelings and our being able to share these feelings with whoever cares for us." (L'Abate & Laird, unpublished manuscript). Despite its greater conceptual precision, the possible disadvantage of this model may be its too great specificity limiting intimacy essentially to the sharing of one specific type of feeling i.e. hurt, which may in fact encourage sympathy over intimacy .

In what may seem to be an effort to pull together vertical and horizontal models of intimacy, Tolstedt and Stokes (1983) distinguish three aspects of intimacy: verbal, affective, and physical. Verbal intimacy combines 3 classic variables in the self-disclosure literature: breadth, depth, and valence. Breadth refers to the range of topics about which an individual discloses. Depth refers to how close (ranging from nonintimate to highly intimate) the disclosure

is to the innermost core of the person (cf. social penetration theory). Valence refers to the positive or negative quality of the disclosure. Affective intimacy, in this model, "reflects feelings of closeness and emotional bonding, including intensity of liking, moral support, and ability to tolerate flaws in the significant other" (Tolstedt & Stokes, 1983, p. 574). Physical intimacy encompasses sex and other physical expressions of love.

Tolstedt and Stokes (1983) used their model to study the relation of these three variables of intimacy to marital satisfaction. They found that each variable, independently of the other two, contributed significantly to the prediction of marital satisfaction. Verbal and affective intimacy played the strongest role in determining marital satisfaction, whereas physical intimacy made a much smaller contribution.

The Tolstedt and Stokes model suggests that it may be useful to conceptualize intimacy as a multifaceted construct comporting a vertical as well as a horizontal dimension. However they do not justify their choice of these three particular variables of intimacy over any other possible choice. Furthermore, Tolstedt and Stokes (1984), as most researchers, equate self-disclosure with intimacy, which is an insufficient definition of intimacy. Although self-disclosure may have a significant relation to intimacy, it is possible to delineate the two as separate concepts. Measuring self-disclosure is not the same as measuring

intimacy (Chelune, Robison, & Kommor, 1984).

Chelune et al. (1984) present a cognitive interactional model of intimate relationships described from molecular and molar views. The three molecular components of intimacy are 1) the person with relevant variables such as cognitive and behavioral competencies, encoding strategies and personal constructs, behavior and outcome expectancies, subjective values, and self-regulatory systems and plans; 2) the situational context with variables of who, what, and where; and 3) the communication medium which includes metacommunication and second order change. Communication within a context of intimacy is interpersonal in nature in that it is intended not only to convey information, but to elicit a response from the other. According to this model, intimacy does not lie exclusively within a person or a situation, but emerges out of their interaction.

In the molar view of their model, Chelune et al. (1984) describe six relational qualities that characterize and seem necessary to an intimate relationship: knowledge of the innermost being of one another, mutuality, interdependence, trust, commitment, and caring.

In summary, several attempts have been made in the literature to articulate a definition or model of intimacy. Probably in an attempt to be as comprehensive as possible, many writers have included a number of facets in their model of intimacy giving rise to horizontal and/or vertical models. Although these conceptualizations demonstrate the

complexity of the phenomenon of intimacy, more often than not they lack conceptual precision. The result is blurred conceptual boundaries which do not allow a proper delineation of the concept of intimacy from other related concepts such as general marital satisfaction. There is a need to further clarify the concept of intimacy and to derive a definition which is comprehensive yet simple enough to allow clear conceptual delineation.

A common thread found throughout most of the above definition models seems to be the direct or indirect reference to self-disclosure (eg. Tolstedt & Stokes, 1984; L'Abate & Sloan, 1984) intended to elicit a response from an other (Chelune et al., 1984) which is empathic in nature (Brehm, 1985; Weiss, 1974). Also, the experience of intimacy is seen by many as both intrapsychic and interpersonal in nature (Wilner, 1975; Chelune et al., 1984). These common features should be considered in the search for an operational definition of intimacy.

This section has summarized different definition models found in the research literature on intimacy. In the following section we will attempt to further clarify and operationally define the concept of intimacy per se, and delineate it from confounding variables.

An Operational Definition of Intimacy

The latin root of the word "intimate" (intimus) means inner or innermost. The English word "intimate" therefore points to a special kind of knowing, a knowing of the innermost core of something, that which belongs or characterizes one's deepest nature, that which is marked by very close contact or familiarity (Webster's). This kind of knowledge involves an understanding of the inmost parts and can apply to objects as well as to persons. Although one may not be intimate with something, one may have an intimate knowledge of something, i.e. a close and deep understanding and experiencing of something such as an intimate knowledge of an automobile, of a flower, of a computer language. In each case we are speaking of a deep close (intimate) knowledge of an object, a kind of experiential knowing "from the inside".

Although personal intimacy involves a similar experiential knowing of another it is not sufficient to conceive of it purely as an act of knowledge. Martin Buber (1970), a prominent philosopher known for his classic dialogical or "I-Thou" philosophy, distinguishes between an "I-It" relationship whereby one knows, understands, and explains an other (person or object), and an "I-Thou" relationship whereby we "become" through an encounter in the present: "I require a You to become" (p. 62); "All actual life is encounter" (p. 62); "Man becomes an I through a You" (p. 80)." The essence of an intimate personal

relation is the shared experience of each other's innermost life. An intimate relationship includes a process in which two persons disclose, deeply respond to, and participate in the inner reality of each other, and thus "become" together.

Intimacy is an interpersonal occurrence, an "event of relation" (Buber, 1970) as well as an intrapsychic experience. An operational definition will have to take into account that intimacy is not only an act of knowledge, but also a shared encounter between two living beings.

The operational definition used in this study was taken from Wynne & Wynne (1986) who were inspired by Buber's work in their definition of intimacy. Hence, for the purposes of this study, intimacy is defined as:

a subjective relational experience in which the core components are trusting self-disclosure to which the response is communicated empathy (p. 384).

The relational experience is one of being close, engaged and in contact with oneself as well as with the other.

The above operational definition has been chosen for several reasons. First, this operational definition includes the major features used by researchers to articulate definition models of intimacy. These features include a reference to self-disclosure as well as an empathic response which are the two major components of the above operational definition. Furthermore, a definition based on self-disclosure to which the response is

communicated empathy also implies that intimacy is both intrapsychic (self-disclosure) and interpersonal (empathic response) in nature, as suggested by certain definition models in the literature.

A second reason underlying the choice of this operational definition of intimacy is because it is conceptually simple and clear, yet sufficiently complex and complete so as not to exclude any essential properties of the phenomenon. Third, this definition is sufficiently precise to allow a clear delineation from other interpersonal concepts found in the literature which are often associated or confused with intimacy.

The above operational definition is also consistent with major school of thought which have addressed the issue of intimacy in the psychologic literature. Sullivan's concept of "chumship" (when the child becomes capable of empathy) as a basis for intimate relationships and Erikson's reference to self-disclosure as a way of discovering one's identity suggest a definition of intimacy based on empathy and self-disclosure. Social penetration theory sees intimacy as a gradual process of disclosure and penetration to the core layers of a person. Existential/humanistic approaches represented by such authors as Fromm, Rogers, Perls, and Berne all suggest self-disclosure and empathy as key components of intimacy.

A further explication of the rationale for basing a definition of intimacy on self-disclosure and empathy is now

presented.

Why self-disclosure? Wynne and Wynne (1986) define trusting self-disclosure as:

the willingness to share, verbally or nonverbally, personal feelings, fantasies, and emotionally meaningful experiences and actions, positive or negative, with the expectation and trust that the other person will emotionally comprehend, accept what has been revealed, and will not betray or exploit this trust. (p. 384).

Self-disclosure has long been recognized as valuable in terms of general psychological health as well as an important element in the development of intimate relationships (Derlega & Chaikin, 1975; Altman, 1973; Altman & Taylor, 1973; Swenson, 1973; Taylor, 1968; Jourard & Lasakow, 1958; Hatfield & Walster, 1981). Sullivan (1953) was probably the first to suggest that self-disclosure had a therapeutic value. Fromm (1955) noted that self-disclosure could decrease the phenomenological distance between persons. Jourard (1971) too argued that interpersonal distance could be decreased through self-disclosure which he claimed also to be a prerequisite to the development of intimate relationships: "Self-disclosure between men reduces the mystery that one man is for another" (p. 6). Jourard and Lasakow (1958) were the first to systematically

investigate the phenomenon of self-disclosure. Both of these authors considered authentic self-disclosure to be a "symptom of health" and "a means to interpersonal effectiveness".

Authentic self-disclosure necessarily includes congruence which is a condition in which "self-experiences are accurately symbolized, and are included in the self-concept in this accurately symbolized form" (Rogers, 1959, p. 206). Authentic self-disclosure therefore means owning one's own experiencing process as it really is without defending against it. Living in a culture where certain "negative" feelings are not to be expressed, many find it difficult to disclose their experiencing processes to someone else. Persons who find it hard to be close to themselves are less capable of being close to others.

Most studies on intimacy have emphasized aspects of self-disclosure to operationalize their definitions of intimacy (Tolstedt & Stokes, 1983; 1984). The close connection between intimacy and self-disclosure is also reflected in popular definitions. Couples in the general population view self-disclosure as a primary determinant of intimacy (Waring, Tillmann, Frelick, Russell, & Weisy, 1980).

Although intimacy bears a striking resemblance to dyadic self-disclosure, evidence suggests that while self-disclosure is a major covariate of intimacy, the two are not synonymous (Waring & Chelune, 1983). While the

relational process of intimacy may be based on self-disclosure, (self-disclosure being a necessary but not sufficient condition to intimacy), self-disclosure does not in itself constitute intimacy (Chelune, Robison, & Kommor, 1984). Waring (1981) has presented evidence that self-disclosure is a major determinant of a couple's level of intimacy and assumes that facilitating self-disclosure will enhance intimacy. Finally, Burke, Weir and Duwors (1979) suggest that self-disclosure may be facilitated through training or psychotherapy.

Why trust? In this study, authentic trusting self-disclosure is seen as a necessary condition, along with empathy, to the occurrence of intimacy. The occurrence of self-disclosure may be seriously impeded if there is not a basic trust that what is disclosed will be comprehended and accepted without betrayal or exploitation. Depth of self-disclosure is positively associated with dyadic trust and findings support Altman and Taylor's (1973) idea that trust is a prerequisite for intimate self-disclosure in ongoing relationships (Larzelere & Huston, 1980). Furthermore, Larzelere and Huston (1980) also found that dyadic trust always correlated more with depth of self-disclosure than did generalized trust. Dyadic trust thus becomes an essential prerequisite to the occurrence of 'trusting self-disclosure', and consequently an essential condition to intimacy. This suggests the

hypothesis in this study that dyadic trust will correlate positively with intimacy and that both interventions used in this study to enhance intimacy will also have a positive effect on levels of dyadic trust.

Why empathy? Empathy is "placing oneself in the other person's shoes", it is the capacity to enter another person's phenomenological world, to experience it as he/she does, "as if" one were the other person. Empathy in the psychotherapeutic context, could be defined as "the sensing of the client's inner world of private personal meanings 'as if' it were the therapist's own, but without ever losing the 'as if' quality" (Mathieu-Coughlan & Klein, 1984, p. 217). In an intimate relationship, empathy is the verbally or nonverbally communicated acceptance and acknowledgement of what has been disclosed. Empathy thus plays an important role in establishing an atmosphere of trust necessary for the occurrence of 'trusting self-disclosure'. Without this communicated empathic feedback intimacy does not take place (Wynne & Wynne, 1986).

Empathic feedback does not only acknowledge what the other has said (literal message), but attempts to acknowledge and understand what the other person meant (metacommunication). By acknowledging the subjective meanings of another's messages, we render the implicit explicit and transcend the ordinary rules of social communication in that the outcome can no longer be

predicted. Metacommunication is considered to be part of the process of second-order change by systems theorists (Watzlawick, Weakland, & Fisch, 1974), and is considered as essential to the occurrence of intimacy (Perlmutter & Hatfield, 1980). Through authentic trusting self-disclosure and communicated empathic feedback partners may transcend what Buber (1970) describes as an I-It relationship and enter an I-Thou encounter.

Being essentially a shared experience, intimacy is not possible without mutual consent, without reciprocity, such as in the form of communicated empathy. There is no such thing as unilateral intimacy; if one person desires an intimate relation with another who refuses it, intimacy does not exist. One may speak of unilateral affection or unilateral self-disclosure, but this is not intimacy, where the flow moves both ways. "Relation is reciprocity. My You acts on me as I act on it." (Buber, 1970, p. 67). This does not exclude however the possibility that a unilateral self-disclosure on the part of one person may bring about a reciprocal flow between both persons.

Inherent in the idea of reciprocity is the one of duality, i. e., in order to have reciprocity there must be two. This rules out a fusion type of intimacy where the differences are lost and the two become one. Without individual boundaries, reciprocity, and hence intimacy is impossible because there is no "between" anymore.

Intimacy, therefore, is a relational property which

emerges out of the interaction of two essential interdependent conditions: self-disclosure and empathy.

Delineation of Intimacy From Other Related Concepts

In light of the above operational definition, we will now look at some related concepts and differentiate them from intimacy. In the literature, there is a tendency to confuse intimacy with related concepts such as attachment, dependence, cohesion, commitment, love, and marital satisfaction.

Attachment. The importance of attachment in infancy has been well articulated and documented by people like Bowlby (1958; 1973; 1989) and Ainsworth (1972; 1979). What role, if any, does attachment play in adult life? Weiss (1982) has shown that in relationships of central emotional importance, adults establish bonds to other adults which are essentially identical to the attachment made by children to their primary caretakers. Attached adults meet the same criteria for attachment as infants do:

need for ready access to the attachment figure, desire for proximity to the attachment figure in situations of stress, heightened comfort and diminished anxiety when in the company of the attachment figure, and a marked increase in discomfort and anxiety on discovering the attachment figure to be inexplicably inaccessible (Weiss, 1982, p. 173).

Attachment in adults differs from attachment in infants in that for adults it usually occurs between peers, and is often directed at another adult with whom a sexual relationship also exists. Adults are also usually better able to attend to other matters when attachment bonds are threatened.

Attachment in human relationships is fostered by accessibility and responsiveness. Accessibility means being available for contact when the other person is in need. Johnson (1986) refers to "responsiveness" as being the ability and willingness to respond to the other person's reality, "to be affected or influenced by the other and to recognize the other's needs or desires."

Although attachment is probably a major component of most intimate relationships, attachment does not constitute intimacy. Theoretically, it is possible to have attachment without intimacy and intimacy without attachment. Despite their claim to being 'in love', some couples show evidence of an absence of attachment (Rapoport & Rapoport, 1964). Intimacy without attachment is obvious in the "strangers on the train" phenomenon where two strangers meet and disclose very personal information to each other and then go their separate ways without ever seeing each other. In other cases, such as marriage breakups, attachment is evident although both partners agree there is no longer any intimacy between them.

Attachment is viewed as an innate disposition and has been found to persist even in the absence of reinforcement or in the face of repeated punishment (Bowlby, 1973). It is a perceptual-emotional system which continues in force while undergoing changes in object throughout childhood, adolescence and adulthood and dominates over other behavior systems under conditions of threat. Intimacy is not an innate disposition but rather a relational event which may occur within or without attachment. However, intimacy as defined in this study, tends to create and maintain emotional bonds because self-disclosure and empathy promote responsiveness and accessibility which in turn foster attachment. Conversely, attachment may offer a secure context for trusting self-disclosure and empathy, i. e. intimacy.

Wynne and Wynne (1986) see attachment/caregiving as a basic relational process characteristic of enduring systems. They further comment that "until attachment/caregiving is incorporated into a relationship system, the relationship is not likely to become enduring and reliable" (p. 386). Attachment therefore may contribute to securing a relationship in which intimacy is more likely to occur, but an attachment relationship in itself does not constitute intimacy.

Dependence. Dependence is a concept which may appear to be closely linked to the concept of attachment and may be

associated with certain forms of intimacy. But upon closer examination one realizes that these concepts are far from being synonymous. Dependence refers to the extent to which one individual relies on another for existence; whereas attachment refers to a strong disposition "to seek proximity to and contact with a specific figure and to do so in certain situations, notably when ... frightened, tired or ill" (Bowlby, 1984, p. 371).

An adult relationship whereby one individual relies on the other for existence, i.e. cannot survive without the other, would fall into the psychoanalytic pathologic term of 'dependence' and evidently would not be defined here as an intimate relationship. A symbiotic relationship where both depend on the other for their existence, or a pseudo-mutual relationship (Wynne, Ryckoff, Day & Hirsch, 1958) where the members are united in their capacity to satisfy each others' neurotic needs are also not considered as intimacy.

Cohesion and Commitment. Cohesion and commitment are two closely related concepts which have been blurred in the literature on intimacy. Cohesion is seen by some as synonymous to attachment and is also confused with intimacy. Schaefer and Olson (1981) essentially define cohesion as attachment, i.e., "the emotional bonding which members feel toward one another" (p. 50). They see cohesion as the resultant condition of sharing of intimate experience, and intimacy as a precondition for cohesion. Others equate

cohesion to a feeling of commitment to the marriage (Waring, 1988). Still others go to the extent of defining intimacy as "the capacity to commit oneself to concrete affiliations and partnerships and to develop the ethical strength to abide by such commitments" (Erikson, 1963, p. 263). It is necessary to clearly define cohesion and commitment in order to delineate them from intimacy.

Cohesion is best defined using the behaviors assessed by the items in the Dyadic Cohesion Subscale of the Dyadic Adjustment Scale (Spanier, 1976). These items were derived empirically and together constitute a significant component of dyadic adjustment according to a factor analysis. Cohesion is then specifically defined as engaging in outside interests together, exchanging ideas, laughing together, calmly discussing things, and working together on a project. It is clear that these activities may or may not involve disclosure of one's personal core aspects in the hope of eliciting an empathic response. Sharing ideas, interests, and work may induce an atmosphere propitious to self-disclosure and empathy; and conversely, personal self-disclosure and empathy may encourage a couple to share ideas, interests and work. Cohesion may favor the creation of intimacy, and intimacy may create greater cohesion; but cohesion and intimacy are two different constructs.

Commitment is typically conceptualized as a constellation of affects, behaviors and cognitions that mark an individual's disposition to maintain a particular

relationship (Beach & Tesser, 1988; Sternberg, 1986). A decision to maintain a relationship may have nothing to do with self-disclosure and empathy. Conversely, very personal self-disclosure and empathy may occur between two complete strangers who do not in any way wish to continue a relationship. However, self-disclosure and empathy may nourish a disposition to maintain a relationship just as commitment may protect and facilitate intimacy by giving it a safe and trusting context to risk personal disclosure.

Commitment and cohesion, then, are concomitant variables which are reciprocally linked to intimacy in that each facilitate or protect the occurrence of the other. Neither cohesion nor commitment is a precursor to nor an effect of intimacy, and no two of these three variables are identical constructs. Intimacy defined as self-disclosure and empathy can be meaningfully differentiated from the related concepts of cohesion and commitment.

Love. Despite increased interest over the last few years in research on the topic of love, psychology's understanding of the phenomenon is still rudimentary. Several attempts however, have been made to define love in its various forms. In an attachment-theoretical approach to romantic love, Shaver, Hazan, & Bradshaw (1988) divide love into three behavioral systems: attachment, care giving, and sexuality. A factor analysis of Rubin's (1973) love scale revealed three components which include trust, caring, and

need (Steck, Levitan, McLane, & Kelley, 1982). Maxwell (1985) found that the word love is used by people to describe a relationship that is committed, close, and sexual. One of the most widely cited conceptualizations of love is Sternberg's (1986, 1988) triangular theory which comprises three components that are consistent with Maxwell's findings: intimacy, passion, and decision/commitment.

According to Sternberg's theory, intimacy refers to feelings of closeness, connectedness, and bondedness; passion includes drives that lead to romance, physical attraction, and sexual consummation; and decision/commitment encompasses the decision that one loves somebody, and in the long term, the commitment to maintain that love. Beach & Tesser (1988) also include intimacy as a component of love, the others being commitment, cohesion, and sexual interaction. Although intimacy as defined by Sternberg and Beach & Tesser is somewhat wider than the definition used in this study, both conceptualizations are compatible with the idea of self-disclosure and empathy. For instance, in a more specific definition Sternberg states that intimacy includes:

...sharing of one's self and one's possessions with the loved one, receipt of emotional support from the loved one, giving emotional support to the loved one, intimate communication with the loved one...(1986, p. 121)

Beach and Tesser (1988) also refer to self-disclosure when they assert that "intimacy refers to a relationship state in which inner or innermost feelings, thoughts, and dispositions can be revealed or explored" (p.336). In these conceptual schemes, intimacy, being a component of love, is a more specific construct and as such is not identical to love. As with attachment and other related concepts mentioned earlier, love may provide a context which facilitates and protects the occurrence of intimacy, and intimacy, on the other hand may increase feelings of love.

Marital satisfaction. General marital satisfaction (or dyadic adjustment) has been criticized as being a vague and ambiguous concept (Spanier, 1976). This vagueness has undoubtedly contributed to the conceptual confusion in the literature between intimacy and general dyadic satisfaction. Marital satisfaction is a composite of various elements which may include intimacy and which may contribute to facilitating it, but it must not be equated with intimacy per se.

Marital satisfaction measures include such components as affectional expression (Spanier, 1976) which would be expected to tap some aspects of intimacy such as self-disclosure. However, these measures also typically assess problem areas, conflict-resolution abilities, and overall levels of happiness/unhappiness with the

relationship. These items would seem to belong to the more general domain of relationship skills and functioning. One way of differentiating intimacy from general marital satisfaction is that intimacy is a more specific construct than is marital satisfaction.

There are good reasons to believe that the components of intimacy would be related to general processes of marital adjustment. Intimacy recurs most reliably within a context of basic, well-functioning relational processes (Wynne & Wynne, 1986). Surely, conflicts and the inability to resolve them would impede empathic responding and decrease the likelihood of trusting self-disclosure. Nevertheless, it is possible for self-disclosure and empathy to occur even if the relationship is currently frustrating and problems have been difficult to resolve. Intimacy may also feed into basic relational processes and may determine marital harmony as suggested by Waring and associates (1981). Marital satisfaction, therefore, facilitates intimacy, and conversely intimacy fosters marital satisfaction; whence the hypothesis that intimacy levels in this study correlate positively with dyadic adjustment levels.

In summary, love, attachment, marital satisfaction, and other concepts related to intimacy contribute to creating a context which may facilitate and encourage the occurrence of intimacy, and intimacy in turn may contribute to these experiences, but intimacy per se refers to a unique and discrete phenomenon. A clear delineation between intimacy

and other related interpersonal concepts is a move toward greater specificity in the study of marital relationships and, hopefully, will contribute to a better investigation of the intricate dynamics of marriage (Beach & Tesser, 1988).

Now that an operational definition of intimacy has been put forward, and a conceptual delineation attempted, we return to Hinde's (1978) call for research on interventions aimed at facilitating intimacy. The following section reviews studies done on interventions for improving intimate relationships.

Interventions for Improving Intimate Relationships

A systematic search of the literature revealed very few studies on interventions specifically aimed at increasing intimacy. On the other hand, a number of studies examining the effects of different programs or interventions on the general relationship quality of couples have included in their outcome criteria variables related to intimacy such as empathy and expressiveness. Because many of these programs use interventions which impact on outcome variables directly related to intimacy, an overview of studies examining such interventions is presented in the section below.

Couple Based Programs

In the last two decades there has been an increased interest in preparing people better for marriage and in helping basically sound marriages to become more satisfying and "enriching" (Brehm, 1985; Giblin, Sprenkle, & Sheehan, 1985; Gurman & Kniskern, 1977). Most of these marital programs focus on the enhancement of communication skills as well as conflict-resolution and negotiation skills.

Religious groups have played a leading role in developing marital enrichment programs such as the Catholic Marriage Encounter Program and the Methodist Marriage Communication Labs (Garland, 1983). Most of the active programs however are not church-related, eg. Association of Couples for Marital Enrichment (Mace & Mace, 1976), Couples Communication Program (CCP), (Miller, Nunnally, & Wackman, 1976), and Relationship Enhancement (RE), (Rappaport, 1976; Guerney, 1977).

Gurman and Kniskern (1977) have reviewed 29 marital and premarital enrichment studies and have grouped the outcome criteria used in these studies into three categories: 1) Overall marital satisfaction, 2) Relationship skills, and 3) Individual personality variables. The two programs most frequently studied, the CCP and the RE, have both consistently produced significant positive effects, particularly on variables related to relationship skills such as self-disclosure and empathy. These results are not surprising since the procedures used in these programs are

specifically to train in the awareness, expression and empathic understanding of feelings, thoughts, and intentions.

The Couple Communication Program (Miller et al., 1976) is an educational approach that teaches couples to be aware of and to express their thoughts and their feelings in a clear and satisfactory manner. Couples learn better communication through the sender-receiver-clarification sequence where the sender discloses his or her feelings or beliefs, the receiver listens and summarizes what the sender has said, and the sender clarifies for the receiver if the summary was inaccurate. Participants are taught different types of communication and the effect they produce on the partner. Training is done in a way that builds one's own self-esteem as well as that of the partner.

Relationship Enhancement (Guerney, 1977) is typically taught in a group setting consisting of three or four couples. The leader works with one couple at a time while the others observe and give feedback. The leader teaches how to disclose personal feelings, thoughts and desires clearly and honestly without accusing or hurting the other, and how and when to "switch modes" and respond empathetically by accepting the other's communication and reflecting as accurately as possible what the other has disclosed. The leader uses positive reinforcement and modelling in teaching these skills.

In a more recent meta-analysis of 85 outcome studies of

premarital, marital, and family enrichment programs representing 3,886 couples or families, Guerney's Relationship Enhancement Program (1977) yielded the highest effect size average (.96), whereas the Couple Communication Program revealed an intermediate effect size average of .44 (Giblin, Sprenkle & Sheehan, 1985). These findings were consistent with results from a previous study directly comparing CCP and RE (Brock & Joanning, 1983). Based on Gurman and Kniskern's (1977) typology for enrichment outcome, Giblin and associates (1985) found that across the 85 studies which they analysed, effect sizes were significantly larger for relationship skills (including problem solving variables and communication variables such as empathic ability and self-disclosure) than for satisfaction/adjustment or individual personality variables. The behavioral-exchange programs (which put particular emphasis on conflict-management skills) do not fare as well in terms of research support (Gurman & Kniskern, 1977; Giblin et al., 1985; Brehm, 1985).

