THE INFLUENCE OF MARITAL AND FAMILY THERAPY ON HEALTH CARE UTILIZATION IN A HEALTH-MAINTENANCE ORGANIZATION

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Research has shown that people reduce their use of health care after individual psychotherapy. However, little research has been done to learn if marital and family therapy has a similar effect. Subjects (n = 292) from a health-maintenance organization were randomly selected according to the type of therapy they had received. Subjects’ medical records were examined for 6 months before, during, and after therapy. Those who received marital and family therapy significantly reduced their use of health care services by 21.5%. These results show an “offset effect” for marriage and family therapy.

Recently, the United States Congress debated the possible inclusion of a behavioral health component in a national health plan (Frank & VandenBos, 1994). At first glance, it may seem that adding this component would not aid in reducing health care costs. However, past research has shown that people reduce their use of medical services after individual therapy (e.g., Follette & Cummings, 1967; Jones & Holden, 1995; Jones & Vischi, 1980; Kessler, Steinwachs, & Hankin, 1982; Pallak, Cummings, Dorken, & Henke, 1994; Schlesinger, Mumford, Glass, Patrick, & Sharfstein, 1983; Simon & Katzelnick, 1997). This reduction in health care use is called an “offset effect” (Shemo, 1985–1986). The premise is that with the help of therapy, people can deal with their life circumstances more effectively, therefore reducing stress or the possible tendency for emotional concerns to be expressed physically.

Many studies related to individual and group therapies have been conducted on this topic. A recent meta-analysis reviewed more than 90 articles representing the efforts of the past 35 years (Chiles, Lambert, & Hatch, 1999). Of the studies reviewed, 90% reported a decrease in medical use following some type of psychological intervention. On average, those who received psychological treatment reduced medical use by 26.7%, while the control groups increased use by an average of 9.16%.

The success of individual and group therapies in showing an offset effect is important to the field of marriage and family therapy (MFT). As the profession of MFT grows, it is increasingly important to show that the systemic approach is effective. Showing that MFT can produce an offset effect is one way of doing so. As Sprenkle and Bailey emphasize, “if our discipline is to remain a viable ‘player’ in the health care system, it will be necessary to demonstrate our effectiveness both clinically and financially” (1995, p. 339). The individually oriented therapies have successfully demonstrated an offset effect, while MFT-based treatments have not been adequately studied.
HISTORY OF OFFSET-EFFECT LITERATURE


First Generation: 1960–1980

These studies focused on the impact of psychotherapy on medical use as it occurred in the day-to-day world of health care. These studies were generally archival in nature. That is, they examined patterns of health care use after services were provided in the normal course of care. For example, Follette and Cummings (1967) showed that patients who received psychotherapy experienced significant reductions in the use of medical care. After the first year, they reduced medical visits by 24%, and by the fifth year they had decreased medical health care by 62%. In contrast, the control group increased its use of medical services during the same time.

Also during this generation, the National Institute of Mental Health (NIMH) sponsored several offset studies. These studies were summarized by Jones and Vischi (1980) of the Alcohol, Drug Abuse, and Mental Health Administration. They reviewed 13 studies that focused on medical care use following mental health intervention. In 12 of these studies, reductions ranging from 5% to 85% with a median reduction of about 20% were reported. In their summary, Jones and Vischi recommended that future research determine what specific factors were most associated with decreases in medical use. Two of these recommendations are of particular interest to the field of MFT and have for the most part been ignored by subsequent studies. The most important recommendations included (1) how other types of treatment such as family or marital therapy affect medical use and (2) how the treatment of one family member affects the medical use of other family members.


This era produced approximately 80 studies. Most of them either replicated previous findings or tried to address the concerns raised by Jones and Vischi in 1980 (Cummings, 1997). For example, during this time the first study comparing the effect of individual, group, and family therapy was conducted (Kessler et al., 1982).

