THE INFLUENCE OF INDIVIDUAL, MARITAL, AND FAMILY THERAPY ON HIGH UTILIZERS OF HEALTH CARE

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Research has shown that people reduce their use of health care after individual, marital, and family therapy, which is known as the “offset effect.” However, little research has been done to learn if high utilizers of health care reduce health care usage after therapy. Medical records of research participants (n = 65) from a health maintenance organization (HMO) were randomly selected and examined for 6 months before, during, and after therapy. Persons who received individual, marital, or family therapy all reduced their health care use after therapy, with the largest reductions coming from those participants who had some form of conjoint therapy.

The U.S. health care system has achieved a leveling off of health care costs in recent years, from 2000–2002 (Jacob, 2002). This is mainly attributable to managed care (Crane, 1995; Jacob, 2002). The term managed care is broadly defined as any patient care that is not determined solely by the provider (Cummings, 1999). However, recent reports show that health care costs are again on the rise in the United States, whereas satisfaction with managed care companies such as health maintenance organizations (HMOs) has dropped (Baumgarten, 2002). For instance, enrollment in HMOs decreased in many states in 2000 by 3% and continued to decrease in the first half of 2001 (Baumgarten, 2002).

High utilizers of medical services comprise a small proportion of all patients, yet they account for a disproportionate amount of expenses in the health care system (Smith, Rost, & Kashner, 1995). The term high utilizers has been defined in a variety of ways, but in general they are individuals who utilize health care services about twice as frequently as the average person (Cummings, 1999). Health care companies are faced with the dilemma of how to deal with high utilizers of medical services, because they are less numerous but more costly than the general population, and it is not cost effective for more money to go to a smaller proportion of the people they serve. The major concern is for those individuals whose use of medical services is not clearly disease related, not clearly medically necessary, or where an emotional or mental health condition may be involved.

OFFSET EFFECT

An interesting phenomenon known as the “offset effect” (Shemo, 1985–1986) may help health care companies to address the high utilizer dilemma. An offset effect occurs when people reduce their use of

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medical services following some type of therapy or behavioral health intervention. 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 (Antonovsky, 1979; Law & Crane, 2000; McDaniel, Hepworth, & Doherty, 1992; Rolland, 1994). Thus, the primary purpose of this study is to investigate whether the modalities of individual psychotherapy in general, and conjoint therapies in particular (e.g., marriage therapy and family therapy), are associated with a reduction of health care use by patients identified as high utilizers.

This phenomenon of the offset effect has been widely studied in psychology. Large offset effects were found in pre–managed care settings (e.g., Follette & Cummings, 1967; Jones & Vischi, 1980) when money for health care expenditures was more readily available. In today’s leaner managed care settings, the offset effect continues to be evident as people reduce their use of medical services after individual or group therapy (e.g., Jacobsen, 1998; Pallak, Cummings, Dorken, & Henke, 1994; Simon & Katzelnick, 1997). In a recent meta-analysis on the offset-effect literature, Chiles, Lambert, and Hatch (1999) reviewed 91 articles representing the efforts of the past 35 years. Forty percent of the studies took place in inpatient medical settings, whereas the remaining 60% were conducted in outpatient medical facilities. The types of treatments used in the studies that operationally defined psychological intervention were behavioral, cognitive–behavioral, psychodynamic, and interpersonal therapy. Those who received psychological treatment reduced medical use by 26.7% on average, whereas the comparison groups, which received no treatment, increased use by an average of 9.16%.

Mental health treatment could potentially benefit patients (by reducing their need for medical services) and managed care companies by reducing the costs of care for those who are high utilizers. Because the modality of marriage and family therapy (MFT) often treats more than one person at a time, practitioners of MFT are in a good position to offer cost-effective treatments to managed care companies.

Studies that have focused on the impact of marital and/or family therapy on health care utilization are sparse. The most recent study by Law and Crane (2000) compared participants’ utilization patterns for 6 months before and after marriage or family therapy treatment and found that they significantly reduced their use of medical visits by 21.5%. In the same study, participants receiving individual therapy nonsignificantly decreased 10%, and the comparison group of participants receiving no therapy nonsignificantly increased utilization by 12.2%. There are no known studies that focus on MFT and high utilizers of health care.

