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Research Article

Effectiveness of Emotion-Focused Therapy in Reducing Emotional Regulation Difficulties Among Married Women: A Quasi-Experimental Study in Saudi Arabia

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Abstract

This study aimed to evaluate the effectiveness of Emotion-Focused Therapy (EFT) in reducing emotional regulation difficulties among married women in the Qassim region of Saudi Arabia through a quasi-experimental design. A pilot sample of 400 wives was used to establish the psychometric properties of the Difficulties in Emotion Regulation Scale (DERS), which demonstrated satisfactory reliability and construct validity in the local context (α =.79-.89). From a screening sample (N = 400), 16 wives with elevated emotional regulation difficulties were selected and randomly assigned to an experimental group (n = 8) or a control group (n = 8). The experimental group participated in a structured 12-session EFT-based intervention delivered over six weeks, while the control group received no treatment. Nonparametric analyses (Wilcoxon Signed-Rank and Mann-Whitney U tests) revealed significant reductions in emotional regulation difficulties from pretest to posttest in the experimental group ($Z = -2.52$, $p = .012$), with a large effect size (Cohen's $d = 0.98$). Significant posttest differences were also found between the experimental and control groups ($Z = -3.36$, $p = .001$), favoring the intervention group. No significant differences emerged between posttest and one-month follow-up assessments ($p = .157$), indicating maintenance of therapeutic gains. These findings provide empirical support for EFT as an effective, culturally adaptable intervention for improving emotional regulation among married women, and contribute to the limited body of research on experiential therapies in Arab cultural contexts. Replication with larger and dyadic samples is recommended.

Keywords

Emotion-Focused Therapy (EFT), Emotional Regulation Difficulties, Married Women, Quasi-Experimental Design, Saudi Arabia, DERS

1. Introduction

The family constitutes the fundamental social unit upon which society is built, and serves as the primary context for the formation of individual identity, values, and behavioral patterns. Family stability occupies a central position in the attainment of social cohesion and psychological well-being [6]. Within the family system, the wife represents a pivotal axis in the management of familial relationships, child-rearing, and spousal support. Accordingly, any impairment in the wife's psychological health may negatively reverberate throughout the entire family unit [4].

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The empirical literature has extensively documented associations between emotional regulation difficulties (ERD) and a wide spectrum of psychological and social disorders. Multiple therapeutic approaches have emerged to address these difficulties, most notably third-wave behavioral interventions—including Dialectical Behavior Therapy (DBT [37]) and Acceptance and Commitment Therapy (ACT [21]). These models have demonstrated effectiveness in teaching skills such as emotional awareness, acceptance, and impulse control. However, they do not position emotion itself as the primary mechanism of therapeutic change.

Emotion-Focused Therapy (EFT), developed by Johnson and Greenberg in the 1980s, addresses this gap by placing emotion at the very center of psychological change [15, 23]. Grounded in attachment theory [9] and humanistic-experiential psychology [38], EFT conceptualizes many psychological difficulties as arising from insecure attachment patterns and unprocessed emotional experiences. It operates across three principal phases: (1) de-escalation and cycle identification, (2) restructuring interaction through accessing and expressing primary emotions, and (3) consolidation of new emotional patterns and secure attachment bonds [24, 25].

Research has consistently supported EFT's efficacy across a range of clinical presentations, including marital distress [36], depression [19], trauma [24], and anxiety. Notably, a systematic review spanning over 25 studies concluded that EFT significantly reduces marital conflict, enhances emotional security, and improves relationship quality—often outperforming alternative therapeutic approaches [36]. Despite this robust international evidence base, there remains a significant gap in research examining EFT within Arab and Saudi cultural contexts. This study addresses that gap by testing a structured EFT-based program among married women attending family welfare centers in the Qassim region, Saudi Arabia.

1.1. Research Problem and Questions

Although various therapeutic models address emotional regulation difficulties, most existing approaches—such as DBT and ACT—do not treat emotion as the primary vehicle of change [21]. EFT distinguishes itself by targeting primary, adaptive emotions (e.g., fear of abandonment, need for closeness) rather than secondary defensive responses (e.g., anger, blame), thereby facilitating genuine emotional restructuring [16, 24]. Despite growing empirical evidence for EFT, its application within Arab populations remains limited.

The present study was guided by the following primary research question:

What is the effectiveness of Emotion-Focused Therapy in reducing emotional regulation difficulties among married women in the Qassim region?

The following sub-questions were derived from this primary question:

1) Are there statistically significant differences between pretest and posttest mean rank scores on the DERS within the experimental group?
2) Are there statistically significant differences between the experimental and control groups on posttest DERS scores?
3) Are there statistically significant differences between posttest and one-month follow-up DERS scores within the experimental group?

1.2. Study Objectives

The present study aimed to:

1) Verify the effectiveness of EFT in reducing emotional regulation difficulties, via pretest-posttest comparison within the experimental group.
2) Compare EFT with a no-treatment condition by examining posttest differences between experimental and control groups.
3) Assess the durability of therapeutic gains through post-test-follow-up comparisons within the experimental group.