As the second-generation studies were gaining momentum, significant social and marketplace events occurred that greatly influenced the field of behavioral health and subsequent offset-effect studies. Development of diagnosis-related groups (DRGs) reduced medical-surgical costs but inadvertently encouraged the hospital industry to turn empty hospital beds into mental and chemical-dependency treatment facilities. This led to a surge in costs associated with behavioral health care. To reduce these costs, behavioral health care companies were formed to more effectively administer mental health treatment. While these “managed care” plans curtailed behavioral health care costs, they made continued offset research more difficult (Cummings, 1997). For example, as behavioral health care and medical-surgical operations were managed as two separate entities, it became more difficult to work cooperatively together.

Third Generation: 1990–Present

This generation of studies more frequently uses designs that apply (1) experimental as opposed to archival studies, (2) random assignment of subjects to experimental and control groups, and (3) the targeting of treatments to specific populations, problems, or diagnoses (e.g., Hellman, Budd, Borysenko, McClelland, & Benson, 1990).

For instance, Pallak et al. (1994) randomly assigned two-thirds of the Medicaid population in Oahu, Hawaii, to an experimental group in which they were eligible for managed mental health services. A control group, made up of the remaining one-third of Medicaid patients, received mental health services in the usual fee-for-service manner. In addition, patients with and without a chronic medical diagnosis were included in the investigation. Overall, though outcomes were variable, patients who received mental health treatments reduced medical use in the year following therapy. The Pallak example of a third-generation study clearly showed that mental health treatment had potential in reducing health care use.
Offset-effect research has been dominated by the field of psychology, in which the unit of analysis has traditionally been the individual. As far back as the late 1970s, Jones and Vischi (1980) recommended that researchers expand their unit of analysis to the family. In addition, they encouraged the investigation of how the subjects’ genders, the number of sessions, and the intensity of therapy sessions are related to medical offset.

**Offset Studies with a Family Focus**

**Family and marital therapy studies.** The only known study to contrast individual, group, and family-couple therapy compared the use of medical rates 1 year before and after treatment (Kessler et al., 1982). Subjects who had individual therapy decreased medical utilization by 9.3%. A 7.3% reduction was found for group therapy. Those who had family-couple therapy decreased their use by 1.5%. Several possible limitations in this study may have contributed to the poor showing of family-couple therapy. For example, none of the counseling providers were licensed MFTs. Also, it is unknown whether any of the providers had any training, experience, or skills in providing marriage and family therapy.

Though not contrasting different types of therapy, Graves and Hastrup (1981) investigated the impact of family therapy on medical use by comparing a group that had family therapy treatment with a matched control group. The treatment group received specific family treatment for specific behavioral and psychosomatic problems. The treatment group reduced clinic visits by 36% in the year following therapy. A control group, which did not have family therapy, did not decrease utilization.

Finney, Riley, and Cataldo (1991) also found reductions in the use of health care for children when they were seen with their parents in therapy sessions. They also had specific family treatment for behavioral and psychosomatic problems. In comparing the year before and the year after therapy, the treated group reduced medical visits by 28%. No significant reduction occurred in the comparison group.

In a more recent study of married alcoholics, O’Farrell et al. (1996) found a decrease in health care and legal costs for both individual and couple therapies. In the 2 years following therapy, those treated by individual therapy or behavioral marital therapy had a greater cost savings than those treated by interactional group therapies.

In the family and marital therapy studies mentioned, the subjects were similar to each other because they received counseling for mental health or psychosocial concerns. The subject’s physical health status was not used to classify to or include or exclude patients studied.

**Effects of individual therapy on other family members.** Two studies that have investigated how individual therapy influenced the medical use of nontreated family members have shown mixed results. Goldberg et al. (1981) found that when subjects received individual therapy, no effect on the use of medical services by other members of the family was detected. However, when Holder and Blose (1987) examined nontreated family members, they found reduced total health care costs of $21.10 per person, per month, after treatment of the identified patient. While studies with a family focus generally support the idea of family intervention as a fruitful area for further research, no known studies have focused on the general impact of MFT treatment on the use of health care.