Thus, this study helps fill the gap in the research by investigating whether the modalities of individual therapy in general and conjoint therapies such as marital therapy and family therapy in particular can produce an offset effect with high utilizers of medical services.

**BIOPSYCHOSOCIAL HEALTH CARE MODEL**

The research questions of this study were guided by the assumptions of the biopsychosocial health care model (Engel, 1977, 1980). This perspective emphasizes the interdependence of the biological, psychological, and social functioning of individuals. Each of these domains of human life is conceptually distinct in some ways, but any one of the domains can simultaneously influence the others. Having a physical ailment often presents psychological reactions and social consequences. Conversely, an already existing psychological or social problem can exacerbate the complications of physical ailments by lessening the likelihood that the person with the physical ailment adheres to his or her health regimen. Patients who have biological problems may be helped by psychological or social interventions. In addition, those with emotional problems may experience physical symptoms as well. Thus, intervention on the psychological or social levels may produce benefits in the biological level.

**LITERATURE REVIEW**

*Definition and Characteristics of High Utilizers*

There is little consensus in the literature of what identifies a “high utilizer” of health care, although many researchers have studied the issue. Toomey, Haggery, Raft, and Stroatz (1982) offered a definition
as one who makes more than five walk-in visits to a doctor’s office in the space of 6 months. Von Korff, Ormel, Katon, and Lin (1992) used the working definition of those who are in the top 10% of number of medical care visits for their age and gender. Simon and Katzelnick (1997) defined high utilizers as those who received twice as much medical care as did their normal comparison group. Other researchers did not give an operational definition (Katon et al., 1995; Pallack et al., 1994). In sum, although various definitions have been proposed by different researchers, there is not a consistent one that has been used as a universal definition.

Regardless of definition, there are some characteristics of patients that emerge in relation to diagnosis, age, and gender. Katon, Von Korff, Lin, and Lipscomb (1990) indicated that high utilizers in their study had similar diagnoses including major depression, dysthymic disorder, generalized anxiety disorder and/or somatization disorder. This diagnosis commonality among high utilizers was significant at \( p < .01 \). Two-thirds of these patients also had a lifetime history of major depression. The authors hypothesized that high utilizers would most likely be those who had a life-long mental illness and were experiencing a current major mental health disorder while utilizing medical care systems.

Researchers have also examined whether high utilizers differ by age. Not surprisingly, Semke and Jensen (1997) found that older patients (50–90 years old), regardless of gender, were more likely to be high utilizers than were younger patients (20–49 years old). Likewise, Daugird and Spencer (1989), in their study of the characteristics of those patients who made frequent calls to the doctor’s office, found that high utilizers were older, had more medical problems, and had less social support. These findings of age as associated with greater medical utilization are not surprising, given the greater health problems experienced by older patients.

Some literature also seems to point to women, more than men, as being high utilizers, although there are few studies that specifically examine this variable. Katon, Lin, Von Korff, and Russo (1991) studied the characteristics of patients with somatization disorder who were high utilizers. They found that women were better represented than men in this population. The most important characteristics of high utilizers seem to be in the link between utilization and emotional or mental illness.

Offset Studies of High Utilizers

Researchers have found that high utilizers who receive mental health services subsequently average fewer medical visits than do comparison groups that receive no mental health treatment (Katon et al., 1992, 1995; Otto, 1999). The results become more interesting when discussing two of the most common types of patients being considered. Patients with somatization disorder and patients with chronic illnesses have been identified as persons who are the most likely to be high utilizers of health care (Katon et al., 1992; Smith et al., 1995). This finding fits particularly well with the biopsychosocial model of health care, because people who have a physical ailment often present with psychological and/or social reactions to their biological ailment, such as individuals with chronic illnesses. Likewise, according to the biopsychosocial model, preexisting psychological and/or social problems can exacerbate physical reactions (e.g., individuals with somatization disorder).

Offset effect with high utilizers with somatization disorder: Smith et al. (1995) focused on somaticizing patients who were high utilizers of health care. Patients were randomized into treatment and comparison groups. The treatment group received care from a family physician trained in psychiatric consultations for dealing with somaticizing patients. The comparison group received normal treatment from their primary care physicians.

