

**CAREER PRACTICES AND TRAINING PERSPECTIVES OF
MARRIAGE AND FAMILY THERAPY PROGRAM GRADUATES**

SHANNON ANDERSON PANKOW

Dissertation submitted to the Faculty of the
Virginia Polytechnic Institute and State University
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

HUMAN DEVELOPMENT,
Marriage and Family Therapy Program

APPROVED:

Scott Johnson, Chair

Anne M. Prouty

Howard O. Protisnky

Eric E. McCollum

Fred P. Piercy

September 11, 2000

Blacksburg, Virginia

Keywords: Marriage and Family Therapy, Training, Career, Mental Health

Copyright 2000, Shannon Anderson Pankow

CAREER PRACTICES AND TRAINING PERSPECTIVES OF MARRIAGE AND FAMILY THERAPY PROGRAM GRADUATES

by

Shannon Anderson Pankow

ABSTRACT

Using survey data gathered by both Internet and mailed questionnaires, 125 graduates of COAMFTE-accredited marriage and family therapy (MFT) programs imparted information about their perspectives on their MFT training, their current and desired career practices, and their advice to MFT trainees and graduates about maximizing career options. The results demonstrated that MFT graduates attach many different meanings to the training and career experiences they've had. Marriage and family therapists work in a variety of settings, including agency and administrative work, private practice, academia, pastoral settings, school settings, medical administration and education, and residential treatment settings. Some graduates have left the MFT field to pursue other career avenues. The average income for MFT graduates in this sample was approximately \$52,000 for doctoral-level graduates and \$36,000 for masters-level graduates.

Although approximately 72% of the participants reported satisfaction with their current professional position, several themes emerged in the data which indicate areas in which graduates felt unprepared when they entered the work force. These areas include: information about the contemporary mental health marketplace, such as working with managed care and insurance companies and the political ramifications of being a marriage and family therapist in a professional climate dominated by other mental health disciplines. MFT graduates also reported lacking sufficient training in diagnosis and use of the DSM. Among the most valuable training experiences for participants were the clinical internship/practicum and the associated supervision received. Implications for the training and socialization of MFTs into the world of professional practice are discussed, along with suggestions for future research.

TABLE OF CONTENTS

ABSTRACT	ii
LIST OF TABLES	iv
CHAPTER 1: INTRODUCTION	1
CHAPTER 2: REVIEW OF LITERATURE	5
Introduction	5
History of MFT Training and Accreditation	6
Goals and Skills in MFT Training	9
Training Response to the Healthcare Revolution	22
Graduate Perspectives on MFT Education	27
Careers for Marriage and Family Therapists	30
Summary and Implications for Present Study	36
CHAPTER 3: METHODS	38
Theoretical Background	38
Research Design	38
Participants	38
Instrument	40
Procedure	41
Analyses	44
CHAPTER 4: RESULTS	47
Background Information	47
Perspectives on MFT Training	50
Career Practices and Perspectives	61
Larger Themes and Issues Discussed by MFT Graduates	72
CHAPTER 5: DISCUSSION	79
Summary of Major Research Findings	79
Challenges Facing MFTs in the Professional Marketplace	84
Recommendations for MFT Training Programs	89
Recommendations for Future Research	95
CHAPTER 6: CONCLUSION	98
REFERENCES	102
APPENDICES:	
APPENDIX A: Instructions to MFT Programs on Mailing Participant Letters	112
APPENDIX B: Invitation to Participate in Research Letter	114
APPENDIX C: Informed Consent for Mail-Option Questionnaire	117
APPENDIX D: Mailed Questionnaire	120
APPENDIX E: Informed Consent for Internet Option Questionnaire	128
APPENDIX F: Internet Questionnaire	131
APPENDIX G: Follow-up / Thank-you Letter	132
APPENDIX H: Follow-up Letter #2	134
APPENDIX I: Pearson Product-Moment Correlation Matrix	136
VITAE	137

LIST OF TABLES

TABLE 1: Participant Characteristics: Gender, Age, Marital Status, Dependents	40
TABLE 2: Educational Credentials: Degrees, AAMFT Membership, and Licensure . . .	48
TABLE 3: Most Relevant Aspects of MFT Training	51
TABLE 4: Least Relevant Aspects of MFT Training	54
TABLE 5: Aspects of Training that were Missing from MFT Program	56
TABLE 6: Initial Career Goals of MFT Graduates, Number who Changed, and Number Currently Working in Original Goal Area.	62
TABLE 7: Reasons for Changing Career Goal	63
TABLE 8: Current Professional Position	66
TABLE 9: Annual Income	67
TABLE 10: Reasons Given for Participants Reporting Dissatisfaction with Current Professional Position	68
TABLE 11: Participants' Advice to MFT Graduates on Maximizing Career Options . . .	69

CAREER PRACTICES AND TRAINING PERSPECTIVES OF MARRIAGE AND FAMILY THERAPY PROGRAM GRADUATES

As we observe the dawn of a new millennium, Americans seem to be examining their history as well as postulating new paths for their future. Marriage and family therapists (MFTs) have not been immune to what seems to be the human tendency to try and place oneself or one's profession in a context of time. During the 1999 annual conference of the American Association for Marriage and Family Therapy (AAMFT), entitled "Family Therapy in the Mainstream," the organization's president, Anna Beth Benningfield, outlined the key questions for the MFT profession in this new millennium: "Where have we been? Where are we going?" (Chismar, 1999, p. 1).

AAMFT President Benningfield is not alone in her wonderings. Throughout the 1990s, many articles appeared in the marriage and family therapy (MFT) literature which traced the history of professional MFT practices and postulated the profession's future. Traditionally, marriage and family therapists have pursued careers devoted primarily to professional clinical practice: seeing clients who present for therapeutic assistance. Private practice has been the most frequently cited goal of family therapy and other psychotherapy trainees (Patterson, McIntosh-Koontz, Baron, & Bischoff, 1997; Plante, 1996, 1998). Those who obtain doctoral degrees in marriage and family therapy have also had the option to enter the world of academia: teaching, supervising, and conducting research in colleges and universities across the country.

In the last decade, the traditional career paths for marriage and family therapists in the United States, along with those of other healthcare professionals, have met with challenges. Obtaining tenure-track, academic positions is becoming increasingly competitive. Graduates of MFT programs seeking this career goal may have to bide their time until a desired position is available. The healthcare revolution which gained momentum in the U.S. during the 1990s and increased the presence of managed care companies has altered the ability for therapists to simply "hang out a shingle" in private practice after graduation. Most Americans currently receive their medical and behavioral health insurance coverage through some type of managed care organization, and it has become increasingly difficult for therapists to be a part of these insurance panels (Crane, 1995a; Tuttle, 1999c). Peter Steinglass, the editor of *Family Process*, called this reshaping of mental health care delivery "the most serious challenge [to the profession of marriage

and family therapy]...since [the MFT field's] inception...This challenge is most acute in the U.S...It dominates the emotional climate of practitioners' everyday lives and the atmosphere at collegial gatherings," (Steinglass, 1996, p. 403).

Graduates from marriage and family therapy advanced degree programs may now be required to enter a professional field which has changed dramatically since they first began their educational process. According to Plante, "Many [students] appear concerned that the types of careers they once envisioned may no longer exist. Furthermore, many lack strategies and information regarding how to go about finding work" (Plante, 1998, p. 508). Where then, do marriage and family therapy graduates go to find information on potential jobs for which they qualify with their specialized type of training? The professional literature does not provide much guidance. Studies on MFT practice patterns usually focus on the types of presenting problems therapists in traditional clinical practice see, or their fees per session, or types of therapy models they use (American Association for Marriage and Family Therapy [AAMFT], 1999e; Doherty & Simmons, 1996; Hines, 1996; Simmons & Doherty, 1998). This investigator found no studies which surveyed marriage and family therapists in order to obtain an idea of the broader range of career opportunities available to them. A graduate who searches the AAMFT Internet web site will find a selection of articles which discuss potential career options, but little information is provided on how to pursue these options. In this dynamic time of change in the therapy profession, MFTs may need a more thorough source of information about their entire range of employment opportunities.

Another area needing examination is the training these MFT graduates receive -- How is it preparing them to encounter the complexities of contemporary mental health practice? Managed behavioral healthcare has brought new focus and vocabulary to the MFT arena: Regardless of their desired career path, MFTs who work within their field must be familiar with concepts such as brief therapy, outcome, utilization review, pre-authorization, disease management, and primary care referral. The ability to work with these concepts requires a contemporary set of skills in addition to the traditional set of skills needed by an MFT to conduct effective therapy.

The AAMFT's Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) is the credentialing organization for MFT education, sanctioned by the U.S. Department of Education (Sprenkle & Wilkie, 1996; Touliatos & Lindholm, 1992). COAMFTE

has established a set of training standards for MFT programs that wish to be accredited. These standards were constructed to standardize the educational curricula of MFT graduate programs and to establish minimum areas of competency and skills MFT students should obtain by the end of their training. COAMFTE however, does not specifically define the types of skills these trainees should possess (Nelson & Johnson, 1999). The MFT training literature is filled with articles which do describe these important skill sets, but the criteria comprising a well-educated marriage and family therapy graduate consist largely of the opinions of the researchers and trainers themselves. Although required by COAMFTE to be “clinically active” in therapeutic practice, these instructors may not be as familiar with the contemporary world of mental health practice, and their opinions have not been empirically validated (Broskowski, 1995).

Those studies on training outcomes which have been conducted focus little on the training experience of the MFT graduates themselves. Most outcome research focuses on the efficacy of a particular modality of therapy, or whether a therapist learned a particular skill, such as showing increased complexity in interventions or increased in-session verbal behavior (Tucker & Pinsof, 1984). Still fewer studies have been conducted which asked for feedback from the marriage and family therapy trainees. Those which have been published asked for training evaluations from trainees who were still involved in the educational process. Trainees may lack the perspective that post-graduation professional experience provides, and their reflections on their training tend to be unanimously positive because they generally don't have an experienced perspective from which to make more realistic evaluations (Henry, Sprenkle, & Sheehan, 1986; Liddle, 1991). In a search of the MFT literature, only a few studies were found which asked MFT graduates possessing at least a few years of professional experience for their perspectives on their MFT training. The lack of research on this important subject has been confusing: After all, it is these graduates who must be well-prepared to thrive in their professional field; who must represent the profession of marriage and family therapy in such a way that MFT will continue to grow.

The purpose of this study was to obtain information on perceived training relevance as well as information on a wider range of career opportunities for marriage and family therapists working in the United States. This information was gathered from 125 MFT graduates who work in the U.S. and who had at least 3 years of post-graduation professional experience. The research questions which sparked this project were: What career options are available for graduates of

COAMFTE-accredited MFT programs? How do marriage and family therapists in the professional world perceive the relevance and usefulness of their training as it pertains to their chosen career? In light of their professional experience, what advice would these graduates give to current MFT trainees about developing a career? It was anticipated that this study is the first to collectively answer these questions that many marriage and family therapists embarking on a career must ask themselves.

CHAPTER 2

REVIEW OF LITERATURE

Introduction

The review of literature was conducted using the following general questions as guidelines: First, what does marriage and family therapy education train graduates to do? Second, how do MFT graduates evaluate the training they received? Third, what are these graduates actually doing with their training? Regarding the third question, particular interest was paid to the range of reported jobs/ career opportunities actually being performed by graduates of MFT programs.

The definition of marriage and family therapy “training” used in this study will be as outlined by Sprenkle and Wilkie (1996), who define training as “a process by which individuals learn to become family therapists and acquire specific marriage and family therapy education,” (p. 351). Training in this context also refers to the broader, more comprehensive teaching of marriage and family therapy through instructing trainees in theories and techniques (Saba & Liddle, 1986).

For purposes of this study, “trainee” or “MFT trainee” is defined as a student enrolled in a formalized program of marriage and family therapy education. A “graduate” or “MFT graduate” is an individual who has completed the requirements of his or her MFT education program and has received a graduate-level (i.e., masters or doctorate) degree with an emphasis in marriage and family therapy. “Career” or “career practice” refers to a particular job or line of work in which an MFT graduate is currently engaging or wishes to engage.

The review of literature will proceed in the following manner: In order to place the MFT training literature in a historical context, an abbreviated history of marriage and family therapy training and accreditation is offered. The next section discusses specific skills and other outcomes MFT trainees and graduates may attain as a result of training. Following the MFT skills review is a section on the impact managed care and the health insurance revolution have had on marriage and family therapy education in the last decade. Information and research on MFT graduate evaluation of the training experience is then reviewed. The fifth major section of this literature review discusses existing and potential career practices for people with degrees in marriage and

family therapy. This chapter will conclude with a summary of major points and implications for the present study.

History of MFT Training and Accreditation

According to Nichols (1979a), marriage counseling first became recognized as a profession in post-World War I Europe. In the early 1930s, the first institutes offering training in marriage counseling appeared in the United States. The development of family therapy as a professional specialization paralleled marriage counseling as a separate, but rapidly growing movement. The 1950s and 60s saw the emergence of training institutes for the now-integrated discipline of marriage and family therapy. These institutes offered apprenticeship-style training to individuals already established in a helping profession (Nichols, 1979a; Sprenkle & Wilkie, 1996). The primary emphasis in these settings was supervised clinical training in the style advocated by the particular institute of attendance (Touliatos, Lindholm, & Nichols, 1997). As the theoretical base of the field continued to expand in the 1970s, training programs combining didactic courses and clinical experience flourished in settings such as hospitals, psychiatric and family services clinics, and family therapy training centers (Constantine, 1976; Falicov, Constantine, & Breunlin, 1981; Ferber & Mendelsohn, 1969; Tucker & Pinsof, 1984).

Paralleling the growth of the marriage and family therapy field, the affiliated professional organization also evolved. The American Association of Marriage Counselors was established in 1942 to provide cohesion and regulation to an evolving profession. Its name has also changed over time: In response to the complete integration of the family and marital therapy fields, the organization was renamed the American Association of Marriage and Family Counselors in 1970, and changed again to the American Association for Marriage and Family Therapy (AAMFT; its present name) in 1978. Throughout its history, AAMC/AAMFT issued training and credentialing standards in various versions beginning in 1949 and continuing through the present day (AAMFT, 1999b; Nichols, 1979a). This continuous establishment and improvement of professional training and practice standards was accompanied by other related events. State regulatory boards for the profession of marriage and family therapy were established beginning in the 1960s and '70s, along with the formation of educational accreditation (COAMFTE) in 1974, and of AAMFT membership standards in 1978.

The increase in the presence of these regulatory and organizational bodies, along with an increased professional literature base, moved the trend of training settings from apprenticeship-style institutes to a more formalized, university-based education and training model (Touliatos et al., 1997). In his 1979 article, Nichols summarized this trend by stating “The knowledge base [of marriage and family therapy] has expanded to the point that it cannot adequately be passed on to the neophyte through simple apprenticeship training or in the confines of essentially clinically oriented endeavors in post-degree institutes” (p. 22).

Although post-degree training institutes and workshops continue to be available for professionals with backgrounds other than marriage and family therapy, the field has seen a dramatic increase in the number of university programs granting degrees with specific emphasis in MFT. At the present time, there exist 14 accredited Ph.D. programs (an additional 2 in Candidacy status), 45 masters programs (additional 8 in Candidacy status), and 17 accredited post-graduate programs (1 Candidacy) (AAMFT, 1999d). Additional programs begin the accreditation process every year. This increased availability of university-based MFT training has made this route the most direct way to enter the field, one now chosen by hundreds of graduate students each year. As Bloch (1981) summarized earlier in the trend toward university-based training, marriage and family therapy is seen as a “...distinctive career line; there is a new profession of [marriage and] family therapy, with its own entry point and academic pathway” (in Woody & Weber, 1983, p. 122).

As this distinctive career pathway developed, the lenses through which MFT training may be viewed were further focused. A collection of publications on feminist family therapy training and cultural/ethnic sensitivity in MFT training brought increased attention to the need to weave gender and cultural/ethnic awareness and sensitivity into the basic fabric of MFT education (see Hardy & Laszloffy, 1995; Hare-Mustin, 1986; Roberts, 1991; Storm, 1991; Wheeler, Avis, Miller, & Chaney, 1989). These approaches further refined MFT training through emphasizing collaboration of therapist and client and through training the therapist to recognize and work with issues of power, to place systemic analysis into a larger social frame, and to develop the therapist’s attention to and use of affect in the therapeutic process (Roberts, 1991; Storm, 1991; Wheeler et al., 1989). Currently, the COAMFTE Accreditation Standards require that accredited MFT programs “include significant material on issues of gender and sexual orientation,...ethnicity,

race, socioeconomic status, and culture as they relate to marriage and family therapy theory and practice,” (AAMFT, 1999b, sections 330.05 and 330.06).

While graduate training programs in marriage and family therapy continued their expansion in the 1980s and 1990s, the world of healthcare began a dramatic structural revolution that has ultimately impacted the course of today’s MFT training. Managed care companies were created in their various forms in an attempt to control rising health care costs. The now-pervasiveness of these organizations has resulted in regulation of health care reimbursement, often to the detriment of the direct care provider in terms of reduced reimbursement rates for services (Tuttle & Ambrose, 1999). These effects have extended to behavioral health care as well. The once-omnipresent goal for psychotherapy graduate students to work in “private practice” has become endangered in favor of large group practices and the provision of internal and contracted managed care therapeutic services (Patterson, McIntosh-Koontz, Baron, & Bischoff, 1997). Depending on who is writing the article, some authors view managed care with dread, believing reform is placing the entire marriage and family field in danger (Steinglass, 1996), while others view managed care as a permanent institution which offers unique opportunities for marriage and family therapists (Crane, 1995a, 1995b; Patterson & Scherger, 1995).

Regardless of their perspective on managed care, many authors have called on marriage and family therapy training programs to respond to the changing training needs of the contemporary MFT trainee (Broskowski, 1995; Crane, 1995a, 1995b; Figley & Nelson, 1989; Liddle, 1991; Patterson & Scherger, 1995; Patterson et al., 1997; Plante 1996, 1998):

Students may not be attuned to the changing world in which they will practice. Many highlight private practice as their postgraduate goal – clearly demonstrating the need for educators, regardless of their personal reactions, to consider how best to prepare the next generation of marriage and family therapists for work in the managed care environment. (Patterson et al., 1997, p. 446)

A detailed discussion of suggested ways to prepare MFT trainees for operating in the world of managed care is included later in this chapter. In the meantime, throughout the history of MFT training, a more basic concern has often been discussed: As summarized by Hines (1996), “Perhaps even more fundamental is the matter of determining what knowledge and skills marriage and family therapy trainees need” (p. 181). It is to this matter that the following section now turns.

Goals and Skills in MFT Training

When considering the overall topic of career opportunities for marriage and family therapy program graduates, an important area of review is the intended outcome of MFT training; that is: What does marriage and family therapy training prepare its graduates to do? Rosenbaum and Serrano (1979) conveyed the answer to this question more succinctly than other authors: MFT graduates should be competent in the practice of marriage and family therapy.

Though historically there has been little consensus as to what constitutes appropriate or effective family therapy training (Falicov, Constantine, & Breunlin, 1981; Nelson & Johnson, 1999), some authors have outlined some general goals and practices in MFT education. These goals include providing the student with an adequate basis for conducting marriage and family therapy (Ganahl, Ferguson, & L'Abate, 1985; Nichols, 1988; Street, 1988), providing scientific training and teaching the acquisition of post-graduation professional knowledge (Ganahl, Ferguson, & L'Abate, 1985), and socializing the MFT to effective and appropriate professional conduct (Everett, 1979; Liddle, 1991; Nichols, 1979a, 1988; and O'Sullivan & Gilbert, 1989). An overall summary of goals for all MFT programs is offered by Deacon and Piercy (2000), who state that these training programs are designed to produce effective researchers, educators, and clinicians.

In their 1979 review of the existing training literature, Kniskern and Gurman encouraged MFT programs to identify their training objectives in terms of specific skills trainees should obtain throughout their educational experience.¹ They rationalized that specific identification of program objectives and skill sets would make outcome research on training efficacy easier to conduct and evaluate. Since that time, authors have structured their training discussions in terms of a variety of identified outcome skills. An increase in skill-focused training has been observed in several theoretical schools (Saba & Liddle, 1986; Street, 1988). Unfortunately, even though COAMFTE

¹ Like the areas covered by the proposed goals for marriage and family therapy education, the body of training literature itself encompasses several areas of emphasis. A complete review is beyond the scope of this chapter; the interested party is referred to the following articles for in-depth reviews of the following topics: overall review - Kniskern & Gurman, 1979, 1996; Street, 1988; training and supervision - Liddle, 1991; Sprenkle & Wilkie, 1996; outcome research - Avis & Sprenkle, 1990.

standards emphasize the development of MFT trainees' "clinical skills," the nature of these skills are not defined nor specified by the Commission (Nelson & Johnson, 1999).

As there has been no consensus on what constitutes appropriate MFT training in general, there also exists no consensus on what constitutes appropriate skills for MFT training (Nelson & Johnson, 1999). Adding to the difficulty of creating such a consensus are the facts that operationally defined skills will overlap in actual practice (Falicov et al., 1981), and skill sets vary extensively depending on which theoretical model is being emphasized (Figley & Nelson, 1989; Liddle, 1991; Nelson & Johnson, 1999; Street, 1988). Hines (1996) and Figley and Nelson (1989) also point out that the skills advocated by particular theoretical schools and training programs were not derived empirically. Said Hines:

The criteria on which these programs are esteemed are almost invariably the authors' professional opinion and/or commonly held through empirically untested beliefs as to what constitutes a high-quality approach for training marital and family therapists...the need remains for data from other sources supporting or refuting the importance and usefulness of specific aspects of marriage and family therapy training. (Hines, 1996, p. 182)

To assist in bringing empirical order to which types of skills marriage and family therapy trainees should obtain, Figley and Nelson conducted a series of studies known as the Brief Family Therapy Skills (BFTS) project (Nelson & Johnson, 1999). In a series of four studies, the BFTS team asked an expert panel of 488 members of the American Association for Family Therapy (AFTA) and Approved Supervisors from AAMFT to enumerate skills which should be obtained by the beginning (i.e., up to the first 500 client contact hours) marriage and family therapist. The team narrowed and sorted the initial list of thousands of items into conceptual areas, then returned the reduced list to the panel members and asked them to rank order the defined skills from most to least important. The initial report (Figley & Nelson, 1989) provided a categorized list of the top 100 most important skills for beginning MFTs to acquire. Subsequent studies used the same method to obtain skill sets based on particular theoretical orientations: structural family therapy (Figley & Nelson, 1990), brief and systemic therapy (Nelson & Figley, 1990), and transgenerational theories of family therapy (Nelson, Heilbrun, & Figley, 1993).

The BFTS project culminated in the Basic Skills Evaluation Device (BSED), an instrument designed to measure an MFT trainee's skill level and progress (Nelson & Johnson, 1999). The authors tout the instrument as the first trainee evaluation tool that has been

empirically derived. The BSED outlines 5 major categories of skills, each containing a set of subcategories identifying skill sets which MFT graduates should be expected to obtain by the end of their degree-based training. More detail about the BSED will be provided below in an in-depth discussion of the specific skills MFT graduates should possess. This detailed discussion will attempt to provide the answer to the initial guiding question of this literature review: What are MFTs supposed to be able to do as a result of their training?

Prior to this discussion, a few issues should be articulated regarding the advantages and disadvantages of using a skills approach to define the capabilities of marriage and family therapy graduates. Perhaps the most significant disadvantage in focusing on skills would be the possibility of forgetting that “the whole is greater than the sum of its parts.” Falicov et al. (1981) believe that focusing too thoroughly on skills and therapeutic techniques can be an impediment to quality training. It could be easy for trainees to absorb themselves in the acquisition of skills to the exclusion of developing sensitivity to the overall context and process of their education and clinical experiences (Nichols, 1988).

Conversely, there are advantages to viewing MFT abilities in terms of skills. Already discussed was the belief of Kniskern and Gurman (1979) that operationalizing skill sets facilitates the conducting of training outcome research and evaluation. Liddle (1991) also points out that the more recent work in defining MFT skills and training objectives has become increasingly sophisticated: The efforts to delineate these skill sets are driven more by various theoretical approaches, providing a context for the thousands of possible skills which have been enumerated. Psychotherapy in general has been diverging from the “one psychotherapy, one theory” approach that characterized earlier research; increasing recognition is given to the fact that different sets of skills and theoretical approaches can all result in positive therapeutic outcomes (Liddle, 1991). One final advantage to specifying skills has a practical application. Figley and Nelson (1989) reported that beginning marriage and family therapists obtain reassurance from the idea that identifiable skills which lead to the ability to conduct marriage and family therapy can be defined, taught, and acquired. This discussion now moves to the particular skills themselves: What are these skills? What specifically can MFT graduates do?

Specific skills obtained in MFT training. When the MFT training literature moved to a skills-enumeration trend in the mid-1970’s, the most common way to discuss these skills was by

separation into two categories: relationship skills and structuring skills (Kniskern & Gurman, 1979). As defined by Alexander, Barton, Schiavo, and Parsons in their 1976 study on factors influencing therapeutic outcome, relationship skills are the therapist's integration of feelings with behavior, use of humor, degree of emotional warmth, and the overall ability to establish positive relationships with clients. These are the skills which are considered necessary to create an interpersonal climate where change can take place (Sprenkle & Wilkie, 1996). Structuring skills refers to structuring the flow of a therapy session, and include the therapist's modeling of direct, clear communication, self-confidence, and the ability to gather information and stimulate interaction (Kniskern & Gurman, 1979; Sprenkle & Wilkie, 1996). These skill categories are considered to be "generic" in that they transcend any particular theoretical orientation (Sprenkle & Wilkie, 1996). The therapy outcome research which operationalized these skills resulted in a finding that structuring and relationship skills together accounted for 60% in the variance of treatment outcome, and relationship skills analyzed alone explained 45% of the outcome variance (Alexander et al., 1976; Kniskern & Gurman, 1979; Sprenkle & Wilkie, 1996).

Looking at MFT training skill sets in terms of relationship and structural skills was not the first systematic method for categorizing skills. Cleghorn and Levin (1973) were first to identify and categorize three sets of family therapy training skills: perceptual, conceptual, and executive skills. The meaning of these categories will be defined later in this section. Although their categories were not empirically based, Cleghorn and Levin's method of conceiving skills has been widely adopted by authors in the MFT training arena since this landmark publication (Kniskern & Gurman, 1996; Street, 1988). Descriptions of MFT training programs and their objectives based on these categories of perceptual, conceptual, and executive skills have been provided by Tomm and Wright (1979) and Falicov et al. (1981). Other authors utilizing the Cleghorn and Levin skill model include Figley and Nelson (1989), Jenkins (1984), Kniskern and Gurman (1996), Nelson and Johnson (1999), and Wheeler et al. (1989).

The article by Nelson and Johnson (1999) reported the creation of the Basic Skills Evaluation Device (BSED). As discussed in the previous subsection, the BSED is an instrument designed to evaluate beginning MFT trainees based on 5 major categories. These categories were derived inductively from the MFT training literature and include Cleghorn and Levin's Conceptual, Perceptual, and Executive Skill categories. The creators of the instrument developed

an additional 2 categories: Professional Skills and Evaluation Skills. An optional sixth category in the instrument provides training evaluators an area to assess trainees' Theory of Change, whether asking for trainees' personal theory or to demonstrate understanding of a particular theoretical framework the training program espouses. After an informal analysis of all MFT skills found during the literature review, it appears that most of these skills can be described by the categories of the BSED. The following discussion of skills marriage and family therapy graduates should have obtained through training is organized based on these BSED categories as described by Nelson and Johnson (1999, pp. 23-28).

