The Influence of Professional License Type on the Outcome of Family Therapy

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The Influence of Professional License Type on the Outcome of Family Therapy

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While research documents the effectiveness of marriage and family therapy (MFT) as a clinical practice, few studies have focused on the MFT profession. This study examined the influence of the MFT license on family therapy treatment effectiveness. Outcome measures included treatment dropouts, recidivism, and cost effectiveness. Data spanning 2001 to 2004 from CIGNA, a health care insurer in the United States, was examined. Provider types compared included medical doctors (MDs), nurses, psychologists, social workers, professional counselors, and marriage and family therapists. MFTs had the lowest dropout rates and recidivism and were more cost effective than psychologists, MDs, and nurses.

There is a need for mental health care professionals to document the effectiveness of various therapies (Simons & Doherty, 1998). The practice of marriage and family therapy has demonstrated effectiveness in the treatment of many clinical disorders. These include youth delinquency (Gordon, Graves, & Arbuthnot, 1995), substance abuse for adolescents (Liddle et al., 2001) and adults (Winters, Fals-Stewart, O’Farrell, Birchler, & Kelley, 2002), child depression, anxiety, and coping skills (Mendlowitz et al., 1999), couple
difficulties (Jacobsen et al., 1984), domestic violence (Fals-Stewart, Kashdan, O’Farrell, & Birchler, 2002), and adult depressive symptoms (Emanuels-Zuurveen & Emmelkamp, 1996). There is a sizable body of research documenting that marriage and family therapy (MFT), as a clinical practice, is effective in treating a variety of disorders. However, comparatively little research documents the effectiveness of MFTs within the profession of marriage and family therapy. Specifically, little is known about the impact of training in marriage and family therapy on the clinical practice of family therapy.

Marriage and family therapy proponents and practitioners have argued that the systemic perspectives on treatment of mental health problems are unique and more than simply an alternative approach to treatment (Knapp, 1996). Instead, they propose that their unique training provides a specialized framework for working with couples and families (Knapp, 1996). They further believe these frameworks are distinct from merely adopting therapeutic approaches from an individual paradigm and applying them to relational domains. Though a variety of mental health professionals provide services to troubled couples and families, only MFTs claim professional status on the ability to treat family systems (Knapp, 1996). The claim that marriage and family therapists’ training is distinct among various mental health professions is also influenced by the nature of training curriculum and licensure standards across the United States for MFTs.

Crane, Shaw, Christenson, Larson, Harper, and Feinauer, (2010) determined that among the major, nationally recognized mental health providers, only two were required to meet specific family therapy training and practice standards in order to license at the state level: MFTs and licensed professional counselors (LPC). None of the other professions examined, including clinical psychology, psychiatry, psychiatric nursing, and social work were required to receive specialized relational training or clinical experience as part of their licensure requirements. MFTs are also required to have more than three times the amount of coursework in family therapy as compared to LPCs. Specifically, the average MFT licensure applicant must have completed 349 face-to-face relational client contact hours while LPC licensure requires only 22 hours. Major differences also exist in supervision requirements for licensure. MFTs are required to complete up to sixteen times more professional relational supervision when compared to any other discipline (Crane et al., 2010). In fact, while 51% of AAMFT members self-identify as being MFTs, only 15% actually receive training within an MFT framework (Knapp, 1996).

In sum, professionally licensed MFTs are required to have far more relational training and experience than any other mental health discipline. As such, it would be expected that MFTs should have better results when providing relational therapy in comparison to those of other professions. The present study addresses this question using managed-care data.
Profession versus Practice

Because the practice and the profession of MFT are often confused, it is important to clearly differentiate between the two. The present study compares the profession of MFT to other mental health care professions. Summarizing the differences between the profession and practice of MFT, Simmons and Doherty (1998) note that the practice refers to a clinical treatment modality while the profession refers to a professional discipline. They note that many mental health care professionals who lack the professional title of “marriage and family therapist” provide marriage and family therapy. For example, Crane and Payne (in press) found that MFTs provided about 17.4% of the total sessions of family therapy within the CIGNA network, while MSW provided 12.5%, psychologists provided 12.5%, and professional counselors provided 17.1%.

