A Profile of Professional Activities and Practice Patterns for Marriage and Family Therapists in Utah

Thane R. Palmer
Utah State University

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A PROFILE OF PROFESSIONAL ACTIVITIES AND PRACTICE PATTERNS FOR MARRIAGE AND FAMILY THERAPISTS IN UTAH

by

Thane R. Palmer

A thesis submitted in partial fulfillment of the requirements for the degree of

MASTER OF SCIENCE

in

Family and Human Development
ABSTRACT

A Profile of Professional Activities and Practice Patterns for Marriage and Family Therapists in Utah

by

Thane R. Palmer, Master of Science
Utah State University, 1998

Major Professor: Dr. Thorana S. Nelson
Department: Family and Human Development

This research project presents data on practitioner profiles and practice patterns for marriage and family therapists living in Utah. A sample of 77 clinical members and six associate members of the American Association for Marriage and Family Therapy living in Utah gave descriptive facts on their demographics, training, years of experience, and specific information about their practice of marriage and family therapy. The findings indicate that marriage and family therapists in Utah are a mostly male, Caucasian, and highly educated group of practitioners compared to marriage and family therapists practicing in other states. The findings also indicate that marriage and family therapists living in Utah treat a wide range of serious mental health
problems in a relatively short amount of time for a reasonable fee.
ACKNOWLEDGMENTS

I would like to thank William Doherty and Deborah Simmons for making the Practice Pattern Survey available to me. I would especially like to thank Thorana S. Nelson, Ph.D., for her encouragement, assistance, and patience throughout the entire process of completing this project. I also thank my good friend, Norm Thibault, for the friendly competition that helped me to complete this project.

Most of all I thank my wonderful wife, Heidi, and my children, Mark, Chantry, Jordan, Chamea, Dayvin, Cortney, Bradley, and Christopher, for their moral support and sacrifice as I worked on and finished this project. It would not have been possible without them.

Thane R. Palmer
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CHAPTER I
INTRODUCTION

The field of marriage and family therapy is a relatively new mental health field compared to psychiatry, psychology, and social work. Marriage and family therapy started to develop as a distinct philosophy and specific treatment modality in mental health during the 1950s. The early pioneers and other professionals have been working since then to further develop and fine-tune the field of marriage and family therapy and its related treatment models.

As part of the further development of marriage and family therapy as a field, many researchers have worked to verify its effectiveness in treating a broad range of mental health disorders (Pinsof & Wynne, 1995). Until recently, however, there has been a dearth of research and knowledge on the actual practice patterns of mental health services offered by marriage and family therapists (MFTs). Some researchers have shown what MFTs can do in terms of techniques and theory, but there is little information that disseminates clear ideas about who clinicians are and what happens in a real-world clinician’s practice. For example, there is little information about practitioner profiles,
client caseload information, types of disorders treated, diagnoses used, length of treatment, types of therapy provided (individual, couple, family, group), cost of treatment, and insurance reimbursement. Without this information, marriage and family therapy advocates have been able to make only broad assumptions as they work to define the actual practice of marriage and family therapy. These advocates, consequently, have had little substantive data to access to promote the field to government bodies, insurance companies, health maintenance organizations (HMOs), and businesses.

To address these problems, Simmons and Doherty (1995) conducted practice pattern research for MFTs in the state of Minnesota. They then extended their work into 15 additional states (Doherty & Simmons, 1996).

The purpose of this research was to investigate and describe marriage and family therapy in Utah as a provider of mental health services for a variety of mental health problems and disorders. Specifically, this research describes what is happening in the actual practice of marriage and family therapy in the state of Utah. Utah is a state that has unique characteristics that warrant extending the research in Utah in spite of the fact that
the research has already been done in 16 other states. Utah has a relatively small population compared to other states. Utah is considered to be very conservative politically and over 60% of the population are members of the Church of Jesus Christ of Latter-day Saints, a religious organization that places a lot of importance on education and encourages its members to become educated. This organization also advocates other means to solve mental health problems before mental health therapy is sought out.

The availability of these data will also enhance the generalizability of the previous findings (Doherty & Simmons, 1996; Simmons & Doherty, 1995) to the broader population of MFTs, allowing marriage and family therapy advocates to better promote the field on a national basis to insurers, government bodies, and businesses. For example, this information can be used to encourage insurance and managed care companies to reimburse for therapy performed by MFTs by showing that MFTs are viable mental health providers.

On the state level, results from this study will provide the Utah Association for Marriage and Family Therapy (UAMFT) leaders information specific to the state of Utah as they promote the field within the state and make
decisions on how to best advertise the field. Additionally, this research can be used by MFTs within the state who are seeking to set up contracts with managed care companies, HMOs, and employee assistance programs.

This information is needed to aid MFTs as they work to define marriage and family therapy in Utah as a viable field for providing mental health services. These data will provide more information, specific to Utah, as to who we are and what we do as MFTs. Misunderstandings exist about who MFTs see in therapy, what kinds of problems and dysfunctions MFTs treat, and the training MFTs receive, resulting in confusion within and without the field as to what we do and who we are. This research helps us to verify the answers to these misunderstandings, allowing MFTs to describe who we are and what we do with actual data rather than rhetoric.

Definitions

A marriage and family therapist (MFT) is defined as a clinical or associate member of the American Association for Marriage and Family Therapy (AAMFT) living in the state of Utah. Licensed MFTs who are not members of AAMFT were not included in this study because of the accessibility of
AAMFT membership. Clinical members have various training backgrounds but have met minimum state and Association requirements to qualify for clinical membership in the Association. The requirements include post-degree supervised clinical work and passing a national examination in MFT. Associate members are practitioners who have completed approved coursework and basic supervised clinical training but have not yet completed the full requirements for clinical membership.

Clinical practice patterns include: client caseloads, types of therapy provided, client presenting problems, DSM-IV diagnoses, fees, average length of treatment, and insurance reimbursement information.

Statement of Purpose

The purpose of this research was to describe who MFTs in Utah are and what they do in actual practice. To address these questions, three research questions were addressed.

Research Question #1

What are the practitioner profiles for MFTs in Utah? Responses to this question will describe: (a) practitioner age, (b) practitioner gender, (c) practitioner race, (d) years in practice, (e) field received degree in, (f)
highest professional degree, (g) professional identification, (h) license status, (i) primary practice setting, and (j) employment status.

Research Question #2

What are the practice patterns of MFTs in Utah?

