

EVALUATING THERAPY EFFECTIVENESS IN AN MFT TRAINING CLINIC:
CURRENT PRACTICES AND RECOMMENDATIONS FOR THE FUTURE

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(Abstract)

While a significant amount of attention has been paid to the efficacy of marriage and family therapy (MFT), research on the effectiveness of MFT is lacking. Furthermore, university training clinics are an underutilized, yet excellent resource for collecting effectiveness research data. This study examined the current practices at the Center for Family Services, an MFT university training clinic, by examining therapists' ratings of therapy effectiveness for clients seen more than once over the past five years ($n = 558$). Data on therapy modality, treatment length, fee for services, presenting problems, and termination category were examined. A statistically significant relationship was found between treatment outcome and each of the following variables: treatment length, number of presenting problems, and termination category (completed or dropout). Furthermore, termination category best discriminated membership in the three outcome groups. A statistically significant relationship was not found between treatment outcome and the following variables: therapy modality and fee for services. Strengths, limitations, suggestions for future research, and implications of the findings are discussed.

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CHAPTER ONE: INTRODUCTION

Statement of Problem and Rationale for Study

Recently, the Surgeon General of the United States, Dr. David Satcher, stated, "Few Americans are untouched by mental illness, whether it occurs within one's family or among neighbors, co-workers or members of the community" (Department of Health and Human Services, 1999a). In fact, the first-ever Surgeon General's report on mental health found that 15% of the U.S. adult population use mental health services in any given year. Furthermore, in 1996 alone, the direct costs of mental health services in the U.S. totaled 69 billion dollars (Department of Health and Human Services, 1999b). Given the wide use of mental health services and the amount of money that is spent on them, clinicians in the mental health field have a responsibility to demonstrate the effectiveness of what they do. At the most recent AAMFT National Conference, Sprenkle (2001) discussed the "ethics of evidence" and stated several times that "our ethics demand evidence." Others have echoed this cry. Neufeldt and Nelson (1998), for example, contend that "ethics demand that treatment be evaluated" (p. 310).

Researchers have been evaluating the effects of mental health treatment for decades. Efficacy research, which seeks to determine whether a certain treatment works in a controlled environment (i.e. researchers attempt to control for everything except the treatment effect), was once universally accepted as the "gold standard." However, some researchers have begun to question the superiority of efficacy research, and have suggested effectiveness research (outcome research performed in a real-world setting) as an alternative and/or a complement to efficacy research (Andrews, 1999; Beutler & Howard, 1998; Clarke, 1995; Pinsof & Wynne, 1995a; Seligman 1995, 1996). This switch in focus was fueled by Weisz, Weiss and Donenberg (1992). They compared four large meta-analytic studies of the efficacy of child and adolescent psychotherapy to the limited number of studies performed in actual clinical settings. While the meta-analyses reported large effect sizes of treatment efficacy (.71 to .84), none of the clinic-based studies had effect sizes significantly different from zero, which suggests that treatment in the real world was no better than no treatment.

Furthermore, there has long been a debate about the usefulness of efficacy research in actual clinical practice (Weisz, Donenberg, Han, & Weiss, 1995). Weisz et al. (1992) and others (e.g., Seligman, 1995; Pinsof & Wynne, 2000) have suggested that efficacy studies often do not

translate into the real-world setting of therapy practice. Very few therapists practice the type of "pure" therapy found in efficacy research. Pincus and Wynne (2000) state that "almost every survey of clinicians conducted within the last 10 years shows that most clinicians are becoming increasingly eclectic and integrative." Thus, efficacy studies, which focus on one specific intervention or type of therapy, are often not useful to the eclectic therapist. Practicing therapists are dedicated to clients, not to treatment modality (Pincus & Wynne, 2000). In other words, given the choice of sticking to a model even though it is not working or finding a more applicable model, therapists choose the latter. Thus, the translation problem from efficacy research into real practice makes it difficult for practicing clinicians to use what is found in efficacy research.

One of the most critical views against efficacy research being deemed the "gold standard" comes from Seligman (1995), who states:

I came to see that deciding whether one treatment, under highly controlled conditions, works better than another treatment or a control group is a different question from deciding what works in the field... I have come to believe that the "effectiveness" study of how patients fare under actual conditions of treatment in the field, can yield useful and credible "empirical validation" of psychotherapy... The efficacy study is the wrong method for empirically validating psychotherapy as it is actually done, because it omits too many crucial elements of what is done in the field. (p. 966)

Despite such support for effectiveness studies, they have been uncommon in the professional literature (Pincus & Wynne, 1995a), perhaps because they are seen as second-class research. As Neufeldt & Nelson (1998) recently stated:

Effectiveness studies have seldom been performed in the past, we believe, because the academic community does not respect them. . . .We suggest that we in the academic enterprise change our attitude towards effectiveness studies. (p. 316)

Fortunately, more and more researchers are noticing the neglected field of effectiveness research and are calling on other researchers to focus more attention on this area of study (e.g. Doherty and Simmons, 1996).

Why is it important for therapists to show that their work is effective? Simply put, because people need and want to know. Practitioners, prospective clients, professionals looking for places to refer clients, and managed care companies want to have confidence that their

investment of time and money will be worth it (Clement, 1994, 1999). Unfortunately, many therapists cannot answer the simple question, "How effective are you?" As Clement (1994) states, "in talking to psychologists across the country about how they answer such [a question], most are clear: Either they guess or they simply make up their answers" (p. 173).

University Clinics As A Resource

Effectiveness studies do occur in the real world, but it is often hard for practitioners to find time to conduct them. This reality is unfortunate. However, university clinics may fill this void by providing an obvious place and an excellent resource for performing effectiveness research. What makes university training clinics an excellent resource? As Neufeldt and Nelson (1998) explain, training clinics have researchers on site to conduct evaluations in a systemic manner. Also, the way therapy is done in training clinics can be easily generalized to off-campus settings. Furthermore, clients at these locations are also more likely to be receptive to research than at community agencies because they know they are coming to an academic center. Finally, training clinics offer a variety of resources conducive to research such as student observers, audio and video recording, and supervision.

Several benefits will come to the training clinic that analyzes its own effectiveness. First, effectiveness research can provide helpful feedback to faculty and students about their work (Todd, Jacobus, & Boland, 1992). Faculty and students can learn what problem areas they see most often, and what problem areas they treat more effectively/less effectively. This information will point to strengths and weaknesses of the program and indicate areas where more training is needed. Showing effectiveness will increase the confidence of faculty, students, clients, and referring professionals that the services provided are helpful and worth the investment. With all these benefits, it seems logical that a substantial body of research would exist in this area. Unfortunately this is not the case. There are few studies that have used training clinics for effectiveness research (Neufeldt & Nelson, 1998).

Purpose of the Study and Significance

The Center for Family Services (CFS) in Northern Virginia is one such training clinic. Up to this point, no comprehensive study has looked at the effectiveness of the clinic or given a description of the characteristics of the therapy offered and the clientele it serves.

The main purpose of this study is to answer Sprenkle's (2001) call by evaluating the effectiveness of treatment provided in the clinic through examining therapist ratings of client outcome, and examining the relationship between that outcome and the following client factors:

1. Therapy modality;
2. What problems and how many problems clients present with;
3. How much clients pay for their services;
4. For how many sessions clients remain in therapy; and
5. Client termination -- whether they drop out or complete therapy.

In the process of examining treatment effectiveness, I will also provide descriptive statistics on these five different characteristics of clients and their therapy at the CFS. These descriptive statistics will be useful to the clinic administration as they think about training needs. For example, a better understanding of the most common presenting problems can guide training that takes place in supervision.

A second purpose is to offer suggestions to the CFS and other university training clinics around the country. For example, through the lessons learned in my study, I will suggest a process by which effectiveness research can be conducted in the training clinic setting.

Finally, it is my hope that this research will serve as a springboard for other universities to assess their effectiveness. I believe effectiveness research in marriage and family therapy training clinics will provide the field with relevant empirical support.

Theoretical Framework

Two theoretical frameworks guide this study: General Systems Theory and Postpositivism. General Systems Theory is not so much a theory as it is a way of thinking about all kinds of systems (Nichols & Schwartz, 1998). Ludwig von Bertalanffy, a biologist, developed this model of thinking. The basic tenet of General Systems Theory is that the system is greater than the sum of the parts. As applied to family therapy, the family system is greater than the sum of the individual members. The interaction between family members becomes the focus rather than the individual personalities.

Another important contribution of Bertalanffy was his focus on wholeness. He disagreed with the focus science placed on reductionistic thinking--the dissection of the system in order to study the individual parts. Although he agreed that this type of research had a place, he felt the study of the system as a whole had been greatly neglected (Nichols & Schwartz, 1998).

Just as Bertalanffy focused on wholeness, this study of effectiveness asks how well therapy works *in* the context of real-world therapy, as opposed to trying to single out one specific component of treatment. Outcome is looked at with the inclusion of all the factors that make therapy in the clinical setting different than the research setting.

General Systems Theory also guides the therapists in the training clinic where this effectiveness study will be performed. They use this framework, and the theories that have developed from this framework, to guide their work with individuals, couples, and families.

Postpositivism also guides this research. Postpositivism holds that:

No longer can it be claimed there are any absolutely authoritative foundations upon which scientific knowledge is based... The fact is that many of our beliefs are warranted by rather weighty bodies of evidence and argument, and so we are justified in holding them; but they are not absolutely unchallengeable (Phillips, 1990, p. 32).

Thus, this study, and the field of effectiveness research, is a challenge to the belief that efficacy is the "gold-standard" of outcome research. Efficacy and effectiveness studies are, instead, different ways of providing justification for the belief that therapy works.

Research Questions

There are two main research questions that this study will answer. First, does effectiveness (outcome) vary as a function of:

1. Therapy modality,
2. Presenting problem,
3. Number of presenting problems,
4. Fee,
5. Number of sessions, or
6. Termination category.

Second, what, if any, combination of variables predicts successful treatment outcomes.

CHAPTER TWO: LITERATURE REVIEW

With the high number of people seeking mental health services (Department of Health and Human Services, 1999b), mental health professionals have an ethical obligation to show that what they do works (Neufeldt & Nelson, 1998; Sprenkle, 2001). Until recently, efficacy research dominated the research agendas in academia. However, scholars are increasingly calling on the research community to perform effectiveness studies (Pinsof & Wynne, 1995a).

In this chapter I will describe efficacy research and discuss what we know about the efficacy of marriage and family therapy (MFT). I will also discuss why there has been a recent push in the field towards effectiveness research. Next, I will describe effectiveness research and discuss what we know about the effectiveness of psychotherapy in general, and marriage and family therapy specifically. Additionally, I will describe how university clinics have been used in the past for research in general and specifically for effectiveness research. Finally, I will look at our current knowledge of the relationship between treatment effectiveness and the variables to be examined in this study.

Efficacy Research

The purpose of efficacy research is to create conditions where internal validity is so strong that only the treatment administered can account for any observed change in clients. This climate is most commonly obtained through randomized clinical trials (Howard et al., 1996).

Pinsof and Wynne (2000) describe six characteristics of well-conducted efficacy research:

1. It occurs within a controlled laboratory clinical setting.
2. It is focused on a specific and definable psychiatric disorder or problem.
3. It involves at least two groups or conditions: an experimental condition in which clients receive the treatment under investigation, and a control condition in which clients receive either no treatment (waiting list) or an alternative treatment.
4. Clients are randomly assigned to either the experimental or the control condition.
5. The experimental and control treatments are specified and directed with manuals, and the therapist's application of these treatments is monitored during the study by adherence ratings.
6. All clients are assessed at least pre- and post-therapy on standardized outcome measures.

They also report that follow-up beyond termination has been added in several efficacy studies.

In 1995, an entire issue of the Journal of Marital and Family Therapy was dedicated to examining the efficacy of marriage and family therapy. The goal of the special issue was to "meet the felt need for accessible knowledge about currently available scientific findings from outcome studies of family interventions" (Pinsof & Wynne, 1995a, p. 341).

One important article in the special issue, by Shadish, Ragsdale, Glaser, and Montgomery (1995), summarized the findings of their own meta-analysis (Shadish et al., 1993) on the effects of marital and family therapy. One hundred sixty-three randomized trials (62 marital and 101 family) were located that tested the effects of MFT with distressed clients. The authors concluded that marriage and family therapy not only worked, but that the "literature supporting that conclusion is at least as strong as it is for other forms of psychotherapy" (p. 345). In fact, 71 studies specifically compared MFT clients to untreated controls and found an effect size (d) of .51. This finding suggests that two out of three times, people treated by MFT's do better than people who receive no treatment.

In the special issue's concluding article, the editors, Pinsof and Wynne (1995b) summarize the other findings presented in the issue, which clearly demonstrate that marital and family therapy is efficacious (or at least improves efficacy when added to other treatments) in the treatment of several mental disorders and family problems. These include: schizophrenia, alcoholism, marital distress and cardiovascular risk factors in adults; conduct disorders, drug use, and obesity in adolescents; and conduct disorders, autism, aggression, non-compliance, and ADHD in children.

Other reviews have echoed these findings. For example, Lebow & Gurman (1995) state in reference to couple and family therapy, "Reviews of the research literature conducted over the past 30 years conclude almost without exception that the outcomes achieved by treatment groups have exceeded those of control groups" (p. 32).

