Jundishapur J Health Sci. 2026 January; 18(1), 51-61 https://jjhs.ajums.ac.ir /

Published Online: 2026 June 30 Research Article

https://doi.org/10.22118/jjhs.2026.573930.1036

The Impact of Emotionally Focused Couple Therapy on Emotional Empathy, Sexual Functioning, and Marital Relationship Quality in Couples Experiencing Marital Conflict

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Article Info.

Received: 4 February, 2026 **Revised:** 26 February, 2026 **Accepted:** 24 May ,2026

Abstract

Background and Objective: Marital conflict can profoundly impair interpersonal dynamics and individual psychological and emotional well-being. The present study aimed to investigate the impact of Emotionally Focused Couple Therapy (EFCT) on emotional empathy, sexual functioning, and marital relationship quality among couples experiencing marital conflict.

Methods: This study employed a pretest–posttest clinical trial design with a control group. The study was prospectively registered in the Iranian Registry of Clinical Trials (IRCT20250531065993N1). The statistical population consisted of all couples attending psychological counseling centers in Ahvaz, Iran, during 2025. Thirty couples (60 individuals) were selected via convenience sampling and randomly assigned to either the experimental group (15 couples; 30 individuals) or the control group (15 couples; 30 individuals). The experimental group participated in ten 90-minute sessions of EFCT, following the protocol developed by Johnson and Greenberg, while the control group was placed on a waiting list. Data were collected using the following instruments: the Emotional Empathy Scale, the Marital Sexual Functioning Scale, and the Revised Dyadic Adjustment Scale (RDAS).

Findings: Results of multivariate analysis of covariance revealed that EFCT led to statistically significant improvements in emotional empathy, sexual functioning, and marital relationship quality in the experimental group compared to the control group (multivariate $P<0.001$; univariate $P<0.001$ for emotional empathy, sexual functioning, and marital relationship quality).

Conclusion: EFCT constitutes an effective intervention for reducing marital distress by strengthening emotional bonding and enhancing functional intimacy within the couple relationship.

Keywords*:* Emotionally focused therapy, Empathy, Sexual health, Marital conflict, Couples therapy

Introduction

The family institution serves as the fundamental unit of society, and the quality of the marital relationship is a primary determinant of individual mental health and social stability (1). However, marital conflict remains a pervasive phenomenon that threatens the integrity of this institution. Marital conflict arises when couples perceive incompatible goals, disparate needs, or chronic emotional disconnection (2). In contemporary societies, the prevalence of marital discord has escalated, leading to increased rates of psychological distress, domestic instability, and divorce. Couples experiencing chronic conflict often fall into rigid, maladaptive interactional patterns characterized by criticism, defensiveness, and emotional withdrawal (3). These dysfunctional cycles not only jeopardize the longevity of the marriage but also manifest as significant impairments in emotional regulation and interpersonal functioning (4). In the context of Iranian society, specifically in urban centers like Ahvaz, factors such as urbanization, economic instability, job-related stress, shifting traditional family roles, and related socio-economic pressures including poverty and financial strain have further exacerbated marital tensions (5). Therefore, this necessitates effective, evidence-based psychological interventions to restore relational harmony.

One of the critical psychological components of marital success is emotional empathy which acts as the "emotional glue" that binds partners together. It involves the ability to perceive, understand, and vicariously experience the emotional states of one's spouse (6). In distressed marriages, empathy often erodes, and it is replaced by emotional blindness or cognitive biases that lead to the misinterpretation of the partner's intentions (7). Research indicates that a deficit in emotional empathy is strongly correlated with increased hostility and a decrease in prosocial behaviors within the dyad (8). When partners are unable to resonate with each other's vulnerabilities, they become trapped in "demand-withdraw" cycles, wherein one partner (the "demander") persistently seeks discussion, change, connection, or emotional engagement (e.g., through criticism, nagging, or repeated requests). The other partner (the "withdrawer"), on the other hand, avoids or withdraws from the interaction to reduce discomfort or conflict (e.g., by becoming silent, changing the subject, or physically leaving the conversation), further alienating the other partner and perpetuating distress (9). In the Iranian culture, gender differences in empathy expression may influence these dynamics, with women often socialized to exhibit more overt emotional responsiveness and interpersonal attunement compared to men, who may prioritize emotional restraint and independence due to traditional gender norms. Therefore, enhancing emotional empathy is not merely a clinical goal but a prerequisite for rebuilding trust and emotional safety in a conflicted relationship.