I. Conceptual Skills. Following the definition outlined by Cleghorn and Levin (1973), conceptual skills refer to the MFT trainee's ability to view the "raw data" of a therapy session by using the lens of family systems theory and its related concepts. Nelson and Johnson (1999) divide this skill category into four subcategories: knowledge base, systems perspective, familiarity with therapy models, and self as therapist. The following descriptions are taken directly from Nelson and Johnson (1999), from the appendix of their article (pages 23-28). Skills found in other publications are interspersed and referenced throughout the Nelson and Johnson-based descriptions.

a. Knowledge base. This category of marriage and family therapy skills refers to the general knowledge of MFT obtained primarily through didactic modalities, including lectures and course readings. MFTs should possess a basic understanding of family systems theory, normal and abnormal human development and family development principles, and family life cycle issues. The therapist should be able to convey understanding of human interaction, normal and abnormal family processes, and the interplay between individual and family process and development (Christensen, Brown, Rickert, & Turner, 1989; Ferber & Mendelsohn, 1969; Nichols, 1979; Rosenbaum & Serrano, 1979; Woody & Weber, 1983). Understanding how issues of gender, culture, and socioeconomic status impact the client, the client's interaction with the therapist, and the therapeutic issues is also important (Hardy & Laszloffy, 1995; Hare-Mustin, 1986; Roberts, 1991; Storm, 1991; Wheeler et al., 1989). The marriage and family therapist should establish and work within the clients' worldview and recognize the importance of a "non-objective reality" (Liddle, 1991). Proficiency in areas of human sexuality, basic assessment strategies, and DSM-based psychopathology should also be obtained (Ferber & Mendelsohn, 1969; Gawinsky,

Edwards, & Speice, 1999; Rosenbaum & Serrano, 1979). Several authors add that MFT graduates should have the ability to evaluate, interpret, and conduct research (Kniskern & Gurman, 1979; Nichols, 1979a; O'Sullivan & Gilbert, 1989).

b. Systems perspective. The MFT graduate should be able to convey understanding of basic systems concepts, including open systems, feedback, boundaries, rules, structure, process, power, and family myths and secrets (Falicov et al., 1981; Street, 1988; Wheeler et al., 1989). He or she demonstrates the ability to think systemically by conversing about client problems and hypotheses in systemic and contextual ways. There is a clear understanding of the difference between content and process issues, and the graduate can recognize matters of hierarchy. Marriage and family therapists should also be able to make a paradigm shift when working with clients from the intrapersonal perspective to the interpersonal perspective.

c. Familiarity with training models. The MFT can demonstrate a basic knowledge of family therapy theories. He or she shows the ability to link therapeutic hypotheses, treatment plans, interventions, and evaluation/termination of therapy to a specific therapeutic model (including an integrated model). The ability to critically think about, construct, and evaluate therapeutic models is obtained (Liddle, 1991). A therapist can also recognize his or her own perceptions, client resources, and links between problems and the solutions attempted to solve them.

d. Self as therapist. In general, a marriage and family therapist should be able to develop and recognize the impact of his or her own personality, behavior, and style on the therapy being conducted (Constantine, 1976; Falicov et al., 1981; Kniskern & Gurman, 1979; Liddle, 1991; O'Sullivan & Gilbert, 1989; Tucker & Pinsof, 1984; Woody & Weber, 1983). An MFT should be able to articulate his or her preferred model of therapy, demonstrate self-curiosity and an awareness of/ability to manage his or her own anxiety in therapy. He or she possesses a sense of humor, can be flexible, creative, and think critically, and can reframe case issues (Nichols, 1988; Rosenbaum & Serrano, 1979). The ability to accept feedback and to reflect on issues of self-development, including personal experience of gender and cultural/ethnic issues, is present (Hardy & Laszloffy, 1995; Hare-Mustin, 1986; Roberts, 1991; Storm, 1991; Wheeler et al., 1989). The therapist is comfortable in the presence of displayed affect (Constantine, 1976; Tucker & Pinsof,

1984; Wheeler et al., 1989). Overall, the MFT should convey legitimate personal maturity (Everett, 1979; Nichols, 1979a; Tomm & Wright, 1979).

II. Perceptual Skills. Perceptual skills refer to what takes place in a therapist's mind in order to make pertinent and accurate observations of the data which emerges during a therapy session (Cleghorn & Levin, 1973; Tomm & Wright, 1979). Nelson and Johnson (1999) separate this skill category into three subcategories: recognition skills, hypothesizing, and integration of theory and practice.

a. Recognition skills. The MFT should be able to recognize hierarchies, boundaries, triangling, family interaction, and family behavioral patterns as these systemic principles become manifest during the course of therapy. Family coping skills and strengths are noted and expressed (Nichols, 1988). The graduate can track process and recognize both verbal and non-verbal communication patterns (Jenkins, 1984; Liddle, 1991; Nichols, 1988; Rosenbaum & Serrano, 1979; Woody & Weber, 1983). He or she can also recognize the presenting problem and considers that the patterns around the presenting problem might be similar to other patterns of client interaction. Other issues such as gender, ethnic, cultural, and socioeconomic status and the therapeutic dynamics these influence are also recognized when they arise (see also Hardy & Laszloffy, 1995; Hare-Mustin, 1986; Roberts, 1991; Storm, 1991; Wheeler et al., 1989). The therapist can recognize the above issues not only in a given therapeutic context, but also in the interaction of the primary therapeutic system with larger systems of influence (Christensen, et al., 1989; Constantine, 1976; Ferber & Mendelsohn, 1969; Hardy & Laszloffy, 1995; Jenkins, 1984; Kniskern & Gurman, 1979; Liddle, 1991; Nichols, 1998; Tucker & Pinosof, 1984). The MFT can also articulate the impact he or she has on the client system.

b. Hypothesizing. Hypothesizing in this category refers to the MFT's ability to formulate general systemic hypotheses in model-specific or general formats. The therapist can generate both long- and short-term treatment plans based on these general hypotheses, and the implication of process issues will be considered when forming treatment plans. Client system patterns and problems are reframed appropriately.

c. Integration of theory and practice. The ability of a marriage and family therapist to integrate his/her conceptual learning of theory with applied clinical practice was the most frequently identified skill in the MFT training literature, mentioned in at least 16 publications

(Christensen et al., 1989; Everett, 1979; Figley & Nelson, 1989, 1990; Liddle, 1991; Nelson & Figley, 1990; Nelson & Johnson, 1999; Nelson, Heilbrun, & Figley, 1993; Nichols, 1979a, 1979b, 1988; Rosenbaum & Serrano, 1979; Saba & Liddle, 1986; Street, 1988; Tucker & Pinsof, 1984; Woody & Weber, 1983). The MFT should have the ability to describe and justify interventions that coincide with the guiding theory and hypothesis, and to evaluate the appropriateness of a particular theory using specific data from therapy sessions. If the therapist uses an integrated theory, he/she can distinguish the various theoretical concepts from one another.

III. Executive Skills. Executive skills consist of two general components: the therapist's ability to manage his or her affective responses during therapy, and the overt interventions and conduct applied to the process of therapy (Cleghorn & Levin, 1973; Tomm & Wright, 1979). In general, executive skills refer to the MFT's ability to conduct conjoint/marital therapy in a competent manner (Ferber & Mendelsohn, 1969; Nichols, 1979a). This skill set has been broken down into seven subcategories: joining, assessment, hypothesizing, interventions, communication skills, personal skills, and session management.

a. Joining. Joining primarily refers to the broader category of therapeutic skills known as relationship skills (Alexander et al., 1976), those skills which are necessary in order to establish a therapeutic climate. The therapist needs to be able to develop rapport with each family member to create a therapeutic alliance (Jenkins, 1984; Kniskern & Gurman, 1996; Nichols, 1988; Rosenbaum & Serrano, 1979; Tomm & Wright, 1979). The ability to communicate compassion for "the dilemma of the system" (Falicov et al., 1981) helps to convey empathy, warmth, caring, and respect. Simultaneously, the therapist should convey a sense of competency, authority, and trustworthiness. The gathering of information from clients should be done without clients feeling that they are being interrogated. The ground rules for therapy, working a treatment contract, elucidating the clients' expectations, preparedness for change, and worldview should be reviewed without alienating the client. All these behaviors should be accomplished while setting appropriate boundaries and avoiding triangulation.

b. Assessment. A marriage and family therapist possesses the ability to utilize basic interviewing strategies and techniques in conjunction with the following to assess clients: genograms, family histories, suicide/depression interviews or inventories, discussion of SES, employment, school, and developmental stages. The MFT can formulate their assessment to

correspond with a particular theory of change, using sensitivity to issues of culture, gender, SES, or race (Hardy & Laszloffy, 1995; Hare-Mustin, 1986; Roberts, 1991; Storm, 1991; Wheeler et al., 1989). He or she can identify and clarify the presenting problem, explore the clients' previous attempts at solutions, and determine client goals (Jenkins, 1984; Liddle, 1991; Rosenbaum & Serrano, 1979; Tomm & Wright, 1979). The therapist can gather information about family patterns and behavioral sequences, and has the ability to determine the presence of identifiable psychopathology (Ferber & Mendelsohn, 1969; Gawinsky et al., 1999; Rosenbaum & Serrano, 1979).

c. Hypothesizing. Hypothesizing in this category is different from that found in the Perceptual Skills category. Executive hypothesizing refers to the therapist's ability to form multiple and more elaborate hypotheses which lead to detailed treatment plans. These hypotheses are based on information gathered in the assessment and utilize the therapist's theory of change in their formation. The ability to set clear, attainable goals with the family and to focus treatment on the accomplishment of these goals is observed. The MFT can change the established therapeutic strategy when alternative information necessitates such a change (Christensen et al., 1989; Liddle, 1991; Nichols, 1988; Woody & Weber, 1983).

d. Interventions. Marriage and family therapists should have the ability to use specific techniques to intervene in a variety of therapeutic situations, including: defusing violent or chaotic situations, deflecting system scapegoating and blaming, and interrupting negative interactional patterns and communication cycles. Intervention ability also includes appropriately challenging clients on stated positions, directly structuring interactions among system members, and assisting a family in establishing boundaries (see also Constantine, 1976; Jenkins, 1984; Kniskern & Gurman, 1979; Liddle, 1991; Nichols, 1988; Tucker & Pinsof, 1984; Woody & Weber, 1983). The ability to elicit family strengths, utilize strengths in session discussions and homework assignments is also observed, along with the overall ability to be directive and to facilitate change (Cleghorn & Levin, 1973; Kniskern & Gurman, 1979, 1996; Rosenbaum & Serrano, 1979; Sprenkle & Wilkie, 1996; Tucker & Pinsof, 1984; Woody & Weber, 1983).

Nelson and Johnson also list additional interventions which, when utilized by the MFT, demonstrate good therapeutic skill. These include: normalizing the problem when appropriate, helping clients find their own solutions to problems (see also Woody & Weber, 1983), giving

credit for positive changes, reframing, and appropriately using self-disclosure. Returning to the use of theory, the therapist uses theory-based interventions and can provide a rationale for the chosen approach.

e. Communication skills. One of the most important purposes of an MFT possessing excellent communication skills is the ability to generate information from clients and use that information to induce change (Christensen et al., 1989; Constantine, 1976; Kniskern & Gurman, 1979; Liddle, 1991; Rosenbaum & Serrano, 1979; Tucker & Pinsof, 1984). The therapist can demonstrate a precise use of language (Liddle, 1991), and sufficiently displays communication skills such as active listening, reflecting, and using open-ended questions. Messages communicated verbally to the client are short, specific, and clear. Awareness of congruent body language is viewed in the MFT's actions. He or she also has the ability to teach and coach clients in appropriate communication skills rather than merely providing a lecture on how to communicate.

f. Personal skills. This subcategory is similar to the Conceptual Skill area of Self-of-Therapist, but differs in that these skills may occur naturally in the MFT graduate's personality or may be learned as part of appropriate therapeutic behavior. Personal skills include: a desire to be a family therapist, intelligence, curiosity, common sense, ability to direct oneself, commitment, patience, empathy, sensitivity, flexibility, creativity, the ability to manage one's own anxiety, authenticity, expression of a caring attitude, and conveying an acceptance of others (see also Constantine, 1976; Falicov et al., 1981; Jenkins, 1984; Liddle, 1991; Nichols, 1988). The marriage and family therapist should also be able to exhibit warmth, a sense of humor, a nondefensive attitude, congruency, the ability to take responsibility for mistakes, the ability to apply his/her personal style of therapy, and should not possess any debilitating personal pathology. He or she demonstrates emotional maturity and self-reflexivity. The attitude of "expertness" is balanced and congruent with the therapist's theory of change.

g. Session management. Session management refers to the therapist's ability to handle the policy and procedural matters of therapy. These skills include the ability to effectively introduce the clients to the therapy room, including use of equipment and particular settings. Policies and procedures specific to the agency or clinic in which the MFT works should be explained to the clients' understanding. The capability of engaging the family in therapeutic conversation and

controlling the flow of communication based on the therapy plan is demonstrated. The therapist possesses the skill to both escalate and de-escalate emotional intensity during the session as appropriate (i.e., to “control the session;” Tomm & Wright, 1979; Woody & Weber, 1983). Time management is also an important component of this subcategory: the MFT graduate should be able to finish sessions on time, schedule additional appointments and meetings, and collect fees appropriately and effectively.

IV. Professional Skills. This category refers to an MFT’s ability to attend to the broader contextual issues of being a marriage and family therapy professional. Five subcategories are outlined here. They are supervision, recognition of ethical issues, paperwork, professional image, and professional conduct.

a. Supervision. While remaining in a training or pre-licensure phase, a marriage and family therapist displays appropriate use of clinical/professional supervision through attending supervision meetings as scheduled, being prepared to discuss pertinent cases through audio, video, and/or report format. Respect for the work of other therapists presenting during a supervision session is demonstrated. The MFT offers helpful suggestions to others without demeaning their skills. The MFT graduate can also accept and incorporate feedback from his or her supervisor and peers.

b. Recognition of ethical issues. A competent marriage and family therapist will know and observe the AAMFT Code of Ethics and the laws of the state in which he or she practices, particularly the laws covering privileged communication, mandatory reporting, and duty-to-warn (see also Everett, 1979; Nichols, 1979a; O’Sullivan & Gilbert, 1989). Woody and Weber (1983) advocate that MFT trainers accomplish three general objectives when teaching ethics and law to family therapy trainees: (a) trainees need to appreciate the interface of law and professional practice, (b) they should have knowledge of those legal principles and practices which are relevant to MFT clients, and (c) should be equipped to investigate the law to obtain more thorough information pertaining to any particular case. These authors suggest that MFT programs take a closer look at these topics as they are being taught to ensure students are receiving the most accurate and current information.

Other skills applicable to this subcategory include: the therapist seeks supervision or consultation appropriately when ethical concerns arise and avoids relationships which may be

potentially exploitative. A marriage and family therapist also agrees to deal with his or her personal issues as they arise during therapy, including seeking counseling if necessary. Lastly, he or she will take responsibility for the actions performed inside and outside the context of marriage and family therapy practice.

c. Paperwork. The marriage and family therapist demonstrates the ability to keep accurate and up-to-date case files, to manage the confidential information contained in these files, and to follow clinic or reimbursing procedures for paperwork. Based on the researcher's own experience, as well as those reported by Edwards and Speice (1999, also Virginia Tech graduates), an MFT graduate should also be able to write an appropriate case note (process and progress-oriented), keep track of non-session contacts such as telephone conversations, and write progress-oriented treatment plans. Liddle (1991) advises that these topics be covered in professional practice training.

d. Professional image. It seems that little attention is paid to this skill subcategory in the literature. Both in education and career practice, the assumption is often made that professionals understand the importance of image and "first impressions." In the professional "real-world," this assumption is often erroneous. Nelson and Johnson point to the necessity of attention to professional image, including manner of dress appropriate to the practice setting, presenting an aura of confidence without manifesting a sense of arrogance, and conveying professional collegiality. The MFT graduate should be on time for appointments and should treat the staff with whom she or he works with respect.

e. Professional conduct. The MFT graduate should be able to combine the maintenance of a professional image with appropriate contact with other professionals. Public criticism or denigration of colleagues is avoided. Consultations with professionals are conducted with the correct use of releases of information, and communication in a professional manner. The well-being of the client is placed above all other motivations. Unexpected or crisis situations are handled with poise and skill, and the therapist will obtain assistance when appropriate. The marriage and family therapist should be capable of providing therapeutic services to a cross-section of the population, including variations in socioeconomic status, length of care, culture, gender, and other aspects (Everett, 1979). Punctuality in professional meetings is observed, and clinic policy is followed in setting and collecting fees. Finally, the MFT graduate should be

equipped to obtain continuing education in the field following completion of training and licensure (Liddle, 1991; Nichols, 1979a, 1988). Said Nichols, “Students cannot be equipped once for all time – an impossibility – and should not be left to rely on the authority of others without being able to make their own informed and discriminatory observations and decisions” (1988, p. 116).

V. Evaluation Skills. This final category of marriage and family therapy skills refers to the MFT’s ability to critically analyze and evaluate the therapy process and outcome, and the impact he or she has on that process or outcome.

a. Therapy. Marriage and family therapists skilled in evaluating therapy can discuss the thoroughness of the assessment and the link between theory, assessment, and hypotheses/interventions. They have the ability to evaluate the effectiveness of interventions and determine how well the objectives of therapy have been met, in terms of both client goals and therapist perspective. MFTs can evaluate client feedback about assessment and intervention, and demonstrates the ability to articulate links between conceptual, perceptual, interventive, and outcome data. They evaluate clients’ readiness for termination and assess family outcomes post-therapy (Kniskern & Gurman, 1979; Rosenbaum & Serrano, 1979; Tomm & Wright, 1979).

b. Self. The MFT graduate is capable of self-evaluation in all skill categories: Conceptual, Perceptual, Executive, Professional, and Evaluative. He or she engages in self-reflection to perpetuate continuous understanding and analysis of a case in process and demonstrates awareness of personal issues that may interact with the therapeutic process. The graduate can articulate strengths and weaknesses in behavioral terms. The therapist integrates multiple perspectives into a plan for continuous self-enhancement as a marriage and family therapist. Evaluating skills is an ongoing process, performed in conjunction with a supervisor or consulting colleague.

In summary, specific skills which graduates of COAMFTE-accredited programs should possess can be separated into five major categories and their associated subcategories. Conceptual Skills include the graduate's knowledge base, ability to utilize a systems perspective, familiarity with training models, and factors associated with the self as therapist. Perceptual Skills include recognition skills, hypothesizing, and the ability to integrate theory with practice. Executive Skills include joining, assessment, advanced hypothesizing, creating and implementing interventions, communication skills, personal skills, and the ability to manage the therapy session.

Professional Skills include the ability to utilize supervision appropriately, recognition of ethical issues, effective and accurate keeping of paperwork, professional image, and professional conduct. Evaluation Skills include the graduates' ability to evaluate themselves as therapists and the therapy they conduct.

This concludes an overwhelming but thorough list of specific skills marriage and family therapists should possess as a result of their training and education. The literature on which this discussion was based was largely generated during the 1970s and 1980s, before the impact of managed care was felt heavily by marriage and family therapy and other psychotherapy professions. In recognizing the need for MFT training to respond to the changing healthcare arena, Figley and Nelson stated, “To effectively compete with more established fields of mental health professions, to more effectively raise the standard of practice, family therapy education must be dynamic and innovative” (1989, p. 362). The following section reviews additional skills MFT graduates need and changes many MFT programs have made in response to the so-called “healthcare revolution.”

Training Response to the Healthcare Revolution

When considering the implications of managed care on the training of marriage and family therapists, Crane summarized, “In many ways, the old rules for training are in transition” (1995a, p. 123). Managed care is defined as those who pay for health care services and who attempt to limit growth in the cost of health care (Crane, 1995a). Since over 70 percent of Americans are now enrolled in some type of managed care health plan and the number is growing (Patterson et al., 1997), many therapists in the United States have found it necessary to re-create their professional practice styles in order to adapt (Tuttle & Ambrose, 1999). Some practitioners have been forced to affiliate completely with managed care companies or large group practices in order to survive (Mize, Sutter, & Eisner, 1996). Psychotherapy trainees, including students of marriage and family therapy, have been forced to re-consider their oft-cited professional goals of independent private practice; unfortunately, some go through their entire training experience naively oblivious to the impact of managed care changes (Patterson et al., 1997; Plante, 1996, 1998). Several authors of psychotherapy and MFT training articles have called on graduate training programs to take the lead in educating and socializing their trainees into contemporary mental health practice (Broskowski, 1995; Crane, 1995a, 1995b; Figley & Nelson, 1989; Liddle,

1991; Patterson & Scherger, 1995; Patterson et al., 1997; Plante 1996; Plante, 1998). Such responsibility calls for changes in the traditional methods of MFT training: changes in research trends, didactic and clinical training, and skill focus.

Faculty of psychotherapy training programs willing to emphasize contemporary educational needs may face a considerable task. As Broskowski states:

...graduate education will follow, not lead, [psychotherapists] into the future. Unfortunately, the faculty of most [psychotherapy] departments have no experience working within any version of a contemporary health care system, much less managed care systems, and their current incentives are geared to reinforcing traditional practices. (1995, p. 161)

If marriage and family therapists are to meet the challenge of maintaining viability and employability as a profession, both faculty and trainees may want to obtain at least a general knowledge of managed care functions.

As part of the considerable task of modernizing MFT training, educators may also consider preparing the MFT trainee to face the political ramifications of being a systemically-oriented marriage and family therapist (Liddle, 1991; Sprenkle & Wilkie, 1996). As the situation stands currently, marriage and family therapy is not as widely recognized as some other mental health professions. Kuehl (1999) points out that MFTs practice throughout the United States and in many other countries, yet only 42 U.S. state governments recognize MFT as a distinct mental health discipline. Even then, the reimbursement rate for MFTs is not always as high as that of social workers, psychologists, or professional counselors (Kuehl, 1999). Although AAMFT is currently lobbying for change (Bergman, 2000), the federally-sponsored Medicare system includes the practice of family therapy as part of its reimbursable services, but historically excludes MFTs in the types of mental health practitioners who are eligible to provide that service (Simmons & Doherty, 1998). Many decision-makers in contemporary managed health care are completely unaware that marriage and family therapy is a specific profession (Simmons & Doherty, 1998). Kuehl clearly states the implications of this fact:

Employers seldom advertise for an MFT. Instead, they ask for the more familiar social worker. When MFTs get interviewed, they must spend considerable time and energy trying to convince the employer (often unsuccessfully) that they can do the job. (1999, p. 9)

Another change in MFT training trends can be discussed in terms of changes in skill focus. The previous section of this chapter discussed a variety of skills marriage and family therapy trainees are expected to obtain. The presence of managed care has created the necessity for a set of contemporary skills which have not historically been part of MFT program objectives. As with the previous section on MFT skills, this discussion of contemporary MFT skills is organized by the five major skill categories: Conceptual, Perceptual, Executive, Professional, and Evaluation skills.

I. Conceptual Skills. Several knowledge-based skills are necessary for the marriage and family therapist to be able to work effectively in a managed care environment. Since managed care businesses are a specific kind of system, MFTs may find a general business background useful, including general knowledge of organizations, management theory, labor relations, and human resource management (Crane, 1995b; Smith, Salts, & Smith 1989). MFTs should have a basic understanding of the general implications of managed mental health care on insurance reimbursement, evaluations, and the field in general (Patterson & Scherger, 1995). Some specific therapist skills may also help the marriage and family therapist who wishes to be more marketable in the managed care arena: chemical dependency education and experience, a background in curriculum design and training, and the ability to speak a second language (Mize et al., 1996; Smith et al., 1989). Because managed care-based therapy utilizes brief therapy models, and because these models are based on adult learning principles, a family life or general education background may also be helpful (Budman & Armstrong, 1992).

II. Perceptual Skills. Most perceptual skills needed in the contemporary mental health era are the same as those outlined earlier. Due to the fact that most managed care companies rely on DSM-based diagnoses and congruent treatment plans, the MFT who wishes to affiliate with behavioral managed care must understand the importance of using the DSM and know the most common disorders and research-based treatment modalities (Mize et al., 1996). The marriage and family therapist may also be well-served by having the ability to perceive the corporate or cultural politics in the working environment (Liddle, 1991).

III. Executive Skills. Probably the most important executive skill in the managed-care era is the ability of the MFT to conduct progress-oriented, brief therapy (Broskowski, 1995; Budman & Armstrong, 1992; Crane, 1995a; Patterson & Scherger, 1995; Smith et al., 1989). Brief

therapy is not often taught in other psychotherapy training programs, making many MFTs particularly strong candidates in this area (Budman & Armstrong, 1992). Strong crisis intervention and assessment skills are also necessary, particularly the ability to accurately diagnose a client pattern of chronic mental illness (Crane, 1995a; Smith et al, 1989

IV. Professional Skills. The largest category of skill expansion as a result of the influence of the healthcare revolution is seen here. The most cited professional skill in the literature is the ability for the MFT to work in an interdisciplinary setting (Broskowski, 1995; Gawinski et al., 1999; Mize et al., 1996; Patterson & Scherger, 1995; Patterson et al., 1997). Marriage and family therapists should be prepared to interact and consult professionally with physicians, nurses, physicians' assistants, nurse practitioners, social workers, administrators, and other staff. MFTs may find it helpful to understand what it means to work in a primary care model, where the primary care provider (usually a physician) acts as a "gatekeeper" to regulate the client's use of other services, including mental health services (Crane, 1995a; Patterson & Scherger, 1995). Accurate and progress-oriented record-keeping and organized treatment planning become critical in managed care-related practice (Crane, 1995a).

Other professional skills have to do with the "business" of therapy: MFTs must have the ability to perform case management duties, understand practice economics, and manage treatment costs. Marriage and family therapy trainees should also be taught how to become a "preferred provider" on a managed care panel, how to work in a managed mental health care organization, how to work in the private pay market, and how to market oneself and one's practice (Crane, 1995a). Lastly, with several different systems being involved in one patient's care (i.e., insurance, primary care provider, mental health practitioner, employer, etc.), it is particularly important for the contemporary MFT to identify who the client is and what is in that client's best interest (Plante, 1996).

V. Evaluation Skills. Evaluation in a managed care-influenced world has also become increasingly important. Due to the emphasis on controlling costs, managed care representatives are looking for the most-efficient, cost-effective services for their subscribers. MFTs looking to provide these services should be prepared to offer outcome statistics on therapeutic costs and effectiveness. Marriage and family therapy graduates must be prepared to offer efficient, cost-effective treatment and to keep track of client utilization patterns, accessibility of therapy to the

client, and clients' satisfaction with the therapy provided (Crane, 1995b; Patterson & Scherger, 1995).

Most of the above skills are not traditionally taught in accredited marriage and family therapy programs (Patterson & Scherger, 1995); however, some MFT programs in the United States are adapting their curriculum to the current mental healthcare environment. Authors in the training literature have discussed some curriculum changes specific to their programs: Auburn University has focused on creating opportunities for their masters-level trainees to gain experience in an employee assistance program (EAP) environment through partnering with a local corporation to provide student internships (Smith, Salts, & Smith, 1989). Brigham Young University has increased their emphasis on career options and clinical specialty areas by offering a courses on these topics (Crane, 1995b). The University of San Diego (M.S. program) has partnered with local managed care companies and family medicine training sites to offer their students increased experience in medical family therapy and managed care practicum settings (Patterson et al., 1997). In addition to this contemporary re-tooling of standard MFT curriculum, USD has also added courses in psychopharmacology and psychoeducational group therapies. The efforts of these universities demonstrate the types of foundational curriculum changes needed in accredited marriage and family therapy programs.

This section and the previous section in this literature review discussed many skill proficiencies and recommended curriculum changes in marriage and family therapy training. Although these advocated skills and training curricula reflect the opinions and research findings of family therapy's foremost trainers and researchers, the fact that these skills come only from this type of source is somewhat problematic. As mentioned earlier, Broskowski (1995) pointed out that graduate researchers and trainers may have little to no experience with contemporary health care systems. These training "experts" determine what MFT trainees should and should not be taught during their educational experience. The potential problem occurs when marriage and family therapy students graduate and integrate into professional realms other than academia. Once immersed in a variety of professional clinical and administrative activities, MFT graduates often find gaps in their knowledge which render them unprepared to negotiate certain areas of professional practice (Hines, 1996). It logically follows that a good source for feedback on training efficacy and relevance lies in the graduates themselves. The present study was designed

to obtain this feedback from MFT graduates, a population of training “experts” who has largely been neglected in the professional literature (Deacon & Piercy, 2000).

Graduate Perspectives on MFT Education

In a study of marriage and family therapy program graduates conducted by Hines (1996), the author describes his rationale for using a graduate sample to obtain valid information on MFT education: "Open systems incorporate feedback, and feedback from graduates who have work experience...is important and relevant" (p. 193). Although COAMFTE requires student feedback for an MFT program’s continued accreditation, few studies exist in the current marriage and family therapy literature which obtain this feedback from graduates who have had enough time to immerse themselves in the contemporary professional climate. The importance of having some time to develop professionally before giving feedback is explained by the fact that students coming out of a training program often respond in a highly impressionistic and emotional way, based on their immediate subjective experience of their training (Hentry, Sprenkle, & Sheehan, 1986; Liddle, 1991). Time away from the training setting and into a professional identity may enable the MFT graduate to give feedback based on practical, real-world experiences; experiences offered after the initial idealism, which often comes with training completion, has waned (Plante, 1998).

Only three relevant articles were obtained in this literature review which offer feedback from MFT graduates about their training. Two of the articles are research studies and the third consists of reflections provided by two graduates and their internship supervisor.

In a study published in 1996, Hines obtained questionnaires from 205 graduates of COAMFTE-accredited marriage and family therapy programs. The topics explored in the questionnaire were current work/employment activities, the extent and nature of MFT training obtained, the extent to which the training prepared the graduates for clinical work, and training recommendations.

Graduates in this study were primarily working in one of three settings: non-profit outpatient clinics, private practices, and colleges/universities. Some of the most common presenting problems seen by these graduate professionals included marital/couple problems, depression, parent/adolescent conflict, individual growth issues, and alcoholism (Hines, 1996). Participants were asked to identify areas in which they wished they had received more training

while in their MFT programs. Increased emphasis was recommended in the areas of individual therapy training with children, adolescents, adults, and groups. Results differed slightly for graduates with a terminal masters degree versus a doctoral degree. Masters degree participants also recommended increased emphasis in treatment of chemical dependency issues, diagnosis and psychological assessment, sexual abuse, and domestic violence. Doctoral-level participants recommended increased emphasis in chemical dependency, sexual abuse, and domestic violence issues. Other areas for doctoral graduate emphasis included MFT research, consultation, marital/family assessment, self of therapist, and therapist's family of origin issues as they relate to treatment. Doctoral participants also recommended decreased emphasis in some areas. These areas included: diagnosis, psychological assessment, and gender/ethnicity issues. Overall, the participants in this study considered themselves sufficiently well-prepared to engage in clinical practice.