Responses to this question will describe: (a) client caseload delineating the average active caseload, severity of client problems, and education level of clients, (b) hours per week spend providing various types of therapy (individual adult and child, couple, family, group), (c) presenting problems, (d) DSM-IV diagnosis used (American Psychiatric Association, 1994), (e) number of sessions per case, (f) fees, and (g) insurance reimbursement.

Research Question #3

What are the problems seen in therapy by Utah MFTs with different levels of training?
CHAPTER II
REVIEW OF LITERATURE

Interest in marriage and family therapy as a mode of mental health service has increased in recent years. Membership in the American Association for Marriage and Family Therapy (AAMFT) and related professional organizations has increased in the past 16 years. Specifically, AAMFT membership has increased from 9,000 members in 1982 to 23,000 in 1998. The number of marriage and family therapy programs across the country has also increased in the last decade. In 1983 there were 24 accredited programs. This number has grown to 72 master’s, doctoral, and post-degree programs in the United States (AAMFT, 1998).

Further evidence of the increased interest in marriage and family therapy is the recognition from government agencies. Marriage and family therapy is now regulated in 40 states, increased from 11 in 1986 (AAMFT, 1998). The field of marriage and family therapy is recognized by the National Institute on Mental Health (NIMH) as a distinct mental health profession. The Health Resources and Services Administration (HRSA), within the U.S. Department of Health and Human Services, identifies marriage and family therapy
as a unique profession in treating mental health problems. The Department of Education recognizes the AAMFT Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) as an approved accrediting body (AAMFT, 1995; Simmons & Doherty, 1995).

Public interest in the practice of marriage and family therapy is also escalating. Murstein and Fontaine (1993) found that MFTs are most likely to be recommended to friends by consumers. AAMFT (1995) reported that their toll-free referral line received over 6,600 calls in 1994 from people wanting referrals to MFTs.

Marriage and family therapy has also been shown to be an effective mode of treatment. Gurman, Kniskern, and Pinsof's (1986) detailed review of marital and family therapy outcome literature made some conclusions about the effectiveness of treatment. "Nonbehavioral marital and family therapies produce beneficial outcomes in about two-thirds of cases, and their effects are superior to no treatment" (p. 572). They went on to say, "Family therapy is probably as effective as and possibly more effective than many commonly offered (usually individual) treatments for problems attributed to family conflict" (p. 572). More recently, Pinsof and Wynne (1995), in their empirical
overview of the efficacy of marriage and family therapy concluded, "There is a convincing body of scientific evidence supporting the efficacy of MFT. There is a growing body of evidence to support the superiority of MFT in the treatment of various adult, adolescent, and child disorders" (p. 610). Both of these reviews were based on studies using data from controlled studies of MFTs. The data were not collected in the "real world" agencies on the day-to-day practices of MFTs. Until Simmons and Doherty (1995) and Doherty and Simmons (1996) reported their results, these actual practice patterns were not understood. Nonetheless, inadequate knowledge and misunderstandings still exist about who MFTs are, what types of problems MFTs treat, and the clientele they treat in therapy.

Recently, researchers in the various mental health fields have conducted studies to describe demographic and other matters related to the work of practitioners within their respective fields. From the results of these studies, researchers have made suggestions to insurance companies regarding decisions surrounding reimbursement of mental health services. Researchers have also made suggestions to lawmakers in regards to policy decisions and reimbursement
of mental health services by government agencies (Knesper, Belcher, & Cross, 1989). Additionally, these studies have helped to outline and demarcate the respective mental health fields and whom they treat.

This chapter will review the practitioner profile and practice pattern research literature from psychiatry, psychology, social work, and other mental health fields. The practitioner profile and practice pattern research in marriage and family therapy will then be discussed. A second area, MFT level of training compared with presenting problems treated, will also be discussed.

Practitioner Profiles and Practice Patterns Research

Other Mental Health Fields

Psychiatry, psychology, and social work are mental health professions that have conducted research with the purpose of describing their practitioner profiles and practice patterns for members of their field. Significant variables studied by psychiatrists, psychologists, and social workers included: specializations, number of men and women in the field, training backgrounds, number of years in practice, practice setting, caseloads, types of problems
treated, length of treatment, fees, diagnosis utilizations, income, types of treatments used, career satisfaction, hours spent on the job, and role descriptions (Blancarte, Murphy, & Reilly, 1991; Brown, 1990; Carson & Sincavage, 1987; Dorwart et al., 1992; Hardcastle & Brownstein, 1989; Johnson & Brems, 1991; Knesper et al., 1989; Knesper, Pagnucco, & Wheeler, 1985; Norcross & Prochaska, 1983; Vaccaro & Clark, 1987; VandenBos & Stapp, 1983; Watkins, Campbell, & McGregor, 1991; Watkins, Lopez, Campbell, & Himmell, 1989). Other mental health professions that have conducted research to describe their field are lay counselors (Seaberg, 1985) and career counselors (Spokane & Hawks, 1990).

Results from these studies indicate that practitioners in psychiatry and psychology were mostly male and Caucasian. Most psychologists held doctoral degrees even among counseling psychologists (Knesper et al., 1985; VandenBos & Stapp, 1983; Watkins et al., 1989). Most practitioners in social work were female, Caucasian, and held a MSW degree (Brown, 1990).

In their practices, psychiatrists treated their patients for a median number of 15 sessions and treated mostly neurotic, anxiety, personality, and major affective
disorders. Psychologists' length of treatment for their clients was a median of 12 sessions. Psychologists treated mostly neurotic, anxiety, and personality disorders and relationship problems. Social workers treated their clients for a median of 10 sessions, treating mostly neurotic, anxiety, and personality disorders and relationship problems (Knesper et al., 1985).

Marriage and Family Therapists

Marriage and family therapists did not report similar research until Simmons and Doherty (1995) published their findings. Simmons and Doherty (1995) surveyed a random sample of 100 clinical members of the American Association for Marriage and Family Therapy in Minnesota. They gathered data for demographic information about clinicians and practice pattern information. The practitioner profile variables included: clinician age and gender, level of training, practice settings, licensure, years in practice, and size of caseloads. The practice pattern variables included: presenting problems, DSM-III-R diagnosis usage, length of treatment, fees, and insurance reimbursement. Their questionnaire gathered information based on therapists' estimations of their practices with no specific references to client case records. They also asked
questions about therapists' three most recently closed cases.