It has been noted that the profession of family therapy has been established through the creation of a distinct knowledge base required for mastery in the field, an ethical code, peer-reviewed journals, a field newspaper, accredited graduate programs, and recognition from legislative bodies (Nichols & Everett, 1986). Simmons and Doherty (1998) indicate that rather than being an unimportant difference, the practice/profession question has real impact. For example, Medicare will pay for family therapy treatment but excludes MFTs as treatment providers. As such, there is clear evidence that the practice of MFT is distinct from the profession of MFT.

In the present study, the difference between the practice of MFT and the profession of MFT is important primarily because those of the MFT profession have received specialized training in providing family therapy. Other professionals who practice family therapy may or may not have received this training. It would be impossible to generalize about any particular individual within a given profession, but general differences among professions regarding the practice of family therapy may be important in determining whether specific MFT training actually affects the practice of family therapy.

Marriage and Family Therapy Training

The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) determines the nationally accepted educational training requirements for accrediting programs in MFT. It is beyond the scope of this article to address the various state requirements that exist for licensure in marriage and family therapy. However, the majority of states accept COAMFTE standards for accreditation as a measure of sufficient training for MFT licensure. These COAMFTE requirements are delineated below.

The COAMFTE MFT Educational Guidelines (2005) specify that all MFT graduates complete 500 hours of psychotherapy, 250 of which must be with
couples or families, during their training. COAMFTE requirements also encompass clinical supervision of client contact. MFT students from accredited programs receive a minimum of 100 hours of face-to-face supervision from an approved AAMFT supervisor. At least 25 hours of the supervision must be live therapy supervision or involve observation of an audio or video recording of therapy. In addition to having licensing requirements related to educational experience, most states require MFT licensees to pass a national examination for MFT training. The national examination measures understanding of the practice of MFT, assessment and diagnosis, treatment design and implementation, client progress evaluation and treatment termination practices, and legal, ethical, and professional standard practices.

Accredited training and national examinations are performed to help ensure that MFTs are competent in the treatment of mental health disorders in general as well as issues related to couples and families in particular. Simmons and Doherty (1998) surveyed MFTs to determine what they do and how they fare in clinical practice. Results indicated that nearly half of MFTs' caseloads involve some type of couple or family treatment. MFTs provided relatively brief treatment with a mean of 22.3 sessions and a median of 16.3 sessions. More recent research found that within a comprehensive study of psychotherapy services provided within the U.S., MFTs utilized family therapy in 12.7% of their cases (Crane & Payne, in press). Crane and Payne also determined that MFTs provide brief and effective treatment, with a mean of 6.95 sessions and a success rate of 86.6%.

Measures of Effectiveness

Appropriate measures of treatment effectiveness are necessary in order to make comparisons across professions. Effective therapy interventions are those that show measured benefit to individuals, couples, and families in real-world situations. Further, effectiveness research is defined to include “the effects of ‘clinic therapy’ conducted ‘in the field,’ in the ‘normal’ circumstances in which most therapies are provided” (Pinsof & Wynne, 1995, p. 586). Effectiveness can be measured by various treatment-related variables such as dropout rate (Wierzbicki & Pekarik, 1993), cost-effectiveness (Krupnick & Pincus, 1992), recidivism (Barton, Alexander, Waldron Turner, & Warburton, 1985), therapist-rated therapy outcome (Hampson, Prince, & Beavers, 1999), or a client-rated measure including therapeutic alliance (Horvath & Symonds, 1991). Rather than using a single measure of effectiveness, it is reasonable to assume that a combination of effectiveness outcome measures would provide a more descriptive set of results. The present study uses three indicators of effectiveness, namely dropout rates, recidivism, and cost-effectiveness.
The purpose of the present study is to fill the gap in the literature regarding the influence of training in marriage and family therapy on effectiveness in the provision of family therapy services. Given that no study has compared these differences, the present study attempts to determine whether persons licensed as MFTs are more or less effective in providing family therapy than providers from other disciplines.