The present study was based loosely on this Hines study. Hines was interested in career practices and training perspectives and contacted COAMFTE-programs to obtain his participants in a manner similar to the present research. As did this investigation, he also employed a modified Dillman's method to maximize participants' response rate. The present study and the Hines study differ in a few ways. Although published in 1996, Hines collected his data in 1988, before the field felt, in a widespread way, the changes imposed by the healthcare revolution. Hines also used a closed-response, 192-item questionnaire which focused more in-depth on the number of credits participants completed in various areas of study, along with in-depth questions about participant clinical experience based on various types of presenting problems. The current study employed a shorter questionnaire using several open-ended or fill-in-the-blank items. The employment questions focused less on specific types of clinical practice and more on the wider range of employment engaged in by MFT graduates in a contemporary world of managed care-influenced mental health practice.

Returning to the literature on MFT graduate feedback, Mize, Sutter, and Eisner (1996) presented the survey results of 237 graduates of all psychotherapy masters-level programs offered at the University of Houston Clear Lake. The questionnaire results were obtained in 1993, and were compared to those of a similar 1981 survey (N = 109). The investigators inquired about topics such as credentialing, employment patterns, annual income, managed care, and program

evaluation in light of post-graduate experience. Regarding the MFT program graduates surveyed: At the time of the 1993 study, over one-half of the students from the 1991-established MFT program had obtained their clinical licenses (57%). An updated survey was sent to these graduates in 1995. Most respondents indicated that the words "family therapist" were in their job title. Other findings related to these students' employment: The average time an MFT masters graduate spent looking for a job was 2.5 months, with the longest period being 4 months. The average, first-year annual income in this Texas study was \$23,000, which was considered to be similar to other mental health workers. Most graduates were working in community mental health centers, with only 5 percent having private practice work. The authors explain the disparity with this and the 1993 study by pointing out that most non-licensed practitioners (comprising the majority of the 1995 study's respondents) are not eligible for insurance reimbursement. The authors also mention that due to the lack of DSM psychopathology emphasis in their MFT program, a popular Texas managed care/insurance company refuses to reimburse MFTs at the same rate as licensed professional counselors or licensed psychologists. In light of this finding, the authors advocate an interdisciplinary framework when training MFTs.

When reflecting on their medical family therapy internship, Virginia Tech graduates Jenny Speice and Todd Edwards (Gawinsky, Edwards, & Speice, 1999) offered some feedback about their preparation for their internship setting based on their MFT program training. These graduates felt that they were well-prepared to be family therapists, but in-effect, family therapists in a vacuum. They reported that prior to their internship, each had practiced in a sort of isolation from non-MFT professionals due to their skepticism about how well other professionals understood families and family therapy. Their interdisciplinary internship forced them to adapt to a new professional culture that was composed of individuals from diverse professional and personal backgrounds. They mention that significant "growing pains" were present during that adaptation.

As reported in the other studies mentioned in this section, Speice and Edwards mentioned a lack of training in DSM diagnosis and in the brief, medically descriptive language of treatment planning and charting. Other areas in which Edwards and Speice felt a needed increase in attention included: learning to recognize the impact of multiple systems on a client or family, including the larger medical, economic, and community systems, and knowledge of managed care

operating methods. On a more positive note, these graduates felt that pursuing internship training in an area of specialization opened up more employment opportunities than a general family therapy internship would. Gawinsky, Edwards, and Speice also advocate that MFT programs continue to encourage feedback from their trainees and graduates. The present study follows this advice, asking graduates to list training aspects which were the most useful, least useful, and those which were lacking in their MFT training.

In summary, it seems that the few MFT graduates who have reflected on their training in the professional literature feel sufficiently well-prepared to conduct marriage and family therapy. It is when these MFT graduates embark on their professional employment endeavors that the more intricate dearths in training may emerge. These challenges, combined with the often confusing dilemma of negotiating a career in a mental health world that is different from the one they visualized when entering their therapy training, can create feelings of being unprepared to engage in a career as a marriage and family therapy professional. Said Plante:

...[psychotherapy trainees] often feel unprepared to deal with these changes, and report uncertainty about their career prospects. Many appear concerned that the types of careers they once envisioned may no longer exist. Furthermore, many lack strategies and information regarding how to go about finding work. Almost all trainees report that no one in graduate school formally discussed job-searching strategies with them and that all discussions regarding employment occurred informally among peers or sympathetic faculty members or practicum supervisors. (1998, p. 508)

In an attempt to partially correct this lack of direction many MFT graduates experience when embarking on a career path, the present study asks employed graduates to offer insights and advice on approaching employment after graduation. The next and final section of this literature review discusses specific career opportunities for individuals who hold an advanced degree and training in marriage and family therapy.

Careers in Marriage and Family Therapy

Returning to one of the guiding questions of this literature review, "What are MFT graduates doing with their training?" an answer was found similar to the earlier question about what MFT graduates are trained to do: family therapy. This general response may not be informative enough for those graduates who wish to change careers or desire to broaden their

overall employment options. After all, it has been reported that an individual may change careers three or more times during his or her lifetime (Hukill, 1999). As Plante observed,

I have noticed, over the past few years in particular, a striking increase in the sense of pessimism among trainees who are about to embark on a career that once appeared very different (and perhaps much more appealing) when they decided to enter graduate school. Many appear worried that the type of career they envisioned may no longer exist. (1996, p. 304)

In an attempt to decrease my own sense of pessimism and to seek further clarification on this topic, I conducted a search of the professional and popular-professional literature.

Surprisingly, very little was found in standard professional journals (i.e., *Journal of Marital and Family Therapy*, *Family Process*, *Contemporary Family Therapy*, etc.) to provide career guidance to marriage and family therapists.

The most relevant and timely information was discovered on AAMFT's web site, in their Members Only section (1999, <http://member:accept@aamft.org/members>). Here, articles previously published in popular-professional publications such as *Family Therapy News* and *Practice Strategies Newsletter* were displayed covering some of the emerging markets for marriage and family therapists. In the 1999 AAMFT annual conference, AAMFT President Anna Beth Benningfield was quoted as saying, "AAMFT's goals are to expand opportunities for MFTs so they can contribute in as many settings and in as many ways as possible" (Chismar, 1999, p. 6). If AAMFT will prioritize this web site area for attention, this could be the best source for MFTs to track the expansion of these opportunities in terms of changes in the professional practice field. Unfortunately, the site shows signs of neglect: the same articles appeared in December of 1999 that were there in August of the same year. Those selections mentioned as "coming soon" back in August had still not been posted as of September 2000.

Returning to the particular findings on career options for MFT graduates, several potential career paths were discovered. Those established career options found in the literature include: general clinical practice, academia, medical family therapy, managed care/EAP employment, systems consultation, personal coaching, school consultation, forensic family therapy, in-home family therapy, and other specific niche markets engaged in by MFTs. The discussion will continue with an outline of each of these areas. Prior to this study, no research had been published regarding the number of MFT graduates who engaged in each of these career options.

This study was designed to remedy this dearth, and to establish a fundamental idea of career directions MFT graduates are taking.

General clinical practice. The desire to see clients in a private practice-type setting continues to be the career goal cited most by marriage and family therapy and other psychotherapy graduates (Patterson et al., 1997; Plante, 1996,1998). Doherty and Simmons (1996) analyzed questionnaires received from 526 AAMFT clinical members and 492 of their clients to obtain data about therapist background, practice setting, employment status, type of treatment provided, fees charged, types of presenting problems seen, types of clients seen, and perception of therapist competency by both client and therapist. Despite concerns about managed care decreasing the ability of clinicians to practice privately, most respondents in the Doherty and Simmons sample reported private practice as their primary work setting. Other MFTs worked in private nonprofit agencies, state or community agencies, and other settings. Other clinical settings for MFTs include group practice settings, managed care companies, employee assistance programs, and medical centers. Most respondents worked full-time (67.4%), with 36.7 percent holding two or more positions simultaneously.

The majority of AAMFT clinical members see clients individually, with the remainder of cases being conducted in couple, combination, family, and group formats. These MFTs see a wide variety of presenting problems, the most frequent being depression, marital problems, anxiety, parent-child problems, and other psychological problems. Some MFTs have gravitated toward seeing their clients in home-based offices (Daw, 1996). Overall, clients treated by MFTs report being very satisfied with the services they received. The average hourly rate charged by an MFT is \$80.00, with the average reduced fee being \$50.00 an hour (Doherty & Simmons, 1996). Fifty-eight percent of MFTs report earning \$50,000.00 or less per year in private practice, compared to 67 percent of psychotherapists overall (AAMFT, 1999e). According to AAMFT (1999e), MFT's reimbursement rates are continuing to increase while those of psychologists are decreasing, and MFT's share of managed care income is also increasing when compared to professional counselors. In the same article, it was reported that female MFTs earn 99 percent of what men in the same therapy profession earn.

Academia. Historically, a career in university teaching and research has been another frequently cited goal for MFT graduates, primarily for those who obtain the doctoral degree.

Graduates who wish to follow this path usually need to be socialized early, with advisors and faculty encouraging early involvement in research, teaching, and professional publication. Those who find themselves in the running for a tenure-track university position will usually face considerable competition for the slot. If the position is successfully obtained, the MFT must be prepared to juggle a variety of duties effectively: teaching classes, conducting and supervising research, publishing articles, participating in administrative meetings, sitting on committees for the university or professional organizations, attending professional conferences, and conducting and supervising therapy (Azar, 1999).

Medical family therapy. Medical family therapists are typically employed by hospitals. They may be working in conjunction with a family medicine department or an outpatient family practice clinic. Medical family therapists work as part of an interdisciplinary team, which includes physicians, nurses, psychiatrists, psychiatric nurses, social workers, and other medical specialists (Gawinsky et al., 1999). Clients, typically called "patients" in this setting, present with problems not always seen in traditional MFT practice. Medical issues usually complicate psychiatric and family/systemic problems: Cancer, chronic pain disorders, diabetes, HIV, infertility and pregnancy loss, chronic depression and anxiety, and chemical dependency comprise just a few of the many issues which a medical family therapist may encounter.

Managed care/Employee assistance program settings. Managed care companies and employee assistance programs both provide employment for MFTs. Although many managed care companies will contract with outside providers for mental health services, many of these companies also have an in-house behavioral health division where subscribers to that particular plan may go for therapy. Employee assistance programs (EAPs) have a similar structure: Some companies will create an internal EAP division to assist employees and management with personal or work-related problems. Other companies may contract with a larger EAP corporation for services on an as-needed or capitated basis (Budman & Armstrong, 1992).

Systems consultation. An rapidly expanding career option for marriage and family therapists is consulting for business. Since businesses are large systems, and since MFTs are specifically trained as experts in systemic assessment and intervention, the combination of efforts is a logical one. Perrott (1999) defines business consultation as a collection of loosely related services which may include employee/management training and development, organizational

development, mediation, and an overall helping people in a corporation improve communication and strengthen the systemic structure. Consultation for family businesses in particular is an available niche for MFTs desiring consulting work (Paul & Wiseman, 1999). Family businesses often have unique relational issues in which MFTs possess particular expertise (Cole, 1997; Hunter, 1997).

Personal coaching. Second only to management consulting, personal coaching is the fastest-growing consulting field in the United States (Hukill, 1999). A personal coach acts as a mentor to an individual, assisting the person in identifying personal or professional goals and providing a vehicle for accountability while the client works to accomplish those goals. This service is usually provided by phone, in half-hour sessions, at a rate of \$75 to \$150 per hour. Therapists performing coaching duties must focus strictly on a client's behavior change, not on understanding the reasons behind the behavior. An MFT with some business experience who doesn't mind doing some heavy networking and marketing may find personal coaching an interesting career option.

School consultation. Marriage and family therapists are making increased appearances in school settings. Some work in interdisciplinary student health centers (Daw, 1998; Mock, 1998). Several COAMFTE-accredited programs have also been involved with Head Start in a joint project bringing MFTs into the Head Start organization as clinical consultants to work with staff, children, and families. McDowell (1999) reports that many MFT students have gone on to secure paid positions with Head Start or affiliated community mental health centers after graduation. Silvestri, Steinberger, and Scambio (1996) have pioneered a Collaborative School Consulting Model in which consultants work with a school system to integrate educational, administrative, and community efforts through working with teachers, parents, administrators, and the school board.

Forensic family therapy. MFTs are finding increased opportunity in the realm of the justice system as well as in the schools. Many juvenile detention facilities will employ MFTs to work with juvenile offenders and their families. Family intervention often reduces the instances of offending, and as with other career avenues, MFTs are specially qualified to offer these types of interventions (Henggeler, 1998). Marriage and family therapy graduates also find part- or full-time employment in prisons as chemical dependency and family therapists (Flacy, 1999), in state

family services departments running therapeutic supervised visitation for court-ordered, supervised parent-child visits (Sudol & Marsh, 1998), and in law firms as legal therapist counselors who help clients prepare for the emotional impact of divorce proceedings and dealing with the legal system (Daw, 1997).

In-home family therapy. As an alternative to on-site therapy, some managed care companies are now offering in-home therapy (Crane, 1995a). These in-home therapy programs are modeled after family preservation interventions, where a team of therapists and case managers is on-call 24 hours a day, 7 days a week to provide assessment, crisis intervention, reassessments, and joining with difficult families (Daw, 1996). These in-home treatment teams often provide alternatives to costly hospitalization for at-risk or in-crisis individuals and families. In-home therapy is also provided by some community mental health centers which are responsible for providing services to large, rural areas (Morris, 1996).

Other niche markets. In response to the overall influence of managed care, marriage and family therapists have become creative when searching for an area of specialization in order to maintain professional viability. MFTs are offering more "consumer-friendly" services to increase affordability and accessibility to clients. Tuttle and Ambrose (1997) conducted a survey of therapists to see what strategies they used to maintain their private practices. These authors report that 68 percent of the therapists surveyed offered evening appointments, 32 percent offered weekend appointments, and 20 percent accepted payment by credit card. MFTs are also scheduling 15-minute, brief check-ups when clients don't feel the need for a full session, are charging for services such as physician consultations, and conduct phone and e-mail therapy (Tuttle, 1999d; Tuttle & Ambrose, 1997).

Other MFTs expand their careers by developing niche markets in their practice. Krauth (1997b) discusses the opportunities and pitfalls when working with the media as an expert in family therapy. Tuttle (1999a) expands on how a therapist can obtain speaking engagements on a variety of topics. Leaders in marriage and family therapy continue to report that the key to maintaining the vitality of MFT as a profession is continued creativity, specialization, and mainstreaming (Chismar, 1999; Krauth, 1997a; Tuttle, 1999a, 1999b). Specialization refers to therapists developing one or more professional niches, for example: working with attorneys, telephone coaching, combining therapy and spirituality to serve religious clients, and professional

speaking/workshops (Krauth, 1997a; Tuttle, 1999a, 1999b). Mainstreaming refers to the political efforts of AAMFT and members of the MFT profession; the goal being to make MFT a part of the dominant mental health culture similar in status to psychology or social work, while retaining the systems-based values and identity which renders the MFT discipline unique (Chismar, 1999).

This review of career options for marriage and family therapists is by no means comprehensive, but reviews those job opportunities which are documented in the literature. Contemporary MFTs not only continue to maintain traditional private practices in the office and at home, they form group practices, work in medical settings, conduct therapy for managed care or employee assistance companies, perform coaching and consulting for businesses, individuals, and schools, provide clinical services in a variety of forensic settings and in the homes of clients, and develop professional practice niches that are as unique as the clinicians themselves. In the literature, at least, it seems that there are many professional opportunities for marriage and family therapy graduates. Little is known about the broader practice of these career paths outside of the anecdotal reports found in the literature. This study attempts to gather more thorough information about the practice of these various career options among marriage and family therapy graduates.

Summary and Implications for Present Study

From its inception, marriage and family therapy training has moved from post-graduate, theory-specific institute settings to accredited masters and doctoral-level specialization programs housed in university departments. The traditional skills acquired by most graduates of these COAMFTE-accredited marriage and family therapy graduate programs can be separated into five main categories: Conceptual, Perceptual, Executive, Professional, and Evaluation Skills. The presence of managed care during the overall healthcare revolution has required MFTs wanting or needing to affiliate themselves with managed care to master a new set of skills. Unfortunately, not all accredited MFT programs may teach these skills to their trainees, and those skills which are taught are often based on the opinion of researchers and academicians who are not thoroughly steeped into the world of contemporary mental health practice. Few trainees and even fewer MFT graduates who have professional work experience have been asked for their opinions of the relevance and importance of their training.

A similar trend has been observed in the literature on available career options for those graduating from COAMFTE-accredited MFT programs. Some popular-professional articles have outlined a variety of possible career avenues for marriage and family therapists. These avenues include: general clinical practice, medical family therapy, managed care and EAP settings, systems consultation, personal coaching, school consulting, forensic family therapy, in-home therapy, and specialized niche markets. Those studies which have been conducted on MFT career practices focus solely on the types of clinical settings in which these therapists work. No research was found that asks MFT graduates about their career practices in these other available areas.

The present study attempts to correct the previous lack of research on marriage and family therapy program graduates' reflections on topics of career and training. The purpose of this study is to obtain information on perceived training relevance and on a wide range of career opportunities for marriage and family therapists working in the United States.

CHAPTER 3

METHODS

Theoretical Background

The theoretical lens through which this study was viewed was that of phenomenology, a school of philosophical thought which assumes the subjectivity of reality (“Phenomenology,” 2000). According to Gubrium and Holstein (1993; in Pascoe, 1998), the four main assumptions of phenomenology are: (1) human experience is subjective, (2) language and meaning are significant in everyday life, (3) objects have an indeterminate quality, meaning that the same meaning is not always attached to the same object or event, and (4) objects are intersubjective, meaning that the nature of reality is not only determined by the meaning an individual gives to it, but also by the context in which the object or event is placed.

Phenomenology was applied to this research project in that the project’s focus was knowing what meaning a set of individuals (MFT graduates) gave to their experiences of MFT training and career practices. Some respondents hailed from the same university training program, and yet the meanings they gave to their educational experiences differed in content and focus. This study inquired about the broad range of meanings and experiences assigned by these graduates, and the themes which emerged are catalogued in the Results chapter.

Research Design

This study utilized a cross-sectional survey method designed to assess career practices and training perspectives of graduates from accredited marriage and family therapy masters and doctoral programs who work in the United States. The survey instrument was administered by mail and through the Internet during March through June 2000, and was designed to collect informational and evaluative data which was analyzed using a combination of quantitative and qualitative methods.

Participants

The participants in this study were graduates of COAMFTE-accredited marriage and family therapy masters and/or doctoral programs who currently work in the U.S. Graduates from the year 1997 and earlier were sought, allowing for participation of graduates who have been working in the field long enough to establish a career and to develop opinions about their MFT training based on this work experience (Hines, 1996). Additional rationale for this minimum 3-

year post-graduation guideline was explained by the fact that most states which license marriage and family therapists require an additional 2-3 years of post-graduation training and clinical work experience before a therapist can practice as an unrestricted member of the profession (Mize, Sutter, & Eisner, 1996).

Although there exist a few COAMFTE-accredited programs in Canada, and although some Canadian students return to their country after attending U.S.-based MFT programs, no Canadian-based graduates were included in this study. The reasoning for this limitation concerned expressed data regarding income and job descriptions: Since the Canadian dollar differs in value from the U.S. dollar, it would have been difficult to have to adjust income values for Canadian participants. Canada's reliance on a socialized medicine and behavioral healthcare system would likely also have resulted in job descriptions which were not available to U.S.-based MFTs. For these reasons, the participants were confined to U.S. residents only.

The initial targeted number of participants for this study was 300. After some letters were returned due to incorrect addresses and after replacement participants were selected, the total number of invitation letters mailed was 321; 30 were returned to the investigator, resulting in a potential participant number of 291. Of the 291 letters delivered, 125 graduates (77 women and 48 men) participated in the study, a 43% response rate. Participants averaged an age of 40 years ($SD = 9.1$ years; range 26-71 years) and most (79.2%) were married, with 13.6% single, 3.2% divorced, 2.4% cohabiting, and 1 participant widowed. Participants reported an average of 1.4 dependents (range 0-6 dependents); the men in the sample reported a greater number of dependents than the women (mean difference = $M = .99$, $t(121) = 3.85$, $p \leq .001$). Participants were working in 40 of the 50 United States. The largest clusters of participants resided in Utah ($n = 20$), Texas ($n = 8$), and Colorado ($n = 6$). Table 1 contains a summary of participant demographic characteristics.

Table 1: Participant Characteristics: Gender, Age, Marital Status, Dependents

Characteristic	<i>n</i>	%
Gender		
Female	77	61.6
Male	<u>48</u>	38.4
Total <i>n</i>	125	
Age		
25 - 29 years	16	12.9
30 - 39 years	50	40.3
40 - 49 years	39	31.5
50 - 59 years	17	13.7
60 - 69 years	1	.8
70 + years	<u>1</u>	.8
Total <i>n</i>	124	
Marital Status		
Single	17	13.7
Married	99	79.8
Cohabiting	3	2.4
Divorced	4	3.2
Widowed	<u>1</u>	.8
Total <i>n</i>	124	
Number of Dependents		
0	46	37.4
1	28	22.8
2	23	18.7
3	13	10.6
4	9	7.3
5	3	2.4
6	<u>1</u>	.8
Total <i>n</i>	123	

Instrument

The questionnaire used was developed for this study by the investigator and members of the dissertation committee (see Appendices D and F). It consisted of 26 forced-choice and open-ended/short answer questions, and contained three main parts. Part I asked for demographic and educational background information, including: degrees received, post-graduate training/certifications, marital status and number of dependents, income, number of hours worked per week, and geographic location. Part II investigated perceptions of MFT training as it related to

the participant's career, and Part III obtained information about the participants' current and desired career activities. The questionnaire was available both on an Internet web site and by mail.

The items of the questionnaire were developed based on the general research questions. Many items were open-ended in order to facilitate a qualitative analysis of information generated by the participants themselves, rather than forcing the participants to respond to categories delineated by the researcher.

Procedure

Once approval for the study was obtained, program directors for 10 of the 45 accredited MFT masters programs and for 10 of the 14 accredited doctoral programs were contacted by phone or e-mail. The university programs were geographically selected to represent regions of the entire United States. Graduate programs were categorized by type: offering only a masters degree, offering only a doctoral degree, or offering both a masters and doctoral degree. Five universities were selected from each category in order to limit the number of potential participants. Programs currently possessing only "candidacy" status from COAMFTE were not represented. The programs which participated in this study included:

<u>MASTERS DEGREE</u>	<u>DOCTORAL DEGREE</u>	<u>BOTH</u>
Auburn University	Iowa State University	Brigham Young University
Colorado State University	Purdue University	Kansas State University
Univ. of Wisconsin-Stout	Texas Tech University	Syracuse University
University of San Diego	University of Georgia	Virginia Tech University
Utah State University	University of Minnesota	University of Connecticut

Once the program directors were contacted, they were informed about the study and current addresses of program graduates from 1997 and earlier were requested. Some programs had a policy which prohibited the release of alumni addresses to outside parties. In these instances, this investigator requested permission to mail the participant invitation letters to these universities. The MFT programs at these universities in turn disseminated the letters to their alumni, thus preserving the anonymity of student names and addresses (instructions to these MFT programs are included in Appendix A). This option was selected by 8 of the 15 programs contacted. The remaining 7 programs made their alumni address lists available to the investigator.

Once MFT graduate addresses were obtained, or once an agreement was made with those MFT programs willing to send letters to their graduates for the investigator, an “Invitation to Participate in Research” letter was sent out to 20 randomly selected graduates (graduating year 1997 or earlier) from each program (Appendix B). This letter introduced the study and asked graduates for their participation. The initial number of introductory letters totaled 300. As letters with incorrect addresses were returned to the investigator, replacement participants were selected from the same university (when available), and invitation letters were sent to these replacements. As mentioned earlier, a total of 321 invitation letters were sent and 30 of these were returned, resulting in a net mailing of 291 initial letters. The “Invitation” letter outlined two possible options for participants: The first indicated that the questionnaire was available on the Internet (the “Internet Option”), and the second offered a mailed-questionnaire option (the “Mailing Option”). Each invitation letter contained a “registration number” by which those participants who needed follow-up letters were tracked, as per Dillman’s (1978) Total Design Method (described later in this section). The two response options are outlined below.

For those participants who selected the Internet Option: The web page address where the questionnaire and informed consent information were located were provided. Once participants entered their algorithmic registration number, accepted the informed consent procedures, and completed the questionnaire, they were required to click on a button which indicated their desire to “send” the questionnaire, and their responses were automatically electronically mailed to the investigator. The e-mail address and phone number of the investigator were also provided to participants in case they had questions or desired follow-up information about the study.

Regarding the subject of confidentiality on the Internet: The questionnaire used in this study did not ask for the participants’ identity. Since the participants visited a web site to access the survey, any messages which were submitted to the investigator directly from the web site were untraceable. The return address on the e-mailed response simply indicated that it came from the server hosting the web page; thus, all e-mailed questionnaire responses had an identical return address. The registration number allowed follow-up requests for participation only for those whom the graduate program provided addresses. For those programs who did not release alumni addresses to the investigator, the registration number only indicated the university from which the

respondent graduated. Any identifying connection between the registration number and participants' names or addresses was destroyed after all data was collected.

The second response option for participants consisted of a mailed questionnaire. The invitation letter invited those interested in participating in the study who did not have access to the Internet to call a toll-free number where, on voice mail, they left their registration number and address for a questionnaire to be mailed to them (Appendix B). A paper copy of the questionnaire and informed consent agreement was mailed to these participants with a postage-paid return envelope (Appendices C and D). A modified version of Dillman's Total Design Method (Dillman, 1978) was employed in an attempt to maximize the response rate for participants in both the Internet Option (where addresses were available) and Mailing Option categories. Overall, 84 (67.2%) of the 125 participants responded by Internet and 41 (32.8%) completed a mailed questionnaire.

Dillman's Total Design Method (1978) is an empirically developed strategy which maximizes the response rate for mail-out surveys. The method emphasizes personalization of research materials for the participants; including, but not limited to, use of participant names on the introductory letter (if the participants' names are available) and hand-written signatures from the researcher on all correspondence. The crux of Dillman's method involves a structured follow-up procedure for all potential participants: One week after mailing the introductory letter, a follow-up "reminder" was sent to all participants, thanking those who responded or requested questionnaires and reminding those who had not yet responded about the importance of their participation (Appendix G).

Three weeks after the initial mailing, follow-up letters and replacement questionnaires were sent to those subjects who had not yet participated (Appendix H). The questionnaires were numbered to correspond with participant names and/or addresses, which is how the investigator tracked those who had not returned the questionnaire. The identifying information was destroyed after all data was collected.

The last step in the Total Design Method is a final follow-up mailing of the introductory letter and replacement questionnaire to non-respondents. This final mailing is sent 7 weeks after the initial mailing and comes to prospective participants by certified mail. In the interest of time and cost, this latter step of Dillman's method was omitted in this study. The procedure utilizing

the first two follow-ups was followed for all study participants when addresses were available. For those subjects who received the invitation letter directly from their graduate programs, follow-up consisted only of the “reminder” letter sent to all subjects one week after the initial mailing (Appendix G). Again, the investigator did not have the addresses available for follow-up from those MFT graduate programs that did not release alumni addresses.

Analyses

Researcher background. The investigator in this dissertation project is a white female in her early 30s. She was raised in California in an upper-middle class-status family and, except for her two years in Virginia for her Ph.D. coursework, has lived in the western United States throughout her life. Educational background includes: a bachelor of science degree in psychology and a master of science degree in family sciences, emphasis in family life education. Her Ph.D. major is human development with special emphasis in marriage and family therapy. In addition to working as a marriage and family therapist, the investigator’s professional experience includes adjunct university teaching, mental health treatment and program coordinating, and working as a career assessment specialist.

This research project was prompted by the investigator’s personal career goal changes. Due to some negative experiences with her doctoral internship supervisor (who was also her post-internship employer), the researcher’s career goal has presently moved away from clinical practice. Consequently, this dissertation was largely conducted to investigate career options available to people with graduate degrees in marriage and family therapy.

There are many possible sensitizing perspectives possessed by the investigator which may have influenced the interpretation of the research results. The investigator holds the status of “participant/observer,” meaning that since she has experienced the graduate school environment of a COAMFTE accredited MFT program, she sympathized with the research participants and their experiences. The investigator’s own struggles with issues of career change may also have influenced her to more readily identify with negative comments or themes offered by participants than positive comments made about the MFT field. As a person who experienced the privilege of undergraduate and postgraduate education as well as an upper-middle socioeconomic status upbringing, the investigator may also have been influenced by certain expectations of income level and career advancement. The researcher’s personal challenges regarding career and income

advancement have been more difficult than expected with the level of education she possesses. All these issues held the potential to consciously or unconsciously influence the themes extracted from the research data.

Analyses. The analyses for this study combined both quantitative and qualitative methods. Those item responses that were quantifiable were transferred into an SPSS for Windows (version 6.0) database for statistical analysis. Analyses for this quantitative data consisted of descriptive statistics: means, ranges, standard deviations, and percentages. In order to examine possible differences along participant categories, t-tests on continuous variables grouped by both gender and terminal degree status (masters versus doctorate) and chi-square analysis on categorical variables grouped by gender and terminal degree status were run. The rationale for using both gender and terminal degree status as categories for further analysis was that upon initial examination, the research data appeared to vary along these categorical variables. Further analysis confirmed that both gender and terminal degree status did yield results which varied significantly in certain areas. These significant areas are mentioned in the next chapter.