What is Wrong with Applying Efficacy Research to the Clinical Setting?

Despite the value of the above findings regarding the efficacy of MFT, it has become evident that clinicians pay little attention to what is done in the research world because they do not feel it applies to them (Sandberg, Johnson, Robila & Miller, 2002; Seligman, 1995). Why is this? As Seligman (1995) states, clinicians pay little attention because the actual practice of

therapy is very different than the type of therapy performed in efficacy research. Seligman points out five ways that psychotherapy, as done in the field, differs from the setting where efficacy research is performed.

First, unlike efficacy studies where treatment duration is determined before treatment begins, therapy in the field is not a fixed duration. Clients remain in treatment until they or their therapist decide that it is no longer needed or helpful.

Second, when therapy is not producing results, therapists are self-correcting: they change modalities when one is not working. Conversely, efficacy studies not only adhere to one treatment strategy, they usually use observational methods and supervision to assure all therapists are complying with the treatment protocol.

Third, clients actively seek their own therapist. This course of action makes it more likely that clients and therapists will establish a good relationship - a key component of successful therapy. In efficacy research, clients have no choice in deciding who will provide their treatment.

Fourth, clients usually have multiple problems. Efficacy studies do their best to restrict their samples to the single presenting problem on which the treatment is being tested. Anyone who has worked outside of the research setting knows that this is rarely the case. Clients present with multiple challenges and are often seeking solutions to all of them.

Finally, therapy in the field focuses on general improvement of functioning, not just a single presenting problem.

Beutler and Howard (1998) summarize their view of efficacy research by stating: Efficacy research in the arena of mental health has been handicapped by a myriad of differences between the populations studied and those seeking treatment, by wide differences in how different clinicians apply even highly detailed treatments, by wide differences among patients as a function of where they are seen and how they got there, and by the complexity of the problems for which diagnostically similar people seek help. (p. 298)

Thus, it is no wonder that clinicians pay little attention to what is done in the research world. Therapy as they know it has little resemblance to the controlled and restricted environment of efficacy research. This gap between research and practice is unfortunate, and raises the question of whether efforts should be turned away from efficacy studies.

However, as Seligman (1996) explains, both efficacy and effectiveness research serve important purposes. Efficacy research can "tell us whether a new therapy is likely to work if it is exported to the field and added to the repertoire that clinicians already have, [and can] tease out the causal ingredients from the inert ingredients within a therapy by the judicious use of manualized control procedures" (p. 8). Effectiveness studies can examine whether treatment, as it is actually practiced and delivered in the real world, is effective. Both types of research are necessary and can work together to provide a clearer picture regarding treatment outcome.

Effectiveness Research

One solution, then, which closes the gap between research therapy and therapy in the clinical setting, is effectiveness research. Hahlweg and Klann (1997) define effectiveness research as the study of:

The effects of natural clinical psychotherapy conducted in the field, (e.g., in private practice or in mental health centers) using quasi-experimental procedures, trying to establish a high degree of external validity or generalizability of results to various settings. (p. 411)

Thus, effectiveness studies look at outcome in the context of actual therapy practice. "By studying eclectic, integrative, and multimodal therapies as they are naturally practiced, effectiveness research moves closer to the phenomenal reality of couple and family therapy practice" (Pinsof & Wynne, 2000, p.3).

As stated earlier, the field of effectiveness research has largely been neglected by researchers (Pinsof & Wynne, 2000). The main opposition is the lack of internal validity, due to the fact that effectiveness studies rarely use the random assignment or control groups which efficacy studies use in order to obtain their results. This lack of internal validity leaves open the possibility that changes found in client outcome has nothing to do with the treatment received. As Beck (1976) put it, effectiveness studies do not "indicate what happens to a comparable group in the absence of treatment, and they fail to put to rest a lingering doubt that improvement may have been reported for some reason other than real gains" (p. 443).

However, proponents of effectiveness research argue that the lack of external validity in efficacy research makes it nearly impossible to apply to the real world, and suggest alternative methods (e.g., causal modeling) to compensate for the lack of a control group or random assignment (Seligman, 1996). Effectiveness studies fill in the important gap between research

and practice that efficacy studies leave out, and is the model used in the present study. What follows is a review of the effectiveness research that does exist in the mental health field.

Effectiveness of Psychotherapy

One of the first clinicians to ask the question, "How well does therapy work in the real world setting?" was Heilbrunn (1966). She examined the effectiveness of her own practice of psychoanalysis with 173 clients over a 17-year period. She looked at the number of people who improved in three types of therapy that she performed: psychoanalysis (treatment duration exceeding 300 hours, usually seen four to five hours a week), extended psychoanalytic therapy (treatment duration from 100-300 hours, usually seen two to three times a week), and brief psychoanalytic therapy (treatment span 20-100 hours, usually seen one to three times a week). Client problems were mainly psychotic reactions and personality disorders. Based on her self-reported dichotomous rating of improvement at termination (improved or unimproved) she found that 38 to 45 percent of her clients improved. Overall, a higher percentage (45%) of patients seen in brief psychoanalytic therapy improved when compared to psychoanalysis (38%) and extended psychoanalytic therapy (43%).

Clement (1999) states that it was not until thirty years later that another therapist (Clement, 1994) examined personal effectiveness in private practice. In his study of his own work, Clement (1994) reported outcome on 444 completed cases that he had seen in private practice over a 26-year period. He determined outcome by reviewing each case file cover to cover, and then assigning an outcome of much worse, slightly worse, no change, improved, or much improved from the time of intake. These cases included presenting problems ranging from eating disorders and social phobia to marital and parent-child problems. He reported that 75% had benefited (improved or much improved) from his treatment and less than one percent were worse at termination than at intake.

While these two studies examined effectiveness of individual therapists, by far the largest study of the overall effectiveness of psychotherapy was a *Consumer Reports* study in November of 1995. Seligman (1995) gives a detailed review of this study, which reports the results of a *Consumer Reports* survey that asked about mental health experiences over the past three years. Surveys were sent to 180,000 subscribers of *Consumer Reports*. Seven thousand subscribers responded to the mental health questions and 2900 had actually visited a mental health professional in the past three years. Of the participants who were feeling "very poor" when they

began therapy, 87% were feeling "very good, good, or at least so-so" by the time of the survey. Of those feeling "fairly poor" when they began therapy, 92% were feeling "very good, good, or at least so-so."

In his article, Seligman shares how this study "shook [his] belief" about efficacy as the "gold standard" because he realized how different the real world setting was from the setting used in efficacy studies. In turn, this study was a turning point in the inclusion of effectiveness research as a viable and valid method of outcome research.

Of course, this study was not without controversy. Seligman (1996) himself discussed "well-founded criticisms" of the research. These criticisms included sampling bias (that those who liked treatment were more likely to return their surveys), the sole reliance on self report by the clients, and that the study was cross-sectional (people were asked to look back at treatment instead of having pre, post, and follow-up measures). Nonetheless, the above studies suggest that psychotherapy, as performed in the real world by individual therapists and in general, is effective for a clear majority of clients.

Effectiveness of Marriage and Family Therapy

Several studies have looked at the effectiveness of marital therapy, and a few have examined effectiveness of family therapy. Beck (1976) looked at the effectiveness of marital therapy specifically, through data collected in the 1970 census conducted by the Family Service Association of America (FSAA). This census yielded records of 1,257 cases of marital therapy with marital problems as the primary issue. Of these, the researchers were able to obtain not only counselors' ratings of outcome, but also follow-up data regarding 585 clients' views of therapy outcomes. According to the counselors' ratings, 67% of the cases reported improvement in their "total problem situation." Specific to the marital problem, 55% reported improvement. Interestingly, 66% of clients reported overall improvement and 60% of clients reported improvement in marital problems, nearly identical to the figures reported by counselors.

Hahlweg and Klann (1997) examined the effectiveness of marital counseling in Germany. Eighty-four counselors participated, providing pretest and posttest data on 252 cases of marital therapy. The pre-post comparisons found significant improvements for wives and husbands on several subscales of the Marital Satisfaction Inventory: global distress, problem-solving communication, time together, and a decrease in depression. The wives also reported improvement in affective communication and less psychosomatic symptoms as reported on a

German psychosomatic measure (Befindlichkeitsskala). However, when they examined whether the change in global distress scores exceeded chance expectations (i.e., amount of change in global distress that could reliably be attributed to therapy and not random events), they concluded that only 30% of the clients could be regarded as reliably improved.

In another study of marital therapy, Hampson, Prince, and Beavers (1999) studied the effectiveness of services at the Southwest Family Institute's sliding-fee clinic in Dallas, Texas. Therapists at the clinic were student therapists from a variety of disciplines who mainly used communication training, behavioral conflict resolution, and solution-focused therapy. At the termination of treatment, therapists recorded the amount of "positive change" that occurred during therapy for 139 couples (1 = a large amount of change occurred, to 5 = no change occurred). The rates of improvement were: 10% of clients made significant gains, 38% made moderate gains, 35% made some gains, 11% made very few gains, and 6% made no gains. For those attending only one session, all had either made very little or no gains. For those attending three sessions or more, 92.1% made some, moderate, or significant gains. The authors did not report outcome for clients attending two or more sessions.

With respect to the effectiveness of family therapy in general, Doherty and Simmons (1996) performed a national survey of 526 marriage and family therapists. The therapists provided information regarding 850 completed cases, and also sent the same questionnaires to their clients so that the researchers could use both therapist and client reports of outcome. Therapists reported that 69.6% of therapy goals had been mostly or completely achieved. Interestingly, 83% of the clients indicated that their goals had been mostly or completely achieved. In cases that were primarily couples or family therapy, some improvement in the couple relationship was reported in 76.6% of all cases (client report).

In a study similar to their marital therapy study, Hampson and Beavers (1996) examined 434 cases of family therapy (at least two-generations of relatives presenting for therapy) over a 15-year period. Most of the presenting problems dealt with child and adolescent behavior/school problems. The researchers found that overall, 75.8% of the families "improved" to some extent, with at least "a few" goals met. When they did not include families who had only attended one session, the overall improvement rate was 86.6%. When families who attended fewer than four sessions were deleted, this rate was 93.8%.

Thus, in the case of marital therapy effectiveness studies, rates of improvement range from 30% in the more rigorous examination by Hahlweg and Klann (1997), to 92% in a sliding-fee clinic. For family therapy effectiveness studies, outcomes ranged from 70% to 87% of clients who improved. The present study is significant in that none of the above marriage and family therapy effectiveness studies were performed in a university clinic.

Use of Training Clinics for Research

As stated previously, training clinics are an excellent resource for use as research facilities, yet they have historically been underutilized (Neufeldt & Nelson, 1998). This is unfortunate because, as Kiesler (1981) explains, they should be at the forefront of research:

Our psychological centers need to incorporate empirical data collection and analysis into their routine functioning so that our students can observe us systematically evaluating the effectiveness and efficiency of our service delivery. University psychological centers should be in the forefront of those who seriously address the accountability issue, especially as trainers and modelers for our graduate students. (p. 214)

While Stevenson and Norcross (1985) assert that 68% of psychology clinics reported current quantitative evaluation of client treatment, a review of the literature suggests that rarely do these efforts produce published findings on the effectiveness of therapy performed in clinics. Those that do use clinics for research purposes often do not report on overall effectiveness. Neufeldt and Nelson (1998) suggest that the lack of effectiveness studies in university clinics setting may be a result of the emphasis on efficacy methodologies in training programs. There are, however, some published effectiveness studies that were done in psychology clinics. Following are representative examples.

Aubry et al. (2000) reviewed 209 cases of individual therapy clients seen at a sliding-fee training clinic for doctoral students in clinical psychology. They obtained follow-up data from 87 of these clients. Treatment outcome was measured by subtracting a client's score on the 10-item Symptom Checklist at follow-up from his or her score at intake. While they report demographic, presenting problem, and fee information, they report no data on overall effectiveness. As will be discussed below, the only relationship they examined was between outcome and the fees paid by clients.

Richmond (1992) looked at 624 cases of individual adult therapy at a university clinic in order to find variables that identified those who dropped out of therapy at intake, evaluation, and

therapy phases of treatment compared to those who completed those phases. The author found that different variables predicted dropout at the various phases of treatment. Unfortunately, he reported no data on overall effectiveness of therapy.

In a large study, Lichtenberg and Hummel (2000) used 1299 counseling clients seen mostly by counseling psychologists at 38 different U.S. college and university counseling centers. Their purpose was to predict client outcome based on a number of variables, including: demographics, previous counseling experience, current medication, and stages of change, to name a few. A logistic regression pointed to four variables that made the biggest difference in outcome: previous counseling, symptom distress, interpersonal relationships, and contemplation of change. Unfortunately, they too reported nothing about the overall effectiveness of therapy. Other examples from the field of psychology include Garfield and Bergin (1971) and Hilsenroth et al. (1995).

Fortunately, one study performed in a psychology university clinic (Messer & Boals, 1981) gave detailed information about therapy outcome. The authors looked at outcome in 59 individual, 3 marital, and 28 child/family cases. At the time of termination, each therapist listed the clients' major problems and rated problem severity before and after treatment on a 7-point scale from mild to severe. They also rated overall helpfulness of therapy on a 7-point scale from unhelpful to very helpful. Overall helpfulness was 4.61, which fell between moderately to very helpful. On average there was a 2.5 point reduction in specific problem severity. In other words, clients reported reduced problem severity 2.5 points (on average) on a 7-point scale ($p < .0001$). Based on the significance level, the authors considered this change to be "very substantial" and "highly significant."