METHOD

Design
This study examined administrative data from CIGNA, a major health care insurer in the United States. Claim entries were limited to patient age and gender, treatment date, U.S. state where the treatment occurred, a current procedural terminology (CPT) code indicating individual or family therapy, a primary DSM-IV diagnosis, the therapy provider's license type, and a dollar amount of the claim. A more detailed explanation of the data cleaning process as well as detailed information regarding the data set can be found in Crane and Payne (in press).

Sample
The subjects included all individuals who received services for family therapy from CIGNA from 2001 through 2004. The ages of patients ranged from zero to 96 (M = 27.8, SD = 15.9). The data included 36,333 women (53.6%) and 31,488 men (46.4%). Providers included medical doctors (MDs), nurses, psychologists, social workers, professional counselors, and marriage and family therapists.

Definitions

EPISODES OF CARE
Episodes of Care (EoC) were defined by CIGNA as a series of continuous services ending after the patient had no psychotherapy claims for 90 days. The number of family therapy sessions in the first EoC per patient in the data set ranged from 1 to 137 (M = 4.45, SD = 5.03). Approximately 85% of patients completed therapy in only one EoC. The first EoC was the focus of this study except when measuring recidivism.

RECIDIVISM AND TREATMENT SUCCESS
For the present study a recidivist was defined as a patient who returned to the same provider type for a second EoC after completing their first EoC. Those
patients who had only one EoC were considered a “successful” treatment case. Since most people in the CIGNA network (84.6%) completed care in the first EoC, those who returned for care after the first EoC were considered treatment failures in the first EoC.

Cost

The cost of treatment for a patient was defined as the number of treatment sessions multiplied by the amount paid to the treatment provider per session.

Cost Effectiveness

In order to make comparisons based on cost effectiveness, a cost effectiveness formula was created. A useful cost-effectiveness formula takes into account what treatment providers are paid per unit of treatment (e.g., one therapy session), the number of sessions required for successful treatment, and the quality of treatment (i.e., the relative number of successful treatment outcomes compared to treatment failure). Using previous research as the model (Crane & Payne, in press) the present estimated cost effectiveness as: 1st EoC average cost + (1st EoC average cost * recidivism rate).

Therapy Dropouts

Consistent with other studies, psychotherapy dropouts are defined as patients who attended only one session of therapy (Allgood & Crane, 1991; Hamilton, Moore, Crane, and Payne, in press; Johansson & Eklund, 2006). In the present study dropouts (N = 10,427) included 15.4% of the total cases and only attended one session. In order to examine results for individuals who did not drop out of treatment, all dropouts were removed from further analysis (i.e., research questions 2 and 3). The remaining sample included 57,394 individuals.

Control Variables

The following variables were tested to determine whether they had a significant effect on the dependent cost variable: region, patient gender, DSM-IV diagnosis category, and patient age. Those with significant effects would later be entered as control variables. An analysis of variance indicated significant differences between groups by region (F = 245.91, p < .001), client age (F = 110.33, p < .001), and DSM-IV diagnosis category (F = 368.84, p < .001). As a result, these variables were used as statistical controls in linear regressions predicting costs. The same variables were examined for both recidivism and dropouts as well, using logistic regression. For recidivism, significant predictors included region, $\chi^2 (1, N = 67,821) = 12.28, p < .001$; patient age, $\chi^2$
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(1, \( N = 67,821 \)) = 9.04, \( p < .01 \); and patient gender, \( \chi^2 (1, \ N = 67,821) = 16.83, \ p < .001 \). For dropouts, significant predictors were profession type, \( \chi^2 (1, \ N = 67,821) = 10, \ p < .01 \); region, \( \chi^2 (1, \ N = 67,821) = 6.91, \ p = .009 \); patient age, \( \chi^2 (1, \ N = 67,821) = 56.81, \ p < .001 \); patient gender, \( \chi^2 (1, \ N = 67,821) = 11.03, \ p = .001 \), and DSM-IV diagnosis group, \( \chi^2 (1, \ N = 67,821) = 171.27, \ p < .001 \). The significant predictors were used as control variables in the subsequent regression analyses.