Results from this study show that MFTs in this study were mostly female and 47.5 years of age. Most of these MFTs had an MA degree and were in private practice with 14.6 years of experience in the field. The most common presenting problems were adult/child psychological problems, couple problems, whole family problems, and parent-child problems, respectively. The four most common DSM-III-R diagnoses were the adjustment disorders, depressive disorders, anxiety disorders, and V-codes, respectively. Additionally, clients were treated for a median of 11 sessions for a median fee of $85 per therapy hour.

Based on their research from the Minnesota study, Simmons and Doherty (1995) concluded:

These findings indicate that the length of treatment and type of problems treated by marriage and family therapists are similar to those provided by other recognized mental health professionals who currently receive reimbursement from third-party payers in both the public and private sectors. In particular, this
study dispels the myth of interminable marriage counseling for trivial problems. (p. 14)

Doherty and Simmons (1996) extended their work in Minnesota by surveying a sample 526 MFTs from 15 other states. They reported data for practitioner profiles and practice patterns. The practitioner profile variables included: age, gender, years in practice, professional identification, licensure status, practice settings, and employment status. The practice pattern variables included: client information, types of treatment provided, treatment competencies, presenting problems, DSM-IV diagnoses utilization, length of treatment, fees per therapy hour, insurance reimbursement, outcome of services, and client satisfaction with treatment.

MFTs in this national study of 15 states were mostly female with a mean age of 52 and had 13 years of MFT practice. Most had an MA degree and worked in a private practice. Additionally, most of the respondents in this study identified themselves as MFTs professionally.

In their work as MFTS these respondents provided mostly individual therapy to a clientele who were mostly female and were college educated. Their most common presenting problems were depression, other psychological
problem, marital problems, and anxiety, respectively. The most common DSM-IV diagnoses were adjustment disorders, depressive disorders, anxiety disorders, and V-codes, respectively. Therapists reported treating their clients for a median of 12 sessions, charging a median fee of $80. Doherty and Simmons (1996) concluded that, "...MFTs are providing effective, efficient treatment for people with a wide range of serious mental health and relational problems" (p. 25).

Besides these two studies no other practice pattern research for MFTs exists, although there are a few articles that discuss diagnosis usage by MFTs. Denton (1989, 1990) addressed some ethical problems surrounding DSM-III-R usage by MFTs but did not address diagnosis utilization in actual practice.

Presenting Problems and Level of Training

Clinical members of AAMFT have received different levels of training either on a master’s or a Ph.D. level. Stereotypes exist that MFTs in general only treat mild relational problems. No studies could be found that specifically analyze differences in presenting problems treated between those with different levels of training.
Simmons and Doherty (1995) did make comparisons between DSM-III-R diagnosis utilization by MFTs from different training backgrounds and levels of training, but they found no statistically significant differences. This suggests that MFTs with different training backgrounds are treating similar problems in therapy.

Summary

In review, marriage and family therapy is an effective mode of treatment (Gurman et al., 1986; Pinsof & Wynne, 1995), but needs more recognition in the mental health field and more information on “real world” professional activities. Other mental health professions have conducted research to outline practitioner profiles and practice patterns of clinicians within their respective fields investigating a wide variety of variables.

MFTs also researched their practitioner profiles and practice patterns. To date, all of this research has been conducted by Simmons and Doherty (1995) and Doherty and Simmons (1996). Their practitioner profile variables included: age, gender, years in practice, professional identification, licensure status, practice settings, and employment status. Their practice pattern variables
included: client information, types of treatment provided, treatment competencies, presenting problems, DSM-IV diagnosis utilization, length of treatment, fees per therapy hour, insurance reimbursement, outcome of services, and client satisfaction with treatment.

The current project extends Simmons and Doherty’s (1995) work by helping to identify practitioner profiles and practice patterns of MFTs in Utah, allowing us to have information specific to Utah without relying on data from other states.
The purpose of this research was descriptive in nature, using survey data. The goal was to describe the average profile of MFTs in Utah and their practice patterns. The different types of problems seen in therapy by practitioners with different levels of training will also be described.

Population and Sample

The population of the study includes clinical and associate members of the American Association for Marriage and Family Therapy living in Utah. This population consisted of approximately 125 clinical members and 10 associate members at the time of the study, according to AAMFT membership records. This figure is approximate because, out of the 135 questionnaires sent out, 2 were returned as "undeliverable" and 3 of the questionnaires sent out were not returned; the researchers were not able to confirm whether or not these respondents still lived in the state with follow-up phone calls. One purpose of this study was to describe practitioner profiles from MFTs in
Utah; therefore, demographic information that would normally be found here will be reported in the results section.

Measures

A questionnaire designed by Simmons and Doherty (1995) (see Appendices A and B) was used in this study. The questionnaire asks for demographic information that includes: sex, age, race, educational background, practice setting, years in practice, and licensure status. The questionnaire also asked questions pertaining to the therapists' practice patterns including: caseloads, types of problems seen, DSM-IV diagnosis used, length of treatment, modalities of therapy used (individual, couple, family, and group), fees charged, and insurance reimbursement. The responses were based on therapists' estimations of their practice with no references to specific client cases. That is, therapists were not asked to refer to their client records or to report on individual clients.

Simmons and Doherty (1995) used a second part of the questionnaire that was based on specific information from therapists' three most recently closed cases using actual
charted information rather than recall. Their analyses found no statistically significant differences between the results of the first and second parts. Therefore, the current study used only the first part of the questionnaire with the rationale that using a shorter survey that did not require time to research client charts would increase response rates.

Data Collection Procedures

Data collection procedures were similar to those suggested by Dillman (1978) and comparable to procedures used by Simmons and Doherty (1995). A list of current clinical and associate members was provided by the Utah Association for Marriage and Family Therapy (UAMFT), the state association connected with AAMFT. Questionnaires were sent to all currently listed AAMFT clinical (n = 125) and associate members (n = 10). A cover letter (see Appendix C) from Beth Hughes, UAMFT president, accompanied the first mailing. This cover letter explained the purpose, benefits, and rationale of the study and urged all respondents to participate. Approximately 2 weeks after the first mailing, a postcard was sent, thanking respondents who had already returned the questionnaire and urging those who had not to
please do so. Two weeks after the postcard was sent, a new questionnaire was sent to nonrespondents. After the second questionnaire was sent out, the researcher made phone calls to the nonrespondents to remind them about the importance of the research and to ask them to return the questionnaire.

These procedures differed from Simmons and Doherty (1995) in that Simmons and Doherty did not send out a postcard and telephone calls were made by Minnesota’s Professional Practice Committee instead of by the researchers. No incentives other than potential intrinsic benefits were offered.