In contrast to the field of psychology, a study like the one above, reporting the effectiveness of a university training clinic, has never been published in the field of marriage and family therapy. My attempts to locate (via literature review and email communication with AAMFT programs) an effectiveness study performed in at an MFT training clinic yielded no results. This does not mean, however, that training clinics have not been used for research purposes. A recent study (McWey et al, 2002) examined the research efforts of MFT training clinics throughout the United States through the use of a questionnaire. The researchers reported that 46.15% of programs that responded to their survey conducted clinic-based research. Unfortunately, this is 22% lower than reported in the psychology field. Furthermore, of those

programs, only five programs stated that they had published their research. Since the article did not give specific reference to those studies, I contacted the author and asked for the specific citations of the research published by these five programs. Unfortunately, she indicated that specific citations were not requested in her survey. A search of the literature, however, found the following examples of research performed in MFT clinics. As was generally true in the psychology clinic studies, none of them report on overall effectiveness.

The Dyadic Adjustment Scale has been tested, revised, and compared to other marital adjustment tools through the use of clients from training clinics (Busby, Crane, Larson, & Christensen, 1995; Crane, Allgood, Larson, & Griffin, 1990; Crane, Bean, & Middleton, 2000; Crane, Busby, & Larson, 1991). For example, Crane et al. (2000) used 142 clinic couples from MFT clinics at Auburn and BYU to establish criterion scores for the Kansas Marital Satisfaction Scale and the Revised Dyadic Adjustment Scale.

Denton, Burlison, Clark, Rodriguez, and Hobbs (2000) used a marriage and family therapy clinic to examine the efficacy of emotion-focused couples' therapy with novice therapists. Twenty-two couples were randomly assigned to an 8-week EFT treatment group, while 18 were assigned to an 8-week wait-list group. After controlling for pre-test scores, the researchers found that participants in the treatment group had significantly higher levels of marital satisfaction than the wait-list group.

Other examples of research performed in MFT clinics include: research on the process of change in couples therapy (Christensen, Russell, Miller, and Peterson, 1998); differences between clinical and volunteer samples on level of social support (Allgood, Crane, & Agee, 1997); predicting divorce in clinical samples (Crane, Soderquist, & Frank, 1995); reflecting teams (Smith, Jenkins, & Sells, 1995); the factor structure of the Beavers Interactional Scales (Lee, Jager, Whiting, & Kwantes, 2000); client drop-out (Allgood & Crane, 1991; Allgood, Parham, Salts, & Smith, 1995); gender issues (Crane, Soderquist, & Gardner, 1995; Jordan & Quinn, 1997; Werner-Wilson, 1997); family and individual assessment (Harris & Busby, 1997); and issues surrounding live supervision (Gallant, Thyer, & Bailey, 1991; Locke & McCollum, 2001).

While the above studies demonstrate that MFT clinics have been used for research, none of these studies' purpose was to examine a clinic's effectiveness, and none of them report effectiveness outcome. The present study will fill this gap in the research.

Study Variables

Although the research is limited, some studies report data on the relationship between outcome and the independent variables included in this study. What follows is a review of what literature there is for each of the independent variables, and why it is important to consider these variables' relationship to outcome.

Therapy Modality

Marriage and family therapists are trained to work with systems large and small. While students are taught to include as many parts of the system as possible in therapy, it would seem important to know if effectiveness in training clinics varies depending upon whether clients are seen individually, in dyads, or as a family. Effectiveness among the different modalities may differ for a couple of reasons. First, therapists in training may struggle with the challenge of working with multiple family members at the same time; and second, often families who attend therapy have individual as well as systemic issues to resolve. Being able to juggle the various family issues can be a challenge. Thus, significant differences in effectiveness within the different therapy modalities could guide training efforts at the CFS. While no effectiveness study has examined this relationship, the following studies do report on the frequency of clients being seen individually, as a couple, and as a family.

Simmons and Doherty (1995), in a study on MFT practice patterns, received responses from 67 MFT's in Minnesota who gave information regarding 199 cases. They were asked to report on their last three closed cases who had been seen at least twice, and who had completed treatment. The authors report that 54% were seen individually, 31% as a couple, and 15% as a family. Doherty and Simmons (1996) used the same methods in a national study and found that 49.4% were seen individually, 23.1% as a couple, and 12% as a family (15% were seen in some combination).

Thus, it appears that practicing marriage and family therapists most often treat individuals, then couples, and least commonly, families. Unfortunately, none of these studies reported on the differences in effectiveness among the different therapy modalities.

Treatment Length

Treatment length (i.e., number of sessions) is probably the best-researched variable of those examined in this study. In general, it appears that the longer clients remain in therapy, the better their chances of positive change.

For example, Beck (1976) found that therapists (n=582) and clients (n=582) reported a positive relationship between number of sessions and the average amount of positive change in both the specific presenting problems and in family relationships. The best outcomes were found in clients who received 20 or more sessions.

Hampson and Beavers (1996) found a relationship between lower goal attainment and fewer visits. Of the families that only attended one visit, 63 out of 79 were rated by their therapists as not having met any goals. The researchers also looked at the relationship by dividing the families into two categories: those that had been seen five or fewer times and those who had been six or more. Twenty-eight percent of families seen less than five times had attained at least some of their goals. In contrast, 81% of families seen six or more times had achieved at least some of their goals. In a subsequent study, Hampson, Prince and Beavers (1999) also found a direct relationship between the number of sessions and degree of improvement as rated by therapists at the final session.

In the only study performed in a university clinic, Messer and Boals (1981) found that the longer the treatment duration, the better the outcome. While the purpose of the study was to report the effectiveness of psychotherapy conducted by clinical psychology students, the researchers did not provide more detailed information about their results in relation to treatment length.

Only one study in this review obtained results contrary to those presented above. Hahlweg and Klann (1997) found that clients with 6-10 sessions had higher mean effect sizes (taken from Marital Satisfaction Inventory, a depression scale, and a psychosomatic symptoms scale) from preassessment to postassessment than clients with either 16-20 sessions or more than 21 sessions.

Therefore, it appears that length of treatment plays an important role in obtaining positive outcome in therapy. Only one study in the review suggests that outcome diminishes after a certain number of sessions. As with other variables, this relationship has not been examined specifically in an MFT training clinic setting, and the current study will fill this gap.

Fee for Services

Although there is a common belief among practitioners that fees play a role in outcome, empirical research shows that fees have limited to no influence. (Aubry et al., 2000; Bishop &

Eppolito, 1992). Since sliding-fee scale and outcome have not been examined in an MFT clinic that does not provide pro-bono services, this study will serve to fill this hole in the literature.

Sliding-fee scale payment and outcome have been examined in a psychology clinic. As mentioned above, Aubry et al. (2000) reviewed 209 cases of individual therapy clients and followed up with 87 of them. The majority of clients (63%) paid \$20 or less. Twenty-seven percent paid \$40 or more. When looking at the relationship between fees based on a sliding-fee scale and treatment outcome, they found no statistically significant relationship.

Yates et al. (2001) randomly selected 152 cases from over 1,500 cases at their MFT clinical training facility. Fee assessment was divided into three categories: Full, reduced, or pro-bono. Fifty five percent paid full fees; 15% paid reduced fees; and 26% received services pro-bono. They found no relationship between fee assessment and achievement of therapeutic goals.

Presenting Problems

An important part of the question, "How effective are you?" resides in demonstrating effectiveness with a wide range of presenting problems, and with clients with multiple presenting problems, since this is the situation most practicing therapists face. From a training perspective, understanding areas of strength and weakness with regard to particular presenting problems could provide useful information for training efforts. For example, if it was concluded that student therapists rate themselves as doing significantly worse with clients presenting with marital discord, educators could focus on this area in practicum and other courses. Unfortunately, no MFT effectiveness study has looked at the different outcomes obtained with various presenting problems at one clinic. Furthermore, as the following studies will demonstrate, classification of presenting problems is in no way standard, making it difficult to compare across studies.

Simmons and Doherty (1995) provide a description of presenting problems reported by therapists. Each therapist reported up to five presenting problems per case, thus, the percentages represent the total percent of cases with a certain presenting problem. Adult and child psychological problems were the most common (74.4%) followed by couple problems (58.8%), whole family problems (42.2%), parent child problems (13.1%), larger systems problems (8%), physical illness (8%), substance use (6.5%) and other (2.5%). On average, their respondents reported 2.6 problems per case.

Doherty and Simmons (1996), who also allowed therapists to indicate more than one presenting problem, found 36 different categories of presenting problems. The most common were depression (44%), other psychological problems (35%), marital problems (30%), anxiety (21%), and parent-child problems (12.5%). Again, no mention was made as to the effectiveness of the therapy in relation to the different presenting problems.

As part of a study of 474 couples requesting therapy at Brigham Young University's MFT training clinic, Allgood and Crane (1991) reported the most common presenting problems. Thirty-seven percent of clients at that clinic presented with marital dissatisfaction, 27% with family-related problems (e.g. parenting, in-laws), 20% with individual-related problems (e.g., sexual dysfunction or depression in only one spouse), and 16% presented with skill deficiencies (e.g., communication or problem solving).

In another MFT training clinic study, Yates et al. (2001) randomly selected 152 cases from over 1,500 cases at their clinical training facility. They reported that 16% of the presenting problems were individual focused, 38% were marital/couple focused, 34% were parent/child focused and 7% were family focused.

Finally, Allgood, Parham, Salts, and Smith (1995) reported the presenting problems of 200 clients or client families who were seen at an MFT clinic. Presenting problems included: marital problems (28%), parental/discipline problems (28%), individual problems (24%), relationship break-ups/divorce (15%), sex abuse (5%), and court-referred (1%).

Obviously, an evaluation of the above studies yields inconclusive results in respect to the common presenting problems seen by MFT's in private practice and MFT's in university clinics. The Doherty and Simmons studies produced multiple specific categories while the two clinic studies used very general problem areas. What can be said is that MFT's treat a wide range of presenting problems. Unfortunately, no MFT effectiveness study has looked at the relationship between these various presenting problems and treatment outcome at one clinic.

Termination: Completion or Dropout

Considering the importance of treatment length for positive treatment outcome, the issue of treatment completion versus dropout becomes an important one to examine. While this study does nothing to understand why clients dropout, it can compare dropout rates in the MFT training clinic to other clinical settings. For example, Richmond (1992) reported that 36.5% of clients dropped out of therapy from a psychology training clinic by the end of the third session.

He also cites research by Pekarik and Wierzbicki (1986) who found that 40% of clients in community mental health centers terminated within 2 visits.

Allgood and Crane (1991) used an MFT clinic to understand predictors of dropout in marital therapy. Of the 474 couples that sought therapy over a four-year period, 72 (15%) dropped out after the first session. Unfortunately, they do not report on dropout that occurred after two or more sessions.

Fortunately, Allgood, Parham, Salts, and Smith (1995) examined the association between pretreatment change and unplanned termination using a definition similar to the one used in the present study (i.e., unilateral terminations initiated by the client as indicated by the therapist). They used 200 clients or client families who presented at a university MFT clinic. They found that there was an association between not having any pretreatment change and an unplanned termination. Important to the present study is the fact that, according to the therapists, almost 50% of the clients had unplanned termination.

Conclusion

Efficacy research has long been heralded as the gold standard due to its rigorous methodology. Recently, however, researchers have questioned the usefulness of the results of efficacy studies in the real world setting. Furthermore, clinicians appear to pay little attention to findings from efficacy studies. Therefore, effectiveness research has been proposed as an alternate research methodology. Due to the dearth of effectiveness research, there is limited support for the effectiveness of psychotherapy in general, and for couple and family therapy specifically.

University training clinics are an excellent yet underutilized resource for performing effectiveness research. No MFT clinic has ever published data on their general effectiveness. This study will serve to fill this gap in the research, and will hopefully be a springboard for other university clinics to report on their effectiveness.

CHAPTER THREE: METHODS

Setting

This study is a retrospective analysis of data from a university training clinic, the Center for Family Services (CFS). The CFS is part of the COAMFTE accredited Marriage and Family Therapy program at Virginia Polytechnic Institute and State University. This program trains both master's and post-master's students in marriage and family therapy. Each year 10 to 15 students are admitted to the program. The program's primary goal is to train highly skilled marriage and family therapists. During the first year of study, students take courses in the history, development, and theoretical models of the field of marriage and family therapy. These models include Bowen family systems, structural/strategic, solution-focused, and narrative therapy, to name a few. Students are also asked to look at their own families of origin through the use of a genogram. In preparation for interning in the CFS, students frequently observe sessions and practice mock therapy with other first-year students. These mock therapy sessions are taped, and observed by their professor in order to provide feedback on their performance.

The CFS is located in the Washington D.C. metropolitan area, a densely populated and diverse community, and treats clients mostly from Northern Virginia. The CFS has provided mental health services since 1986 and is dedicated to treating families and training skilled family therapists. The CFS uses live supervision via one-way mirrors and video recording in order to enhance the training of the therapists and improve the services offered to the clients. Supervision is intense with supervisors present whenever clients are being seen. Supervisors can call in interventions to the therapists via telephones located in each therapy room. All supervisors are licensed marriage and family therapists.