1.3. Significance of the Study

1.3.1. Theoretical Significance

This study contributes to the growing body of specialized psychological literature on EFT and emotional regulation within the domain of family counseling. It adds to a limited corpus of Arabic-language research on experiential therapies, opens new research avenues by foregrounding married women as central agents of family health, and invites further investigation of emotional and psychological factors affecting Arab family well-being.

1.3.2. Applied Significance

The study provides a validated, culturally adapted EFT program that can be deployed in family counseling centers, psychological clinics, and educational institutions. It supports contemporary trends in family counseling and offers practitioners a replicable therapeutic framework applicable across diverse populations and clinical presentations.

2. Literature Review

2.1. Emotional Regulation Difficulties: Conceptual Framework

Emotional regulation has been conceptualized variously across theoretical frameworks. Thompson [34] defined it as "the extrinsic and intrinsic processes responsible for monitoring, evaluating, and modifying emotional reactions, especially their intensive and temporal features, to accomplish one's goals." Gross [20] provided a more differentiated framework, describing emotional regulation as the processes influencing

which emotions occur [32], when they occur, and how they are experienced and expressed—a framework that distinguishes antecedent-focused strategies (e.g., cognitive reappraisal) from response-focused strategies (e.g., suppression).

The seminal contribution of Gratz and Roemer [14] shifted the focus toward emotional regulation difficulties (ERD), defining them as deficits in (a) awareness and understanding of emotions, (b) acceptance of emotions, (c) ability to control impulsive behaviors when distressed, and (d) access to effective regulation strategies. This multidimensional conceptualization underpins their Difficulties in Emotion Regulation Scale (DERS), which has since become a gold-standard measurement tool applied across hundreds of studies internationally.

Aldao et al. [1] identified a meta-analytic trend showing that individuals who rely on maladaptive strategies—rumination, suppression, avoidance—demonstrate significantly higher rates of psychopathology compared to those employing adaptive strategies such as reappraisal and problem-solving. Bardeen and Fergus [6] further established ERD as a transdiagnostic factor contributing to anxiety, depression, and personality disorders, underscoring the clinical importance of targeted intervention.

2.2. Dimensions of Emotional Regulation Difficulties

delineated six core dimensions of ERD, each representing a distinct facet of regulatory failure [14]:

Table 1. *Dimensions of Emotional Regulation Difficulties (Gratz & Roemer, 2004).*

Dimension	Description
Non-Acceptance	Tendency to react negatively to one's own emotional distress; guilt or shame about having negative emotions.
Goal-Directed Difficulties	Difficulty maintaining concentration and task-completion during emotional distress [11].
Impulse Control Deficits	Difficulty controlling behavior when experiencing negative emotions; associated with greater interpersonal conflict [12]
Lack of Awareness	Reduced attention to and acknowledgment of emotional signals, preventing early identification and regulation.
Limited Strategies Access	Belief that little can be done when distressed; poverty of regulatory skills repertoire [1].
Lack of Clarity	Difficulty identifying, labeling, and articulating emotional states; impairs communication and needs negotiation [6].

These dimensions form an interconnected system: deficits in awareness and clarity undermine acceptance and control, reduce access to adaptive strategies, and amplify impulsivity under stress [1]. For married women, ERD is particularly consequential given their complex role demands—managing multiple familial obligations, child-rearing, marital partnership, and occupational responsibilities simultaneously [8, 30].

2.3. Emotion-Focused Therapy: Theoretical Foundations and Mechanisms

EFT is grounded in four interlocking theoretical frameworks: (1) Attachment Theory [9, 28], which posits that secure emotional bonds are fundamental human needs and that many psychological difficulties stem from insecure attachment patterns; (2) Humanistic Psychology [38], emphasizing unconditional positive regard, empathy, and the organism's innate growth tendency; (3) Emotion Theory [16], which positions emotion as the primary organizer of experience and behavior; and (4) the concept of Emotional Schemas [22], describing how patterned emotional responses are formed and restructured through therapeutic experience [5].

Greenberg's [16] emotion theory distinguishes among three types of emotion: (a) primary adaptive emotions—direct responses to situations that reflect genuine needs (e.g., grief at loss); (b) primary maladaptive emotions—chronic, entrenched responses arising from traumatic experience (e.g., chronic shame, deeply rooted anger); and (c) secondary emotions—defensive reactions that mask primary states (e.g., anger concealing fear of abandonment). Therapeutic change in EFT occurs through emotional transformation: accessing and restructuring maladaptive emotional schemes by activating primary adaptive emotions within a safe therapeutic relationship [10, 18] Empirical findings further reinforce the efficacy of Emotion-Focused Therapy in facilitating emotional awareness and transforming maladaptive emotional schemes [40].