Although the intervention had no statistically significant effect on emotional health or social functioning, treatment patients averaged fewer visits to the referring physicians than comparison patients. During the year after intervention, annual medical care charges decreased by $289 for treatment patients, which equates to a 32.9% reduction in annual median charges for medical care.

A similar study involving psychiatric consultation as treatment found no significant difference between treatment and comparison groups of high utilizers of health care (Katon et al., 1992). An important difference between Katon et al.’s (1992) study and Smith et al.’s (1995) study was that Smith et al.’s consul-
tation was targeted at a specific population of somaticizing patients, whereas Katon et al.’s was targeted to a population of depressed, anxious, or somaticizing patients. This suggests that the offset effect is more likely to occur when patients have a diagnosable somatization disorder.

**Offset effect with high utilizers with chronic illnesses.** A study that measured the cost savings with high utilizers with chronic illnesses, confirmed that high utilizers reduce their visits after therapy and save HMOs money (Caudill, Schnable, Zuttermeister, Benson, & Friedman, 1991). These researchers analyzed the clinic visits of chronic pain patients after treatment in a 10-week behavioral intervention group. Using a within-subject, repeated measures design, the 109 participants significantly reduced their visits from 1.07 per month pretreatment to 0.68 visits at 1 year postintervention. This study indicated that at an average cost to the HMO of $45 per visit, the projected gross savings would be $23,000. Including the cost of the intervention (estimated at $1,000 per group), the net savings to the HMO of providing behavioral medicine intervention was approximately $12,000 for the first year postintervention and $23,000 for the second year.

In the best known cost-offset study to date, Pallack, Cummings, Dorken, and Henkes (1994) randomly assigned two-thirds of all Medicaid enrollees in Oahu, Hawaii, to a treatment group in which they were eligible for focused managed mental health services in which mental health treatment was provided in a brief therapy format. A comparison group, made up of the remaining one-third of Medicaid patients, received mental health services in the usual fee-for-service manner. In the year following therapy, participants who had a chronic medical diagnosis decreased total medical costs by 28%, whereas those in the control group increased costs by 17%. Although it is unclear if the chronically ill patients were high utilizers, this study demonstrates that even patients with chronic medical conditions may benefit from mental health services. In summary, the offset effect has been established for high utilizers of health care and the literature suggests that it is worthy of further study.

**Offset Studies with a Family Focus**

As previously mentioned, Law and Crane (2000) compared participants’ (n = 272) utilization patterns for 6 months before and after marriage or family therapy treatment and found that they significantly reduced their use of medical visits by 21.5%. More specifically, participants who had marital therapy (n = 52) decreased health care visits by 21%. Participants who had family therapy in which they were the “identified patient” (n = 60) decreased utilization by 9.5%, and participants who had family therapy in which they were not the identified patient (n = 60) had a 30.5% reduction of health care visits.

Others studies have also indicated that an offset effect occurs when using MFT as the mental health service. Graves and Hastrup (1981) investigated the impact of family therapy on medical use by comparing a group that received family therapy treatment to a matched comparison group. The treatment group reduced clinic visits by 36% in the year following therapy. The comparison group, which did not have therapy, did not decrease utilization. Similarly, Finney, Riley, and Cataldo (1991) found reductions in the use of health care for children when they were seen with their parents in therapy sessions. They received specific family treatment for behavioral and psychosomatic problems in family members. In comparing the year before and after therapy, the treated group reduced medical visits by 28%. No significant reduction occurred in the comparison group.

In summary, the literature review points out that the offset effect is real, but for high utilizers, it is not as well established. The best evidence comes from the study of somatization disorders and chronic illnesses. Although there are promising signs, little is known about the influence of MFT-based treatments on medical offset, especially for high utilizers.