Much of the data generated by the questionnaire was in text format. Since the primary research questions were best answered by describing categories and observations of trends, patterns, and relationships between categories, qualitative analysis using open and axial coding methods was incorporated as outlined by Strauss & Corbin (1990). Open coding required breaking the data down into discrete parts and then examining it for similarities and differences. Once the data was collected, it was transferred into an Excel matrix format: The axes in the matrix consisted of participant registration numbers and the responses to each question. After all data was entered into the matrix, the entire matrix was printed out. Individual participant responses to each question were cut out and pasted onto four-by-six inch cards. Cards were color coded to correspond to each questionnaire item which generated text (i.e., non-quantifiable) responses.

Once all qualitative data was transferred to the cards, each set of cards which corresponded to one questionnaire item was analyzed. One set of cards was analyzed at a time until all sets of cards were analyzed. As the investigator read and re-read the data, clusters and themes began to emerge. The cards were organized according to these clusters, whereafter

category names were assigned which reflected the most dominant themes contained in the data for each questionnaire item response.

Axial coding is designed to reconfigure the concepts and categories in new ways through observing connections between them. Once all individual questionnaire items were analyzed, the cards were re-combined and sorted again into dominant themes which arched across all questionnaire items. Demographic information such as gender, terminal degree status, income, age, state of residence, and job title were compared in each theme to determine the existence of other relationships in the data. This procedure was completed for the individual item analysis as well as for the overall qualitative data analysis. As in the individual item analysis, categories of themes were assigned names which reflected the sub-themes contained in the data.

In order to establish reliability and validity in qualitative research, a verification method known as triangulation was incorporated into the data analysis. Triangulation involves comparing the research findings to at least two other sources to verify the conclusions which have been drawn (Strauss & Corbin, 1990). Some sources for triangulation include: additional researchers who code and analyze the same data, published literature, the review of data by research subjects, individuals with characteristics similar to the research subjects, expert panels, and the researcher. For this study, triangulation was accomplished through comparing the researcher's findings with existing literature and having the research subjects themselves review the preliminary findings and offer feedback. Those subjects who indicated through the questionnaire that they were willing to take part in offering feedback and those who indicated they would like a copy of the research results ($n = 43$) were contacted with a summary of research conclusions and were asked for their feedback about the validity of the data and their general impressions of the information.

Of the 43 participants contacted, 20 responded with feedback. Their input was compared to information found in the literature to establish commonalities and/or discrepancies between subject feedback and the investigator's conclusions. All participants who offered feedback reported seeing their views reflected in the results, and believed the data also accurately represented the various views held by other MFTs in the field.

CHAPTER 4

RESULTS

I. Background Information

Educational background. Table 2 provides a summary of participants' educational background, AAMFT membership status, and licensure status as reported in this segment. Most (68.8%) MFT graduates in this sample had bachelors degrees in a social science discipline (36% in psychology). Other bachelor degree majors included liberal arts, education, and other majors. About 14% had double majors, most of them combining social science and liberal arts emphases.

Most participants held masters degrees in the specialization area of marriage and family therapy (68.8%). Other masters degrees included counseling degrees such as counseling, school, or clinical psychology, social work, or counselor education (14.4%); social science specializations such as human development/family relations, family studies, or human and family resources (7.2%); Masters of Divinity or religion degrees (4.8%); and other masters degrees (2.4%). A few participants (5.6%) held more than one masters degree, usually an MFT degree combined with a divinity or business degree.

A little over one-half (51.2%) of participants held doctorate degrees, most of which participants stated were in the MFT specialization (79.7% of all doctorates reported). Other doctorates were earned in human development/family relations or similar majors such as family studies or child/human development (7.8%), counseling or clinical psychology (6.3%), and ministry, adult education, or philosophy (6.2%).

It should be pointed out that those participants who reported a degree "major" in marriage and family therapy were largely inaccurate. With the exception of a few programs that actually grant a major in marriage and family therapy, MFT training programs are housed in broader university departments such as family studies, human development, family and child development, consumer sciences, etc. The degree emphasis awarded by these departments are actually the broader major of the department itself (i.e., Ph.D. in human development). The marriage and family therapy "degree" is actually an area of specialization within the major. Participants reported their major in various ways; therefore, it is difficult to discern how many family studies-type majors were actually MFT emphasis or broader family studies-related emphasis.

Table 2: Educational Credentials: Degrees, AAMFT Membership, and Licensure

Credential	<i>n</i>	%
Bachelors Degree		
Social sciences (Psychology, <i>n</i> = 45)	86	68.8
Liberal arts	16	12.8
Education	6	4.8
Other	10	8.0
Did not answer	<u>7</u>	5.6
Total <i>n</i>	125	
Double majors	18	14.4
Masters Degree		
Marriage and family therapy	86	68.8
Other counseling degree	18	14.4
Social sciences	9	7.2
Religion/Master of Divinity	6	4.8
Other	3	2.4
Did not answer	<u>3</u>	2.4
Total <i>n</i>	125	
More than one masters degree	7	5.6
Doctoral Degree		
Marriage and family therapy	51	79.7
Family/human sciences	5	7.8
Psychology	4	6.3
Doctorate of ministry	2	3.1
Other	<u>2</u>	3.1
Total <i>n</i>	64	
AAMFT Membership		
Currently a member	83	66.4
Used to be member	33	26.4
Never a member, plan on joining	5	4.0
Never a member, don't plan on joining	<u>4</u>	3.2
Total <i>n</i>	125	
Licensure		
LMFT	52	41.6
Dual license (MFT + another)	21	16.8
LPC or Psychologist	8	6.4
Temporary MFT license	7	5.6
Other	7	5.6
No professional license	<u>30</u>	24.0
Total <i>n</i>	125	

Other training/certifications. About half of the respondents (51.2%) reported additional training and/or certifications. Most certifications were clinically-related, and included specialization areas such as mediation, EMDR, psychometric testing, substance abuse, domestic violence, neuro-linguistic programming, Imago therapy, and school counseling. Other certifications were related to an educational or psychoeducational topic or area of didactic study. The educational certifications included certified family life educator, Miller's Couple Communication Program instructor, financial counseling, CPR, teaching, yoga instructor, and parenting instructors. Other didactic areas included gerontology, women's studies, pastoral care, and systemic management/leadership.

Some respondents completed a formal postdoctoral training program or other type of clinical externship ($n = 9$). Postdoctoral training was completed in areas such as medical family therapy, psychiatry, substance abuse, and at established family therapy institutes.

Other participants (34.4%) reported specific supplemental clinical training they had received after graduating from their MFT programs. Some graduates obtained additional training in specific clinical theories such as strategic, emotionally-focused, or brief therapy. Additional graduates reported training in specific presenting problem areas or clinical populations, the most common being play therapy, sexual abuse, chemical dependency, hypnosis, domestic violence, supervision, crisis intervention, and psychopharmacology.

AAMFT membership. The majority of participants (66.4%) reported current membership status in the American Association for Marriage and Family Therapy. About one-quarter (26.4%) used to be members, 4% plan to join AAMFT, and 3.2% were never members and do not plan on joining the association. Table 2 provides a summary of these statistics.

Professional licensure. Approximately three-quarters of participants (76%) held some type of professional license (see Table 2 for summary). Although most licenses were in marriage and family therapy (58.4%; another 5.6% held MFT training licenses), 16.8% of those with licenses were dually licensed as an MFT and as another mental health professional (i.e. licensed professional counselor, licensed psychologist), 6.4% held only a different mental health license, and 5.6% earned licenses in professions other than mental health, including nursing, real estate, and spiritual directorship.

Those participants who noted they did not have an MFT license were asked to explain. Of the 60 participants who indicated they did not have an MFT license, the majority (n = 36) reported that the LMFT was either not needed for their current professional position (n = 19), they did not have MFT licensure in their state of residence (n = 14), or they lacked the ability to obtain the required relational clinical hours in their current position (n = 3). Twelve respondents were in the process of obtaining their MFT license. The remaining participants who responded to this question cited reasons related to the marriage and family therapist in the current mental health marketplace (n = 8). These reasons included the perception that other clinical licenses are more prestigious or credible, MFT licensure was not worth the time and money needed to obtain it, MFT licensure was introduced in the participant's state after the participant had already obtained a different clinical license, and some reported needing a different license for their job or alternate clinical emphasis (i.e., psychology).

II. Perspectives on MFT Training

In an attempt to answer the research question about how MFT graduates perceive the relevance and usefulness of their MFT training as it relates to their chosen career, participants responded to a series of questions about MFT training. These questions asked them to name the most and least relevant/useful aspects of their MFT training, as well as areas missing from their MFT training that they wish had been included. Participants also responded to a series of Likert-type questions which assessed the degree to which they felt their MFT programs prepared them for their current job, for their career goal, and for finding employment.

A. Most relevant/useful aspects of MFT training

The results from this question are summarized in Table 3. The responses were categorized into six major themes (listed from most to least frequently cited): experiences related to clinical work, didactic clinical training, professional development/training, research, personal development, and specific aspects of the MFT training program.

Table 3: Most Relevant Aspects of MFT Training

Most Relevant	%*
Experiences related to clinical work	
Practicum/internship	48.0
Supervision	44.0
Specific clinical skills	11.2
Supervision of supervision (doctoral only)	5.6
Experience w/specific clinical population/ format (masters only)	5.6
Other	5.6
Didactic clinical training	
Working with systems theory/perspective	32.0
Range of therapy models/theories/techniques	26.4
Specific theory	10.4
Ethical and legal issues	4.8
DSM/diagnosis training	4.0
Other	3.2
Professional development/training	32.8
Research	12.0
Personal development	10.4
Specific aspects of MFT training program	8.8

N = 125 participants

* Percents total more than 100 because participants offered more than one answer to this question.

Experiences related to clinical work. Forty-eight percent of participants mentioned their practicum and/or internship experiences among the most relevant and useful aspects of their MFT training.

[Most relevant was] hands-on clinical training. I believe the more time a program can provide for the student to be developing therapy skills with clients the better. (From a doctoral level graduate.)

Clinical preparation - how to deal with people in general. To be able to use my clinical experiences in day to day work environment. (From a masters-level graduate.)

Closely following (44%) was the clinical supervision received: participants frequently mentioned the live, individual, and group supervision formats specifically. As one masters-level graduate shared:

My supervision...taught me about myself and how to look at myself in the therapy process. I enjoyed the peer supervision as well as the supervision from my professors.

Other graduates mentioned specific clinical skills they had obtained through their training, such as helping and listening skills, the ability to not become “sucked in” to a client system, and communication skills.

Maintaining an appropriate therapeutic position in working with families such as staying neutral, balanced, and not getting “sucked in.” (Masters-level graduate.)

A handful of doctoral-level graduates (5.6% of all participants) mentioned their supervision of supervision training, and approximately the same amount of masters graduates cited the experience they gained with a specific therapeutic format (i.e., family therapy, groups) or population (i.e., couples, families). The remaining themes mentioned aspects of training such as the ability to generalize therapy skills to other settings and the opportunity to observe other therapists at work.

Didactic clinical training. Approximately one-third of graduates specifically cited working within a systems perspective/theory as one of the most relevant and useful aspects of their training (32%). One graduate mentioned,

Learning how systems work has truly helped to give me a way to examine problems and help families achieve their goals.

A doctoral-level graduate expanded this usefulness in a broader way:

[Most useful was the] ability to apply a systemic understanding of human behavior in various contexts, not just marriage and family.

Other aspects of didactic training reported as most relevant included the broad range of therapy models, theories, and techniques taught, specific theories (i.e., narrative, brief, structural), ethical and legal issues, DSM diagnosis training, and other aspects such as workshops, systemic assessment, MFT literature, and the texts used in the program. One doctoral-level graduate answered,

On a general level, the coursework associated with the MFT degree has provided both a context and a language to think about families and relationships.

Some masters-level graduates mentioned specific theories:

Training in brief approaches to therapy has been a great help. I am limited in how many times I can see clients, so I have to be able to pack a powerful “punch” in a few sessions.

Professional development/training (32.8%). Graduates also reported aspects of general professional development, including the opportunity to network and to make professional

contacts, teaching experience obtained, faculty mentoring and expertise, developing writing skills, developing the ability to continue learning after graduation, the Ph.D. designation obtained, how to deal with academic politics, and the practical work experience obtained. Examples of this theme are as follows:

[Most useful were] relationships with other grad students and professors which helped teach much about boundaries and conceptualization of treatment with clients. (Masters-level graduate.)

It is helpful, as a professional in the field, to have personal connections with the faculty at the graduate school I attended. (Doctoral-level graduate.)

Team orientation — the ability to work with other professionals — strong focus of my program. (Doctoral-level graduate.)

Research (12%). Participants mentioned the knowledge of research methods or their thesis/dissertation experience as being one of the most relevant/useful aspects of their MFT training. Most of the participants who responded in this area were working in academic/research settings.

Personal development (10.4%). This theme includes personal growth experiences which occurred during training, self of therapist training, and training received in dealing with family of origin issues (10.4%). One participant saw as most useful,

The sheer “doing” of the degree. Learning to “walk through walls.” Learning to persist in the face of unthinking bureaucracy. Learning the self-discipline of self-learning and the self-discipline of learning what others wanted me to learn.

Specific aspects of the MFT training program (8.8%). This themes includes other, more idiosyncratic aspects of participants’ MFT programs such as the existence of a student support group, the program’s emphasis on diversity, the thoroughness/intensity of the program, the use of experiential training techniques and seminar discussion formats, guest speakers, the breadth of knowledge obtained, and the COAMFTE accreditation.

B. Least relevant aspects of MFT training

Table 4 summarizes the themes which emerged from the responses to this question. Six major themes were extracted: research, experiences related to clinical work, didactic coursework, theory, specific aspects of participants’ MFT training programs, and all aspects of the MFT program were relevant.

Table 4: Least Relevant Aspects of MFT Training

Least Relevant	%*
Research	47.2
Experiences related to clinical work	20.0
Didactic coursework	20.0
Theory	15.2
Specific aspects of MFT training program	11.2
All aspects of MFT training program were relevant	21.6

N = 125 participants

* Percents total more than 100 because participants offered more than one answer to this question.

Research (47.2%). Nearly half of the MFT graduate participants mentioned some part of research as being one of the least relevant or useful aspects of their MFT training. This theme includes research methods, statistics, and the thesis/dissertation requirement. In the emphatic words of one masters-level participant,

My thesis [was the least relevant aspect]! I have NO plans to ever do research. It should be an option. It felt like a total hoop jump.

Others were a little more circumspect:

My thesis research. Although this was helpful in developing a more professional writing style and understanding the importance and significance of research, I have used my research skills minimally in my current career.

Experiences related to clinical work (20%). This category includes the actual therapy training received, sex therapy/human sexuality, the internship experience, the MFT program's antagonism toward other mental health disciplines, undesirable supervision processes, testing/assessment training, issues related to private practice (i.e., licensure, practice building strategies), DSM training, not emphasizing DSM training enough, and psychopharmacology.

Here are some responses from participants who were categorized in this larger theme:

Sometimes, when one of us had an opinion about a case, it seemed that we all fell into the habit of trying to deconstruct the opinion – you know – dig for the bias, expose the subjectivity. There's only so much of that kind of thing that makes one a skilled therapist.

Another doctoral-level graduate states,

Oddly, the actual therapy training has been the least relevant. I've learned far more about doing therapy from attending workshops and conferences and intensives, and from colleagues, than I learned in any therapy class. I guess the therapy theory and technique classes gave me a good starting point for using

language that other MFTs use, but I do not do therapy in any of the ways I was taught in my graduate program.

“Traditional MFT” approach to de-emphasizing the DSM-IV and integration with other mental health and medical systems. The goal being not to pathologize, but [the] result for me was to not expose me to a necessary fund of knowledge for my future career work. (Doctoral-level graduate.)

Didactic coursework (20%). This category includes the mention of coursework outside of therapy, redundant coursework, and specific courses such as anthropology, group dynamics, ethnicity/culture, psychology courses, and a Gestalt therapy course. Said one masters-level participant,

[Least relevant was] cultural class which focused on the Hispanic culture but did not teach that even within a certain ethnicity there are significant differences in families’ culture.

Other comments from graduates include:

[Least relevant were] departmental courses in child development and family theory which should have been great but were taught by ancient professors who failed to make the material meaningful and dynamic. (Doctoral-level graduate.)

[Least relevant was] jumping hoops in graduate school, like taking coursework that was irrelevant to MFT. (Doctoral-level graduate.)

Theory (15.2%). Participants reported that their programs included too much emphasis on theory, not enough training on theory-practice integration, or perceived some theories to be irrelevant or lacking in use, such as strategic, feminism, object-relations, solution-focused, structural, and existential. In hearing from three masters-level graduates:

Heavy, heavy emphasis on one theory after another without the interface between theory and interventions. I had a hard time trying to figure out how to apply all those theories in session.

Emphasis on theory rather than practice.

All the theory training without learning 2-3 really well.

Specific aspects of MFT training program (11.2%). This category included faculty/academic politics, too much reading/coursework/lecturing, not enough career/employment information provided, networking, the degree itself, lack of faculty support, and the qualifying examination requirement. Examples of this theme follow:

[Least relevant were] the politics among the students, professors, and between each of the groups. (Masters-level graduate.)

I found the emphasis on professional publication not to be helpful in my independent practice and university teaching. (Doctoral-level graduate.)

All aspects of MFT program were relevant (21.6%). Some graduates specifically stated that all aspects were relevant, while others could not think of any portions of their training which were not relevant. Quoting from one doctoral-level graduate,

Can't think of anything. Either everything was relevant, or I've managed to repress the irrelevant stuff.

C. What was missing from MFT training that should be included

Table 5 provides a summary of the themes categorized from the responses to this question. Responses were somewhat more varied in this area, resulting in nine major themes. These themes included: more information about the marriage and family therapist in the professional marketplace, more training in the use of the DSM and diagnosis procedures, more experience and/or training in specific clinical formats, more training in specific didactic areas, training for handling specific presenting problems and/or diagnostic conditions, training for handling specific client populations, more professional development/training, specific aspects relating to participants' MFT programs, and the belief that nothing was missing.

Table 5: Aspects of Training Missing from MFT Program

<u>What was Missing</u>	<u>%*</u>
Information about MFT in professional marketplace	63.2
Use of DSM/assessment/diagnosis training	28.8
More training in specific clinical formats	28.0
More training in specific didactic areas	24.8
Training for specific problems/conditions	21.6
Training for handling specific clinical populations	13.6
Professional development/training	12.8
Specific aspects of MFT training program	6.4
Nothing was missing/don't know	7.2

N = 125 participants

* Percents total more than 100 because participants offered more than one answer to this question.

Information about the MFT in the professional marketplace (63.2%). This theme occurred frequently throughout the data, and will be discussed later in more detail. Responses in this area included the desire for “Greater emphasis on the ‘business’ aspects of being a therapist – issues related to setting up a private practice, marketing , keeping clinical records,” (17.6%). One

graduate specified that this topic should be “taught by an adjunct who would have experience [in private practice] and not by a full-time faculty [member].”

Other suggestions for MFT program additions in this category include information on career options, employment placement assistance, information on the position of MFTs in the mental health marketplace, licensure issues, how to deal with insurance and/or secure a position on managed care panels, how to deal with paperwork/treatment planning, and more information about legal/malpractice issues. Examples of this sub-theme follow:

[Missing was] a focus on what to expect following graduation in regards to potential job options, areas in which MFTs could be used other than for just clinical practice.

1. A more realistic picture of how many hours would be required upon graduation to become licensed. 2. Options/job opportunities within the range of the degree (such as people and personnel services which only required a few more classes and qualifies the student for several [human resources] and school district positions.

A better view of where the LMFT fits in terms of the marketplace; i.e., the LCSW is far more desirable and they make more money.

The fact that MFTs are not well known and the degree, while excellent (and which better prepares the degree holder for situations which MSWs, etc., never receive the training for), hinders professional progression in a state where basically only social work is recognized. (Masters-level graduate from Idaho.)

More training in DSM use/diagnostic procedures (28.8%). The graduates elucidate their feelings best:

[More was needed on] using the DSM-IV for diagnosis – there was a quick overview in our program, but nothing prepared me for how much a diagnosis is expected and required by other professionals, managed care companies, etc. (masters-level graduate).

A doctoral-level graduate shared her experiences on this issue:

I wish I had had more of an understanding of diagnosis using DSM-IV. MFTs at the time of my training were trying to make a ‘statement’ about moving away from the medical model. I embraced this philosophy, but it left me completely unprepared to work in the real world of agencies and organizations that were funded by insurance and staffed primarily with social workers and psychologists.

More experience/training in specific clinical formats (28%). This theme includes the reported desires for training in the following areas: group therapy, play therapy, individual psychopathology/therapy, mediation, and brief therapy. A masters-level graduate wrote:

We were not required to take group therapy courses and I found this difficult later on.

From a doctoral-level graduate:

[Missing was] training in individual therapy, individual clinical diagnosis, and individual treatment for mental disorders. My training focused on working with couples, families, and other systems.

Some graduates also requested more overall clinical hour requirements, more overall supervision, more focus on self of therapist and personal development, and more opportunities to observe the therapy of others. As an example of this latter suggestion, a masters-level participant wrote,

I wished I had had the opportunity to observe an experienced therapist, or even better, a variety of experienced therapists, rather than observing the cohort ahead of me barely learning how to do therapy themselves. I felt it was the blind leading the blind.

More training in specific didactic areas (24.8%). Participants offering feedback in this category most frequently cited psychopharmacology training as a missing element. In the words of a doctoral-level graduate,

In my program there seemed to be a bias that to acknowledge the value of psychotropic medication was to surrender to the enemy. It is my experience that psychiatric medications can be a powerful adjunct to psychotherapy. Medications certainly do not replace the need for therapy, but the work of the therapist can be greatly enhanced with the use of medication.

Other graduates suggested programs include more therapy theories and/or a more eclectic range of theories, more on parenting and child development, career counseling training, public policy information, administration/management strategies, focus on agency work, school programming, physiology and medical information, financial counseling strategies, human sexuality information, leadership training, and more specific coursework overall. One example was provided by a doctoral-level graduate:

[Missing was] a focused class on child and adolescent therapy that applied developmental theory and play therapy to family treatment.

Training for handling specific presenting problems/diagnostic conditions (21.6%). The training area most frequently cited here was that of chemical dependency/addictions (9.6%).

Other specific areas recommended for MFT training include sexual abuse/dysfunction, depression

and other mood disorders, domestic violence, crisis intervention, eating disorders, family of origin issues, worklife issues, and working with families where multiple mental illness is present. A masters-level graduate offered an example:

Should have had more focus on drug and alcohol therapy to make us more competitive for jobs.

Training for handling specific clinical populations (13.6%), including children and adolescents, ethnically and culturally diverse populations, severe/chronic mental illness, and court-ordered clients.

Not enough on serious mental illness, and ways of working with this population. (Doctoral-level graduate.)

[Missing were] workshops or courses on specific populations and problems; i.e., court-ordered clients, sexual problems, treatment of depression. (Masters-level graduate.)

More professional development/training (12.8%). Some participants expressed the desire for more networking opportunities, more mentoring from faculty, assistance in learning how to deal with the politics of academia, and learning grant-writing. Others wished they'd had more information on continuing development as an employee or mental health professional, more opportunities to teach, to publish research, or to have become involved with AAMFT as a student representative.

Not enough opportunity to work with faculty on research projects and publications. Much more mentoring in the process would have been very helpful. (Doctoral-level graduate.)

Specific aspects of MFT training program (6.4%). A few graduates made specific responses about their training programs. One thought the program should have included more faculty who were trained as MFTs, another wanted more independence in designing the plan of study. Other graduates believed students should be required to receive therapy for themselves. Other aspects included the desire for more time to integrate learning, more support during the qualifying exam experience, more affordable education, an equal emphasis in training for both clinical and academic settings, and the opportunity to utilize a more spiritual perspective during the training experience.

Nothing was missing/don't know what was missing (7.2%). Nine participants responded with this theme.

D. Other aspects of MFT training/career preparation

Participants were asked to respond to a cluster of questions which asked them how well their MFT programs prepared them for (a) their current job, (b) for their career goal (if this goal differed from their current job, and (c) for finding a job. Each of these questions offered a 1-5 Likert-type response option, with the higher number indicating the higher level of perceived preparedness.

Overall, participants viewed their programs as having prepared them fairly well for both their current job and for their career goal. Sixty-six percent of participants answered “well” or “very well” when asked about how well their programs had prepared them for their current job (24.8% answered “adequately,” the remaining 9.1% answered “poorly” or “not at all”). This result was similar to the 69.1% of respondents who answered “well” or “very well” to the “prepared for career goal” question. Participants tended to respond to these two questions in a similar fashion (Pearson $r(106) = .463, p \leq .001$; see Appendix I for a correlation matrix of all continuous variables).

When asked how well their MFT programs prepared them for finding a job, participants were somewhat polarized on their responses: 37.6% felt that they were poorly or not at all prepared for finding a job, 22.4% were adequately prepared, and 36.8% were well or very well prepared.

Participants were also asked to indicate the degree to which AAMFT membership and graduation from a COAMFTE accredited program helped/would help them in securing employment. Half of the participants did not believe that AAMFT membership helped them secure employment ($n = 123$): 49.6% answered “not at all” or “unlikely.” The remainder of the graduates responded equally in the “possibly” and the “probably”/“definitely” categories. Participants who were working in academic settings were most likely to answer this question affirmatively. Those who held doctoral degrees were significantly more likely to view AAMFT membership as positively impacting their employability than were those who completed their education at the masters degree level ($M = .538, t(118) = 2.18, p \leq .05$). This significant relationship did not hold true for employability as it related to graduating from a COAMFTE accredited program.

Regarding graduating from a COAMFTE accredited program and subsequent employability, participants were once again somewhat polarized: 33.6% believed that graduating from an accredited program “not at all” or “unlikely” helped them in securing employment; 17.2% replied “possibly,” and 49.2% replied “probably” or “definitely.”

III. Career Practices and Perspectives

In order to answer the research questions regarding career options for marriage and family therapy program graduates and career advice for MFT trainees from those established in the field, participants responded to another series of questions containing open- and closed-ended response options (see Appendices D and F). These questions asked participants to report their original career goal at the time they entered their MFT program and, if they’d changed their goal, the reasons for doing so. Graduates were also asked to describe their current job(s) and associated duties, to report their condition of satisfaction with their current professional position, and to offer advice to a recent MFT graduate on how to maximize career options. In addition, participants indicated the degree to which they believed career options for MFTs were narrowing, broadening, or staying the same. Along with the themes extracted from the above questions, data obtained from participants regarding income, income type, number of jobs held, and number of hours worked per week will be reported in this section.

A. Original career goal

Career goal areas reported by participants were consistent with the career opportunities found in the literature. Table 6 summarizes these goal areas, the number of graduates who changed their focus, and the number actually working in their originally intended area.

Table 6: Initial Career Goals of MFT Graduates, Number who Changed,
and Number Currently Working in Original Goal Area

Career Goal	<i>n</i>	# Changed	# Working Original Goal
Private practice	63	46	8
Agency setting	22	13	12
Academia*	18	9	8
Academia and private practice	10	5**	5
Hospital setting	4	1	0
Pastoral care/counseling	3	2	2
Adolescent residential	3	1	2
Clinical/supervisory	2	0	2
School setting	2	1	1
Other	3	2	1
TOTALS:	130***	80	41

N = 125 participants
 * = Only doctoral level graduates reported academia as a career goal.
 ** = Only masters level graduates changed their combined private practice/academia goal.
 *** = 5 participants reported more than one career goal.

At the time they entered their MFT graduate programs, one-half of participants (50.4%) listed their career goal as private practice. Other goals, listed from most to least frequently cited, include working in an agency setting, academia (doctoral graduates only), a combination of academia and private practice, work in a hospital setting, pastoral care/counseling, adolescent residential treatment, clinical/supervisory position, school setting, and other settings such as behavioral medicine and family life education. On the average, half of the participants reported changing their original career goal with the exception of those who cited private practice as their goal: Sometime during or after their MFT training, 73% of these participants changed their mind about entering private practice.

B. Reasons for changing career goal

Overall, 64% of MFT graduates changed their career goal after entering their MFT graduate program(s). In the themes outlined below which categorize the reasons participants cited for changing their original goals, percent totals are more than 100 because many participants offered more than one reason for change. Table 7 summarizes the themes below.

Table 7: Reasons for Changing Career Goal

Reason	%*
Managed care/insurance/licensure issues	44.7
Interests/professional focus changed	40.8
Financial/security issues	32.9
Specific requirements/elements of private practice	26.3
Specific requirements/elements of academia	15.8
Other elements	15.8

N = 76 participants

* = Percents total over 100 because respondents gave more than one reason for changing careers.

Managed care/insurance/licensure issues (44.7%). This theme was echoed by those who primarily reported private practice or agency work as their original career goal. Issues cited for changing career goals include the requirement of dealing with managed care companies, MFTs not being able to get on insurance panels/reimbursed, agencies wouldn't hire MFTs, participants would need to obtain a clinical license or an additional license, and a lack of training in working with managed care. Examples of this theme follow:

Decided to remain in government employment due to 4 developments: impact of managed care, cost in time and money to pursue LPC and lack of support for MFT degree holders in pursuing this endeavor. Financial cost of switching careers... (Masters-level graduate.)