2.4. EFT Process: Phases and Steps

Johnson and Greenberg [25] articulated EFT as a nine-step clinical model organized across three phases:

Table 2. EFT Phases and Steps.

Phase	Step	Clinical Task
Phase I: De-escalation	1	Identify core relational issues and negative interaction cycles.
	2	Identify secondary emotions and defensive reactions.
	3	Reframe the problem as a shared interactional cycle, reducing blame.
Phase II: Restructuring	4	Access and acknowledge underlying primary emotions (fear, need for closeness).
	5	Facilitate authentic expression of emotional needs and attachment longings.
	6	Support partner in responding with empathy and openness.
	7	Facilitate new interactional sequences with supportive responses.
Phase III: Consolidation	8	Develop new solutions to old relational problems using new communication patterns.
	9	Consolidate secure emotional bonds and positive interactional patterns.

2.5. Evidence Base for EFT

EFT has been validated across diverse clinical populations and problem presentations. Wiebe and Johnson's [36] comprehensive review of over 25 randomized and quasi-experimental studies documented significant improvements in marital satisfaction, emotional security [26, 27], and communication, with EFT outperforming several alternative interventions. Greenberg and Watson [19] demonstrated EFT's superiority over client-centered therapy in the treatment of major depression. In the domain of emotional regulation specifically, Teymouri et al. [33] found significant reductions in anger rumination and improvements in regulatory skills among women affected by marital infidelity. Bazyari et al. [7] reported improvements in emotional regulation and reductions in emotional divorce among couples in Iran. Vejdani et al. (2024) demonstrated EFT's superiority over an empowerment-based program in enhancing psychological resilience and reducing ERD among women experiencing domestic violence. Furthermore, contemporary research has highlighted that Emotion-Focused Therapy [30] significantly reduces marital stress while augmenting behavioral emotion regulation among married women [31] found EFT effective in reducing marital violence.

Within the Arab context, Al-Tantawi [3] demonstrated EFT efficacy in alleviating marital problems among recently married women in Egypt. Al-Mulayhim and Al-Hawrani [2] reported reductions in alexithymia among delayed-childbirth women using EFT-based protocols. Despite this emerging evidence, studies systematically testing EFT's effects on emotional regulation difficulties in Saudi populations remain scarce, constituting the primary justification for the present investigation.

3. Method

3.1. Research Design

A quasi-experimental, pre-posttest control group design was employed, featuring an experimental group receiving EFT and a no-treatment control group. This design corresponds to the equivalent group design (experimental-control) with repeated measurements (pretest-posttest-follow-up), appropriate for evaluating intervention efficacy when true random assignment from a general population is not feasible.

3.2. Participants

3.2.1. Pilot Sample

A convenience sample of 400 married women attending Al-Usra Family Association centers in the Qassim region during the 2025-2026 academic year (1447 H) was recruited for the purpose of establishing psychometric properties of the DERS in the local context.

3.2.2. Main Sample

From the larger screening sample (N = 400), 16 wives who scored at or above the clinical cutoff (≥ 108) on the DERS and who consented to participate in the intervention were selected. Participants were aged 24-50 years (M ≈ 37 years). They were randomly assigned to either the experimental group (n = 8) or the control group (n = 8).

Equivalence between groups was verified using Welch's t-test for independent samples prior to intervention, yielding no significant difference on pretest DERS total scores ($t = -0.064$, $p = .95$), confirming baseline comparability (Table 3).

Table 3. Baseline Equivalence of Experimental and Control Groups (Welch's t-test).

Measure	Group	n	M	t	p
DERS Total (Pretest)	Experimental	8	115.88	−0.064	.950
	Control	8	116.00		

Table 4 presents the distribution of participants by years of marriage in the pilot sample (N = 400).

Table 4. Distribution of Pilot Sample by Years of Marriage (N = 400).

Years of Marriage	n	%
Less than 5 years	82	20.5
5-10 years	87	21.8
More than 10 years	231	57.7
Total	400	100.0

3.3. Measure: Difficulties in Emotion Regulation Scale (DERS)

The Difficulties in Emotion Regulation Scale [14] is an original 36-item self-report instrument assessing six dimensions of emotional regulation difficulties: Non-Acceptance of Emotional Responses, Difficulties Engaging in Goal-Directed Behavior, Impulse Control Difficulties, Lack of Emotional Awareness [29], Limited Access to Emotion Regulation Strategies, and Lack of Emotional Clarity. Items are rated on a 5-point Likert scale (1 = almost never to 5 = almost always). Following the psychometric assessment in the current sample, items 27 and 33 were excluded because their standardized factor loadings were below 0.40. The adapted version used in the study therefore comprised 34 items, with total scores ranging from 34 to 170; higher scores indicate greater emotional regulation difficulties.

Ten items were reverse-scored (items 9, 15, 18, 19, 20, 21, 22, 23, 26, and 32). The two items excluded after confirmatory factor analysis (items 27 and 33) were not included in the final 34-item total score. The final adapted version retained the six original subscales.