Another pivotal dimension of marital health that is deeply intertwined with emotional intimacy is sexual functioning. It encompasses the physiological and psychological aspects of sexual desire, arousal, and satisfaction (10). Marital conflict commonly spills over into the sexual domain, manifesting in reduced libido, erectile difficulties, lubrication problems, orgasmic dysfunction, and lowered sexual satisfaction (11). Unlike a purely physiological issue, sexual functioning in the context of marriage is often a reflection of the "relational climate." When couples are in conflict, the lack of emotional safety prevents the vulnerability required for healthy sexual intimacy (12). Studies have shown that chronic relational stress elevates cortisol levels and triggers sympathetic nervous system dominance, which, from an attachment perspective, stems from insecure attachment bonds. These bonds heighten perceived relational threats, impair emotional regulation, and disrupt physiological processes necessary for sexual arousal and intimacy, which is biologically antithetical to sexual arousal (13). Consequently, addressing sexual concerns without repairing the emotional bond is often ineffective, and this highlights the need for systemic approaches that integrate emotional and physical intimacy.

Marital relationship quality is a multidimensional construct that reflects the overall subjective evaluation of a couple's partnership, including satisfaction, cohesion, and consensus. High-quality relationships are associated with numerous positive outcomes, including better physical health, lower rates of depression, and enhanced parenting efficacy (14). Poor marital quality, on the other hand, is a significant predictor of psychosomatic disorders such as chronic headaches, gastrointestinal issues, hypertension, cardiovascular problems, and sleep disturbances and general life dissatisfaction. In couples with marital conflict, the quality of the relationship is often characterized by a lack of shared activities and a breakdown in communication (15). The erosion of marital quality is not a sudden event but a cumulative process resulting from unresolved conflicts and emotional neglect. Restoring marital quality requires shifting the focus from individual grievances to the "we-ness" of the relationship, fostering a shared sense of meaning and mutual support (16).

Emotionally Focused Couple Therapy (EFCT), developed by Sue Johnson and Leslie Greenberg, is a short-term, structured approach that views marital distress through the lens of attachment theory. EFCT aims to reorganize the emotional responses and interactional patterns that define the couple's bond (17). Attachment theory posits that secure bonds promote emotional empathy by providing a foundation of safety that allows partners to openly express and respond to vulnerabilities; enhance sexual functioning through reduced relational anxiety, increased emotional accessibility, and greater physiological relaxation conducive to intimacy;

and elevate overall relationship quality by fostering mutual support, resilience to stressors, and a shared sense of security. Previous research has consistently demonstrated the efficacy of EFCT in various clinical populations (18, 19). For instance, studies have shown that EFCT significantly improves marital satisfaction and reduces symptoms of depression in distressed couples (18). Furthermore, international longitudinal research suggests that the gains made during EFCT are stable over time, with low relapse rates primarily observed in Western samples compared to other therapeutic modalities (20). By helping couples identify their "negative cycle"—the dance of pursuit and withdrawal—EFCT allows partners to express their underlying attachment needs for safety, comfort, and contact, thereby creating a more secure emotional bond (21, 22).

The necessity of this research stems from the increasing demand for culturally adapted and evidence-based interventions for couples in Iran. The effectiveness of EFCT has been validated in Western contexts, with minimal adaptations to address conservative norms around vulnerability and sexuality expression. However, its impact on the specific triad of emotional empathy, sexual function, and marital quality in an Iranian clinical sample—particularly in Ahvaz—requires further empirical investigation. While most existing studies have focused on general satisfaction, this study targets the specific mechanisms of emotional and physical intimacy. We hypothesized that EFCT would significantly improve emotional empathy, sexual functioning, and marital relationship quality compared to a waitlist control. Understanding how EFCT influences these variables can provide clinicians with a more nuanced roadmap for treating marital discord. Therefore, the present study sought to investigate the effectiveness of EFCT on emotional empathy, sexual functioning, and marital relationship quality among couples experiencing marital conflict.