The findings from the Gurman and Kniskern (1977), and Giblin et al. (1985) analyses suggest that teaching and training in the expression and empathic understanding of feelings and thoughts will enhance variables closely associated with intimacy. However, none of the enrichment studies have delineated intimacy as a specific outcome criterion.

A number of studies, using outcome variables closely

linked to intimacy, have compared the effects of RE or CCP with other approaches aimed at enhancing dyadic relationships. Relationship Enhancement has been compared with five therapists' own preferred non-RE methods (Ross, Baker, & Guernsey, 1985). Results reveal that RE clients gained significantly more in the quality of their relationship, particularly on variables pertaining to trust and intimacy levels. Using two groups of nonclinical married couples, Greene and Kelley (1985) studied the effects of combining cognitive restructuring with Relationship Enhancement on spousal self-definition and marital communication. Cognitive Relationship Enhancement (CRE) participants made significant improvements on differentiation of self whereas both groups (RE and CRE) obtained significant gains from pretest to posttest on expressor-empathy skills ratings.

A comparative study of the Couples Communication Program (CCP) with Structured Behavioral Exchange (SBE) training determined significant gains over time in speculative (intellectual, searching, tentative) and open (self-revealing, supportive, attentive) styles of communication as well as relationship quality for both treatment groups (Russell, Bagarozzi, Atilano, & Morris, 1984). The CCP emphasizes accurate understanding while SBE includes accurate understanding but goes beyond it to achieve agreement on an equitable contract for behavior change.

Gordon and Waldo (1984) assessed the effect of assertiveness training of one partner in a couple on both partners' perceptions of trust and intimacy in their relationship. Results indicate that both assertion trainees and their nonparticipating partners perceived significantly higher levels of trust and intimacy as measured by the Interpersonal Relationship Scale (Guerney, 1977). Unfortunately the authors fail to describe specific interventions used in the assertiveness training, thus making it impossible to determine which variables actually influenced the trust and intimacy levels.

In recent years, three couple-based approaches specifically aimed at enhancing intimacy have been published. Working out of a social learning framework Margolin (1982) developed behavioral strategies for the enhancement of intimacy. These include teaching partners to discriminate and "objectify" specific behaviors that impact positively or negatively on the relationship, increasing positive exchanges, communication training (including emotional expressiveness and understanding as well as problem solving), specifying concrete changes in terms of contractual agreements, and cognitive restructuring. Although Margolin claims to be specifically enhancing intimacy, it should be noted that she fails to clearly delineate the concept of intimacy per se from general marital satisfaction (Perlman et al., in press).

To teach people how to be intimate with others, Elaine

Hatfield (1984; 1988) uses the assumption that "people must be capable of independence in order to be intimate with others; capable of intimacy if they are to be independent" (1984, p. 213). She therefore encourages people to accept themselves as they really are and to recognize their intimates for what they are. She also encourages people to express their ideas and their feelings and teaches them to deal with their partner's reactions. However, Hatfield fails to include research data pertaining to the efficacy of this approach on intimacy.

L'Abate and Sloan (1984) share Erikson's assumption that to be intimate one must be properly differentiated with a well developed identity. They developed a structured enrichment workshop to facilitate intimacy in married couples featuring three modules: 1) self-hood and differentiation; 2) communication of emotions; and 3) rational negotiation of actions. Each module carries the participants through a series of exercises which are done within the workshop as well as at home. These exercises gradually bring the partners to acknowledge and share hurt feelings before moving on to a rational negotiation and resolution of an issue. More specifically, participants are asked to think about what intimacy means to them, to see the good in themselves and in their partners, to show care to each other, to express feelings directly to the other (particularly hurt feelings), to put themselves in the other's place (which is related to empathy), and to set

goals and plan steps for change in themselves and in their relationship.

The L'Abate and Sloan approach has been tested and has succeeded in increasing couples' intimacy, as measured by the Interpersonal Relationship Scale and the Sharing of Hurt scale (IRS and SOH; Sloan, 1984). A crucial component of the program's effectiveness may have been training in pre-negotiation sharing of anger and hurt (Perlman et al., in press).

In summary, the central interventions used and tested in the literature consist mainly of teaching communication skills such as empathy and self-expression of feelings and private thoughts. These skills seem to have the most positive effect on variables closely related to intimacy. However, the majority of the studies listed above do not properly delineate intimacy as the outcome variable. Furthermore, they do not distinguish between self-expression of feelings as opposed to that of private thoughts and therefore fail to examine their possible differential effects on intimacy.

This study compares interventions from two approaches to marital therapy, CMT and EFT, which include as their major process variables two different types of self-disclosure, i. e. cognitive and emotional. Referring to Chelune's (1978) work on self-disclosure, Waring (1981) classifies self-disclosure as 1) expression of emotion; 2) expression of need; 3) expression of thought; and 4)

self-awareness. The latter two are defined by Waring as cognitive self-disclosure. Emotional self-disclosure, as defined in this study focuses upon the first two elements, i. e. expression of emotion and needs.

Furthermore, the present study differs from the majority of studies listed above in that empathy or self-disclosure are not taught as communication skills. Empathy is not actively attended to within sessions, and self-disclosure is facilitated, not taught, by the therapist's interventions. This is in conformance with the belief that the most important responses in marriage such as love, trust and respect (Broderick, 1981) are often not "teachable", but may be evoked in a process of mutual self-expression (Greenberg & Johnson, 1986a).

Finally, this study differs from the majority of the above studies in that the outcome variable is explicitly delineated as intimacy per se.

Interventions used in this Study to enhance Intimacy

Two recent approaches to marital therapy, aimed at alleviating distress, have also addressed intimacy as part of their treatment goals and rely on process variables such as cognitive or emotional self-disclosure as their means. These two approaches are Cognitive Marital Therapy (CMT), put forward by Waring and Russell (1980), and Emotionally Focused Therapy (EFT) developed by Greenberg and Johnson (1986b). The essential contrast between these two approaches 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 aims at accessing underlying thoughts and theories in order to gain better knowledge and understanding of the relationship, whereas EFT accesses underlying emotions and needs and facilitates the expression and sharing of these in such a way as to evoke a meaningful response from the other and thus foster attachment bonds and enhance intimacy. (A table contrasting both interventions can be found at the end of the section presenting EFT.)

Despite their sharp contrasts in assumptions and applications, both approaches are compatible with the definition of intimacy put forward in this study, i. e. trusting self-disclosure and communicated empathy. Both approaches are also similar in that neither directly teach communication skills as in most relationship enhancement

programs, but rather facilitate a specific kind of self-disclosure. This section will briefly describe each one of these approaches and how they might increase or facilitate intimacy.

Cognitive Marital Therapy

Cognitive marital therapy is a short-term psychotherapy aimed at helping spouses to develop interpersonal intimacy through cognitive self-disclosure. Spouses are encouraged to disclose their ideas, attitudes, beliefs and theories regarding their marital problems as well as the influence of their parents' relationship on their own. This approach is based on the theory that families with individual psychopathology are families where the spouses have failed to develop interpersonal intimacy. This failure to develop intimacy is seen as the clinical operational definition of a "negative affective potential", a necessary etiological variable in all family dysfunction, marital maladjustment and nonpsychotic emotional illness. Waring and Russell suggest that intimacy may be the primary determinant of family functioning and individual development. Empirical findings suggest that intimacy is the primary dimension which determines marital adjustment (Waring, McElrath, Mitchell, & Derry, 1981).

Waring and Russell (1980) have defined intimacy very broadly as "an emotional closeness, a cognitive understanding and a mutual sexual satisfaction" (1980,

p.259). In an attempt to operationally define intimacy, Waring and associates have identified eight qualitative aspects of intimacy: affection, cohesion, expressiveness, compatibility, conflict resolution, autonomy, sexuality, and identity (Waring, McElrath, Mitchell, & Derry, 1981; Waring, 1984). It is assumed that any intervention which facilitates the couple's intimacy will improve family functioning, marital adjustment, and reduce symptoms of nonpsychotic emotional illness (Waring, 1981; Russell & Russell, 1980). Referring to Beck's work on depression using cognitive behavior therapy, Waring and Russell (1980) state that a cognitive variable, such as cognitive self-disclosure, may be the primary determinant of an affective or emotional variable, such as the couple's feeling of closeness or intimacy. In another report, Russell, Russell and Waring (1980) state that "the sharing of personal cognition is an important variable which determines affective, (emotional) intimacy" (p. 65). Emotion in this context is assumed to be a response to cognition, and is seen as a behavior to be modified and controlled through rational means.

Grinker (1967) observed that cognitive knowledge or "knowing" of one's partner may be a primary determinant of a couple's level of intimacy, whereas Murstein (1974) suggests that disclosing attitudes, values and beliefs early in the relationship would avert situations in which conflicting value systems prevent closeness. On the other hand,

Levinger and Senn (1967) have demonstrated that there is more negative affective disclosure (disclosure of unpleasant feelings) in unsatisfied couples. Referring to Levinger and Senn's study, Waring (1981) concludes that "disclosure of negative feelings produces distance and is characteristic of disturbed families" (p. 35). In a preliminary report on Cognitive Marital Therapy, Russell, Russell, and Waring (1980) state that "negative results in family therapy occur when affective expression is encouraged leading to a confrontation of emotional issues..." (p. 64). In their presentation of CMT, Waring and Russell (1980) define emotional disclosure as "revealing one's feelings" and further state that "emotional disclosure often produces distance rather than closeness" (p. 258-259). The basic assumption underlying these statements is that emotion is maladaptive and detrimental to intimacy.

Cognitive marital therapy therefore attempts to increase intimacy through facilitating cognitive self-disclosure. Its technique is derived from the work of Bowen (1975), Zuk (1967), and Framo (1972). Waring and Russell (1980) believe that Bowen's concept that the therapist should "respond" (cognitive) rather than "react" (emotional) to the couple, "suggests a specific and explicit suppression of affect throughout therapy sessions" (p. 259). This suggests that emotion is conceptualized as being disruptive to the rational control of behavior and must therefore be bypassed or suppressed. Based on Zuk's idea of

the therapist as a "go between", CMT actively prohibits the couple from talking to each other within the session thus limiting the spouses to talking each alternately to the therapist. The rationale for getting the couple to disclose their beliefs, theories and ideas about why their parents were or were not close and the influence of this on their relationship is inspired by the work of Bowen and Framo.

The CMT therapist facilitates cognitive self-disclosure by asking only "why" or "theory" questions: "The interviewer asks only 'why' or 'theory' questions and avoids and suppresses affective interchange and/or behavioural interpretation or confrontation" (Waring & Russell, 1980, p. 260). The spouses may talk only to the therapist and take turns in 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 understand 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.

Waring uses Kelly's personal construct theory to explain why cognitive self-disclosure enhances intimacy (Waring, 1988; Kelly, 1955). Kelly's theory suggests that we develop cognitive schemas to understand the relationships we observe and experience growing up. These personal constructs about our parents' marriages tend to be

transferred onto our own marriages. We selectively attend to our partners' behaviors that will confirm our belief system and ignore evidence that may be discrepant from this belief. Both spouses should therefore be helped to see one another as discrepant from their cognitive schema in order to become truly intimate with one another. To accomplish this, Waring (1988) suggests that spouses be encouraged to disclose these personal constructs and explore how they were developed through observation of past (parental) intimate relationships.

Couples are often reluctant to give up certain personal constructs and will resort to behaviors such as denial, blaming, or angry negative interactional cycles that prevent them from being confronted with discrepant information. According to CMT, discouraging affect and prohibiting interruption while the other spouse is talking in the session increases the chances that spouses will listen and "respond" empathetically to each other's disclosures instead of "reacting" emotionally (such as tears and anger used instrumentally) to disclosures that they do not wish to hear. Couples report that CMT has improved their closeness through understanding their partner, listening more adequately without reacting defensively or emotionally, and learning about their parents (Waring, 1988).

Waring reports that his clinical observation has shown that couples who derive the greatest benefit from CMT spend more time disclosing about the past than the present as well

as about their parents' marriages rather than their own. Waring thus believes that observation of one's parents' level of intimacy has a more obvious influence on the development of intimacy in adulthood than the quality of the affectionate bond between the spouse as a child and either parent (Waring, 1981). Couples often report that they have consciously decided not to fall into the same patterns they observed in their parents' marriages. Exploration of the motives underlying the attraction to and choice of their partners is expected to help couples to better understand their problems with intimacy.

The request in CMT that each partner speak only to the therapist in an alternate fashion is believed to foster reciprocity and equity in the relationship. According to social exchange theory, greater intimacy is associated with an equal balance in the amount of self-disclosure between partners (Levinger & Senn, 1967). This equity has also been shown to operate at an unconscious level where couples may collude to continue a relationship for unconscious neurotic reasons and remain at the same level of emotional immaturity (Willi, 1982; Dominion, 1979). Couples may avoid self-disclosure out of fear of revealing incompatibilities or inequities and thus miss out on true intimacy. Facilitating cognitive self-disclosure in an alternate fashion is expected to increase reciprocity and facilitate the couple's intimacy by revealing and understanding their equity or compatibility for specific insecurities (Waring,

1988).

Empirical evidence for the effectiveness of CMT in the enhancement of intimacy is still in the pilot stage. Waring and Russell (1980) report on an uncontrolled pre and post treatment measurement design with eleven distressed couples. It was hypothesized that affection compatibility, a FIRO-B scale judged to be conceptually related to intimacy, would increase. Although the results were not statistically significant, trends were in the direction of an increase on all three types of affection compatibility (reciprocal, originator and interchange compatibility).

In a one case study of a couple containing a husband who was self-referred for depressive symptoms, the couple's total intimacy score on the Waring Intimacy Questionnaire (WIQ) increased over a ten-week period (Waring, 1981). In his recent book, Waring (1988) reports on a study done with 18 couples referred to him by their physician. This study was uncontrolled and only 9 of the 18 couples completed the posttherapy measurements. Results indicate a statistically significant increase in the wife's perceived level of intimacy (as measured by the WIQ) and a non-significant increase in the husband's level of intimacy. These increases were upheld for 4 couples at a 6-month follow-up, but were not significant.

In summary, there is some theoretical and empirical evidence suggesting the hypothesis that Cognitive marital therapy would create a positive differential effect on

intimacy levels as compared to a control group.

A more detailed description of the cognitive marital intervention used in this study is available in appendix A in the form of a therapist's manual.

Emotionally Focused Therapy

Emotionally focused 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 (Rogers, 1951; Perls, Hefferline, & Goodman, 1951; Satir, 1967), whereas the systemic tradition emphasizes the role of communication and interactional cycles in the maintenance of a given system (Watzlawick, Beavin, & Jackson, 1967; Sluzki, 1978). Emotionally focused therapy aims at changing the couple's negative interactional cycles by reframing them in terms of underlying feelings and unmet needs. According to EFT, accessing and expressing previously unacknowledged feelings, needs and wants in the partners not only changes negative interactional cycles but also helps facilitate intimacy in the couple.

In EFT, partners are therefore encouraged to directly interact with each other in the sessions and to disclose the underlying feelings and needs which they are involved in at the current moment. These feelings are heightened and explored fully with the help of the therapist in terms of personal and interpersonal meanings. This is in keeping with Satir's idea that authentic communication lies in the

affective domain (Satir, 1967). It is believed that concrete here and now involvement and congruent expression of emotion are more likely to enhance intimacy and change than would intellectual insight or discussion. This is different from Cognitive Marital Therapy which believes that intimate communication lies not in the emotional domain but rather in the cognitive domain and that direct interaction between the spouses should be suppressed within therapy.

Contrary to Cognitive marital therapy which sees emotion as something negative to be suppressed, Emotionally focused therapy conceptualizes emotion as something positive which is part of adaptedness and an aid to problem resolution. Emotion is seen as:

"a construction arising from a complex synthesis of concepts, schemas, and expressive motor responses which then form the basis for the perception of new experience and the creation of meaning" (Greenberg & Johnson, 1986a, p. 3).

This is different from cognitive-behavioral or rational emotive approaches where emotion is seen as a response to cognition. People in EFT are seen as "active perceivers, constructing meanings and organizing experience on the basis of current emotional states " (Greenberg & Johnson, 1986a, p. 3). EFT sees emotion as being a privileged source of information about a person's present way of being, an access route to the core of who that person really is.

The EFT therapist seeks to heighten emotional experience in order to facilitate the owning and integration of previously disowned feelings. It is the belief of this approach that what becomes problematic for the partner is not emotion per se but rather its disavowal which results in self-alienation and distancing from the other. The EFT therapist focuses on disowned feelings, such as the fear of abandonment underlying a pattern of attacking critical behavior, to reframe the negative interactional cycle in terms of fears, vulnerabilities and unmet needs. The CMT therapist, on the other hand, restricts the focus to each partner's theory underlying the negative interactional cycle and actively discourages emotional expression.

While a major hypothesis in the CMT approach is that intimacy is enhanced through accessing and disclosing personal theories about why the relationship is the way it is, and that "emotional disclosure often produces distance rather than closeness" (Waring & Russel, 1980; p. 258-259), EFT hypothesizes that accessing and expressing primary emotion helps facilitate intimacy in a couple. According to the EFT model, expressing unacknowledged emotions such as vulnerability or fear of abandonment tends to foster attachment bonds between adults and to facilitate the growth of intimacy (Greenberg & Johnson, 1986a).

Affect, in EFT is not expressed for the sake of catharsis but serves as a biologically adaptive primary signalling system which tends to override other cues and

dominate the creation of meaning. The disclosure of previously disowned feelings is different from the ventilation of superficial defensive reactions and from merely "talking about". It is important to distinguish between primary adaptive emotions, secondary reactive emotions, and instrumental emotions (Greenberg & Safran, 1984a, 1987). Primary emotions are often out of the client's awareness at the beginning of therapy. They usually involve a bodily felt component and are accompanied by concrete language and evocative images indicating that the emotion is actually being experienced and not just talked about. Secondary emotions are often painfully present in awareness when the client comes to therapy. They take the form of a defensive reaction and are usually maladaptive and disruptive to the relationship. They create distance more than closeness. These are the emotions that cognitive-behaviorists attempt to eradicate or control. Instrumental emotions aim at making impacts on others in order to get them to respond in a specific way. They are often referred to as manipulative feelings such as crying to make someone feel guilty or getting angry to avoid responsibility. Secondary reactive and instrumental emotions do not enhance change or intimacy because they are detrimental to authentic communication and are therefore discouraged in an emotionally focused approach.

It may be argued that in the context of intimacy, primary emotional experience has primacy over cognitive

processes. Arguments in favor of the primacy of emotions can be found in Clark & Fiske, 1982; Epstein, 1983; Field & Fogel, 1982; Pervin, 1983; Lewis & Michalson, 1983; and L'Abate, 1985.

On a developmental level the infant reacts according to pleasure and pain, learning in time to differentiate more specific emotions (L'Abate, 1964; Lewis & Michalson, 1983). From birth, infants, through certain organized behaviour patterns, communicate their needs, wants and distress. They have the ability to communicate these through their facial musculature which is developed long before their capacities for exclusively human cognitive operations. Evidence of a wired in timing for different emotions has been produced. For instance, distress and smiling appear in the first months, followed by anger and fear after four and eight months, respectively (Izard, 1979).

The facial expression of emotion is also known to be cross-culturally consistent (Ekman, 1982). Primary emotions such as happiness, sadness, anger, fear, disgust, and surprise are easily identified by people around the world (Ekman & Friesen, 1975; Ekman, Friesen, & Ellsworth, 1982).

In an adult intimate bond, feelings and their communication play a powerful role. Primary emotions such as anger and sadness are most clearly expressed in close relationships; and emotional states such as vulnerability and love are most powerfully experienced (Greengerg & Johnson, 1990).

Most of the techniques used to access previously unacknowledged feelings are taken from Gestalt therapy (Perls, Hefferline & Goodman, 1951) and from recent developments in client-centered therapy (Rice, 1974; Rice and Saperia, 1984). These techniques include non-verbal referents, feeding sentences, specific directions such as "talking directly to", and evocative responding.

A therapist's intervention manual provides a detailed description of the emotionally focused intervention used in this study and is available in appendix A.

The reason why EFT is expected to enhance intimacy is based on the way it views emotion in human functioning and on how it uses emotion in therapy. Emotionally focused therapy views primary emotion as a felt action tendency that allows us to adapt to our environment. Primary emotions direct people toward or away from objects in the environment; we are rarely just angry or sad but rather "angry at someone" or "sad about a loss". Emotions are functional connections between people and the world, and are therefore fundamentally relational in nature.

Emotionally focused therapy views the conscious experience of emotion as the product of a preattentive synthesis of subsidiary components including expressive motor processing, schematic emotional memory, and abstract conceptual systems (Greenberg & Safran, 1987). Each partner may discover, or more precisely synthesize new aspects of self and thus bring about a powerful significant

change similar to a corrective emotional experience. Partners experience each other as different as new emotional experience is available to them for the creation of a new self organization. Emotionally focused therapy facilitates self-disclosure not only to the other but to one's self, allowing for a better definition of self and creating the potential for authentic contact.

Emotionally focused therapy is expected to increase intimacy beyond CMT because accessing primary emotion is more likely to evoke an empathic response than talking about one's thoughts and past experiences. The focus in EFT is upon facilitating the synthesis of primary emotions here and now which translate into new action tendencies and elicit new responses towards the partner such as expressing a fear of abandonment underlying a blaming stance and seeking comfort instead of attacking. This in turn will help the observing partner to change his/her view of the disclosing spouse as vulnerable rather than attacking and thus evoke an empathic response instead of a defensive withdrawal.

Disclosing previously unacknowledged emotion, especially feelings of vulnerability, lowers the partners' tendency to protect themselves and encourages responsiveness. Disclosure of primary feelings can elicit responses from others that lead to greater love and intimacy. Communicating this way becomes an invitation for others to sensitively respond to our needs and concerns and perhaps voluntarily change their behavior. It is believed

therefore that EFT would be superior to CMT in facilitating intimacy because accessing primary emotions is more likely to evoke an empathic response.

Emotionally focused therapy maintains, as does CMT, that changing interpersonal perceptions is important to foster intimacy in a couple. Segraves (1982) clearly asserts the importance and the role of interspousal perceptions in marriages. He states that couples often have misperceptions of the opposite-sex partner and tend to act toward significant others in such a way as to obtain confirmatory data of their inner representational systems. To modify these misperceptions, the observing partner must attend to persistent, unambiguous and unusual information which is discrepant with the internal representational model for that partner. The result is an interpersonal change as well as an intrapsychic one whereby partners see each other more for what they are, thus facilitating authentic contact.

EFT would be more successful than CMT at enhancing intimacy because EFT would more likely effect a change in the partners' perception of each other. Calmly talking about past emotional experience is less likely to change interpersonal constructs than would accessing primary emotions in the present. Acknowledgement of primary feelings by one of the partners alters the interpersonal perception in that observation of a partner's emotional experiencing, or one's own emotional experiencing, results in a new perception of the partner which leads to a new way

of relating to that partner (James, 1985 in Greenberg & Johnson, 1988). The expression of primary emotion enables partners to "engage" each other in constructive ways that promote closeness (Greenberg & Plysiuk, 1985). Research indicates that couples who resolve conflict by "engagement" rather than avoidance have greater access to one another's interpersonal perceptions and constructs (Knudson, Sommers & Golding, 1980).

Accessing and expressing primary feelings becomes a tool to change perceptions and meanings in the interpersonal context and indeed couples involved in EFT report a change in their dominant perception of their partner (Johnson & Greenberg, 1985). Furthermore, Fincham and O'Leary's (1983) finding that behavioral responses in couples seem to be primarily mediated by affective responses rather than causal attributions suggest that asking "why" questions, as in CMT, would be less efficient than accessing emotional responses in discovering the underlying interpersonal belief system to facilitate change and promote intimacy.

No empirical studies specifically aimed at measuring the efficacy of EFT in the promotion of intimacy have been conducted. However, in a differential effects study comparing EFT with a cognitive-behavioral intervention in resolving marital conflict, EFT significantly increased the intellectual and conventionality subscale of the Personal Assessment of Intimacy in Relationships Inventory (PAIR; Schaefer & Olson, 1981) (Johnson & Greenberg, 1985). In an

outcome study of EFT on 14 couples, significant increases were found on the intellectual and recreational subscales of the PAIR (Johnson & Greenberg, 1985a). In both studies, trends on all other subscales of the PAIR, especially emotional intimacy, were in the direction of an increase, although not statistically significant.

In summary, EFT is expected to enhance intimacy, and to do so beyond CMT because 1) accessing and expressing primary emotion are more likely to evoke an empathic response; and 2) couples are more likely to be engaged in a constructive encounter which will experientially disconfirm their dysfunctional interpersonal belief system and change their perception of each other, thus increasing authentic contact and intimacy. Conceptual and empirical evidence suggests the hypothesis that EFT would increase intimacy levels as compared to a control group, as well as compared to CMT.

The essential differences between the two interventions are highlighted on the following page.

Essential differences between CMT and EFT

CMT	EFT
1. Assumes primacy of cognition, i.e. a cognitive variable determines an affective variable.	1. Assumes primacy of affect, i.e. people organize experience and create meaning on the basis of current emotional states.
2. Assumes that emotion is mal-adaptive and detrimental to interpersonal functioning, eg. expression of emotions produces distance rather than closeness.	2. Views emotion as a biologically adaptive primary system which is basic to healthy interpersonal functioning, i.e. expressing primary emotion facilitates intimacy.
3. Assumes that true intimate communication lies in the cognitive domain.	3. Assumes that authentic communication lies in the affective domain.
4. Explicitly suppresses affect throughout therapy.	4. Explicitly heightens feelings and explores them fully throughout therapy.
5. Spouses disclose ideas, attitudes, beliefs and theories regarding their relationship.	5. Spouses access and express unacknowledged feelings, needs and wants.
6. Promotes knowledge and cognitive understanding of the relationship.	6. Evokes responsiveness in the partner and fosters emotional bonds.
7. Prohibits spouses from directly talking to each other within sessions.	7. Encourages spouses to directly interact with each other in the sessions.

This section has described the two interventions used in this study along with the reasons why they are expected

to enhance intimacy in couples. The following section presents the research hypotheses derived from these reasons.

Hypotheses

The following research hypotheses were examined in this study:

1. Both CMT and EFT were expected to have a positive effect on levels of intimacy as compared to a wait-list control group.