3.3.1. Reliability and Internal Consistency

Internal consistency was examined using Cronbach's alpha. Coefficients ranged from.79 to.89 across the six subscales. Item-total Pearson correlations ranged from.51 to.87 (all p <.01), while subscale-to-total correlations ranged from.86 to.90 (all p <.01). These results provide evidence of internal consistency and coherence among the items and subscales in the current sample.

3.3.2. Construct Validity: Confirmatory Factor Analysis

Construct validity was examined using a second-order confirmatory factor analysis (CFA) in AMOS version 20. The model fit indices were $\chi^2(521) = 992.23$, CMIN/df = 1.90, GFI =.81, CFI =.81, IFI =.81, NFI =.66-.67, and RMSEA =.09. The indices provide mixed evidence regarding model fit: the CMIN/df value is favorable, whereas the GFI, CFI, IFI, and NFI values indicate limitations in fit, and the RMSEA value suggests that the model fit is not optimal. Accordingly, the results should be interpreted as preliminary evidence regarding the six-factor second-order structure rather than as unequivocal confirmation of model fit (Table 5).

Table 5. CFA Fit Indices and Reliability Coefficients for DERS in the Current Sample.

Fit Index	Value / Interpretation
X^2/df (CMIN/df)	1.90 — favorable
GFI	.81 — limited fit
CFI	.81 — limited fit
IFI	.81 — limited fit
NFI	.66-.67 — limited fit
RMSEA	.09 — suggests room for improvement
Cronbach's α range	.79-.89 — subscale reliability coefficients

3.4. Intervention: EFT-Based Therapeutic Program

The therapeutic program was developed based on established EFT principles [15-17, 23, 24] and comprised 12 individual sessions delivered twice weekly, each lasting 40-60 minutes, over six weeks. The program targeted the enhancement of six core emotional competencies: (1) self-awareness, (2) emotional expression, (3) self-regulation, (4) emotional experience, (5) empathy, and (6) impulse control.

Table 6. Session-by-Session Overview of the EFT Therapeutic Program.

Session	Therapeutic Phase	Objectives	Techniques
1	Phase I: Alliance Building & Awareness	Build therapeutic alliance; establish treatment goals; create safe environment.	Reflective empathy; icebreaking; discussion.
2		Increase awareness of emotions and underlying drivers; differentiate primary/secondary emotions.	Mindfulness; emotion exploration; self-monitoring.
3		Understand attachment theory; reframe problems in attachment terms.	Psychoeducation; safe place; reframing.
4		Identify negative interactional cycles; understand attachment obstacles.	Cycle interruption; discussion.
5	Phase II: Restructuring	Reduce defensive behaviors; de-escalate negative interactional cycles.	Cycle interruption; emotional reframing; role-play.
6		Use EFT tapping technique to release negative emotions tied to specific situations.	EFT tapping; guided discussion.
7		Deepen sense of internal emotional safety; enhance self-compassion.	Compassionate imagery; body scan; mindfulness; self-compassion letter.
8		Improve emotional communication skills; promote authentic emotional expression.	Emotional intensification; guided expression; self-assertion.
9	Phase III: Consolidation	Rebuild bridges of open communication; facilitate new emotional interactional patterns.	New emotional response facilitation; role-play; positive reinforcement.
10		Strengthen self-awareness and self-esteem within the relational context.	Self-compassion imagery; mindfulness; discussion.
11		Integrate new positive relational experiences; co-author new relational narrative; plan for sustained healthy interaction.	Narrative reconstruction; reframing; role-play; discussion.
12		Review progress; reinforce skills; prevent relapse; closure.	Review; consolidation; feedback.

3.5. Procedure

Ethical approval was obtained prior to data collection. Informed consent was secured from all participants. Participants in the experimental group attended individual sessions at the Al-Usra Family Association centers. The control group received no treatment during the intervention period. All participants completed the DERS at pretest (T1), posttest (T2), and one-month follow-up (T3). The control group was offered the intervention following data collection.

3.6. Statistical Analysis

Given the small sample size (n = 8 per group) and failure to meet normality assumptions, nonparametric statistical tests were employed. The Wilcoxon Signed-Rank test was used to examine within-group differences (pretest-posttest; posttest-follow-up). The Mann-Whitney U test was used to compare posttest scores between the experimental and control groups. Effect size was reported using Cohen's d. All analyses were conducted using SPSS version 26.

4. Results

4.1. Research Question 1: Pretest-Posttest Differences in the Experimental Group

The first research question examined whether there were statistically significant differences between pretest and posttest mean rank scores on the DERS within the experimental group. Results of the Wilcoxon Signed-Rank test are presented in Table 7.