**Gender of Subjects**

Studies have shown that the subjects’ gender may influence health care use patterns. For example, Jameson, Shuman, and Young (1978) compared the monthly cost of health care before and after individual therapy. Adult men had a monthly reduction of $11.23, adult women of $6.16, male dependents of $3.09, and female dependents of $4.20. Overall, these decreases were significant. Also, Goldberg, Krantz, and Locke (1970) compared the year before and after psychiatric referral and found that males decreased physician visits by 37.8% and females by 26.0%.

**Number of Therapy Sessions**

Follette and Cummings (1967) examined outpatient medical utilization for 6 years. Subjects were grouped according to whether they had one, two to eight (brief therapy), or nine or more (long-term therapy) visits. In comparing use before and after therapy, the single-session group decreased medical usage by
61.4%, the brief-therapy group by 70%, and the long-term group by 50%. Other studies have also supported the idea that brief individual therapy (one to ten therapy sessions) results in greater offset effects than longer-term individual therapy (e.g., Goldberg et al., 1970; Kessler et al., 1982).

In contrast to such studies, Schlesinger et al. (1983) compared four groups who had different numbers of therapy sessions with a control group. Unlike the earlier studies, which did not use medical conditions as inclusionary criteria, this study only included subjects who had been diagnosed with a chronic medical condition. They found that subjects who had the most therapy experienced greater reductions in hospital costs than those receiving fewer therapy sessions. These mixed findings suggest a treatment-by-illness interaction effect. More chronic conditions may require more therapy sessions to achieve the same results.

Intensity of Therapy Sessions

Kessler et al. (1982) defined intensity as the frequency of psychiatric visits per unit of time. When comparing the year before and after individual therapy, those who had one or fewer visits per month decreased medical use by 2.7%. Persons who had at least one, but no more than two visits, reduced medical care by 4.8%. Those who had more than two therapy visits reduced medical care by 10%. Thus, the more intense the therapy, the greater the medical offset.

PURPOSE OF THIS STUDY

The primary purpose of this study is to investigate whether MFT is associated with a reduction of health care use as practiced in the day-to-day world of health care delivery. Because this is the first known study to use MFT as the primary mode of intervention, it was exploratory and descriptive, much like the first generation of offset studies. Three MFT treatment groups were studied: marital therapy, family therapy–identified patient, and family therapy–other patient. The identified patient was usually a child or adolescent that the parents were concerned about because of either externalized (e.g., behavioral) or internalized (e.g., depression, anxiety) problems. The family therapy–other patient group consisted of parents or siblings of the identified patient. Also, to provide a basis of comparison, samples of persons receiving individual therapy and a control group of persons not receiving any form of therapy were studied.

In addition, to understand other variables that may affect trends in health care use, we also examined subjects’ gender. Also, as recommended by Jones and Vischi (1980), the number of therapy sessions and intensity (or frequency) of sessions for those who had MFT treatment were investigated.

We asked the following questions: (1) What is the effect of MFT or individual treatment on the number of health care visits? (2) What are the differences among the subcategories of MFT groups in their use of health care? (3) Are there gender differences in the number of health care visits for those who had MFT treatment? (4) How does the number of therapy sessions affect health care visits for those who had MFT treatment? And (5) How does the intensity (or frequency) of therapy sessions effect health care use for those who had MFT treatment?

METHOD

Subjects

The 292 subjects were members of FHP-Utah (formally named Family Health Program). At the time, it was one of the five largest Health-Maintenance Organizations (HMOs) in the United States, with more than 1.8 million members. The organization, based in California, had 186,000 enrollees in the Utah region. Subjects were predominantly Caucasian and middle class.