2. A differential effect in favor of EFT on levels of intimacy as compared to CMT was expected. Because dyadic trust is seen as a prerequisite to trusting self-disclosure and has been found to be associated with depth of self-disclosure (Larzelere & Huston, 1980), it was expected that the trust level would increase with intimacy. Hence, the following hypotheses:

3. Both CMT and EFT interventions were expected to have a positive effect on levels of dyadic trust as compared to a wait-list control group.

4. A differential effect in favor of EFT on levels of dyadic trust as compared to CMT was expected. Based on the assumption that any intervention which facilitates a couple's intimacy will also improve marital adjustment (Russell & Russell, 1980; Waring, 1981), the following hypotheses were put forward:

5. Both CMT and EFT interventions were expected to have a positive effect on levels of dyadic adjustment as

compared to a wait-list control group.

6. A differential effect in favor of EFT on levels of dyadic adjustment as compared to CMT was expected.

Significance of this Study

1. As noted earlier, none of the enrichment studies have clearly delineated intimacy as a specific outcome variable. Virtually all of these studies have used overall marital satisfaction and various relationship skills as their outcome criteria. This study clearly specifies intimacy as its outcome variable.

2. Studies which do claim to use intimacy as an outcome variable fail to clearly delineate the concept of intimacy from general marital satisfaction or other related concepts (Margolin, 1982; Waring, 1981). This study has made an effort to clearly delineate the concept of intimacy from other related concepts with which it is confused in the research literature and to operationalize it.

3. Couple-based interventions specifically aimed at enhancing intimacy often lack research data pertaining to the efficacy of their approach (Hatfield, 1984). Thus a call has been made to examine different interventions specifically intended to improve intimacy (Hinde, 1978). Yet studies which specifically focus on such interventions and their actual effect on intimacy levels are still lacking (Stauffer, 1987). This study addresses the need to specify and empirically validate such interventions.

4. The present study differs from the majority of studies listed above in that intimacy (i. e., trusting self-disclosure and empathy) is not taught as a communication skill but rather facilitated by the therapist's interventions. The assumption is that the most important responses in marriage such as love, trust and respect (Broderick, 1981) are often not "teachable", but may be evoked in a process of mutual self-expression (Greenberg & Johnson, 1986b).

5. Although a measure of intimacy was used in the Johnson and Greenberg study (1985), the main focus of the study was marital conflict resolution and not intimacy per se. Waring (1981, 1988) has published preliminary data suggesting that cognitive self-disclosure facilitates marital intimacy defined as global marital satisfaction. Both of these studies have used distressed couples as their subjects. This study used distress-free couples to control for reported gains in intimacy which in fact may be due mostly to an increase in general marital satisfaction rather than intimacy per se (Wynne & Wynne, 1986).

METHODOLOGY

Research Design

A pretest-posttest wait-list control group design with two experimental groups was used to investigate the hypotheses of this study. The classic pretest-posttest control group design is the most widely used between-group experimental design in psychotherapy research (Kazdin, 1980). The design used in this study can be diagrammed as follows using Campbell & Stanley's (1963) notation:

R	O1	X1	O2
R	O3	X2	O4
R	O5		O6

where R represents random assignment of subjects; O is for observation or pretest-posttest measures, and X for the interventions used (CMT and EFT).

The present study evaluated two therapeutic conditions using a distress-free population and thus cannot be considered as identical to the typical clinical situation. Because it resembles or approximates the clinical situation, it could be referred to as an analogue study (Kazdin, 1980). The purpose of an analogue study is to bring a carefully defined question under well-controlled conditions in order to illuminate a particular treatment process which is

important in actual clinical applications. In this study the particular question under investigation was the differential effect of two treatment conditions in marital therapy (CMT and EFT, the independent variables) on levels of couple intimacy (dependent variable). The general advantages and utility of analogue research for evaluating treatment outcome in situations that closely resemble therapy have been outlined and discussed by Kazdin (1980).

Setting

The study was conducted at the Centre for Psychological Services of the University of Ottawa, an APA accredited doctoral training facility serving the general adult population. The Centre is equipped with soundproof rooms and audio-recording equipment.

Subjects

The sample consisted of couples responding to newspaper advertisements and an article describing a research project with basically happy couples wishing to enhance their relationship. A total of 172 couples were screened over the telephone and 50 were called in for an assessment interview. Of these 50, 36 were admitted into the study. The size of this sample is consistent with a total sample mean size of 30 found in 85 enrichment outcome studies reviewed by Giblin, Sprenkle and Sheehan (1985). A sample of 36 couples allowed for the constitution of three groups of twelve each,

which is the mean for treatment groups in enrichment outcome research (Giblin, Sprenkle, & Sheehan, 1985).

The inclusion criteria determined in this study were designed to reduce variation among subjects as well as help exclude couples who experienced major difficulties in their relationship. Couples were therefore screened through telephone and assessment interviews using the following inclusion criteria:

- presently living together and having cohabited for a minimum of 2 years
- no consideration of separation in the last 2 years
- free of alcohol or drug related problems
- no psychiatric treatment or medication in the past year
- presently not receiving other psychological treatment
- a minimum individual and couple score of 95 on the Dyadic Adjustment Scale (DAS;Spanier, 1976)

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 were together ranged from 3 to 43 and averaged at 15.7 ($SD = 10.7$).

Therapists

Ten therapists participated in this study -- five administering each intervention. Therapists included Ph.D clinical psychology interns experienced in couples interventions as well as marital therapists with a minimum experience of one year. Both groups of therapists were matched for level of experience. Three male and two female therapists implemented the cognitive intervention, and two male and three female therapists implemented the emotionally focussed intervention. All therapists were trained for the intervention which they were to implement. Training was given in a 1-day workshop for each group and was based on a manual describing the intervention to be used (see Appendix A for copy of manuals). The EFT workshop was conducted by Dr. Susan Johnson (originator of EFT), and the CMT workshop was given by Claudia Carver, a clinical and research collaborator with Dr. E. M. Waring (originator of CMT) from the University Hospital in London, Ontario.

Group supervision was given once a week to each group of therapists during the study. Supervision was provided by Dr. Susan Johnson for the EFT intervention, and by Claudia Carver for the CMT intervention. To offset any potential disadvantage to CMT because of the absence of an originator on site, an additional 1-day supervision workshop was offered by C. Carver after all CMT therapists had seen at least one couple for two sessions. Regular supervision was conducted by C. Carver through long distance telephone as

well as on an ongoing basis by the author of this study who received training from Dr. E. M. Waring at the University of Western Ontario in London.

Instruments

This section presents the instruments, questionnaires, and forms used in this project. They are presented in the relative order in which they were utilized during the study.

Standardized Telephone Screening Procedure

The Telephone Screening Procedure was especially devised for the purposes of this study to screen respondents to advertisements over the telephone. It includes questions pertaining to the inclusion criteria for this study, some general information concerning what is required from the selected subjects, as well as additional information in case callers required clinical references for problems such as substance abuse or sexual dysfunction. The form also includes the setting up of the initial appointment (if the caller met telephone criteria) to come in and complete screening instruments.

A copy of the Standardized Telephone Screening Procedure may be found in Appendix B.

Information and Consent Form

The purpose of the Information and Consent Form is to clearly inform potential subjects of the major procedures of the study, what was required of them, and most important, how confidentiality would be assured throughout the project. Couples were reminded that their participation was voluntary and that they could withdraw from the study without penalty. Their signed consent was requested before the administration of screening instruments as well as a confirmation of consent once they were accepted into the study.

The Information and Consent Form was approved by the University Human Research Ethics Committee. A copy of the form is attached in Appendix B.

Demographic Data Questionnaire

The demographic data questionnaire allowed proper description of the population sampled for this study. Couples were asked questions pertaining to their age, number of years of cohabitation, number of children, whether they had previous marital counselling, their gross family income, present occupation, and whether they had been previously married. Questions relevant to the couple were completed together, whereas individually focused items were answered separately. The demographic data questionnaire may be found in Appendix B.

Dyadic Adjustment Scale (DAS; Spanier, 1976)

The DAS is a widely used self-report questionnaire which yields an index of global couple adjustment. It was used in this study to determine whether a given couple's level of functioning was relatively free of distress. Distressed relationships often become paralysed by unmet needs and alienating interactional cycles. Until basic relational processes are mended, efforts for more intimacy would prove to be inadequate (Wynne & Wynne, 1986).

Because of the assumption that any intervention which facilitates a couple's intimacy will also improve marital adjustment (Russell & Russell, 1980; Waring, 1981), the DAS was also used as an outcome measure and served to verify the correlation between intimacy and adjustment.

Although some of the items assess the individual's adjustment to the dyad, most of the items attempt to assess the respondent's perception of the adjustment of the relationship as a functioning group.

Reliability. Reliability was established for each of the component subscales as well as for the total scale using Cronbach's Coefficient Alpha. Reliability coefficients ranged from .73 to .94 for subscales. The total scale reliability was computed at .96.

Validity. Content validity was determined by three judges who evaluated each item as to its relevancy to contemporary relationships, its consistency with nominal definitions of adjustment and for its careful wording with

appropriate fixed choice responses. Items not meeting these criteria were eliminated.

Criterion-related validity was supported by the fact that for each item, the divorced sample differed significantly from the married sample. Furthermore, the mean total scale scores for the married and divorced samples were significantly different at the .001 level. Construct validity was established through a factor analysis and a correlation with the most frequently used scale at the time, the Locke-Wallace Adjustment Scale. Three of the four components revealed by factor analysis had been hypothesized as components of adjustment. Correlations with the Locke-Wallace were .86 for married respondents, and .88 for divorced respondents.

This scale has a theoretical range of 0-151. Higher scores indicate less distress and better adjustment. The mean total scale scores were 114.8 for the married sample and 70.7 for the divorced sample. For research purposes, the distress cut-off point (97) has been set at one standard deviation (17.8) below the mean for the married sample. In order to assure that only relatively distress-free couples would be included in this study, it was decided that any couple scoring below 95 or containing an individual score under 95 would be excluded from this study.

A copy of the DAS is found in Appendix C.

The Miller Social Intimacy Scale (MSIS)

The MSIS (Miller & Lefcourt, 1982) is a 17 item measure of the maximum level of intimacy currently experienced in a given relationship. Perlman, Fehr, & Duck (in press) suggest its use "for a variety of research purposes when investigators wish to assess intimacy in relationships" (p. 8). Each item was screened for face validity and compatibility with the definition offered for this study. A group of nine doctoral interns with experience in couples counselling and two marital therapists with eight years experience in private practice were asked to judge whether the MSIS and the definition of intimacy used in this study were compatible. The degree of compatibility between the definition and the MSIS was judged by all to be at least adequate. It was also found to be free of bias in favor of either intervention used in this project. It was used in this study as an outcome measure of intimacy.

Reliability. Cronbach alpha coefficients of .86 and .91 ascertain that the 17 items measure a single construct. Test-retest reliability was computed from two administrations of the test over a 2-month interval. Test-retest correlations were .96 ($p < .001$) over a 2-month interval, and .84 ($p < .001$) over a 1-month interval.

Validity. Convergent validity was based on a high correlation (.71, $p < .001$) with a version of the Interpersonal Relationship Scale assessing interpersonal trust and intimacy in the marital relationship (Schlein,

Guerney, & Stover, 1971, cited in Guerney, 1977). The MSIS also correlated inversely ($-.65, p < .001$) with the UCLA Loneliness Scale (Russell, Peplau, & Ferguson, 1978) thus adding to its convergent validity.

Construct validity was investigated by asking a group of subjects to complete the MSIS twice: once for their closest relationship and once for a casual relationship. scores of tests describing closest relationships were significantly higher than for descriptions of casual relationships ($t = 9.18, p < .001$). Further exploration of construct validity was done by comparing mean intimacy scores of married subjects with those of unmarried subjects, and the scores of married subjects with those of couples in marital therapy. Mean intimacy scores were significantly higher for married than unmarried respondents ($t = 8.17, p < .001$). Mean scores were also significantly greater for the married sample than for the distressed clinic sample ($t = 6.14, p < .001$). Unmarried subjects scored significantly higher than married clinic subjects ($t = 2.56, p < .02$), which supports the MSIS as a more precise measure of intimacy than marital status.

Ratings on the 10-point scales are summed to obtain the maximum level of intimacy currently experienced in the relationship. The theoretical range is 17-170. The total mean scores are for the unmarried sample, 137.5; for the married sample, 154.3; and for the clinic sample, 126.3. The standard deviation for the total scores of the married

sample was 9.3.

The MSIS is included in Appendix C.

Dyadic Trust Scale (DTS; Larzelere & Huston, 1980)

The Dyadic Trust Scale contains 8 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. Because dyadic trust is seen as an essential prerequisite to the occurrence of 'trusting self-disclosure' (Larzelere & Huston, 1980; Altman & Taylor, 1973), and consequently an essential condition to intimacy as defined in this study, it was expected that the trust level would increase with intimacy. The DTS was therefore used in this study to verify the levels of trust experienced in couples.

Reliability. A factor analysis of the item pool data revealed that dyadic trust was a unidimensional construct. The DTS yielded a coefficient alpha of .93 thus rendering it a highly reliable scale.

Validity. Low correlations with social desirability and generalized trust scales show that the DTS is unaffected by social desirability and operationally distinct from generalized trust. Finally, the DTS yielded excellent discriminant validity as witnessed by the fact that dyadic trust consistently correlated more with love or depth of self-disclosure than did generalized trust or social desirability.

The eight items on the test are scored on a 7-point scale. Five of the eight items are reverse-scored to reduce acquiescence response bias.

A copy of the eight items is included in Appendix C.

Modified Intimacy Scale

The Modified Intimacy Scale was proposed as a possible measure of intimacy as specifically defined in this study. Although the MSIS is a recognized and psychometrically valid measure of intimacy which was judged as generally compatible with the conceptualization of intimacy in this study, it was noted that some of its items did not specifically measure self-disclosure and empathy. The proposed Modified Intimacy Scale included only those items of the MSIS which directly tap into self-disclosure or empathy. The other items of the proposed scale were borrowed from the Interpersonal Relationship Scale (Guerney, 1977) and were judged to specifically reflect self-disclosure or empathy. These items were modified to a 10-point scale (from the original 5-point scale) to concord with the rating scale of the MSIS.

A copy of the items selected for the Modified Intimacy Scale are included in Appendix C.

Target Concerns Questionnaire

The Target Concerns Questionnaire (TC) was adapted from the Target Complaints instrument (Battle, Imber, Hoehn-Saric, Stone, Nash & Frank, 1966). Spouses were asked to describe the two main blocks to intimacy that they hoped to resolve during the counselling sessions. After treatment and again at follow-up, couples are asked to rate on two five-point scales the amount of change on the two concerns identified at the outset of the study. It was used in this study as an alternative measure of intimacy.

Measures such as the TC are recommended by Waskow and Parloff (1975) as a core battery instrument for use in psychotherapy outcome research. Jacobson (1985) suggests that measures which tap the couples presenting problems most directly such as problem checklists like this instrument are the instruments of choice in marital therapy.

Battle et al. (1966) give evidence as to the validity of the Target Complaints measure in terms of significant correlations with other outcome measures, particularly the correspondence of target complaints to the complaints obtained in an intensive psychiatric interview. These authors found this measure to "informative, and it made good clinical sense and seemed to respond differentially to experimental manipulation" (p. 187).

A copy of the Target Concerns Questionnaire may be found in Appendix C.

Verbal Interaction Task (VIT; Guerney, 1977)

The Verbal Interaction Task was adapted from Guerney (1977) and is designed to stimulate emotionally meaningful dialogue between a couple of intimate partners. It was used in this study for the purpose of generating intimate data to be rated on an objective measure of intimacy using the two Carkhuff scales described below. In essence, the VIT consists of asking the couple to talk to each other about something they would like to change in themselves. The instructions are given out in a standardized manner by the researcher who then leaves the couple alone to carry out the dialogue. Partners are aware that their conversation is being tape-recorded.

Studies by Ginsberg (1971), Rappaport (1976), and Guerney (1977) have successfully used the material generated by the VIT to verify experimental hypotheses. The performance of participants in the VIT who knew it would be rated for research purposes was significantly correlated with their performance immediately afterwards, when they believed that it would no longer be assessed.

A description of the Verbal Interaction Task may be found in Appendix D.

Couples Post Session Questionnaire

The aim of this questionnaire was to explore the subjects' experience and impressions immediately after each session. It consists of three items, two of which ask the couple to rate the progress they feel they have made in the session, as well as the degree of resolution they feel they have attained in regard to the concerns brought in at the beginning of treatment. A third item asks them to describe any change they may have perceived occurring in the session and what might have led to this change.

A copy of the questionnaire is found in Appendix C.

Couples Therapy Alliance Scale (AS)

The Couples Therapy Alliance Scale (Pinsof & Catherall, 1986) is a 29 item measure designed to assess the couple's perception of the therapeutic alliance, i.e. "that aspect of the relationship between the therapist system and the patient system that pertains to their capacity to mutually invest in, and collaborate on, the therapy" (Pinsof & Caterall, 1986, p. 139). The AS instrument was used in this study to control for therapeutic relationship variables susceptible of influencing therapeutic outcome. More specifically, it helped to avoid confounding lack of treatment effect with lack of alliance. It provided verification that clients in both experimental groups were equivalently engaged in both types of interventions and perceived them as equally relevant. The scale was administered after the second session to ensure that it would pick up any difference in alliance which usually tends to appear earlier than later in the overall treatment process.

Reliability. Two preliminary studies have been conducted to assess the rate-rerate reliability of the scale. Both studies were done at the Family Institute of Chicago with a non-psychotic population. The first study was completed with an earlier 5-point version of the scale which was administered to 12 couples (24 individuals) who filled out the scale twice, i.e. after each of two consecutive therapy sessions approximately one week apart.

The rate-rerate Pearson correlation coefficient was $r = .84$ ($p < .005$). The second study used the more recent 7-point version of the scale and administered it using the same procedure as in the first study. The overall scores yielded a Pearson reliability coefficient of .79 at the .005 level.

Validity. Preliminary results of studies testing the predictive validity have shown a positive ($p < .05$) correlation between the overall alliance score and patient progress.

The overall score for one given partner is based on the mean rating of all the items on the scale. Scores range from a low of 1 to a high of 7. The overall mean score for the couple is based on the mean of both partners' overall scale scores. For the purposes of this study, a couple score of 3 (disagree) and under was used as a cutoff point. Data collected from couples scoring 3 and under were to be discarded from the study.

The Couple Therapy Alliance Scale is in Appendix C.

Implementation Checklist

A key concern in comparative studies is to ensure that each experimental condition is faithfully and differentially implemented. In order to ascertain whether the interventions stipulated in the treatment manuals have taken place, a checklist of therapist interventions was adapted to the purposes of this study from a similar checklist used in a previous study (Johnson & Greenberg, 1985).

The checklist consists of 22 interventions selected from both treatment manuals (11 from each of the cognitive and emotional manuals). An additional 3 general interventions not exclusive to any of the treatment conditions such as "information gathering", "refocus on topic", and "other" bring to 25 the total number of categories in this checklist. A pilot-test was conducted during role plays within training workshops given to participating therapists in order to verify the applicability of the checklist, i.e. if the process of treatment is easily codable in the given categories.

Trained raters (3 hours of training) were asked to screen one ten-minute segment taken in the middle third of sessions picked at random for each experimental condition. A copy of the Implementation Checklist along with the explication of its different categories are included in Appendix A.

Empathic Understanding in Interpersonal Processes Scale

The Empathic understanding in interpersonal processes scale (Carkhuff, 1969) is derived from empathy scales which have been validated extensively in process and outcome research on counseling and psychotherapy (Carkhuff, 1969). It is devised to apply to all interpersonal processes and attempts to systematically reduce ambiguity and increase reliability. The scale outlines and defines five different levels of empathic understanding which are used to rate

units of interaction taken from conversation material such as the one generated by the VIT.

The Empathic Understanding in Interpersonal Processes Scale was used in this study in conjunction with the Facilitative Self-disclosure in Interpersonal Processes Scale to yield an objective measure of intimacy. Three trained raters blind to the purposes of this study used this scale to rate statements uttered by couples in the VIT.

A copy of the scale is attached in Appendix D.

Facilitative Self-disclosure in Interpersonal Processes Scale (Carkhuff, 1969)

The Facilitative Self-disclosure in Interpersonal Processes Scale has been derived in part from a previous scale for the measurement of therapist self-disclosure which has been validated in process and outcome research in psychotherapy (Carkhuff, 1969). The present scale has been designed to apply to all interpersonal processes and was used in this study to rate material generated through the VIT. It was used in conjunction with the Empathic Understanding in Interpersonal Processes Scale to constitute an objective measure of intimacy.

A copy of the scale is attached in Appendix D.

Procedure

After the initial telephone screening procedure, couples who met the inclusion criteria were invited to come

in for an assessment interview. At this interview, couples were given information on the major procedures and requirements of the project and were assured of confidentiality of information. Each partner was asked to sign an information and consent form, reminding them that their participation was voluntary and that they were free to withdraw from the study at any time. Couples then completed a demographic data questionnaire and filled out the DAS, MSIS, MIS, TC and DTS.

The DAS was scored immediately and if the score was under 95, the couple was advised that they did not meet the requirements of this study, that according to our instruments they were reporting some distress, and that if they wished they could be referred either to the Centre for Psychological Services or another service for help. If the DAS criterion was met, i.e. at least 95 couple score and individual score, the couple was informed immediately and asked to sign a confirmation of consent to participate in the study.

Upon completion of the self-report instruments, each couple was asked to perform a Verbal Interaction Task involving a brief conversation on a given theme which was tape recorded for later rating of self-disclosure and empathy by independent raters in order to establish a baseline objective measure of intimacy.

Chosen couples were randomly assigned to one of three groups: 1) Cognitive; 2) Emotional; and 3) Wait-list control

group. Couples in both experimental groups were seen for six 1-hour sessions, a week apart. All sessions were audiotaped. After every session, the Couples Post Session Questionnaire was administered to each couple to gather descriptive data on the couple's perception of the treatment process. Couples were asked to complete the Couples' Therapy Alliance Scale after the second session. All couples obtained scores of at least 4, hence no couples had to be replaced on the grounds of inadequate alliance.

After the sixth session, each individual partner was asked to complete the post-treatment measures, i. e. the MSIS, MIS, TC, DTS, and the DAS. Upon completion of these measures, couples were again asked to perform the Verbal Interaction Task to be rated by independent raters for comparison with baseline levels. These ratings were conducted on the VIT data collected at pretest and posttest only. The VIT was not administered at the follow-up period, and therefore no observational measures of self-disclosure and empathy were made at that time. For complete detailed procedures used for the VIT as well as for the rating of the VIT, please see Appendix D.

Informal screenings of initial sessions were conducted by the supervisors to ensure a proper differential implementation of treatments. Upon completion of the six experimental sessions, implementation checks were conducted by independent raters to ascertain accurate and differential applications of the two interventions. Trained raters (3

hours of training) used objective checklists adapted to the purposes of this study, and screened one 10-minute sample section of the middle third of sessions picked at random.

One CMT couple chose to withdraw from the study after two counselling sessions. They were replaced by another couple with similar pretest scores in order to maintain equally numbered groups.

A ten-week follow-up was conducted by personally contacting couples and asking them to come in and complete the post research questionnaires, i. e. MSIS, MIS, TC, DTS, and DAS. Debriefing on the study was offered at that time.

Wait-list couples were called in after a 6-week waiting period to complete the same post-treatment measures as above and to perform the Verbal Interaction Task and commence counselling sessions.

RESULTS

Data analysis was conducted in three major steps. First, a reliability analysis (internal consistency) was completed on all self-report measures and a Pearson correlation was calculated on all dependent measures. Second, assumptions of group equivalences on demographic variables and therapeutic alliance were tested for all groups, and proper implementation of treatment interventions was verified. Third, outcome scores were tested for the hypothesized differential treatment effects after treatment and at follow-up.

Step One: Reliability Analysis and Relationship between Dependent Variables

Reliability Analysis

The sample used for the reliability analysis of internal consistency included all thirty-six couples admitted into the study as well as the fifteen who were screened out. This gave a total N of 102 subjects (51 couples). The analysis was conducted on the pre-test scores on the following measures: the Miller Social Intimacy Scale (MSIS), the Dyadic Trust Scale (DTS), and the Dyadic Adjustment Scale (DAS). In addition, an analysis was done on the Couples Therapy Alliance Scale (CTAS) for both treatment groups (N = 24). The SPSS-X computer program was

used in the above analyses.

The reliability analysis (internal consistency) calculated on the MSIS yielded a coefficient of .89 for the entire sample. This reflects a high inter-item correlation and suggests the presence of a single major construct. All remaining self-report measures also yielded satisfactory reliability statistics ranging from .85 to .94 for the entire sample. Reliability statistics for all self-report measures can be found in Table 1.

Table 1

Reliability Statistics for Self-Report Measures

Tests	Alpha		
	Male (N = 51)	Female (N = 51)	Total (N = 102)
MSIS	.86	.91	.89
DTS	.76	.89	.85
DAS	.87	.90	.89
CTAS	.95	.94	.94

Relationship between Dependent Variables

In keeping with the literature reviewed which suggested a positive relationship between intimacy, trust, and dyadic adjustment, Pearson product moment correlations were

performed between the MSIS, the DTS and the DAS pretest scores. The sample used for this analysis was the same as the one used for the reliability analysis yielding a total N of 102 subjects.

A relatively strong positive correlation was found between pretest scores on the intimacy and on the adjustment measures (.62), and a weaker but significant correlation was found between pretest levels of trust and intimacy (.28), as well as between trust and dyadic adjustment (.27). None of the self-report measures correlated with either of the two observational measures (Self-disclosure and Empathy), except for the DTS which correlated negatively with Empathy (-0.46 , $p = .002$). These correlations may be found in Table E-1, Appendix E.

At the end of stage 1, it was then possible to confirm that all self-report measures were statistically reliable for the purposes of this study. Because of the high correlation between both self-report intimacy measures (the MSIS and the Modified Intimacy Scale (MIS), $r = .83$, $p = .000$), and since the MIS had no independent test validity or reliability data using a sample outside of this study, it was judged that the MIS did not add significantly to the MSIS which had satisfactory independent validity and reliability data. Thus, the remainder of the analysis was conducted without the scores obtained on the Modified Intimacy Scale.