Each year the center receives over two hundred intakes. Clients who call for an intake are introduced to the center's team approach (i.e. one-way mirror, live supervision, etc.) over the phone and are asked to describe their presenting problems. The clinic administration then assigns clients to student therapists, who call and set up an initial visit.

The CFS treats individuals, couples, and families with a wide range of presenting problems. Clients are normally seen on a weekly basis and pay on a sliding-fee scale based on income and number of people being supported by that income. Therapists in this study were either master's interns (58%, $n = 45$), post-master's interns (38%, $n = 30$), or faculty (4%, $n = 3$) in the marriage and family therapy program. The master's interns treated 72.7% of the clients,

while post-master's interns treated 25.3% of the clients, and professors treated 2% of clients. Twenty percent (n = 16) of therapists were male and 80% (n = 62) were female. The female therapists treated 77% of clients. Therapist interns receive a year of classroom preparation before beginning to see clients at the center.

Sample

This retrospective study examined client records (n=1127) of all clients who made their initial contact with the CFS after January 1, 1997, and who ended treatment by March 12, 2002. Thirty three percent (n=372) of clients who requested an appointment never attended any therapy sessions, and another 5 percent (n=59) were referred to other services, leaving a total of 696 clients who attended at least one session of therapy.

Measures

Therapist Termination Summary

Upon completion of treatment, therapists fill out a termination summary, which gives an overview of the treatment they provided to their client(s). The Therapist Termination Summary form (see Appendix A) asks the therapist to indicate the therapy modality (individual, couple, or family), presenting problems from a list of 37 (see Table 1), fee charged, number of sessions, termination category (completed, dropped, or referred elsewhere), and a rating of treatment outcome. The outcome rating asks therapists to indicate "In your opinion, to what extent was the presenting problem(s) resolved?" Four options are given: completely, greatly, somewhat, and not at all. These data are then entered into a database by the clinic staff.

Is Therapist Self-Report Valid?

Although there are obvious limitations to using therapists' self-report, a review of the literature revealed several important findings in support of the use of therapists' report of treatment outcome. Clement (1994) performed a study of his own effectiveness from 26 years in private practice. As his outcome rating, he indicated whether clients were much worse, slightly worse, no change, improved, or much improved. In discussing his use of self-report he states:

Although a therapist's self-evaluation is likely to produce more positive results than that of a blind assessor, there is no agreement in the evaluation literature as to whose perspective is the most valid. In contrast, self-evaluation by the therapist seems to have the greatest professional validity . . . [Practicing psychologists] make the initial diagnoses on Axes I and II. We determine the severity of psychosocial stressors on Axis IV. We

determine the client's global level of functioning at a given point in time on Axis V.

That's what we get paid to do. (p. 175)

Hampson and Beavers (1996) used therapists' ratings of change (1 = all goals met, to 5 = no goals met) to determine therapy outcome for 434 families. They used this measure because it correlated + .63 with gains in observational ratings, and + .83 with family ratings of goal attainment.

Hampson, Prince, and Beavers (1999) again used therapists' ratings of change (1=a large amount of change, to 5 = no change occurred) and goals met (1=large number were met, 5=no goals were met). They compared these to ratings of neutral raters and the families' self-report. They found that:

There was a strong relationship between therapist ratings of goal attainment and gain scores on the observational and self-report measures of family competence in the subsample of families with both types of measures. (p. 422)

Beck (1976) and Doherty and Simmons (1996) also compared client and therapist ratings of outcome and found that, in general, clients rated themselves as having improved more than therapists rated their improvement. Therefore, therapist ratings may even be an underestimate of outcome.

In an effort to further validate the use of therapist ratings of outcome, I analyzed data collected at the CFS to determine the relationship between therapist and supervisor ratings of outcome. This data was collected between 1997 and 2000. During that time, supervisors and therapists independently rated treatment outcome of clients who had terminated therapy, by assessing to what extent presenting problems had been resolved. Supervisor ratings of treatment outcome were performed on the same scale as therapist ratings of outcome. Outcome was coded as: not at all = 1, somewhat = 2, greatly = 3, and completely = 4. I performed an analysis of all the existing supervisor ratings from 1997 to 2000 (n=97). Therapists' and supervisors' ratings were highly correlated (Spearman Rho = .77, $p < .001$). In fact, supervisors and therapists had the same outcome rating 76% of the time, and only once were their scores different by more than one point. Thus, the use of therapist ratings as an outcome measure has some support in the literature, and in this specific case, is highly correlated with supervisor ratings in the setting I am studying. Therefore, I have decided to use therapist ratings in this study.

Data Analysis

For the initial descriptive analysis, all clients who began treatment after January 1997 and terminated treatment on or before March 12, 2002 were included. For the analysis of the relationship between the independent variables and outcome rating, only clients who were seen two or more times were included, as in the study by Doherty and Simmons (1996) who asked therapists to excluded one session assessments and consultations in the survey.

As stated above, there were two main research questions that this study examined. First, does effectiveness (outcome) vary as a function of:

1. Therapy modality,
2. Presenting problem,
3. Number of presenting problems,
4. Fee,
5. Number of sessions, or
6. Termination category.

Second, what, if any, combination of variables predicts successful treatment outcomes.

In order to obtain more equal groups for the analysis, the completely resolved and greatly resolved groups were combined, leaving three outcome categories (not at all resolved, somewhat resolved, and greatly/completely resolved).

For the continuous independent variables (fee, and number of sessions) one way ANOVA's were used to examine differences between the three outcome groups and these variables. Since therapy modality and termination categories are categorical variables, a chi-square test was performed to understand the relationship between these variables and outcome. Furthermore, number of sessions and fee were made into categorical variables by dividing the sample into thirds based on those variables. This was done as a second way of examining the relationship between these independent variables and outcome. Similarly, the number of presenting problems was divided into categories. These categories were determined by examining the frequencies of the total number of presenting problems. Three categories fit the data best: one presenting problem, two presenting problems, and three or more presenting problems. Furthermore, the 37 presenting problem categories were reduced to six (see Table 1) and were compared to outcome. A chi-square test was also used for these analyses.

In order to test the second research question, I used discriminant analysis. The purpose of discriminant analysis is to "identify variables...that best discriminate members of two or more groups from one another" (Silva & Stam, 1998, p. 277). In this case, it was to find the variables that best discriminated membership in the three outcome categories.

The following variables were entered into the analysis simultaneously: number of sessions, fee, number of presenting problems, termination category, and therapy modality. Effect coding was used in order to allow the use of one of the categorical variables, therapy modality, in the analysis. To accomplish this, two new variables were created. In the first variable, those seen individually were coded as 1, those seen as a couple were coded 0, and those seen in family therapy were coded -1. In the second variable, those seen individually were coded as 0, those seen as a couple were coded 1, and those seen in family therapy were coded -1. This coding scheme produces raw coefficients for individual and couple therapy modalities directly, and allows for the calculation of a coefficient for the family therapy modality (reverse sign of the sum of the individual and couple therapy modality coefficients).

Table 1

Presenting Problems

<u>Enrichment</u>	<u>Parenting/Child Problems</u>
Personal enrichment	Single parenting
Relationship enrichment	Parenting- two parent family
Marital enrichment	Child behavior problem
Family enrichment	Adolescent behavior problem
	Runaway
<u>Romantic Relationship Problems</u>	Truancy
Premarital issues/dating problems	Child/adolescent misdemeanor
Marital conflict	Child/adolescent felony
	School problems
<u>Separation/Divorce Issues</u>	<u>Other</u>
Spouse absence/separation	Sexual dysfunction
Divorce mediation	Sexual addiction
Divorce adjustment	Sexual abuse-child
Child custody	Adult misdemeanor
	Adult felony
<u>Physical Abuse</u>	Drug abuse - child/adolescent
Physical abuse- parent	Drug abuse - Adult
Physical abuse- spouse/partner	Alcohol abuse - child/adolescent
Physical abuse-child	Alcohol abuse - adult
Physical abuse - sibling	Adult molested as child
Physical abuse - child and parent	Other (explain)
Physical abuse - spouse & child	
Past physical abuse of child	

CHAPTER FOUR: RESULTS

The purpose of this study was to examine the effectiveness of the therapy provided at a university MFT training clinic by examining therapists' ratings of outcome. Another purpose was to examine the relationship between outcome and several independent variables. This section first describes characteristics of the clients and the therapy provided them at the clinic. Next, the relationship between outcome and therapy modality, number of sessions, presenting problems, fee, and termination category is examined. Finally, results of the discriminant analysis, which determined which variables best discriminated between the three groups, are presented.

Participant Characteristics

With regard to therapy modality, therapists indicated that 40.5% ($n = 226$) of those who attended two or more sessions were seen individually; 39.8% ($n = 222$) were seen as a family; and 19.7% ($n = 110$) sought treatment as a couple. On average, clients attended 10.38 sessions ($SD = 12.29$). The total number of sessions ranged from 1 to 108. The median number of sessions was 6, suggesting that the few clients (6%) attending over 30 sessions increased the mean considerably. The mean, median, and mode number of sessions for clients attending therapy were: for those seen individually, 13.22, 9, 2; for those seen as a couple, 10.66, 7, 2; and for those seen as a family, 13.19, 9, 4. No significant differences ($F = 1.75$, $p = .18$) between therapy modality and number of sessions were found. Almost 20% ($n = 138$) of clients only attended their first session. Another 25% ($n = 178$) attended 2 - 5 sessions, and another 30% ($n = 218$) attended 6 - 14 sessions. The remaining 25% of clients ($n = 160$) attended 15 or more sessions.

Clients paid an average of \$23.27 ($SD = \16.58) per therapy session. The three most common charges for services were \$50.00 ($n = 107$), \$5.00 ($n = 90$), and \$10.00 ($n = 55$). The median charge for services was \$20.00. Significant differences in the amounts ($F = 23.79$, $P < .001$) were found among the three therapy modalities. People seen individually paid significantly less ($M = \$17.72$, $p < .001$) than either couples ($M = \$29.84$) or families ($M = \24.89). Furthermore, families paid significantly less than couples ($M = \$29.84$, $p > .01$).

According to therapists' reports, clients presented with anywhere from one to nine presenting problems. Most commonly, however, clients had one presenting problem (43.3%, $n = 248$). Thirty-four percent ($n = 192$) of clients presented with two presenting problems and the remainder of clients (33.2%, $n = 133$) had three or more presenting problems according to the

therapists' reports. On average, families presented with more problems ($M = 2.32$) than either individuals ($M = 1.71$) or couples ($M = 1.72$).

For clients who attended two or more sessions, the five most common presenting problems were: marital conflict (19.5%), personal enrichment (16.4%), school problems (15.3%), child behavior problems (14.4%), and single parenting issues (14.1%). For those seen individually, the five most common presenting problems were: personal enrichment (34.1%), physical abuse of spouse (20.4%), marital conflict (14.2%), relationship enrichment (8.8%), and single parenting issues (7.5%). For couples, the most common presenting problems were: marital conflict (53.3%), physical abuse of spouse (19.6%), relationship enrichment (17.8%), marital enrichment (15%), and premarital issues/dating problems (14%). Finally, the most common presenting problems for clients seen as a family were: school problems (34.7%), child behavior problems (33.8%), single parenting issues (27.5%), adolescent behavior problems (27.5%), and family enrichment (18.5%). Table 2 presents the frequency of all presenting problems, as well as the frequency of presenting problems for each therapy modality.

Table 2

Percentages of Presenting Problems of Entire Sample

	Overall	Individual	Couple	Family
Marital Conflict	19.5	14.2	53.3	8.6
Other	17.8	28.8	8.4	11.3
Personal Enrichment	16.4	34.1	1.9	5.4
School Problems	15.3	2.2	2.8	34.7
Child Behavior Problem	14.4	0.9	2.8	33.8
Single Parenting	14.1	7.5	0	27.5
Physical Abuse-Spouse/Partner	13.3	20.4	19.6	3.2
Adolescent Behavior Problem	13.2	4	2.8	27.5
Family Enrichment	9.5	4.4	1.9	18.5
Divorce Adjustment	8.1	7.1	1.9	12.2
Relationship Enrichment	8.1	8.8	17.8	2.7
Premarital Issues/Dating Problems	5.9	7.1	14	0.9
Marital Enrichment	5.2	3.1	15	2.7
Parenting-Two Parent Family	4.7	0.9	3.7	9
Alcohol Abuse-Adult	4	4.4	8.4	1.4
Spouse Absence/Separation	3.8	2.7	1.9	5.9
Child Custody	2.7	1.8	0.9	4.5
Adult Molested as Child	2.5	4.9	2.8	0
Drug Abuse-Adult	2.3	1.8	0	1.8
Drug Abuse-Child/Adolescent	1.8	0	0	4.5
Truancy	1.3	0.4	0.9	2.3
Past Physical Abuse of Child	1.3	0.4	0.9	2.3
Child/Adolescent Misdemeanor	1.1	0	0	2.7
Sexual Abuse-Child	1.1	0.4	0	2.3
Physical Abuse-Child&Parent	1.1	0.9	0.9	1.4
Physical Abuse-Child	1.1	1.8	0.9	0.5
Adult Misdemeanor	1.1	2.7	0	0
Runaway	0.7	0.4	0	1.4
Alcohol Abuse-Child/Adolescent	0.7	0.9	0	0.9
Physical Abuse-Spouse&Child	0.7	0.9	0	0.9
Sexual Dysfunction	0.7	0.9	1.9	0
Child/Adolescent Felony	0.5	0	0	1.4
Adult felony	0.5	0.9	0	0.5
Divorce Mediation	0.4	0	0.9	0.5
Physical Abuse-Parent	0.4	0.4	0	0.5
Physical Abuse-Sibling	0.4	0.9	0	0
Sexual Addiction	0.2	0	0.9	0

Note. Due to multiple presenting problems for some clients, the total percentage for each therapy modality above exceeds 100%.