Methods

Design and Participants

This study adopted a randomized pretest–posttest control group design in a clinical trial framework. A post-hoc power analysis using G*Power software indicated adequate power (>0.90) to detect medium-to-large effect sizes based on observed partial eta-squared values ranging from 0.35 to 0.65, with a sample of 60 individuals. The statistical population comprised all couples experiencing marital conflict who sought assistance at psychological counseling centers in Ahvaz, Iran, during 2025. Through convenience sampling, 30 couples (60 individuals) were selected based on clinical screening for marital distress. Participants were then randomly assigned using block randomization to either the experimental group (15 couples; 30 individuals) or the control group (15 couples; 30 individuals) (Figure 1). Inclusion criteria were: a minimum of two years of marriage, a minimum education level of a high school diploma, and scoring below the cutoff of 48 on the Revised Dyadic Adjustment Scale (RDAS), indicating marital distress based on established clinical thresholds. Exclusion criteria included receiving concurrent psychotherapy, a history of psychiatric hospitalization, or substance abuse. Ethical considerations were strictly observed; all participants provided informed written consent, were assured of data confidentiality, and were informed of their right to withdraw from the study at any stage. The study was prospectively registered in the Iranian Registry of Clinical Trials (IRCT20250531065993N1) prior to participant enrollment (registration date: June 20, 2025; Ethics Committee approval: IR.IAU.AHVAZ.REC.1403.395).

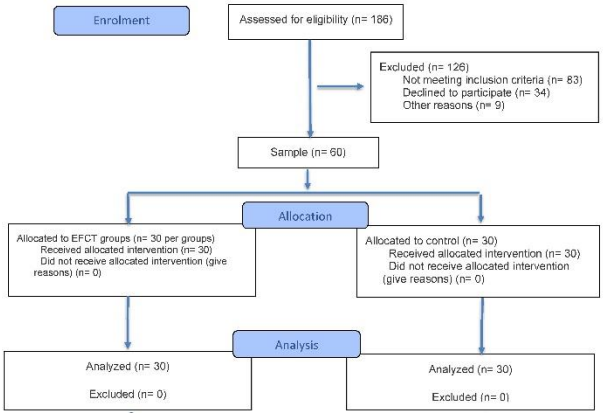

Figure 1. CONSORT flow diagram

Procedure

Following the receipt of the IRCT registration code, the research was conducted from July to October 2025. Both groups underwent a pretest to establish baseline measurements for emotional empathy, sexual function, and marital quality. Outcome assessors were blinded to group allocation to minimize detection bias. The experimental group subsequently participated in ten 90-minute weekly sessions of EFCT based on the protocol by Johnson and Greenberg (17). During this period, the control group received no intervention and remained on a waiting list. To address ethical concerns with the waitlist control, EFCT was offered to control participants post-study. Upon completion of the intervention, a posttest was administered to both groups under identical conditions to evaluate the treatment's efficacy.

Instruments

Emotional Empathy Scale (EES): Developed by Mehrabian and Epstein (23), this 33-item instrument measures emotional empathy across seven subscales.

Items are scored on a 4-point Likert scale (from 1 to 4). Higher scores indicate a greater capacity for emotional resonance and empathy. In previous Iranian studies, Cronbach's alpha was reported at 0.89 (24), while the current study yielded a reliability coefficient of 0.81, confirming its high internal consistency. The EES has demonstrated robust psychometric properties in distressed Iranian samples, with forward-backward translation ensuring cross-cultural validity.