**Purpose of this Study**

The three modalities of therapy in this study are individual therapy, marital therapy, and family therapy. Though all three modalities of therapy are investigated, the primary purpose of this study focuses on whether the conjoint therapies of marital therapy and family therapy is associated with a reduction of health care use by patients identified as high utilizers. Because this is the first known study to primarily focus on marital or family therapy as the intervention for high utilizers, it was exploratory and descriptive in nature.
Using a treatment-only comparison design, the three modalities of therapy were investigated. Because the primary interest in this study was on conjoint therapies, the modality of family therapy was further differentiated into two subgroups, family therapy for an identified patient and family therapy other patient. Therefore, the following four unique groups comprise this study. Group one is the marital therapy group that received the modality of marital therapy. Group two is the family therapy identified patient group (FTIP) that received the modality of family therapy. The FTIP group was usually a child or adolescent that the parents were concerned about because of either externalized (e.g., behavioral problems) or internalized (e.g., depressed, anxious) problems. Group three is the family therapy other patient group (FTOP) which received the modality of family therapy. The FTOP group consisted of parents or siblings of the identified patient who also attended family therapy. Members of these first three groups all share the common element that they experienced therapy with a family member. The fourth group is the individual therapy group that received the modality of individual therapy. For further clarification of therapy groups, see the “Therapy” section.

METHOD

Sample
The study sample for the current research was drawn from the data set of Law and Crane’s (2000) study who were subscribers or family members of subscribers of FHP-Utah (formerly named Family Health Program). At the time, it was one of the five largest HMOs in the US, with more than 1.8 million members. The organization, based in California, had 186,000 enrollees in Utah region. As described in Law and Crane (2000), in 1995, the researchers received hard copies of records for participants who had received individual, marital, or family therapy in the last 6 years. The FHP identification numbers were then randomly selected and medical charts reviewed to see who met the inclusionary criteria.

Inclusionary criteria. Participants 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. To be considered for selection in the Law and Crane (2000) study, participants were required to have had at least three visits in a particular modality of therapy (individual, marital, or family therapy). Also, to assure distinct groups for comparison purposes, the ratio of the predominant type of therapy to other types needed to be at least 3:1. After meeting the 3:1 ratio, participants’ medical records were then entered into a pool where they were randomly selected and reviewed for an 18-month period of time. Time One represented 6 months before the start of therapy. Months 7–12 were designated as Time Two, beginning the day participants started therapy. Time Three was the 6-month period beginning 6 months after the initiation of therapy. The start of therapy was the central point in defining the time periods, with Times One and Three based on calculations from that date. As a result, the 18-month period differed for each participant, depending on the date therapy began. Client medical condition or the source of referral for those receiving therapy had no bearing on selection. Patients were self-referred to therapy or were referred by medical services staff. Because of the retrospective design of this study, the FHP Clinical Research Committee did not require informed consent.

In addition to the inclusionary criteria for the large study, participants for this particular study also had to be high utilizers of health care. Participants were defined as high utilizers in this study (n = 75) if they had four or more medical visits in the 6-month period (Time One) before treatment. This number was chosen because it was one standard deviation above the comparison group’s mean in the original Law and Crane (2000) study. Thus, this high utilizer sample is a subset of the larger study by Law and Crane. Only high utilizers in each type of therapy were considered in the subsequent analysis.

Therapy
All 21 therapists hired by the local region of the HMO participated in this study and comprised the multidisciplinary team of 9 men and 12 women. There were 4 MFTs, 2 psychologists, 13 social workers, 1 chemical dependency counselor, and 1 professional counselor. Although each therapist was licensed solely in his or her respective field, all were eligible to provide either individual, marital, or family therapy. Type
of therapist license (e.g., marriage and family therapist or psychologist) or therapy approach (e.g., systemic
or psychodynamic) had no bearing on the group in which participants were placed.

The study was an effectiveness study, meaning that the treatment being tested was in field conditions,
or the “real world,” where therapy does not follow treatment manuals or exact protocols. It was not an
efficacy study, where the treatment being tested is under well-controlled conditions (Pinsof & Wynne,
1995).

As previously mentioned, participants in the original Law and Crane (2000) study received a
predominant modality of either individual, marital, or family therapy. To be included in this study, partic-
ipants had to be high utilizers of health care services. Because of these criteria, there are different numbers
of males and females in each group. Participants receiving family therapy were further categorized into the
FTIP or FTOP group. A description and example of the four therapy groups follows.