*Table 7. Wilcoxon Signed-Rank Test: Pretest-Posttest Differences in the Experimental Group. *p <.05.*

Comparison	Ranks	n	Mean Rank	Z	p (2-tailed)
DERS Posttest − Pretest	Negative Ranks	8	4.50	−2.52	.012*
	Positive Ranks	0	.00		
	Ties	0	—		
Cohen's d	0.98 (Large)				

The Wilcoxon Signed-Rank test yielded Z = −2.52 (p =.012), indicating a statistically significant reduction in DERS scores from pretest to posttest in the experimental group. All eight participants demonstrated lower posttest scores (negative ranks = 8; positive ranks = 0; ties = 0). Cohen's d = 0.98 indicates a large effect size, confirming that the observed change is not only statistically significant but clinically meaningful.

4.2. Research Question 2: Posttest Differences Between Experimental and Control Groups

The second research question examined whether posttest DERS scores differed significantly between the experimental and control groups. The Mann-Whitney U test results are reported in Table 8.

*Table 8. Mann-Whitney U Test: Posttest Differences Between Groups. **p <.01.*

Group	n	Mean Rank	Sum of Ranks	Z	p
Control	8	12.50	100.00	−3.36	.001**
Experimental	8	4.50	36.00		

The Mann-Whitney U test revealed a statistically significant difference between groups at posttest (Z = −3.36, p =.001), with the experimental group showing lower DERS scores than the control group. This result is consistent with a beneficial effect of the EFT intervention; however, given the quasi-experimental design and small sample, it should not be interpreted as definitive evidence that the intervention alone caused the observed difference.

4.3. Research Question 3: Posttest-Follow-Up Differences in the Experimental Group

The third research question examined whether therapeutic gains were maintained at one-month follow-up. Results are presented in Table 9.

Table 9. Wilcoxon Signed-Rank Test: Posttest-Follow-Up Differences in the Experimental Group. ns = non-significant.

Comparison	Ranks	n	Mean Rank	Z	p (2-tailed)
DERS Follow-up − Posttest	Negative Ranks	0	.00	−1.41	.157 (ns)
	Positive Ranks	2	1.50		
	Ties	6	—		

The Wilcoxon Signed-Rank test found no significant difference between posttest and one-month follow-up scores (Z = −1.41, p =.157), indicating that therapeutic gains were maintained over the follow-up period. Six of eight participants maintained identical scores at both time points (ties = 6), further demonstrating the stability of intervention effects.

5. Discussion

The present study examined the effectiveness of a structured EFT-based intervention in reducing emotional regulation difficulties among married women in Saudi Arabia. Three principal findings emerge: (1) significant pretest-to-posttest reductions in ERD within the experimental group (large effect size); (2) significant posttest superiority of the experimental group over the untreated control group; and (3) maintenance of therapeutic gains at one-month follow-up. Collectively, these findings provide robust support for the efficacy of EFT in the Saudi Arabian family counseling context.

5.1. Discussion of Hypothesis 1: Pre-Post Effects

The significant reduction in DERS scores from pretest to posttest (Z = −2.52, p =.012; d = 0.98) is consistent with and extends prior EFT research. These findings align with Ghahari et al. [13], Vejdani et al. [35], Bazyari et al. [7], and Teymouri

et al. [33], all of whom documented significant EFT-related improvements in emotional regulation among married women. The large effect size observed here surpasses the small-to-medium effects frequently reported in pharmacological and non-experiential psychological interventions for ERD, underscoring EFT's distinctive capacity to address the emotional core of regulatory difficulties.

From a theoretical standpoint, EFT's efficacy is attributable to its direct targeting of the primary emotional sources of regulatory dysfunction. Rather than teaching cognitive reappraisal or behavioral coping strategies—approaches that address emotional dysregulation indirectly—EFT helps participants access and differentiate primary adaptive emotions (e.g., fear of loss, need for closeness) from secondary defensive states (e.g., anger, withdrawal), and restructure maladaptive emotional schemas through corrective emotional experiences within the therapeutic relationship [16, 18]. The therapeutic alliance established in Phase I appears to have created the psychological safety necessary for participants to engage in deeper emotional processing.

A case illustration from the intervention is instructive. One participant reported: 'In the beginning, I thought I was simply angry all the time. During the session, I realized that anger was not the real feeling—it was concealing a deeper sense of sadness and fear of rejection. When I began focusing on and accepting this core feeling rather than resisting it, I felt a greater sense of inner peace. It helped me understand myself more clearly, and I became able to express my needs calmly rather than reacting impulsively.' This narrative exemplifies the EFT mechanism of secondary-to-primary emotional differentiation, and its downstream effects on regulatory capacity.

5.2. Discussion of Hypothesis 2: Between-Group Differences

The significant posttest difference between the experimental and untreated control groups ($Z = -3.36$, $p = .001$) is consistent with a beneficial effect of the EFT intervention. Nevertheless, the quasi-experimental design and small sample size warrant caution in attributing the entire between-group difference exclusively to the intervention. This finding is considered alongside results reported by Ghahari et al. [13], Teymouri et al. [33], Vejdani et al. [35], and Bazyari et al. [7].

