

Meta-Analytic Review of Marital Therapy Outcome Research

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ABSTRACT

This meta-analytic review examines the findings of 15 methodologically rigorous marital therapy outcome studies reported in 19 journal articles. These findings were used to assess the efficacy of three treatment approaches in fostering change in spouses' relationship-related behavior, cognitions, affect, and general assessment of their relationship. Behavioral marital therapy (BMT), cognitive—behavioral marital therapy (CBMT), and insight-oriented marital therapy (IOMT) were all found to be more effective than no treatment in bringing change in spouses' behavior and in the general assessment of their relationship. IOMT was more effective than BMT or CBMT in bringing change in spouses' general relationship assessment, while CBMT was the only approach that induced significant change in spouses' posttherapy relationship-related cognitions. The role of meta-analytic reviews of marital therapy approaches is also discussed.

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Although most narrative reviewers of marital therapy outcome studies have concluded that this intervention is effective (e.g., [Gurman, Kniskern, & Pinsoff, 1986](#); [Piercy & Sprenkle, 1990](#)), some authors have been more skeptical ([Bednar, Burlingame, & Masters, 1988](#)), while others suggest that some approaches are effective and others are not ([Beach & O'Leary, 1985](#)). One explanation for these conflicting conclusions is that each reviewer has approached the literature with a unique perspective. As [Cooper \(1989\)](#) noted, "traditionally, reviewers [have] interpreted data using rules of inference unknown even to them. . . . Analysis and interpretation methods were idiosyncratic . . . [and] this subjectivity in analysis and interpretation led to skepticism about the conclusions of many reviews" (p. 82).

In contrast to the more-or-less "eyeball" judgments that narrative reviewers must make about a discrete group of studies ([Hahlweg & Markman, 1988](#); [Rosenthal, 1984](#)), meta-analytic reviewers use empirical methods that remove much subjectivity in the evaluation of a body of literature. In addition, meta-analytic reviewers are less likely to underestimate treatment efficacy than narrative reviewers who, in an effort to avoid Type I errors, are prone to make Type II errors ([Lipsey & Wilson, 1993](#)).

Meta-Analysis in Marital Therapy

[Hahlweg and Markman \(1988\)](#) published the first meta-analysis that addressed marital therapy outcome studies separately from family therapy outcome studies. They assessed 17 behavioral marital therapy (BMT) outcome studies and reported (a) that BMT is more effective in alleviating marital distress than no treatment in both Europeans and Americans, (b) that improvements are likely to remain stable for at least a year, (c) that self-report and observational measures indicate similar changes in couples, and (d) that despite improvement, clinical measures suggested that many couples remained distressed after BMT treatment.

[Plattor \(1990\)](#) conducted a more comprehensive meta-analytic review. It included 25 studies published between 1970 and 1988 that had randomly assigned participants to marital therapy approaches and that had used a no-treatment or waiting-list control group. Treatment groups were categorized following [Beach and O'Leary's \(1985\)](#) divisions: communication training alone, contracting alone, contracting with communication training, and insight-oriented marital therapy. [Plattor \(1990\)](#) found no differences in effectiveness among these approaches across a general population of distressed couples.

Although Plattor's (1990) review represented a significant advance in methodological rigor, it did not address several important issues. First, studies from the early 1970s to the late 1980s were grouped together, which is problematic in light of the evolving nature of most marital therapies (e.g., [Jacobson, 1991](#)). Second, three of the four treatment group categories compared are standard components of behavioral therapy, share identical paradigms, use similar and often overlapping techniques, and have been shown to have similar effects ([Jacobson, 1984](#)). Third, couples with presenting problems of chronic pain and alcoholism were combined with couples complaining of marital conflict and communication problems, thus increasing heterogeneity and reducing power. Fourth, because multiple data sets from some studies were included in the analyses, inappropriate weighting may have been given to certain samples ([Baucom, 1982](#); [Baucom & Lester, 1986](#); [Hahlweg, Revenstorf, & Schindler, 1982](#); [Hahlweg, Schindler, Revenstorf, & Brengelmann, 1984](#)). Finally, although Plattor's study reported useful comparative data, it did not address the absolute effectiveness of each approach—that is, if it was significantly more effective than no treatment and, if so, by how much more.