Step Two: Testing Assumptions of Group
Equivalence and Implementation Checks

Group Equivalence

The assumption of equivalence between the three groups was verified for the following demographic variables: age of both partners, number of years together, level of couple's income, level of education and level of occupation of both partners. As may be noted in Table E-2, Appendix E, no significant differences between groups were found.

Scores on the Couples Therapy Alliance Scale were analysed using a oneway analysis of variance to verify the assumption of equivalence between treatment groups. No significant differences in therapeutic alliance were found between EFT couples and CMT couples. The group mean 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. A summary of the analysis of variance is presented in Table E-3, Appendix E.

Implementation Checks

To confirm that the treatments were implemented faithfully in accordance to 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 correctly identify which group they were in. In addition to this, an implementation check was conducted by two trained independent raters.

For the purpose of this implementation check, 72 of the total 144 sessions were randomly selected to be coded according to the Implementation Checklist. One ten-minute segment was taken from the middle third of each of these 72 sessions. A total of 925 therapist interventions were coded by the raters who were blind as 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, 16 (1.7%) were found to be inappropriate to the treatment condition being observed. Seven inappropriate interventions occurred in the EFT approach and nine in CMT. This small percentage

of inappropriate interventions suggests that the approaches were easily distinguishable and able to be implemented according to treatment manuals.

Inter-rater reliability was calculated on 15 randomly chosen sessions yielding a total of 287 observations (31% of total observations). The overall percentage of agreement between both raters was 88.2%. Raters disagreed on 34 observations, 30 of which were cross intervention disagreements (out of a total of 22 possible interventions), and 4 of which were cross treatment disagreements (total possible: 2).

At the end of Step 2 of the analysis it was possible to establish that for the purposes of this investigation all three groups were statistically equivalent on demographic variables and on therapeutic alliance. Implementation checks further revealed that both experimental conditions were properly and faithfully implemented and inter-rater reliability on these checks were found to be satisfactory.

Preliminary analyses of Steps 1 and 2 therefore warrant further analysis of the outcome scores with a good margin of confidence that whatever difference may be found between groups will be due to experimental conditions and not to extraneous variables present at the outset of the study.

Step Three: Treatment Effects

Hypothesized Treatment Effects

Because comparisons among means were specified by a set of hypotheses prior to collection of the data, t ratios were used to make the planned comparisons (Kirk, 1968). Comparisons were conducted between group means for each hypothesis at post-treatment and at follow-up. As suggested by Tabachnick and Fidell (1989), the error terms (mean squares within cells) used for these comparisons were taken from ANCOVA's performed on the MSIS, DTS, DAS, SD, and EMP measures, and from the ANOVA on the TC (ANCOVA on TC was not possible because TC does not yield a pretest score to be used as covariate).

The potential problem of "probability pyramiding" or inflated Type 1 error rate (Huberty & Morris, 1989) 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, i.e. male plus female divided by 2 for each couple unit.

Hypothesis 1

Both CMT and EFT were expected to have a positive

effect on levels of intimacy as compared to a wait-list control group.

Separate analyses of covariance were performed on the MSIS, SD and EMP measures using the pretest scores as covariates to adjust the posttest/post-wait and follow-up scores. The results of these analyses may be found in Tables E-3a, E-3b, and E-3c in Appendix E. Table 2 presents pretest, posttest, and adjusted group means and standard deviations for the MSIS, SD and EMP.

Table 2
Pretest, Posttest and Adjusted Group Means
on MSIS, SD, and EMP

Measures Groups (n=12/group)	Time		
	Pre	Post	Adjusted Post
	M (SD)	M (SD)	M
MSIS			
EFT	130.3 (9.7)	136.3 (8.8)	136.6
CMT	128.7 (15.8)	138.0 (13.7)	139.6
Con	133.1 (10.4)	131.1 (11.9)	129.2
SD			
EFT	2.43 (.67)	2.76 (.58)	2.69
CMT	2.08 (.38)	1.93 (.44)	2.01
Con	2.34 (.51)	2.36 (.32)	2.34
EMP			
EFT	1.95 (.58)	2.11 (.67)	2.07
CMT	1.71 (.36)	1.46 (.10)	1.55
Con	1.97 (.46)	1.62 (.24)	1.57

Both CMT and EFT posttest adjusted group means on the MSIS were compared to the post-wait adjusted control group mean with a planned comparison test using a t ratio as described by Kirk (1968). The comparison test yielded a t ratio of 3.33 ($df = 66$, $p < .001$), thus meeting the adjusted alpha level of .008. This supports the first hypothesis that both CMT and EFT have a positive effect on levels of intimacy as compared to a control group.

Group means on the observational measures of intimacy were also submitted to planned comparison tests. Both CMT and EFT posttest adjusted means on the SD and EMP were compared to the post-wait adjusted control means. A non significant t ratio was found on the SD measure ($t = .06$, $df = 30$, $p > .008$), as well as on the EMP measure ($t = 1.32$, $df = 30$, $p > .008$). Thus, no significant differences were found between treatment and control groups on both observational measures.

On the Target Concerns questionnaire couples described the main blocks to intimacy that they hoped to resolve during counselling. At posttest they indicated how much these blocks changed on a scale of 1 -- worse to 5 -- much better, with 2 meaning no change. Planned comparison tests between treatment and control group means yielded a t ratio of 6.8 ($df = 33$, $p < .0005$) which supports hypothesis one.

In brief, results on both self-report measures of intimacy supported the hypothesis that treatment group means on intimacy would be significantly larger than control group

means. The observational data, however, did not support this hypothesis.

A summary of the planned comparison test results on the MSIS, TC, SD, and EMP measures may be found in Table E-4, Appendix E.

Hypothesis 2

A differential effect in favor of EFT on levels of intimacy as compared to CMT was expected.

This hypothesis was tested at two different time periods: posttest and follow-up. At posttest, no significant difference was found between EFT and CMT group means neither on the MSIS nor on the TC. However, EFT group means were significantly higher than CMT at posttest for both SD and EMP observational measures ($p < .005$). These results are summarized in Table E-6, Appendix E.

At follow-up, an analysis of covariance was conducted using the pretest score on the MSIS as the covariate and the follow-up score for the EFT and CMT groups as the dependent variable. The results of this analysis may be found in Table E-5, Appendix E. Table 3 presents pretest, follow-up, and adjusted follow-up group means and standard deviations for the MSIS.

Table 3

Pretest, Follow-up and Adjusted Group Means on MSIS

Groups (n = 12/group)	Time		
	Pre	Follow-up	Adjusted Follow-up
	M (SD)	M (SD)	M
EFT	130.3 (9.7)	143.3 (9.5)	142.7
CMT	128.7 (15.8)	133.0 (13.2)	133.7

A planned comparison test was conducted between EFT and CMT adjusted group means on the MSIS at the follow-up time period. The EFT group mean was found to be significantly larger ($t = 4.29$, $df = 66$, $p < .0005$). The large difference at follow-up is due to a decrease in CMT scores back toward pretest levels and an increase in EFT up and beyond the posttest scores. A similar pattern is observed in the TC scores at follow-up where the EFT group mean was significantly higher than CMT ($t = 2.96$, $df = 33$, $p < .005$).

A summary of these comparisons may be found in Table E-6, Appendix E.

In summary, Hypothesis 2 is supported by the observational data at posttest. Self-report data support the second hypothesis at follow-up but not at posttest. No

observational data were collected at the follow-up time period.

Hypothesis 3

Both CMT and EFT interventions were expected to have a positive effect on levels of dyadic trust as compared to a wait-list control group.

An analysis of covariance was conducted using the pretest score on the DTS as the covariate and the posttest/post-wait score as the dependent variable. The results of this analysis may be found in Table E-7, Appendix E. Table 4 presents pretest, posttest, and adjusted group means for the DTS.

Table 4

Pretest, Posttest and Adjusted Group Means on DTS

Groups (n = 12/group)	Time		
	Pre	Adjusted Post	Post
	M (SD)	M (SD)	M
EFT	43.5 (5.7)	43.7 (4.3)	44.7
CMT	47.7 (5.9)	48.9 (4.0)	48.3
Con	47.5 (6.1)	46.5 (5.7)	46.0

Both adjusted treatment group means together on the DTS were compared to the adjusted control group mean at posttest using a t ratio. No significant difference was found ($t = .27$, $df = 66$, $p > .008$). CMT and EFT did not have a significant positive effect on levels of dyadic trust as compared to a control group. The third hypothesis is therefore not supported. Statistics are summarized in Table E-4, Appendix E.

Hypothesis 4

A differential effect in favor of EFT on levels of dyadic trust as compared to CMT was expected.

At posttest, no significant difference was found between EFT and CMT group means on the DTS (see Table E-6, Appendix E). At follow-up, an analysis of covariance was conducted using the pretest score on the DTS as covariate. The results of this analysis may be found in Table E-8, Appendix E. Table 5 presents pretest, follow-up, and adjusted group means for the DTS.

Table 5

Pretest, Follow-up and Adjusted Group Means on DTS

Groups (n = 12/group)	Time		
	Pre	Follow-up	Adjusted Follow-up
	M (SD)	M (SD)	M
EFT	43.5 (5.7)	46.5 (5.2)	48.1
CMT	47.7 (5.9)	47.9 (5.9)	46.4

A planned comparison test between EFT and CMT adjusted group means on the DTS revealed no significant difference at follow-up ($t = 1.21$, $df = 66$, $p > .008$). Hypothesis 4 is therefore not supported at neither posttest nor follow-up time periods. A summary of these comparisons may be found in Table E-6, Appendix E.

Hypothesis 5

Both CMT and EFT interventions were expected to have a positive effect on levels of dyadic adjustment as compared to a wait-list control group.

An analysis of covariance was computed using the pretest score on the DAS as the covariate. The results of this analysis may be found in Table E-9, Appendix E. Table 6 presents pretest, posttest, and adjusted group means for the DAS.

Table 6

Pretest, Posttest and Adjusted Group Means on DAS

	Time		
	Pre	Post	Adjusted Post
Groups (n = 12/group)	M (SD)	M (SD)	M
EFT	105.9 (6.7)	110.5 (4.9)	111.2
CMT	106.7 (6.9)	110.8 (8.8)	111.0
Con	108.1 (8.4)	109.3 (9.1)	108.4

No significant difference was found between experimental and control group means on the DAS at posttest

($t = 1.06$, $df = 66$, $p > .008$). EFT and CMT did not have a significant positive effect on levels of dyadic adjustment as compared to a control group. Hypothesis 5 is therefore not supported. Statistics are summarized in Table E-4, Appendix E.

Hypothesis 6

A differential effect in favor of EFT on levels of dyadic adjustment as compared to CMT was expected.

No significant difference was found between EFT and CMT group means on the DAS at posttest ($t = .06$, $df = 66$, $p > .008$).

At follow-up, an analysis of covariance was conducted using the pretest score on the DAS as covariate. The results of this analysis may be found in Table E-10, Appendix E. Table 7 presents pretest, follow-up, and adjusted group means for the DAS.

Table 7

Pretest, Follow-up and Adjusted Group Means on DAS

Groups (n = 12/group)	Time		
	Pre	Follow-up	Adjusted Follow-up
	M (SD)	M (SD)	M
EFT	105.9 (6.7)	115.6 (5.6)	115.8
CMT	106.7 (6.9)	109.2 (6.1)	109.0

A planned comparison test between EFT and CMT adjusted group means on the DAS revealed a significant difference at follow-up ($t = 3.44$, $df = 66$, $p < .001$). Hypothesis 6 is therefore supported at follow-up but not at the posttest time period. A summary of these comparisons may be found in Table E-6, Appendix E.

Effect Sizes

Another way of viewing the data is in terms of effect sizes (Cohen, 1977). An estimate of the magnitude of change is provided by computing the difference in means between each treatment group and the control group and dividing by the standard deviation of the control group at post-wait. In this study, if the post-wait mean on the MSIS for the control group (131.1) is subtracted from the means of the

treatment groups at posttest (136.3 for the EFT group, 138.0 for CMT), and divided by the standard deviation of the control group at post-wait (11.9) the effect sizes are .44 for the EFT group and .58 for the CMT group. At follow-up, effect sizes are 1.03 for the EFT group and .16 for the CMT group. The mean effect of the emotionally focused intervention on the MSIS measured at posttest is less than half a standard deviation from the mean of the control group measured after the waiting period, and one standard deviation at the follow-up period. This would seem to be a significant treatment effect in favor of EFT in terms of facilitating intimacy.

The effect sizes for the remaining intimacy measures were also computed. Effect sizes for the Target Concerns was 6.4 for both EFT and CMT at posttest, and 6.4 for EFT and 4.0 for CMT at follow-up. The treatment effect sizes on the observational measure of self-disclosure were 1.33 for EFT and -1.66 for CMT at posttest. Effect sizes on the observational measure of empathy were 2.5 for EFT and -.5 for CMT. No data were collected on the observational measures at follow-up. The reason for the negative effect sizes for CMT is because this group decreased on both observational measures at posttest.

An analysis of statistical power (Cohen, 1977) was also conducted for all variables and was found to be weak. Results of this analysis may be found in tables E-4 and E-6. The weak statistical power suggests that the probability of

finding significant treatment effects with the size of this sample were very low, thus making the significant treatment effects found in this study even more robust. Similarly the non-significant results do not confirm that there are no treatment effects to be found given a larger sample.

To summarize, both EFT and CMT group means were higher than controls on the MSIS and the TC. Observational data collected on the SD and EMP at posttest revealed differential effects in favor of EFT as compared to CMT. At a ten-week follow-up, the EFT group scored higher than the CMT group on the MSIS, TC and DAS. 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 post-test on observational measures of intimacy as well as at follow-up on self-report measures of intimacy and dyadic adjustment.

DISCUSSION

The purpose of this study was to assess the differential effectiveness of two sets of interventions in marital therapy, Emotionally Focused Therapy and Cognitive Marital Therapy, on the dependent variables of marital intimacy, dyadic trust and dyadic adjustment. Empirical evidence for the effectiveness of interventions in marital therapy that enhance intimacy, especially intimacy defined specifically as trusting self-disclosure and communicated empathy rather than globally as general marital satisfaction is still in the pilot stage. There is a need in the field of marital therapy to develop and empirically validate specific interventions for specific problems or results. This study, then, tested the effectiveness of two specifically defined and demonstrably different interventions on the occurrence of open disclosure responded to empathically in basically happy couples.

Waring (1988) reports on a total of three uncontrolled studies on CMT with distressed couples. In all cases intimacy was measured as a global concept using the FIRO-B or the Waring Intimacy Questionnaire (WIQ). Two of these studies showed a significant increase on the WIQ, one was a single case study showing a significant increase in the couple's score and the other yielded significant increases for the female partner only. Only one of the three studies had follow-up scores and these were not significant. To

this date no empirical studies have been conducted to test the effectiveness of EFT in the enhancement of intimacy as specifically defined in this study. Two studies using EFT to resolve marital conflict however showed an increase on the intellectual, recreational and conventionality subscales of the Personal Assessment of Intimacy in Relationships (PAIR, Schaefer & Olson, 1981) which is also a global measure of intimacy. Emotional intimacy also increased but narrowly missed reaching the level of significance set in this study (Johnson & Greenberg, 1985, 1985a).

The strengths of this study include a clear operational definition of intimacy, delineating the concept from other related concepts in the field which have been confused with intimacy in past studies; a wait-list control group; follow-up testing; controlled implementation of interventions; two separate groups of therapists trained by the originators of each intervention; use of non-distressed couples to facilitate control of the intimacy variable, and an attempt at applying an observational measure of intimacy in addition to self-report instruments.

Summary of Results

The thirty-six couples were randomly assigned to one of the two treatment groups or the wait-list control group. No significant differences were found between couples in the three groups on demographic variables and the two treatment groups were equivalent with regards to the quality of the

couples alliance with their therapist.

An analysis of self-report post-measures of intimacy (Miller Social Intimacy Scale and Target Concerns) revealed that couples in both treatments reported significantly greater gains than those in the control group. Couples in the EFT group were observed to display significantly higher gains at posttest than CMT couples on observational measures of self-disclosure and empathy.

There were also significant differences between treatment groups at follow-up. EFT couples reported significantly higher levels on measures of intimacy (MSIS and TC) and on general marital satisfaction (DAS). Thus evidence was found to support the hypotheses concerning the overall effectiveness of both treatments to increase intimacy and the existence of differential treatment effects in favor of EFT on intimacy (both self-report and observational measures) and dyadic adjustment. Results with regards to dyadic trust were not significant.

An analysis of effect sizes (Cohen, 1977) revealed that for all intimacy variables, EFT yielded larger effects sizes than CMT.

Results of the study will be discussed in terms of the relationships between the dependent variables, treatment effects, limitations of the study and suggestions for future research and treatment.

Relationships between the Dependent Variables

Pearson product moment correlations were performed on the pretest scores of the dependent measures used in this study to ascertain whether they reflected the relationship between intimacy, dyadic trust and marital adjustment suggested in the literature (Larzelere & Huston, 1980; Waring et al., 1981; Wynne & Wynne, 1986). As expected, all three variables (as measured by self-report questionnaires) were positively correlated with each other. These correlations support the belief held both by the general population (Waring et al., 1981) and researchers alike that intimacy, trust, and adjustment are interrelated concepts. However, the finding of differential effects for these three constructs at posttest and at follow-up supports the theory that, although they are related, intimacy, trust and adjustment can be seen as unique and discrete phenomena. This would seem to be a move toward greater specificity in the study of marital relationships and would hopefully contribute to a better investigation and understanding of the intricate dynamics of marriage.

No correlation was found at pretest between self-report (MSIS) and observational measures (SD and EMP) of intimacy. This is consistent with an absence of correlation between self-report and observational measures reported in the literature. Margolin (1978), and Margolin and Wampold (1981) failed to obtain significant correlations between communication patterns assessed with the Marital Interaction

Coding System and self-reports of global distress, areas of conflict, or of pleasing and displeasing behaviors. Haynes, Chavez, and Samuel (1984) found no relationship between the DAS and positive verbal communication behaviors in a sample of 33 distressed and 157 nondistressed couples. While most researchers in this area have argued for a combination of observational and self-report methods (Gottman, 1979; Jacobson, 1985; Snyder, Trull, & Wills, 1987), evidence for the convergent validity of these approaches has generally been lacking.

It may be that observational and self-report methods assess substantially different components of the marital relationship. A couple may feel and believe they are close and intimate without necessarily displaying behaviors of self-disclosure and empathy in a four minute conversation. In this study, EFT yielded significantly higher gains than CMT on both observational measures of intimacy (self-disclosure and empathy) at posttest. However, these results should be considered as tentative, because no significant difference was found between treatment and control groups on either observational measures. It should also be noted that the sample used for the observational measures was considerably smaller than the one used for the self-report measures. This was due to technical problems rendering inaudible a good number of audiotapes. Only half of the sample was used to rate couples on the observational measures of self-disclosure and empathy. This therefore

reduced the total sample used for the observational measures to 18 couples compared to the 36 used for the self-report measures. In addition, no significant differences between treatment groups were found at posttest on either self-report measure of intimacy (MSIS and TC). In the event of inconsistency across measurement modalities, Jacobson (1985) argues that self-report measures should be considered primary in ascertaining whether or not a treatment is effective. Based on Jacobson's suggestion, and considering a possible methodological artifact due to technical audio problems, it would appear that no differential treatment effects on intimacy were found at posttest.

Treatment Effects

The design of the study allows us to conclude with a fair degree of confidence that gains on intimacy reported by subjects at posttest were due to treatment and not to chance or spontaneous improvements. However, beyond immediate posttesting, causality could not be established because the wait-list control group had already started their own treatment and could no longer be used as a no-treatment comparison group. Both emotionally focused and cognitively focused interventions appear to have increased intimacy defined as self-disclosure and empathy, as compared to a wait-list control group at posttest.

These results are consistent with psychotherapy outcome studies that show that treatment is generally better than no

treatment as well as with studies on various marital enrichment programs which focus on the enhancement of communication skills closely related to self-disclosure and empathy (Gurman & Kniskern, 1977; Giblin, Sprenkle, & Sheehan, 1985). A comparative outcome study of Relationship Enhancement -- RE (Guerney, 1977), which basically teaches skills in self-disclosure and empathy, and five therapists' own preferred non-RE methods revealed that RE clients gained significantly more on variables pertaining to trust and intimacy (Ross, Baker, & Guerney, 1985).

In a study comparing RE with a combination of RE and cognitive restructuring (CRE) using nonclinical married couples, both RE and CRE obtained significant gains on expressor-empathy skills ratings (Greene & Kelley, 1985). In another comparative study, the Couples Communication Program (Miller, Nunnally, & Wackman, 1976) and Structured Behavioral Exchange both increased speculative (intellectual) and open (self-revealing) styles of communication (Russell, Bagarozzi, Atilano, & Morris, 1984). L'Abate and Sloan (1984) developed a structured enrichment workshop based on the sharing of hurt feelings to facilitate intimacy in married couples and tested it in a non controlled study which found that couples' intimacy scores were significantly increased (Sloan, 1984).

The above studies suggest that the expression of feelings and private thoughts impact positively on intimacy, however, none have properly delineated intimacy as the

outcome variable and none have verified proper implementation of interventions. Despite Hinde's (1978) call for research on interventions aimed at facilitating intimacy, very few studies have been conducted to specify and empirically validate therapeutic techniques that help couples move toward greater intimacy (Stauffer, 1987).

The essence of the results in the present study, then, is that two specific interventions aimed at enhancing intimacy as delineated from other related concepts were stipulated in a therapy manual, implemented according to that manual, monitored during implementation, and empirically tested as to their effectiveness. This would seem to be a positive contribution to the field of marital therapy and the results suggest that helping couples to focus on inner emotional experiencing and disclosing it to one's intimate partner may be a powerful way to help couples move toward greater intimacy.

Since intimacy was the main focus of this study, most of the discussion will centre on this variable. However, the results concerning two other variables, trust and dyadic adjustment, will be discussed first.

Dyadic Trust

No significant differences on the Dyadic Trust Scale were found between treatment and control groups at posttest nor between both treatment groups at follow-up. This result is contrary to expectations based on work done by Larzelere

and Huston (1980) who found evidence suggesting that trust is a prerequisite for intimate self-disclosure in ongoing relationships and who also demonstrated a positive correlation between dyadic trust and depth of self-disclosure (as measured by self-report). If this were true, and since intimacy was increased by treatment in this study, then it would be expected that trust would also be increased by treatment. 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 observed 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. Also, for both the MSIS and the DTS, trends increased from post to follow-up for the EFT group but decreased for the CMT group, thus displaying exactly the same pattern of trends for both intimacy and trust. If results on the DTS behaved in exactly the same pattern as scores on the MSIS but without reaching significance, this may be a reflection of the lesser variation in the DTS scale due to its smaller number of items (eight) compared to the 17 items in the MSIS. It may be that the DTS is less sensitive to change than the MSIS.

Another possible explanation for the lack of significant changes in trust levels may be that trust is a

more stable construct in intimate relationships than intimacy per se, and therefore less sensitive to the impact of treatment. The upward trend on the DTS for EFT from posttest to follow-up suggests the possibility that with time EFT interventions might have the effect of significantly increasing trust. Perhaps a minimal level of trust is required for intimacy to occur in a relationship, and once this minimum is attained then openness and vulnerability can occur more safely thus allowing for greater intimacy which would not impact immediately on trust. With time, however, this greater intimacy may eventually increase levels of trust. Further research would be needed to examine the relationship between trust and intimacy.

DTS scores did not correlate significantly with self-disclosure as observed with the rating scales used in this study. This lack of correlation is consistent with the general lack of correlation between self-report and observational measures reported in the literature (Snyder et al., 1987), and may also suggest that these instruments in fact measure different constructs. However, the DTS correlated negatively with the observational measure of empathy. This result is contrary to the belief that empathy plays an important role in establishing an atmosphere of trust necessary for the occurrence of trusting self-disclosure (Wynne & Wynne, 1986). This unexpected result may in fact be a methodological artifact due to

inaudible tapes which decreased the sample used for observational measures and lowered the variance. Another possible reason for this negative correlation is that the relationship between trust and empathy may be different when seen from the individual's point of view. Perhaps individuals reporting high trust levels in their partner do not display as much empathic behavior themselves, but experience high trust because their partners are more empathic, thus increasing trust levels in them.

Dyadic Adjustment

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 results obtained at follow-up in this study are consistent with those of another study which demonstrated the effectiveness of EFT to significantly increase the total DAS level (Johnson & Greenberg, 1985). Again the trend patterns for adjustment were similar to the trend patterns observed for the intimacy and trust variables. This consistency in patterns would seem to suggest that intimacy, trust and adjustment are related components in an intimate relationship. Perhaps adjustment scores were not significantly increased by treatment at posttest because only distress-free couples were admitted into the study, thus making it more difficult to further increase their

satisfaction level in only six sessions. Adjustment may also be a more stable component in basically happy intimate relationships and therefore less susceptible to change under treatment conditions.

As Wynne and Wynne (1986) suggest, intimacy recurs most reliably within a context of basic, well-functioning relational processes. Couples in this study were selected on the basis that they were not distressed, thereby facilitating the occurrence of intimacy within six sessions. On the other hand, since intimacy can also foster marital satisfaction (Waring et al., 1981), it may be that as intimacy levels for the EFT group kept increasing through to the follow-up period, eventually adjustment was positively affected resulting in the significant difference between CMT and EFT at follow-up. It is interesting to note that contrary to Waring's global definition of intimacy and his finding that such intimacy seemed to determine general marital satisfaction, in this study intimacy as specifically defined as self-disclosure and empathy would also seem to impact on general dyadic satisfaction.

Having discussed the implications of the results on the trust and adjustment variables, we will now return to intimacy, the main outcome variable in this study.

Intimacy

The treatment effects on intimacy will be discussed around two questions. The first question will deal with the

more immediate issue of why EFT was more effective than CMT at follow-up and not at posttest. The second question will address some underlying theoretical issues suggesting why EFT was more effective at increasing intimacy.

Why was EFT more Effective than CMT
at Follow-up and not at Posttest?