As rated by therapists, 46.6% (n = 258 of 554) of clients who attended at least two sessions completed treatment. The remaining 53.4% (n = 296 of 554) dropped out prior to completion of treatment. For clients who attended 2 - 5 sessions, 77% (n = 137 of 178) dropped

out of therapy. For clients who attended 6 - 12 sessions, 52.5% (n = 104 of 198) dropped out of therapy. Finally, 30.9% (n = 55 of 178) of clients who attended 13 or more sessions were rated as dropping out of therapy according to therapists' reports at termination (see Table 3). A chi-square test revealed a significant relationship between number of sessions and completing treatment ($\chi^2 (2) = 76.01, p < .001$).

Table 3

Prevalence (%) of Termination Rating within Number of Sessions Categories

Number of Sessions	Therapists' Termination Rating	
	Complete	Dropout
2 - 5	23.0	77.0
6 - 12	47.5	52.5
13 +	69.1	30.9

$\chi^2 (2) = 76.01, p < .001$

Therapists' outcome ratings, which indicated to what extent presenting problems were resolved, were available for 549 clients who had been seen two or more times at the CFS. According to therapists, 22.8% (n = 125) had their problems "not at all" resolved; 38.4% (n = 211) had their presenting problems "somewhat" resolved; 29.7% (n = 163) had their presenting problems "greatly" resolved; and 9.1% (n = 50) had their presenting problems "completely" resolved. These results indicate that, according to therapists, almost 80% of clients who came at least twice had at least some of their presenting problem(s) resolved.

Relationship Between Independent Variables and Therapists' Outcome Rating

Therapy Modality

Table 4 gives the percentage of individuals, couples, and families whose presenting problems were not at all, somewhat, and greatly/completely resolved, and was the basis for the chi-square test examining the relationship between therapy modality and outcome. Overall, clients seen individually, as a couple, or as a family, did not differ significantly in all three outcome categories ($\chi^2 (4) = 4.29, p = .37$).

Table 4

Prevalence (%) of Outcome Ratings within Each Therapy Modality

Client Type	<u>Therapists' Outcome Rating</u>		
	Not At All	Somewhat	Greatly/Completely
Individual	20.6	37.2	42.2
Couple	28.6	34.3	37.1
Family	22.2	41.6	36.2

$\chi^2(4) = 4.29, p = .37$

Treatment Length

Two sets of analyses were run in order to test the relationship between number of sessions and therapist reported outcome. First, an ANOVA revealed significant group differences among the three outcome categories ($F = 29.77, p < .001$). Post-hoc analyses were run to determine which groups were significantly different among the three groups. As Table 5 reveals, clients in the not at all resolved category attended significantly fewer sessions than those in both the somewhat resolved category and the greatly/completely resolved category. Furthermore, clients in the somewhat resolved category attended significantly fewer sessions than those in the greatly/completely resolved category.

Table 5
Means, Standard Deviations, and Analysis of Variance (ANOVA) Results for Number of Sessions and Fee

Variable	Not at All Resolved	Somewhat Resolved	Greatly/Completely Resolved	F
	n = 125	n = 211	n = 213	
	<u>M</u> (<u>SD</u>)	<u>M</u> (<u>SD</u>)	<u>M</u> (<u>SD</u>)	
Number of Sessions	6.60 (7.41) a	12.12 (10.82) b	17.06 (15.21) c	29.79*
Fee	\$25.29 (16.78)	\$21.53 (16.19)	\$23.45 (16.96)	2.07

Note. Means in a row with different subscripts are significantly ($p < .001$) different.

* $p < .001$.

In the final analysis, clients were divided into three groups based on the number of sessions they attended. Each of these groups contained 33% of the total clients studied. The first third attended 2-5 sessions; the second third attended 6-12 sessions; and the final third attended 13 or more sessions. A chi-square test revealed a significant difference ($\chi^2 (4) = 101.50, p < .001$) between the groups (see Table 6).

Table 6
Prevalence (%) of Outcome Ratings within Each Number of Sessions Category

Number of Sessions	Therapists' Outcome Rating		
	Not At All	Somewhat	Greatly/Completely
2 - 5	47.4	33.7	18.9
6 - 12	12.2	44.9	42.9
13 +	10.1	36	53.9

$\chi^2 (4) = 101.50, p < .001$

Fee for Services

Two analyses were run to determine the relationship between fee and therapists' outcome rating. First, an ANOVA revealed no significant differences between outcome and fee paid ($F =$

2.07, see Table 5). Second, clients were divided into three groups based on the fee they paid. Each of these groups contained 33% of the total clients studied. The first third paid zero to 10 dollars; the second third paid 11 to 29 dollars, and the final third paid 30 to 50 dollars. A chi-square ($\chi^2 (4) = 3.92, p = .42$) revealed similar representation of the three fee categories in the three outcome categories.

Presenting Problems

The relationship between presenting problem(s) and therapists' outcome rating was examined in two ways. First, the participants were divided into three groups: those with one presenting problem, those with two presenting problems, and those with three or more presenting problems as indicated by therapists. A chi-square revealed significant differences among the three groups ($\chi^2 (4) = 12.76, p = .01$, see Table 7). Clients with three or more presenting problems were more likely to have been in the not at all resolved or the somewhat resolved categories than were clients with one or two presenting problems. Furthermore, clients with one or two presenting problems more often had their presenting problems greatly or completely resolved than clients with three or more presenting problems. The association was not found to be linear, since clients with two presenting problems appeared to do the best.

Table 7

Outcome Ratings for Number of Presenting Problems

<u>Presenting Problems</u>	<u>Therapists' Outcome Rating</u>		
	<u>Not At All</u>	<u>Somewhat</u>	<u>Greatly/Completely</u>
1	27.3	32.9	39.8
2	18.3	38.2	43.5
3 +	21.2	48.5	38.8

$\chi^2 (4) = 12.76, p = .01$

Several steps were taken in order to analyze the differences in treatment outcome among the presenting problems. First, in order to create mutually exclusive categories, only clients with one presenting problem were included. Second, the 37 presenting problems were grouped together to produce six presenting problem categories. The six categories created were: enrichment, romantic relationship problems, separation/divorce issues, physical abuse,

parenting/child problems, and other (See Table 1 for the groupings). Finally, a chi-square test was run to determine if outcome differed significantly between the presenting problem categories. The chi-square did not produce significant results ($\chi^2 (8) = 10.8, p = .21$). Overall, no single presenting problem did better or worse than others (see Table 8).

Table 8

Prevalence (%) of Outcome Ratings within Primary Presenting Problems

<u>Presenting Problems</u>	<u>Therapists' Outcome Rating</u>		
	<u>Not At All</u>	<u>Somewhat</u>	<u>Greatly/Completely</u>
Enrichment	12.5	31.3	56.3
Romatic Relationship Problems	30.0	36.0	34.0
Separation/Divorce Issues	22.2	44.4	33.3
Physical Abuse	34.1	19.5	46.3
<u>Parenting/Child Problems</u>	<u>31.3</u>	<u>37.5</u>	<u>31.3</u>

$\chi^2 (8) = 10.8, p = .21$

Termination

A chi-square test revealed a significant relationship between dropping out of therapy and therapists' ratings of outcome ($\chi^2 (2) = 242.74, p < .001$, see Table 9). Over 70% of clients who completed treatment were rated as having greatly or completely resolved their presenting problems, compared to only 10% of those who dropped out of treatment. Furthermore, less than 2% of clients who completed treatment were rated as having not at all resolved their presenting problems, compared to over 40% of dropout clients.

Table 9

Prevalence (%) of Outcome Ratings within Each Termination Category

<u>Termination</u>	<u>Therapists' Outcome Rating</u>		
	<u>Not At All</u>	<u>Somewhat</u>	<u>Greatly/Completely</u>
Completed	1.9	26.7	71.3
<u>Dropped Out</u>	<u>41.2</u>	<u>48.8</u>	<u>10.0</u>

$\chi^2 (2) = 242.74, p < .001$

Predicting Group Membership

In order to answer the second research question - what combination of variables (called attributes in discriminant analysis) best predicts outcome - a discriminant function analysis was run using the three therapist-produced outcome categories as the grouping variable. Termination category, number of sessions, fee, total number of presenting problems and therapy modality (using effect coding) were the attributes used to discriminate between the three groups. They were entered simultaneously into the analysis.

The analysis produced two discriminant functions. The first was significant ($p < .001$, Wilks' $\lambda = .537$) and explained 97.6% of the variance. The second function was also significant ($p = .05$, Wilks' $\lambda = .98$) but explained only 2.4% of the variance. Due to this, only the first function will be examined.

Table 10 gives the correlation between each attribute and the discriminant functions, as well as the standardized discriminant function coefficients. These coefficients allow comparison of the relative importance of each attribute in each discriminant function. As can be seen, the termination category was highly correlated with the first function, and was the most important discriminating attribute. Not surprisingly, number of sessions was the next most important factor, though it only played a small part in discriminating outcome groups when termination was considered. The remaining attributes contributed very little to discriminating the three outcome categories.

Table 10

Correlation of Predictor Variables with Discriminant Functions and Standardized Discriminant Function Coefficients

Predictor variable	Correlation with <u>discriminant functions</u>		Standardized discriminant <u>function coefficients</u>	
	Function 1	Function 2	Function 1	Function 2
Termination	.98	-.09	.95	-.09
Number of sessions	.36	.45	.20	.27
Number of presenting problems	-.03	.71	-.02	.62
Client Type - Individual	.06	-.16	.06	.05
Client Type - Couple	.00	-.42	-.10	-.27
Fee	-.02	.60	.03	.55

Table 11 examines the ability of the two functions to predict therapists' ratings of outcome. In this analysis, 59.1% of cases were correctly classified. While the functions misclassified the somewhat resolved category 85% of the time, they accurately predicted membership in the not at all and greatly/completely categories over 86% of the time.

Table 11

Classification Analysis for Therapists' Ratings of Outcome

Actual group membership	Total n	Predicted group membership					
		Not At All		Somewhat		Greatly/Completely	
		<u>n</u>	%	<u>n</u>	%	<u>n</u>	%
Not At All	124	109	87.9	10	8.1	5	4
Somewhat	211	111	52.6	31	14.7	69	32.7
Greatly/Completely	213	21	9.9	8	3.8	184	86.4

Note. Overall percentage of correctly classified cases = 59.1%

These results give a detailed description of therapy activities at the CFS. Furthermore, they examine the effectiveness of the therapists at the CFS based on their self-reported treatment outcome ratings, and the relationship between that outcome and several independent variables: therapy modality, number of sessions, fee for services, presenting problems, and termination.

CHAPTER 5: DISCUSSION

The main purpose of this study was to evaluate the effectiveness of treatment provided at a university MFT training clinic, the Center for Family Services (CFS). This was accomplished through examining therapists' ratings of client outcome. Furthermore, this study examined the relationship between that outcome and several treatment factors: therapy modality, number of sessions, fee for services, presenting problems, and termination. A second purpose of this study was to offer suggestions to the CFS and other university training clinics on procedures that would improve future effectiveness studies in the training clinic setting. These suggestions will be discussed in the Strengths, Limitations and Improvements for Future Research section below.

Effectiveness of the Center for Family Services

Overall, therapists indicated that almost 80% of clients who came two times or more had at least some of their presenting problems resolved, while almost 40% had their problems greatly or completely resolved. This result compares well to the two studies from the Southwest Family Institute's clinic that used similar outcome ratings by therapists. In the first study (Hampson & Beavers, 1996), therapists rated the extent to which goals were met. Eighty-six percent of families attending therapy had all, most, or some of their goals met. In the second study, (Hampson, Prince, & Beavers, 1999) therapists rated client change and found that 83% of couples attending therapy had a large, moderate, or at least some amount of change upon termination.

The results of this study, however, are not as impressive as those found by Doherty and Simmons (1996) in their survey of practicing MFT's. In that study, when therapists were asked to what extent therapy goals were achieved, 69.6% said that therapy goals had been completely or mostly achieved. As reported above, in the present study, only 40% of therapists rated clients as having completely or greatly resolved their presenting problems. These inconsistent findings could indicate that student therapists are not as successful as professionals are. On the other hand, they may indicate that these student therapists may simply lack the confidence or experience to rate clients as having greatly improved due to the therapy they provided.