Building on [Hahlweg and Markman's \(1988\)](#) and [Plattor's \(1990\)](#) work, the present study reviewed marital therapy outcome studies published 1980–1993 that have investigated the efficacy of BMT, cognitive—behavioral marital therapy (CBMT), and insight-oriented marital therapy (IOMT) approaches. The studies included met methodological criteria identified as important by meta-analytic researchers ([Giblin, Sprenkle, & Sheehan, 1985](#); [Glass & Kliegl, 1983](#)). Specifically, the studies (a) randomly assigned participants to treatment conditions, (b) included a control group, (c) used a design that had no major threats to internal validity, (d) reported sufficient data to allow meta-analytic computations, and (e) clearly described treatment procedures so that informed decisions could be made in grouping treatments.

In planning the present review, we took various factors into account—including the different theoretical underpinnings of BMT, CBMT, and IOMT—and the fact that couples enter marital treatment with different types of problems. Given this, rather than using one overall measure of therapeutic success, we decided to empirically assess the effectiveness of each approach in eliciting changes in four specific areas: spouses' relationship-related behavior, cognitions, affect, and spouses' general assessment of the relationship and its quality.

Method

Sample of Studies

Computer searches were performed on the American Psychological Association's PsycLIT psychological abstract and dissertation abstract databases to locate marital therapy outcome studies published between January 1980 and December 1993. The key words *marital*, *marriage(s)*, or *couple(s)* were crossed with *outcome(s)*, *result(s)*, *effect(s)*, *evaluation*, or *impact* (cf. [Hazelrigg, Cooper, & Borduin, 1987](#)). Additional outcome studies were identified in these papers and in other marital therapy outcome reviews ([Bednar et al., 1988](#) ; [Gurman et al., 1986](#)).

All of the projects located were reviewed, and 15 were found to meet the present criteria (see [Table 1](#)). These projects were described in 19 papers (including follow-up reports provided in [Jacobson & Follette, 1985](#) ; [Jacobson et al., 1985](#) , [Jacobson, Schmalings, Holtzworth-Munroe, 1987](#) ; [Snyder, Wills, & Grady-Fletcher, 1991](#)), 9 of which had been included in earlier meta-analytic studies of marital therapy outcome ([Hahlweg & Markman, 1988](#) ; [Plattor, 1990](#)). These 19 papers reported findings on 21 participating treatment groups (PTGs), each of which is considered a single data source in this study. On the basis of the descriptions of the 21 PTGs, we judged that they fell discretely into three categories: BMT, CBMT, and IOMT.

The PTGs were assigned to the BMT category if they (a) followed the model discussed by [Jacobson and Margolin \(1979\)](#) , [Guerney \(1977\)](#) , or both, (b) involved the use of BMT techniques as detailed above, or (c) involved the use of one or more of BMT's main components (communication and problem-solving training, behavior exchange, or quid pro quo contracting). Eleven studies contained 13 PTGs that met these criteria; posttherapy results were reported for a total of 371 treatment and control couples. The published follow-ups of these studies have 24 data points from these 13 PTGs, containing 364 treatment and control couples. The mean follow-up time was 8.75 months.

PTGs were assigned to the CBMT category if, in addition to some behavioral interventions, overt attempts to identify and change partners' maladaptive cognitions concerning themselves, their partner, or the relationship were emphasized ([Baucom & Lester, 1986](#)). The three studies meeting these criteria contributed three PTGs, involving 74 total couples. Two of these studies included follow-ups that assessed 38 couples, with a mean follow-up time of 6.0 months.

PTGs were assigned to the IOMT category if they involved helping each partner (a) to achieve insight into and attempt to change his or her own behavior and (b) to gain insight into the reasons for that behavior (e.g., past experiences, childhood) and the effect of these dynamics in the relationship. This category included studies that examined the IOMT of [Snyder and Wills \(1991\)](#) and the emotionally focused couples therapy of [Greenberg and Johnson \(1988\)](#) , both approaches being primarily insight-oriented and extremely similar (Wills, personal communication, May 1991). Five studies contributed five PTGs that involved 164 couples in PTG and control groups. Four studies reported follow-up data ($M = 12.4$ months) from 122 couples.