Although both treatment groups were more effective than the control group in increasing the intimacy score at posttest on both self-report measures, no significant difference was found between EFT and CMT group means at posttest. However, differential treatment effects were found at follow-up in favor of EFT. The increase in intimacy and adjustment scores at follow-up for the EFT couples and the ensuing significant difference between EFT and CMT may seem unusual. Outcome gains in psychotherapy would be expected at best to be maintained at follow-up but not to continue to increase. In Johnson and Greenberg's (1985) study, both EFT and a cognitive behavioral problem-solving approach generally maintained posttest gains on the DAS at follow-up.

The unusual results at follow-up in this study may have been influenced by three interrelated factors: time, type of self-disclosure, and type of population used for this study.

It may be that, at least in a shorter time period, it is not so much the content of self-disclosure but rather its process that actually impacts on greater intimacy, particularly in a population of relatively distress-free

couples.

An examination of the Couples Post Session Questionnaires (CPSQ) indicates that both groups reported an increase in closeness due to greater self-disclosure encouraged by the therapists. Although some couples indicated differences in the content of the self-disclosure (EFT reporting more disclosure of feelings and needs, and CMT reporting more disclosure of thoughts and biographical data), these differences were not translated into significant differential treatment outcome scores at posttest. Hence, the suggestion that the process rather than the content of self-disclosure facilitates intimacy, at least on a shorter term.

Results at posttest indicate that initially CMT was as efficient as EFT at increasing intimacy, but on a longer term basis, as evidenced by the follow-up scores, the initial CMT improvements are lost. EFT on the other hand apparently continues to be operative even after termination of the sessions, thus increasing intimacy levels at follow-up. This may suggest that a deeper change has occurred in the relationship. EFT spouses seemed to be relating to each other in a new more satisfying and closer manner, even when the therapist was no longer present. Disclosing underlying feelings may change the relationship and increase intimacy over time as evidenced by the increase in DAS, MSIS and TC scores at follow-up. However, EFT couples may need time to integrate on an intrapsychic and

interpersonal level new previously unsynthesized emotions which change their perceptions of their spouses and in turn create new patterns of interaction. Perhaps EFT couples need more time to experience and "practice" their new interactional cycles before they can experience their full impact on intimacy. This will be discussed further in the following subsection.

Another possible reason why these results occurred may be because couples who were admitted into the study already displayed relatively high levels of intimacy, as they were not distressed. The goal of the interventions used in this study was to help couples who were basically happy to improve their intimacy. Relieving distress in couples may be more readily obvious and easier to measure, whereas making something positive grow may take more time to become obvious.

Yet another possible reason for these results may have to do with the role of cognition and emotion in intimate relationships. It may be that accessing underlying emotions is a more involving and encompassing process, and more crucial to the creation of intimacy than sharing cognitive material such as thoughts, theories and biographical data. This cognitive material may be readily accessible and in short term will increase spouses' knowledge of each other which might then translate into higher scores on the MSIS and on the TC. In fact, some couples in the CMT group did report on the CPSQ that they had learned something new about

their partner. However, these increases may be short lived compared to the EFT process. Perhaps because EFT requires greater personal involvement, increases on intimacy and dyadic adjustment take time to reach optimal levels and may be more enduring as suggested by the significant increases at follow-up. This will be discussed further in the following subsection.

Why was EFT more effective?

This subsection will address some of the theoretical issues which may suggest why EFT was effective in enhancing intimacy. Two very distinct sets of interventions were compared in this study. These two sets of interventions invited couples to engage in very different processes within the sessions, and since an implementation check showed that in fact each approach was properly implemented, it is reasonable to assume that clients engaged in different processes which then had differential effects on intimacy. The significant differences between EFT and CMT at follow-up on intimacy and adjustment may be a reflection of these very different processes in which couples were invited to engage.

Some of these processes will be discussed in this subsection, with the full awareness that future research is still needed for further empirical validation.

This part of the discussion will centre around the following points: how emotion is used in EFT; how accessing underlying feelings is more likely to evoke an empathic

response, discover core beliefs, and change interpersonal perceptions and interactions -- all of which are considered to be important in enhancing intimacy.

How Emotion is used in EFT

Emotions in EFT are not merely discussed or intellectually understood, nor are they simply ventilated. With the help of the therapist, clients actively synthesize new emotion in the present with total involvement. In EFT it is not so much the disclosure of preformed emotional experience (just waiting to be revealed) that seems to create intimacy, but rather the creation of new emotional experience. This new emotional experience does not reside fully formed outside of awareness; rather it exists as disparate pieces of information in different subsystems waiting to be completed, i. e. to be synthesized into a meaningful whole (Leventhal, 1979). Therapist techniques such as evocative responding, probing for schematic emotional memories, and heightening expressive motor behavior, may all contribute to facilitate the synthesis of new affective experience.

The clinical distinction between primary, secondary and instrumental aspects of emotion may have been a crucial element contributing to higher intimacy for EFT couples at follow-up (Johnson & Greenberg, 1987). As the ongoing clinical assessment of these emotions is made throughout the process of therapy, and expression of secondary and

instrumental emotions discouraged, the focus on primary emotions may have enhanced intimacy more efficiently than the indiscriminate suppression of affect as in CMT. This may be explained by referring to the social penetration model of personality (Altman & Taylor, 1973).

According to this model, the more central layers have a greater impact on the whole personality, and the deeper the layer the greater the probability that it represents a vulnerable zone, a more unique and idiosyncratic characteristic, and involves the total personality. It may be that primary emotions are more closely related to these core aspects than secondary or instrumental emotions. Creating a safe context to facilitate the synthesis of primary emotions would become a privileged access route to the innermost core of the person, thus giving the possibility of greater intimacy. Accessing the innermost core is both an intrapsychic and an interpersonal process. As spouses access primary emotion (intrapsychic) linked to the core aspects of self including needs and vulnerabilities, and as they do so in the presence of their partners (interpersonal), they are letting them in, giving greater access to themselves thus creating a closer bond.

Expression of Primary Emotion evokes Empathic Responsiveness

The disclosure of unacknowledged feelings by both partners may lower their need to protect and defend themselves thus reducing the phenomenological distance between them (Jourard, 1971). Accessing previously unacknowledged underlying emotions enables people to define themselves more clearly and to communicate their needs in more satisfying ways for them, i.e. in such a way as to evoke a meaningful response from the other. Primary affective responses are adaptive in nature and provide organisms with important feedback and action tendencies to help satisfy certain needs (Greenberg & Safran, 1989). Through the synthesis of subsidiary components such as expressive motor responses, schematic memories and tacit conceptual rules/beliefs, along with perception of the situation, clients allow into awareness an organization of experience which may have been previously regarded as unacceptable. Full acceptance of such feeling implies accepting the want or desire associated with it. Satisfaction is achieved when the action organized by the emotion can be expressed in some acceptable form.

The focus on facilitating new emotional synthesis may create new action tendencies and evoke new responses in both partners. For example, accessing and expressing a primary fear of abandonment underlying attacking critical behavior may help a spouse see him or herself differently, as

vulnerable or afraid, and lead to new behavior of seeking comfort. The observing spouse on the other hand, upon seeing the expressing spouse differently, may become less defensive and more willing to respond (Greenberg & Johnson, 1986a). This is consistent with L'Abate's conception of genotypic intimacy, the deepest level of intimacy, which involves the risk and vulnerability of sharing hurt feelings and fears (L'Abate & Sloan, 1984; Frey, Halley, & L'Abate, 1979).

It should be noted, however, that expressing primary feelings of hurt and vulnerability is not the same as using instrumental emotions in an attempt to purposefully manipulate another person's sympathy. The sharing of vulnerable feelings is not simply to create mutual sympathy, which would not be viewed as authentic intimacy, because with sympathy the individual boundaries are lost into a fusion type of relationship (Wynne et al., 1958). Rather, the genuine accessing and expressing of primary needs and feelings tends to elicit what may be seen as a natural human response, i.e. empathy (Amodeo & Amodeo, 1986). The difference may lie in the tacit intention of the individual expressing the emotion.

When genuine primary feelings and needs are accessed and expressed, they are first and foremost accessed and expressed for the individual's own sake and well-being and not with the deliberate intention of evoking a particular response in the other. It is, however, in the nature of

adaptive primary emotion to be intrinsically relational, connecting one to one's environment. But when such emotion is being synthesized, the focus is on a total involvement or engagement in a here and now process rather than on a predefined goal. This is the difference between crying to obtain sympathy and crying to express hurt, which may in turn help another to synthesize a genuine empathic response. The process described might best be seen as a genuine I-Thou encounter characterized by presence, directness, immediacy, and inclusion (letting the other in), as opposed to an I-It relationship, a manipulative response focusing only on one's egocentric expectations and definitions deliberately aimed at maneuvering another into a predetermined response (Buber, 1970). By accessing and expressing genuine primary emotion, one may truly give of oneself without imposing on someone else.

Emotional disclosure of this nature increases the quality of contact between partners and enables them to better empathize with each other (Moursund, 1985). The expression of primary emotion, therefore, may promote responsiveness and accessibility and enable couples to "engage" each other in a newly defined relationship where each partner relates to the other in ways which may promote the growth of intimacy.

Core Interpersonal Beliefs

A recurrent concept often used in the literature to

describe change in marital therapy has to do with interpersonal perception and core dysfunctional beliefs (Segraves, 1982; Greenberg & Johnson, 1988).

The aim of CMT is to help spouses uncover information that will disconfirm their personal constructs about marriage which prevent them from being more intimate. In EFT, couples are asked to directly engage in and disclose their underlying feelings and needs and to interact from these new positions. Core dysfunctional relationship beliefs are activated as immediate and lively felt operating principles and not as abstract intellectualized belief systems for therapeutic discussion (Greenberg & Johnson, 1988). The process of state dependent learning (Bower, 1981), suggests that cognitive constructs, such as interpersonal perceptions, are more accessible when the emotional state with which they are associated are aroused. Core dysfunctional beliefs related to important relationships such as "I can't trust anyone" or "Don't get close, you only get hurt", engineers the manner in which couples perceive and interact with each other. These core beliefs can be more easily accessed by evoking the feeling states of anger and helplessness which were originally linked to them, because emotional experience tends to dominate and override other cognitive and behavioral cues (Greenberg & Safran, 1987). Feeling afraid, for example, dominates and organizes our perceptual and creation of meaning processes and may steer us into

construing our partner as threatening.

Once the core belief is operating, the EFT therapist helps the partner to respond in a way that will disconfirm the belief. This happens immediately within the session, thus giving the couple the opportunity to experience each other differently and to change their way of relating to each other, to change the structure of their relationship.

As Weiss and Sampson (1986) pointed out, people, in their struggle toward adaptation, seek evidence to disprove their pathogenic beliefs when they perceive it is safe to do so. When a couple, within the safety of the therapy session, not only become aware of their dysfunctional beliefs, but actually experience their disconfirmation as their partner responds to their needs, then deeper intimacy and satisfaction would seem to follow and continue to grow as evidenced by the significant differences in gains between CMT and EFT at follow-up.

Change in Interactional Cycle

Accessing and expressing primary feelings and needs may increase awareness of and eventually change more general relationship processes which, when integrated into the the partner's experience of self and other as well as into new relationship patterns, results in significant positive increases in outcome scores.

A qualitative analysis of what couples reported in the CPSQ indicates that couples in the EFT group tended to talk

more in terms of cycles and patterns which suggests an awareness of the actual process of their relationship and the different positions the partners held with regards to contact with each other. In response to what led to a change one female partner in the EFT group reported : "Deep feelings and emotions surfaced. It has helped me focus on some of the walls that I put up." In response to the same question after the third session a male partner reported: "trying to clearly identify my own needs and then stating them simply and clearly." His spouse reported after the same session that "being aware of his feelings makes it easier for me to respond to his needs." Another female partner in another EFT couple reported that "he's afraid of being rejected and I'm not easily letting him in. I think we identified a situation which can be turned around and result in increased intimacy."

Although awareness of these processes may not have a differential effect on intimacy as compared to CMT at posttest, such awareness may have contributed to the EFT couples' greater intimacy scores at the follow-up period. Perhaps in CMT, couples gain better knowledge of why their relationship is the way it is, an intellectual understanding of its elements without changing the structure , which is akin to a first-order change (Watzlawick, Weakland, & Fisch, 1974). Couples in the EFT group on the other hand may have engaged in a more profound second-order change by engaging each other at an affective level thus restructuring their

intimate interactions.

Support for a second-order change may be found in an investigation of clients' perceptions of change processes in EFT which showed that the expression of new feelings created a change in how partners perceived and responded to each other thus restructuring the couple's interaction (James, 1985 in Greenberg & Johnson, 1988). It would seem that calmly talking about theories, thoughts, biographical data and past emotional experience is less likely to change interpersonal perceptions and interactions than would vividly experiencing primary emotions in the here and now. This is further supported by another study which found that couples in the last phase of conflict resolution reached higher levels of experiencing which they maintained over a number of interactional sequences while displaying trusting self-disclosure and empathic listening (Greenberg & Plysiuk, 1985). More research would be needed to investigate the nature of the change brought about by EFT and how this change relates to intimacy.

Limitations of this Study

A major issue in evaluating research is the extent to which findings may be generalized. The present section will examine the degree of resemblance of this study to the general clinical situation across such dimensions as target problem, population, manner of recruitment, therapists, selection and setting of treatment, variation of treatment,

and assessment methods (Kazdin, 1980).

Target Problem

The problem under investigation in this study concerned intimacy in the couple. Many clients present complaints directly related to issues of intimacy in the clinical situation. Subjects in this study were asked to identify a problematic event concerning intimacy to help focus the sessions. The target problem in this study therefore bears a moderate to relatively high resemblance to the clinical situation. An examination of the Target Concern questionnaire revealed that the concerns identified by the subjects were properly related to issues of intimacy.

Population

Subjects in this study were screened through a number of inclusion criteria leaving only relatively distress-free couples as participants. Distressed couples were screened out of the study in order to help isolate and impact the variable of intimacy within the relatively small number of sessions available. The fact that distressed couples were screened out may have increased the chances of accessing primary emotions. Distressed couples would presumably be caught in cycles of secondary feelings which would have to be worked through before getting at the primary emotions which are more likely to enhance intimacy.

The results of this study, therefore, may be

generalized only to couples who report that they are basically happy together. These couples are not representative of distressed clients who request marital therapy.

Manner of recruitment

The nature of the motivation of subjects responding to advertisements on free counselling sessions may be different from that of clients who are in pain and who request therapy. The respondees may act more out of free will and participate with interest and curiosity, whereas distressed couples may feel "obliged" by an urgent need and experience more anxiety. Nevertheless, volunteers responding to advertisements were likely to be at least interested in receiving treatment even though they might not have sought out treatment without the advertisement. This would seem to bear at least a moderate resemblance to the manner in which clients normally appear for treatment.

Therapists

Treatment interventions were implemented by a majority of doctoral clinical interns who may have had less training and less experience than professional therapists. The proponents of CMT claim that novice therapists learn quickly and often seem to be better at proper implementation of CMT than therapists originally experienced in another approach (Waring, 1988). This may not be the case for EFT. Some

research data suggests that novice therapists may have greater difficulty helping clients access primary emotions than more experienced therapists (Johnson & Greenberg, 1985; Johnson & Greenberg, 1985a). The use of more experienced therapists may have yielded somewhat different results such as differential effects between treatments at posttest.

On the therapist dimension, the present study yielded a degree of moderate resemblance to the clinical situation.

Selection and Setting of Treatment

Unlike clients in a clinical situation, subjects did not choose the particular type of treatment or therapist. However, the setting in which the treatment was conducted was very similar to the clinical setting, with the possible exception of audiorecordings of sessions.

Variation of Treatment

Contrary to a clinical situation where the therapist would adapt and alter the treatment to the individual's needs, the interventions made in the experimental setting were standardized across all individuals to meet specific needs of the research. This is considered to be of moderate resemblance to the clinical situation.

Assessment Methods

The utilisation of different instruments may have sensitized subjects to certain kinds of performance or

improvement that would not be in effect under usual clinical circumstances. This may also limit the generality of results to the clinical situation.

Suggestions for Future Research

Having demonstrated the effectiveness of EFT to enhance intimacy, future research should be conducted to examine in depth the processes of creating intimacy using emotionally focused interventions as well as the relationship between these processes and outcome. With the help of couples, peak moments of intimacy experienced within a session could be identified and intensively analyzed using task analytic methods (Greenberg, 1984). Peak moments of intimacy could be marked by using interpersonal process recall (IPR; Elliot, 1986) or by using third-party rating scales such as the experiencing scale (Klein, Mathieu, Gendlin, & Kiesler, 1969).

These peak moments could be defined as an interactional sequence containing certain process markers such as a certain depth of self-disclosure reciprocated by an empathic response. It would be expected, for example, that if a couple engage in deeper experiencing, and as feelings are more vividly, fully, and concretely presented (such as a level 5 or 6 on the experiencing scale), then this would be accompanied by greater empathic responsiveness which could be measured by the Carkhuff (1969) scale. Higher levels of self-disclosure and empathy within sessions would be

associated with higher outcome scores on intimacy.

A comprehensive process analysis (Elliot, 1984) procedure could also be used to help discover the processes involved in peak intimacy moments. This procedure involves the use of a battery of process measures applied to specific key events in the therapy session. Both quantitative and qualitative process analysis measures should be used. Phenomenological tools such as the IPR used by both couple and therapist, and rating measures such as the structural analyses of social behavior (SASB; Benjamin, Foster, Roberto, & Estroff, 1986) could be used on the same peak moments of intimacy, drawing on three points of view: couple, therapist, and observer. Such research would facilitate the building of a model of intimacy enhancement as well as help explain the role of emotion in the occurrence of intimacy, and specifically link in-session events to treatment outcomes.

REFERENCES

- Aiello, J., & Thompson, D. (1980). When compensation fail: Mediating effects of sex and locus of control and extended interaction distances. Basic and Applied Psychology, 1, 65-82.
- Ainsworth, M. D. S. (1972). Attachment and dependency: A comparison. In J. L. Gewirtz (Ed.), Attachment and dependency. Washington, D. C.: V. H. Winston.
- Ainsworth, M. D. S. (1979). Attachment as related to mother-infant interaction. In J. S. Rosenblatt, R. A. Hinde, C. Beer, & M. C. Busnel (Eds.), Advances in the study of behavior (vol. 9). New York: Academic Press.
- Altman, I. (1973). Reciprocity of interpersonal exchange. Journal for the Theory of Social Behavior, 3, 249-261.
- Altman, I., & Haythorn, W.W. (1965). Interpersonal exchange in isolation. Sociometry, 23, 411-426.
- Altman, I., & Taylor, D. A. (1973). Social penetration: The development of interpersonal relationships. New York: Holt, Rinehart & Winston.
- Amodeo, J., & Amodeo, K. (1986). Being intimate: A guide to successful relationships. New York: Arkana.
- Andrews, F. & Withey, S. (1976). Social indicators of well-being: Americans' perceptions of life quality. New York: Plenum.
- Angyal, A. (1965). Neurosis and treatment: A holistic theory. New York: John Wiley.
- Argyle, M., & Dean, J. (1965). Eye-contact, distance and affiliation. Sociometry, 28, 289-304.
- Battle, C.C., Imber, S.D., Hoehn-Saric, R., Stone, A.R., Nash, E.R., & Frank, J.D. (1966). Target complaints as criteria of improvement. American Journal of Psychotherapy, 20, 184-192.
- Beach, S. R. H., & Tesser, A. (1988). Love in marriage: A cognitive account. In R. J. Sternberg & M. L. Barnes (Eds.), The psychology of love (pp. 330-355). New Haven: Yale University Press.

- Benjamin, L., Foster, S., Roberto, L., & Estroff, S. (1986). Breaking the family code: Analysis of videotapes of family interactions by Structural Analysis of Social Behaviour (SASB). In L. Greenberg & W. Pinsof (Eds.), The psychotherapeutic process: A research handbook. New York: Guilford Press.
- Berman, E. M., & Lief, H. I. (1975). Marital therapy from a psychiatric perspective: An overview. American Journal of Psychiatry, 132, 583-592.
- Berne, E. (1961). Transactional Analysis in psychotherapy. New York: Ballantine Books.
- Bordin, E. S. (1979). The generalizeability of the psychoanalytic concept of the working alliance. Psychotherapy: Theory, Research and Practice, 16, 252-260.
- Bowen, M. (1975). Family therapy after twenty years. In S. Arieti (Ed.), American Handbook of Psychiatry, Volume 5, (pp. 367-392). New York: Basic Books.
- Bower, G.H. (1981). Mood and memory. American Psychologist, 31, 129-148.
- Bowlby, J. (1958). The nature of a child's tie to his mother. International Journal of Psychoanalysis, 39, 350-373.
- Bowlby, J. (1969). Attachment and loss. Vol. 1: Attachment. New York: Basic Books.
- Bowlby, J. (1973). Attachment and loss. Vol.2: Separation: Anxiety and anger. New York: Basic Books.
- Bowlby, J. (1977). The making and breaking of affectional bonds. British Journal of Psychiatry, 130, 201-210.
- Bowlby, J. (1984). Attachment and loss. Vol. 1: Attachment. (Second edition). Great Britain: Pelican Books.
- Brehm, S. S. (1985). Intimate relationships. New York: Random House.
- Briffault, R., & Malinowski, B. (1956). Marriage: Past and Present. Boston: Porter Sargent.
- Brock, G., & Joanning, H. (1983). A comparison of the relationship enhancement program and the Minnesota Couple Communication Program. Journal of Marital and Family Therapy, 9, 413-421.

- Broderick, C. (1981). A method for deviation of areas of assessment in marital relationships. The American Journal of Family Therapy, 9, 25-34.
- Brown, F. G. (1976). Principles of educational and psychological testing. New York: Holt, Rinehart & Winston.
- Brown, G. W., Bhorlchain, M. N., & Harris, T. (1975). Social class and psychiatric disturbance among women in an urban population. Sociology, 9, 225-254.
- Brown, G. W., Harris, T., & Copeland, J. R. (1977). Depression and loss. British Journal of Psychiatry, 30, 1-18.
- Brown, G. W., Harris, T. (1978). Social origins of depression. London: Tavistock Publications.
- Buber, M. (1970). I and Thou. (W. Kaufman, trans.) New York: Scribner's.
- Burgess, R. L. (1981). Relationships in marriage and the family. In S. Duck & R. Gilmour (eds.), Personal relationships. 1: Studying personal relationships. New York: Academic Press.
- Burke, R. J., Weir, T., & Duwors, Jr., R. E. (1979). Type A behavior in administrators and wives: Report of marital satisfaction and well-being. Journal of Applied Psychology, 64(1), 57-65.
- Campbell, A. (1981). The sense of well-being in America: Recent patterns and trends. New York: McGraw-Hill.
- Campbell, D. T., & Fiske, D. W. (1959). Convergent and discriminant validation by the multitrait-multimethod matrix. Psychological Bulletin, 56, 81-105.
- Campbell, D. T., & Stanley, J. C. (1963). Experimental and quasi-experimental designs for research and teaching. In N. L. Gage, (Ed.), Handbook of Research on Teaching. Chicago: Rand McNally.
- Carkhuff, R. R. (1969). Helping and human relations Vol. 2. New York: Holt, Rinehart and Winston.
- Chelune, G. J. (1978). Nature and assessment of self-disclosing behavior. In P. McReynolds (Ed.), Advances in psychological assessment (Vol. 4). San Francisco: Jossey-Bass.

- Chelune, G. J., Robison, J. T., & Kommer, M. J. (1984). A cognitive interactional model of intimate relationships. In V. Derlega (Ed.), Communication, intimacy, and close relationships (pp. 11-40). Toronto: Academic Press.
- Clark, M. S., & Fiske, S.T. (1982). Affect and cognition: The seventeenth annual Carnegie symposium on recognition. Hillsdale, N.J.: Lawrence Erlbaum Associates.
- Clark, M. S., & Mills, J. (1979). Interpersonal attraction in exchange and communal relationships. Journal of Personality and Social Psychology, 37, 12-24.
- Clinebell, H. J., & Clinebell, C. H. (1970). The intimate marriage. New York: Harper & Row.
- Cobb, S. (1976). Social support as a moderator of life stress. Psychosomatic Medicine, 38, 300-314.
- Cohen, J. V. (1977). Statistical power analysis for the behavioral sciences. New York: Academic Press.
- Costello, C. G. (1982). Social factors associated with depression: A retrospective community sample. Psychological Medicine, 12, 329-340.
- Coutts, L., & Schneider, F. (1976). Affiliative conflict theory: An investigation of the intimacy equilibrium and compensation hypothesis. Journal of Personality and Social Psychology, 34, 1135-1142.
- Cozby, P. C. (1973). Self-disclosure: A literature review. Psychological Bulletin, 79, 73-91.
- Dahms, A. M. (1972). Emotional intimacy: Overlooked requirement for survival. Boulder, Co.: Pruett.
- Derlega, V. J., & Chaikin, A. L. (1975). Sharing intimacy: What we reveal and why. Englewood Cliffs, N. J.: Prentice Hall.
- Diener, E. (1984). Subjective well-being. Psychological Bulletin, 95, 542-575.
- Dominion, J. (1979). Definition and extent of marital pathology. British Medical Journal, 2, 478-479.
- Ehrenberg, D. (1975). The quest for intimate relatedness. Contemporary Psychoanalysis, 10, 320-331.
- Ekman, P. (Ed.). (1972). Darwin and facial expressions: A century of research in review. New York: Academic Press.

- Ekman, P., & Friesen, W. V. (1975). Unmasking the face. Englewood Cliffs, N.J.: Prentice-Hall.
- Ekman, P., Friesen, W. V., & Ellsworth, P. (1972). Emotions in the human face. New York: Pergamon.
- Elliot, R. (1984). A discovery-oriented approach to significant change events in psychotherapy: Interpersonal process recall and comprehensive process analysis. In L. N. Rice & L. S. Greenberg (Eds.), Patterns of change: Intensive analysis of psychotherapy process. New York: Guilford Press.
- Elliot, R. (1986). Interpersonal process recall (IPR) as a psychotherapy process research method. In L. Greenberg & W. Pinsof (Eds.), The psychotherapeutic process: A research handbook. New York: Guilford Press.
- Epstein, S. (1983). A research paradigm for the study of personality and emotion. In M.M. Page (Ed.), Personality and current theory and research: 1982 Nebraska Symposium on Motivation. Lincoln: University of Nebraska Press.
- Erikson, E. H. (1963). Childhood and society (Rev. Ed.) New York: Norton.
- Erikson, E. H. (1968). Identity: Youth and crisis. New York: Norton.
- Erikson, E. H. (1980). Identity and the life cycle. (Rev. Ed.) New York: Norton.
- Erikson, E. H. (1982). The life cycle completed. New York: Norton.
- Fehr, B., & Perlman, D. (1985). The family as a social network and support system. In L. L'Abate (Ed.), Handbook of family psychology and therapy. Homewood, Illinois: Dow-Jones Irwin.
- Field, T., & Fogel, A. (1982). Emotion and early interaction. Hillsdale, N.J.: Lawrence Erlbaum Associates.
- Framo, J. L. (1972). Toward the differentiation of self in one's own family. In J. L. Framo, (Ed.), Family interaction: A dialogue between family researchers and family therapists. New York: Springer.
- Frankfurt, L. P. (1965). The role of some individual and interpersonal factors in the acquaintance process. Unpublished doctoral dissertation, The American University, Washington, D. C.