However, these conclusions may be misleading, because the Doherty and Simmons study asked private practice therapists to report on the three most recently completed cases "where therapy has ended, at least for now, and no specific follow-up is scheduled." A look at the cases in the present study where therapists rated the clients as having completed therapy as opposed to

dropping out ($n = 258$) found that student therapists rated 71.3% of these as having greatly or completely resolved their presenting problems. Thus, examined in this way, private practice therapists may not be achieving any greater success than highly supervised MFT student therapists.

Therapy Modality

With regard to therapy modality, individuals and families are seen most frequently at the CFS, while couples are treated less of the time. The number of individual clients seen at the clinic (40.5%) is somewhat lower than the frequency reported in the national survey of MFT's in private practice (58.5%) (Doherty & Simmons, 1996). However, the percentage of families seen at the CFS (39.8%) is much higher than the percentage reported by MFT's in private practice (14.2%). With regard to couples' treatment, the CFS treats couples less often (19.7%) than MFT's in private (27.3%). In fact, a chi-square test revealed significant group differences between the present study and the Doherty and Simmons study ($\chi^2 (2) = 17.2, p < .001$, see Table 12).

Table 12

Comparison of Therapy Modality in Present Study and a National Survey of Practicing MFT's

Study	Therapists' Outcome Rating		
	Individual	Couple	Family
CFS	40.5	19.7	39.8
Doherty	58.5	27.3	14.2

$\chi^2 (2) = 17.2, p < .001$

The present study is the first known to examine effectiveness in relationship to therapy modality. Overall, no significant differences were found between therapy modality and the therapists' rating of outcome. One implication of this finding is that MFT student therapists are successfully dealing with the challenge of working within various therapy modalities. Whether they are seeing an individual, a couple, or a family, their ratings of outcome are statistically the same.

Of course, this finding could be hampered by the fact that therapists could only choose one therapy modality on the CFS Termination Summary form. Even though a student therapist may have indicated couple or family therapy, it is a common practice among the therapists to meet with individual parts of the system at least some of the time. For example, student

therapists who indicated they were doing family therapy could have spent most of the time with the parental subsystem, integrating interventions that usually are associated with couples' therapy. Thus the classification of therapy modality may not be as meaningful as hoped. Suggestions for this possibility will be discussed below in the Limitations section. On the other hand, any classification may be irrelevant for therapists who use systems theory since theoretically therapists are intervening in families anytime they see someone, so the individual, couple, and family distinction is irrelevant.

Treatment Length

Table 13 compares the mean, median, mode and range of number of sessions found in the different studies of marriage and family therapy effectiveness. Since the ranges of number of sessions are so different among the studies, the median number of sessions provides a better way to make comparisons. In looking at the overall number of sessions, the two studies that surveyed practicing MFT's found higher median number of sessions (Mdn = 11 and 12) than the present study (Mdn = 6). However, the present study fell in line with the study performed in a family clinic (Mdn = 5). Unfortunately, the only other study performed in an MFT clinic did not report median number of sessions, but did have a much smaller range (1-19) and mean (4.7) than the present study.

Finally, Doherty and Simmons (1996) reported that the modal number of sessions in their survey of practicing MFT's was five. In the present study the mode was two. As discussed above, this difference may be misleading since the Doherty study asked therapists to report on the three most recently completed cases. A look at the present study with only completed cases found a median of 12 and a mode of 10. This suggests that clients who complete treatment in an MFT training clinic are similar to those in private practice.

A comparison between the studies on individual and couple therapy followed the same trends: a higher median number of sessions among private practice clinicians than in the present study. Interestingly, however, in comparing number of sessions when families were the clients, the reports are essentially the same.

Unlike Simmons and Doherty (1995), who found that family therapy cases were significantly shorter than individual therapy cases, the present study found no significant difference between therapy modality and number of sessions. Both studies found no significant difference between couple and individual therapy cases in the number of sessions.

The current study appears to be the first to look at the relationship between outcome and length of treatment in an MFT clinic. Not surprisingly, the results fell in line with other studies which have found that the longer the treatment length, the more likely a positive outcome will occur (e.g., Beck, 1976; Hampson et al., 1999; Seligman, 1995). Table 14 gives the mean, median, mode and the range for the number of sessions within each outcome category. While the number of sessions clearly increases, on average, with better outcomes, the minimum number of sessions for all of the outcomes was two. Also, a few clients ($n = 8$) who received over 22 sessions were rated as having not at all resolved their presenting problems. This suggests that more sessions are not necessarily indicative of better outcomes, and fewer sessions do not always lead to poorer outcomes in any individual case. However, it is clear that the likelihood of a positive outcome increases as the number of therapy sessions increases.

Table 13

Comparison of Sessions among MFT Effectiveness Studies

Study	Overall					Individual					Couple					Family				
	N	M	Mdn	Mode	Range	n	M	Mdn	Mode	Range	n	M	Mdn	Mode	Range	n	M	Mdn	Mode	Range
Present Study	694	10.4	6	2	1-108	226	13.2	9	2	2-108	108	10.7	7	2	2-41	222	13.2	9	4	2-87
Doherty & ...	850	25.0	12	5	1-266	420	25	13	5	1-266	196	18	11.5	5	1-97	102	16.2	9	8	2-118
Simmons & Doherty (1995)	199	26.0	11				27	14				17	10			13	8			
Hampson et al. (1999)	139	15.3	5		1-84															
Hahwleg & Klann (1997)											252	14.3	11		3-57					
Allgood et al. (1995)	200	4.7			1-19															

Table 14

Mean, Median, Modal, and Range Number of Sessions by Therapist Outcome Rating

Number of Sessions	Therapists' Outcome Rating		
	Not At All	Somewhat	Greatly/Completely
Mean	6.60	12.12	17.06
Median	4	8	11
Mode	2	6	10
Range	2-38	2-55	2-108

Fee for Services

On average, clients in this study paid \$23.27 per therapy session. Clients seen individually paid significantly less than both couples and families, and families paid significantly less than couples. The reason for this first finding is difficult to determine. Since fee is based on income and the number of people supported by that income, it could mean that individuals made less and/or were supporting more people with their income than families and couples. However, it could also mean that couples and families made more than individuals because of dual incomes. With regard to the second finding, that families paid less than couples, the most obvious reason would be that families were supporting more people than couples. Of course, these are all simple conjectures that merit further investigation.

The current study's findings on the relationship between fee paid and outcome adds to the body of research which has concluded that fee paid does not influence outcome. Specifically, this study was the first to examine the sliding-fee scale form of payment in an MFT training clinic. As with other sliding-fee scale studies, no relationship between fee and outcome was found. One question this study does not answer is whether receiving pro-bono services makes a difference in outcome. Very few clients in this study received services pro-bono since pro-bono service is not part of CFS policy. Thus, this comparison could not be made.

In an attempt to further analyze the relationship between fee and outcome, another possibility -- that dropout was related to fee -- was explored. Since therapists' ratings of dropout were significantly related to outcome, it was thought that maybe this was a way in which fee made a difference. However, this analysis found no difference in termination category based on fee. From a policy standpoint, this finding may imply that therapists are employing the Center's policy that no one should be denied treatment because of the fee charged for therapy. Furthermore, since fees are often a subject that raises anxiety for beginning therapists, these results suggest that their concern is not merited. Thus, despite the common idea that fee affects outcome, the body of research and the present study suggest otherwise.

Presenting Problems

Clients presented with a wide range of presenting problems, and most commonly with multiple presenting problems. On average, clients presented with 1.9 presenting problems, slightly lower than Simmons and Doherty (1995) who found 2.6 presenting problems per client.

When examining those who only presented with one presenting problem, no presenting problem was statistically different than the others in terms of outcome rating by therapists. It would seem, then, that the student therapists are successfully applying their skills to a number of presenting problems. Thus, it is important for training at Virginia Tech to continue to focus on multiple and diverse presenting problems.

Termination

According to therapists, almost 48% of clients who came at least twice completed treatment. This finding is almost identical to the Allgood et al. (1995) MFT clinic study that used a similar definition of dropout. It is much better than Hampson et al. (1999) who reported that only 32% of clients actually attended a final scheduled appointment. However, Hampson and his colleagues' definition of completion may be more stringent than the one used by therapists in the present study. The current study also compares well to another MFT clinic study (Allgood & Crane, 1991) that reported that 15% of marital therapy cases only came once to an initial therapy session. In the present study, 20% only attended an initial therapy session.

Therapists' ratings of termination and therapists' ratings of outcome appear to be strongly related. In fact, over 70% of clients who completed treatment were rated as having greatly or completely resolved their presenting problems, compared to only 10% of those who dropped out of treatment. This points to the importance of client retention. While the CFS dropout rate compares well to other studies, certainly the fact that 20% dropped out after their first session and less than 50% of clients who attended more than one session completed treatment, is a matter of great concern. This problem needs to be examined further to see what efforts can be made to retain more clients.

A good starting place is Bischoff and Sprenkle's (1993) review of the dropout literature in marriage and family therapy. They provide information on four areas pertaining to dropout that could be relevant to the CFS: client variables, therapist variables, therapy process variables, and specific intervention variables. I will only discuss a few findings that I consider important for training purposes at the CFS.

With regard to client variables, two findings the authors discussed could be particularly important: clients in relational therapy who identify their presenting problem as residing in an individual are more likely to drop out, and dropout rates are higher when client expectations are

not met. In terms of training, this points to the importance of framing problems in systemic terms, and overtly asking clients about their expectations.

In reference to therapist variables, three variables seem important: therapist activity, relationship skills, and expectations. Therapists who are more active in sessions, who have higher relationship skills (such as warmth, humor, and affect-behavior integration), and who expect their clients to continue, are less likely to have their clients drop out of treatment. These findings may help therapists in training understand important areas to focus on in order to help their clients remain in treatment.

Predicting Group Membership

The combination of independent variables correctly predicted group membership in almost 60% of the cases. While the analysis misclassified a majority of cases in the somewhat resolved category, the discriminant function correctly classified over 85% of cases in the not at all and greatly/completely resolved groups. Thus, the discriminant function analysis performed well at predicting the extreme categories, but failed to distinguish those in the middle category. This is understandable because the "somewhat" category is less definable to therapists than are the other two extreme categories.

By far the strongest predictor of successful outcome is completion of treatment. In fact, this factor alone explained almost all of the variance in the analysis. This finding reinforces the discussion above regarding the importance of examining factors that influence retention of clients and hence, completion of therapy.

Since termination category was strongly correlated with the therapists' rating of outcome, a second discriminant analysis was performed to determine which variables would be most predictive without termination being included. Not surprisingly, the number of sessions was highly correlated ($r = .96$) with the first function. That function explained 85.8% of the variance. No other variable was even moderately correlated with the first function. Compared to the original functions, which correctly classified almost 60% of cases, without the termination category only 44.5% of the cases were correctly classified.

Strengths, Limitations and Improvements for Future Research

As stated above, a second purpose of this research was to use my experience to suggest improvements in the collection of data at the CFS, as well as influencing other training clinics in

the future. In suggesting these improvements, I want to discuss the strengths and limitations of this study and the present way in which data is collected at the CFS.

Strengths

The first strength of this study, and of the current data collection system at the CFS, is the use of therapists' ratings of outcome. This form of data collection enables the CFS to obtain outcome ratings on all clients seen there for more than two sessions. No other outcome method could replicate this. Full participation by clients in outcome assessments is never accomplished, and observational ratings are too demanding in terms of time and people to do them on all clients. Thus, therapists' ratings are the only viable way to obtain outcome ratings on all clients.

Second, this study explored the real world of treatment. It fell in line with the common aspects of real world treatment as outlined by Seligman (1995) in his critique of efficacy studies. Treatment duration was not fixed. Clients ended when they or the therapist decided to end. Therapists inevitably were self-correcting: they continued to use interventions and strategies that worked, and tried new ones when interventions were not working. No one model was consistently adhered to, and clients had multiple problems. Additionally, therapy focused not only on single presenting problems, but also on general functioning. Due to these characteristics of this study, the implications of this study are important to practicing therapists, not just researchers.

Finally, the results of this study can be a springboard to more traditional research studies. For example, this study has pointed to the need to look more closely at dropout. This finding could be the basis of a qualitative study of completers and dropouts. Furthermore, this study has shown the utility of collecting data at a university training clinic. As will be discussed below, improvements in data collection could provide a wealth of knowledge for more complex analyses.

Limitations and Proposed Remedies of the Present Study

This study is not without several limitations. In this section I will discuss limitations and will propose remedies with regard to current practices at the CFS concerning therapy modality, presenting problems, termination, and outcome assessment. Furthermore, I will discuss limitations with respect to the limited number of independent variables used in the study, the lack of a follow-up on client outcome, the lack of a control group, and the generalizability of these findings.

Therapy modality.

As discussed earlier, the therapy modality variable may not be representative of the way therapists at the CFS actually treated clients because frequently, therapists meet with individual members of a family, even if it is considered "family therapy." Thus, the classification of therapy modality may be meaningless, and the result that modality made no difference could be misleading.

In order to remedy this, therapists could indicate all modalities used, or even more specifically, the number of sessions they spent using each modality. This method could provide clearer evidence as to the significant or insignificant role that therapy modality plays in treatment outcome.

Presenting problems.