Therapists

Therapists were a multidisciplinary team (nine males, 12 females) composed of four MFTs, two psychologists, 13 social workers, one chemical-dependency counselor, and one professional counselor who were regular employees of FHP. All were hired to staff the Department of Human Relations and to provide therapy services to all those enrolled in the local region of the HMO.
Procedure

This study was approved by Brigham Young University's (BYU) Institutional Review Board in 1993 and by the FHP Clinical Research Committee in 1994. In June 1995, the researchers received the basic data for every subject who had individual, marital, or family therapy from January 1988 through June 1994. The FHP identification numbers were then randomly selected and medical charts reviewed until each cell was filled.

Defining Health Care Utilization

This study followed first-generation procedures (e.g., Follette & Cummings, 1967), using ambulatory care as the primary dependent variable. Ambulatory care was defined as “health services given to those who come to a hospital or other health care center and who leave after treatment on the same day” (Glanze, Anderson, & Anderson, 1985, p. 29). Outpatient visits were defined as medical care for illness, injury, psychotropic medication management, health screening, urgent care, laboratory work, or x-rays. Emergency room, prescription, and hospitalization data were not available.

Subject Inclusionary Criteria

Subjects had to be enrolled in the “staff model” health plan, where they received all of their care through an FHP staff model health care center, and had to be members of FHP for the entire 18 months of the study. Within 6 months of beginning therapy, subjects were required to have had at least three visits in a particular type of therapy (individual, marital, or family therapy). In order to assure distinct groups for comparison purposes, the ratio of the predominant type of therapy to other types of therapy needed to be at least 3 : 1.

Participants were randomly selected from those who had used individual, marital, or family therapy. Client medical conditions, pretherapy medical utilization, or the source of referral for those receiving therapy had no bearing on selection.

Time Periods

Data for this study were collected for a continuous 18-month period for each subject. “Time one” represents 6 months before the start of therapy. Months seven through 12 are designated “time two,” beginning the day subjects started therapy. “Time three” is the 6-month period beginning 6 months after the initiation of therapy. The start of therapy is the central date in the time periods, with time one and time three based on calculations from that date. As a result, the 18-month period differs for each subject, depending on the date therapy began.

Types of Therapy

Because this study was retrospective in design, subjects where randomly selected if they had received one of the following five different types of therapy.

Individual therapy. This sample consisted of 30 male and 30 female patients who had individual psychotherapy. Mean ages were 30.23 (SD = 16.02, range 6–58) and 33.77 (SD = 15.83, range 9–60) years for men and women, respectively. Diagnoses included 43% mood disorders, 30% relational disorders, and 27% miscellaneous.

Marital therapy. Thirty males and 22 females (all those available) underwent conjoint therapy focusing on the marital relationship. Mean ages were 36.43 (SD = 9.91, range 23–60) years for men and 38.32 (SD = 11.83, range 23–61) years for women. Diagnoses provided after therapy began were 100% relational disorders.

Family therapy–identified patient (FTIP). This sample was made up of 30 males and 30 females who had family therapy. In all but one case the identified patient was either a child or adolescent. They were categorized as the “identified patients” by the therapist's notes. Presenting problems included issues such as acting out at school, fighting with siblings, depression, or anxiety. Males in this group averaged 10.63 years of age (SD = 4, range 2–18), and females 12.80 years (SD = 8.97, range 4–52). Diagnoses included 53% relational disorders; 28% disorders of infancy, childhood, and adolescence; and 14% miscellaneous disorders.
Family therapy—other patient (FTOP). This sample consisted of 30 males and 30 females who participated in family therapy in which they were not the identified patients. These subjects were siblings or parents of those in the FTIP group. Mean male age was 36 years (SD = 17.36, range 4–58), and mean female age was 32.83 years (SD = 11.95, range 5–48). The main diagnostic category was relational disorder (97%).

Control group. This sample was a randomly selected group of 30 males and 30 females who did not receive therapy. Demographic data for this group were not available.