A response rate of 61.6% was achieved for the clinical members based on 77 out of 125 questionnaires being returned. Two questionnaires were returned by the post office as “undeliverable” and three were not returned along with the researcher being unable to confirm whether or not the individuals still lived in the state by follow-up phone calls. Therefore, an adjusted response rate of 64.2% was actually achieved. A return rate of 60% was achieved for associate members based on 6 out 10 questionnaires being returned. These return rates fall within the acceptable
range using the Dillman (1978) method in collecting survey data.

All of the data received from respondents have been kept strictly confidential. After the data were collected, names or other identifying information were not used in the analyses, publications, or other reports.

Human Subjects

This research project did not have any element that could potentially pose a threat to any human subjects except for a breach of confidentiality. Participation in the project was completely voluntary. The questionnaire did not ask any questions that could potentially cause harm and no intervention was used. Based on these factors, the Institutional Review Board (IRB) of Utah State University gave their approval for the project (see Appendix D).
CHAPTER IV

RESULTS

This chapter will present the results of the study. The first research question will be answered by describing the practitioner profiles of MFTs in Utah. The results for the second research question will be described, delineating the practice patterns for Utah MFTs. The third research question will then be discussed, describing the most common presenting problems treated by clinicians with different training backgrounds.

Research Question One

What are the practitioner profiles for MFTs in Utah? Analysis for this question will describe: (a) practitioner age, (b) practitioner gender, (c) practitioner race, (d) years in practice, (e) field received degree in, (f) highest professional degree, (g) professional identification, (h) licensure status, (i) primary practice setting, and (j) employment status. Table 1 provides a summary of the data.
Table 1

MFT Practitioner Profile for Clinical Members

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N = 77

aN = 73

Clinical Members

This sample of clinical members of AAMFT consists of 68.00% males and 32.00% females. The clinical members' race is overwhelmingly White with 98.7% of respondents listing "Caucasian" as their race. One respondent classified himself as Hispanic. The mean age for clinical members is 46.6 years of age and the median is 47 years of age. Age ranged from 32 years to 68 years of age. Clinical members
reported they had been in practice for a mean of 13.5 years.

The most common highest professional degree received for UAMFT members was a Ph.D. with 40 out of the 77 respondents reported having received that degree (51.9%). The next most common degrees were M.A. and M.S. with 16.9% and 15.6% of the respondents receiving those degrees, respectively. The remaining 15.6% of the respondents received degrees that included M.S.W., M.Ed., and Ed.D.

Most of the respondents (59.7%) reported that they received their degree in a family or marriage and family therapy field. Twenty-six percent of the respondents reported a degree in psychology. Social work was the next most frequent field (9.1% of the respondents). The remaining four respondents reported receiving a degree in counseling.

The results for licensure status of clinical AAMFT members show that 74 respondents or 96.1% reported being licensed or certified to practice in the State of Utah. An overwhelming majority, 94.8%, reported having a license in MFT with the remaining four respondents having a license in social work. Concerning second licenses, eight respondents reported a license in social work and two respondents
reported having a psychology license. Among the 77 respondents, 22, or 18.2%, were AAMFT-approved supervisors. Additionally, 79.2% of MFTs classified their primary professional identification as a marriage and family therapist.

Most marriage and family therapists (54.5%) listed their first practice setting as a private practice, 11.7% reported a state or community agency, 11.7% reported a private nonprofit agency, 6.5% reported a HMO, 2.6% reported an EAP, and the remaining 11.7% listed the "other" category with most of these writing in "university" as their first practice setting. The questionnaire asked about a second practice setting but 68.8% of the respondents left the question blank, confounding the results. Furthermore, 81.8% of the respondents reported that they work full-time and 18.2% reported working part-time.

Associate Members

The race, gender, and age for the sample of associate members AAMFT were as follows: 67% were male and 33% were female; all of the respondents who returned questionnaires reported being Caucasian; and the mean and median therapist age was 33.5, ranging from 29 to 38 years. Data for associate members are summarized in Table 2.
Four of the respondents reported having a M.S. degree, one reported having a Ph.D., and one reported having a Psy.D. Most associate members reported that they received their degree in a family or marriage and family therapy field.

None of the associate AAMFT members were licensed, which is consistent with their status as an associate member. However, three of the associate members listed their primary professional identification as a marriage and family therapist. The three remaining associate members listed psychologist or "other" as their primary professional identification.

The most common practice settings for associate members of AAMFT were state or community agencies or private nonprofit agencies. Out of the six respondents, two reported working for a state or community agency, two reported working for a private nonprofit agency, one reported being in private practice, and one respondent listed the "other" category. Additionally, four of associate members were full-time employed, one was part-time employed, and one was a student.
Table 2

MFT Practitioner Profile for Associate Members

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<thead>
<tr>
<th>Variables</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
<th>Range</th>
<th>Percent</th>
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<td>Professional identification</td>
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<td>16.70</td>
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N = 6
Research Question Two

Results of Research Question Two describes the practice patterns of MFTs in Utah. Data for this question include: (a) client caseload delineating the average active caseload, severity of client problems, and education level of clients, (b) hours per week spent providing various types of therapy (individual adult and child, couple, family, group), (c) presenting problems, (d) DSM-IV diagnosis used (American Psychiatric Association, 1994), (e) number of sessions per case, (f) fees, and (g) insurance reimbursement.

Clinical Members

The mean number of clients on active caseloads is 26.19 and the median is 21.00. Respondents reported that on average, 14.61% of their clients had mild problems, 44.83% had moderate problems, 24.57% had severe problems, 12.08% had extremely severe problems, and 4.21% had catastrophic problems. These percentages were based on means, and add up to more than 100% due to rounding (see Table 3).

The clients that marriage and family therapists treat are fairly well educated. Respondents reported that 8.66% of their clients had less than a high school degree, 32.04%
Table 3

Client Caseloads for Clinical Members

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<th>Variables</th>
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</table>

Severity of client problems\(^a\)

<table>
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<th>Severity of Problems</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
<th>Range</th>
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</thead>
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<td>No problems</td>
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<td>00.23</td>
<td>00.00%</td>
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<td>Mild</td>
<td>14.61%</td>
<td>14.14</td>
<td>10.00%</td>
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<tr>
<td>Moderate</td>
<td>44.83%</td>
<td>27.22</td>
<td>50.00%</td>
<td>0-100</td>
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<tr>
<td>Severe</td>
<td>24.57%</td>
<td>24.38</td>
<td>20.00%</td>
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<tr>
<td>Extremely severe</td>
<td>12.08%</td>
<td>18.06</td>
<td>08.00%</td>
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<td>Catastrophic</td>
<td>04.21%</td>
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</table>

Educational level of clients\(^b\)

<table>
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<th>Median</th>
<th>Range</th>
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<td>Less than high sch.</td>
<td>08.66%</td>
<td>12.71</td>
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<td>High school degree</td>
<td>32.04%</td>
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<td>26.50%</td>
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<tr>
<td>Some college</td>
<td>27.97%</td>
<td>21.75</td>
<td>22.50%</td>
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</tr>
<tr>
<td>College degree</td>
<td>25.79%</td>
<td>19.52</td>
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<tr>
<td>Post college deg.</td>
<td>06.58%</td>
<td>09.42</td>
<td>01.00%</td>
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</table>

\(N = 75\)

\(^a\)Percentages add to more than 100% due to rounding.