- Freedman, J. (1978). Happy people: What happiness is, who has it, and why. New York: Harcourt Brace Jovanovich.
- Frey, J., Halley, J., & L'Abate, L. (1979). Intimacy is sharing hurt feelings: A comparison of three conflict resolution models. Journal of Marital and Family Therapy, 5, 35-41.
- Fromm, E. (1955). The sane society. New York: Holt, Rinehart & Winston.
- Fromm, E. (1956). The art of loving. New York: Harper & Row.
- Gadlin, H. (1977). Private lives and public order: A critical view of the intimate relations in the United States. In G. Levinger & H. Raush (Eds), Close relationships: Perspectives in the meaning of intimacy (pp.33-72). Amherst: University of Massachusetts Press.
- Garland, D. S. R. (1983). Working with couples for marriage enrichment: A guide to developing, conducting, and evaluating programs. San Francisco: Jossey-Bass.
- Giblin, P., Sprenkle, D. H., & Sheehan, R. (1985). Enrichment outcome research: a meta-analysis of premarital, marital and family interventions. Journal of Marital and Family Therapy, 11, 257-271.
- Goldberg, H. (1976). The hazards of being male: Surviving the myth of masculine privilege. New York: Nash.
- Gordon, S., & Waldo, M. (1984). The effects of assertiveness training on couples' relationships. American Journal of Family Therapy, 12, 73-77.
- Gottman, J. M. (1979). Marital interactions: Experimental investigations. New York: Academic Press.
- Gove, W. (1973). Sex, marital status and mortality. American Journal of Sociology, 79, 45-67.
- Gove, W. R., Hughes, M. & Style, C. B. (1983). Does marriage have positive effects on the well-being of the individual? Journal of Health and Social Behavior, 24, 122-131.
- Gove, W, R. & Shin, H. C. (1989). The psychological well-being of divorced and widowed men and women: An empirical analysis. Journal of Family Issues, 10, 122-144.

- Gove, W. R., Style, C. B., & Hughes, M. (1990). The effect of marriage on the well-being of adults. Journal of Family Issues, 11, 4-35.
- Greene, G. J., & Kelley, P. (1985). Cognitive relationship enhancement: an exploratory study. Family Therapy, 12, 231-244.
- Greenberg, L. S. (1984). A task analysis of interpersonal conflict resolution. In L. N. Rice & L. S. Greenberg (Eds.), Patterns of change: Intensive analysis of psychotherapy process. New York: Guilford Press.
- Greenberg, L. S., & Johnson, S. M. (1986a). Affect in marital therapy. Journal of Marital and Family Therapy, 12, 1-10.
- Greenberg, L. S., & Johnson, S. M. (1986b). Emotionally focused couples therapy: An integrated affective systemic approach. In N. S. Jacobson & A.S. Gurman (Eds.), The clinical handbook of marital therapy. New York: Guilford Press.
- Greenberg, L. S. & Johnson, S. M. (1988). Emotionally focused therapy for couples. New York: Guilford Press.
- Greenberg, L. S. & Plysiuk, M. (1985). Towards task analysis of couples conflict resolution. Paper presented at American Family Therapy Association, San Diego, CA.
- Greenberg, L. S., & Safran, J. (1984a). Hot cognitions: Emotion coming in from the cold. A reply to Tachman & Mahoney. Cognitive Therapy and Research, 8, 591-598.
- Greenberg, L. S., & Safran, J. (1984b). Integrating affect and cognition: A perspective on therapeutic change. Cognitive Therapy and Research, 8, 559-578.
- Greenberg, L. S., & Safran, J. D. (1987). Emotions in psychotherapy: Affect, cognition, and the process of change. New York: Guilford Press.
- Greenberg, L. S., & Safran, J. D. (1989). Emotion in psychotherapy. American Psychologist, 44, 19-29.
- Grinker, R. R. (1967). Toward a unified theory of human behavior. (2nd edition). New York: Basic Books.
- Guerney, B.G. (1977). Relationship enhancement. San Francisco: Jossey-Bass.
- Gurin, G., Veroff, J., & Feld, S. (1960). Americans view their mental health: A nationwide interview survey. Joint Commission on Mental Illness and Health Monograph Series

4. New York: Basic Books.

- Gurman, A. S., & Kniskern, D. P. (1977). Enriching research on marital enrichment programs. Journal of Marriage and Family Counseling, 3, 3-11.
- Hames, J., & Waring, E. M. (1979). Marital intimacy and nonpsychotic emotional illness. The Psychiatric Forum, 9(1), 13-19.
- Harlow, H. F., & Zimmerman, R. R. (1953). Affectional responses in the infant monkey. Science, 130, 421-432.
- Hatfield, E. (1984). The dangers of intimacy. In V. J. Derlega (Ed.), Communication, intimacy and close relationships (pp. 207-220). Orlando, Florida: Academic Press.
- Hatfield, E. (1988). Passionate and companionate love. In R. J. Sternberg & M. L. Barnes (Eds.), The psychology of love (pp. 191-217). New Haven: Yale University Press.
- Hatfield, E., & Walster, G. W. (1981). A new look at love. Reading, MA: Addison-Wesley.
- Haynes, S. N., Chavez, R. E., & Samuel, V. (1984). Assessment of marital communication and distress. Behavioral Assessment, 6, 315-321.
- Henderson, S., Bryne, D. G., & Duncan-Jones, P. (1981). Neurosis and the social environment. London: Academic Press.
- Hendrick, S. S. (1981). Self-disclosure and marital satisfaction. Journal of Personality and Social Psychology, 40, 1150-1159.
- Hendrick, C., & Hendrick, S. (1983). Liking, loving, and relating. Monterey, CA: Brooks/Cole.
- Hinde, R. A. (1978). Interpersonal relationships: In quest of a science. Psychological Medicine, 3, 378-386.
- Hinde, R. A. (1979). Towards understanding relationships. New York: Academic Press.
- Hodgson, J. W., & Fischer, J. L. (1979). Sex differences in identity and intimacy development. Journal of Youth and Adolescence, 8, 37-50.
- Horowitz, L. M. (1979). Cognitive structure of interpersonal problems treated in psychotherapy. Journal of Consulting and Clinical Psychology, 47, 5-15.

- Huberty, C. J., & Morris, J. D. (1989). Multivariate analysis versus multiple univariate analyses. Psychological Bulletin, 105, 302-308.
- Izard, C.E. (Ed.). (1979). Emotion in personality and psychotherapy. New York: Plenum.
- Jacobs, T., & Charles, E. (1980). Life events and the occurrence of cancer in children. Psychosomatic Medicine, 42, 11-23.
- Jacobson, N. S. (1985). Uses versus abuses of observational measures. Behavioral Assessment, 7, 323-330.
- Johnson, S. M. (1986). Bonds or bargains: Relationship paradigms and their significance for marital therapy. Journal of Marriage and Family Therapy, 12, 259-267.
- Johnson, S. M., & Greenberg, L. S. (1985). The differential effects of experiential and problem solving interventions in resolving marital conflict. Journal of Consulting and Clinical Psychology, 53, 175-184.
- Johnson, S. M., & Greenberg, L. S. (1985a). Emotionally focused couples therapy: An outcome study. Journal of Marital and Family Therapy, 11, 313-317.
- Johnson, S. M., & Greenberg, L. S. (1987). Emotionally focused marital therapy. Psychotherapy, 24, 552-560.
- Jourard, S. M. (1971). The Transparent Self (Rev. ed.) New York: Van Nostrand Reinhold.
- Jourard, S. M., & Lasokow, D. (1958). Some factors in self-disclosure. Journal of Abnormal and Social Psychiatry, 56, 91-98.
- Jung, C. G. (1928). Contributions to analytical psychology. New York: Harcourt Brace.
- Kacerguis, M., & Adams, G. (1980). Erikson stage resolution: The relationship between identity and intimacy. Journal of Youth and Adolescence, 9, 117-126.
- Kazdin, A. E. (1980). Research design in clinical psychology. New York: Harper & Row.
- Kirk, R. E. (1968). Experimental design: procedures for the behavioral sciences. Belmont, Cal.: Brooks/Cole.
- Kelly, G. A. (1955). The psychology of personal constructs. New York: Norton.

- Klein, M., Mathieu, P., Gendlin, E., & Kiesler, D. (1969). The experiencing scale: A research and training manual. Madison: Wisconsin Psychiatric Institute.
- Knudson, R. M., Sommers, A. A., & Golding, S. L. (1980). Interpersonal perception and mode of resolution in marital conflict. Journal of Personality and Social Psychology, 38, 751-763.
- L'Abate, L. (1985). The status and future of family psychology and therapy. In L'Abate (Ed.), The handbook of family psychology and therapy. Homewood, Illinois: Dorsey Press.
- L'Abate, L. (1964). Principles of clinical psychology. New York: Grune & Stratton.
- L'Abate, L., & Laird, D. Toward an operational interpretation of being. Unpublished manuscript.
- L'Abate, L., & Sloan, S. (1984). A workshop format to facilitate intimacy in married couples. Family Relations, 33, 245-250.
- Larzelere, R. E., & Huston, T. L. (1980). The dyadic trust scale: Toward understanding interpersonal trust in close relationships. Journal of Marriage and the Family, Aug, 595-604.
- Leventhal, H. (1979). A perceptual motor processing model of emotion. In P. Pliner, K. R. Blankstein and I. M. Spigel (Eds.), Advances in the Study of Communication and Affect, Vol. 5. Perception of Emotions in Self and Others. New York: Plenum Press
- Levinger, G., & Raush, H. L. (1977). Close relationships: Perspectives on the meaning of intimacy. Amherst: University of Massachusetts Press.
- Levinger, G., & Senn, D. J. (1967). Disclosure of feelings in marriage. Merrill Palmer Quaterly, 13, 237-249.
- Lobdell, J., & Perlman, D. (1985). The intergenerational transmission of loneliness: A study of college females and their parents. Unpublished manuscript, University of British Columbia, Division of Family Science, Vancouver, Canada.
- Lowenthal, M. F., & Haven, C. (1968). Interaction and adaptation: Intimacy as a critical variable. American Sociological Review, 33, 20-30.

- Lowenthal, M. F., & Weiss, L. (1976). Intimacy and crises in adulthood. The Counseling Psychologist, 6, 88-94.
- Lynch, J. (1977). The broken heart. N.Y.: Basic Books.
- Mace, D., & Mace, V. (1976). Marriage enrichment: A preventive group approach for couples. In D. H. Olson (Ed.), Treating relationships. Lake Mills, Iowa: Graphic Publishing.
- Marcia, J. (1976). Identity six years after: A follow-up study. Journal of Youth and Adolescence, 5, 146-160.
- Margolin, G. (1978). Relationships among marital assessment procedures: A correlational study. Journal of Consulting and Clinical Psychology, 46, 1556-1558.
- Margolin, G. (1982). A social learning approach to intimacy. In M. Fisher & G. Stricker (Eds.), Intimacy (pp. 175-201). New York: Plenum.
- Margolin, G. & Wampold, B. E. (1981). Sequential analysis of conflict and accord in distressed and nondistressed marital partners. Journal of Consulting and Clinical Psychology, 49, 554-557.
- Maslow, A. (1970). Motivation and personality (2nd ed.). New York: Harper & Row.
- Matteson, D. R. (1975). Adolescence today: Sex roles and the search for identity. Homewood, Ill.: Dorsey Press.
- Maxwell, G. M. (1985). Behavior of lovers: Measuring closeness of relationships. Journal of Social and Personal Relationships, 2, 215-238.
- Medalie, J. H., & Goldbourt, U. (1976). Angina pectoris among 10,000 men. American Journal of Medicine, 60, 910-921.
- Milardo, R. M., & Murstein, B. I. (1979). The implications of exchange orientation on the dyadic functioning of heterosexual cohabitation. In M. Cook & G. Wilson (Eds.), Love and attraction. Oxford: Pergamon Press.
- Miller, R. S. & Lefcourt, H. M. (1982). The assessment of intimacy. Journal of Personality Assessment, 46, 514-518.
- Miller, S., Nunnally, E. W., & Wackman, D. B. (1976). Minnesota Couples Communication Program (MCCP): Premarital and marital groups. In D. H. Olson (Ed.), Treating relationships. Lake Mills, Iowa: Graphic Publishing.

- Mills, J., & Clark, M. S. (1982). Exchange and communal relationships. In L. Wheeler (Ed.), Review of personality and social psychology, Vol. 3, (pp. 121- 144). Beverly Hills, Ca: Sage publications.
- Mitchell, R. E., & Trickett, E. J. (1980). Social networks as mediators of social support: An analysis of the effects and determinants of social networks. Community Mental Health Journal, 16, 27-45.
- Morris, D. (1971). Intimate behavior. New York: Random House.
- Moursund, J. (1985). Contact, intimacy, and need. Transactional Analysis Journal, 15, 116-119.
- Murstein, B. I. (1974). Love, sex, and marriage through the ages. New York: Springer.
- Murstein, B. I., Cerreto, M., & MacDonald, M. G. (1977). A theory and investigation of the effect of exchange-orientation on marriage and friendship. Journal of Marriage and the Family, 39, 543-548.
- Orlofsky, J., Marcia, J., & Lesser, I. (1973). Ego identity status and the intimacy versus isolation crises of young adulthood. Journal of Personality and Social Psychology, 27, 211-219.
- Pattison, E. M. (1977). A theoretical-empirical base for social system therapy. In E. F. Feulks, R. M. Wintrob, J. Westenmayer, & A. R. Favazza (Eds.), Current Perspective in culture and psychiatry. New York: Spectrum.
- Perlman, D., Fehr, B. & Duck, S. (in press). The development of intimate relationships. In S. Duck & D. Perlman (Eds.), Intimate relationships: Development, dynamics and deterioration. Beverly Hills, California: Sage.
- Perlmutter, M. S., & Hatfield, E. (1980). Intimacy, intentional metacommunication and second order change. American Journal of the Family, 8, 17-23.
- Perls, F., Hefferline, R., & Goodman, P. (1951). Gestalt therapy. New York: Julian Press.
- Pervin, L. A. (1983). The stasis and flow of behaviour: Toward a theory of goals. In M.M. Page (Ed.), Personality current theory and research: (1982) Nebraska Symposium on Motivation. Lincoln: University of Nebraska Press.
- Pinsof, W. M. & Catherall, D. R. (1986). The integrative psychotherapy alliance: Family, couple and individual

- therapy scales. Journal of Marital and Family Therapy, 12, 137-151.
- Rappaport, A. F. (1976). Conjugal relationship enhancement program. In D. H. Olson (Ed.), Treating relationships. Lake Mills, Iowa: Graphic Publishing.
- Rapoport, R., & Rapoport, R. (1964). New light on the honeymoon. Human Relations, 17, (1).
- Reis, H. T. (1984). Social interaction and well-being. In S. Duck (Ed.), Personal relationships 5: Repairing personal relationships (pp. 21-45). London: Academic Press.
- Rice, L. (1974). The evocative function of the therapist. In D. Wexler & L. Rice (Eds.), Innovations in client-centered therapy. Wiley Interscience.
- Rice, L., & Saperia, E. P. (1984). Task analysis of the resolution of problematic reactions. In L. Rice & L. Greenberg (Eds.), Patterns of change: Intensive analysis of psychotherapy process. New York: Guildford Press.
- Rogers, C. R. (1951). Client-Centered Therapy. Boston: Houghton Mifflin.
- Rogers, C. R. (1959). A theory of therapy, personality, and interpersonal relationships, as developed in the client-centered framework. In S. Koch (Ed.), Psychology: A study of a science, Vol. 3, (pp. 184-256). New York: McGraw-Hill.
- Rogers, C. (1972). Becoming partners: Marriage and its alternatives. New York: Dell Publishing Co.
- Ross, E. R., Baker, S. B., & Guerney, B. J. (1985). Effectiveness of relationship enhancement therapy versus therapist's preferred therapy. The American Journal of Family Therapy, 13, 11-21.
- Roy, A. (1981). Vulnerability factors and depression in men. British Journal of Psychiatry, 138, 75-77.
- Rubenstein, C., & Shaver, P. (1982). The experience of loneliness. In L.A. Peplau & D. Perlman (Eds.), Loneliness: A sourcebook of current theory research, and therapy. New York: Wiley Interscience.
- Rubin, Z. (1973). Liking and loving: An invitation to social psychology. New York: Holt, Rinehart, & Winston.

- Rubin, Z., Hill, C. T., Peplau, L. A., & Dunkel-Schetter, C. (1980). Self-disclosure in dating couples: Sex roles and the ethic of openness. Journal of Marriage and the Family, 42, 305-317.
- Russell, C. S., Bagarozzi, D. A., Atilano, R. B., & Morris, J. E. (1984). A comparison of two approaches to marital enrichment and conjugal skills training: Minnesota Couples Communication Program and Structured Behavioral Exchange Contracting. The American Journal of Family Therapy, 12, 13-25.
- Russell, D., Peplau, L. A., & Ferguson, L. A. (1978). Developing a measure of loneliness. Journal of Personality Assessment, 42, 290-294.
- Russell, A., & Russell, L. (1980). Brief structured family therapy. In L. R. Wolberg & M. L. Aronson (Eds.), Group and Family Therapy 1980. New York: Brunner/Mazel.
- Russell, A., Russell, L., & Waring, E. M. (1980). Cognitive family therapy. Canadian Journal of Psychiatry, 25, 64-67.
- Sager, C. G., Gundlach, R., Kremer, M., Lenz, R., & Royce J. R. (1968). The married in treatment. Archives of General Psychiatry, 19, 205-217.
- Satir, V. (1967). Conjoint Family Therapy. Palo Alto, Ca.: Science and Behavior Books.
- Schaefer, M. T., & Olson, D. H. (1981). Assessing intimacy: The Pair inventory. Journal of Marital and Family Therapy, Jan, 47-60.
- Segraves, R. T. (1982). Marital therapy: A combined psychodynamic-behavioral approach. New York: Plenum.
- Seligman, C., Fazio, R. H., & Zanna, M. P. (1980). Effects of salience of extrinsic rewards on liking and loving. Journal of Personality and Social Psychology, 38, 453-460.
- Sexton, R. E., & Sexton, V. S. (1982). Intimacy: A historical perspective. In M. Fisher & G. Stricker (Eds.), Intimacy (pp. 1-20). New York: Plenum Press.
- Shaver, P., Hazan, C., & Bradshaw, D. (1988). Love as attachment: The integration of three behavioral systems. In R. J. Sternberg & M. L. Barnes (Eds.), The psychology of love. New Haven: Yale University Press.

- Skolnick, A. (1978). The intimate environment: Exploring marriage and the family. (2nd ed.). Boston: Little, Brown.
- Slater, P. E. (1968). Some social consequences of temporary systems. In W. G. Bennes & P. E. Slater (Eds.), The Temporary Society. New York: Harper & Row.
- Sloan, S. (1984). Assessing the differential effectiveness of two enrichment formats in facilitating marital intimacy and adjustment. Dissertation Abstracts International, 44, 2569B. (University Microfilms No. DA8327354).
- Sluzki, C. (1978). Marital therapy from a systems theory perspective. In T. Paolino, & B. McCrady (Eds.) Marriage & Marital Therapy. New York: Brunner/Mazel.
- Soloman, Z. & Bromet, E. (1982). The role of social factors in affective disorder: An assessment of the vulnerability model of Brown and his colleagues. Psychological Medicine, 12, 123-130.
- Snyder, D. K., Trull, T. J., & Wills, R. M. (1987). Convergent validity of observation and self-report measures of marital interaction. Journal of Sex and Marital Therapy, 13, 224-236.
- Spanier, G. (1976). Measuring dyadic adjustment. Journal of Marriage and the Family, 38, 15-28.
- Speck, R. V. & Rueveni, U. (1969). Network therapy: A developing concept. Family Process, 8, 182-191.
- Spitz, R. A. (1949). The role of ecological factors in emotional development in infancy. Child development, 20, 145-155.
- Stauffer, J.R. (1987). Marital intimacy: Roadblocks and therapeutic interventions. Family Therapy, 14, 179-185.
- Steck, L., Levitan, D., McLane, D., & Kelley, H. H. (1982). Care, need, and conceptions of love. Journal of Personality and Social Psychology, 43, 481-491.
- Sternberg, R. J. (1988). Triangulating love. In R. J. Sternberg & M. L. Barnes (Eds.), The psychology of love. New Haven: Yale University Press.
- Sternberg, R. J. (1986). A triangular theory of love. Psychological Review, 93, 119-135.

- Sullivan, H. S. (1953). The interpersonal theory of psychiatry. New York: Norton.
- Swenson, C. H. (1973). Scales of feelings and behavior of love. In J. E. Jones & J. W. Pfeiffer (Eds.), The 1973 annual handbook for group facilitators (pp. 71-85). La Jolla, Ca.: University Associates.
- Tabachnick, B. J., & Fidell, L. S. (1989). Using multivariate statistics. New York: Harper & Row
- Taylor, D. A. (1968). The development of interpersonal relationships: Social penetration processes. The Journal of Social Psychology, 75, 79-90.
- Thibaut, J. W., & Kelley, H. H. (1959). The social psychology of groups. New York: Wiley.
- Toffler, A. (1979). Future shock. New York: Random House.
- Tolstedt, B. E., & Stokes, J. P. (1983). Relation of verbal, affective, and physical intimacy to marital satisfaction. Journal of Counseling Psychology, 30(4), 573-580.
- Tolstedt, B. E., & Stokes, J. P. (1984). Self-disclosure, intimacy, and the depenetration process. Journal of Personality and Social Psychology, 46, 84-90.
- Veroff, J., Douvan, E., & Kulka, R. A. (1981). The inner American. New York: Basic Books.
- Walster, E., & Walster, G. W. (1978). A new look at love. Reading, Mass.: Addison-Wesley.
- Walster, E., Walster, G. W., & Berscheid, E. (1978). Equity: Theory and research. Boston, MA: Allyn & Bacon.
- Waring, E. M. (1981). Facilitating marital intimacy through self-disclosure. American Journal of Family Therapy, 9, 33-42.
- Waring, E. M. (1984). The measurement of marital intimacy. Journal of Marital and Family Therapy, 10, 185-192.
- Waring, E. M. (1988). Enhancing marital intimacy through cognitive self-disclosure. New York: Brunner/Mazel.
- Waring, E. M., & Chelune, G. J. (1983). Marital intimacy and self-disclosure. Journal of Clinical Psychology, 39, 183-190.

- Waring, E. M., McElrath, D., Mitchell, P., & Derry, M. E. (1981). Intimacy and emotional illness in the general population. Canadian Journal of Psychiatry, 26, 167-172.
- Waring, E. M., & Patton, D. (1984). Marital intimacy and depression. British Journal of Psychiatry, 145, 641-644.
- Waring, E. M., Patton, D., Neron, C. A., & Linker, W. (1986). Types of marital intimacy and prevalence of emotional illness. Canadian Journal of Psychiatry, 31, 720-726.
- Waring, E. M., & Reddon, J. R. (1983). The measurement of intimacy in marriage: The Waring Intimacy Questionnaire. Journal of Clinical Psychology, 39, 53-57.
- Waring, E. M., & Russell, L. (1980). Cognitive family therapy. Journal of Sex & Marital Therapy, 6, 258-273.
- Waring, E. M., Tillmann, M. P., Frelick, L., Russell, L., & Weisz, G. (1980). Concepts of intimacy in the general population. Journal of Nervous and Mental Disease, 168, 471-474.
- Watzlawick, P., Beavin, J. H., & Jackson, D. D. (1967). Pragmatics of human communication: A study of interactional patterns, pathologies, and paradoxes. New York: Norton.
- Watzlawick, B., Weakland, J. H., & Fisch, R. (1974). Change: Principles of problem formation and problem resolution. New York: W. W. Norton & Co.
- Weiss, J., & Sampson, H. (1986). The psychoanalytic process. New York: Guilford Press.
- Weiss, L., & Lowenthal, M. (1975). Life-course perspectives on friendship. In M. Lowenthal, M. Thurnher, D. Chiriboga, & Associates (Eds.), Four stages of life: A comparative study of women and men facing transitions. San Francisco: Jossey-Bass.
- Weiss, R. S. (1974). The provisions of social relationships. In Z. Rubin (Ed.), Doing unto others (pp. 17-26). England Cliffs, N.J.: Prentice Hall.
- Weiss, R. S. (1982). Attachment in adult life. In C. M. Parkes & J. Stevenson-Hinde (Eds.), The place of attachment in human behavior. New York: Basic Books (pp. 171-184).

- Weissman, M. M. & Paykel, E. K. (1974). The depressed woman: The study of social relationships. Chicago: Chicago Press.
- Wiggins, J. S. (1979). A psychological taxonomy of trait-descriptive terms: The interpersonal domain. Journal of Personality and Social Psychology, 37, 395-412.
- Willi, J. (1982). Couples in collusion. New York: Jason Aronson.
- Wilner, W. (1975). The nature of intimacy. Contemporary Psychoanalysis, 11, 206-226.
- Wilner, W. (1982). Philosophical approaches to interpersonal intimacy. In M. Fisher & G. Stricker (Eds.), Intimacy (pp. 21-38). New York: Plenum Press.
- Wynne, L. C., Ryckoff, I., Day, D., & Hirsch, S. (1958). Pseudo-mutuality in the family relations of schizophrenics. Psychiatry, 21, 205-220.
- Wynne, L. C., & Wynne, A. R. (1986). The quest for intimacy. Journal of Marital and Family Therapy, 12, 383-394.
- Zajonc, R. B. (1980). Feeling and thinking: Preferences need no inferences. American Psychologist, 35, 151-175.
- Zuk, G. H, & Boszormenyi-Nagy, I. (1967). Family Therapy and Disturbed families. Palo Alto: Science and Behavior Books.