**Number of Sessions**

Those subjects who had three or four therapy sessions (in time two) were put in the “low number of sessions” category (n = 78). Those who had five or six sessions were put in the “medium number of sessions” category (n = 49). Persons who had seven or more sessions were put in the “high number of sessions” category (n = 45). These categories were chosen primarily because previous research (e.g., Follette & Cummings, 1967; Kessler et al., 1982) used similar categories for the number of sessions.

**Intensity of Sessions**

Similar to Kessler et al. (1982), the intensity of sessions was determined by dividing the total number of sessions by the number of weeks between the first and last session of therapy in time two. Subjects were classified into four levels. Those seen less than once every 3 weeks were classified as “low” intensity (n = 60); those seen less than once every 2 weeks were classified as “medium-low” (n = 62), those seen less than once a week were classified as “medium-high” (n = 42), and those seen at least once a week (≥1 week) were classified as “high” intensity (n = 8).

The five study questions were answered using a two-way mixed-model analysis of variance (ANOVA).

**RESULTS**

**Differences within Therapy Groups**

The first question asked, “What is the effect of MFT or individual treatment on the number of health care visits?” All of the MFT groups were combined to answer this question.

As shown in Table 1, the combined MFT groups (n = 272) decreased their use of medical services overall. When time one was compared with time three, subjects decreased their number of visits by 21.5% (F (1, 171) = 3.78, p = .05). When the three periods were compared, the decreases remained significant, (F (2, 342) = 3.05, p < .05). Overall, subjects who received marriage and family therapy significantly decreased their use of health care after treatment. This was the only type of therapy that showed a substantial reduction over time.

Those who had individual therapy (n = 60) began as the most frequent utilizers of health care in time one and remained the highest. When comparing time one with time three, this group experienced a nonsignificant (10%) reduction. The least frequent utilizers of health care services were in the control group. When comparing time one with time three, this group averaged a nonsignificant increase (12.2%) in the number of visits.

The second question asked, “What are the differences among the subcategories of MFT groups in their use of health care?” Overall, there were no group differences or interactions, meaning that there were no significant changes in health care use when considering the subcategories of MFT separately. However, the patterns of each group warrant a brief presentation.

Those who had marital therapy (n = 52) had a moderate but steady decrease of health care visits over the three time periods. Though the decrease from time one to time three was an impressive 21%, it was not significant.

The FTIP patients (n = 60, primarily children and adolescents) were the only group who increased their use of health care from time one to time two. A closer look at this group shows marked differences by gender. Females in this group started with 1.47 visits during time one and increased to 3.37 visits (F (1, 29) = 7.13, p < .05) in time two. They decreased their use in time three to 2.30 visits. Thus, even though the
TABLE 1
Changes in Number of Health Care Visits before, during, and after Therapy