The intervention's effectiveness can be understood through multiple theoretical lenses. From an attachment theory perspective [9, 23], the experimental group's exposure to a consistent, safe therapeutic relationship likely activated and partially reorganized insecure internal working models—reducing the defensive reactivity and emotional flooding that characterize ERD. The program's systematic use of techniques such as cycle interruption, emotional reframing, self-compassion imagery, and EFT tapping collectively targeted the full spectrum of DERS dimensions, from non-acceptance and impulse control deficits to limited strategy access and emotional clarity. The untreated control group's lack of comparable change underscores the specific rather than non-specific nature of EFT's mechanisms.

5.3. Discussion of Hypothesis 3: Follow-Up Stability

The absence of significant differences between posttest and follow-up ($Z = -1.41$, $p = .157$) indicates that therapeutic gains were not only achieved but maintained over one month post-treatment. This finding replicates the follow-up results reported by Teymouri et al. [33] and is consistent with the meta-analytic evidence reviewed by Elliott et al. [39], who found EFT's effects durable across follow-up assessments in over 20 experimental studies.

The durability of effects can be attributed to EFT's emphasis on lived experiential learning within sessions—through role-play, mindfulness, body scan, and experiential exercises—that participants generalize to daily life situations. Wiebe and Johnson [36] note that EFT's focus on creating new in-session emotional experiences, rather than merely discussing problems, is the key mechanism underlying long-term change. The consolidation phase (Phase III, Sessions 10-12) of the present program was specifically designed to anchor these new emotional and interactional patterns within participants' real-life contexts, further supporting sustained gains.

5.4. Limitations

Several limitations warrant acknowledgment. First, the small sample size ($n = 8$ per group) limits statistical power and generalizability; findings should be interpreted with appropriate caution. Second, the study used a no-treatment control rather than an active comparison condition (e.g., CBT, DBT), precluding definitive conclusions about EFT's relative superiority. Third, follow-up was limited to one month; longer-term durability remains unknown. Fourth, the absence of a therapist fidelity measure limits conclusions regarding treatment integrity. Fifth, the study did not include pre-existing clinical diagnostic information, which may have influenced baseline ERD levels.

6. Conclusion

This study provides the first quasi-experimental evidence from Saudi Arabia for the efficacy of a structured EFT program in reducing emotional regulation difficulties among married women. The intervention produced significant, large-effect improvements from pretest to posttest, demonstrated superiority over a no-treatment control at posttest, and maintained gains at one-month follow-up. These findings bridge an important gap in the evidence base for experiential therapies in Arab cultural contexts and validate EFT as a clinically meaningful and culturally adaptable intervention.

6.1. Clinical Recommendations

1) EFT-based programs should be incorporated into family counseling centers and psychological clinics in Saudi Arabia as evidence-based interventions for ERD.
2) Specialized pre-marital and marital training programs should include structured emotional regulation skills modules consistent with EFT principles.
3) Psychoeducational workshops for married women focused on emotional awareness and adaptive regulation strategies are warranted.
4) Family counselors and psychologists should be trained in EFT techniques; professional development curricula should include experiential therapy competencies.
5) The DERS, as validated in this sample, offers a psychometrically sound tool for routine screening and outcome monitoring in Saudi family counseling settings.

6.2. Future Research Directions

1) Examine EFT efficacy on related constructs (anxiety, depression, burnout) in Saudi married women.
2) Conduct comparative trials of EFT versus CBT or family therapy to establish relative efficacy.
3) Apply the program with larger, more diverse samples (e.g., recently married, engaged, divorced women) to assess generalizability.
4) Investigate mediators and moderators of EFT effects, including attachment style and cultural values.
5) Conduct longitudinal studies with extended follow-up periods (6-12 months) to assess sustained effects.
6) Explore predictors of ERD among Saudi married women as potential prevention targets.
7) Expand the EFT evidence base within Arab and Islamic cultural contexts through multi-site collaborative research.

Abbreviations

EFT	Emotion-Focused Therapy
DERS	Difficulties in Emotion Regulation Scale
ERD	Emotional Regulation Difficulties
DBT	Dialectical Behavior Therapy
ACT	Acceptance and Commitment Therapy
CFA	Confirmatory Factor Analysis
CMIN/df	Chi-square Divided by Degrees of Freedom
GFI	Goodness-of-Fit Index
CFI	Comparative Fit Index
IFI	Incremental Fit Index
NFI	Normed Fit Index
RMSEA	Root Mean Square Error of Approximation
SPSS	Statistical Package for the Social Sciences
T1	Pretest
T2	Posttest
T3	One-month Follow-up

Author Contributions

Wasan Al-Bulayhi: Conceptualization, Data curation, Formal Analysis, Investigation, Methodology, Software, Writing – original draft

Jihan Awad: Conceptualization, Methodology, Project administration, Resources, Supervision, Validation, Writing – review & editing

Conflicts of Interest

The authors declare no conflicts of interest.