Marital Sexual Functioning Scale (MSFS): This scale, which has already been adapted for the Iranian population by Farajnia et al. (25), is a comprehensive 60-item instrument designed to assess various dimensions of sexual health within a marital context. The scale utilizes a 5-point Likert-type response format, ranging from 1 (strongly disagree) to 5 (strongly agree). Higher scores reflect a more positive perception of sexual functioning and higher sexual satisfaction. The scale's multidimensional nature allows for a precise evaluation of physical and psychological sexual dynamics. In the present study, the internal consistency (Cronbach's alpha) for the MSFS was calculated at 0.86, demonstrating robust reliability for this clinical sample. The MSFS has been validated in Iranian populations, including distressed couples, with forward-backward translation confirming equivalence.

Revised Dyadic Adjustment Scale (RDAS): Developed by Busby et al. (26), this 14-item questionnaire assesses three dimensions: consensus, satisfaction, and cohesion. Scores range from 0 to 69, where higher scores signify superior marital relationship quality and lower scores indicate distress. The RDAS is a widely validated tool globally (27). In this research, the internal consistency was found to be 0.89, demonstrating excellent reliability for assessing marital dynamics. The RDAS has shown strong psychometric properties in Iranian samples, with forward-backward translation applied for validity. A cutoff score of <48 was used to identify distressed couples, consistent with established clinical thresholds and Persian validation studies.

Intervention Program

The intervention consisted of ten 90-minute sessions of EFCT. The sessions aimed to shift the couples' interactions from negative, reactive cycles to secure, accessible, and responsive bonding. The protocol was delivered with minimal cultural adaptations, emphasizing universal attachment needs while respecting conservative norms around emotional vulnerability. The therapist was certified in EFCT and ensured fidelity through audiotaping sessions, with adherence rated at $>80\%$ by a certified EFCT supervisor using the EFT Coding System. Session attendance was monitored, requiring ≥ 8 sessions for inclusion; all participants met this threshold. Adverse events were monitored via weekly check-ins, with none reported. As summarized in Table 1, the ten sessions followed a structured progression based on the standard EFCT protocol by Johnson and Greenberg (17) .

Table 1. Summary of emotionally focused couple therapy (EFCT) sessions occasions

Session	Core Themes and Clinical Objectives
1 & 2	Assessment and Alliance Building: Establishing a safe therapeutic environment; identifying the "Negative Cycle" (e.g., pursue-withdraw); assessing attachment histories and the impact of marital conflict on emotional safety.
3 & 4	Identifying Underlying Emotions: Moving beyond surface anger or silence to access primary attachment emotions (fear, loneliness, or shame); exploring how these emotions fuel the couple's repetitive conflictual patterns.
5	Reframing the Problem: Defining the conflict not as a partner's flaw, but as a "negative cycle" that traps both individuals; validating each partner's experience within this cycle to reduce blame.
6	Promoting Emotional Engagement: Helping the "withdrawn" partner re-engage by expressing their vulnerability; fostering a sense of being reachable and responsive within the relationship.
7	Facilitating Pursuer Softening: Assisting the "pursuing/critical" partner in expressing their needs for connection from a place of vulnerability rather than criticism, creating a "softened" emotional state.

8	Restructuring the Bond: Creating new interactional events where partners can ask for their attachment needs to be met; reinforcing new, secure cycles of accessibility and responsiveness.
9	Consolidation and Integration: Reviewing the progress made; identifying how the couple successfully navigated conflicts using new emotional tools; solidifying the newfound secure attachment.
10	Termination and Future Planning: Strengthening the couple's ability to maintain these positive changes; discussing potential future triggers and relapse prevention; concluding the therapeutic process.

Data Analysis

Data were analyzed using SPSS version 26. Descriptive statistics (mean and standard deviation) were used to summarize the data. For inferential analysis, Multivariate Analysis of Covariance (MANCOVA) and Univariate analysis of covariance (ANCOVA) were employed to compare the experimental and control groups while controlling for pretest scores, ensuring the assumptions of normality and homogeneity of variance were met. MANCOVA was selected due to the correlated nature of the dependent variables, enhancing statistical power despite randomization; complementary repeated-measures ANOVA yielded similar results (not shown). No correction for multiple comparisons was applied, as these were predefined primary outcomes, though this increases Type I error risk. There were no missing data, so complete-case analysis was used.