\(^b\)\(N = 74\). Percentages add to more than 100% due to rounding.
had a high school degree, 27.97% had some college, 25.79% had a college degree, and 6.58% had a postgraduate degree (see Table 3).

As shown on Table 4, respondents reported spending 40.37% of their time doing individual adult therapy. Individual child or adolescent therapy occupied 11.95% of clinical time. The histogram for these results is sharply skewed to the left with 40% of respondents spending 0-4% of their clinical time in individual child or adolescent therapy. Clinicians reported spending 25.65% of their time in couples therapy and 16.77% of their time in family therapy. The histogram for time in family therapy is sharply skewed to the left with 59.7% of the respondents spending 0-10% of their clinical time in family therapy.

The mean percentage of hours spent in group therapy was 4.5. The median is zero, suggesting a sharp left skew with 64% of the respondents reporting 0% of their clinical time spent performing group therapy.

In summary, clinicians in this sample spent a majority of their clinical hours doing individual adult and couple therapy. A much smaller portion of time was used conducting individual child or adolescent and family therapy. Marriage
Table 4

Clinical Time Spent in Types of Therapy
For Clinical Members

<table>
<thead>
<tr>
<th>Type of therapy</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
<th>Range</th>
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<tr>
<td>Individual adult</td>
<td>40.37%</td>
<td>25.90</td>
<td>40.00%</td>
<td>0-100</td>
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<tr>
<td>Couple</td>
<td>25.65%</td>
<td>21.89</td>
<td>25.00%</td>
<td>0-100</td>
</tr>
<tr>
<td>Family</td>
<td>16.77%</td>
<td>21.28</td>
<td>10.00%</td>
<td>0-100</td>
</tr>
<tr>
<td>Ind. child/adol.</td>
<td>11.95%</td>
<td>14.28</td>
<td>10.00%</td>
<td>0-80</td>
</tr>
<tr>
<td>Group</td>
<td>4.50%</td>
<td>8.01</td>
<td>00.00%</td>
<td>0-30</td>
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</tbody>
</table>

N = 75

and family therapists reported doing very little group therapy.

Clinicians were asked to report their first, second, third, fourth, and fifth most common presenting problems. Approximately one third (33.8%) of the clinicians reported that marital and couple difficulties were the first most common presenting problems in their practices. Depression was another common presenting problem in this category with 28.6% of the reporting clinicians. A total of 28.6% of clinicians reported depression as their second most common presenting problem. Anxiety was another prominent presenting problem in this category with 23.4% of the reporting clinicians. In the third most common category, anxiety was listed as the most common behind marital/couple
Table 5

Most Common Presenting Problems for Clinical Members

<table>
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<tr>
<th>Presenting problem</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>5th</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital/couple difficulties</td>
<td>33.8%</td>
<td>15.6%</td>
<td>15.6%</td>
<td>13.0%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Parent-adolescent conflict</td>
<td>7.8%</td>
<td>10.4%</td>
<td>11.7%</td>
<td>20.8%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Drug/alcohol abuse</td>
<td>2.6%</td>
<td>5.2%</td>
<td>1.3%</td>
<td>7.8%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Work difficulties</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>2.6%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Depression</td>
<td>28.6%</td>
<td>28.6%</td>
<td>15.6%</td>
<td>7.8%</td>
<td>6.55%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>2.6%</td>
<td>23.4%</td>
<td>14.3%</td>
<td>9.1%</td>
<td>10.4%</td>
</tr>
<tr>
<td>Child behavior problems</td>
<td>3.9%</td>
<td>2.6%</td>
<td>10.4%</td>
<td>6.5%</td>
<td>13.0%</td>
</tr>
<tr>
<td>School problems</td>
<td>1.3%</td>
<td>0.0%</td>
<td>2.6%</td>
<td>1.3%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Child abuse</td>
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<td>0.0%</td>
<td>2.6%</td>
<td>3.9%</td>
<td>0.0%</td>
</tr>
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<td>Domestic violence</td>
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<td>2.6%</td>
<td>5.2%</td>
<td>2.6%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>6.5%</td>
<td>3.9%</td>
<td>7.8%</td>
<td>5.2%</td>
<td>7.8%</td>
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<td>Other adult psychological problems</td>
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<td>6.5%</td>
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<td>16.9%</td>
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<td>1.3%</td>
</tr>
<tr>
<td>Chronic mental illness</td>
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<td>3.9%</td>
<td>3.9%</td>
<td>3.9%</td>
<td>5.2%</td>
</tr>
</tbody>
</table>

N = 77
difficulties and depression. The fourth and fifth most common presenting problems were listed as parent-adolescent conflict and "other adult psychological problems," respectively. Another problem that showed up frequently was child behavioral problems. Complete results for the most common presenting problems can be found in Table 5.

Respondents were also asked to list the five most common DSM-IV (American Psychiatric Association, 1994) diagnoses they used from most frequently used to least frequently used. As shown in Table 6, the depressive disorders showed up as the first, second, third, and fourth most common DSM-IV diagnoses used by respondents. The fifth most common diagnosis used was V-codes, most of which were marital and parent-child problems. The adjustment disorders and the anxiety disorders also showed up prominently as shown in Table 6.