References

[1] Aldao, A., Nolen-Hoeksema, S., & Schweizer, S. (2010). Emotion-regulation strategies across psychopathology: A meta-analytic review. Clinical Psychology Review, 30(2), 217-237. https://doi.org/10.1016/j.cpr.2009.11.004

[2] Al-Mulayhim, J. M., & Al-Hawrani, A. K. (2025). Effectiveness of an EFT- and EMDR-based counseling program in reducing alexithymia among women with delayed childbirth in Jeddah. Journal of Educational and Specialized Research, 31, 1-90. https://doi.org/10.21608/jeor.2025.406132

[3] Al-Tantawi, B. (2024). Effectiveness of emotion-focused therapy in alleviating marital problems among recently married women. Arab Studies in Education and Psychology, 2(152), 505-545. https://doi.org/10.21608/saep.2024.425561

[4] Asadi, M., Ghasemzadeh, N., Nazarifar, M., & Sarvandani, M. N. (2020). The effectiveness of emotion-focused couple therapy on marital satisfaction and positive feelings towards the spouse. International Journal of Health Studies, 6(4), 36-40. https://doi.org/10.22100/ijhs.v6i4.804

[5] Babakhani, V., Ataeimehr, N., & Alijani, F. (2023). The effectiveness of emotion-focused couple therapy on marital adjustment and emotion regulation. Journal of Contemporary Psychotherapy, 53(3), 215-227. https://doi.org/10.1007/s10879-022-09574-0

[6] Bardeen, J. R., & Fergus, T. A. (2016). Emotion regulation difficulties as a transdiagnostic factor underlying multiple anxiety disorders. Journal of Anxiety Disorders, 44, 35-43. https://doi.org/10.1016/j.janxdis.2016.01.002

[7] Bazyari, K., Hooman, F., Shoushtari, M. T., & Saadi, Z. E. (2024). Effectiveness of emotionally focused therapy for couples in improving emotion regulation and relationship distress of emotionally divorced couples. Zahedan Journal of Research in Medical Sciences, 26(2). https://doi.org/10.5812/zjrms-142128

[8] Bloch, L., Haase, C. M., & Levenson, R. W. (2014). Emotion regulation predicts marital satisfaction: More than a wives' tale. Emotion, 14(1), 130-144. https://doi.org/10.1037/a0034272

[9] Bowlby, J. (1969). Attachment and loss: Retrospect and prospect. American Journal of Orthopsychiatry, 52(4), 664-678. https://doi.org/10.1111/j.1939-0025.1982.tb01456.x

[10] Elliott, R., Watson, J. C., Goldman, R. N., & Greenberg, L. S. (2004). Learning emotion-focused therapy: The process-experiential approach to change. American Psychological Association. https://doi.org/10.1037/10725-000

[11] Etkin, A., Büchel, C., & Gross, J. J. (2015). The neural bases of emotion regulation. Nature Reviews Neuroscience, 16(11), 693-700. https://doi.org/10.1038/nrn4044

[12] Garofalo, C., Velotti, P., & Zavattini, G. C. (2018). Difficulties in emotion regulation and interpersonal problems: The role of negative affect in clinical and nonclinical populations. Personality and Individual Differences, 134, 75-80. https://doi.org/10.1016/j.paid.2018.06.011

[13] Ghahari, S., Jamil, L., Farrokhi, N., & Davoodi, R. (2021). Comparing the effects of emotion-focused couple therapy and acceptance and commitment therapy on marital conflict and emotion regulation. Practice in Clinical Psychology, 9(2), 121-132. https://doi.org/10.32598/jpcp.9.2.718.1

[14] Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation. Journal of Psychopathology and Behavioral Assessment, 26(1), 41-54. https://doi.org/10.1023/B:JOBA.0000007455.08539.94

[15] Greenberg, L. S. (2002). Emotion-focused therapy: Coaching clients to work through their feelings. American Psychological Association. https://doi.org/10.1037/10447-000

[16] Greenberg, L. S. (2010). Emotion-focused therapy: A clinical synthesis. FOCUS: The Journal of Lifelong Learning in Psychiatry, 8(1), 32-42. https://doi.org/10.1176/foc.8.1.foc32

[17] Greenberg, L. S. (2017). Emotion-focused therapy (Rev. ed.). American Psychological Association. https://doi.org/10.1037/15971-000

[18] Greenberg, L. S., & Pascual-Leone, A. (2006). Emotion in psychotherapy: A practice-friendly research review. Journal of Clinical Psychology, 62(5), 611-630. https://doi.org/10.1002/jclp.20252

[19] Greenberg, L. S., & Watson, J. C. (2006). Emotion-focused therapy for depression. American Psychological Association. https://doi.org/10.1037/11286-000