The number of studies reviewed here is comparable to other meta-analyses in the marital therapy and marital and family therapy (MFT) field ([Hahlweg & Markman, 1988](#) , 17 studies; [Hazelrigg et al., 1987](#) , 20 studies; [Markus, Lange, & Pettigrew, 1990](#) , 19 studies; [Plattor, 1990](#) , 25 studies). The number of PTGs in each category is also comparable. Previous reviewers used as many as 17 PTGs ([Hahlweg & Markman, 1988](#)) and as few as 4 ([Plattor, 1990](#)), 3 ([Hazelrigg et al., 1987](#)), or 2 ([Markus et al., 1990](#)) per category.

The 21 PTGs used in the present review included 558 couples (180 couples in control groups and 378 couples in treatment groups). The couples presented for treatment with problems of marital discord, communication problems, or depression that were apparently related to marital discord ([Beach, Jouriles, & O'Leary, 1985](#)). Data were collected after treatment in each study. Follow-up assessments on the PTGs were conducted from 0—3 times, producing 31 sets of follow-up data collected from 1 to 48

months after termination ($M = 9.2$ months).

Treatment Approaches

The mechanism of change with both of the well-known BMT and CBMT therapies primarily involves the learning of new behaviors and expectations, which theoretically facilitates more adaptive and less conflictual functioning in the relationship. The BMT approach ([Jacobson & Margolin, 1979](#)) is primarily a straightforward skills-learning approach, in which the therapist uses standard clinical and behavioral techniques to teach couples new and more effective marital behaviors. These typically include communications skills, negotiation and problem-solving skills, and quid pro quo contracting. Behavioral techniques are often included in CBMT therapy approaches, but with a strong emphasis on the identification of unrealistic and maladaptive beliefs and expectations in the relationship, and their replacement by more realistic and helpful beliefs ([Baucom & Lester, 1986](#)).

The IOMT approaches are less well-known and significantly different, and therefore are described in much greater detail. These approaches propose that increased insight into the conflict, emotional processes, interaction cycles, and suppressed affect in relationships enables couples to redefine and change their interactions, and thus their relationships, to be more mutually satisfying.

The IOMT therapist must shift frequently between intrapsychic and interpersonal perspectives and techniques, trying to facilitate insight for each partner into his or her own personality and behavior, as well as into the dynamics of the relationship. The effect of insight is enhanced by a deliberate use of affect within the session. Such affect may be produced spontaneously or through the use of experiential techniques adopted from Gestalt and client-centered approaches. The therapist highlights and emphasizes these emotional experiences, using images, metaphors, or repetition of key phrases. Such emotional experiences are used to change partners' interactions, by evoking new responses that stem directly from the identified emotional need, which elicit reciprocal positive behaviors in the partner.

This process proceeds through a series of steps ([Greenberg & Johnson, 1988](#) ; [Johnson & Greenberg, 1987](#)). First, the traditional intake assessment of the couple is augmented to include how each partner experiences the relationship and views the couples' interactions, and the position each takes in the *negative interactional cycle*, which is a self-sustaining, reciprocal interaction pattern with a negative outcome. Emotional responses are legitimized in terms of the interactional pattern, in which each partner has positive intentions. Relationship problems are interpreted and reframed in terms of deprivations of normal needs, particularly needs for assurance, support, and reassurance of worth.

Second, unacknowledged affect is accessed through experiential techniques, with such affect used to further clarify and explore relationship patterns. Unacknowledged affect is consciously examined as the source of the partner's motivation for a negative response, thus placing such behaviors in a different context. This process can lead to the development of new interactions that more directly and positively meet the partner's expressed needs. For example, a critical response by a partner can be probed for underlying feelings such as abandonment, betrayal, or fear of isolation. Such identification can lead to the de-escalation of the negative cycle. The de-escalation can occur because of the change of focus from producing a defensive response to the criticism, to directly addressing the now identified emotional motivators.

Third, therapy facilitates the exploration and acceptance of disowned needs and aspects of self. These might include a desire for nurturance and support, and reassurance of worth, which can legitimately be requested and met in the context of an intimate relationship.

Fourth, partners are encouraged to directly communicate these legitimate aspects of self to one another, thus redefining their relationship as one in which partners can ask each other for key emotional responses. This process initiates positive interaction cycles to replace the previously used negative ones.