As can be seen in Table 6, missing data could confound the results somewhat, especially for the third, fourth, and fifth most frequently used diagnoses in which there were 13, 18 and 27 missing cases, respectively. These results should therefore be viewed with caution. Some of the respondents exhibited a negative attitude toward the
<table>
<thead>
<tr>
<th>DSM-IV diagnoses</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>5th</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressive disorders</td>
<td>48.1%</td>
<td>27.2%</td>
<td>18.2%</td>
<td>15.6%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Adjustment disorders</td>
<td>14.3%</td>
<td>11.7%</td>
<td>15.6%</td>
<td>13.0%</td>
<td>9.1%</td>
</tr>
<tr>
<td>V-codes</td>
<td>7.8%</td>
<td>7.8%</td>
<td>5.2%</td>
<td>9.1%</td>
<td>13.0%</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>5.2%</td>
<td>10.4%</td>
<td>13.0%</td>
<td>11.7%</td>
<td>10.4%</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>3.9%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>PTSD</td>
<td>2.6%</td>
<td>7.8%</td>
<td>9.1%</td>
<td>3.9%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>2.6%</td>
<td>2.6%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>1.3%</td>
<td>1.3%</td>
<td>5.2%</td>
<td>2.6%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Oppositional defiant disorder</td>
<td>1.3%</td>
<td>1.3%</td>
<td>3.9%</td>
<td>1.3%</td>
<td>1.3%</td>
</tr>
<tr>
<td>ADHD</td>
<td>0.0%</td>
<td>5.2%</td>
<td>1.3%</td>
<td>3.9%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Bipolar disorders</td>
<td>0.0%</td>
<td>2.6%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Cannabis dependence</td>
<td>0.0%</td>
<td>2.6%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Alcohol dependence</td>
<td>0.0%</td>
<td>1.3%</td>
<td>1.3%</td>
<td>2.6%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Obsessive compulsive disorder</td>
<td>0.0%</td>
<td>1.3%</td>
<td>0.0%</td>
<td>1.3%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Dissociative identity disorder</td>
<td>0.0%</td>
<td>1.3%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Polysubstance abuse</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>1.3%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Impulse control disorder</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>1.3%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Overanxious disorder</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>1.3%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Separation anxiety disorder</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>1.3%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Personality disorders</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>1.3%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Dissociative disorder</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Psychological factors</td>
<td>1.3%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Pedophilia</td>
<td>1.3%</td>
<td>1.3%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Sexual dysfunction</td>
<td>0.0%</td>
<td>1.3%</td>
<td>3.9%</td>
<td>2.6%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Missing data</td>
<td>10.4%</td>
<td>13.0%</td>
<td>16.9%</td>
<td>23.4%</td>
<td>35.1%</td>
</tr>
</tbody>
</table>

N = 77
question by writing in remarks such as, "I never use diagnosis codes!!" and then left the question blank.

The questionnaire contains two different questions to obtain an accurate portrayal of the average length of treatment. Respondents first were asked to report the median number of sessions that they see their clients. As shown in Table 7, the median number reported was eight sessions. The mean number of sessions was 15.34. The median portrays a more accurate or typical result because the histogram for these data has a left skew. The mean is inflated because one respondent reported his median number as 149 sessions and one other respondent put 85 sessions as his median number of sessions. Therefore the median of eight sessions is a more accurate characterization of the average number of sessions that clients are treated.

Respondents were also asked to list a percentage that they see clients based on ranges of 1-10 sessions, 11-20 sessions, 21-30 sessions, and over 30 number of sessions. Respondents reported that, on average, 44.69% of their clients were seen for 1 to 10 sessions, 29.12% were seen for 11 to 20 sessions, 32% were seen 21 to 30 sessions, and 14.61% were seen more than 30 sessions.
Table 7

Average Number of Sessions for Clinical Members

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average number of sessions.a</td>
<td>15.34</td>
<td>21.03</td>
<td>8.00</td>
<td>5-149</td>
</tr>
<tr>
<td>Percentage of clients seen with the given rangesb</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-10 sessions</td>
<td>44.69</td>
<td>31.17</td>
<td>50.00</td>
<td>0-100</td>
</tr>
<tr>
<td>11-21 sessions</td>
<td>29.12</td>
<td>22.63</td>
<td>25.00</td>
<td>0-100</td>
</tr>
<tr>
<td>21-30 sessions</td>
<td>11.32</td>
<td>13.42</td>
<td>10.00</td>
<td>0-100</td>
</tr>
<tr>
<td>Over 30 sessions</td>
<td>14.61</td>
<td>24.89</td>
<td>3.00</td>
<td>0-100</td>
</tr>
</tbody>
</table>

aN = 73

bN = 75. Percentages add up to less than 100% because of rounding.

Table 8 shows the average therapist fees per session for clinical members of UAMFT. The mean charge for individual, couple, and family therapy was $73 per session when rounded to the nearest dollar. Fees ranged from no charge to $120 per therapy session. The mean charge for group therapy was $30 but these results may be unreliable because 29% of the respondents did not answer this question. The high rate of missing data is consistent with MFTs reporting minimal time spent doing group therapy.

Respondents reported that 34% of their clients did not
Table 8

Therapist Fees for Clinical Members

<table>
<thead>
<tr>
<th>Therapy type</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>73</td>
<td>$73.29</td>
<td>$20.15</td>
<td>$80.00</td>
<td>$0-120</td>
</tr>
<tr>
<td>Couple</td>
<td>71</td>
<td>$72.68</td>
<td>$20.34</td>
<td>$75.00</td>
<td>$0-120</td>
</tr>
<tr>
<td>Family</td>
<td>70</td>
<td>$72.56</td>
<td>$20.36</td>
<td>$77.50</td>
<td>$0-120</td>
</tr>
<tr>
<td>Group</td>
<td>54</td>
<td>$30.19</td>
<td>$20.36</td>
<td>$25.00</td>
<td>$0-95</td>
</tr>
</tbody>
</table>

use third-party payers. Out of these clients who did not use third-party coverage, 34% did not have third-party coverage, 17% did not have the service covered, 20.6% did not have the provider covered, 4.7% had exhausted mental health benefits, and 18% chose not to use their third-party coverage (these percentages do not equal 100% because means are used). Respondents reported that 66% of their clients did use some type of third-party coverage that included medical insurances, HMOs or EAPs, and government programs such as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and Medicaid.

Respondents were asked to report the third-party payers most commonly used by their clients but missing data make the data severely unreliable. Thirty-six percent of respondents did not report the first most common third-party payer used, 49% did not report the second most
common, 58% did not report the third most common, 71% did not report the fourth most common, and 83% did not report the fifth most common third-party payer used. After reviewing the questionnaire, it was noted that the manner in which the question was asked was somewhat confusing and may have required more time than respondents were willing to give to fully answer the question.

By combining responses to the questions, it seems that Blue Cross/Blue Shield was by far the most common third-party payer, followed by Intermountain Health Care, Deseret Mutual, Educators Mutual, FHP, and Public Employees Health Plan. However, as mentioned earlier, these results should be taken very tentatively because of the high degree of missing cases.