I saw that managed care affected the practice of MFTs and decided to pursue the path of obtaining a doctorate in clinical psychology. (Doctoral-level graduate.)

Most private practice therapists were unable to take on anyone else; also the fact that the MFT designation is not desirable in terms of insurance meant looking at community mental health for a job. (Masters-level graduate.)

Interests/professional focus changed (40.8%). This category includes participants who enjoyed a job other than their original career goal, raising children became a priority, and those who accomplished their goal and set a different career goal. Some examples of this theme include:

I enjoyed administration and supervision and disliked the managed care aspect of private practice work. I enjoy multitasking and having each day be different. (From a masters-level graduate.)

The more I did therapy, the more I realized that what I really wanted to do was teach...I noticed that during counseling, I eagerly looked for any opportunity to “go to the white board” and diagram something visually. I think it was in me all the time, it just took awhile to come out... (Doctoral-level graduate.)

I found outpatient work was not interesting enough for me. I did home based counseling for two years...and got burned out from the amount of hours I worked...I can't do private practice because I am not yet licensed...so, I am a foster care worker for the county that I live in...I love it! (Masters-level graduate.)

I had two children and had the option of staying home...feeling the most important job was parenting my small children. (Masters-level graduate.)

Financial/security issues (32.9%). This category included many of those participants citing private practice and/or agency settings as their original goal. These graduates were looking for more money/opportunity/benefits, believed they couldn't make enough money working in the goal area, wanted more job security, and/or experienced funding problems with the agency where they worked.

The time needed to begin a private practice was too long...I felt I needed a predictable, steady income...I was not comfortable with the unpredictability of income from private practice (i.e., ebb and flow of clients), and with the need to pay office expenses. (Masters-level graduate.)

I recently decided to pursue the Program Coordinator side of mental health...[due to] the change in the industry; specifically the arrival of HMOs which resulted in a change in the method and amount of payment we receive from insurance companies. With the reduction of pay (going from 80%/20% split to flat lowered rates), I decided that it would be more stable to work for an agency and to get benefits too. (Masters-level graduate.)

Specific requirements/elements of private practice (26.3%). This category applies only to those who cited private practice as their original goal. These participants held the opinion that too much work is required in setting up a private practice (i.e., working too many hours for limited financial gain), not enough opportunity for private practice exists, possessed a fear of/realized burnout, wanted more variety, lacked confidence in therapeutic abilities, didn't like business aspect of private practice, and/or believed private practice was too isolated.

After having worked in an agency and talked with many people in private practice, I am not as anxious to have to drum up my own clients. It is much easier to have the agency draw in the clients. (Masters-level graduate.)

Individuals in private practice seem to be working more and more hours for less and less pay. (Doctoral-level graduate.)

Specific requirements/elements of academia (15.8%). This category applies only to those citing academia as their goal. Some participants found that they didn't like doing research. Others believed that academia had too few jobs for white males. Other explanations included graduates feeling disillusioned due to graduate school experiences/academia politics, lacking mobility for finding academic jobs, and lacking confidence in their therapeutic abilities.

I love teaching...I even enjoy most of the research process. However, between the 1) spectre of "publish or perish," 2) the field of MFT academe being glutted with white males when there is a strong push for females and minorities by COAMFTE, and 3) negative interactions with faculty disillusioned me from an academic lifestyle, [I changed my career goal.] (Doctoral-level graduate.)

As I learned more about the academic world, and its emphasis on sociostatistical research...[and] after completing a theoretical dissertation, I realized that I enjoyed being a therapist more than publishing research. (Doctoral-level graduate.)

Other elements (15.8%). Additional graduates reported career goal changes for reasons such as wanting more flexibility, wanting more control/decision-making ability, wanting to give more to community, desiring a more spiritual direction, and one graduate developed a chronic illness which affected her ability to work full-time.

C. Current professional position

Table 8 provides a summary of graduates' current professional positions. The largest group of participants was working in a clinical for-profit or non-profit agency setting (20.8%). These settings included mental health agencies, employee assistance programs, chemical dependency or adolescent residential treatment centers, forensic settings such as agencies helping sexually abused children, and foster care settings. Another portion of the sample (16%) worked in an administrative or supervisory capacity within these types of agencies, and also in state or non-profit foundation administrative positions. Other career practice areas included private or group practice (16.0%), academic setting (14.4%), school setting (8.8%), pastoral or pastoral counselors (4.8%), in-home therapists (4%), those who combined academia and private practice (4.0%), and medical settings (2.4%). A few female participants were currently working in the home full time raising their children (3.2%).

Table 8: Current Professional Position

Position	<i>n</i>	%*
Clinical agency setting	26	20.8
Agency or other administration	20	16.0
Private/group practice	20	16.0
Academia	18	14.4
School/university setting	11	8.8
Pastor/pastoral counselor	6	4.8
In-home/family preservation	5	4.0
Combination academia/private practice	5	4.0
Homemaker/mother	4	3.2
Medical setting	3	2.4
Other	11	8.9

N = 125 participants
 * = Percents total more than 100 because some participants reported more than one professional position.

Approximately 9% of the participants were working in areas outside of those provided by their family therapy training. These graduates' job titles included: medical electrolygist, creative writing instructor, financial compliance specialist, freelance writer, software consultant/developer, government career counselor, agency fundraiser, construction company CEO/executive coach, real estate broker, and part-time yoga instructor.

D. Income, Number of Jobs, Number of Hours Worked Per Week

Table 9 summarizes the annual income reported by graduates. The average annual income for MFT graduates in this sample was approximately \$45,000. Men in this sample reported significantly more money than the women, with an average salary of \$52,830 compared to the women's annual income of \$39,690 ($\underline{M} = \$13,140$, $t(116) = 3.44$, $p \leq .001$). Men also worked more jobs, for more total hours per week, and were more likely than women to hold doctoral degrees ($\phi = .345$, $p \leq .001$). These factors may account in part for the significantly greater income of men.

A difference was also noted in the annual income of graduates with masters degrees versus those with doctoral degrees. The doctoral-level graduates reported significantly greater income than the masters-level graduates: \$52,661 and \$36,642, respectively ($\underline{M} = \$16,020$, $t(113) = 4.34$, $p \leq .001$).

Table 9: Annual Income

Annual Income		Average Annual Income	
<u>Range in dollars</u>	<u><i>n</i></u>	For all participants:	\$44,924.
0. - 10,000.	7	For masters level participants:	\$36,642.*
11,000. - 20,000.	7	For doctoral level participants:	\$52,661.*
21,000. - 30,000.	9		
31,000. - 40,000.	33	For women:	\$39,690.**
41,000. - 50,000.	29	For men:	\$52,830.**
51,000. - 60,000.	11		
61,000. - 70,000.	8		
71,000. - 80,000.	5		
81,000. - 90,000.	5		
91,000. - 100,000.	3		
Over 100,000.	1		
<u>Did not answer</u>	<u>7</u>		
TOTAL	125		

* $\underline{M} = \$16,020$, $t(113) = 4.34$, $p \leq .001$
** $\underline{M} = \$13,140$, $t(116) = 3.44$, $p \leq .001$

The MFT graduates in this sample worked an average of 40 hours per week (sd = 14.2, range 0-70 hours); 38% worked at 2 or more places of employment (overall range 0-4 jobs). Along with significantly greater income, men worked a significantly greater number of hours per week ($\underline{M} = 11.12$, $t(122) = 4.56$, $p \leq .001$). Regarding differences between graduates with masters and doctoral degrees: In addition to making significantly greater income, doctoral-level graduates worked more hours per week and at a greater number of places of employment than did masters-level graduates (\underline{M} hrs. per week = 8.31, $t(119) = 3.34$, $p \leq .001$; \underline{M} number of jobs = .35, $t(119)=2.62$, $p \leq .01$).

Income type. Most participants reported that their annual income shared the financial burden of the household (59.7%). Approximately one-quarter of participants provided sole income (26.6%), 10.5% provided secondary income (mostly women), and 3.2% reported no monetary income.

E. Level of Satisfaction with Current Professional Position

Overall, 71.8% of MFT graduates reported satisfaction with their current professional positions; 25.8% reported dissatisfaction, and 2.4% indicated the question was not applicable. Of

those reporting dissatisfaction, the largest reason given was the desire for a different overall professional focus, such as more or less clinical work, desire to be in a corporate setting, and other alternate foci. Others desired a different clinical focus, more money/job security/control, more teaching opportunities, or preferred to stay in the same line of work but at an alternate location. Percentages are given in Table 10.

Table 10: Reasons Given for Participants Reporting
Dissatisfaction with Current Professional Position

Reason Given	%*
Would like a different professional focus	43.8
Would like a different clinical focus	21.9
Would like more money, control, job security	21.9
Would like more teaching opportunities	12.5
Would like same line of work, different location	6.3

N = 32 participants
 * = Percents total more than 100 because some participants reported more than one reason for dissatisfaction with their current position.

G. Career opportunities for MFTs

Participants responded about evenly when asked the extent to which career opportunities for MFTs are narrowing (29%), broadening (34.7%), or staying the same (36.3%). No significant difference was observed when the responses were analyzed along the lines of gender and degree level. Some graduates qualified their responses. The following are examples of qualifying statements made after participants answered this question:

Career options are narrowing because social work has a larger lobby and greater recognition.

Narrowing in traditional provision of therapy work due to reduction in reimbursement for mental health services and restrictions due to licensure. Broadening in a less traditional sense — incorporating into medical health settings, organizational consulting, etc.

I would say broadening, but VERY slowly, due to licensing stuff and getting the information about our degree out there. People don't know the difference and why MFTs are better than most MSWs.

H. Advice to MFT graduates on maximizing career options

Participants were asked to offer advice to an MFT graduate asking how to expand his/her career opportunities. Once again, responses varied considerably. Participants demonstrated a tendency to offer advice related to the career path each had taken, rather than offering advice on maximizing general career options. Results were categorized along seven different themes; these included issues relating to the MFT in the current mental health marketplace, developing an area of interest and/or expertise, preparation during training experience, specific skill development areas, continuing education/development, professional development, and advice given for specific career areas. A few participants (3.2%) were unsure what to advise or did not answer this question. Table 11 summarizes the themes presented below.

Table 11: Participants' Advice to MFT Graduates on Maximizing Career Options

Category of Advice	%*
Issues relating to the MFT in the current mental health marketplace	82.4
Develop area of interest/expertise	43.2
Use in-school resources to prepare	42.4
Develop specific skill areas	33.6
Obtain continuing education/development	30.4
Continue professional development activities	24.0
Advice given for specific career areas	10.4
Did not know/did not answer	3.2

N = 125 participants

* = Percents total more than 100 because participants offered advice in more than one category.

Issues relating to the MFT in the current mental health marketplace (82.4%). Graduates recommended that MFT trainees should be flexible in one's worldview/therapeutic approach, find out state licensure existence/requirements in advance and practice in a state with MFT licensure, be prepared to work in multidisciplinary settings, and learn to work with managed care. They also suggested that MFTs understand the political limitations/implications of having an MFT degree, know the local/state market and identify the competition (i.e., MSWs, LPCs, etc.), know career options, be willing to move to the east or west coast, have pride in being an MFT/avoid pressure to conform to other mental health paradigms, be willing to start working for lower pay in order to get practical experience when starting out, and some offered specific job search/interviewing techniques. Examples of this theme follow:

Be FLEXIBLE and open to various opportunities. Stretching outside of the “typical” MFT career zone can add depth and breadth to your skills AND your resume. (Masters-level graduate.)

Check out licensing requirements in the state he/she wants to work in. Find out how insurance companies view MFTs. Be clear on what kind of setting you want to work in and make sure an MFT fits in this type of setting. Be clear on licensing requirements so there are no surprises. (Doctoral-level graduate.)

He or she should know how to really advocate why MFTs are better suited for a job. As I interviewed I would run into many people who did not know what an MFT was. I would end up spending many interviews explaining what I was trained in and why it is so relevant to a job. Also, be prepared to apply for jobs that ask for social workers, he or she will not see many MFT jobs listed. (Masters-level graduate.)

A larger sub-theme was also contained in this overall theme: 26.4% of all participants recommended an alternate or additional degree, license, or occupation.

Develop area of interest/expertise (43.2%). This theme also contained a major sub-theme: 22.4% of all participants advised specific niche areas in which to develop expertise (chemical dependency, systems consultation, etc.). Others recommended simply to find a niche area, to obtain clinical experience in an area of interest, and to talk to other professionals who are already working in the area of interest.

Obtain a specialty, a niche. Also obtain various other, less time-consuming practices to prevent burnout from the above-mentioned specialty. If the choice is conducted in a competent manner, managed care will not be a factor. (Doctoral-level graduate.)

Follow your interests wholeheartedly. Open doors for yourself by visiting those who have made strides in your areas of interest. Learn from their experience and try out a related project on your own, just because you enjoy it. When you later seek employment, you will truly KNOW a particular area well and will have a specialty to offer either an academic department or a community. (Doctoral-level graduate.)

In-school preparation (42.4%). Participants also recommended that MFT trainees take advantage of their opportunity to maximize learning during their MFT programs. Graduates suggested that MFTs obtain broad clinical experience, maximize the value of clinical internships, take business and marketing classes, develop mentor relationships with faculty or other professionals, prepare through program coursework, receive therapy to address personal issues, and select an accredited MFT program which matches the trainee’s desired professional focus.

Use your internship and practicums widely to get exposure to the field before having to interview for a full-time position. (Doctoral-level graduate.)

Do a good job in your program and internships. Try to expose yourself to as many issues as possible. Take extra courses in the psychology department and health courses; expose yourself to the social work role and philosophy... (Masters-level graduate.)

Skill areas (33.6%). About one-fifth of graduates (20.8%) recommended that MFT trainees obtain specific clinical skills to help prepare for their professional career. Examples of recommended skills include relational skills, learning to work with difficult couples, develop a broad understanding of human behavior, and develop the ability to apply systems theory broadly.

Get specific skills in areas of domestic violence, alcohol use, etc.; specialize in something.... (Masters-level graduate.)

Sex offender work is a growing field that needs MFTs. There is a lot of money going in that direction. Go to specialized trainings. (Masters-level graduate.)

An additional 12.8% of graduates recommended other types of skills, including research skills, paperwork management, writing skills, office and business management, how to develop outcome measures, and teaching skills. Some participants also recommended obtaining fluency in a second language such as Spanish or American Sign Language.

Continuing education/development (30.4%). Respondents suggested that trainees attend to self of therapist issues (13.6%), attend workshops and conferences, keep current in clinical and professional developments, and obtain post-graduation supervision.

Get as much supervision as possible. Follow what is happening in the field: innovative therapy, trends in health care, legislative actions. (Masters-level graduate.)

Professional development (24%). Graduates also advised that elements of continued professional development be attended to, including network opportunities, involvement in professional organizations, remaining focused on helping people, involvement in the community, becoming an approved supervisor, being realistic/deciding how much money one wants to make, and creating opportunities to collaborate and consult.

...network — be real; don't focus on your career but building bridges to people...stay in touch with your previous faculty and utilize their wisdom... (Doctoral-level graduate.)

Get involved in...state MFT organization(s) to maximize networking opportunities. (Masters-level graduate.)

Advice for specific career areas (10.4%). Advice was offered to MFT graduates intending to pursue careers in private practice and in academia. Any MFT graduate planning on going into private practice was advised to know how to market, to be prepared to work more than one job while getting established, to conduct market analysis prior to setting up the practice, and to know how to write a business plan and obtain legal assistance. Those intending to pursue an academic line of work were advised to publish while still in school and to practice doing research with minimal assistance from others.

An excellent and very thorough passage of advice was offered by a doctoral-level graduate. It is included here in its entirety as an example of the many themes and sub-themes which comprised this section:

Actively seek out excellent mentors. Look beyond the discipline of MFT and the AAMFT organization if needed to meet career goals and to receive additional training. Consider doing post-doc fellowship work in a specialized area of interest. Be a strong advocate for yourself within your program. Find mutually supportive colleagues. Read the literature — including literature outside of traditional MFT. Expose yourself to diverse clinical populations and problems. Learn to be culturally sensitive and competent. Build relationships with your professional collaborators similar to the families with whom you work. Find ways to keep connected to the spirit of the work and the people with whom you work. Practice what you preach. Take at least as good care of yourself as you encourage your clients/families to take care of themselves.

Try not to limit yourself to the traditional discipline of MFT. Look for other creative opportunities to be a systems consultant in other settings. This might mean learning new skills that aren't emphasized in traditional MFT programs — how to “really” use the DSM-IV and to work with insurance providers as well as other healthcare system professionals. Learn the community in which you plan to live and work — find out the specific needs of the families and be open to their ideas for solutions and recommendations for their needs. Find collaborators and mentors in various disciplines (not only mental health — but public service, health care, religion/spirituality, the law, schools, etc.). Find ways to build on each others' strengths when working together. Think MUCH more broadly than you ever imagined. Be curious and open.

IV. Larger Themes and Issues Discussed by MFT Graduates

As the analysis of specific questionnaire items was carried out, several themes emerged which transcended each individual item response and pointed toward a few larger issues. These issues involve aspects of MFT training and several issues relating to the condition of marriage and

family therapists in the current mental health and career marketplace. These results were significant not only for their frequency in occurrence, but also for the emotional intensity contained in the participants' comments. Graduates' feelings of frustration, confusion, dismay, and pride in their MFT identities were some of the emotions clearly conveyed as their responses were reviewed. It appears that the MFT graduates who participated in this study felt strongly about many of the issues on which they were asked to provide input.

A. Issues pertaining to MFT training.

Three larger themes related to MFT training emerged during data analysis. These include MFT graduates' desire for assistance in transitioning from the world of MFT training to the "real world," the perceived need for the ability to work with professionals from other disciplines, and a theme which reflects a sort of "MFT elitism" expressed by some graduates.

Transitioning: preparation for the "real world." Graduates often expressed confusion or dismay when discussing their initial exposure to the professional world and their struggle with career opportunities. Some felt that the startling discrepancy they perceived between the training setting and "real world" practice could have been avoided by having more information provided during their MFT program. Most of those who reported their struggle were masters-level graduates. The following are responses from graduates on what their training programs could have done to help them as they left the program:

[Program could have provided] help on finding a job as a family therapist, or learning before the training that my MFT degree would not ever be put to its real use.

Another masters-level graduate writes:

More attention could have been paid to the licensing requirements of different states...in short, the practical realities that are facing masters level clinicians. It wasn't until I graduated and tried to find a job that I learned my MA degree was not reimbursable in my state.

From another masters-level graduate:

My friends who have graduated struggled in finding a job as well. I wish I would have known that...or understood it...before embarking in the program. I...think that I have excellent training, but applying out there in the 'real world' and convincing people of its worth has been difficult!

From a doctoral-level graduate:

I would...encourage programs to teach the students about the “real world:” how working in this field will have an impact on your personal life.

This masters-level MFT graduate went on to earn a doctoral degree in a different major in order to expand her career options:

I wish my training had done a better job of preparing me for the brutal unemployment I would face in certain states. So many agencies would not hire me because I was not reimbursable by insurance.

Another doctoral-level MFT focused MFT program assistance toward the internship experiences:

I think as a field, we need to take more responsibility to nurture new students and graduates into diverse clinical settings. There is such a lack of internship sites and post-doctoral opportunities that our trainees are needing to create many opportunities themselves, and the supervision and mentoring is sometimes suboptimal.

Preparation for working in interdisciplinary settings. Graduates emphasized the importance of being prepared to work with professionals trained in other disciplines. Examples of this include:

We have focused too little on interfacing with other professionals and ignoring the broader health care field.

Another participant emphasized:

It would be important for [MFT graduates] to be trained in working with professionals in other disciplines...such as knowing their mandates for treating children and families to build more collaborative working relationships to better serve clients.

One graduate cited the benefits interdisciplinary training would have had on her ability to interact with other professionals:

In retrospect, I see even more value in working with multiple professors and from multiple theoretical perspectives than I did during my training. I function as part of a Multidisciplinary Trauma Team with social workers, law enforcement officers, and attorneys...groups of people who frequently don't think like therapists!

MFT elitism. A subtler theme emerged during data analysis which demonstrated an attitude of “elitism,” or the belief that MFTs are superior to the exclusion of all other mental health approaches . One example of this attitude was offered by a doctoral-level graduate who said,

Be proud of yourself as an MFT and don't ‘sell out’ by trying to pass as something else.

Other graduates were also aware of this attitude but cautioned against it:

At the time that I trained there was a defensive need among family people to see systems work as the only legitimate way to be helpful to a family; professional counseling and individual work was discounted as “less than” systems therapy. The need for sort of an ethnocentric elitism was not helpful to me in learning to work beside other family professionals with different educational backgrounds, and different cultures. It is taking us a long time to truly be more pluralistic, even though we are giving much better lip service to multiculturalism, and accepting that there are lots of ways to be helpful to families.

Another participant echoed the experience of the graduate above:

I would...encourage the student to resist being painted into a corner by the hubris present in many MFT perspectives. While in many ways I think MFT thought is superior, alienating oneself in order to remain faithful to a particular mental health perspective will neither help a person find gainful employment nor maintain it.

Another doctoral-level graduate wrote:

My own MFT training was often a polemic against traditional mental health practices. While some of this antagonism may have been understandable, I think that the extent to which it biased my opinions was unhelpful. Because I simply accepted the authority of the instructors, it took awhile for me to learn and appreciate the perspectives of the traditional mental health approaches. Furthermore, I don't see these perspectives as having to be mutually exclusive.

B. The MFT in the current mental health marketplace

The most pervasive series of larger themes found in the data were issues relating to the position of marriage and family therapists in the current mental health marketplace. Four major themes were extracted in this area. They include issues relating to managed care and insurance reimbursement, the lack of respect and recognition many MFT graduates experience once they are seeking employment, the belief that graduates would have better career positioning if they obtained an alternate or additional degree and/or clinical license, and a dissatisfaction with AAMFT. Participants who elucidated these thoughts were graduates from both masters and doctoral programs; primarily those involved in private practice, agency, agency administration, and other clinically-related jobs.

Managed care and reimbursement. Included in this theme were reports of graduates not able to obtain a position on any or few insurance provider lists because these lists are “closed” to MFTs. Others report having to work far more hours and see many more clients in order to keep the same income they had before managed care came into the picture. Many graduates cited

managed care as one of the primary reasons they decided to get out of private practice or not pursue that goal in the first place. The following participants summarized these issues well:

I think that the MFT field needs to address issues relating to reimbursement, and diagnoses which will be reimbursable. Also effective ways of dealing with HMO and PPO and approved provider lists. These are so often “closed,” especially to MFTs...it is not a level, or fair, playing field.

A masters level graduate expressed the frustration experienced by many graduates in the sample:

Private practice was viable for awhile, but in Tennessee 80% are covered by managed care, the state contract does not include MFTs as acceptable providers, and managed care provider lists are “closed” to all new providers....Agencies are dominated by social workers and LPCs and do not recognize MFTs...My private practice is very low and essentially does not cover the rent and expenses in some months...Private pay is small because so many people have managed care coverage and can only pay \$10 a session. I have worked for a while at “K-Mart wages” but feel I have to get established in a [different] part time or full time career...

Lack of respect for/recognition of MFTs. Participants also reported their feelings of being devalued when compared to other mental health disciplines. This devaluation not only limited participants’ career opportunities, it seemed to contribute to a sense of impotence and frustration among MFT graduates. One doctoral-level graduate writes,

MFTs are not established as recognized providers of service. Consequently, the options available to us are diminished. I wish I had a better understanding of this prior to embarking upon my education.

A masters-level graduate agrees:

There is a strong bias against MFTs in the professional community — those that manage care, those that run hospitals, and mental health, and social service agencies...the irony is that this is not necessarily because of our training but because it is an excuse to reduce access and therefore cost.

Another graduate perceives that the lack of national credentialing standards contributes to the lack of recognition of and respect for marriage and family therapists:

I think the MFT profession should not have given up accreditation to the states. The state laws are not well-administered, and water down the requirements... The training program itself was very active in maintaining high standards and in giving me a great education. What we do not do is claim our position in the insurance area, in agency work, etc....Where there is no [accredited MFT] program, the profession suffers. I think we are well prepared...but we do not get the jobs, the same level of pay, or level of responsibilities because the service system does not recognize us as viable providers. We also do not have the respect of the

psychiatrists and psychologists as colleagues, though they are now trying to learn what we know so they can have more impact with clients.

Obtain an alternate degree/license. A large number of graduates advocated earning a mental health degree other than MFT along with the license associated with that degree in order to maximize job opportunities and reimbursement. About half those who recommended this course of action recommended obtaining dual degree or licensure, with the MFT emphasis being one of the two. Masters level graduates tended to specifically recommend the social work degree and LCSW license, while doctoral-level graduates recommended psychology or counseling degrees along with the associated licenses. In the words of the participants themselves,

I have struggled throughout my career...often feeling that I may have been much better off with a Social Work degree. It seems to be more accepted and widely known.

Get MFT training in a Clinical Psychology or MSW/DSW program. The professional status of a Ph.D. in MFT is on a par both in pay and prestige with an LPC outside an academic setting

You will need an MSW or Ph.D. to get paid a decent salary to practice family therapy.

An LCSW is still a much more marketable degree even if that LCSW is a terrible therapist.

Dissatisfaction with AAMFT. Related to the issues discussed above was a feeling that AAMFT could or should somehow be doing more to impact the position of MFTs in the marketplace. Some view AAMFT as refusing to represent the nation as a whole; others view AAMFT as being “apathetic” toward seeing through legislation which would give MFTs equal vendorship with other mental health disciplines. A few graduates mentioned the “disorganization” of AAMFT. This quote from a doctoral-level graduate summarizes many of the expressed feelings about the MFT profession’s national organization:

It would be my desire to see MFT doctoral training programs be allowed to focus on what they have strengths in rather than having AAMFT require that certain politically correct theories be taught. I think that AAMFT could do more to promote the difference of MFTs in the work place and promote the field in general. I see the field of MFT as losing ground and one in which jobs will become harder to get and the pay will be lower.

C. Positive Experiences of MFT Graduates

Not all participants held the views of frustration or dissatisfaction that were expressed above. A few shared their feelings about their experiences in their training and also when working with other MFTs:

I believe I had an excellent education and I am grateful for the training and opportunities I was provided with. I want to train future MFTs who are proud of their MFT identity and are committed to systemic thinking and practice.

A supervisor who employs many MFTs in a residential treatment facility reported,

MFTs are remarkably well-suited to work in a therapeutic milieu, as compared with therapists trained in other disciplines. The MFTs adapt quickly to working as a member of a team. They seem to more readily recognize their place in the treatment process, and they more adequately utilize other elements of the milieu in meeting their treatment goals.

V. SUMMARY

Many elements of the data collected have been reviewed in this section. A great deal of information was obtained regarding the training paths and perspectives as well as the career practices and perspectives of MFT program graduates. Tables were provided to offer assistance in presenting summaries of the information. The following section is provided to place the data gathered into a more useful context, integrating previous literature and research with the findings of this study.

CHAPTER 5

DISCUSSION

The results of this project provide a fundamental set of answers to the research questions which prompted this study, namely: What career options are available to graduates of COAMFTE-accredited marriage and family therapy programs? How do MFTs in the professional world perceive the relevance and usefulness of their training as it pertains to their chosen career? In light of their professional experience, what advice would these graduates give to current MFT trainees about developing a career?

The theoretical lens of phenomenology was applied to view the data generated by participants' responses. Supporting this theoretical perspective, MFT graduates in this study applied many diverse meanings to their training and career experiences. As tends to be the case in research of this type, some meanings and experiences contradicted one another while others clustered to form dominant themes. A few of these themes arched across many topics covered by the questionnaire; through this pattern, larger groups of meaning emerge for discussion.

The information gathered in this study provides educational/training background, offers perspectives on training, reports career practices, and gathers advice on maximizing career options from the 125 marriage and family therapy program graduates who participated. This chapter will proceed with a summary of the major research findings and an integration of these findings with existing literature. Challenges facing the marriage and family therapist in the professional marketplace are then highlighted. Recommendations for MFT training will be offered, and the chapter will close with a discussion about the limitations of this research and suggestions for future research.

Summary of Major Research Findings

Educational/training background. No prior research was found which delineates the educational and training progression of MFT graduates. Based on the results of this study, in addition to masters and/or doctoral specializations in marriage and family therapy, MFTs hold graduate degrees in a few other major areas, including psychology, counseling, family studies/human development specializations, and ministry. Many graduates seek additional training experiences after graduation in the form of postdoctoral fellowships, professional conferences and

workshops, and certification programs. About two-thirds of respondents are currently members of AAMFT, and three-quarters possess a current professional license of some kind.