With regard to presenting problems, an examination of the current list of presenting problems is clearly inadequate (see Table 1). Several common presenting problems, like depression, are missing; and several rarely seen problems, like child/adolescent and adult felony or misdemeanor, are included. The list needs to be updated to reflect current practice at the CFS. The findings of this study suggest which commonly occurring presenting problems should be maintained on the list. To obtain a more complete list, practicum students could bring in lists of common presenting problems they see, and these lists could be synthesized into a more accurate and useful presenting problem list.

Another idea is to use DSM diagnoses as the presenting problem categories. This format has several strengths and weaknesses. In terms of strengths, it would provide a standardized, well recognized, and understandable measure of presenting problems that is accepted by mental health professionals. On the downside, reliance on these diagnoses would take away the voice of the client in determining their presenting problems. Furthermore, the diagnoses are pathologizing, something many therapists try to avoid as they work with clients. Finally, many of the student therapists are not trained in DSM until they have been in the clinic for over a year. Thus, reliance on these categories could be very misleading.

Another limitation of the current system is that it does not allow therapists to indicate the primary presenting problem. Due to this, over half of the cases had to be dropped in order to analyze how effectiveness varied among the presenting problems. As will be discussed in the

Outcome section, a new system that not only allowed primary problems to be indicated, but also gave outcome for each of the problems, would improve the usefulness of the data collected.

Termination.

While the termination categories (completed or dropped) are used almost universally in the literature, the definitions vary greatly. One weakness of the current study was the lack of a clear understanding of what therapists used to determine whether to consider a client as dropped or completed. For example, if a client had completed their goals, but never came to a last session, were they considered dropouts? Similarly, were clients who did come to a last session, but who, in the therapist's mind, had not completed treatment goals, considered dropouts? This may have been the case, considering the strong relationship between dropout and outcome as rated by the therapist. Clinic administration needs to determine an appropriate definition and orient therapists to the Termination Summary Form in practicum or the MFT Techniques course. I suggest the termination category be expanded to better represent termination situation. This new measure would have three options: whether therapy was unilaterally terminated by the client, unilaterally terminated by the therapist, or jointly determined termination by the client(s) and the therapist.

Outcome rating.

Clearly, the outcome rating used in the study, "In your opinion, to what extent was the presenting problem(s) resolved?" and the given responses: completely, greatly, somewhat, and not at all, are inadequate for several reasons. First, since most people present with more than one presenting problem, it does not allow for multiple ratings of outcome among the different presenting problems. Second, the current outcome options do not include a rating of clients actually getting worse during the treatment. Third, there is no way of knowing how much of a change occurred. A client who left completely resolved that had severe depression would be much more of a significant outcome than a client who left with the same outcome, but was only mildly depressed at intake. Finally, the outcome rating provides no indication of the general functioning of the client and whether that functioning is in the "normal" range of functioning. Remedies to these problems are discussed in the next section.

Outcome Assessment.

While the therapists' self-report of treatment outcome is a strength in that all clients can be rated, it only provides one piece of the outcome puzzle. Strupp (1996) identifies three

vantage points of outcome: society, the individual client, and the mental health professional. Put together, these ratings provide a complete picture of outcome. According to Strupp, the societal view focuses on outward behavior, the individual client's view is concerned with well-being, and the professional's view is mostly concerned with mental health based on some theoretical model. While acknowledging the validity of each perspective, Strupp states that "evaluations based on a single vantage point are inadequate and fail to give necessary consideration to the totality of an individual's functioning" (p. 1019-1020). Thus, ideally, outcome should take into account multiple perspectives (patient self-report, significant others, therapist report, clinical evaluators, and standardized tests) as well as multiple aspects of functioning (behavior, well being, and mental health).

Due to constraints on time and money, rarely, if ever, are all perspectives taken into account in any one study. In consideration of the resources at the CFS, I propose that three perspectives (client, therapist, and supervisor) and two aspects of functioning (specific problem change and global change in well-being and mental health) be assessed. The specific problem change could be accomplished through the use of Target Complaints (see Ogles, Lambert, & Masters, 1996) during the initial sessions and at termination. This outcome tool asks the patients and/or the therapist to indicate presenting problems or complaints and then rate their severity. The suggested 5-point scale ranges from severe to absent. The global change could be measured at termination by asking the therapist and/or the client to indicate whether the client got significantly worse, moderately worse, slightly worse, did not change at all, made small gains, made moderate gains, or made significant gains. In this way both specific problem and general functioning could be assessed. Additionally, it would be important to follow-up with these questions by asking the client what it was about therapy that influenced the change that had occurred, as suggested by Bischoff and Sprenkle (1993).

Another possibility would be to use the Global Assessment of Functioning (GAF) for individual functioning and the Global Assessment of Relational Functioning (GARF) for relationship functioning, as found in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000). These assessments ask therapists to rate functioning on a scale from 1 to 100 based on the client's psychological, social, and occupational functioning for the GAF, and the client's problems solving, organization, and emotional climate for the GARF.

No follow-up.

Another limitation of this study is the complete absence of data collection beyond termination. This is a considerable limitation. Without this knowledge one can only conclude that treatment helped while the person was in treatment. Nothing can be said regarding the long-term effects of treatment. It would be interesting to implement a follow-up process at the CFS where therapists, at six months following termination, or at the end of their internship, make follow-up calls to previous clients and ask them to rate their presenting problem severity and general functioning since termination.

No control group.

One of the major complaints of effectiveness research is the lack of control groups or the use of random assignment. Because of this, internal validity is greatly compromised. Aikins, Hazlett-Stevens, and Craske (2001) express concern over internal validity by stating:

We have no indication as to whether it is the treatment components believed to be therapeutic, the nonspecific effects of increased human contact, the client expectancies, or some other factor that accounts for [success]. Without comparison conditions, we have no way to interpret observed changes. We are left with correlational data that describe relations among the variables measured...without any understanding of the cause-and-effect relations between those variables and without any direction for research or practice development. (p. 906)

Seligman (1996), however, suggests a way that the lack of control groups and random assignment can be overcome in effectiveness research. He believes that "both effectiveness studies using causal modeling and efficacy studies using control groups and random assignment of participants are methodologically sound, rigorous, and powerful ways of empirically validating psychotherapy outcomes. The two methods have complementary flaws and strengths" (p. 5 of 13).

He goes on to explain that control groups and random assignment eliminate alternate causes of treatment effects in one fell swoop, whereas naturalistic methods (like regression, structural equations, and causal modeling) can eliminate alternative causes one by one. The key to using naturalistic methods is to operationalize and test alternative internal and external causes. In fact, one of the assumptions of those methods, like discriminant analysis, is that ideally the set of independent variables "should represent as complete and accurate a description of the entities

as possible" (Silva & Stam, 1998, p. 280). Thus, in order to use naturalistic methods appropriately, all possible alternative causes of treatment effects need to be considered. What are those alternative causes?

Alternative causes.

A review of the literature suggests five areas of alternative causes (independent variables) which need to be included in a comprehensive examination of outcome: therapist variables, client variables, the interaction of client and therapist variables, therapeutic procedures, and the influence of external events (Garfield, 1986). The present study examined several attributes of the therapeutic procedure, but included nothing on the other four possible alternative causes. Examples of the first two alternative causes, client and therapist variables, are provided below.

The key therapist variables to look at include demographic variables (age, sex, ethnicity, education), emotional well-being, attitudes and values, therapy style, expectations, and most importantly, the ability of the therapist to create a strong therapeutic alliance (Beutler, Crago, & Arizmendi, 1986). Therapeutic alliance (Miller, Duncan, & Hubble, 1997, Strupp, 1996) includes empathy, warmth, genuineness, and respect. It is a more important variable than specific treatment approach (see Chatoor & Krupnick for a review) and accounts for as much as 30 (Miller et al., 1997) to 85% of the outcome variance (Strupp, 1996). A comprehensive effectiveness study must include these important therapist variables.

Furthermore, in the training clinic setting, several other variables may influence treatment outcome. These include experience in the clinic (in years or semesters), number of client contact hours, and supervisory experience.

In addition, there are key client variables that may influence outcome, which must also be included. These are demographics, personality variables (degree of disturbance, life situation, support system, type of symptoms, motivation for treatment, ability to form a therapeutic relationship, etc.), diagnosis, intelligence, and client expectations. A good example of naturalistic research examining client characteristics is Lichtenberg and Hummel (2000). The authors examined 1299 counseling clients seen at 38 different college and university counseling centers in order to determine client characteristics that predicted outcome. The included demographics, GPA, previous counseling, current medication, symptom distress, stage of change, a measure of quality of interpersonal relationships, and a measure of social role performance. In their analysis, clients who reported greater levels of symptomatic and

interpersonal distress, a greater readiness to change, and who had not previously been in counseling were more likely to improve in counseling. It is this type of research that Seligman suggests can overcome the lack of control groups and random assignment.

Generalizability.

Another limitation to consider is the generalizability of the current study. "There are problems, of course, with generalizing from counseling and therapy conducted in training clinics to that which is conducted in outpatient settings where the focus is entirely on treatment rather than training" (Neufeldt & Nelson, 1998, p. 320). However, as discussed earlier, the results of the present study are comparable to the national survey of private practice MFT's (Doherty & Simmons, 1996). Furthermore, Todd et al.(1994, as cited in Neufeldt & Nelson, 1998) indicates the following regarding the applicability of training clinic studies:

Many community service and hospital facilities hire paraprofessionals or intern therapists with varying preparation who operate under supervision, and training clinic studies may be applicable to the many settings that utilize a number of practicum, intern, and fellowship level therapists. (p. 321)

Thus, the results of this study are most likely generalizable to other training clinics and settings where therapist interns are used.

Process of change.

Finally, the present study says nothing about the process of change. As Pinsof and Wynne (2000) concluded with regard to the findings from the 1995 special edition of the Journal of Marital and Family Therapy, only one finding was "minimally instructive in the treatment of families with clients with these disorders" (p. 2 of 7). That finding was that negative-emotion-reducing interventions are more effective than negative-emotion-heightening interventions for families with schizophrenic clients and bipolar disorders. As will be discussed below, new research paradigms have been developed to fill this void.

Beyond Effectiveness Research

Before discussing completely new methodologies, I want to discuss an attempt by Westen and Morrison (2001) to improve the effectiveness research methodology. After reporting the results of their meta-analysis on treatments for depression, panic, and generalized anxiety disorder, these authors give a detailed example of what they call Type II effectiveness research. In this type of research, not only is data collected on outcome in a real world setting,

but also qualitative data is collected in order to understand the process by which change occurs. Their proposed methodology would involve enlisting clinicians to recruit their next client with a particular presenting problem to participate in the study regardless of comorbidities. Patients, clinicians, and independent assessors would provide periodic data using several measures. Furthermore, recordings of sessions would randomly occur and be independently coded to assess therapeutic interventions and process. "This design would allow researchers to discover which features of actual treatments are associated with outcome and to see what intervention strategies appear to work with what kinds of patients" (p. 888).

Other researchers suggest that neither efficacy nor effectiveness research are the direction in which the field should be headed. For example, Lambert (2001) said in response to the call for effectiveness research that "effectiveness research as it has been conducted in the past is not likely to provide much more clarity than has heretofore been obtained" (p. 912). He proposes a research paradigm, first suggested by Howard, Moras, Brill, Martinovich, and Lutz (1996) that involves measuring client status on a session-by-session basis during ongoing treatment. Through this paradigm, called patient-focused research, clinicians are alerted to clients who are failing to respond to treatment, and can then adjust. Lambert cites his own forthcoming research which found that clinicians who used this information had clients who remained in treatment longer and had a greater likelihood of completing treatment with a positive outcome. In conclusion Lambert states:

Patients in treatment would be best served if clinicians and clinics utilize outcome management procedures rather than rely on the use of so-called empirically supported therapy and research designs that are directly aimed at improving clinical practice outcomes. (p. 912)

In the MFT field, Pinsof and Wynne (2000) have also suggested a move to what they call "progress research." In fact, Pinsof and his colleagues are developing and testing the use of a brief therapist-report instrument that would inform therapists of changes in client functioning on a session-by-session basis. This would enable therapists to meet the individual needs of clients, instead of only understanding overall effectiveness of therapy.

While Lambert (2001) suggested a move away from efficacy and effectiveness research, interestingly, just months earlier he wrote:

All three types of research [efficacy, effectiveness, and patient-focused] are essential to enhancing the quality of treatment offered to patients and to placing psychotherapy on a firm empirical foundation. They are complementary to each other, often overlapping, and can inform one another, providing the synergy that may be necessary for rapid scientific progress and improved outcomes. (Lambert, Hansen, and Finch, 2001, p. 159)

I agree with this view of current research needs with regard to outcome research. All three paradigms can work together to inform clinical practice. Efficacy studies can provide useful information about treatments that could be tested in the real world setting. Effectiveness studies maximize external reliability and can use naturalistic methods to assess and predict outcome. Patient-focused research takes us from the general question of effectiveness (How effective is treatment overall?) to the specific question of effectiveness (How effective is this treatment for this particular client?). Furthermore, I see training clinics as an excellent resource for effectiveness research. The implementation of improvements to effectiveness data collection, as suggested in the Limitations section above, will lead to better services, more skilled family therapists, and outcome data for the field.