Marital therapy. Fifteen patients (8 men and 7 women) had marital therapy. With his or her spouse,
each met with a therapist to focus primarily on their marital relationship. Mean age for the men was 39.50
(SD = 14.62) and the mean age for women was 38.14 (SD = 11.75). For example, a husband and wife met
with a therapist to try and improve their marriage. During Time Two, they had six marital therapy sessions,
making both eligible to be included in the original Law and Crane (2000) marital group. After random-
zation, only the wife was selected for inclusion in the original 2000 study. She is also included in this study,
because she meets the criteria as a high utilizer.

Family therapy identified patient. There were 12 patients who received family therapy as an identified
patient (FTIP). This group consisted of 9 males and 3 females. Each received family therapy in which he or
she and at least one other member of the family met with the therapist, with the focus on family
relationships. The 12 patients were categorized as the identified patient because they had been identified by
the therapist’s notes as the family member associated with “the problem.” The mean age of males in this
category was 10.44 (SD = 3.64) and the mean age of women was 25.66 (SD = 26.31). For example, parents
seek family therapy to help them deal with their 10-year-old son who has been acting out at school and
home. The parents also bring in their six-year-old daughter, but they are clearly seeking help for their son.
During Time Two this family meets with the therapist eight times, making all family members eligible to
be included in the original Law and Crane (2000) FTIP or FTOP pools. Because the son is clearly identified
as the reason the family seeks therapy, the son is placed in the original FTIP pool. After randomization,
the son is selected and becomes a participant in the original Law and Crane FTIP group. Because he is also a
high utilizer of health care, he is selected as a participant in this study. The FTIP group consists
of the subjects identified as the “reason” the family is seeking therapy, it generally consists of children or
adolescents, the only exception being a 55-year-old mother who was being treated for depression using
family therapy. This patient is the reason for the age discrepancy between males and females in the FTIP
group, and the large standard deviation for females.

Family therapy other patient. A total of 16 patients were in the FTOP group. This group consisted of
8 men and 8 women who had family therapy, but not as the identified patient. These participants and at least
one other family member met with the therapist, with the focus on family relationships. They were
categorized as the “other patient,” because a different family member had been identified by the therapist’s
notes as the family member associated with “the problem.” The mean ages were 44.87 (SD = 13.87) and
32.25 (SD = 4.16) for men and women, respectively. For example, using the same example from the
previous FTIP section, the 10-year-old son is placed in the FTIP pool, whereas the parents and 6-year-old
sister are placed in the FTOP pool. After randomization, the father is selected and becomes a participant in
the original Law and Crane (2000) FTOP group. Because the father is also a high utilizer of health care, he
is selected as a participant in this study. The FTOP group generally consists of parents.

Individual therapy. There were 22 patients who received individual therapy, 7 men and 15 women. The
mean ages were 32.00 (SD = 20.50), for men and 35.34 (SD = 16.92) for women. For example, a married
woman seeks individual therapy to help her cope with anxiety. During Time Two, she had nine individual
therapy sessions, making her eligible to be included in the original Law and Crane (2000) pool. After randomization,
she was selected as a participant and included in the original (Law & Crane, 2000) study. She is also included in this study, because she meets the criteria as a high utilizer.
Measures of Utilization of Health Care

This study used ambulatory care (referred to as medical utilization) as the primary dependent variable. Ambulatory care was defined as “health services rendered to individuals under their own cognizance, any time when they are not in a hospital or other health care institution” (Barker, Burton, & Zieve, 1995, p. 4). Outpatient visits were defined as medical care for illness, injury, psychotropic medication management, health screening, urgent care, laboratory work, or x-rays. Office visits for mental health therapy were not included in ambulatory care. Emergency room, prescription, and hospitalization data were not available. Although it would be beneficial to distinguish between high utilizers who have somatization disorder or a chronic illness, our data lacked the capacity to split high utilizers into these distinct categories. The current data are analyzed using all ambulatory care visits regardless of patients’ medical diagnoses or mental health status.