Training perspectives. Regarding their MFT training, graduates reported training aspects they believed to be most relevant/useful, least relevant/useful, and missing from their training when they related these experiences to their professional career. Although not all graduates assigned meaning about their training by reporting these aspects in terms of specific skill sets, many of the skills and aspects which were reported fit those outlined by Nelson and Johnson (1999) in the Basic Skills Evaluation Device (BSED). Participants' cited responses which fit all five BSED categories: Conceptual skills, including knowledge of therapy models and theories, using a systems perspective, and self of therapist issues; Perceptual skills, which included the ability to recognize client processes and form hypotheses; and Executive skills, which involved therapy skills such as assessment, joining, communication skills, and session management. Many graduates also mentioned aspects of the Professional Skills category, such as supervision, ethical and legal issues, learning to manage paperwork, and professional image and conduct. Graduates did not specifically mention Evaluation Skills, but in assigning meaning to aspects of training into most useful, least useful, and missing aspects, graduates demonstrated the ability to evaluate aspects of themselves, their therapeutic abilities, and their MFT training (Nelson & Johnson, 1999).

In a review of the MFT literature, no other study was found which asked marriage and family therapy graduates to report the most and least useful aspects of their training. Hines (1996) did ask MFT graduates to report areas in which they desired further training, but the focus of this research was narrowed to include only desired clinical training. The present study is the first to inquire about any aspect of training MFT graduates felt was missing from their program. Among the most relevant and useful aspects of training reported by graduates were experiences related to their clinical work, their didactic clinical training/coursework, and the professional development training they received. Some of the least relevant and useful training aspects reported included research training, specific experiences related to clinical work, and some of the didactic coursework required. The vast majority of MFT graduates believed that they were not given enough information about issues relating to the MFT in the current professional marketplace. This finding supports the assertions made by Patterson et al. (1997) and by Plante

(1996, 1998) that many MFT trainees travel through their training program oblivious to the changes managed care has wrought on the mental health field. Other aspects of training believed to have been missing were more intensive training in diagnosis and use of the DSM and in specific didactic areas. Supporting findings in the Hines (1996) survey, graduates also desired additional training for handling specific presenting problems, diagnostic conditions, and clinical formats, including: working with children, adolescents, groups, chemical dependency, domestic violence, and sexual abuse.

The fact that graduates in this study reported DSM and diagnosis training as being another aspect largely missing from their MFT programs differs from that reported by Hines (1996). In the Hines study, doctoral level graduates reported that they would prefer less DSM emphasis. In the present study, both masters and doctoral level graduates reported that DSM and diagnosis experience were necessary and useful aspects of their professional work; those who were not as familiar with these skills felt a professional disadvantage. The differing results may be accounted for by noting that Hines collected his survey data in 1988, largely before the impact of managed care was felt on the mental health practice arena. This finding illustrates one example of the changing world of mental health and quite possibly, a shift in the evolution of MFT as a profession.

Overall, two-thirds of participants feel their training prepared them well or very well for their current job and for their career goal. This finding is consistent with a similar study of MFT graduates by Hines (1996), who reported that participants in his study also felt “sufficiently well prepared” to engage in clinical practice. Given this finding, one might wonder how we should interpret the complaints contained in the data. The area of the questionnaire which elicited this information confined participants to closed-ended, Likert-type responses. What remains unknown are the meanings behind the answers of “well” or “very well.” Those therapists working in a clinical area should, based on the curricula of their accredited programs, be sufficiently prepared to perform as therapists. The complaint areas however, appear to reflect MFT graduates’ lack of preparedness to negotiate the larger career context of the mental health marketplace.

Career practices and perspectives. As previously reported by Patterson et al. (1997) and Plante (1996,1998), participants in this sample also most frequently cited private practice as their original career goal. Most participants changed their goal of private practice, which supports the

belief of Patterson et al. (1997) that the goal of private practice may be endangered for MFTs. In this study, the most frequently reported reasons for changing this goal and that of working in an agency setting were issues related to the impact of managed care, insurance reimbursement, and licensure issues. This supports statements made by Tuttle and Ambrose (1999) that the impact of managed care is forcing therapists to re-create their professional goals and styles in order to adapt to a changing marketplace. Other reasons reported by graduates for changing their original career goals include their interests and professional focus changed, and/or issues of finance or job security became a factor.

MFT graduates are employed in many of the areas reported in the literature. They work as therapists and administrators in agencies, for universities as educators and counselors, in private practice, residential treatment centers, pastoral settings, schools, and in medical settings. Again supporting the findings of Hines (1996), masters and doctoral level graduates had some tendency to work in different settings: Masters graduates were more likely to be employed by agencies and schools, while doctoral graduates were more likely to work in academic and combined academic/private practice settings, agency administration, and medical settings. Both types of graduates were equally likely to be working in private practice.

A few career options discussed in the literature review were not largely found in this sample. Only one participant was working in a forensic-type setting (child sexual abuse treatment center). Very few graduates reported working in an EAP setting, and none were employed by a managed care company. At this point, it is unknown whether these graduates applied for work in the above settings and were rejected, or whether they never sought this type of employment in the first place. Future research into MFT experiences and employment relating to managed care settings may clarify the position of the marriage and family therapist in this segment of the marketplace.

A few graduates were also working in areas reported in the literature, but in a broader context. In addition to providing medical family therapy, those graduates who reported working in medical settings also held directorship and teaching positions in medical schools and departments of behavioral medicine (see also Gawinsky, Edwards, & Speice, 1999). Rather than “school consultation” as found during the literature search (see Daw, 1998; Mock, 1998; Silvestri et al., 1996), some participants worked as school employees. Expanding the previously reported

literature on MFT career options in this area, these professional positions included school therapists, administrative positions in residential schools, and a special education coordinator.

Other graduates reported working in fields unrelated to their MFT training, including real estate, computer programming, nursing, finance, and writing. Overall, the most common work setting reported by participants in this study was an agency setting, which differs from that found by Doherty and Simmons (1996), who reported that most AAMFT clinical members they surveyed were working in private practice. Of course, the basis for collecting these two samples was different: It may be that those who hold clinical membership status in AAMFT are more likely to be engaged in private practice; only two-thirds of the present sample were members of any type in AAMFT.

Mean income for MFT graduates in this study was around \$45,000 annually. Masters level graduates earned an average income in the \$30,000s, while doctoral level graduates averaged income in the \$50,000s. Men reported higher income than women, but in this sample it was the men who were more likely to hold doctoral degrees, to work in more than one employment setting, and to work more hours per week. All these factors likely contributed to this income discrepancy. When controlled for type of degree, there was no major difference between men and women in average income, which supports an AAMFT (1999e) finding that women earn 99% of what men earn in the MFT profession.

The investigator found no published research which offered information on the level of career and/or employment satisfaction experienced by MFTs. Most graduates in the present study (72%) were satisfied with their current professional positions. Among those who were not satisfied, the most commonly cited set of reasons related to participants' desire for a different professional focus. No study was found in the literature which contains advice offered to MFT trainees from the graduates who have gone before them. When offering advice to MFT trainees on maximizing their career opportunities, some of the most frequently offered words of wisdom included advice to the trainee on obtaining information about issues in the current mental health marketplace (as in Crane, 1995a, 1995b; Patterson & Scherger, 1995), to develop an area of interest and/or expertise (as in Chismar, 1999, Krauth, 1997a; Tuttle, 1999a, 1999b), and to utilize MFT graduate program resources such as coursework and internships to maximize professional preparation. Based on the advice offered by graduates' retrospect, it appears that the

MFTs in this sample would have taken greater advantage of and initiative in the training provided by their MFT programs had they known what challenges they would face on the other end. It is evident that graduates in this study were forced to negotiate an environment of professional practice which was more political and complex than they had envisioned during their educational process.

Challenges Facing MFTs in the Professional Marketplace

Based on the information gathered in this study, two main challenges are facing marriage and family therapy graduates in the professional marketplace. One challenge is negotiating a managed care dominated clinical practice world. The other involves the “political” ramifications of establishing oneself as an MFT in a marketplace dominated by a variety of other mental health disciplines.

The managed care marketplace. As reported by Tuttle and Ambrose (1999) and throughout this study, it is clear that MFT graduates are feeling the impact of managed care’s presence. More than 60% of participants cited managed care and/or reimbursement issues as a factor in their decision to change their career goal. Given the fact that the responses were open-ended and that managed care was not a specific response option, it is significant that such a large percentage of participants mentioned their managed care experiences.

MFTs reported difficulty obtaining reimbursement from managed care companies and obtaining positions on insurance panels in the first place. While these are issues likely plaguing all mental health practitioners, marriage and family therapists often reported being denied access to limited or “closed” panels due to the lack of recognition the profession experiences. Shields, Wynne, McDaniel, and Gawinsky (1994) refer to this phenomenon as a reflection of the “marginalization” of the marital and family therapy field.

For those MFTs who have obtained managed care panel access or agency work, the pace and process of the work can be remarkable. Many participants engaged in full- or part-time private practice reported they work far more hours and see far more clients in order to make financial ends meet. Others found themselves unable to meet the increasingly frantic pace, and experienced feelings of burnout, or were placed in financial binds by their restricted client load. Still others cite the volumes of paperwork required to access reimbursement sources and to obtain treatment approval and subsequent payment. Many MFTs claimed they were inadequately

prepared for the rigorous demands managed care has brought to a discipline that was once more of a “helping” profession, but now serves as a “hoop-jumping” profession. When they left their MFT training programs, several graduates reported having no understanding of treatment planning procedures, progress-oriented charting, how to become a panel provider, and how to justify the need for continuing mental health care. These are skills which play a large role in the contemporary process of insurance reimbursement for therapeutic services (Crane, 1995a). Based on the data, it is unknown what these graduates meant when they indicated they had “left” their training programs. Some graduates may have been referring to moving on from the didactic portion of their MFT training, while others may have been referring to the completion of their degree, including any internship portion of their training. This distinction will be discussed later in this chapter.

While some authors in the MFT field (i.e., Crane, 1995a, 1995b; Patterson & Scherger, 1995) view managed care as an institution which offers unique opportunities for marriage and family therapists due to their experience with brief therapy and ability to work within a larger system, no participants in this study expressed similar views. MFT training programs which have not already done so may need to review their curriculum and make adjustments to provide more orientation to and/or training in managed care issues. The above findings may, however, allude to a perceived difference between some authors in the MFT field and MFT graduates about what it means to be a marriage and family therapist in the contemporary mental health climate. While some authors (i.e., Crane, 1995a, 1995b; Patterson & Scherger, 1995) promote managed care employment as a potential career option for MFTs, the graduates in this sample may not view these types of options as viable career choices. It is possible that the climate of MFT training either explicitly or implicitly continues to promote those traditional MFT values which shun heavy reliance on diagnosis and identification of a patient. Given the treatment values they may hold, graduates emerging from these programs may not recognize behavioral healthcare as a compatible option. These treatment values may constitute a core component of MFT identity, particularly since they have traditionally distinguished MFTs from other mental health providers. Further research in this area could clarify graduates’ beliefs about what it means to be a marriage and family therapist in the current behavioral healthcare-dominated market.

MFTs marginalized in the marketplace. One may wonder how many marriage and family therapists have had some variation of the following conversation sometime during their careers: The MFT is asked what it is he or she does for a living. With some amount of pride, the MFT responds, “I’m a marriage and family therapist.” The reply?

“Oh, so you’re a psychologist.” (The words “social worker” may be substituted in the professional designation slot.)

Kuehl (1999) reported that it is important for marriage and family therapists to understand the political ramifications of their degree. Based on the information obtained from participants in this study, many have come to understand these ramifications the hard way. Participants frequently reported having been denied a job or admission to an insurance/managed care panel due to having “only” an MFT degree and license. Others reported job interview experiences where they were required to spend a significant portion of the interview explaining what an MFT is and why the profession stands alone from the other mental health disciplines. One participant was “hidden” from the state agency auditors because the auditors wanted her employment terminated due to her lacking an MSW degree. The agency retained the graduate on staff because they valued her work and expertise with families. Some states do not license marriage and family therapists, compounding the problem of insurance and agency recognition.

These graduates are experiencing at first-hand what Shields et al. (1994) call the “marginalization” of family therapy. The authors consider marginalization to be one of the most critical issues facing the marriage and family therapy profession, a field which they maintain is “at a critical, even decisive, turning point in its emergence as a major health care profession,” (p. 118). Shields, Wynne, McDaniel, and Gawinsky believe that with the increase in MFT graduate programs, MFT journals, and MFT organizations and conferences, the profession is becoming self-contained to the point that it has also risked being cut off from the foundational mental health roots which have sustained it. In order to combat the phenomenon of marginalization, Shields et al. recommended increased multidisciplinary research endeavors, increased promotion of MFT as both a profession and an interdisciplinary field, increased clinical training and staff opportunities, and strengthening the reimbursability of the MFT degree and license. Specific recommendations were offered to MFT training programs as well, which are discussed later in this chapter.

Of the many results obtained in this study, the dismay and confusion which emanated from participants' accounts of experiencing this marginalization, this lack of respect and recognition, impacted the investigator most. Most MFT graduates took great pride in their training, often reporting that they believed MFT training and theory to be more rigorous and thorough than the training programs of other mental health disciplines. They could not understand how such quality education and clinical experience was lost on prospective employers or third-party payors. They could not understand how someone in their program did not warn them that this could happen. This sense of "invisibility" was also reported as a dominant theme in a study of factors which contribute to the development of a professional identity in MFT interns by Franklin, Killian, and Targhetta (1999).

Perhaps the attitude of "MFT elitism" mentioned by several graduates in this study is partly to blame for the marginalization of the profession. MFTs take great pride in their training and theoretical perspective. Perhaps by territorializing the family systems approach, we have isolated ourselves in an ivory tower of theoretical thought and clinical practice. Such danger of professional isolation was also highlighted by Shields et al. (1994). Why is it that in their advice to MFT trainees about maximizing their career options, participants wrote phrases such as "it's okay to interact with and learn from therapists from other disciplines." Wherever did these MFT graduates get the idea that it wasn't? Those participants quoted on this topic in the latter part of the Results section suggested that their MFT faculty were responsible for conveying such a notion. Johnson (in press) also points out that this type of elitist dialogue is pervasive in MFT literature.

The American Association for Marriage and Family Therapy also came under fire in this study for not doing enough to promote general knowledge and visibility of the MFT profession. Some participants reported their perception that the organization serves merely as a figurehead which pays only lip-service to a profession which is suffering. These graduates often lived in states with AAMFT chapters, but felt that these state organizations held little power or ability to truly make an impact on state issues such as licensure, reimbursement, and mental health parity laws.

Ironically, all participants who expressed their dissatisfaction with AAMFT were themselves members of the organization. That these AAMFT members somehow saw themselves

as being separate from the organization they criticized points toward an interesting assignment of meaning. Perhaps these graduates are attempting to distinguish AAMFT leaders from the body of members that make up the majority of the organization. Like many clients who present for therapy, it is possible that these graduates perceive the flaws in AAMFT but feel powerless to initiate change. Perhaps there also exist discrete factions in the body of the professional organization of our profession; factions which may possess conflicting agendas about the direction of the profession in the new millennium. Those who lead AAMFT have recently claimed to be engaging in a profession-wide dialogue about the direction of marriage and family therapy. Michael Bowers, executive director of AAMFT, invited all members to examine their contribution to the evolution of the profession:

What role are you playing in the present? What role have you played? What is your definition of the profession's core? How are you helping define and move that core forward? In your work are you role bound, or can you also embrace and honor those who have other roles in the development of the field? (1999, p.3)

From the perspective of graduates participating in this study, it seems evident that the type of dialogue in which AAMFT members are invited to participate is critical to preserving the cohesion and momentum of the profession. Perhaps the AAMFT organization and MFT training programs could provide more information to their members on how to become involved with the professional and political development of the field. Those MFTs who accept such an invitation or challenge may then experience feelings of personal power and ownership of our evolving profession to the point that their complaints and fears may be ameliorated.

Based also on the perspectives of graduates in this study, AAMFT leaders and marriage and family therapy training programs should hope that some of the MFT graduates in this study do not aim their current dialogue toward those who are prospective MFT students. One-quarter of the sample recommended obtaining either an additional or an alternate degree and clinical license to those in MFT. Many stated that if they had the chance to go through their educational process over again, they would not get a degree in MFT, but would make sure they obtained some MFT training. It seems sad that so many graduates believe in the foundational principles and practices of marriage and family therapy, but feel trapped in the profession. This dynamic supports the idea of a distinction between the profession and the practice of marriage and family therapy, as offered by Simmons & Doherty (1998).

In general, it is true that about 72% of participants reported satisfaction with their current professional position. Based on the closed-ended response option for this questionnaire item, it is unknown what graduates meant by “satisfaction.” What we also do not know are the processes involved in establishing the condition of satisfaction. It is probable that several of these graduates were able to find a position which met their interests and minimum income requirements. It is also probable that some graduates in this sample were forced to reconsider their original goals and dreams. Although graduates with this latter experience may have readjusted their expectations and goals, the extent to which any significant mental, emotional, or physical burdens were experienced in the re-adjustment to the “reality” of the professional arena is unclear. No research in this area specific to marriage and family therapists currently exists. Future research into the career journey of MFT graduates and exploration of the condition of career satisfaction may shed some light in this area.

Steinglass (1996) proposed that health care reform could be placing the survival of the marriage and family therapy profession in danger. While the accuracy of such a proposal has yet to be determined, the above issues raised by this study certainly provides several warning signs. It is up to the profession as a whole, including AAMFT, COAMFTE, MFT training programs, and the graduates and practitioners themselves to decide whether or not each is responsible for heeding these signals.

Recommendations for MFT Training Programs

Based on the above discussion of the research results, the literature, and the challenges faced by the marriage and family therapy profession, several recommendations for MFT training can be made. These recommendations include addressing the usefulness of research training, providing information in specific presenting problem areas, preparing trainees for the practical application of their training, standardizing the goals of both didactic and practicum/internship portions of MFT training, helping trainees plan for a possible career change, and transitioning trainees into the professional world.

Nearly half of the MFT graduates in this study cited research training and experience as one of the least relevant or useful aspects of their MFT training. While many of these graduates did not end up performing research as they moved toward clinical practice, they did not seem to

understand the larger skills and potential career opportunities research requirements develop.

One doctoral level graduate reporting annual earnings of \$100,000 per year stated:

Trivializing research...limits therapists to one thing: clinical work. If you pay any attention to your statistics and research background you open yourself up to many avenues of consultation and evaluation that are far more lucrative than either therapy or teaching.

If they are not already doing so, perhaps faculty teaching in MFT programs could emphasize helping their trainees find meaning in the skills developed through research training, a course of action also recommended by Shields et al. (1994). Among other skills, research experience forces students to think critically and in an organized fashion. As needed in treatment planning, it teaches them to be able to back up what they say, and allows them to critically evaluate knowledge and research claims of others. These skills are not only useful, they often prove critical for succeeding in the professional world. MFT graduates in this study have clearly attached quite a different meaning to research requirements than what likely was intended by COAMFTE. As evidenced by the participant's quote above, just because some graduates don't perceive certain aspects of their training as useful doesn't mean these aspects are without merit. Further research which triangulates the perception of MFT graduates, MFT faculty, and employers of MFTs on most and least useful aspects of MFT training may provide more depth regarding this issue.

Many participants also reported the desire for specific training in presenting problem areas or clinical formats. As reported in an earlier study of MFT graduates (Hines, 1996), many graduates in the present study reported being less than adequately prepared to deal with issues of chemical dependency, sexual abuse, domestic violence, and eating disorders. While many states provide certificate programs which recognize these areas as specializations requiring more intensive training, marriage and family therapists often encounter these issues in the context of general practice. Whether it be to refer or treat in the context of a larger therapeutic issue (i.e., marital, family, or individual problems), MFTs need to be equipped to handle these issues as they arise. Other graduates felt they lacked an understanding of how to work with groups and individuals. Incorporating specific didactic segments and/or highlighting practicum experiences in these areas may help MFT graduates feel more confident in their professional practice activities

(whether clinical, academic or supervisory). Attention to these areas may also increase an MFT's employability immediately following graduation.

This investigator joins a long list of authors who advocate that MFT and other psychotherapy programs educate and socialize their trainees into contemporary mental health practices (Broskowski, 1995; Crane 1995a, 1995b; Figley & Nelson, 1989; Liddle, 1991; Patterson & Scherger, 1995; Patterson et al., 1997; Plante, 1996, 1998). As evidenced by the results of this study, MFT trainees need accurate and thorough information on managed care principles and practices, training in diagnostic practices and use of the DSM, information on employment options and job search techniques, and understanding of the principle of state licensure and corresponding information on licensure requirements. It is significant that the graduates in this study felt more-than-adequately prepared to conduct marital and family therapy, yet experienced high levels of distress and feelings of inadequacy when forced to negotiate the contemporary context in which their skills are practiced. In order to prepare trainees for such negotiation, MFT faculty need experience and knowledge in these areas (Broskowski, 1995).

Given that many members of state licensing boards are also MFT faculty, it is interesting that graduates perceived themselves as lacking to such a degree on licensure information. This supports the need for more dialogue on this and other issues in MFT training, mentioned above. Such augmentation of training could be implemented without undue growing pains: Students could be given assignments to investigate these areas as they pertain to their career and area of residence interests. MFT trainees should also obtain information about and experience in interdisciplinary settings wherever possible. Increased interdisciplinary training is also recommended to MFT training programs by Shields et al. (1994), along with increased didactic and clinical experience in assessment and treatment of a wide variety of presenting problems.

As discussed earlier in this study, there are mixed feelings among mental health professionals about managed care. For marriage and family therapists and those who train them, an ideological barrier may exist which could create resistance against socializing MFT trainees to "accept what is" in the current mental health climate. MFT faculty may have knowledge of managed care principles and practices, but may not choose to teach this information because they may be ideologically opposed to it. Since managed care is driven by cost containment and academia by the pursuit and expansion of knowledge, there may exist a symbiotic relationship

whereby these institutions check and balance one another. Where managed care seeks to limit health care costs, academia is present to remind these corporations about the people/patients who may become lost in the business shuffle. While academic clinical settings allow exploration of long-standing, complex family or marital issues for little to no financial cost, managed care is present to point out that outside of non-profit settings, such clinical practice is impractical in the world of profit and financial survival. Regardless of MFT faculty members' viewpoints on managed care issues, it still behooves the faculty and the MFT trainees to explore these issues and their associated advantages and disadvantages. It can be argued that MFT graduates who are exposed to these principles will be better prepared to make informed choices about their potential career paths.

When graduates in this study discussed their feelings of unpreparedness in negotiating the professional marketplace, a distinction emerged between didactic training and internship experiences. Some graduates who reported feeling unprepared as they "left" their program referred to embarking on their internship experience while others referred to graduating from their MFT program. It appears that further clarification is needed on the specific roles of the didactic portion of MFT programs versus internship or practicum experiences. Some MFT faculty may argue that socialization of the MFT trainee on issues relating to managed care, insurance reimbursement, treatment planning, and licensure should be covered by an internship supervisor or setting. This necessary socialization becomes difficult for masters-level graduates who are not always required to obtain clinical experience outside of their university-based practicum site. Additionally, since MFT internship sites are not regulated nor standardized, it is difficult to determine exactly what MFT interns will learn during their internship experience. Although debate exists regarding standardization and accreditation of MFT internship sites (as currently required by American Psychological Association-accredited programs in psychology), perhaps MFT programs should develop a set of knowledge goals to be acquired by MFT interns during their experience. Internship supervisors could then be required to work in conjunction with the intern and the MFT program to ensure these knowledge goals are met. Masters-level MFT programs who do not already provide internship settings may want to look at doing so, particularly since it was these graduates who felt least adequately prepared to find a job. Shields

et al. (1994) also recommend further examination of the MFT internship and other clinical experience issues.

Another recommendation for MFT training programs involves orienting students to the likelihood that their careers will change to some degree. Many students enter their MFT training experience with a desired career goal. Like many of the participants, this investigator was “sure” she would only go into private or group practice! As evidenced by this sample, many MFT graduates change their career goals at some point during or after their training. Perhaps requiring one or two elective courses in an area outside MFT would provide some rudimentary supplemental training from which graduates could draw if it became necessary or desired. Should this investigator have had such a requirement, she would have taken a course in human resources/organizational behavior and perhaps another in career counseling. When it came time for her career to change, she would have had a greater chance at obtaining employment in an alternate field.

A final recommendation for MFT training programs involves a process of “transitioning” the MFT trainee into the professional world. This was a desire reported by many in this study; both masters and doctoral level graduates. In their responses, graduates in this study assigned distinctly different meanings to their experience of the MFT profession while in training and after graduation. Only one-third of participants felt more than adequately prepared to find a job. Transitioning would involve not only providing knowledge of and skills in negotiating the contemporary professional marketplace, it would include helping trainees review specific career opportunities and methods of securing employment. Perhaps programs could promote alumni networks as one way to provide employment assistance to trainees making the transition.

The question has been posed by Hines (1996) and others about the extent to which MFT training programs should provide training and employment assistance specific to career areas in which graduates may engage. After all, most graduate students are well into adulthood by the time they complete their programs. It would be easy to assume that graduate students possess the skills and knowledge necessary to discover the information themselves. Unfortunately, at least for this sample, this did not appear to be the case. Masters and doctoral level graduates alike consistently expressed the desire for more guidance as they completed their program and moved into the post-graduation professional world. While it may not be the specific responsibility of

MFT programs to secure employment for their graduates, one must consider the reflection on the program if their graduates are known to have difficulty finding employment.

It is also important to consider the career developmental stage of MFT graduates when examining the importance of transitioning. Graduates who are emerging from the somewhat “protected” environment of MFT education must be sufficiently prepared to negotiate the next stage in their professional development if they are to succeed in their careers. Unfortunately, the developmental stage(s) of the participants in this study is unknown. Information regarding the amount of time lapsed since participants’ graduation from their MFT programs and the amount of time spent working in the MFT field would have yielded more information about this factor. Such information would have provided a more defined context for graduates’ expressed concerns and difficulties regarding managed care and other marketplace issues.

A question regarding the responsibility of MFT trainees and graduates may also emerge here. After all, in order to arrive at the decision to apply to a marriage and family therapy program in the first place, these students must have at least a basic idea of what the profession is about. Unfortunately, it is likely that pre-graduate knowledge of larger MFT professional issues varies widely. In order to obtain “good” answers about the MFT profession, prospective MFTs must have the ability to ask “good” questions. In order to ask “good” questions, one must possess a “good enough” knowledge base from which to generate the questions. The dilemma is circular. Perhaps MFT faculty and graduates should work together to more clearly identify the most important information prospective MFT students need in order to make an informed decision about entering the program.

The above argument is supported by Crane (1999), who submitted that MFT programs should provide comprehensive information to prospective students in support of the ethical principles of informed consent, nonmaleficence, beneficence, and the prevention of student exploitation. The author points toward other counseling fields such as the American Counseling Association (ACA) which, among other aspects of informed consent, include orienting graduates to “up-to-date employment prospects” among their code of ethics.

This investigator’s opinion on the issue is clear: It is ethically incumbent upon MFT programs to provide assistance in transitioning their graduates from the sheltered world of MFT training to the “real world” of the professional marketplace. Marriage and family therapy isn’t

just a set of skills, it is also a profession. Authors in the field of MFT training recognize that such professional socialization is a separate and equally important element of MFT training (Everett, 1979; Liddle, 1991; Nichols, 1979a, 1988; O'Sullivan & Gilbert, 1989). MFT programs train students who most frequently use their skills in some aspect of professional practice, whether that practice be clinical, academic, administrative, or applied otherwise. To offer students the caliber of knowledge and experience that accredited MFT programs do and then to turn these students loose after graduation without adequate transitioning information or guidance is questionable practice.

Marriage and family therapists who treat clients help these clients evolve to a level which provides these clients greater opportunity to impact their own lives and the lives of others in their systems of interaction. Our professional code of ethics specifically requires us to “assist [these] persons in obtaining other...services,” and specifically prohibits us from “abandon[ing] or neglect[ing] clients in treatment,” (AAMFT Code of Ethics, 1998, sections 1.6 and 1.7). Many MFT programs speak of isomorphism in systems. If the process of training a family therapist is not actually therapy, is it not assisting a person in evolving to a level which provides them greater opportunity to impact lives: their own and the lives of others? The ethical argument can easily be extended to the responsibility MFT programs and faculty have to their trainees and graduates, whom they educated and (hopefully) socialized as the next generation of a profession searching to be a part of the mental health “mainstream.”

Recommendations for Future Research

In a recent article on qualitative evaluation of family therapy training programs, Deacon and Piercy (2000) highlighted the need to hear from “one group of neglected ‘experts’ — family therapy trainees,” (p.40). This investigation followed that recommendation and provided foundational information about MFT graduates’ perspectives on their training, as well as their career practices and perspectives.

As with any research project, there exist some limitations with this study. A sample of 125 participants hardly constitutes a substantial representation of COAMFTE-accredited program graduates, but it does provide a basic start in gathering information pertaining to the research questions. It is likely that a greater number of respondents would have been obtained had the investigator utilized the time 3 follow-up (mailing a copy of the questionnaire with a postage-paid

return envelope) for all prospective participants, not just those for whom addresses were given. There was a particular lack of male respondents (only 38%). It is also not known how many of the graduates who were contacted tried to access the Internet web page where the questionnaire was located, but were unable to do so. The investigator did receive a few calls and e-mails when some participants had difficulty accessing the site, so it is not known how many had similar problems but did not contact the investigator.

In retrospect, some additional information would have been helpful when analyzing the data: The participants in this study were not asked how long it had been since they graduated from their MFT program, nor were they asked how long they had actually worked in an MFT-related field. As mentioned earlier in regard to the number of participants who reported being satisfied with their current professional position, information could have been gathered which provided more insight as to the extent and nature of their satisfaction level. It would also have been helpful to see information about participants' actual job history rather than learning only about their current professional position.