The final step involves the consolidation and integration of the changes made in therapy. Previously problematic issues that were never resolved with the negative interaction cycles can now often be constructively addressed. Strategies for preserving the new intimacy and trust developed in therapy are explicitly discussed.

Instruments

The following instruments were used in the studies included in the present review:

1. Behavior-oriented measures: the Marital Interaction Coding System ([Weiss & Summers, 1983](#)), the Areas-of-Change questionnaire ([Weiss, Hops, & Patterson, 1973](#)), the Couples Interaction Scoring System ([Gottman, 1979](#)), the Spouse Observation Checklist ([Weiss & Perry, 1979](#)), and Target Complaints questionnaire ([Battle et al., 1966](#)).
2. Cognition-oriented measures: the Relationship Beliefs Inventory ([Eidelson & Epstein, 1982](#)) and the Irrational Beliefs Test ([Jones, 1968](#)).
3. Affect-oriented measures: the Interpersonal Relationship Scale ([Schlein, Guerney, & Stover, 1977](#)), the Acceptance of Other Scale ([Stover, Guerney, Ginsberg, & Schlein, 1977a](#)), the Self-Feeling Awareness Scale ([Stover, Guerney, Ginsberg, & Schlein, 1977b](#)), and the Passionate Love Scale ([Hatfield & Sprecher, 1986](#)).
4. General assessment of the relationship and its quality (GARQ) measures: the Dyadic Adjustment Scale ([Spanier, 1976](#)), the Goal Attainment Scale ([Kiresuck & Sherman, 1968](#)), the Marital Adjustment Scale ([Locke & Wallace, 1959](#)), the Maudsley Marital Questionnaire ([Boelens, Emmelkamp, MacGillavry, & Markvoort, 1980](#)), the Marital Satisfaction Inventory ([Snyder, 1981](#)), the Partnership Questionnaire ([Hahlweg, 1979](#)), the Problem List ([Hahlweg et al., 1984](#)), the Psychosocial Intimacy Questionnaire ([Tesch, 1985](#)), the General Happiness Rating Scale ([Terman, 1938](#)), the Problem Description Scale ([Epstein & Eidelson, 1981](#)), and the Communication Scale ([Fournier, Olson, & Druckman, 1983](#)).

Procedure

Following meta-analytic procedures described by [Cooper \(1989\)](#), four statistics were calculated. These are (a) the Δ , or weighted effect size, for each PTG, used to assess how effective a treatment was, (b) the "weighted Z" for each PTG, used to assess the statistical significance of the effect size, (c) the "fail-safe N," used to assess how resistant present conclusions are to future research findings, and (d) the homogeneity of variance statistic, used to rule out excessive heterogeneity of sample variances and to make comparisons between treatments concerning relative effectiveness.

The results reported in participating studies were converted to a standardized form. The effect size index ([Smith & Glass, 1977](#)) is a standardized measure of a treatment group's relative standing to its appropriate control group. It is generated by comparing the mean scores of two groups in a study on a given measure in standard deviation units (for treatment group [T] and control group [C]: $\Delta = [\text{mean } T - \text{mean } C] / \text{standard deviation}$). To be conservative and consistent with earlier psychotherapy meta-analyses ([Hahlweg & Markman, 1988](#) ; [Smith, Glass, & Miller, 1980](#)), the control group standard

deviation was used in calculations rather than the mean standard deviation of the control and treatment groups. If means and standard deviations were not reported, the effect size index was calculated from the t statistic (Rosenthal, 1984, equation 2.14). or from the F statistic (Rosenthal, 1984, pp. 22–23).

Given the assumption of nonindependent observations, only a single effect size from each treatment group was used. Because effect size is a standardized score, a mean effect size could be calculated from multiple dependent measures when necessary to produce a single representative statistic for each PTG. Improvement or deterioration of intervention groups relative to control groups is expressed in terms of positive or negative effect sizes, respectively. Because the meaning of the effect size may not be intuitively clear, it is often converted to a U_3 score (Cooper, 1989). U_3 indicates the percentage of the group with the lower mean that was exceeded by 50% of the higher mean group.