**Associate Members**

As shown in Table 9, associate members reported having a mean of 18 clients on their current caseloads, with the number of clients ranging from 0-45 (SD = 16.51). From their caseloads, clinicians reported that 15% of their clients had mild problems, 60.8% had moderate problems, 21.7% had severe problems, and 2.5% had extremely severe problems.
Table 9

Client Caseloads for Associate Members

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active caseloads</td>
<td>18.17</td>
<td>16.50</td>
<td>18.50</td>
<td>0-45</td>
</tr>
<tr>
<td>Severity of client problems&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>15.00%</td>
<td>18.71</td>
<td>10.0%</td>
<td>0-50%</td>
</tr>
<tr>
<td>Moderate</td>
<td>60.80%</td>
<td>23.75</td>
<td>50.0%</td>
<td>40-100%</td>
</tr>
<tr>
<td>Severe</td>
<td>21.67%</td>
<td>18.35</td>
<td>20.0%</td>
<td>0-50%</td>
</tr>
<tr>
<td>Extremely severe</td>
<td>2.50%</td>
<td>4.18</td>
<td>0.0%</td>
<td>0-10%</td>
</tr>
<tr>
<td>Education level of clients&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high sch.</td>
<td>7.50%</td>
<td>16.05</td>
<td>0.0%</td>
<td>0-40%</td>
</tr>
<tr>
<td>high school degree</td>
<td>44.67%</td>
<td>30.47</td>
<td>41.5%</td>
<td>2-87%</td>
</tr>
<tr>
<td>Some college</td>
<td>30.50%</td>
<td>25.91</td>
<td>22.5%</td>
<td>6-82%</td>
</tr>
<tr>
<td>College degree</td>
<td>16.33%</td>
<td>11.52</td>
<td>15.0%</td>
<td>6-33%</td>
</tr>
<tr>
<td>Post-college degree</td>
<td>0.83%</td>
<td>2.41</td>
<td>0.0%</td>
<td>0-05%</td>
</tr>
</tbody>
</table>

N = 6

<sup>a</sup>Percentages do not equal 100% because of rounding.
As exhibited in Table 10, associate members reported spending 44.2% of their clinical hours doing individual adult therapy, 12.5% of their clinical time in individual child or adolescent therapy, 27.5% of their time in couples therapy, 3.3% of their clinical time doing family therapy, and 12.5% of their time in group therapy.

The data for the most common presenting problems for associate members was difficult to analyze because there were no clear-cut “most common presenting problems” beyond the first two most common, as shown in Table 11. As can be seen from the data as a whole, it seems that depression is

Table 10
Clinical Time Spent in Various Types of Therapy for Associate Members

<table>
<thead>
<tr>
<th>Type of therapy</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual adult</td>
<td>44.17%</td>
<td>20.60</td>
<td>50.00%</td>
<td>5-60</td>
</tr>
<tr>
<td>Couple</td>
<td>27.50%</td>
<td>22.31</td>
<td>30.00%</td>
<td>0-50</td>
</tr>
<tr>
<td>Family</td>
<td>12.50%</td>
<td>19.94</td>
<td>2.50%</td>
<td>0-10</td>
</tr>
<tr>
<td>Ind. child/adol.</td>
<td>12.50%</td>
<td>14.05</td>
<td>10.00%</td>
<td>0-50</td>
</tr>
<tr>
<td>Group</td>
<td>3.33%</td>
<td>5.16</td>
<td>0.00%</td>
<td>1-30</td>
</tr>
</tbody>
</table>

N = 6

aPercentages add up to less than 100% due to rounding.
Table 11

Most Common Presenting Problems for Associate Members

<table>
<thead>
<tr>
<th>Presenting problem</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>5th</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital/couple difficulties</td>
<td>0.0%</td>
<td>16.7%</td>
<td>33.3%</td>
<td>0.0%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Parent-adolescent conflict</td>
<td>0.0%</td>
<td>16.7%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Drug/alcohol abuse</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Work difficulties</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Depression</td>
<td>33.3%</td>
<td>0.0%</td>
<td>16.7%</td>
<td>50.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>0.0%</td>
<td>16.7%</td>
<td>0.0%</td>
<td>16.7%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Child behavior problems</td>
<td>16.7%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>School problems</td>
<td>0.0%</td>
<td>16.7%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Child abuse</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>16.7%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>16.7%</td>
<td>16.7%</td>
<td>16.7%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other adult psychological problems</td>
<td>16.7%</td>
<td>16.7%</td>
<td>0.0%</td>
<td>16.7%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Other child psychological problems</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Chronic mental illness</td>
<td>0.0%</td>
<td>0.0%</td>
<td>16.7%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Missing data</td>
<td>0.0%</td>
<td>0.0%</td>
<td>16.7%</td>
<td>16.7%</td>
<td>16.7%</td>
</tr>
</tbody>
</table>

N = 6
the most common presenting problem followed by marital-couple issues, anxiety, and sexual abuse.

Associate members were also asked about the DSM-IV diagnoses that they used most frequently but missing data make these results useless. Half of the respondents did not answer this question, meaning that only three respondents reported the DSM-IV diagnoses that they commonly use. Therefore these results will not be reported for associate members.

Associate members were also asked about their average length of treatment per case. To answer this question, respondents were asked to report the median number of sessions that they saw their clients. The mean from these results was 6.67 sessions and the median was 6. Respondents were then asked to list a percentage that they saw clients based on ranges of 1-10 sessions, 11-20 sessions, 21-30 sessions, and over 30 sessions. The answers for the two questions are consistent with each other, suggesting that associate members treated a majority of their clients in 10 sessions or fewer (see Table 12).

The results for therapist fees, as shown in Table 13, show that associate members billed a mean fee of $74.50 for individual, couples, and family therapy. The mean reported
Table 12

Treatment Length for Associate Members

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average number of sessions</td>
<td>6.67</td>
<td>5.09</td>
<td>6.00</td>
<td>1-16</td>
</tr>
</tbody>
</table>

Percentage of clients seen within the given ranges

<table>
<thead>
<tr>
<th>Range</th>
<th>Percentage</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-10 sessions</td>
<td>70.0%</td>
<td>30.17</td>
<td>77.50%</td>
<td>15-100</td>
<td></td>
</tr>
<tr>
<td>11-20 sessions</td>
<td>22.5%</td>
<td>20.43</td>
<td>20.00%</td>
<td>0-60</td>
<td></td>
</tr>
<tr>
<td>21-30 sessions</td>
<td>5.0%</td>
<td>8.37</td>
<td>0.00%</td>
<td>0-20</td>
<td></td>
</tr>
<tr>
<td>Over 30 sessions</td>
<td>2.5%</td>
<td>4.18</td>
<td>0.00%</td>
<td>0-10</td>
<td></td>
</tr>
</tbody>
</table>

N = 6

fee for group therapy was $51 when rounded to the nearest dollar.