RESULTS

Description of High Utilizers

The first part of question one is, “What are the patient characteristics, such as diagnosis, age, and gender of those who received treatment and who are high utilizers of health care?” The most common diagnosis was relationship problems (59%), followed by mood disorders (17%), anxiety disorders (8%), childhood disorders (6%), and adjustment disorders (5%). Sexual and gender identity disorders, eating disorders, and nonrelational problems comprised the remaining 5%. In comparison, the larger data set of Law and Crane (2000) showed relationship problems (67%), mood disorders (13%), anxiety disorders (4%), childhood disorders (8%), and adjustment disorders (3%). The average age of high utilizers was 33 years, and ranged from 4 to 72 years, whereas the average age in the original data set was 30 years, with a range from 3 to 72 years. Similar to the original study, gender was almost evenly split with 32 men and 33 women.

The second part of question one is, “Do these characteristics relate to utilization patterns, thus needing to be treated as covariates?” To see if diagnosis, age, and gender affected medical utilization, they were treated as independent covariates using a repeated measures analysis of covariance (ANCOVA) model. When Time One was compared with Time Three, the within-subjects effects of diagnosis, age, and gender were all nonsignificant. The between-participants effects of diagnosis, age, and gender were also nonsignificant. The nonsignificant F values for the within-subject effects mean that neither diagnosis, age, nor gender related to changes in medical utilization over time. The nonsignificant F values for the between-subjects effects mean that there were no group differences at the beginning or end of treatment. Thus, diagnosis, age, and gender do not need to be treated as covariates.

Treatment Modality

The second question asked is, “What is the association between MFT and the number of health care visits by high utilizers?” All of the conjoint therapy groups (marital therapy and family therapy) were combined to answer this question. As shown in Table 1, the combined MFT groups (n = 43) decreased their use of medical services overall. When Time One was compared with Time Three, high utilizers decreased their number of visits by 3.89 (53%). When the three periods were compared, the decreases remained significant. The effect size of participants who had individual therapy was $d = .293$. A t-test determined that the 53% decrease experienced by the MFT group and the 48% drop in participants receiving individual therapy did not differ significantly.
Table 1
Changes in Number of Health Care Visits for High Utilizers Before, During, and After Therapy

<table>
<thead>
<tr>
<th>Type of Therapy</th>
<th>n</th>
<th># of health care visits</th>
<th>F</th>
<th># of visits Change</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1</td>
<td>T2</td>
<td>T3</td>
<td>T1-</td>
<td>T1-</td>
<td>T2-</td>
</tr>
<tr>
<td>MFT</td>
<td>43</td>
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<td>3.88</td>
<td>3.44</td>
<td>28.89*</td>
</tr>
<tr>
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<td></td>
<td>3.62</td>
<td>3.82</td>
<td>2.95</td>
<td></td>
</tr>
<tr>
<td>Marital</td>
<td>15</td>
<td>6.60</td>
<td>4.47</td>
<td>3.27</td>
<td>9.98*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.87</td>
<td>3.44</td>
<td>2.87</td>
<td></td>
</tr>
<tr>
<td>FTIP</td>
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<td>6.50</td>
<td>3.00</td>
<td>3.25</td>
<td>7.66*</td>
</tr>
<tr>
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<td></td>
<td>1.93</td>
<td>3.72</td>
<td>2.70</td>
<td></td>
</tr>
<tr>
<td>FTOP</td>
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<td>8.63</td>
<td>4.00</td>
<td>3.75</td>
<td>13.31*</td>
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<td>5.24</td>
<td>3.52</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 - T2 = Time One compared to Time Two, and so on.
* p < .05

Types of Conjoint Therapy
The fourth and last question is, "What is the association between the subcategories of MFT (Marital, FTIP, FTOP) on the number of health care visits by high utilizers?" All three subcategories of MFT show a similar pattern. Although there are no group differences regarding decreases in utilization patterns, the authors thought the results interesting enough to warrant further description, especially regarding the FTOP group. The predominant change occurred from Time One to Two, as all three groups experienced significant decreases in health care use during therapy. The marital group’s pattern of utilization was between the FTIP and FTOP groups. They experienced a pronounced decrease from Time One to Two, and a less dramatic decline to Time Three. The decrease in Time One from 6.6 visits to 3.27 visits in Time Three represents a 50% decrease. As shown in Table 1, this decline of 3.33 visits was significant. The effect size for the marital group was d = .35. High utilizing adults who were seeking marital help reduced their health care visits after marital therapy.