From the effect size for each PTG, a Z was generated. The Z is the standard normal deviate associated with the one-tailed probability value of each result (Cooper, 1989), that is, where the probability value of the effect size would fall on the normal probability curve, expressed in standard deviation units. The Z , which is a standardized score, can be combined with Z s from other studies, whereas probability values cannot be so manipulated. Once Z s were generated for each PTG, they were combined using the "adding (weighted) Z s" procedure (Rosenthal, 1984), producing an overall Z for the PTGs under consideration. This overall Z was then evaluated against probability tables to assess the likelihood that the combined result of the PTGs occurred by chance, given that the null hypothesis is true.

The fail-safe N (Cooper, 1989) statistic indicates the resistance of the current findings to future null results. It estimates the number of unreported or unpublished studies or future studies with null results (i.e., $\Delta = 0.00$) needed before the present meta-analytic findings would be reduced to the edge of statistical nonsignificance ($p = .05$.) This statistic is calculated by setting the overall probability level at .05, then solving for the number of studies with null findings needed to shift the current results to that level.

The final statistic generated was Q , a measure of the homogeneity of the effect sizes of a group of studies (Rosenthal, 1984). Traditional inferential statistics can lead to erroneous conclusions (a) because they do not assess the possibility that variability in effect sizes is due solely to sampling error rather than to design characteristics and (b) because differing variances across the different study samples would violate the homogeneity of variance assumption on which traditional inference statistics are based. The use of Q avoids both problems (Cooper, 1989). If Q is nonsignificant, it can be assumed that all participants were drawn from the same population and that treatment effects did not differentially affect the groups' outcomes.

Q was computed for each approach and for the overall sample, and comparisons were made concerning the relative homogeneity within each approach (Q_w) and homogeneity overall (Q_t), that is, variability across groups as compared within groups. These statistics were used to assess the variability between groups ($Q_b = Q_t - \sum Q_{wk}$). Significance of Q_b was assessed by comparing it to a chi-square table at $k - 1$ degrees of freedom.

Weighting

It has become accepted practice to weight the results from each study by its sample size, since a larger sample will give a more reliable estimate of population effect size, and the average effect size should reflect this (Cooper, 1989). The present review weighted the effect sizes calculated from each study by the associated sample size. The fail-safe N was calculated with unweighted Z s, however, because this

statistic ignores sample size and involves only how many data points it would take to reduce current findings to nonsignificance.

Results

Several questions were asked concerning the effects of BMT, CBMT, and IOMT in eliciting improvement in couples: Are the spouses' relationship-related behavior, cognitions, affect, and general assessment of the relationship and its qualities improved following treatment? Is one treatment approach more effective than the others in any area?

Analyses indicated that all participating marital therapy projects, together, produced significant effects on posttherapy behavior ($Z = 6.78, p < .001$, fail-safe $N = 332$), cognitions ($Z = 3.36, p < .001$, fail-safe $N = 17$), affect ($Z = 2.12, p < .05$, fail-safe $N = 2$), and GARQ measures ($Z = 11.28, p < .001$, fail-safe $N = 1087$). However, at follow-up significant effects were found only for behavior ($Z = 6.15, p < .001$, fail-safe $N = 309$) and GARQ measures ($Z = 9.58, p < .001$, fail-safe $N = 943$).

The results presented in [Table 2](#) show that all three approaches promoted significant changes in treated couples in behavior, as compared with control couples, with weighted mean effect sizes of 0.79, 0.54, and 0.87 for BMT, CBMT, and IOMT, respectively. No significant differences in effectiveness were found across approaches ($Q_b = 1.36, p > .50$). Similarly, at follow-up treated couples differed significantly from untreated controls (Δ : BMT = 0.52, CBMT = 0.75, and IOMT = 0.69), but there were no differences among approaches ($Q_b = 0.36, p > .50$).

Relationship-related cognitions were assessed only by BMT and CBMT researchers, and only CBMT demonstrated significant differences between treated couples and controls at posttherapy ($Z = 3.11, p < .001$, fail-safe $N = 9$). However, the effect sizes of BMT and CBMT (0.35 and 0.78, respectively) did not differ significantly. Only one study reported follow-up data on each approach, and no significant treatment effects were found.