APPENDIX A

(Intervention manuals and implementation checklists)

Cognitive Marital Therapy Intervention Manual

This intervention is an explication of Cognitive Marital Therapy described in Waring & Russell (1980). The main goal of this intervention is to facilitate cognitive self-disclosure of one's thoughts, ideas, opinions, theories on a problematic reaction concerning intimacy.

Timetable - Sequence

Session 1.

Establish rapport. Take a short history of attraction, dating and courtship and family life cycle (cf. Waring's paper on marital assessment). Get background information concerning parents' marriages. Assess current functioning in different areas of intimacy (cf. paper on assessment). Give rationale of approach to couple (see "Rationale"). Explain and obtain agreement on ground rules to be followed throughout every session (see "Process and technique"). Elicit problematic reaction or event (see "Eliciting problematic reactions" below). Brief exploration of each spouse's cognitive theories of why the problem has developed.

Sessions 2 to 5.

Facilitate disclosure and exploration of each partner's theories, thoughts, opinions, ideas about the relationship. This is done using two basic questions (or variations

thereof):

1) What are your ideas or theories on ... (any particular aspect of the relationship)?

and

2) What were you thinking about while your partner was talking?

The therapist also uses any non-directive facilitative responses to encourage disclosure of thoughts, i.e. "Tell me more..." or "I'm interested in that..."

See "process and technique" for details.

Session 6.

Ask each partner to summarize what he/she has learned about themselves and their relationship. Ask for each partner's subjective opinion about what in the sessions has led to improvement. Ask for theories on why the problematic event might appear again in the future.

N.B. For all sessions, the therapist makes notes at the end of each session, writing down the major "why" question the couple is trying to understand.

Each session begins with the major "why" question of the previous session (even if they had a fight during the week -- they may use this as a diversion). The therapist must keep the focus on a continuing line of understanding.

Rationale (Given to the couple)

We are here to understand what gets in your way of feeling closer to each other. We will particularly focus on your theories, thoughts, ideas about why you are unable to achieve greater intimacy. I am going to ask you different "why" questions that will help elicit your own theories about why certain problematic events recur in your relationship. I will especially focus on your parents' marriage and elicit your ideas on how their relationship may be influencing your own. The end result of this process is that couples gain a better understanding of their relationship in terms of their own upbringing and background. This greater understanding helps couples to talk about never before discussed family issues and thus achieve a closer more satisfying relationship.

Eliciting problematic reactions

In every intimate relationship partners at times experience problems getting close and feeling intimate with one another.

Would you please take a moment to think about your relationship, particularly issues around closeness and intimacy and any problems that you may think occur in this area.

Maybe, you could tell me the kind of things that occur when one of you, or perhaps both of you, try to get close.

What kinds of things prevent you from getting close?

Take a moment to go over the past week or so and see if there aren't any incidents where this issue came up for you.

(At the end of the first session, the therapist may invite the couple to be attentive to this issue in the upcoming week.)

It may be a reaction or event that feels "loaded" to you, that is troublesome to both of you and which doesn't seem to make any sense, but it keeps happening anyway. And it leaves you with negative feelings or behaviors such as sulking, withdrawing, slamming the door, name calling, arguing, spiting, etc. It may be some kind of vicious circle or familiar argument that you keep getting yourselves locked into.

Some examples are:

Wife: When I begin to talk about how I feel, you become very logical, and try to find solutions, ways to resolve that feeling and I don't respond to that. You try to change the subject, so I can't get close.

Husband: Well, that's the way I am. I try to help by taking a problem-solving approach.

He: I feel like I'm living with a stranger. We each do our own thing. We never really talk. I want to know what's going on inside you. We need to communicate better.

She: Why can't you just accept me for what I am? I like to just sit and relax in the same room with you. But you talk constantly, you always want to know what I'm thinking.

She: I hate it when you laugh after we've been embracing a few seconds. Feels like you're trying to distance yourself from me.

He: I can't help it. I just feel happy and I want to laugh.

Wife: I wish you would take more time off work to be with me and relax.

Husband: I'd love to, but you have to understand how important this next promotion is to me.

Process and technique

1. After the intimacy problematic reaction event has been properly defined and agreed upon by both partners, the therapist begins by telling the couple, "We are here to understand why you are not close."

2. The therapist explains the ground rules to the couple: "I will ask you questions about your ideas, beliefs, theories concerning your relationship. You will not be allowed to talk to each other, or to interrupt or cause confusion while the other is talking. Any 'acting up' within the session will be stopped lest the session be discontinued. Do you agree to these rules?"

N.B. When a couple break the rules, it signals issues that they don't want to deal with. Affect (tears, anger) can be used to stop listening and to create a diversion.

3. Once the couple have agreed to the ground rules, the therapist tries to elicit each partner's "theory" of why the intimacy problematic event has appeared. He may let it up to the couple to decide who will go first, or he may arbitrarily ask one partner to start first. The therapist must not shy away from taking control of the interview.

4. The therapist asks only "why" or "theory" questions and avoids and suppresses affective interchange, and/or behavioral interpretation, or confrontation. No feeling or behavior is accessed confronted or interpreted.

5. The therapist encourages each partner to talk about oneself and to say "I think, I am, my family ..." and

discourages them from talking about the other.

6. During the session, there is a direct prohibition of the couple talking to each other. Each partner may talk only to the therapist in an alternate fashion.

7. The couple alternates in disclosing any biographical data that they may judge to be relevant to answering the "why" question. They are encouraged to talk about their ideas, beliefs and theories regarding how their parents' couple relationship may have influenced their own. The therapist facilitates cognitive self-disclosure but without attempting to restructure the couple's cognitions.

8. When one partner cannot answer the "why" question, or has finished answering, the therapist in a standardized manner asks the other partner, "What were you thinking while your partner was talking?" This is to facilitate cognitive self-disclosure. The therapist may also ask for one partner's theory on the question the other partner cannot answer.

9. When the couple seem blocked by a particular "why" question and are unable to come up with theories, the therapist invites them to speculate about general explanations they might consider for couples with similar problems. The therapist may also call upon the couple's natural curiosity and general knowledge obtained from different readings, films, novels, etc. that may help explain human behavior. Ex. "In general, why are people like that?"

10. When the client has no theory, the therapist may also share his or her cognitive theories, but must be careful to avoid interpretation or cognitive restructuring. For example, the therapist may offer a possible theory to trigger the partners' thinking such as "Often one of the reasons a married man has an affair is because he feels bored at home. What would your ideas be on that?" or "In the general population people think that people drink because they are unhappy. What do you believe?" The idea is to offer possible theories to stimulate client's thinking.

11. When one partner has a tendency to blame the other, the therapist defuses the blaming pattern by eliciting the blamer's theory of how he/she was attracted to and got involved with such a person. The therapist may simply ask "How did you manage to pick such a ("stubborn", "dislikable", etc.) person?" This may also be a good time to explore any similarities perceived by the blamer between the partner and one or both of his/her own parent(s).

12. When the couple understand a particular "why" question a more sophisticated "why" question becomes apparent. The therapist therefore moves on to more refined "why" questions as new information is revealed.

13. No specific change is aimed at within the session, nor is it explicitly intended to make the unconscious conscious. The only goal is to facilitate cognitive self-disclosure of one's thoughts, ideas, opinions, theories about the

relationship. This is done using two basic questions (or variations thereof): What are your ideas or theories on ... (any particular aspect of the relationship)? and What were you thinking about while your partner was talking?

Additional process notes

Actual causes are not that important. The important thing is to stimulate, facilitate cognitive self-disclosure.

Client: I wasn't thinking, I was just listening.

Therapist: What did you hear that might get you to thinking?

Defuse blaming by stopping it with authority.

Use clarification to find out what exactly is being described or talked about. This is to help keep the focus.

Redirection may be used to keep the focus: "You gave me an answer to that, but what about this..." Redirect them to a stimulus that will trigger their thinking: "What about other people in general? next door neighbors, friends, T.V. shows, books you've read..."

Take what is happening in the present and take it back to the past, to their parents' relationship.

Reading material

1. Waring, E. M., & Russell, L. (1980). Cognitive family therapy. Journal of Sex & Marital Therapy, 6, 258-273.
2. Waring's manuscript on marital assessment.
3. Russell, A., Russell, L., & Waring, E. M. (1980). Cognitive family therapy: A preliminary report. Canadian Journal of Psychiatry, 25, 64-67.
4. Waring, E. M. (1981). Facilitating marital intimacy through self-disclosure. American Journal of Family Therapy, 9, 33-42.
5. Waring, E. M. (1988). Enhancing marital intimacy through facilitating Self-disclosure. New York: Brunner/Mazel. Chapter 4 "The technique", pp.97-147.

Emotionally Focused Therapy Intervention Manual

This intervention is essentially a shortened version of emotionally focused marital therapy which focuses on intimacy and problematic responses concerning intimacy.

Timetable - Sequence

Session 1

Make an alliance. Take a short relationship history. Assess interaction patterns and positions. Hypothesize re underlying vulnerabilities, blocks to intimacy.

Give rationale of approach to couple (see "Rationale"). Elicit problematic event, pattern (see "Eliciting problematic reactions" below). Frame cycle, stress mutual responsibility.

Sessions 2 to 5

Explore underlying feelings re: problematic events. Identify with disowned aspects of self. Communicate those aspects to spouse.

Session 6

Help couples to express needs and wants. Enact new cycle. Contrast new and old cycles. Summarize learning. Help couple plan to maintain new closeness.

N.B. Each session focusses on the problematic event and

responses. Begin each session by summarizing the session before. Prepare for the session by noting potent quotes from the past session and apparent next steps.

The goal of this intervention is then to reprocess a key event re intimacy and by this reprocessing to evoke acceptance and responsiveness.

Rationale (Given to the couple)

During these sessions, we are going to look at what happens between the two of you that gets in the way of feeling closer. How you interact at special times when there is a chance for closeness. We will especially focus on emotional responses that occur, that might get in the way of closeness, and we will look at where you get stuck with each other, what happens for each of you at that point that derails the process of becoming closer. So I am going to be focusing on typical patterns and incidents in your relationship and asking you to explore your emotional responses as we look at those incidents. The end result of this process is that couples become more open to each other, see each other more clearly and learn to respond to each other in a way that evokes a sense of safety and sharing.

Eliciting problematic reactions

In every intimate relationship partners at times experience problems getting close and feeling intimate with one another.

Would you please take a moment to think about your relationship, particularly issues around closeness and intimacy and any problems that you may think occur in this area.

Maybe, you could tell me the kind of things that occur when one of you, or perhaps both of you, try to get close. What kinds of things prevent you from getting close?

Take a moment to go over the past week or so and see if there aren't any incidents where this issue came up for you. (At the end of the first session, the therapist may invite the couple to be attentive to this issue in the upcoming week.)

It may be a reaction or event that feels "loaded" to you, that is troublesome to both of you and which doesn't seem to make any sense, but it keeps happening anyway. And it leaves you with negative feelings or behaviors such as sulking, withdrawing, slamming the door, name calling, arguing, spiting, etc. It may be some kind of vicious circle or familiar argument that you keep getting yourselves locked into.

Some examples are:

Wife: When I begin to talk about how I feel, you become very logical, and try to find solutions, ways to resolve that

feeling and I don't respond to that. You try to change the subject, so I can't get close.

Husband: Well, that's the way I am. I try to help by taking a problem-solving approach.

He: I feel like I'm living with a stranger. We each do our own thing. We never really talk. I want to know what's going on inside you. We need to communicate better.

She: Why can't you just accept me for what I am? I like to just sit and relax in the same room with you. But you talk constantly, you always want to know what I'm thinking.

She: I hate it when you laugh after we've been embracing a few seconds. Feels like you're trying to distance yourself from me.

He: I can't help it. I just feel happy and I want to laugh.

Wife: I wish you would take more time off work to be with me and relax.

Husband: I'd love to, but you have to understand how important this next promotion is to me.

The therapist clarifies that both recognize this event and clarifies how it is viewed as a block to intimacy. The therapist validates and expands upon each person's response.

This expansion includes the use of heightening, evocative responding, etc. The goal is to reprocess this event and structure a new event based on the results of this reprocessing.

Process and technique

After the intimacy problematic reaction point has been properly defined and agreed upon by both partners, the therapist begins by trying to get a vivid feel for the scene in order to increase the immediacy with which the client experiences the scene. The therapist attempts to grasp what the incident is like for each partner as concretely as possible and to bring it alive again by focussing on the particulars, on patterns, sequences of behavior, and by being specific and explicit. The therapist then expands upon the positions-responses of the couple, in the event, in terms of the responses they evoke in each other and the experience underlying each response. the therapist validates each partner's experience.

In sessions 2 to 5, the therapist basically implements steps 3 to 7 (chap. 5, Greenberg & Johnson, 1988) of emotionally-focussed therapy, except that the focus is on a particular problematic event and intimacy issue.

In session 6, the therapist implements steps 7 to 9 (chap. 5, Greenberg & Johnson, 1988) of emotionally-focussed therapy. Summarizing the process of treatment and the progress made and facilitating a metaview of the relationship and the intimacy process. The therapist can also help the couple maintain the progress achieved in terms of how to avoid the problematic event in the future and in terms of how to plan general facilitators of intimacy, for

example, time spent together.

The techniques that are employed to implement these treatment strategies are found in chapter 6 of Greenberg & Johnson, 1988.

Additional Process Note

The couples are encouraged to interact with each other in the sessions and to share their underlying feelings as they emerge in the session in reaction to their partners. There is a strong focus on what is occurring in the present between the partners. These feelings are explored fully, both in terms of their personal meanings and their meanings of the partner. The therapist must be seen as equally accepting of the realities of both partners and legitimizing the responses of each partner within the context of the relationship, by placing seemingly unacceptable behaviors in the context of universal human needs.

Reading material

1. Greenberg, L. S. & Johnson, S. M. (1986). Emotionally focused couples therapy: An integrated affective systemic approach. In N. S. Jacobson & A.S. Gurman (Eds.), The clinical handbook of marital therapy. New York: Guilford Press.
2. Rice, L. (1974). The evocative function of the therapist. In D. Wexler & L. Rice (Eds.), Innovations in client

centered therapy. Wiley Interscience.

3. Rice, L., & Saperia, E. P. (1984). Task analysis of the resolution of problematic reactions. In L. Rice & L. Greenberg (Eds.), Patterns of change: Intensive analysis of psychotherapy process. New York: Guildford Press.
4. Greenberg, L. S., & Johnson, S. M. (1988). Emotionally focused therapy for couples. New York: Guilford Press.

Facilitating Intimacy - Implementation Checklist

Couple No. _____ Session No. _____ Rater _____

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

Intervention Checklist

Definition of problematic event

1. _____ The problematic event is defined/redefined in terms of the emotions and needs underlying the positions taken in the relationship.
2. _____ The therapist elicits the couple's ideas/theories/beliefs about why the problematic event has developed.
3. _____ The therapist clarifies and elaborates the basic positions taken by the partners in the relationship.
4. _____ The therapist asks the couple to disclose any biographical data that may be relevant to explaining why the relationship is the way it is, such as how the parents' marriage influenced their own.

Attacking Behavior

5. _____ The therapist validates or develops the positions implied by negative behavior such as name calling; such behavior is interpreted in terms of underlying needs and feelings.
6. _____ Negative behavior such as blaming or name calling is immediately stopped with authority on the part of the therapist and/or is defused by asking the blamer's theory on how he/she was attracted to and got involved with such a person.

Process Focus

7. _____ The therapist probes for and heightens emotional experience, especially fears and vulnerabilities, clarifying emotional triggers and responses and focusing upon inner awareness.
8. _____ The therapist avoids and suppresses affective interchange, and/or behavioral interpretation, or confrontation. No feeling or behavior is accessed, confronted or interpreted.
9. _____ Emotional meanings are discovered, differentiated and elaborated upon.
10. _____ When the couple understand a particular "why" question the therapist moves on to more refined "why" questions as new information is revealed.

11. _____ The interacting sensitivities underlying behavior are clarified and the meaning of individual emotional experience is interpreted in terms of the other partner and the relationship.
12. _____ The therapist invites the couple to speculate about general explanations they might consider for couples with similar problems and/or offers a possible theory to trigger the partners' thinking.
13. _____ The therapist invites the partners to directly interact with each other within the session.
14. _____ The therapist directly prohibits the couple from talking to each other and asks each partner to talk only to the therapist in an alternate fashion.
15. _____ Blocks/resistance to accepting a partner's experience are explored in terms of underlying feelings and/or self-concept. (Focus is on awareness of inner experience).
16. _____ When one partner cannot answer the "why" question, or has finished answering, the therapist in a standardized manner asks the other partner, "What were you thinking while your partner was talking?"
17. _____ Therapist keeps a focus on what is occurring in the present between the partners.
18. _____ Therapist takes what is happening in the present and brings it back to the past, to their parents' relationship, to their background and upbringing.

Resolution of Problematic Event

19. _____ Therapist facilitates expression of affectively based needs and wants to the partner.
20. _____ Therapist helps each partner identify and express to the therapist his/her expectations from the other partner without basing them in feelings.
21. _____ Therapist helps clients to share their new perspective of each other and /or of the relationship, and to explore their new feelings in response to this new perspective.
22. _____ Therapist asks each partner to disclose opinions/thoughts/theories about what throughout the sessions has led to improvement.

Additional Categories

23. _____ Information gathering.
24. _____ Refocus on topic.

25. _____ Other.

Explication of Implementation Checklist Categories

1. So the problem for you in this relationship is that you basically feel alone and isolated from Jim.
2. What's your theory or explanation for how this communication problem came about?
3. So your basic approach to this relationship is that you need to manage it, to take control so that your wife will be able to overcome what you see as her problems. Your approach on the other hand is to resist his taking control, not by confronting him but by withholding yourself from him.
4. Tell me about the family you grew up in. What type of relationship did your parents have? What are your theories about the influence your parents' marriage might have had on your own relationship with your spouse?
5. You're feeling pretty angry right now Penny? Yes, he is always so logical, and that makes me feel..., powerless perhaps? Like you can't get through to him?
6. I'm sorry, but I must interrupt you. Remember the ground rules, no acting up or name calling in therapy, or we'll have to end the sessions here. or How did you manage to pick such a man who doesn't care about children? Any theories on why a person picks someone who has traits that she doesn't like?
7. What happens to you when Linda turns her head like that as you talk? or So as Cory tries to take control of the situation you feel more and more afraid, like a little child is afraid? cf. sheet on Evocative Responding Technique.
8. This category is marked whenever the therapist avoids (throughout the whole 10 minute segment) all references to the immediate here and now of the session such as in category 7. Example of suppression of affective interchange: I know you may be feeling angry just now, but remember you're not here to express anger but to understand why.
9. cf. sheet on Evocative Responding Technique. So although you feel hostile and overwhelmed when he does this you are too unsure of yourself and afraid of his disapproval to tell him so?

10. So you perceived your mother as cold and unemotional. Any theories on why she became cold and unemotional? or Where did that theory come from? that the mother has to do all the mothering? Was this something your father believed? Your grandfather? or That's interesting.
In your family a man who is seen as giving in to his wife's demands is considered as weak and effeminate. Any thoughts on the influence this belief might have on your present relationship?
11. Tom, when you experience Sue withdrawing from you it seems like you become afraid that you are not important to her and you demand reassurance, but then Sue you panic, when people demand responses from you you tend to feel that you are being taken over, and so you withdraw more.
12. In the general population people believe that a spouse has an affair because of some unhappiness at home. What's your opinion on that?
13. Can you tell him this something about "I don't know how you could convince me"? or Would you look at Michael and tell him you feel pain and hurt? or Will you tell her now as you see her cry what you experience?
14. Don't forget the ground rule: you are not allowed to talk to each other during the session. I'd like for both of you to speak only to me each your turn.
15. It seems that you find it hard to accept that Linda is sometimes afraid of you, that you might create that kind of response in her? or What happens to you when Mary gets mad like this... you know I had the image of your mother attacking you, the way you described earlier.
16. What were thinking while your partner was talking? or What would your thoughts be on this subject?
17. What is happening for you right now as you say this? or Stay with that -- it's painful ...
18. As you say this, anything from your background or upbringing that might help you understand why?
19. Brenda can you tell Cory what it is that you really want from him right now? How can he reassure you? or Try it will you. Ask him, "I want you to hold me". I think you need to reach out when you feel bad. I believe you can do it.

20. Tell me what would you like from Jim? What do you expect from him?
21. So Cory this is a new view for you, to understand that Brenda is truly afraid to have sex with you, to let you in. How do you respond to that? Client: I feel softer, not so angry. So you feel closer to her?
22. Any changes in your relationship since the beginning of these sessions? What are your ideas on what may have brought these changes about?

APPENDIX B
(Telephone screening)
(Consent and demographic forms)

Standardized Telephone Screening Procedure

Thank you for calling.

We will be conducting a research study on different counselling approaches aimed at helping couples to achieve greater intimacy in their relationship. The study has been approved by the Research Ethics Committee of the University of Ottawa and is conducted by counsellors experienced in working with couples. The project is closely supervised by a registered psychologist in the province of Ontario.

Participation in the study involves coming in for a total of 4 consecutive counselling sessions of approximately one hour each one week apart. To participate you will need to satisfy certain criteria. In a moment, I will ask you some questions that will help me determine if you might be suitable for this study. If you do seem suitable you will be asked to come in to the Centre for Psychological Services of the University of Ottawa to complete some questionnaires that will in fact determine if you can participate in this study. If you come in to complete these questionnaires you will be given more information about the study and will be asked to read and sign a consent form before completing the questionnaires.

If you are selected, there is a possibility that you may be placed on a waiting list for approximately 4 to 5 weeks. In the event of such a delay, would you still be willing and able to participate in the study?

YES _____ NO _____

Answer must be YES.

REFERRAL SOURCE

How did you find out about this study?

Specific source of referral _____

I would now like to ask you some questions to see if you and your partner are suitable for this study.

1. Are you and your partner currently living together?

YES _____ NO _____

Answer must be YES

2. How long have you been living together?

_____ years/months

Minimum: 2 years

3. Are you both English-speaking or fluently bilingual?

YES _____ NO _____

Answer must be YES

4. Have you ever considered separation or divorce in the last two years?

YES _____ NO _____

Answer must be NO

5. Does either one of you experience any problems related to alcohol or drugs?

YES _____ NO _____

Answer must be NO to both

N.B. If caller reports substance abuse ask if they wish to be referred for treatment elsewhere.

Treatment for alcohol and/or drug abuse:

Al-Anon 725-3431
Rideauwood Institute 728-1727
Royal Ottawa Hospital 724-6508

6. Is your relationship affected by any sexual dysfunction?

YES _____ NO _____

No primary sexual dysfunction

N.B. If couple appears to have a primary sexual dysfunction, eg. couple has never had sex, wife has always been anorgasmic, or husband has always been impotent, ask if they wish to be referred for treatment elsewhere.

Sexual Dysfunction Clinic at Civic Hospital 725-4111

7. Has either one of you received any psychiatric treatment or medication in the past year?

YES _____ NO _____

Answer must be NO

7. Are you currently receiving any other psychological treatment?

YES _____ NO _____

Answer must be NO

8. Will either one of you be participating in any form of psychological or psychiatric treatment in the next three to four months?

YES _____ NO _____

Answer must be NO

Must not be involved in other treatment or marital enrichment (marriage

encounter etc.) for the duration of the study

Disposition of call

Does not meet criteria

If the caller does not meet inclusion criteria, explain why and thank them for their interest in the study.

Has the caller been referred elsewhere for treatment?

YES _____ NO _____

If Yes, please specify _____

Meets criteria

If couple meet all inclusion criteria, obtain the names of the potential subjects and their phone numbers.

Names: _____ Tel: (H) _____
 _____ (W) _____
 _____ (H) _____
 _____ (W) _____

Set up appointment for completion of questionnaires and, if selected, for the Verbal Interaction Task (small tape recorded conversation between the partners on a given theme). The maximum duration of this appointment is 1 1/2 hours.

Date _____ Time _____

Place: Centre for Psychological Services -- give appropriate directions.

Couples Intimacy Project

Information and Consent Form

The purpose of this research project is to examine methods of helping couples achieve closeness/intimacy in their relationship. The present study will include couples who would like to improve their relationship by increasing their intimacy but who experience a particular difficulty in doing so.

Major procedures

If you agree to participate in this project, both you and your partner will be required to complete questionnaires in order to assess your suitability for this study. If you do not meet the inclusion criteria for this study, you will be given feedback on your initial testing and referred here or elsewhere for counselling if you so desire.

If you meet our criteria for participation, you will be asked to perform a verbal interaction task involving a brief tape recorded conversation on a given theme. You will then be assigned to a counsellor who will call you within a five to six week period. You will be seen for six weekly sessions of approximately one hour. Both you and your partner will be required to attend the sessions together each week. Sessions will be conducted by senior doctoral level interns or experienced marital counsellors under the supervision of Dr. Susan Johnson, a registered clinical psychologist at the Centre for Psychological Services of the University of Ottawa. All sessions will be taped for supervision and to ensure that the approach is faithfully implemented. The counselling sessions are free of charge and will take place at the Centre.

At the end of the sixth session, you will be asked to complete final research questionnaires. Ten weeks after the end of the counselling sessions, you will be contacted to complete follow-up questionnaires (approximately 30 to 45 minutes).

Counselling approaches used in this study

The forms of counselling used in this research have been especially developed to help couples to overcome relationship difficulties and have been found to be effective. In this study they are specifically used to enhance closeness and intimacy.

Testing

Both partners of couples participating in this project will be required to complete research questionnaires. These include the initial testing before the beginning of counselling, as well as testing after the sixth session and at the ten-week follow-up. Each testing period will last approximately 30 to 45 minutes. In addition each partner will be required to complete one or two short questionnaires after each session (5 minutes). Questionnaires assess the status of the relationship as well as each partner's perception of the counselling process. All

testing is done free of charge.

Confidentiality

Confidentiality of all electronic recordings and written responses will be respected according to the ethical guidelines of the Ontario Board of Examiners in Psychology. Your names will be known only to the people who are directly involved in the research. These include the principal investigators, the clinical supervisor, the counsellors, and the research assistant. Anonymity will be assured through the pooling of all data so that published results will be presented in group format and no individual or couple will be identified.