Results

Demographic characteristics of the participants were comparable across groups at baseline. The mean age of individuals was 34.2 years (SD = 6.8) in the experimental group and 35.1 years (SD = 7.2) in the control group. Regarding educational attainment, all participants had at least a high school diploma as per the inclusion criteria. In the experimental group, 63.3% (19 out of 30 individuals) reported having a university degree (bachelor's or higher), while 36.7% held only a high school diploma or an associate degree. In the control group, 66.7% (20 out of 30 individuals) had a university degree, and 33.3% had high school or associate-level education. The average duration of marriage was 8.4 years (SD = 4.9) in the experimental group and 9.1 years (SD = 5.3) in the control group. No attrition occurred, as all 30 couples (60 individuals) completed the study (see participant flow: 30 couples screened and randomized, all assessed at pretest and posttest).

Descriptive statistics for the three outcome variables are presented in Table 2. In the control group, mean scores remained essentially stable from pretest to posttest across all measures: emotional empathy (81.60±17.60 to 81.87±17.81), sexual functioning (137.77±34.57 to 137.90±34.51), and marital relationship quality (29.50±9.76 to 29.60±9.68). In contrast, the experimental group showed clear increases in mean scores following the intervention: emotional empathy rose from 79.23±18.31 to 84.43±18.85, sexual functioning from 134.33±35.12 to 140.50±35.51, and marital relationship quality from 31.07±10.05 to 35.73±11.40.

Table 2. Means and standard deviations for study variables by group and time point

Variable	Group	Pre-test	Post-test	Variable	Group	Pre-test	Post-test
		Mean ± SD	Mean ± SD			Mean ± SD	Mean ± SD
Emotional empathy	Control group	81.60±17.60	81.87±17.81	Emotional empathy	Control group	81.60±17.60	81.87±17.81

	Experimental group	79.23 ±18.31	84.43±18.85		Experimental group	79.23 ±18.31	84.43±18.85
Sexual functioning Marital relationship quality	Control group	137.77 ±34.57	137.90±34.51	Sexual functioning	Control group	137.77 ±34.57	137.90±34.51
	Experimental group	134.33±35.12	140.50±35.51		Experimental group	134.33±35.12	140.50±35.51
	Control group	29.50±9.76	29.60±9.68	Marital relationship quality	Control group	29.50±9.76	29.60±9.68

Prior to conducting the main analyses, data were examined for adherence to statistical assumptions required for MANCOVA. Shapiro–Wilk tests confirmed that pretest and posttest scores for emotional empathy, sexual functioning, and marital relationship quality were approximately normally distributed within each group. Levene's test indicated homogeneity of variances across groups for all dependent variables ($P>0.05$). Box's M test supported homogeneity of covariance matrices ($P=0.214$). These preliminary checks confirmed that the assumptions for MANCOVA were satisfactorily met.

Multivariate analysis of covariance (MANCOVA), controlling for pretest scores, revealed a significant overall effect of the intervention on the combined dependent variables (emotional empathy, sexual functioning, and marital relationship quality). As shown in Table 3, all multivariate test statistics were highly significant (Pillai's Trace = 0.77, Wilks' Lambda=0.23, Hotelling's Trace=3.42, Roy's Largest Root=3.42; $F=60.39$, $P<0.001$, partial $\eta^2=0.77$).

Table 3. Multivariate tests of between-subjects effects (MANCOVA Results)

Variable	Value	df		Error df		F	
Pillais Trace	0.77	3	53	60.39	P	Mean Difference	P
Wilks Lambda	0.23	3	53	60.39	0.001	0.47	0.999
Hotelling's Trace	3.42	3	53	60.39	0.001	0.73	0.999
Roy's Largest Root	3.42	3	53	60.39	0.540	0.26	0.999
Variable	Value	df	Error df	F	0.001	1.14	0.999
Pillais Trace							
Wilks Lambda	0.77	3	53	60.39	0.001	1.54	0.999
	0.23	3	53	60.39	0.188	0.40	0.999