[20] Gross, J. J. (1998). The emerging field of emotion regulation: An integrative review. Review of General Psychology, 2(3), 271-299. https://doi.org/10.1037/1089-2680.2.3.271

[21] Varra, A. A., Hayes, S. C., Roget, N., & Fisher, G. (2008). A randomized control trial examining the effect of acceptance and commitment training on clinician willingness to use evidence-based pharmacotherapy. Journal of consulting and clinical psychology, 76(3),449. https://doi.org/10.1037/0022-006X.76.3.449

[22] Holowaty, K. A., & Paivio, S. C. (2012). Problematic emotion and its regulation: Clinical applications of emotion-focused therapy. Psychotherapy, 49(1), 80-87. https://doi.org/10.1037/a0022182

[23] Johnson, S. M. (2004). The practice of emotionally focused couple therapy (2nd ed.). Brunner-Routledge. https://doi.org/10.4324/9780203843871

[24] Greenman, P. S., & Johnson, S. M. (2013). Process research on emotionally focused therapy (EFT) for couples: Linking theory to practice. Family Process, 52(1), 46-61. https://doi.org/10.1111/famp.12015

[25] Johnson, S. M., & Greenberg, L. S. (1987). Emotionally focused marital therapy: An overview. Psychotherapy: Theory, Research, Practice, Training, 24(3S), 552-560.

[26] Kian, N., Maleki, H., & Amani, A. (2019). Effectiveness of emotion-focused therapy on marital satisfaction, empathy, and emotional regulation among couples. Journal of Family Psychology, 33(4), 456-465. https://doi.org/10.1037/fam0000527

[27] Kula, S., Arslan, R., & Ceylan, V. (2022). Effectiveness of emotion-focused therapy on marital adjustment and attachment styles. Journal of Marital and Family Therapy, 48(3), 555-570. https://doi.org/10.1111/jmft.12536

[28] Mikulincer, M., & Shaver, P. R. (2012). Adult attachment orientations and relationship processes. Journal of family theory & review, 4(4), 259-274. https://doi.org/10.1111/j.1756-2589.2012.00142.x

[29] Paivio, S. C., & Pascual-Leone, A. (2010). Emotion-focused therapy for complex trauma: An integrative approach. American Psychological Association. https://doi.org/10.1037/12077-000

[30] Shabankare, E., Saffarinia, M., & Abdi, M. (2021). Emotion regulation difficulties and marital satisfaction: The mediating role of interpersonal problems. Journal of Family Issues, 42(7), 1674-1694. https://doi.org/10.1177/0192513X20965944

[31] Shahmoradi, S., Afshar, H. K., Goudarzy, M., & Lavasani, M. G. A. (2019). Effectiveness of emotion-focused therapy in reduction of marital violence and improvement of family functioning. Iranian Red Crescent Medical Journal, 21(11). http://dx.doi.org/10.5812/ircmj.97183

[32] Tanhaeinowghabi, M., Khezeli, M., & Abolghasemi, A. (2023). Effectiveness of emotion-focused therapy on emotion regulation and quality of life. Journal of Health Psychology, 28(5), 635-646. https://doi.org/10.1177/13591053211069867

[33] Teymouri, Z., Mojtabaei, M., & Rezazadeh, S. M. R. (2020). The effectiveness of emotionally focused couple therapy on emotion regulation, anger rumination, and marital intimacy. Caspian Journal of Health Research, 5(4), 78-82. http://dx.doi.org/10.29252/cjhr.5.4.78

[34] Thompson, R. A. (1994). Emotion regulation: A theme in search of definition. Monographs of the Society for Research in Child Development, 59(2-3), 25-52. https://doi.org/10.2307/1166137

[35] Vejdani, N., Ahmadian, H., Yarahmadi, Y., & Karimi, Q. (2025). Comparison of the effectiveness of an empowerment-based educational program and emotion-focused therapy. International Journal of Education and Cognitive Sciences, 6(1), 67-80. https://doi.org/10.61838/kman.ijecs.6.1.7

[36] Wiebe, S. A., & Johnson, S. M. (2016). A review of the research in emotionally focused therapy for couples. Family Process, 55(3), 390-407. https://doi.org/10.1111/famp.12229

[37] Linehan, M. M. (1993). Cognitive-behavioral treatment of borderline personality disorder. Guilford Press.

[38] Rogers, C. R. (1951). Client-centered therapy: Its current practice, implications, and theory. Houghton Mifflin.

[39] Elliott, R., Greenberg, L. S., Watson, J. C., Timulak, L., & Freire, E. (2013). Research on humanistic-experiential psychotherapies. In M. J. Lambert (Ed.), Bergin and Garfield's handbook of psychotherapy and behavior change (6th ed., pp. 495-538). John Wiley & Sons.

[40] Kramer, U., et al. (2026). Effectiveness of emotion-focused therapy: Main results of a practice-research network study. Psychotherapy Research, 36(1), 1-9. https://doi.org/10.1080/10503307.2025.2454455