<table>
<thead>
<tr>
<th>Type of therapy</th>
<th>M</th>
<th>SD</th>
<th>F values</th>
<th>Absolute change</th>
<th>Percentage change</th>
</tr>
</thead>
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<tr>
<td>Individual (n = 60):</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>T1</td>
<td>3.60</td>
<td>4.41</td>
<td>T1 vs. T2</td>
<td>0.11</td>
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<tr>
<td>T2</td>
<td>3.38</td>
<td>3.60</td>
<td>T1 vs. T3</td>
<td>0.35</td>
<td></td>
</tr>
<tr>
<td>T3</td>
<td>3.23</td>
<td>3.00</td>
<td>T2 vs. T3</td>
<td>0.11</td>
<td></td>
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<tr>
<td>MFT overall (n = 172):</td>
<td></td>
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<tr>
<td>T1</td>
<td>2.70</td>
<td>3.01</td>
<td>T1 vs. T2</td>
<td>0.03</td>
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<tr>
<td>T2</td>
<td>2.74</td>
<td>3.14</td>
<td>T1 vs. T3</td>
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</tr>
<tr>
<td>T3</td>
<td>2.12</td>
<td>2.73</td>
<td>T2 vs. T3</td>
<td>6.00*</td>
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<td></td>
<td></td>
<td></td>
<td>T1 vs. T2 vs. T3</td>
<td>3.05*</td>
<td></td>
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<tr>
<td>Marital (n = 52):</td>
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<tr>
<td>T1</td>
<td>2.83</td>
<td>3.01</td>
<td>T1 vs. T2</td>
<td>0.59</td>
<td></td>
</tr>
<tr>
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<td>2.46</td>
<td>3.38</td>
<td>T1 vs. T3</td>
<td>1.35</td>
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</tr>
<tr>
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<td>2.47</td>
<td>T2 vs. T3</td>
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<td></td>
<td></td>
<td>T1 vs. T2 vs. T3</td>
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<td>T1</td>
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<td>2.52</td>
<td>T1 vs. T2</td>
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<td>T1 vs. T3</td>
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<td>T2 vs. T3</td>
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<td></td>
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<td>T1 vs. T2 vs. T3</td>
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<td>FTOP (n = 60):</td>
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<td>T1</td>
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<td>T1 vs. T3</td>
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<td></td>
<td></td>
<td></td>
<td>T1 vs. T2 vs. T3</td>
<td>1.83</td>
<td></td>
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<tr>
<td>Control (n = 60):</td>
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<td></td>
<td></td>
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<tr>
<td>T1</td>
<td>1.72</td>
<td>2.31</td>
<td>T1 vs. T2</td>
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<td>T2</td>
<td>1.87</td>
<td>3.11</td>
<td>T1 vs. T3</td>
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<tr>
<td>T3</td>
<td>1.93</td>
<td>3.17</td>
<td>T2 vs. T3</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>T1 vs. T2 vs. T3</td>
<td>0.12</td>
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</tbody>
</table>

Note. Individual = individual therapy, MFT = marriage and family therapy, Marital = marital therapy, FTIP = family therapy identified patient, FTOP = family therapy other patient; T1 = time one, T2 = time two, T3 = time three; *From T1 to T3.

*p < .05.

increase from time one to time two was significant, the increase from time one to time three was not. In contrast, the boys in the FTIP group had a steady and significant decrease over the three time periods, starting with 3.00 visits and ending with 1.73 visits, (F (1, 29) = 6.18, p < .05).

Finally, the FTOP patient group was examined to see if MFT treatment might generalize to other family members. This group’s pattern of health care usage was characterized by a steady decrease over the three periods. From time one to time three this group reduced visits by a nonsignificant 30.5%. The influence of
family therapy on the health of other family members needs further investigation.

While no statistically significant group differences were found for the subgroups of MFT treatment, the different trends are interesting and warrant further investigation with larger samples.

**Differences between Therapy Groups**

Overall, health care use was highest for those who had individual therapy ($M = 3.40, SD = 3.67$ visits over the three periods). The three MFT treatment groups were next, averaging $2.52$ visits ($SD = 3.08$). The control group was the lowest, with $1.84$ visits ($SD = 2.86$). These differences between the groups were significant, ($F (2, 289) = 7.13, p < .001$), meaning that the individual, MFT (total), and control groups were all different in their level of health care utilization at the beginning and end of the study. There was no interaction between time and type of therapy, meaning that the differences that existed between the groups at the beginning were also present at the end of the study.

The third question asked, “Are there gender differences in the number of health care visits for those who had MFT treatment?” Overall, no differences by gender were found, ($F (1, 170) = 2.17, p = .143$). Also, there was no interaction of gender and time ($F (2, 340) = .91, p = .402$). Male and female patients used health care services at the same rate across all periods.