Follow-up univariate analyses of covariance (ANCOVA), adjusted for pretest scores, confirmed significant improvements in each individual outcome measure (Table 4). For emotional empathy, a large effect was observed ($F=59.99$, $P<0.001$, partial $\eta^2=0.51$, 95% CI for adjusted mean difference: 3.2 to 7.4). Sexual functioning showed the strongest intervention effect ($F=106.25$, $P<0.001$, partial $\eta^2=0.65$, 95% CI: 4.1 to 8.2), indicating particularly robust gains in this domain. Marital relationship quality also improved significantly ($F=30.92$, $P<0.001$, partial $\eta^2=0.35$, 95% CI: 2.8 to 7.5), though with a somewhat smaller (yet still medium-to-large) effect size. According to Cohen's benchmarks, partial η^2 values of 0.51 and 0.65 represent very large effects, while 0.35 represents a large effect. These results demonstrate that ten sessions of EFCT led to statistically and practically significant enhancements in emotional empathy, sexual functioning, and overall marital relationship quality among couples experiencing marital conflict.

Table 4. Univariate analyses of covariance (ANCOVA) for each dependent variable

Variable	SS	df	MS	F	P	η^2
Emotional empathy	379.67	1	379.67	59.99	0.001	0.51
Sexual functioning	546.35	1	546.35	106.25	0.001	0.65
Marital relationship quality	306.43	1	306.43	30.92	0.001	0.35

Discussion

The primary objective of this study was to investigate the efficacy of EFCT on emotional empathy, sexual functioning, and marital relationship quality in couples grappling with marital conflict. The statistical analysis confirmed that EFCT significantly improved all three dependent variables in the experimental group compared to the control group. These findings align with the core tenet of EFCT: that marital distress is fundamentally an attachment-related issue, and by restructuring the emotional bond, various dimensions of the relationship—both emotional and functional—can be rehabilitated. However, results should be interpreted cautiously, as self-report biases in the RDAS (and potentially in the other scales) may inflate perceived improvements. Future studies should therefore incorporate observational measures or partner-report validation to strengthen the evidence base.

Regarding the improvement in emotional empathy, the results are consistent with the emphasis of Johnson and colleagues that as couples move from a state of defensive reactivity to emotional vulnerability, their capacity for empathic resonance increases (17). In EFCT, partners are encouraged to identify and express their primary attachment fears. When a spouse perceives their partner's anger not as a personal attack but as a protest against disconnection, a "softening" occurs. This shift allows for the emergence of empathy, as partners begin to see the world through each other's emotional lenses. The significant increase in empathy scores in this study suggests that EFCT successfully dismantled the "empathy-blocking" walls built by years of conflict (6, 7).

The enhancement of sexual functioning observed in this study is a noteworthy finding. This result is in line with studies demonstrating that sexual intimacy is deeply contingent upon emotional safety (21). From an attachment perspective, sexual dysfunction in conflicted couples is often a "secondary symptom" of a lack of secure bonding. By fostering accessibility and responsiveness between partners, EFCT reduces the performance anxiety and emotional withdrawal that often impede sexual desire and satisfaction. As the "negative cycle" de-escalates, the bedroom transforms from a battlefield of rejection into a safe haven for vulnerability, thereby naturally improving sexual functioning without the need for direct behavioral sex therapy (11, 21). The particularly large effect on sexual functioning warrants deeper theoretical and empirical exploration. Improvements may be mediated by increased emotional safety, reduced performance anxiety, greater frequency of intimate encounters, or enhanced physiological relaxation. Future research should test these potential mechanisms using mediation or path analysis models.