Regarding future research in this area, it would be helpful to hear from a greater number of graduates representing all accredited programs. To accomplish this, it would be more feasible to utilize a questionnaire which provides quantitative data. The categories which emerged from the different questions/variables here could provide a starting point for constructing a closed-response questionnaire. To assist in validating the body of MFT training literature on important skills for MFTs, graduates could be asked to report the most/least relevant and missing aspects of their education in terms of "skills" rather than the more general term of "aspect."

Another area of recommended research would be comparisons of MFT graduates who received training in managed care issues/skills and other areas of contemporary mental health care practice to those who had not received such training. Differences in their perceived level of preparedness, satisfaction, and functioning in professional clinical settings could then be assessed. A similar study could be conducted after implementing a "transitioning"-type program for graduating trainees such as recommended above.

Additional information about the issues discussed in the present study could be obtained by triangulating the responses of MFT program graduates with the responses of MFT faculty to

similar questions. Also surveyed about the research questions on which this study was based should be those who employ MFTs after graduation.

Summary

This chapter began with a review of the main research questions and the data generated by this study. The major research findings were then integrated with existing literature. Challenges facing the MFT in the professional marketplace were highlighted, including issues related to the existence of managed care and MFTs' experiences of marginalization in the mental health marketplace. Recommendations were offered to those who train marriage and family therapists. These recommendations included addressing the usefulness of research training, providing information in specific presenting problem areas, preparing trainees for the practical application of their training, clarifying the goals of internship, helping trainees plan for a possible career change, and transitioning graduates into the professional world. Finally, limitations of this study were discussed and recommendations were made for future research.

CHAPTER 6

CONCLUSION

The goal of this research was to provide preliminary information on career practices and training perspectives of graduates from COAMFTE-accredited marriage and family therapy programs. This goal was indeed accomplished, and this project is the first to provide a contemporary “snapshot” of the career activities of these graduates as well as their reflections on their MFT training experiences.

As mentioned in the introduction to this dissertation, the question has been recently asked of the marriage and family therapy field as a whole, “Where have we been? Where are we going?” (Chismar, 1999). Students are applying for admission to marriage and family therapy programs by the hundreds; gaining entrance into these programs is becoming increasingly competitive. More MFT programs apply for COAMFTE-accreditation each year. National conferences of AAMFT and other family therapy-oriented organizations draw large numbers of MFTs from across the country and the world (Shields et al., 1994). As evidenced by the literature and by this study, marriage and family therapy graduates pursue careers in a variety of settings. These practice avenues include the more traditional areas of agency work and administration, private practice, pastoral settings, and academia. Also included are less traditional employment avenues for MFTs, such as school settings, employee assistance programs, medical schools and hospitals, and business/consultation settings.

“Where are we going?” Based on the above information, it can be said that the field of MFT is certainly expanding. The results of this study support the perception of authors in the last decade who have highlighted issues and challenges the profession of marriage and family therapy is facing as the healthcare marketplace changes. Marriage and family therapists making the transition from student to employed professional need useful information about working with managed care and the political ramifications of being an MFT in the present marketplace. Since private practice continues to be the most frequently cited career goal of MFTs as well as other psychotherapy trainees, graduates also need information on remaining viable in private or group practice settings.

Given the complaints and concerns uncovered by this study which related to managed care issues, more intensive training in diagnosis/use of the DSM, lack of sufficient pre-graduate

information on licensure, and other areas in which graduates felt unprepared, a broader look at MFT training must be taken. For instance, to what extent do the concerns of the MFT graduates in this study parallel the concerns of graduates from other mental health disciplines? The presence of managed care has imposed new structure and limitations on the mental health field as a whole. Graduates of psychology, social work, professional counseling, and other mental health programs are likely facing similar dilemmas pertaining to preparing for professional licensure, operating a private practice, and negotiating situations unique to this contemporary mental health culture.

On the other hand, MFTs may face post-graduate transitional challenges which are unique to our profession: As marriage and family therapy has sought to establish itself as a distinct discipline in mental health, heavy reliance on diagnosis and use of the DSM, treatment planning, and other components of an individualized, medically-oriented treatment model have evolved to a de-emphasized status in marriage and family therapy training (Shields et al., 1994). This evolution is also apparent through the feedback obtained by the graduates in this study. Although the debate regarding the propriety of thoroughly educating MFTs in DSM and managed care philosophies rages on, it is important to understand that marriage and family therapists are still regarded as a minority in the mental health arena. In order to function in the context of the dominant culture, minorities are required to become multicultural. Multiculturalism for marriage and family therapists would mean not only understanding their own discipline's unique history, theoretical foundations, and methods of practice, but understanding the same elements of mental health practice as a whole. After all, MFT graduates are still required to compete against graduates from other mental health disciplines in order to find and maintain viable employment and practice.

When reviewing the Results and Discussion chapters of this study, a broader question regarding MFT training and career preparation emerged: Who is responsible for preparing MFTs to succeed as therapists and as professionals in the larger realm of mental health? Conversely, who is to blame if these graduates fail to establish themselves as representatives of the MFT profession? Based on the feedback given by MFT graduates in this study, it would be easy to focus solely on the COAMFTE-accredited training programs from which they emerged. Certainly, it is imperative that MFT training programs look at the issues raised by this study and decide the extent to which they wish to address them. Marriage and family therapy, however,

distinguishes itself from other mental health professions by its reliance on a systemic foundation. A good family therapist knows that to dwell on the issue of blame is counterproductive to the evolution of the system as a whole. Each member of the system which is the marriage and family therapy profession: the MFT program faculty, AAMFT leaders and members, COAMFTE leaders and members, and students and practitioners of marriage and family therapy -- it is incumbent upon each member of this system to maintain responsibility for preparing the MFT graduates of today to be the standard-bearers of the profession tomorrow. If you, the reader, are part of this system, what are you doing today to keep our profession viable in this new millennium?

Phenomenology was the theoretical lens applied to this study to explore the meaning MFT graduates gave to their career practices and training perspectives. As mentioned above, marriage and family therapy graduates felt unprepared to negotiate several aspects of professional practice that the pioneers of the MFT field may never have intended MFT training to address, such as reliance on DSM-based individual diagnosis, training in psychopharmacology, and treatment based on a medical model. In fact, these graduates are now requesting such information to better prepare them to survive professionally. What are the implications of these graduates' reported needs for the field of marriage and family therapy as a whole? What does it mean to be a marriage and family therapist in the year 2000? Is this meaning different in the 21st century than it was in the 20th, when MFT was first established as a distinct profession?

Perhaps what we are seeing here is another step in the evolution of marriage and family therapy. If we consider the history of the MFT profession using a developmental perspective, perhaps MFT has emerged from its infancy and is now prepared to own its maturity. As with an adolescent, marriage and family therapy was required to "individuate" before it could "reintegrate." Perhaps we had to move our focus away from the principles we hold in common with other mental health disciplines in order to discover and embrace our own strengths and uniqueness. We have moved through a stage of rebellion as we argued the superiority of our theories and methods and were viewed as the "bastards" of the psychotherapy professions (Nichols & Everett, 1986, p. 377). Through our conferences and campaigns, we have made professional noise as if to say, "Look at us! We are different!" Perhaps the mental health world has not yet taken notice to the degree we wish they would, but sometimes the adolescent needs to speak the adults' language in order to be heard.

Part of owning one's maturity involves having confidence enough in one's abilities and assets to step into the fray of mental health perspectives and join the dialogue. AAMFT's recent confrontation with Medicare regarding MFT reimbursement and its psychoeducational partnerships with pharmaceutical companies demonstrate the beginning of this process. There are factions in our field which vehemently oppose such action. The people comprising these factions are likely exhibiting the fear that in order to become part of the mental health mainstream, MFT will betray its identity. Perhaps they have forgotten that sometimes, in order to bring about desired change in a system, one must first join the existing process.

The question posed of the MFT profession by its primary organization's president must be asked at every level in marriage and family therapy: globally, nationally, and locally. It must be asked by AAMFT, by COAMFTE, by MFT faculty, by those who practice MFT, by MFT trainees and graduates, and by the clients whom we serve: "Where have we been? Where are we going?" To equip the MFT graduates of today to succeed, we must give them knowledge of the MFT field and a way to make their place in it. As marriage and family therapists, we may not collectively know or agree about exactly where we want to go, but one thing is certain: We have the ability to make it quite the ride.

REFERENCES

- Alexander, J.F., Barton, C., Schiavo, R.S., & Parsons, B.V. (1976). Systems-behavioral intervention with families of delinquents: Treatment characteristics, family behavior, and outcome. *Journal of Consulting and Clinical Psychology*, *44*, 656-664.
- American Association for Marriage and Family Therapy (1999a). *Family therapy in the mainstream: 57th annual conference brochure*. Washington, DC: author.
- American Association for Marriage and Family Therapy (1999b, July). Accreditation standards (Ver. 9.0). URL <http://www.aamft.org/resources/97stnds.htm>
- American Association for Marriage and Family Therapy (1999c, December). A career as a marriage and family therapist [WWW document]. URL: <http://www.aamft.org/resources/career.htm>
- American Association for Marriage and Family Therapy (1999d, December). Directory of MFT training programs [WWW document]. URL <http://www.aamft.org/resources/coamfte.htm>
- American Association for Marriage and Family Therapy (1999e, December). Studies on fees and salaries of marriage and family therapists [WWW document]. URL: <http://www.aamft.org/resources/salaries.htm>
- American Psychological Association (1999, July). Divisions of the American Psychological Association [WWW Document]. URL <http://www.apa.org/about/division.html>
- American Psychological Association Research Office (1999, July). Data on education and employment – Doctoral [WWW Document]. URL <http://research.apa.org/doc05.html>
- Avis, J.M., & Sprenkle, D.H. (1990). Outcome research on family therapy training: A substantive and methodological review. *Journal of Marital and Family Therapy*, *16*(3), 241-264.
- Azar, B. (1999, July). Students need a broader outlook on career [WWW Document]. URL <http://www.apa.org/students/g-employ.html>
- Becvar, D.S., & Becvar, R.J. (1988). *Family therapy: A systemic integration*. Boston: Allyn and Bacon.
- Bergman, D. (2000, April). MFTs, medicare and the new millennium: A call for action. *Family Therapy News* *31*(2), pp. 1, 6.

Bettis, F.A. (1997, August). The road from therapist to consultant with families in business. *Family Therapy News*. (also WWW Document -- URL:

http://member:accept@www.aamft.org/members/newarenas/Business/bsns_road.htm)

Bowers, M. (1999, December). Spirit of the field. *Family Therapy News*, 30(6), p. 3.

Broskowski, A.T. (1995). The evolution of health care: Implications for the training and careers of psychologists. *Professional Psychology: Research and Practice*, 26(2), 156-162.

Budman, S.H., & Armstrong, E. (1992). Training for managed care settings: How to make it happen. *Psychotherapy*, 2(3), 416-421.

Chismar, J. (1999, December). Family therapy in the mainstream: General session highlights. *Family Therapy News*, 30(6), p. 1, 6-7.

Christensen, D., Brown, J.H., Rickert, V., & Turner, J. (1989). Rethinking what it means to specialize in MFT at the master's level. *Journal of Marital and Family Therapy*, 15(1), 81-90.

Cleghorn, J., & Levin, S. (1973). Training family therapists by setting learning objectives. *American Journal of Orthopsychiatry*, 43, 439-446.

Cole, P.M. (1997, October). Meetings are therapeutic in family business consultation. *Family Therapy News*. (also WWW Document -- URL:

http://member:accept@www.aamft.org/members/newarenas/Business/bsns_meet.htm)

Constantine, L.L. (1976). Designed experience: A multiple, goal-directed training program in family therapy. *Family Process*, 15, 373-387.

Crane, D.R. (1995a). Health care reform in the United States: Implications for training and practice in marriage and family therapy. *Journal of Marital and Family Therapy*, 21(2), 115-125.

Crane, D.R. (1995b). Marriage and family therapy in health care reform: A response to Patterson and Scherger. *Journal of Marital and Family Therapy*, 21(2), 137-140.

Crane, D.R., & Law, D.D. (1999, August). Research shows health care usage decreases after marriage and family therapy [WWW document]. URL:

<http://member:accept@www.aamft.org/members/newarenas/Medical/HealthCareDecreases.htm>

Crane, J.M. (1999). Marriage and family therapy programs: Responsibilities to prospective students. *Journal of the Texas Association for Marriage and Family Therapy*.

(WWW Document -- URL <http://www.txmft.org/news/journalv4-1.html>)

Daw, J. (1996). In-home therapy gaining popularity. *Family Therapy News*, 27(3). (also WWW Document --- URL

<http://member:accept@www.aamft.org/members/newarenas/InH.../In%20Home%20Therapy.htm>
)

Daw., J. (1997, December). Divorce lawyers could use therapists. *Family Therapy News*, 28(6). (also WWW Document – URL

http://member:accept@www.aamft.org/members/newarenas/Forensic/fnsc_divorce.htm)

Daw, J. (1998, February). Helping children at school: Spotlight on Berkeley High School Health Center. *Family Therapy News*, 29(1). (also WWW Document – URL

http://member:accept@www.aamft.org/members/newarenas/Schools/schl_berkeley.htm)

Deacon, S.A., & Piercy, F.P. (2000). Qualitative evaluation of family therapy programs: A participatory approach. *Journal of Marital and Family Therapy*, 26(1), 39-46.

Dey, I. (1993). *Qualitative data analysis: A user-friendly guide for social scientists*. London: Routledge.

Dillman, D.A. (1978). *Mail and telephone surveys: The total design method*. New York: Wiley.

Doherty, W.J., & Simmons, D.S. (1996). Clinical practice patterns of marriage and family therapists: A national survey of therapists and their clients. *Journal of Marital and Family Therapy*, 22(1), 9-25.

Everett, C.A. (1979). The masters degree in marriage and family therapy. *Journal of Marital and Family Therapy*, 5(3), 7-13.

Falicov, C.J., Constantine, J.A., & Breunlin, D.C. (1981). Teaching family therapy: A program based on training objectives. *Journal of Marital and Family Therapy*, 7, 497-505.

Farr, M. (1999, Winter). Labor of love: Best jobs for a bright future. *Friendly Exchange Magazine*, 21-27.

Ferber, A., & Mendelsohn, M. (1969). Training for family therapy. *Family Process*, 8, 25-32.

Figley, C.R., & Nelson, T.S. (1989). Basic family therapy skills I: Conceptualization and initial findings. *Journal of Marital and Family Therapy*, 15(4), 349-365.

Figley, C.R., & Nelson, T.S. (1990). Basic family therapy skills II: Structural family therapy. *Journal of Marital and Family Therapy*, *16*(3), 225-239.

Fink, A., & Kosecoff, J. (1985). *How to conduct surveys: A step-by-step guide*. Beverly Hills, CA: Sage.

Flacy, F. (1999, February). Change behind bars: In-prison family therapy increases success on the “outside.” *Family Therapy News*, *30*(1). (also WWW Document – URL <http://member:accept@www.aamft.org/members/newarenas/Forensic/Prison.htm>)

Franklin, S., Killian, K.D., & Targhetta, M. (1999). Becoming a family therapist: A qualitative study of factors contributing to the development of a professional identity in MFT interns. *Journal of the Texas Association for Marriage and Family Therapy*, *4*(1). (WWW Document -- URL <http://www.txmft.org/news/journalv4-1.html>)

Ganahl, G., Ferguson, L.R., & L'Abate, L. (1985). Training in family therapy. In L. L'Abate (Ed.), *The handbook of family psychology and therapy*. Homewood, IL: Dorsey Press.

Gawinski, B.A., Edwards, T.M., & Speice, J. (1999). A family therapy internship in a multidisciplinary healthcare setting: Trainees' and supervisor's reflections. *Journal of Marital and Family Therapy*, *25*(4), 469-484.

Hardy, K.V., & Laszloffy, T.A. (1995). The cultural genogram: Key to training culturally competent family therapists. *Journal of Marital and Family Therapy*, *21*(3), 227-237.

Hare-Mustin, R.T. (1986). Autonomy and gender: Some questions for therapists. *Psychotherapy*, *23*(2), 205-212.

Henggeler, S. (1998, April). Family-based services and juvenile justice. *Family Therapy News*, *29*(2). (also WWW Document – URL http://member:accept@www.aamft.org/members/newarenas/Forensic/fnsc_alter.htm)

Henry, P.W., Sprenkle, D.H., & Sheehan, R. (1986). Family therapy training: Student and faculty perceptions. *Journal of Marital and Family Therapy*, *12*(3), 249-258.

Hines, M. (1996). Follow-up survey of graduates from accredited degree-granting marriage and family therapy training programs. *Journal of Marital and Family Therapy*, *22*(2), 181-194.

Homework: Experienced therapists find personal, professional satisfaction with home offices. (1999, June). *Family Therapy News*, 30(3). (also WWW Document -- URL <http://member:accept@www.aamft.org/members/newarenas/home.htm>)

Hukill, T. (1999, May). Mentoring for the 90's: Personal coaching is becoming a legitimate career path. *Family Therapy Networker*, p. 48-53.

Hunter, C. (1997, August). Family therapist hosts family business talk radio show. *Family Therapy News*. (also WWW Document -- URL: http://member:accept@www.aamft.org/members/newarenas/Business/bsns_radio.htm)

Jenkins, H. (1984). Which skills how: Options for family therapy training. *Journal of Family Therapy*, 6, 17-33.

Johnson, S. (In press). Family therapy saves the planet: Messianic tendencies in the family systems literature. *Journal of Marital and Family Therapy*.

Kniskern, D.P., & Gurman, A.S. (1979). Research on training in marriage and family therapy: Status, issues, and directions. *Journal of Marital and Family Therapy*, 5(3), 83-94.

Kniskern, D.P., & Gurman, A.S. (1996). Research. In D.H. Sprenkle and S.M. Moon (Eds.), *Research methods in family therapy*. New York: Guilford Press.

Krauth, L. (1997a, October). The business of therapy. *Family Therapy News*. (also WWW Document -- URL: http://member:accept@www.aamft.org/members/newarenas/Marketing/mrkt_bus.htm)

Krauth, L. (1997b, October). Working with the press: Free publicity means playing with fire. *Family Therapy News*. (also WWW Document -- URL: http://member:accept@www.aamft.org/members/newarenas/Marketing/mrkt_press.htm)

Kuehl, B. (1999, December). MFTs can learn from their own marginalization experiences. *Family Therapy News*, 30(6), pp. 8-9, 21.

Liddle, H.A. (1991). Training and supervision in family therapy: A comprehensive and critical analysis. In A.S. Gurman and D.P. Kniskern (Eds.), *Handbook of family therapy, vol. II* (pp. 638-697). New York: Brunner/Mazel.

McDowell, T. (1999). Systems consultation and Head Start: An alternative to traditional family therapy. *Journal of Marital and Family Therapy*, 25(2), 155-168.

Mize, L.K., Sutter, E., & Eisner, H. (1996). Graduate trends for one marriage and family therapy program in an interdisciplinary setting. *Contemporary Family Therapy, 18(2)*, 305-313.

Mock, M.R. (1998, February). School-based crisis consultation: A multicultural approach. *Family Therapy News, 29(1)*. (also WWW Document – URL http://member:accept@www.aamft.org/members/newarenas/Schools/schl_crisis.htm)

Morris, J. (1996, June). Reflections on doing home-based family therapy. *Family Therapy News, 27(3)*. (also WWW Document – URL http://member:accept@www.aamft.org/members/newarenas/InHome/inhm_reflect.htm)

Nelson, T.S. (1996). Survey research in marriage and family therapy. In D.H. Sprenkle and S.M. Moon (Eds.), *Research methods in family therapy* (pp. New York: Guilford.

Nelson, T.S., & Figley, C.R. (1990). Basic family therapy skills III: Brief and strategic schools of family therapy. *Journal of Family Psychotherapy, 4*, 49-62.

Nelson, T.S., Heilbrun, G., & Figley, C.R. (1993). Basic family therapy skills IV: Transgenerational theories of family therapy. *Journal of Marital and Family Therapy, 19(3)*, 253-266.

Nelson, T.S., & Johnson, L.N. (1999). The basic skills evaluation device. *Journal of Marital and Family Therapy, 25(1)*, 15-30.

Nichols, W.C. (1979a). Education of marriage and family therapists: Some trends and implications. *Journal of Marital and Family Therapy, 5(1)*, 19-28.

Nichols, W.C. (1979b). Doctoral programs in marital and family therapy. *Journal of Marital and Family Therapy, 5(3)*, 23-28.

Nichols, W.C. (1988). An integrative psychodynamic and systems approach. In H.A. Liddle, D.C. Breunlin, and R.A. Schwartz (Eds.), *Handbook of family therapy and supervision* (pp. 110-127). New York: Guilford Press.

Nichols, W.C., & Everett, C.A. (1986). *Systemic Family Therapy*. New York: Guilford Press.

O'Sullivan, M.J., & Gilbert, R.K. (1989). Master's degree programs in marital and family therapy: An evaluation of admission and program requirements. *Journal of Marital and Family Therapy, 15(4)*, 337-347.

Pascoe, D.L. (1998). Emotional indicators disclosed during the debriefing process in the figure drawings of child-witnesses of domestic violence. Unpublished Doctoral Dissertation, Texas Women's University.

Patterson, J.E., McIntosh-Koontz, L., Baron, M., & Bischoff, R. (1997). Curriculum changes to meet challenges: Preparing MFT students for managed care settings. *Journal of Marital and Family Therapy*, 23(4), 445-459.

Patterson, J., & Scherger, J.E. (1995). A critique of health care reform in the united states: Implications for the training and practice of marriage and family therapy. *Journal of Marital and Family Therapy*, 21(2), 127-135.

Paul, J.J., & Wiseman, K. (1999, August). Family owned business and corporate consulting [WWW document]. URL:

http://member:accept@www.aamft.org/members/newarenas/Business/bsns_menu.htm

Perrott, L.A. (1999, January). Changing horses: Handling the transition to business consultation. *Family Therapy Networker*, p. 19-20.

“Phenomenology” (2000, February). [WWW Document]. URL

<http://www.connect.net/ron/phenom.html>

Piercy, F.P., Laird, R.A., & Mohammed, Z. (1983). A family therapist rating scale. *Journal of Marital and Family Therapy*, 9, 49-60.

Plante, T.G. (1996). Ten principles of success for psychology trainees embarking on their careers. *Professional Psychology: Research and Practice*, 27(3), 304-307.

Plante, T.G. (1998). How to find a first job in professional psychology: Ten principles for finding employment for psychology interns and postdoctoral fellows. *Professional Psychology: Research and Practice*, 29(5), 508-511.

Roberts, J.M. (1991). Sugar and spice, toads and mice: Gender issues in family therapy training. *Journal of Marital and Family Therapy*, 17(2), 121-132.

Rosenbaum, I.S., & Serrano, A.C. (1979). A rationale and outline for a training program in family therapy. *Journal of Marital and Family Therapy*, 5(3), 77-82.

Saba, G.W., & Liddle, H.A. (1986). Perceptions of professional needs, practice patterns, and critical issues facing family therapy trainers and supervisors. *The American Journal of Family Therapy*, 14(2), 109-122.

Shields, C.G., Wynne, L.C., McDaniel, S.H., & Gawinski, B.A. (1994). The marginalization of family therapy: A historical and continuing problem. *Journal of Marital and Family Therapy*, 20 (1), 117-138.

Silvestri, K., Steinberger, C., & Scambio, E. (1996, December). Collaboration and reform: A model for MFT in the schools. *Family Therapy News*, 27(6). (also WWW Document – URL http://member:accept@www.aamft.org/members/newarenas/Schools/schl_collab.htm)

Simmons, D.S., & Doherty, W.J. (1998). Does academic training background make a difference among practicing marriage and family therapists? *Journal of Marital and Family Therapy*, 24(3), 321-336.

Smith, T.A., Jr., Salts, C.J., & Smith, C.W. (1989). Preparing marriage and family therapy students to become employee assistance professionals. *Journal of Marital and Family Therapy*, 15(4), 419-424.

Snyder, W., Herman, S., Shepley, R., & Walsh, M. (1996, June). Professional friends: MFT interns find that home-based therapy fosters familiarity. *Family Therapy News*, 27(3). (also WWW Document – URL http://member:accept@www.aamft.org/members/newarenas/InHome/inhm_profess.htm)

Sprenkle, D.H., & Wilkie, S.G. (1996). Supervision and training. In F.P. Piercy, D.H. Sprenkle, and J.L. Wetchler (Eds.), *Family Therapy Sourcebook, 2nd Edition*. New York: Guilford Press.

Steinglass, P. (1996). Editorial: Family therapy's future. *Family Process*, 35(4), 403-405.

Storm, C. (1991). Placing gender in the heart of MFT masters programs: Teaching a gender sensitive systemic view. *Journal of Marital and Family Therapy*, 17(1), 45-52.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

Street, E. (1988). Family therapy training research: Systems model and review. *Journal of Family Therapy*, 10, 383-402.

Sudol, P., & Marsh, K. (1998, February). Family therapists and supervised visitation: A natural connection. *Family Therapy News*, 29(1). (also WWW Document – URL http://member:accept@www.aamft.org/member/newarenas/Forensic/fnsc_super.htm)

Taylor, R.D., & Hardy, C.A. (1996). Careers in psychology at the associate's, bachelor's, master's, and doctoral levels. *Psychological Reports, 79*, 960-962.

Tomm, K.M., & Wright, L.M. (1979). Training in family therapy: Perceptual, conceptual, and executive skills. *Family Process, 18(3)*, 227-250..

Touliatos, J., & Lindholm, B.W. (1992). The marriage and family therapist: Graduate preparation of a mental health professional. *Psychological Reports, 71*, 1195-1201.

Touliatos, J., Lindholm, B.W., & Nichols, W.C. (1997). The shaping of family therapy education: An update. *Contemporary Family Therapy, 19(3)*, 391-407.

Tucker, S.J., & Pinsof, W.M. (1984). The empirical evaluation of family therapy training. *Family Process, 23*, 437-456.

Tuttle, G. (1999a, August). Niche marketing [WWW document]. URL:
http://member:accept@www.aamft.org/members/newarenas/Marketing/mrkt_niche.htm

Tuttle, G. (1999b, August). Niche marketing: Specialties are the key to private practice success [WWW document]. URL:
http://member:accept@www.aamft.org/members/newarenas/Marketing/mrkt_nichesp.hm

Tuttle, G. (1999c, August). So you want to be a provider? Try these tips for smoother managed care applications [WWW document]. URL:
http://member:accept@www.aamft.org/members/newarenas/Marketing/mrkt_apps.htm

Tuttle, G. (1999d, August). You've got mail! Therapists offer e-mail counseling, take check and credit card payments [WWW document]. URL:
http://member:accept@www.aamft.org/members/newarenas/Marketing/mrkt_email.htm

Tuttle, G., & Ambrose, J. (1999, June). Therapists transform mental health services in wake of managed care, survey shows [WWW document]. URL:

Wheeler, D., Avis, J.M., Miller, L.A., & Chaney, S. (1989). Rethinking family therapy training and supervision: A feminist model. In M. McGoldrick, C. Anderson, and F. Walsh (Eds.), *Women in families* (pp. 135-151). New York: W.W. Norton.

Woody, R.H., & Weber, G.K. (1983). Training in marriage and family therapy. In B.B. Wolman and G. Stricker (Eds.), *Handbook of family and marital therapy*. New York: Plenum Press.

APPENDICES A-F

Appendix A: Instructions to MFT Programs on Mailing Participant Letters

**STEP-BY-STEP INSTRUCTIONS FOR ASSISTING WITH SHANNON PANKOW'S DISSERTATION
FOR: [UNIVERSITY NAME]**

Thank you again for your willingness to help me get these letters to your graduates! Because I need to target graduates within certain guidelines, I have developed these instructions to help you select the right candidates. If you have any questions at any time, you can reach me at:

PHONE: (801) 278-9566

E-MAIL: shannon_pankow@hotmail.com

- ! I have enclosed a total of 40 letters: each of the 20 graduates you select will receive 2 letters.
— the first letter introduces the study and invites the graduate to participate.
— the second letter needs to be mailed **exactly one week later**. This letter thanks them for participating, and reminds them to participate if they haven't yet done so.
— I have enclosed sample copies of these letters for your reference.
- ! Notice that the letters are bundled in twos. On the front of each letter are code numbers: 1-A, 1-B; 2-A, 2-B; etc. **It is important** that you match each bundle of letters with the same graduate. **FOR EXAMPLE:** If you send letter 5-A to "Sue Smith," she also needs to receive letter 5-B a week later, **NOT** letter 2-B. The reason for this is: Each graduate has a registration number assigned in order to participate in the study. Letter 5-A and 5-B, for instance, list the same registration number, so we want to make sure different people don't get the same number!
1. **SELECTING GRADUATES:**
- a. Print out or otherwise view your most recent list of graduate names and addresses.
 - b. **REMOVE** anyone who graduated in 1998, 1999, or 2000.
 - c. **REMOVE** anyone who you know is currently in a Ph.D. program. (**EXAMPLE:** If "Joe Jones" graduated in 1997 and you know he went on to a Ph.D., he probably won't be finished yet.) We need to select graduates who have finished their schooling and who are working (EVEN if they switched to another field!).
 - d. **REMOVE** anyone who does not have a United States address, or for whom you don't have a complete address.