Research Questions

The purpose of this study was to determine the influence of MFT training on outcomes associated with the provision of family therapy, particularly in regards to recidivism and dropout rates. These outcomes matter because professionals with fewer dropouts and lower recidivism rates are likely to make the most efficient use of treatment funds in a managed-care environment. Consequently, the following questions were considered:

**QUESTION 1**

What are the relative differences in dropout rates for professions providing family therapy? Binary logistic regression is the best method to answer this type of question, which predicts a binary outcome (dropout or not). Dummy variables representing each of the professions (with MFTs as the reference variable), were included as independent variables in the model. The odds ratio provided in the output of the regression model demonstrates how much more or less likely each profession is to have a patient dropout of treatment when compared to MFTs. For example, an odds ratio of 1.0 means that both professions are equally likely to have a patient dropout of treatment. An odds ratio of 1.5 means that the profession in question is 1.5 times as likely (or 50% more likely) to have a patient dropout compared to MFTs.

**QUESTION 2**

What are the relative differences in recidivism rates for professions providing family therapy? This question was also analyzed using binary logistic regression.

**QUESTION 3**

What is the relative cost effectiveness for each profession providing family therapy compared to MFTs? Rather than being derived from statistical analysis, cost effectiveness is derived from a formula that incorporates average success rates (the inverse of the recidivism rate), average number of sessions and the per-session payment from CIGNA to the therapy provider, for each profession group. To analyze this question, the average cost
effectiveness of each profession was calculated using the cost-effectiveness formula presented earlier.

RESULTS

Question 1
What are the relative differences in dropout rates for professions providing family therapy? Using binary logistic regression, and controlling for patient age, gender, and DSM-IV diagnosis, a significant difference in dropouts was found based on profession, \( \chi^2 (3, N = 67,821) = 203.65, p < .001 \). Table 1 shows how each profession compares to MFTs on dropout rates. Based on the results of the logistic regression, MFTs were found to have the lowest dropout rate among the professions providing family therapy.

Question 2
What are the relative differences in recidivism rates for professions providing family therapy? Patient age, patient gender, and region where services were provided were controlled in the analysis and MFTs were used as the comparison group. Using binary logistic regression, a significant difference in recidivism was found based on profession, \( \chi^2 (8, N = 49,788) = 65.51, p < .001 \). Table 2 shows how each profession compared to MFTs on recidivism rates. MFTs had the lowest recidivism rate among the professions when providing family therapy. MFTs were not significantly different than nurses, but were significantly different than the other professions.

Question 3
What is the relative cost effectiveness for each profession providing family therapy compared to MFTs? In order to examine costs for individuals who did not drop out of treatment, dropouts were eliminated from analysis. The

<table>
<thead>
<tr>
<th>Profession</th>
<th>N</th>
<th>Likelihood of dropout compared to MFTs</th>
</tr>
</thead>
<tbody>
<tr>
<td>MFTs</td>
<td>6,140</td>
<td>—</td>
</tr>
<tr>
<td>MSWs</td>
<td>21,722</td>
<td>15.9% more likely than MFTs</td>
</tr>
<tr>
<td>Counselors</td>
<td>17,647</td>
<td>20.8% more likely than MFTs</td>
</tr>
<tr>
<td>Psychologists</td>
<td>20,313</td>
<td>34.2% more likely than MFTs</td>
</tr>
<tr>
<td>Nurses</td>
<td>615</td>
<td>90.6% more likely than MFTs</td>
</tr>
<tr>
<td>MDs</td>
<td>1,384</td>
<td>402.0% more likely than MFTs</td>
</tr>
</tbody>
</table>