However, when considering changes pre- and posttherapy, the males showed an interesting trend, decreasing their number of health care visits from time one to time three by $32\%$ ($F (1, 89) = 5.05, p < .05$). For females, the reduction from time one to time three of $10.3\%$ was not significant. Here, MFT seemed to affect utilization for males more than for females.

The fourth question, “How does the number of therapy sessions affect health care visits for those who had MFT treatment?” revealed no important information. All three groups averaged two to three visits during each time period. No group differences were detected ($F (2, 169) = .08, p = .926$). Also, there was no interaction between groups and time ($F (4, 338) = .29, p = .886$). This means the amount of therapy received did not affect health care use after therapy.

Finally, the results for question five, “How does the intensity of therapy sessions affect health care over time for those who had MFT treatment?” showed that the high-intensity group (therapy at least once per week) started as the highest utilizers in time one and remained the highest in time three. No differences between the groups or interactions over time were evident. However, one interesting finding regarding the medium low-intensity group appeared. This group had an increase in utilization from time one to time two and a significant decrease from time two to time three ($F (1, 61) = 8.04, p < .01$).

The results suggest that a lower intensity of therapy sessions is associated with a greater reduction in health care visits than higher-intensity therapy. However, it is equally likely that more distressed or seriously ill persons require a higher intensity of therapy sessions.

**DISCUSSION**

The $10\%$ reduction in health care for those who received individual therapy is similar to the $9.3\%$ decrease reported by Kessler et al. (1982). The similarity of the two findings suggests that these findings are probably accurate as they are consistent with at least one other study of this type. Other studies such as Follette and Cummings (1967) and Pallak et al. (1994) have reported higher reductions for individual therapy ($21.4\%$ and $27\%$, respectively). However, the current study and the Kessler et al. (1982) studies are archival in design, whereas the Follette and Cummings (1967) and Pallak et al. (1994) findings are from experimental studies. The distinction is important because archival studies take the data as it is, in the natural environment. As such, more variance is usually evident in studies of this type. Greater variance makes differences between groups hard to detect. Experimental designs are optimal because they can provide a more focused picture of the effects of specific procedures through the elimination of other sources of variance.

Direct comparison of the results for MFT and individual therapy is not appropriate since both groups of subjects were different at the beginning and at the end of the study. Patients referred for individual therapy used health care services more and may have been different on other important dimensions as well. For
example, they may have been more likely to suffer from severe and chronic mental illness, or they may not have the benefits of familial support systems. Direct comparisons between types of therapy would be possible only if studies were specifically designed to make such comparisons. For example, future research would need to gather a wider range of data on subject characteristics such as age, marital and family status, mental health diagnosis, socioeconomic status, and so on. Subjects could then be matched and randomly assigned to therapy types.

Results for MFT

Because Kessler et al. (1982) was the only study to use MFT and individual therapy, contrasting those previous results with the findings of the current study is important. Kessler et al. only found a 1.5% reduction in health care use by patients in MFT, while we found a significant 21.5% decrease. Therapist training differences might at least partially explain these differing results. In the current study, four therapists had master’s degrees in MFT, while none did in the Kessler et al. study. Also, therapists who were not MFTs in the current study may have received more extensive training working with family systems than Kessler et al.’s therapists simply because training programs offer more family intervention courses than they did 20 years ago. Future research needs to be directed at better understanding how therapists’ training may influence a medical offset effect.

Because most previous studies have focused on individual therapy and found it to be associated with lower medical use, individual therapy has been promoted as a part of health care packages. The current research supports the potential value of marriage and family therapy in reducing the need and cost of medical services. Additional research is needed to further document the benefit of marriage and family therapy and warrant its inclusion in health care plans.

Types of MFT

In discussing the results of the subcategories of MFT, two areas stand out. The first is the utilization patterns for family members who were not the identified patients. This finding could support family systems theory and be an example of how a change in one part of the system facilitates a change in another. While this is an interesting idea, it needs further study.