Affect was assessed by one study of each approach at posttherapy, and significant changes were found. However, only one IOMT study assessed affect at follow-up, with no significant treatment effects found.

Significant treatment effects were demonstrated by all three of the approaches on the GARQ measures (see [Table 2](#)), with effect sizes of 0.78, 0.71, and 1.37 and fail-safe N s of 390, 6, and 98 for BMT, CBMT, and IOMT, respectively. There were also significant differences among the treatment approaches on this variable's measures ($Q_b = 7.78, p < .05$). Specifically, post hoc comparisons indicated that IOMT was more effective in eliciting change on the GARQ measures than were BMT ($Q_b = 6.69, p < .01$) and CBMT ($Q_b = 4.95, p < .05$).

At follow-up effect sizes on the GARQ measures for the three approaches were 0.54, 0.54, and 1.04 for BMT, CBMT, and IOMT, respectively, with fail-safe N s of 511, less than 1, and 39, respectively. These effect sizes were not significantly different ($Q_b = 5.43, p < .10$).

Discussion

The present meta-analysis of methodologically rigorous outcome research found that the BMT, CBMT, and IOMT approaches were more effective than no treatment in fostering favorable changes in several areas of couples' relationships. This finding reaffirms the conclusions of earlier narrative ([Gurman et](#)

al., 1986) and empirical reviewers of MFT ([Hazelrigg et al., 1987](#) ; [Markus et al., 1990](#)) and marital therapy ([Hahlweg & Markman, 1988](#) ; [Plattor, 1990](#)) outcome studies. Moreover, effect sizes reported in this study are comparable to those found by Plattor (1990), whose sample included less methodologically rigorous studies.

The outcomes of the separate therapy approaches in the separate areas of change are also of interest in and of themselves. Given the theoretical underpinnings and goals of each treatment, it was notable (a) that BMT, CBMT, and IOMT were all effective in producing changes in behavior and in the GARQ measures at posttherapy and at follow-up, (b) that IOMT was most effective at posttherapy in producing change in the GARQ measures, and (c) that CBMT alone produced significant posttherapy change in partners' relationship-related cognitions.

The presently reported differences in outcomes among the approaches suggest that researchers and meta-analytic reviewers in the MFT area may well be ready to address issues raised by [Paul \(1967\)](#) more than a quarter century ago. At that time, he advised researchers who studied the psychological treatment of individuals to go beyond the question, Is psychotherapy effective? Instead, he indicated, they should address the more specific concerns of "What therapy is most effective for what problems, treated by what therapists, according to what criteria, in what setting?" (Paul, 1967, p. 111). At present, relevant questions about MFT include the following: What approaches are most effective in promoting specific kinds of changes in couples and families? What approaches are more effective with clients from particular backgrounds? What processes unfold in each MFT approach's sessions, and how do they relate to particular outcomes for particular groups of clients who live in particular kinds of family units?

Besides the pre- and posttreatment paradigms that have been useful in earlier studies, this set of questions can be addressed using process research. This investigatory strategy would allow researchers to take a fine-grained look at what occurs during MFT sessions and to identify the aspects of the interventions that foster change in spouses and family members ([Piercy & Sprenkle, 1990](#)).

A similar avenue for addressing these questions is to conduct research that dismantles each approach, systematically testing one part of the intervention at a time in order to demonstrate exactly which parts of the approach cause what outcomes in clients. Such research might also assess spouses separately rather than report only averaged dyad scores as most current studies do, since such combined scores may be distorted by individual effects ([Kenny & La Voie, 1985](#)). Once dismantling research demonstrates precisely what aspects of each intervention are necessary to foster particular kinds of change in specific types of couples, more efficient interventions could be developed. However, it is likely that the experimental power necessary for such specific research of similar interventions would require extremely sensitive and specific instruments and statistical procedures, and may not as yet be currently practical.