 - e. Now, take the remaining list of graduates, and **select every THIRD person** on the list, **until you have 20** graduates. These graduates will be the ones to receive the letters.
If you get to the end of the list and you don't yet have 20 graduates, return to the beginning of the list and continue counting off by threes.
2. Once you have selected 20 graduates, print out **2 ADDRESS LABELS** for **EACH** graduate who will be receiving the letters.
3. Place the labels on the letters, one graduate name to one bundle of letters: **EXAMPLE:** "Sue Smith needs an address label on letter 5-A **AND** letter 5-B. Go ahead and cover up the code numbers. They were placed there only for your convenience.
4. **IMPORTANT!!!** Keep track of WHICH is Letter A and which is Letter B!
5. Please mail the 20 letter As to the graduates **as soon as possible**. Please **e-mail or call me** to let me know when they went out.
6. Please mail the 20 Letter B's **exactly one week after** the letter A's go out. If I know when you sent the Letter As, I can send you an e-mail reminder when it's time to send the B's.
7. **If you get letters returned** because the graduate has moved, **please keep track of the number of returns** you receive. I will ask for this number so I can compute the overall response rate.

THAT'S IT!! THANK YOU SO MUCH!! Contact me if you have questions!
I will send you a copy of the results once the study is complete!

Appendix B: Invitation to Participate in Research Letter

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY
Department of Human Development

Shannon Anderson Pankow, LMFT
Ph.D. Candidate
4811 S. Kings Row Drive #4
Salt Lake City, UT 84117
(801) 278-9566

Scott Johnson, Ph.D., Dissertation Advisor
Family Therapy Center of Virginia Tech
University City Blvd., Suite 1
Blacksburg, VA 24061
(540) 231-3311

[Month, Day, 2000]

INVITATION TO PARTICIPATE IN RESEARCH

Dear MFT Graduate [name placed here if available]:

Have you ever wondered what career opportunities are available for a marriage and family therapy graduate? I sure have! Unfortunately, as MFTs, there aren't many resources for us in the career options arena. I want to change that.

In order to obtain information about the wide range of career opportunities for MFTs, **I need help from you.** For my doctoral dissertation, I am conducting a survey of graduates from COAMFTE-accredited MFT programs to ask you about your current career practices and your opinions about your MFT training. Only a total of 300 graduates from 15 MFT programs across the U.S. are being asked to participate. You are one of the graduates selected to receive this invitation, and your input is very important!

All that is required of you is to fill out a 26-item questionnaire, consisting of both open-ended and closed-ended responses. It should take about 20 - 30 minutes. There are 2 ways for you to participate in this study: on the Internet and by mail.

1. **Internet Option:** If you have access to the Internet, this is the quickest and easiest participation option. Once you are on-line, type this web address in the box at the top of your browser screen exactly as it appears below:

<http://home.earthlink.net/~gfanerson/shannon>

This will take you to the web site containing the questionnaire. After filling out the questionnaire, hit the "SEND" button and your responses will be automatically e-mailed directly to me. Your responses will be completely confidential, since the return address on your e-mail will only be the web site itself. You will not be asked for your name, and I will not be able to see your e-mail address nor your online account information. Check it out!

2. **Mailing Option:** For those of you who do not have Internet access, or who do not wish to participate by Internet, you may participate by calling this toll-free number:

1-877-999-9566

You will be connected to a voice mailbox. Please leave the following information:

- Your 5-digit registration number
- Your name (optional - I want to get it to the right person!)
- Your mailing address (please SPELL it out!)
- Your phone number (optional)

I will immediately mail a copy of the questionnaire to you, along with a postage-paid return envelope.

Whichever option you select, you will be asked to give a 5-digit registration number, included in this letter. This number serves 3 purposes: (1) it verifies that you received this Invitation to Participate in Research, (2) it prevents you from receiving unnecessary follow-up letters, and (3) it provides information about which universities are participating in the study. Any information which links you with your registration number will be destroyed once the data are collected.

Your individual registration number is: 12345

I **thank you** in advance for your willingness to participate. : **(801) 278-9566**, **or** leave a message on the toll-free number and I will call you back Any questions? Please contact me:
e-mail: **shannon_pankow@hotmail.com**;

Thanks again! Sincerely,

Shannon Anderson Pankow, MS, LMFT
Ph.D. Candidate, Virginia Tech University

Appendix C: Informed Consent for Mail-Option Questionnaire

CAREER PRACTICES AND TRAINING PERSPECTIVES OF MARRIAGE AND FAMILY THERAPY PROGRAM GRADUATES

INFORMED CONSENT TO PARTICIPATE IN RESEARCH **Please read this before responding to the questionnaire:**

- I. **Purpose of Research:** The purpose of this study is to discover current career practices and perspectives on training from graduates of COAMFTE-accredited masters and doctoral programs. This research is conducted for the purpose of fulfilling the doctoral dissertation requirement for the researcher's Ph.D. program in Marriage and Family Therapy. Approximately 300 graduates from 20 masters and doctoral programs across the United States will be asked to participate in this study.
- II. **Procedures:** The nature of your participation will involve spending approximately 30 minutes responding to this questionnaire. The questionnaire consists of 26 questions requiring a combination of open-ended and closed-ended responses. Once you have completed the questionnaire, place it in the postage-paid return envelope provided and place in a mailbox as soon as possible. Additional instructions are included in the body of the questionnaire.
- III. **Risks:** There are no foreseeable risks with this research. You are free to discontinue your participation at any time for any reason. If you have specific questions for the researcher at any time during or after your participation, or if you desire a copy of the research findings, please contact the researcher, Shannon Pankow, by e-mail at shannon_pankow@hotmail.com, or by phone at (801) 278-9566. You may also contact Scott Johnson, Ph.D., dissertation advisor – e-mail: scjohnso@vt.edu, phone: (540) 231-3311.
- IV. **Benefits of this Project:** Little is known about the current career paths of MFT graduates in the contemporary age of managed care. Similarly, few studies have been conducted asking graduates with professional work experience about their training. This study represents an exciting opportunity to obtain new information to help MFTs plan their careers, understand the extent of their professional options, and to provide accredited MFT programs with feedback concerning what is and is not needed in MFT training. No promise or guarantee of benefits is being made in asking for your participation.
- V. **Extent of Confidentiality:** Your responses will be completely confidential. You will be asked to write down a "registration number," found in your Invitation to Participate in Research letter. This registration number serves 3 purposes: (1) it verifies that you received an Invitation to Participate in Research and distinguishes your responses from others who may obtain a copy of the questionnaire and send unqualified responses, (2) it prevents you from unnecessarily receiving follow-up letters, and (3) it assists in tracking which universities participated in the study. Once the data has been collected, any identifying information will be destroyed.
- VI. **Compensation:** Your participation in this study is strictly voluntary. There is no compensation offered.
- VII. **Freedom to Withdraw:** You are free to withdraw from participation in this study at any time.
- VIII. **Approval of Research:** This research project has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic Institute and State University and by the Department of Human Development.
- IX. **Participant's Responsibilities:** I, the research participant, voluntarily agree to participate in this study. I have the responsibility to respond to the research questionnaire as accurately and completely as possible, and to mail the questionnaire back to the researcher in the postage-paid envelope provided once I am satisfied with my responses.

Appendix D: Mailed Questionnaire

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Department of Human Development

Shannon Anderson Pankow, LMFT
Ph.D. Candidate
4811 S. Kings Row Drive #4
Salt Lake City, UT 84117
(801) 278-9566

Scott Johnson, Ph.D., Dissertation Advisor
Family Therapy Center of Virginia Tech
University City Blvd., Suite 1
Blacksburg, VA 24061
(540) 231-3311

[Month, Day, 2000]

Dear MFT Graduate [name placed here if available]:

Thank you for agreeing to participate in this study of career practices and training perspectives of marriage and family therapy program graduates. You are one out of only 300 MFT graduates across the United States to be invited to participate. Your input is very important!

Enclosed you will find a statement of "Informed Consent to Participate in Research," the questionnaire, and a postage-paid return envelope. Please read the Informed Consent information carefully before filling out the questionnaire. You will be asked to initial and date your acceptance of the Informed Consent information on the questionnaire itself. The Informed Consent letter is your copy to keep.

The questionnaire will require anywhere from 20 - 30 minutes to complete. More thorough instructions are included on the questionnaire itself. When you are finished, please place your questionnaire in the postage-paid return envelope and place in a mailbox as soon as possible.

If you prefer, this questionnaire is also available on an Internet web site. The location is:

<http://home.earthlink.net/~gfanderson/shannon>

If you decide you would rather participate by using the Internet option, please be assured your responses will be completely confidential. Please see the web site for details.

If you have any questions at any time during or after your participation, or if you would like a copy of the results (available in September 2000), please contact me by e-mail: shannon_pankow@hotmail.com; or by phone: (801) 278-9566 or toll-free at 1-877-999-9566.

Thank you so much for your contribution to this project!

Sincerely,

Shannon Anderson Pankow, LMFT
Ph.D. Candidate
Virginia Polytechnic Institute and State University

**CAREER PRACTICES AND TRAINING PERSPECTIVES OF
MARRIAGE AND FAMILY THERAPY PROGRAM GRADUATES**

DIRECTIONS:

This questionnaire was designed to assess the career practices and educational perspectives of graduates from COAMFTE-accredited Marriage and Family Therapy Masters and Ph.D. programs. You will be asked to complete a total of 26 questions. These questions require a combination of open-ended and closed-ended responses, and will take about 20 - 30 minutes to complete. Your responses will be completely confidential.

If you run out of room while responding to any question, you may write on the back of the sheet or attach additional sheets as necessary. If you select either of these options, please indicate the question number which corresponds to your answer.

Once you have completed this questionnaire, please place it in the postage-paid return envelope provided and mail it back to me. You may also e-mail your responses to me at shannon_pankow@hotmail.com. This questionnaire is also available on the Internet at <http://home.earthlink.net/~gfanderson/shannon>

THANK YOU for your participation!

Shannon A. Pankow, LMFT
Ph.D. Candidate
Virginia Polytechnic Institute and State
University

INFORMED CONSENT ACKNOWLEDGMENT:

I have read the informed consent letter and agree to proceed as a research participant in keeping with the information outlined in that letter.

INITIAL: _____ DATE: _____
5-DIGIT REGISTRATION NUMBER: _____

I. BACKGROUND INFORMATION

1. Please list your educational background:

- (a) Bachelors degree: _____ (Type - i.e., B.S., B.A., etc. - & Major)
- (b) Masters degree: _____ (Type & Major)
- (c) Doctoral degree: _____ (Type & Major)
- (d) Post-graduate training (*please indicate the nature of the training*):

(e) Other education / training certifications (*please specify*):

2. Gender (*Please CIRCLE*): Male Female

3. Age: _____

4. Marital Status (*please CIRCLE one*): Single Divorced Cohabiting
 Married Widowed

5. How many dependents do you have? _____

6. (a) To the nearest thousand dollars, please list your current individual annual income (*This information is requested in order to obtain an accurate picture of current and potential salaries for MFT program graduates*):

\$ _____ .00 per year

(b) If your annual income comes from more than one source, please provide a breakdown of income — give your best estimate:

EXAMPLE: Individual annual income is \$42,000.00 per year

• Source: Therapy practice Amount: \$ 30,000 .00 per year

• Source: Teaching at university Amount: \$ 12,000 .00 per year

Source: _____ Amount: \$ _____ .00 per year

Source: _____ Amount: \$ _____ .00 per year

Source: _____ Amount: \$ _____ .00 per year

Source: _____ Amount: \$ _____ .00 per year

7. What is the average number of hours you work per week? _____

8. Please indicate the type of income you provide for your family:

G Sole income (sole contributor to family income)

G Shared income (family depends on your and other income)

G Secondary income (family is not dependent on your income for economic survival)

G No monetary income

9. In what state do you work? _____

14. Which aspects of your MFT training program have been the **LEAST** relevant / useful in your professional career?

LIST up to 3 — please be specific.

1.

2.

3.

15. What was missing from your MFT training program that would have better prepared you for your professional career?

LIST up to 3 — please be specific.

1.

2.

3.

16. Overall, how well did your MFT program(s) prepare you... ***(CIRCLE your response)***

			Not at All	Poorly	Adequately	Well	Very Well
(a)	...For your current job?	1	2	3	4	5	
(b)	...For your career goal (If different from your current job)?	N/A 1	2	3	4	5	
(c)	...For finding a job?		1	2	3	4	5

17. Are you a member (student, associate, affiliate, or clinical) of AAMFT?

- Yes, currently
 Never a member, don't intend to join
 Not now, but used to be
 Not now, but plan to join

18. Do you think membership in AAMFT has helped / would help you in securing employment? ***CIRCLE your response:***

Not at all Unlikely Possibly Probably Definitely

19. Do you think graduating from a COAMFTE-accredited MFT program has helped you in securing employment?

Not at all Unlikely Possibly Probably Definitely

III. **WORK AND CAREER**

Questions 20 - 26 ask for information about topics relating to your current and desired work activities.

20. List your current job title(s):

21. Please **LIST** your daily work activities and responsibilities (i.e., a job description):

22. (a) Do you have a current professional license? **YES** **NO**

(b) If "YES," in what discipline(s) do you hold a license: _____

(c) If you do not currently hold a license in Marriage and Family Therapy, why not?

23. Are you presently satisfied with the professional position(s) in which you are currently working?

YES NO

24. If you answered "NO" to question 23, in what kind of position(s) would you like to be working)?

25. If an MFT graduate student asked your advice on how to maximize his/her career options, how would you tell that student to prepare? What would he/she need to know?

- *You may LIST your answers if this is easier:*

26. Overall, do you think career opportunities for MFTs are: Narrowing
 Broadening
 Staying the same

*** * END OF QUESTIONNAIRE * ***

Please place your completed questionnaire in the postage-paid return envelope and place in a mailbox as soon as possible. Any questions or wish to receive a copy of the results? Contact me at

shannon_pankow@hotmail.com or at (801) 278-9566

Thank you for your participation!

Appendix E: Informed Consent for Internet Option Questionnaire

INFORMED CONSENT STATEMENT

Please read this before responding to the questionnaire:

- I. **Purpose of Research:** The purpose of this study is to discover current career practices and perspectives on training from graduates of COAMFTE-accredited masters and doctoral programs. This research is conducted for the purpose of fulfilling the doctoral dissertation requirement for the researcher's Ph.D. program in Marriage and Family Therapy. Approximately 300 graduates from 20 masters and doctoral programs across the United States will be asked to participate in this study.

- II. **Procedures:** The nature of your participation will involve spending approximately 20 - 30 minutes responding to this questionnaire. The questionnaire consists of 26 questions requiring a combination of open-ended and closed-ended responses. Once you have completed the questionnaire, click the "Send" button at the end of the questionnaire to have your responses automatically e-mailed to me. Additional instructions are included in the body of the questionnaire.

- III. **Risks:** There are no foreseeable risks with this research. You are free to discontinue your participation at any time for any reason. You can erase any responses you have already input by hitting the "Reset" button located at the end of the questionnaire. If you have specific questions for the researcher at any time during or after your participation, or if you desire a copy of the research findings, please contact the researcher, Shannon Pankow, by e-mail at shannon_pankow@hotmail.com, or by phone at (801) 278-9566. You may also contact Scott Johnson, Ph.D., dissertation advisor – e-mail: scjohnso@vt.edu, phone: (540) 231-3311.

- IV. **Benefits of this Project:** Little is known about the current career paths of MFT graduates in the contemporary age of managed care. Similarly, few studies have been conducted asking graduates with professional work experience about their training. This study represents an exciting opportunity to obtain new information to help MFTs plan their careers, understand the extent of their professional options, and to provide accredited MFT programs with feedback concerning what is and is not needed in MFT training. No promise or guarantee of benefits is being made in asking for your participation.

- V. **Extent of Confidentiality:** Your responses will be completely confidential. You will be asked to input a "registration number" found in your Invitation to Participate in Research letter. This registration number serves 3 purposes: (1) it verifies that you received an Invitation to Participate in Research and distinguishes your responses from others who may have found this website and input unqualified responses, (2) it prevents you from unnecessarily receiving follow-up letters, and (3) it assists in tracking which universities participated in the study. Once the data has been collected, any identifying information will be destroyed.

Your responses from this website itself are protected. When the researcher receives your responses by e-mail, the return e-mail address is listed as this web site. There will be no record of your own e-mail or online account anywhere on this web site.

- VI. Compensation: Your participation in this study is strictly voluntary. There is no compensation offered.
- VII. Freedom to Withdraw: You are free to withdraw from participation in this study at any time.
- VIII. Approval of Research: This research project has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic Institute and State University and by the Department of Human Development.
- IX. Participant's Responsibilities: I, the research participant, voluntarily agree to participate in this study. I have the responsibility to respond to the research questionnaire as accurately and completely as possible, and to hit the "Submit" button located at the end of the questionnaire once I am satisfied with my responses.

Participant's Permission: I have read and understand the Informed Consent and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent for participation in this project. If I participate, I may withdraw at any time without penalty. I agree to abide by the rules of this project.

Should I have any questions about this research or its conduct, I may contact:

Shannon A. Pankow, LMFT, Investigator
(801) 278-9566, e-mail: shannon_pankow@hotmail.com

Scott Johnson, Ph.D., Advisor
(540) 231-3311, e-mail: scjohnso@vt.edu

HT Hurd, IRB Chair, Research Division
(540) 231-5281

Date:
Registration number:

G I Accept **G** I Decline

Appendix F: Internet Option Questionnaire

This questionnaire can be viewed at the following Internet address:

<http://home.earthlink.net/~gfanderson/shannon>

Appendix G: Follow-up / Thank-you Letter #1

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY
Department of Human Development

Shannon Anderson Pankow, LMFT
Ph.D. Candidate
4811 S. Kings Row Drive #4
Salt Lake City, UT 84117
(801) 278-9566

Scott Johnson, Ph.D., Dissertation Advisor
Family Therapy Center of Virginia Tech
University City Blvd., Suite 1
Blacksburg, VA 24061
(540) 231-3311

[Month, Day, 2000]

Dear MFT Graduate [name placed here if available]:

Last week, an "Invitation to Participate in Research" letter was sent to you seeking your perspective, as a graduate of a COAMFTE-accredited marriage and family therapy program, about your career path and your training experience. This research is being conducted as a doctoral dissertation project. **Your input** will provide career and training feedback never before available to the MFT field!

If you have already participated by completing the questionnaire on the Internet web site, or if you have requested or completed a mailed questionnaire, **thank you so much** for your input! Please consider this letter a sincere "thank you" for your time and effort!

If you have not yet participated: Because the invitation letters have been sent only to a small but representative sample of MFT graduates, it is **extremely important** that your input is included in the study. Participation will require only 20 - 30 minutes of your time. If you have not yet received your information, or if it has been misplaced, you may follow one of two participation options:

1. View and fill out the questionnaire on the Internet by going to the web site:
<http://home.earthlink.net/~gfanderson/shannon>

OR

2. Call the following toll-free number to leave your registration number and address (name and phone number are optional), and I will send you a mailed questionnaire right away.
1-877-999-9566
- You will also need a 5-digit registration number to participate.

YOUR REGISTRATION NUMBER IS: 12345

If you have any questions, please contact me: **e-mail: shannon_pankow@hotmail.com** **phone: (801) 278-9566** or call the toll-free number above. Thanks again for your participation!

Sincerely,

Shannon Anderson Pankow, LMFT
Ph.D. Candidate
Virginia Polytechnic Institute and State University

Appendix H: Follow-up / Thank-you Letter#2

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY
Department of Human Development

Shannon Anderson Pankow, LMFT
Ph.D. Candidate
4811 S. Kings Row Drive #4
Salt Lake City, UT 84117
(801) 278-9566

Scott Johnson, Ph.D., Dissertation Advisor
Family Therapy Center of Virginia Tech
University City Blvd., Suite 1
Blacksburg, VA 24061
(540) 231-3311

[Month, Day, 2000]

Dear MFT Graduate [name placed here if available]:

About three weeks ago, I wrote to you seeking your input, as a graduate of a COAMFTE-accredited marriage and family therapy program, about your current career path and perspectives on your MFT training experience. According to my records, I have not yet received a response from you. **If you have already responded** and have received this follow-up letter in error, please accept my apology.

In addition to conducting this study as my doctoral dissertation project, I have initiated this research project because **there is little information available to marriage and family therapy graduates about their employment options**. There is also very little published feedback from experienced MFT professionals on the usefulness and relevance of their MFT training. MFT professionals, educators, and students alike are in dire need of such information.

I am writing you because **your experiences are an important part** of this study. You are one of only 300 MFT graduates across the United States randomly selected to participate in this study. In order for the results of this study to be truly representative of marriage and family therapy program graduates, it is essential that each person in the sample respond by filling out the questionnaire, either on the Internet at **<http://home.earthlink.net/~gfanderson/shannon>** or by completing a mail-in questionnaire.

For your convenience, I have included a copy of the questionnaire, the informed consent information, and a postage-paid return envelope. **I know you are busy**, but if you would take about 20-30 minutes to complete this questionnaire, either on the Internet or this paper copy, and submit your responses, **I would GREATLY appreciate your participation**.

Your **5-digit registration number**, required for participation is: **12345**

Once again, I **thank you** for helping to create a base of information about MFT careers and training that has never before been available! If you have any questions, please contact me either by e-mail: **shannon_pankow@hotmail.com**; or by phone: **(801) 278-9566** or toll-free at **1-877-999-9566**.

Sincerely,

Shannon Anderson Pankow, LMFT
Ph.D. Candidate
Virginia Polytechnic Institute and State University

Appendix I: Pearson Product-Moment Correlation Matrix for all Continuous Variables

<u>Variable</u>	AAMFTJ	AGE	COMFTJ	HRSWK	INCOM	#DEP	#JOBS	PCURR	PGOAL	PJOB
AAMFTJ		.024	.600***	.181*	.293***	.101	.077	.347***	.282**	.307***
AGE			-.127	-.121	.034	.002	.104	-.115	-.076	.035
COMFTJ				.167	.102	.080	-.034	.333***	.180	.278**
HRSWK					.658***	-.036	.328***	.213*	-.016	.172
INCOM						.223*	.217*	.016	-.043	.175
#DEP							-.000	-.005	.085	.057
#JOBS								.226*	.116	.146
PCURR									.463***	.395***
PGOAL										.451***
PJOB										

N = 125 participants

AAMFTJ = Membership in AAMFT helped to secure employment

AGE = Participants' age

COMFTJ = Graduating from COAMFTE-accredited program helped to secure employment

HRSWK = Number of hours worked per week

INCOM = Participants' income

#DEP = Number of dependents

#JOBS = Number of jobs currently held

PCURR = How well MFT program prepared for current job

PGOAL = How well MFT program prepared for career goal

PJOB = How well MFT program prepared to find a job

* = $p \leq .05$

** = $p \leq .01$

*** = $p \leq .001$

SHANNON ANDERSON PANKOW

PROFESSIONAL LICENSE

MARRIAGE AND FAMILY THERAPIST (LMFT), State of Utah

EDUCATION

DOCTOR OF PHILOSOPHY HUMAN DEVELOPMENT, EMPHASIS IN MARRIAGE AND FAMILY THERAPY
Virginia Polytechnic Institute and State University, Blacksburg, VA — 2000

MASTER OF SCIENCE FAMILY SCIENCE, EMPHASIS IN FAMILY LIFE EDUCATION
Brigham Young University, Provo, UT — 1994

BACHELOR OF SCIENCE PSYCHOLOGY
Brigham Young University, Provo, UT — 1991

EMPLOYMENT EXPERIENCE

CAREER ASSESSMENT ADVISOR SALT LAKE COMMUNITY COLLEGE; Salt Lake City, UT: 2000

- Administer battery of career interest, aptitude, and achievement tests.
- Provide career counseling to students and community-referred clients.

PRACTITIONER FACULTY UNIVERSITY OF PHOENIX, UTAH CAMPUS; Salt Lake City, UT: 2000

- Teach psychopharmacology and other courses in the Masters of Mental Health Counseling program.

ADHERENCE SPECIALIST STADT SOLUTIONS PHARMACY; Salt Lake City, UT: 1999 - 2000

- Monitored psychotropic medication compliance in patients; provided education.
- Developed risk assessment / designed interventions to improve adherence.
- Trained mental health professionals in adherence assessment & intervention.
- Developed training curriculum on families and medication adherence.
- Marketed new pharmaceutical care concept to mental health agencies.

THERAPIST SANDY COUNSELING CENTERS; Sandy, UT: 1997 - 1999

- Conducted individual, family, couples, and group psychotherapy
- Clinical experience includes: assessment and treatment of chemical dependency/ addictions, career issues, stress management, depression and anxiety, sexually abused children, domestic violence, sex therapy, perpetrators of sexual abuse, trauma resolution, bipolar disorder, schizophrenia, Axis II disorders, etc.
- Special emphasis in psychopharmacological interventions.

TREATMENT COORDINATOR SANDY COUNSELING CENTERS; Sandy, UT: 1997 - 1999

- Trained clinical staff in administrative protocols; conducted orientations.
- Developed quality control program for clinical records.
- Conducted case reviews to ensure quality care.
- Marketed clinical programs to local courts.
- Conducted chart audits to ensure compliance with Medicaid and Utah Department of Human Services licensing standards.

SHANNON A. PANKOW — Vitae p. 2

EMPLOYMENT EXPERIENCE, continued

- THERAPIST** FAMILY THERAPY CENTER OF VIRGINIA TECH; Blacksburg, VA: 1995 - 1997
- Performed clinical intakes/assessments by phone.
 - Clinical experience includes: family, individual, and couples therapy, sex therapy, anxiety and depression, stress management, parenting issues, trauma resolution, Axis II disorders.
 - Special emphasis in psychopharmacology and biological factors in mental illness.
 - Supervised first-year therapy students and undergraduate interns.
- FIELD STUDY
COORDINATOR** DEPARTMENT OF HUMAN DEVELOPMENT, VIRGINIA POLYTECHNIC INSTITUTE AND
STATE UNIVERSITY; Blacksburg, VA: 1995 - 1997
- Interviewed, screened, and placed students in professional internships.
 - Taught corresponding course to university juniors and seniors emphasizing professionalism, writing skills, employee conduct, and career options.
 - Recruited student participation and new placement sites for students.
 - Provided career consultation for university students.
- QUALITY
ASSURANCE
MANAGER** ADVANCED HOME HEALTH CARE; Orem, UT: 1995
- Audited medical records to ensure compliance with Medicare standards.
 - Trained nurses and aides in detailed records requirements.
 - Supervised reconciliation of records discrepancies.
- OFFICE
MANAGER** ECLIPSE MARKETING; Valley Center, CA: 1994 - 1995
- Screened and interviewed job applicants; coordinated employee training.
 - Assisted in development of sales training course and materials.
 - Maintained detailed and accurate employee files.
 - General office duties: payroll, typing, phones, scheduling appointments.
- RESEARCH
ASSISTANT** DEPARTMENT OF FAMILY SCIENCES, BRIGHAM YOUNG UNIVERSITY; Provo, UT:
1993 - 1994
- Assisted faculty with research and teaching needs.
 - Managed quantitative and qualitative data.
 - Assisted in managing research protocols and reviewing literature.
- NATIONAL
CONFERENCE
COORDINATOR** MATOL COMMUNICATIONS; Orem, UT: 1992
- Organized all aspects of national conferences for international marketing company, including: staffing, scheduling, catering, and registration.
 - Managed conference budget.
 - Explained career development options and related benefits to distributors.

PROFESSIONAL ACTIVITIES

- TRAINER /
GUEST LECTURER** VARIOUS COMMUNITY ORGANIZATIONS; Salt Lake City, UT
- Topics have included stress management, exercising career choices, couple communication, marriage enhancement, dating safety, anxiety/depression.
- COUNCIL
MEMBER** SALT LAKE AREA DOMESTIC VIOLENCE COUNCIL; Salt Lake City, UT: 1998 - 1999
- Reviewed research and conference proceedings on domestic violence topics.
 - Discussed protocols for local domestic violence research.
 - Assessed needs of non-profit organizations to help provide DV prevention/intervention.

SHANNON A. PANKOW — Vitae p. 3

PROFESSIONAL ACTIVITIES, continued

- CONSULTING
TEAM MEMBER** SOLUTION-FOCUSED LEADERSHIP TRAINING SEMINAR; Blacksburg, VA: 1996
- Member of seminar guest expert team for training members of management in more effective corporate interaction styles.
- RESEARCH
PRESENTATION** NATIONAL COUNCIL ON FAMILY RELATIONS; Portland, OR: 1995.
- Presented results of research study at well-attended national conference.
 - Managed controversial discussion of research conclusions.
- STUDENT
MEMBER** AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY (AAMFT)
- 1995 - Present
- COMMUNICATION
TRAINER** MILLER'S COUPLE COMMUNICATION PROGRAM. Completed training in 1994.
- Trained over 150 couples in nationally recognized communication program.
 - Supervised performance of communication coaches.

PUBLICATIONS

Larson, J.H., **Anderson, Shannon M.**, Holman, T.B., & Niemann, B.K. (1998). A longitudinal study of the effects of premarital communication, relationship stability, and self-esteem on sexual satisfaction in the first year of marriage. *Journal of Sex and Marital Therapy*, vol. 24, pp. 193- 206.