*All differences are significant, \( p < .001 \).
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TABLE 2  Recidivism Likelihoods Compared to MFTs

<table>
<thead>
<tr>
<th>Profession</th>
<th>N</th>
<th>Likelihood of recidivism compared to MFTs</th>
</tr>
</thead>
<tbody>
<tr>
<td>MFTs</td>
<td>6,140</td>
<td>—</td>
</tr>
<tr>
<td>Nurses</td>
<td>615</td>
<td>13.2% more likely than MFTs</td>
</tr>
<tr>
<td>*Counselors</td>
<td>17,647</td>
<td>26.3% more likely than MFTs</td>
</tr>
<tr>
<td>*MSWs</td>
<td>20,313</td>
<td>28.9% more likely than MFTs</td>
</tr>
<tr>
<td>*Psychologists</td>
<td>21,722</td>
<td>30.3% more likely than MFTs</td>
</tr>
<tr>
<td>*MDs</td>
<td>1,384</td>
<td>69.7% more likely than MFTs</td>
</tr>
</tbody>
</table>

* p < .001.

analysis controlled for region, age, and DSM-IV diagnosis. Results indicate that MFTs were significantly different than all other professions (p < .001) on the cost variable. Using average cost data, from lowest cost to highest, the professions rank as follows: counselors ($252.23) and MSWs ($253.07), MFTs ($273.24), psychologists ($324.50), nurses ($353.37), and MDs ($463.44). Average cost data was then entered into the cost effectiveness formula along with recidivism rates for each profession.

Table 3 illustrates how each profession compares to MFTs on estimated cost effectiveness for a course of treatment for an “average” family therapy case. It was determined that MFTs are in the middle of the group of professions in terms of cost effectiveness, being more cost effective than psychologists, MDs and nurses and less cost effective than counselors and MSWs.

DISCUSSION

In the present study, MFTs ranked better than the other professions on both dropout rates and recidivism. Given the lower dropout rates, MFTs may have a superior ability to engage and maintain family therapy clients in comparison to that of other professions studied. This decreased likelihood of dropout led to an apparent increase in their cost per family therapy case.

TABLE 3  Cost Effectiveness by Profession Compared to MFTs

<table>
<thead>
<tr>
<th>Profession</th>
<th>N</th>
<th>Cost Effectiveness to MFTs</th>
</tr>
</thead>
<tbody>
<tr>
<td>MFTs</td>
<td>4,774</td>
<td>—</td>
</tr>
<tr>
<td>Counselors</td>
<td>13,128</td>
<td>$16.52 more cost effective than MFTs</td>
</tr>
<tr>
<td>MSWs</td>
<td>16,320</td>
<td>$14.50 more cost effective than MFTs</td>
</tr>
<tr>
<td>Psychologists</td>
<td>14,591</td>
<td>$68.83 less cost effective than MFTs</td>
</tr>
<tr>
<td>Nurses</td>
<td>402</td>
<td>$96.93 less cost effective than MFTs</td>
</tr>
<tr>
<td>MDs</td>
<td>573</td>
<td>$250.44 less cost effective than MFTs</td>
</tr>
</tbody>
</table>
In regards to recidivism, MFTs were found to have equal or better success than the other professions in the provision of family therapy. Specifically, MFTs had fewer patients return for a subsequent EoC after completing their first EoC compared to other professions studied. Only nurses were not significantly different than MFTs on this measure.

Finally, MFTs ranked in the middle of the professions for the estimated cost effectiveness of family therapy treatment. No statistical differences could be measured between profession groups for cost effectiveness because cost effectiveness is calculated from a formula rather than being the result of a regression or other statistical analysis. Therefore, the rankings are considered in terms of clinical or policy importance. Additionally, because cost was calculated by multiplying the total number of sessions by the per-session payment to the therapy provider, MFTs’ cost was higher simply because they maintained clients for more sessions than the other professions on average.