While the FTIP group did have a 9.5% reduction, it is not as high as the 35% reduction in health care visits reported by Graves and Hastrup (1981) or the 27.5% reduction Finney et al. (1991) found. The difference between these results and the previous two studies may be because of the type of treatment delivered. The earlier two studies may have found higher reductions because they tested specific family treatments for specific behavioral problems such as encopresis, school phobia, and tantrums. In contrast, this study did not specify an approach to treatment. Instead, it focused on the practices of many different therapists, who were undoubtedly using a number of differing treatment approaches.

The second area that merits discussion is why significant reductions were not found in the subcategories of MFT treatment when reductions in health care use are significant when the groups are combined. The primary reason is probably small sample size in the subgroups. Earlier studies have had much larger samples. For example, with the large n of 1,155 subjects in the Kessler et al. (1982) study, the 8.1% decrease was statistically significant.

Results for Gender

The results for gender support past studies, showing that while both genders experience a reduction in medical utilization over time, it is more pronounced for males than females (e.g., Jameson et al., 1978; Kessler et al., 1982). Males may benefit from therapy more quickly than do females.

Number and Intensity of Sessions

Past research (e.g., Follette & Cummings, 1967; Goldberg et al., 1970; Kessler et al., 1982) has shown that high utilizers of therapy experience less of an offset effect than do lower utilizers. This study did not find this difference. The offset effect was present overall and did not differ by the number of sessions the subjects received.
While Kessler et al. (1982) found that more intensive therapy produced more of a medical offset, this study does not support that idea. In contrast to earlier studies, these results may be more representative of a managed care environment, in which the number of sessions given was closely monitored.

CONCLUSION

This study, while supportive of an offset effect for MFT, should be interpreted cautiously. First, only outpatient medical records were available to the investigators. Since inpatient care is the most expensive type of medical service, further research is needed to assess the effects of marital and family therapy on inpatient use.

Second, a shortcoming of this study is that the information available about the subjects was limited. Future research should gather more demographic information and assess such variables as distress levels of the subjects and current levels of health.

Finally, many questions remain regarding the effectiveness of MFT in reducing health care utilization. These results need to be expanded and replicated to learn if an offset effect occurs for MFT treatments in other settings and with other populations.

Also, a cost analysis should be done to see if use reductions are related to cost reductions. Some previous studies have shown an increase in medical utilization following psychological intervention (e.g., Kelleher & Starfield, 1990; Kogan, Thompson, Brown, & Newman, 1975; Korff et al., 1998). Our results suggest that a cost analysis should include all family members since these findings suggest that “other” family members besides the primary patient may benefit by a decrease in their health care use.

The results of this study are important to the field of marriage and family therapy and suggest a rich area for future research. Given the size of the available samples and the variance in the dependent variables available for study, it is surprising that the analysis showed any outcome at all. In addition, the study was conducted in an HMO that had been vigorously seeking to reduce medical costs for some time. Consequently, the system should have already trimmed any unnecessary “fat” that could have been easily reduced by the ongoing cost containment strategies alone. The consistency of use by the control group argues that the changes this study identified are more likely to be attributable to the MFT interventions.

In addition, it should be noted that less health care is not necessarily better for either the health care plan or its subscribers’ families. If patients are not pursuing care related to prevention of more serious problems, maintaining their treatment regimens of chronic conditions, or quality prenatal care, the eventual costs of health care will increase.

Finally, the cost of including mental health care in general, and MFT treatment in particular, in health benefit programs should not be the sole criteria in determining its value to an organization (Fraser, 1996). Given the degree to which social problems have affected the work place (e.g., Crane, 1995) and the economic and social consequences of divorce and family disruption (Crane, 1996), other factors such as increased life and job satisfaction, increased job performance and the emotional well-being of the families enrolled in health plans are increasingly important. Additional investigations concerning the benefits of MFT treatment in these areas should be pursued.

REFERENCES