The lowest utilizers of health care services among the subcategories of MFT were the FTIP (n = 12, primarily children and adolescents) group. As shown in Table 1, they averaged 6.5 visits in Time One and ended with 3.25 visits in Time Three. As with the marital group, this decrease of 50% was significant. The effect size of d = .48 makes it highly likely that the decrease in utilization can confidently be attributed to treatment. High utilizing adults who were identified as the reason the family was seeking therapy reduced their health care visits after treatment.

The FTOP patients (n = 16, primarily parents) started out as the highest utilizers in Time One (8.63 visits) and ended up utilizing more services in Time Three (3.75 visits). As shown in Table 1, their decrease of 4.8 visits was the largest among the subcategories of MFT. This 57% decline in health care visits was significant. Although smaller than the FTIP group, the effect size for the FTOP group was d = .36. Participants who were not the focal point of therapy reduced their health care use after family treatment.
DISCUSSION

The main conclusion that can be drawn from this study is that mental health professionals can have a meaningful impact on the utilization of health care services by high utilizers. This has important ramifications for the different fields of mental health care providers, including those who practice MFT. As demonstrated, MFT and individual therapies may benefit patients and have a significant role in reducing the cost of providing health care to those who are high utilizers. Because high utilizers account for a significant proportion of total health care spending, one can easily see the financial impact that mental health in general, and MFT in particular, may have (Smith et al., 1995). This finding is supported by other research that has demonstrated that MFT is useful in reducing medical utilization (Finney et al., 1991; Graves & Hastrup, 1981; Law & Crane, 2000).

In this study, all forms of psychotherapy reduced medical utilization. One of the most exciting results is the 57% reduction in utilization among the FTOP group. Those in this group were parents who sought family therapy, because they were concerned about their child. These parents were not the identified patients in the therapy sessions, but they had the largest drop in health care utilization. As they never presented for any problems themselves, it is unlikely that they would have seen the need to participate in any modality of therapy. This presents the interesting possibility that family therapy for an identified patient may benefit not only the identified patient, but other family members as well. These findings support Finney et al.’s (1991) assertion that MFT may also be more cost effective than other types of therapy because at least two family members are being treated simultaneously. Further research on the topic of other family members who benefit from therapy will continue to be fruitful.

Another interesting aspect of this study is that it provides evidence that all the modalities studied are “fast acting” in reducing medical utilization. Most of the gains made by the mental health care groups were made in the first 6 months of therapy. This finding supports past findings by Caudill et al. (1991) that showed that short-term mental health treatment can have a fast-acting effect on the reduction of medical outpatient visits.

Limitations and Recommendations for Future Research

Although this study has important positive implications for mental health professionals, including those who practice MFT, limitations are acknowledged that would strengthen future studies. Because the majority of participants in the initial Law and Crane (2000) needed a diagnosis of relationship problems to be included in the study, it would be expected that this subsample would also have relationship problems as the primary diagnosis. Therefore, comparisons with the Katon et al. (1990) study that found the type of diagnosis to be related to utilization patterns are limited. Likewise, the variables of age and gender, which others (Daugird & Spencer, 1989; Katon et al., 1991; Semke & Jensen, 1997) found to be related to utilization patterns, but which were not related in this study, need to be viewed with caution because of the small sample size.

The dependent variable for this study was ambulatory care. To give a more complete picture of how mental health treatments affect medical utilization, future studies should gather data on hospital, prescription drug, and emergency room use. In the latest meta-analytic review, Chiles et al. (1999) found the largest offset savings resulted from a reduction in inpatient hospitalization.

Although our data lacked the capacity to split high utilizers into the distinct categories of somatization disorder or chronic illnesses, we recommend that future studies use these categories, as these are very different conditions. Last, if the results are replicated in other settings and with larger numbers of participants, a clearer argument may be made that all types of therapy treatments benefit patients, other family members and health care companies.
REFERENCES


362 JOURNAL OF MARRITAL AND FAMILY THERAPY July 2003