Clinically, this increase in number of sessions may mean that MFTs are better able to identify deeply rooted systemic issues that take longer to mend. In such a case, an increase in cost would not be analogous to poor or undesirable outcome, but rather an indication that change may be slow, but meaningful. Such is the crossroads of clinical versus statistical differences. It is important to note, however, that on average all practitioners treated clients with relatively few sessions.

The present study examined whether marriage and family therapy licensure impacts family therapy treatment outcomes in psychotherapy. The only other study that has examined outcome differences for practitioners of marriage and family therapy found no significant differences among those trained in marriage and family therapy, psychology, social work, and counseling (Simmons & Doherty, 1998). In contrast, the present study found significant differences in therapy outcomes among the professions practicing family therapy.

Several things might account the difference in the two studies’ outcomes. First, Simmons and Doherty’s (1998) sample size (N = 244) used in statistical comparisons was much smaller than that of the present study (N = 67,821). A larger sample size of the same population might have yielded statistically significant results. However, even if this were not true, the lack of outcome differences in the Simmons and Doherty study could be accounted for by other factors. For example, the present study compared licensed MFTs to those with other mental health licenses. Every individual in Simmons and Doherty’s sample was a clinical member of the American Association for Marriage and Family Therapy, meaning that regardless of academic training, they were all licensed MFTs.

Another important factor to consider when addressing the outcome differences by profession in the present study are the natural differences that exist between talk therapy and biomedical providers. Specifically, counselors, MFTs, and social workers are employed in settings that, by their nature, may
illicit more visits from patients compared to patients of biomedical providers, such as doctors and nurses. In such settings, patients may be less likely to perceive nurses or doctors as the primary therapist due to the ways in which their roles are viewed. As such, patients may seek more extensive therapy from counselors, MFTs, or social workers.

One limitation of the present study is that patients who did not return for treatment were considered successful treatment cases, which means that the professions with higher recidivism had lower average costs as well as higher cost effectiveness. Given the retrospective nature of this study, it is not possible to know the reasons why individuals returned for therapy. Patients could have returned to therapy to address separate issues than those originally explored. In contrast, others may have come back because the original issues were not adequately explored and therapy was terminated due to dissatisfaction with the process. However, it is possible that a single session of family therapy from a trained provider could help a couple or family to make sufficient self-improvement after one session. Therefore, it may not be appropriate to assume that those who only had one treatment session were treatment failures. Future experimental studies could correct for this by assessing the nature of therapy termination.

Another limitation is the fact that it was impossible to determine whether any non-MFT providing therapy in the CIGNA network had any relational therapy training. Therefore, other variables may have confounded results, giving MFTs an advantage not related to family therapy training, but not revealed within the data.

Further, while the results may argue that MFTs are more costly per patient than other professions, nothing is known about how the different professions would fare when the long-term results, such as clinical improvements, are considered. One key variable for future studies could be the cost of health care utilization for “physical” problems. If the costs of other forms of health care could be evaluated for each person and family member, a better estimate of cost effectiveness might emerge.

Data limitations aside, there appears to be a strong case in the present data for real differences in treatment outcomes between MFTs and the other professions in the CIGNA network. The required family therapy training MFTs receive appears to have an impact on the practice of family therapy. An advantage of the use of administrative data like CIGNA’s is that the differences seen are similar to those that might be seen in private practice or other managed-care settings, whereas differences seen in controlled studies may not be applicable to real-world situations.

In sum, the present study provides some of the first data regarding the effectiveness of marriage and family therapy as a profession rather than a treatment modality. The results indicate that training in marriage and family therapy is influential in the effective administration of this form of therapy. The data indicated that MFTs have the lowest dropout rate, the lowest
recidivism rate, and average cost effectiveness when compared to other professions providing family therapy in a managed-care setting.

REFERENCES