Furthermore, the significant boost in marital relationship quality supports the effectiveness of EFCT, as reported in studies conducted on Iranian samples and other populations (19). The improvement in the RDAS scores indicates that couples achieved higher consensus, cohesion, and overall satisfaction. This is because EFCT does not merely teach communication skills; it reorganizes the underlying emotional architecture of the relationship. When partners feel securely attached, they become more resilient to future stressors and more adept at navigating disagreements, which inherently elevates the quality of their shared life (19, 20). While the changes were statistically significant, their clinical meaningfulness should also be considered: the approximately 4.7-point increase in RDAS score approaches half of the reliable change index reported in the literature, suggesting moderate but meaningful practical impact for many couples. Future investigations should benchmark changes against minimal clinically important difference (MCID) thresholds where available for these instruments. Iranian cultural norms—including gender roles, taboos surrounding emotional expressiveness, and religious values regarding sexuality—may have moderated the observed effects and could partially explain the particularly robust gains in sexual functioning following culturally sensitive delivery of vulnerability-focused elements.

Couples presenting with active domestic violence, severe individual psychopathology, or extreme emotional dysregulation may constitute non-responders or experience contraindications to standard EFCT. The present study did not include such cases and therefore cannot speak to differential outcomes in higher-risk subgroups. Future trials should explicitly examine predictors of response and identify potential non-responders to enhance clinical decision-making.

The efficacy of this intervention within the Iranian cultural context also highlights the universal applicability of attachment theory. Despite cultural nuances in expressing intimacy, the fundamental human need for a secure "safe haven" remains a core driver of relational health. By addressing these deep-seated needs, EFCT provided the participants in Ahvaz with a transformative experience that transcended superficial conflict resolution (19).

Despite the significant findings, this study has several limitations. The use of convenience sampling and the specific geographic focus (Ahvaz) may limit the generalizability of the results to other cultural or regional populations within Iran or beyond. Convenience sampling may have introduced selection bias by preferentially including more motivated or less severely distressed couples. Therefore, stratified or probability-based sampling in future replications would help address this concern. Additionally, the reliance on self-report instruments introduces the possibility of social desirability bias and common method variance. The absence of long-term follow-up assessments leaves the risk of relapse unknown; longitudinal designs with 6- and 12-month evaluations are strongly recommended. The study relied solely on self-report measures without behavioral observation or physiological indicators, which limits the robustness of the findings; multi-method assessment approaches should be prioritized in subsequent research. Delivery by a single therapist restricts generalizability due to potential therapist effects. Future multi-therapist trials would strengthen external validity. Although the trial was prospectively designed, registration occurred after the start of data collection, which reduces the strength of preregistration credibility.

Conclusion

This study provides empirical evidence that EFCT is a potent, relatively brief intervention for alleviating marital conflict by targeting the core emotional and attachment-related substrates of the relationship. By facilitating a transition from reactive hostility to secure emotional engagement, EFCT significantly enhances emotional empathy, restores sexual functioning, and improves overall marital relationship quality—outcomes that are pivotal for long-term relational health and individual well-being. These gains were particularly pronounced in the domain of sexual functioning, and they highlight the value of attachment-based approaches in addressing both emotional and physical intimacy. The findings suggest that integrating EFCT, with appropriate cultural sensitivity, into clinical practice in Iran can offer couples therapists a comprehensive, evidence-informed framework to help distressed partners rebuild intimacy, foster resilience, and achieve sustainable marital harmony. Future research should extend these results through larger, multi-site trials, longer follow-up periods, mediation analyses, and culturally tailored adaptations to further refine and broaden the application of this promising intervention.

Footnotes

Data Availability : The datasets generated and/or analyzed during the current study are available from the

corresponding author on reasonable request, in accordance with FAIR principles (Findable, Accessible, Interoperable, Reusable).

Authors' Contribution: A.N: Conceptualization, Methodology, Investigation, Resources, Writing – Original Draft, Writing – Review & Editing. M.H: Conceptualization, Methodology, Formal analysis, Investigation, Supervision, Writing – Original Draft, Writing – Review & Editing, Project administration. M.H: Conceptualization, Methodology, Investigation, Data Curation, Writing – Review & Editing.

Conflict of Interests Statement: The authors declare no conflict of interests.

Ethical Approval: This study received ethical approval from the Ethics Committee of Islamic Azad University, Ahvaz Branch (approval code: IR.IAU.AHVAZ.REC.1403.395).

Trial Registration

IRCT20250531065993N1

Funding/Support: This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

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