If researchers wish to keep certain recordings for training purposes, you will be asked to sign a consent form to this effect. All other recordings will be completely erased after the end of the study. Written responses to questionnaires as well as progress notes written by the counsellors will be kept in a confidential file at the Centre for Psychological Services.

I, _____, understand that I am being asked to participate in a study to examine different counselling approaches to the enhancement of intimacy in a couple relationship. I consent to the use of tape recordings of counselling sessions and of my written responses to the questionnaires for the purposes of this research with the understanding that all information gathered will be held in strict confidence within the limits of the law and according to the ethical principles of the Ontario Board of Examiners in Psychology, and that this information will be available only to those who are directly involved in this study.

My participation in this study is voluntary and I may withdraw from this project at any time and/or request that tapes be erased without penalty and without jeopardizing access to further counselling.

I can contact either Dr. Susan Johnson or Michel Dandeneau at the Centre for Psychological Services of the University of Ottawa (564-6875) to answer any questions or concerns that I may have. I also understand that debriefing on the more detailed procedures of the study will be offered after the completion of follow-up questionnaires, and summaries of the results will be sent to couples as soon as they are available.

I have received a copy of this information and consent form and I have read and understood it. I hereby agree to participate in the testing and in this research project if I am selected.

Signature: _____ Witness' signature: _____

Telephone (H) _____
(W) _____

Date: _____

CONFIRMATION OF CONSENT

I have been accepted into this study and assigned to one of the research groups. I hereby confirm my consent to participate in this study.

Signature: _____

Witness' signature: _____

Date: _____

Demographic Data QuestionnaireCouple Number _____

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

2. How many children do you have? _____
3. Have the two of you had any marital counselling before taking part in this project? Yes _____ No _____
4. Please tick the category within which your gross family income falls:
 - _____ Under \$15,000
 - _____ \$15,000 - 25,000
 - _____ \$25,000 - 35,000
 - _____ \$35,000 - 45,000
 - _____ \$45,000 - 55,000
 - _____ Above \$55,000

**Questions 5 to 8 are completed by the MALE partner only:

5. Please state your age (in years) _____
6. What is your present occupation? _____
If you are not presently employed please state reasons why _____
7. Have you had a previous marriage? Yes _____ No _____
8. Please tick the category which best describes your level of education:
 - _____ Grade 10 or less
 - _____ Grade 12 or less
 - _____ 2 years of post secondary education
 - _____ Community college program completed
 - _____ University degree completed
 - _____ Graduate program completed
 - _____ Ph.D. or equivalent completed

**Questions 9 to 12 are completed by the FEMALE partner only:

9. Please state your age (in years) _____
10. What is your present occupation? _____
If you are not presently employed please state reasons why _____

11. Have you had a previous marriage? Yes _____ No _____

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

- Grade 10 or less
- Grade 12 or less
- 2 years of post secondary education
- Community college program completed
- University degree completed
- Graduate program completed
- Ph.D. or equivalent completed

Thank You

APPENDIX C
(Measures completed by subjects)

These are some things about which couples sometimes agree and sometime disagree. Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks.
(Check yes or no)

29. Yes No
 _____ _____ Being too tired for sex.

30. _____ _____ Not showing love.

31. The dots on the following line represent different degrees of happiness in your relationship. The middle point, "happy," represents the degree of happiness of most relationships. Please circle the dot which best describes the degree of happiness, all things considered, of your relationship.

.

Extremely Unhappy	Fairly Unhappy	A Little Unhappy	Happy	Very Happy	Extremely Happy	Perfect
----------------------	-------------------	---------------------	-------	---------------	--------------------	---------

32. Which of the following statements best describes how you feel about the future of your relationship?

- _____ I want desperately for my relationship to succeed, and would go to almost any length to see that it does.
- _____ I want very much for my relationship to succeed, and will do all I can to see that it does.
- _____ I want very much for my relationship to succeed, and will do my fair share to see that it does.
- _____ It would be nice if my relationship succeeded, but I can't do much more than I am doing now to help it succeed.
- _____ It would be nice if it succeeded, but I refuse to do any more than I am doing now to keep the relationship going.
- _____ My relationship can never succeed, and there is no more that I can do to keep the relationship going.

- him/her? 1 2 3 4 5 6 7 8 9 10
13. How important is it to you that he/she understands your feelings? 1 2 3 4 5 6 7 8 9 10
14. How much damage is caused by a typical disagreement in your relationship with him/her? 1 2 3 4 5 6 7 8 9 10
15. How important is it to you that he/she be encouraging and supportive to you when you are unhappy? 1 2 3 4 5 6 7 8 9 10
16. How important is it to you that he/she show you affection? 1 2 3 4 5 6 7 8 9 10
17. How important is your relationship with him/her in your life? 1 2 3 4 5 6 7 8 9 10

Thank You

Dyadic Trust Scale

Couple no.: _____

M _____ F _____

Please use the following questions to describe your current relationship with your partner. We are interested in the relationship as it is, not in the way you think it should be. We would like to know what your relationship seems like to YOU. DO NOT try to figure out how your partner will see your relationship, but DO respond to the statements by giving as true a picture of YOUR own feelings and beliefs as possible.

If you completely agree with the statement, circle number 7. If you completely disagree with the statement, circle number 1. Use the numbers in between to describe variations between the extremes.

Completely Agree	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Completely Disagree	
7	6	5	4	3	2	1	
1. My partner is primarily interested in his/her own welfare.	7	6	5	4	3	2	1
2. There are times when my partner cannot be trusted.	7	6	5	4	3	2	1
3. My partner is perfectly honest and truthful with me.	7	6	5	4	3	2	1
4. I feel I can trust my partner completely.	7	6	5	4	3	2	1
5. My partner is truly sincere in his/her promises.	7	6	5	4	3	2	1
6. I feel that my partner does not show me enough consideration.	7	6	5	4	3	2	1
7. My partner treats me fairly and justly.	7	6	5	4	3	2	1
8. I feel that my partner can be counted on to help me.	7	6	5	4	3	2	1

Thank-you.

Modified Intimacy Scale

(Adapted to the definition of intimacy put forward in this study)

Items taken from MSIS:

	Very Rarely			Some of the Time				Almost Always		
2. How often do you keep very personal information to yourself and do not share it with him/her?	1	2	3	4	5	6	7	8	9	10
4. How often do you confide very personal information to him/her?	1	2	3	4	5	6	7	8	9	10
5. How often are you able to understand his/her feelings?	1	2	3	4	5	6	7	8	9	10
	Not Much			A Little				A Great Deal		
8. How much do you feel like being encouraging and supportive to him/her when he/she is unhappy?	1	2	3	4	5	6	7	8	9	10
10. How important is it to you to listen to his/her very personal disclosures?	1	2	3	4	5	6	7	8	9	10
13. How important is it to you that he/she understands your feelings?	1	2	3	4	5	6	7	8	9	10
15. How important is it to you that he/she be encouraging and supportive to you when you are unhappy?	1	2	3	4	5	6	7	8	9	10

Items taken and modified (5-point to 10-point scale) from Guerney's (1977) Interpersonal Relationship Scale:

	Strongly Disagree			Neutral				Strongly Agree		
2. I feel comfortable expressing almost anything to my partner.	1	2	3	4	5	6	7	8	9	10
3. In our relationship, I feel I am able to expose my weaknesses.	1	2	3	4	5	6	7	8	9	10
5. I can express deep, strong feelings to my partner.	1	2	3	4	5	6	7	8	9	10

16. I share and discuss my problems with my partner. 1 2 3 4 5 6 7 8 9 10
27. I do not show deep emotions to my partner. 1 2 3 4 5 6 7 8 9 10
34. It is hard for me to tell my partner about myself. 1 2 3 4 5 6 7 8 9 10
41. My partner is likely to say what he/she really believes, rather than what he/she thinks I want to hear. 1 2 3 4 5 6 7 8 9 10
49. I talk with my partner about why certain people dislike me. 1 2 3 4 5 6 7 8 9 10
50. I discuss with my partner the things I worry about when I'm with a person of the opposite sex. 1 2 3 4 5 6 7 8 9 10
51. I tell my partner some things of which I am very ashamed. 1 2 3 4 5 6 7 8 9 10
17. I understand my partner and sympathize with his/her feelings. 1 2 3 4 5 6 7 8 9 10
18. I listen carefully to my partner and help him/her solve problems. 1 2 3 4 5 6 7 8 9 10
19. I feel my partner misinterprets what I say. 1 2 3 4 5 6 7 8 9 10
25. My partner doesn't really understand me. 1 2 3 4 5 6 7 8 9 10

Couple Therapy Alliance Scale

Couple no.: _____

M _____ F _____

The following statements refer to your feelings and thoughts about your therapist and your therapy right now. Each statement is followed by a seven point scale. Please rate the extent to which you agree or disagree with each statement at this time.

If you completely agree with the statement, circle number 7. If you completely disagree with the statement, circle number 1. Use the numbers in between to describe variations between the extremes.

Completely Agree	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Completely Disagree
7	6	5	4	3	2	1

Please work quickly. We are interested in your first impressions. Your ratings are confidential. They will not be shown to your therapist or partner and will only be used for research purposes.

Although some of the statements appear to be similar or identical, each statement is unique. Please be sure to rate each statement.

The therapist cares about me as a person.	7	6	5	4	3	2	1
The therapist and I are not in agreement about the goals for this therapy.	7	6	5	4	3	2	1
I trust the therapist.	7	6	5	4	3	2	1
The therapist lacks the skills and ability to help my partner and myself with our relationship.	7	6	5	4	3	2	1
My partner feels accepted by the therapist.	7	6	5	4	3	2	1
The therapist does not understand the relationship between my partner and myself.	7	6	5	4	3	2	1
The therapist understands my goals in therapy.	7	6	5	4	3	2	1
The therapist and my partner are not in agreement about the goals							

for this therapy.	7	6	5	4	3	2	1
My partner cares about the therapist as a person.	7	6	5	4	3	2	1
The therapist does not understand the goals that my partner and I have for ourselves as a couple in this therapy.	7	6	5	4	3	2	1
My partner and the therapist are in agreement about the way the therapy is being conducted.	7	6	5	4	3	2	1
The therapist does not understand me.	7	6	5	4	3	2	1
The therapist is helping my partner and me with our relationship.	7	6	5	4	3	2	1
I am not satisfied with the therapy.	7	6	5	4	3	2	1
The therapist understands my partner's goals for this therapy.	7	6	5	4	3	2	1
I do not feel accepted by the therapist.	7	6	5	4	3	2	1
The therapist and I are in agreement about the way the therapy is being conducted.	7	6	5	4	3	2	1
The therapist is not helping me.	7	6	5	4	3	2	1
The therapist is in agreement with the goals that my partner and I have for ourselves as a couple in this therapy.	7	6	5	4	3	2	1
The therapist does not care about my partner as a person.	7	6	5	4	3	2	1
The therapist has the skills and ability to help me.	7	6	5	4	3	2	1
The therapist is not helping my partner.	7	6	5	4	3	2	1
My partner is satisfied with the therapy.	7	6	5	4	3	2	1
I do not care about the therapist as a person.	7	6	5	4	3	2	1

The therapist has the skills and ability to help my partner.	7	6	5	4	3	2	1
My partner distrusts the therapist.	7	6	5	4	3	2	1
The therapist cares about the relationship between my partner and myself.	7	6	5	4	3	2	1
The therapist does not understand my partner.	7	6	5	4	3	2	1

THANK YOU

Target Concerns Questionnaire

Couple no: _____

Sex: M____ F ____

We are interested at this time in the two main blocks to intimacy/closeness that you hope to resolve during counselling. Please list them below:

a)

b)

Target Concerns Questionnaire

We are interested in how much the following issues in your relationship have changed since you started counselling. Please circle the words that best describe your position.

a)

		slightly	somewhat	
worse...	same...	better...	better...	much better

d)

		slightly	somewhat	
worse...	same...	better...	better...	much better

APPENDIX D

(Verbal Interaction Task and rating scales)

Verbal Interaction Task

The Verbal Interaction Task is done immediately after completion of the pre-treatment measures to establish a baseline level of intimacy, and once again immediately after the end of the fourth session (before administration of post-treatment measures) to determine outcome effects. Upon completion of pre-treatment measures, the couple are brought to a therapy room. The interviewer (which may be other than the therapist) will take a moment to establish rapport by asking the couple's reaction to the testing and if they have any questions. The instructions for the VIT are written out on cards. The interviewer gives the appropriate card to each participant, leaves them approximately one minute to choose what they will talk about, signals the beginning of the task, and limits it to four minutes. The partners are aware that their dialogue is being tape-recorded.

The instructions to each partner define their role as either openly self-disclosing about the issue or empathizing with the other partner. Instructions are given in two different moments and are reversed to ensure that each partner has one turn to self-disclose and one to empathize. The instruction cards look like this:

Verbal interaction task
Instructions for female partner

1a. Please discuss with your partner something you would like to change in yourself. Try to be as open and expressive as possible. When I leave the room you will be given a moment to choose the issue you would like to discuss. Please do not discuss during this time. When you hear three knocks on the door, you may begin to discuss with your partner something you would like to change in yourself. You are asked to discuss this for four minutes. At the end of four minutes, you will hear three knocks on the door signaling the end of this discussion. I'll be in to give you the next question.

Verbal interaction task

Instructions for male partner

1b. Please discuss with your partner something she would like to change in herself. You are to try to help her express herself as much as possible. When I leave the room she will be given a moment to choose the issue she would like to discuss. Please do not discuss during this time. When you hear three knocks on the door, she may begin to discuss with you something she would like to change in herself. You are asked to discuss this for four minutes. At the end of four minutes, you will hear three knocks on the door signaling the end of this discussion. I'll be in to give you the next question.

Verbal interaction task

Instructions for male partner

2a. Please discuss with your partner something you would like to change in yourself. Try to be as open and expressive as possible. When I leave the room you will be given a moment to choose the issue you would like to discuss. Please do not discuss during this time. When you hear three knocks on the door, you may begin to discuss with your partner something you would like to change in yourself. You are asked to discuss this for four minutes. At the end of four minutes, you will hear three knocks on the door signaling the end of this discussion. I'll be in to end the session.

Verbal interaction task

Instructions for female partner

2b. Please discuss with your partner something he would like to change in himself. You are to try to help him express himself as much as possible. When I leave the room he will be given a moment to choose the issue he would like to discuss. Please do not discuss during this time. When

you hear three knocks on the door, he may begin to discuss with you something he would like to change in himself. You are asked to discuss this for four minutes. At the end of four minutes, you will hear three knocks on the door signaling the end of this discussion. I'll be in to end the session.

Interviewer leaves room. At the end of one minute, the interviewer knocks on the door to signal the beginning of the four minute discussion period. At the end of four minutes, the interviewer knocks again and walks in to give further instructions.

For outcome levels, the VIT is done immediately at the end of the sixth treatment session using the same instructions as for the baseline measure.

All VIT's are audiotaped for later rating.

Rating

Each 4-minute conversation was rated by 3 trained raters (12 hours) blind to the purposes of the study. The response unit to be rated is defined as a statement of the person being rated which is made between two statements by another person.

Rating was done using Carkhuff's Empathic Understanding in Interpersonal Processes Scale and the Facilitative Self-disclosure in Interpersonal Processes Scale. The self-disclosure scale was used to rate responses made by the partner who is asked to discuss something he/she would like to change in him/herself; whereas the empathy scale was used to rate responses by the partner who is asked to help

his/her partner express him/herself as much as possible.
Each partner was thus rated twice: once for self-disclosure
and once for empathy.

Empathic Understanding in Interpersonal Processes Scale

Level 1

The verbal and behavioral expression of the first person either do not attend to or detract significantly from the verbal and behavioral expressions of the second person in that they communicate significantly less of the second person's feelings than the second person has communicated him/herself.

EXAMPLES: The first person communicates no awareness of even the most obvious, expressed surface feelings of the second person. The first person may be bored or uninterested or simply operating from a preconceived frame of reference which totally excludes that of the other person.

In summary, the first person does everything but express that s/he is listening, understanding, or being sensitive to even the most obvious feelings of the other person in such a way as to detract significantly from the communications of the second person.

Level 2

While the first person responds to the expressed feelings of the second person, s/he does so in such a way that s/he subtracts noticeable affect from the communications of the second person.

EXAMPLES: The first person may communicate some awareness of obvious surface feelings of the second person, but his communications drain off a level of the affect and distort the level of meaning. The first person may communicate his own ideas of what may be going on, but these are not congruent with the expressions of the second person.

In summary, the first person tends to respond to other than what the second person is expressing or indicating.

Level 3

The expressions of the first person in response to the expressed feelings of the second person are essentially interchangeable with those of the second person in that they express essentially the same affect and meaning.

EXAMPLES: The first person responds with accurate understanding of the surface feelings of the second person but may not respond to or may misinterpret the deeper feelings.

In summary, the first person is responding so as to neither subtract from nor add to the expressions of the second person; but he does not respond accurately to how that person really feels beneath the surface feelings. Level 3 constitutes the minimal level of facilitative interpersonal functioning.

Level 4

The responses of the first person add noticeably to the expressions of the second person in such a way as to express feelings a level deeper than the second person was able to express himself.

EXAMPLE: The facilitator communicates his understanding of the expressions of the second person at a level deeper than they were expressed, and thus enables the second person to experience and/or express feelings he was unable to express previously.

In summary, the facilitator's responses add deeper feeling and meaning to the expressions of the second person.

Level 5

The first person's responses add significantly to the feeling and meaning of the expressions of the second person in such a way as to (1) accurately express feelings levels below what the person himself was able to express or (2) in the event of on going deep self-exploration on the second person's part, to be fully with him in his deepest moments.

EXAMPLE: The facilitator responds with accuracy to all of the person's deeper as well as surface feelings. He is "together" with the second person or "tuned in" on his wave length. The facilitator and the other person might proceed together to explore previously unexplored areas of human existence.

In summary, the facilitator is responding with a full awareness of who the other person is and a comprehensive and accurate empathic understanding of his deepest feelings.

Facilitative Self-disclosure in Interpersonal Processes
Scale

Couple no.: _____ M _____ F _____

Level 1

The first person actively attempts to remain detached from the second person and discloses nothing about his own feelings or personality to the second person, or if he does disclose himself, he does so in a way that is not tuned to the second person's general progress.

EXAMPLE: The first person may attempt, whether awkwardly or skillfully, to divert the second person's attention from focusing upon personal questions concerning the first person, or his self-disclosures may be ego shattering for the second person and may ultimately cause him to lose faith in the first person.

In summary, the first person actively attempts to remain ambiguous and an unknown entity to the second person, or if he is self-disclosing, he does so solely out of his own needs and is oblivious to the needs of the second person.

Level 2

The first person, while not always appearing actively to avoid self-disclosures, never volunteers personal information about himself.

EXAMPLE: The first person may respond briefly to direct questions from the second person about himself; however, he does so hesitantly and never provides more information about himself than the second person specifically requests.

In summary, the second person either does not ask about the personality of the first person, or, if he does, the barest minimum of brief, vague, and superficial responses are offered by the first person.

Level 3

The first person volunteers personal information about himself which may be in keeping with the second person's interests, but his information is often vague and indicates little about the unique character of the first person.

EXAMPLE: While the first person volunteers personal information and never gives the impression that he does not

wish to disclose more about himself, nevertheless, the content of his verbalizations is generally centered upon his reactions to the second person and his ideas concerning their interaction.

In summary, the first person may introduce more abstract, personal ideas in accord with the second person's interests, but these ideas do not stamp him as a unique person. Level 3 constitutes the minimum level of facilitative interpersonal functioning.

Level 4

The facilitator freely volunteers information about his personal ideas, attitudes, and experiences in accord with the second person's interests and concerns.

EXAMPLE: The facilitator may discuss personal ideas in both depth and detail, and his expressions reveal him to be a unique individual.

In summary, the facilitator is free and spontaneous in volunteering personal information about himself, and in so doing may reveal in a constructive fashion quite intimate material about his own feelings and beliefs.

Level 5

The facilitator volunteers very intimate and often detailed material about his own personality, and in keeping with the second person's needs may express information that might be extremely embarrassing under different circumstances or if revealed by the second person to an outsider.

EXAMPLE: The facilitator gives the impression of holding nothing back and of disclosing his feelings and ideas fully and completely to the second person. If some of his feelings are negative concerning the second person, the facilitator employs them constructively as a basis for an open-ended inquiry.

In summary, the facilitator is operating in a constructive fashion at the most intimate levels of self-disclosure.

APPENDIX E
(Tables)

Table E-1

Pearson Correlation Coefficients

(N = 102)

	MSIS	DTS	DAS	MIS	SD	EMP
MSIS	-	.28 P=.009	.62 P=.001	.83 P=.000	-.02 P=.465	-.15 P=.184
DTS		-	.27 P=.011	.25 P=.018	.05 P=.396	-.46 P=.002
DAS			-	.51 P=.000	.02 P=.451	-.07 P=.341
MIS				-	.08 P=.326	-.19 P=.135
SD					-	.38 P=.012
EMP						-

Note. MIS = Modified Intimacy Scale

SD = Facilitative Self-Disclosure in Interpersonal Processes Scale

EMP = Empathic Understanding in Interpersonal Processes Scale

Table E-2

Analysis of Variance: Demographics

Variables (N = 72)	Groups			F(2,69)	p
	EFT	CMT	Con		
	M/SD	M/SD	M/SD		
Age	38.1 12.6	42.1 8.8	42.6 11.3	1.196	.3085
Years together	13.4 10.7	16.2 11.1	17.5 11.3	.8985	.4119
Income	5.2 1.4	5.6 0.7	4.8 1.6	2.122	.1277
Education	4.6 1.3	4.7 0.7	4.5 1.3	.025	.9757
Occupation	4.5 0.9	4.6 0.9	4.6 1.0	.1518	.8596

Note. Occupational categories and numbers are taken from the Blishen Scales.

Income and education level numerals represent nominal categories.

Table E-3

Analysis of Variance: Couples Therapy Alliance Scale

Variable	M	SD	F	p
EFT couples	5.5	.628	.1956	.6626
CMT couples	5.7	.794		

Table E-3a

Analysis of Covariance for MSIS at Posttest with Pretest Score as Covariate

Source	SS	DF	MS	F	p
Within cells	1386.19	32	43.32		
Regression	3103.19	1	3103.19	71.64	.000
Group	677.69	2	338.84	7.82	.002

Table E-3b

Analysis of Covariance for SD at Posttest with Pretest Score as Covariate

Source	SS	DF	MS	F	p
Within cells	2.52	14	.18		
Regression	.65	1	.65	3.61	.078
Group	1.33	2	.66	3.70	.051

Table E-3c

Analysis of Covariance for EMP at Posttest with Pretest Score as Covariate

Source	SS	DF	MS	F	p
Within cells	1.43	14	.10		
Regression	1.13	1	1.13	11.10	.005
Group	1.01	2	.50	4.93	.024

Table E-4

Planned Comparison Tests: EFT, CMT and Control GroupMeans at Posttest

Variables (N = 36)	Groups			t (df)	Power
	EFT M	CMT M	Con M		
MSIS	136.6	139.6	129.2	3.33* (66)	2.5%
TC	3.8	3.8	2.2	6.8** (33)	90.0%
SD	2.7	2.0	2.3	.06 (30)	2.6%
EMP	2.1	1.6	1.6	1.32 (30)	49.0%
DTS	44.7	48.3	46.0	.27 (66)	2.0%
DAS	111.2	111.0	108.4	1.06 (66)	2.5%

* = $p < .001$ ** = $p < .0005$

Note. The t ratio compares EFT and CMT group means pooled together (EFT + CMT/2) to the Control group mean.

Means indicated are adjusted Covariance means with the exception of TC.

Power is the estimated power of t-test at $p = .01$ (one tailed) (Cohen, 1977)

Table E-5

Analysis of Covariance for MSIS at Follow-up with Pretest Score as Covariate

Source	SS	DF	MS	F	p
Within cells	553.71	21	26.37		
Regression	2359.75	1	2359.75	89.50	.000
Group	484.10	1	484.10	18.36	.000

Table E-6

Planned Comparison Tests: EFT and CMT Groups at Posttest and Follow-up

Variables / Time (n = 12/group)	Groups		t (df)	Power	
	EFT	CMT			
	M/SD	M/SD			
MSIS	Post	136.6	139.6	-1.12 (66)	2.5%
	Follow-up	142.7	133.7	4.29*** (66)	32.0%
TC	Post	3.8 .57	3.8 .78	0.09 (33)	2.0%
	Follow-up	3.8 .48	3.2 .55	2.96* (33)	19.0%
SD	Post	2.7	2.0	2.83*	27.0%
EMP	Post	2.1	1.6	2.73*	49.0%
DTS	Post	44.7	48.3	-2.11	17.0%
	Follow-up	48.1	46.4	1.21	5.0%
DAS	Post	111.2	111.0	0.06	1.5%
	Follow-up	115.8	109.0	3.44**	23.0%

* = $p < .005$
 ** = $p < .001$
 *** = $p < .0005$

Note. Means indicated are adjusted Covariance means with the exception of TC.

No follow-up data were taken for SD and EMP.

Table E-7

Analysis of Covariance for DTS at Posttest with Pretest Score as Covariate

Source	SS	DF	MS	F	p
Within cells	568.32	32	17.76		
Regression	168.64	1	168.64	9.50	.004
Group	75.66	2	37.83	2.13	.135

Table E-8

Analysis of Covariance for DTS at Follow-up with Pretest Score as Covariate

Source	SS	DF	MS	F	p
Within cells	257.47	21	12.26		
Regression	422.99	1	422.99	34.50	.000
Group	15.24	1	15.24	1.24	.277

Table E-9

Analysis of Covariance for DAS at Posttest with Pretest Score as Covariate

Source	SS	DF	MS	F	p
Within cells	1188.40	32	37.14		
Regression	831.02	1	831.02	22.38	.000
Group	55.38	2	27.69	.75	.483

Table E-10

Analysis of Covariance for DAS at Follow-up with Pretest Score as Covariate

Source	SS	DF	MS	F	p
Within cells	490.73	21	23.37		
Regression	273.56	1	273.56	11.71	.003
Group	275.18	1	275.18	11.78	.003