Clinical Implications

There are two main clinical implications that stem from this research. First, therapists' reports of outcome may be an efficient and valid way to determine treatment outcome, and the only way to get outcome ratings for all clients seen in therapy. As demonstrated in the Methods section, therapists' ratings of outcome have consistently underestimated clients' ratings of treatment outcome. Furthermore, as part of this study, therapists' ratings were highly correlated with supervisors' independent ratings of outcome. Although in the past therapist ratings have been deemed a less valid way of examining outcome, these results suggest it is a practical and valid way of assessing outcome. Of course, ratings from multiple sources is the ideal; however, I suggest therapists' ratings be given just as much validity as any other individual method.

Second, the results and suggestions for improvement from this study can be used to enhance the use of the scientist-practitioner model at Virginia Tech. This model was recently discussed in the *Journal of Marital and Family Therapy* (Crane, Wampler, Sprenkle, Sandberg, & Hovestadt, 2002). The goal of this model is to provide "education where the separate traditions of research and clinical training could be combined in ways to reduce the gap between research and clinical practice" (Crane et al., 2002, p. 76). While the authors of this article emphasize the

importance of better research training through more research courses, a research practicum, and the requirement of a thesis at the Master's level, one important step they do not discuss is involving students in clinical outcome research as part of their clinical practicum.

At least four benefits will result from implementing research as a more integral part of the clinical practicum. First, it would help to bridge the gap between research and practice. Second, therapists would learn how to evaluate their effectiveness. Third, it would emphasize the importance of evaluation, hopefully encouraging a lifetime pursuit of outcome assessment for those who desire to do primarily clinical work throughout their careers as therapists. By teaching therapists a systematic way of outcome collection during their training, they can take those skills and apply them to private practice. Finally, this would benefit those who want to pursue doctoral degrees through gaining research experience.

A good example of the effects of instilling in student therapists the importance of examining their effectiveness is Clement's (1994) review of 26 years of private practice. As reported in chapter two, Clement reported outcome on 444 completed cases that he had seen in private practice over a 26-year period. His analysis allowed him to not only determine how effective he had been over the course of his career, it guided his future practice. He stated, "During my remaining years I want to limit my practice to those patients I am most likely to benefit and with whom I am likely to produce the greatest treatment effects" (p. 175). Furthermore, it allowed him to provide prospective clients, referring professionals, and managed care companies with answers to questions like, "How many cases of diagnosis X have you treated, how long did you take, and what outcome did you achieve?" (p. 175). I believe this type of accountability, spread throughout our discipline, would greatly increase the quality of care we provide.

The addition of a research focus in the clinical practicum would require minimal changes to the current practices at Virginia Tech. First, changes in data collection procedures, as outlined above, would need to be implemented. Second, a formal orientation to the data collection process would need to occur in practicum or the MFT Techniques course. Finally, an outcome assessment could be added to the evaluations provided to therapists each year, and/or at completion of their internship at the CFS, in respect to their effectiveness as a therapist.

To demonstrate the utility of this approach, I give two examples using the data that is currently collected at the CFS as a way to help therapists understand their effectiveness.

First, Table 15 compares one therapist's activities at the CFS to the mean of the entire CFS over the last five years. On average, this therapist treated more couples and families than the average of all student therapist at the CFS, treated clients for a longer duration, and rated him/herself as somewhat more successful than the average of all student therapists at the CFS. In light of the present studies findings, the most important feature is the fact that less than 17% of this therapist's clients dropped out of treatment. This is well over the average (62%) and may indicate a strength in this therapist's ability to join with clients.

Table 15

Comparison of CFS to Individual Therapist on Therapy Modality, Length of Treatment, Fee, Termination, and Outcome

Variables	CFS	Individual Therapist
Therapy Modality		
Individual	40.5%	25%
Couple	19.7%	25%
Family	39.8%	50%
Sessions (M & Mdn)	10.38, 6	13.25, 8
Fee	\$23.27	\$27.00
Termination		
Completed	37.6%	83.3%
Dropped	62.4%	16.7%
Outcome		
Not at all	22.8%	8.3%
Somewhat	38.4%	41.7%
Greatly	29.7%	25%
Completely	9.1%	25%

Furthermore, therapists could be provided with a chart similar to the following (Table 16) which describes therapy characteristics (therapy modality, length of treatment, fee, presenting problem(s), termination, and outcome) for every family seen by them at the CFS during their internship. This information would be of great benefit to them, because as performance is measured, performance will improve. Student therapists will become more aware of their areas of strength, which will help to build confidence in their ability to help their clients. Also, they will be able to target areas of weakness and work on these with their supervisor while they are still interns. Finally, this type of evaluation during their training will hopefully encourage them to continue evaluating their effectiveness throughout their careers.

It is important to note, however, two potential negative consequences that should be taken into consideration as outcome data is incorporated into the evaluation process. First, the knowledge that effectiveness would be part of the evaluation could inadvertently inflate the effectiveness scores that therapists give to their clients. This possibility speaks to the importance of collecting effectiveness data from supervisors and clients themselves so that comparisons can be made.

Second, this process could create more competition and comparison between therapists if they use the effectiveness scores to compare themselves to one another. This competition could undermine the sense of teamwork that currently prevails at the CFS. Therapists could be cautioned against using their results in this way, or the data could simply be used by supervisors on a semester by semester basis and only given to therapists at the completion of their internship.

On a personal note, this research has strengthened my personal desire to account for my performance as a therapist. As I have thought about the effectiveness of the clinic in general, I have looked at my own therapy practice and asked myself, "With whom am I most effective?" "What presenting problems are most challenging for me?" And "How can I improve my effectiveness?" A critical evaluation of my own skills has and will provide useful feedback for improving my own effectiveness in the future.

Table 16

Therapy Activities for One Intern at the CFS

	Therapy Modality	Number of Sessions	FEE	Presenting Problem	Presenting Problem	Presenting Problem	Presenting Problem	Termination	Outcome
1	Family	5	3	Divorce Adjustment	0	0	0	Completed	Completely resolved
2	Individual	5	25	Divorce Adjustment	Other	0	0	Completed	Somewhat resolved
3	Individual	2	15	Single Parenting	Other	0	0	Dropped	Not at all
4	Couple	3	20	Marital Conflict	0	0	0	Dropped	Somewhat resolved
5	Family	5	44	Adolescent Behavior Problem	School Problems	0	0	Completed	Somewhat resolved
6	Family	12	30	Parenting-two parent family ¹⁸	Child behavior problem	School problems	0	Completed	Somewhat resolved
7	Family	7	40	Child behavior problem	0	0	0	Completed	Completely resolved
8	Family	9	40	Child Behavior problem	School problems	0	0	Completed	Greatly resolved
9	Individual	31	3	Marital Enrichment	Personal Enrichment	Physical Abuse - Spouse	Marital Conflict	Completed	Somewhat resolved
10	Family	19	5	Divorce Adjustment	Single Parenting	Child Behavior problem	0	Completed	Greatly resolved
11	Couple	20	50	Physical Abuse-Spouse	Marital conflict	0	0	Completed	Completely resolved
12	Couple	41	50	Marital Conflict	Parenting - two parent family	Child behavior problem	Other	Completed	Greatly resolved

Conclusion

The main purpose of this study was to evaluate the effectiveness of treatment provided at a university MFT training clinic, the Center for Family Services (CFS). A second purpose of this study was to offer suggestions to the CFS and other university training clinics on procedures that would improve future effectiveness studies in the training clinic setting.

In general, therapists at the CFS indicate that a majority of clients are improving at least to some degree. Completion of treatment, as rated by therapists, appears to be the most

important factor that determines successful outcome. Because of this, future research needs to examine factors that can influence client retention in the university clinic setting.

This study has proven the utility of data collection in the MFT university clinic setting, and has provided suggestions for improvement in data collection procedures at the CFS. I believe these small changes in the current system at the CFS could strengthen the validity and usefulness of the data collected there, and provide important data to therapists in training that will improve their future therapy practice. The dissemination of this research and these ideas will positively influence the research practices of other MFT training clinics, instilling in therapists the desire to measure their own effectiveness, thus improving the quality of the therapy they provide.

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Appendix A
Termination Summary

Family Name: _____ Date: _____

Case #: _____ DSM IV: _____

Case type:

___ Assessment/Consultation ___ Indiv Therapy ___ Couples Therapy ___ Family Therapy

Who has been seen?

Presenting problem(s): _____

Presenting problem category/categories: _____

Number of sessions (to date): ___ Fee category: ___ Regular ___ Late ___ Never Paid

Reason for termination:

Brief summary of treatment:

Identify any risk issues. Describe how each issue was addressed and describe status of issue at present.

In your opinion, to what extent was the problem resolved?

___ Completely ___ Greatly ___ Somewhat ___ Not at all

Termination category:

___ Dropped ___ Completed ___ Referred elsewhere

Therapist Intern Signature: _____

Therapist Name (Print): _____

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EDUCATION

Virginia Polytechnic Institute and State University, Falls Church, Virginia
August 1999 - May 2002

- M.S., Marriage and Family Therapy Program, Department of Human Development
- 3.98 Cumulative GPA

Brigham Young University, Provo, Utah. September 1993 - April 1999

- B.S., Family Science
- Psychology & Portuguese Minors
- 3.90 Major GPA
- 3.80 Cumulative GPA

PROFESSIONAL EXPERIENCE

Virginia Polytechnic Institute and State University, Falls Church, Virginia

Research Assistant, Dr. Sandra Stith, August 1999 - Present

- United States Air Force Family Advocacy Research Project
 - Assisted in development of 75 Item **Risk Assessment Tool** and **Training Manual**.
 - **Meta-Analysis** of Spouse Abuse Risk Factors - coded over 200 articles to obtain effect sizes for spouse abuse risk factors.
 - Assisted in training of clinicians to use assessment tool.
- NIMH Grant, Systemic Treatment of Batterers in Intact Relationships
 - Intake Therapist
 - Data Entry
 - Qualitative Interviewer
 - Qualitative Interview Transcription
 - Assisted in data analysis
- Web Master - updated program web page and managed program listserv
- Data Analysis of ADAPT anger management program outcome
- Editor - 2001 Program Newsletter
- Organizer of One-day Family Play Therapy Conference

Graduate Assistant, Dr. Jamie Callahan, August 1999 - May 2001

- Qualitative analysis of "Critical Incidents" in the work place

Teacher, Missionary Training Center, Provo, Utah

- Portuguese Language Teacher, January 1997 - August 1999
- Brazilian Culture Teacher, September 1997 - September 1998

Private Portuguese Language Tutor, January 1998 - July 1998

Teaching Assistant for *Work and Relationships in the Home*, Brigham Young University

CLINICAL EXPERIENCE

Center for Family Services, Falls Church, Virginia

- Therapist Intern, August 2000 - present
- Couples Domestic Violence Co-Therapist (6 week Women's Group), 2000
- Men's Anger Management Co-Therapist (12 week Group), 2000

Alcohol and Drug Services, Alexandria, Virginia

- Therapist Intern, January 2002 - present

PUBLICATIONS/

Callahan, J. L. & Ward, D. B. (2001). A search for meaning: Revitalizing the 'human' in human resource development. Human Resource Development International, 4, 235-242.

PRESENTATIONS/ PAPERS

Stith, S.M., Tritt, D., Penn, C. & Ward, D. (In press). Partner violence assessment. In D.K. Jordon (Ed.) Handbook of Couple and Family Assessment. Upper Saddle River, NJ: Prentice Hall.

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Lundeberg, K. Stith, S. M., Ward, D. B., & Penn, C. (2001). A comparison of non-violent, psychologically violent, and physically violent college students. Manuscript in preparation.

"Preventing Domestic Violence", One-hour presentation to LDS ecclesiastical leaders, 2000

"Improving Relationships", One-hour presentation to group of LDS women, 2000

"The Field of Marriage and Family Therapy", Career day for George Mason Middle School, December 2000

"Helping Friends Avoid Divorce, Poster Presentation at Brigham Young University family seminar, March 1998

**VOLUNTEER
EXPERIENCE**

Brigham Young University

- Research Assistant, Dr. Alan Hawkins, January 1998 - April 1998
- Marriage Resource Center Volunteer, January 1998 - August 1998

Utah Special Olympics Summer Games

- Games Director, June 1998 - June 1999 (350 hours)
- Assistant Games Director, June 1997 - June 1998 (250 hours)
- Assistant Sports Director, January 1997 - June 1997 (100 hours)

Missionary, LDS Church, São Paulo, Brazil, May 1994 - June 1996

- Regional director and trainer, February 1995 - June 1996

**RECOGNITIONS/
HONORS**

Leschine Service Award (for commitment to service), 1998

Brigham Young University Academic Scholarship, January 1997 - April 1999

Scholar/Athlete Scholarship Award, June 1993

Four-time MVP for High School Water Polo and Swim Teams, 1989-1993

Eagle Scout, May 1991

**SPECIAL
COURSES**

SPSS Software training, 2000

QSR NUD*IST Qualitative Analysis Software training, 2000

**RELEVANT
APPROACHES,
CLINICAL
COURSES**

Systems Theory and Family Therapy, Structural and Strategic

Constructivist Approaches, MFT Professional Ethics, MFT Techniques

Diagnosis and Treatment in the Family Context, Marriage and Family Relationships, Perspectives on Human Sexuality, Child Maltreatment, Family Play Therapy, Medical Family Therapy

**RELEVANT
RESEARCH
COURSES**

Research Methods

Multivariate Statistics