Whatever the form they take, a greater number of methodologically rigorous marital therapy outcome studies are needed to fully establish not only the short-term efficacy of marital therapy in increasing general satisfaction, but whether marital therapy approaches produce change across the many specific areas (e.g., behavior, intimacy, problem solving, and communication) essential to spouses in the continuing maintenance of healthy relationships. While that work is being conducted, the conclusions that reviewers can draw will be limited by the number of methodologically strong studies available. For example, the present review was limited in its assessment of the three approaches' differential impact in the area of spousal affect by the fact that only three studies in the literature considered this variable and only two conducted posttreatment follow-ups. The low fail-safe N in the area of behavior change found after CBMT provides another example of the limitations presently faced because of the small number of methodologically sound studies available. If even a relatively small number of additional CBMT outcome studies had been conducted with results similar to those already published, the fail-safe N and

the confidence in the associated conclusion would have been substantially greater.

A practical benefit of such additional research to address the earlier noted questions would be a deeper understanding about the effectiveness of each therapy approach with different groups of clients, allowing development of a system for referring individuals to the MFT approach most likely to be effective in their case. For example, research might demonstrate that spouses with communication skill deficits respond best to the BMT approach, whereas partners raised in dysfunctional families respond best to IOMT. Such treatment matching is already conducted unsystematically in many clinical treatment settings, where therapists in practice can use their skill and experience to shape interventions to the specific needs of each couple. Even such general matching of a therapy approach to specific couples' needs has already been shown to be more effective than the standardized administration of a therapy approach to all comers, as is usual in research settings ([Jacobson et al., 1989](#)). It is possible that systematically derived treatment protocols may be even more effective.

Research studies and meta-analytic reviews that address these more advanced questions about MFT will also be of value to consumers, psychologists, and other providers in the years ahead as social planners bring change in the health delivery system. Anticipating the challenges ahead, the [Task Force on Promotion and Dissemination of Psychological Procedures \(1993\)](#) advised social scientists to take action to demonstrate the efficacy of their interventions. Calling present times the "heyday of biological psychiatry," the task force further suggested that without such evidence of efficacy, consumers and providers of psychological treatments may find themselves without the support of the general public, social policy planners, and third-party payers. In addition to the ethical responsibility to assess treatment efficacy, such possibilities suggest that it is essential for marital therapy and other psychotherapy approaches to continue to evolve in terms of efficacy and efficiency, with a corresponding increase in the number and methodological rigor of the outcome studies that examine them.

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Table 1.

Author(s)	Year	Sample	Intervention	Outcome
Johnson (1975)	1975	40, 100	Marital Adjustment Scale (MAS), Area of Personal Growth (APG)	100
Johnson & Foster (1980)	1980	100, 100	Marriage Checkup System (MCS)	100
Johnson et al. (1981)	1981	100, 100	Marriage Checkup System (MCS)	100
Johnson et al. (1982)	1982	100, 100	Marriage Checkup System (MCS)	100
Johnson et al. (1983)	1983	100, 100	Marriage Checkup System (MCS)	100
Johnson et al. (1984)	1984	100, 100	Marriage Checkup System (MCS)	100
Johnson et al. (1985)	1985	100, 100	Marriage Checkup System (MCS)	100
Johnson et al. (1986)	1986	100, 100	Marriage Checkup System (MCS)	100
Johnson et al. (1987)	1987	100, 100	Marriage Checkup System (MCS)	100
Johnson et al. (1988)	1988	100, 100	Marriage Checkup System (MCS)	100
Johnson et al. (1989)	1989	100, 100	Marriage Checkup System (MCS)	100
Johnson et al. (1990)	1990	100, 100	Marriage Checkup System (MCS)	100
Johnson et al. (1991)	1991	100, 100	Marriage Checkup System (MCS)	100
Johnson et al. (1992)	1992	100, 100	Marriage Checkup System (MCS)	100
Johnson et al. (1993)	1993	100, 100	Marriage Checkup System (MCS)	100
Johnson et al. (1994)	1994	100, 100	Marriage Checkup System (MCS)	100
Johnson et al. (1995)	1995	100, 100	Marriage Checkup System (MCS)	100
Johnson et al. (1996)	1996	100, 100	Marriage Checkup System (MCS)	100
Johnson et al. (1997)	1997	100, 100	Marriage Checkup System (MCS)	100
Johnson et al. (1998)	1998	100, 100	Marriage Checkup System (MCS)	100
Johnson et al. (1999)	1999	100, 100	Marriage Checkup System (MCS)	100
Johnson et al. (2000)	2000	100, 100	Marriage Checkup System (MCS)	100

Table 2.