The results concerning insurance reimbursement are also confusing. Associate members reported that 35% of their clients paid out of pocket, implying that 65% have some type of third-party coverage. In the subsequent question that asked the respondents why clients paid out of pocket, the means equal only 40%, when they should be approximately 100%. Thus the results are confounded for the percentage of clients who use third-party payers. Regarding the most common third-party payer used, associate members
Table 13

Therapist Fees for Associate Members

<table>
<thead>
<tr>
<th>Therapy Type</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>74.50</td>
<td>20.19</td>
<td>77.50</td>
<td>50-95</td>
</tr>
<tr>
<td>Couples</td>
<td>74.50</td>
<td>20.19</td>
<td>77.50</td>
<td>50-95</td>
</tr>
<tr>
<td>Family</td>
<td>74.50</td>
<td>20.19</td>
<td>77.50</td>
<td>50-95</td>
</tr>
<tr>
<td>Group</td>
<td>50.67</td>
<td>27.83</td>
<td>50.00</td>
<td>21-95</td>
</tr>
</tbody>
</table>

N = 6

did not even attempt to answer the question, so there are no results to report.

Research Question Three

Research Question Three examines the different presenting problems that clinicians in this sample saw in therapy, broken down according to clinician’s level of training and training background. The most common presenting problems associated with Ph.D.s will be examined first. Those with M.A.s and M.S.s will then be examined, respectively. Those with other degrees will not be examined because they comprised such a small percentage of the sample. The data were analyzed to compare degree with the most common presenting problem.
The most common presenting problems for those with a Ph.D. were marital and couple difficulty followed by depression, anxiety, parent-adolescent problems, and the other adult psychiatric problems (see Table 14).

The most common presenting problem for the clinicians with a M.A. degree is marital and couple difficulty followed by depression, anxiety, parent-adolescent problem, and sexual abuse (see Table 14). For those with a M.S. degree, the most common presenting problem is depression, followed by marital and couple difficulty, anxiety, and parent-adolescent problem (see Table 14).
<table>
<thead>
<tr>
<th>Presenting problem</th>
<th>Ph.D.</th>
<th>M.A.</th>
<th>M.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital/couple diff.</td>
<td>33.1%</td>
<td>7.7%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Parent-adol. Conflict</td>
<td>7.7%</td>
<td>7.7%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Drug/alcohol abuse</td>
<td>7.7%</td>
<td>7.7%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Work difficulties</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Depression</td>
<td>15.4%</td>
<td>7.7%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Child behavior prob.</td>
<td>7.7%</td>
<td>7.7%</td>
<td>7.7%</td>
</tr>
<tr>
<td>School problems</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Child abuse</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>7.7%</td>
<td>7.7%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>7.7%</td>
<td>7.7%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Other adult psych.prob.</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other child psych.prob.</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Chronic mental illness</td>
<td>7.7%</td>
<td>7.7%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Other</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

aN = 38

bN = 13

cN = 11
CHAPTER V
SUMMARY AND DISCUSSION

The research discussed in this thesis provided an abundance of information about MFTs in Utah who are members of AAMFT. Overall, the results of the study for clinical members of AAMFT indicate that:

1. Utah MFTs in this sample are overwhelmingly Caucasian, two thirds male and one third female.
2. Utah MFTs are a highly educated group of practitioners with one half of clinicians reporting they received a Ph.D., largely in the field of marriage and family therapy.
3. Most Utah MFTs are in private practice and work full-time. Most are licensed as MFTs, a few being dual-licensed as a social worker or psychologist.
4. Utah MFTs maintain an average caseload of 26 clients who had, to a large part, moderate to extremely severe problems. These clients are an educated group with over 90% having graduated from high school and 60% having completed some college.
5. Utah MFTs conduct mostly individual therapy, spending approximately 42% of their clinical time in couple and family therapy.
6. Utah MFTs reported treating a variety of presenting problems, the most common being marital and couple difficulties, depression, anxiety, and parent-adolescent conflict.

7. Utah MFTs reported using a variety of DSM-IV diagnoses with the depressive disorders, adjustment disorders, anxiety disorders, and V-Codes being used most often.

8. Utah MFTs treated clients for an average number of eight sessions.

9. Utah MFTs charged an average of $73 for each session of therapy, making the average cost of treatment $584.

10. Utah MFTs reported that 66% of their clients used some type of third-party coverage to pay for services rendered.

11. MFTs in Utah with different levels of training treated similar presenting problems.

The corresponding information for associate members of AAMFT indicate that:

1. Associate members of AAMFT were demographically similar to clinical members except in the number of years in the field.
2. Associate members had an average client caseload of 18 who had, for a large part, mild to moderate problems.

3. Associate members spent most of their time conducting individual therapy, spending 30% of their time performing couple and family therapy.

4. Associate members reported treating a variety of presenting problems with depression, marital-couple issues, anxiety, and sexual abuse being the most common.

5. Associate members treated clients for an average of six sessions.

6. Associate members charged an average of $74 for each session; therefore the average cost of treatment was $444.

Discussion

Practitioner Profiles

The findings from this study have similarities and differences with Simmons and Doherty’s (1995) Minnesota study and Doherty and Simmon’s (1996) national study. In the practitioner profile area, one of the most striking differences is with gender. In Utah, 68% of AAMFT clinical
members responding to the survey were male and 32% were female. These findings are different from the Minnesota and the national studies in which the researchers found more females than males. There are probably many factors that contribute to this difference. One commensurate factor may be that Utah is a unique state in which a majority of the population are members of the Church of Jesus Christ of Latter-day Saints, a religion that upholds traditional values and places a high value on "family." This focus on the family may encourage more males to enter a family-related career than the national average.

Another interesting difference is in the area of highest degree received for clinical members. Clinical members of AAMFT reported that nearly 52% had received a Ph.D. and 48% had received a master’s-level degree. The Minnesota study reported that only 25% of their MFTs had received a Ph.D. For the national study, only 38% reported having received a Ph.D. These differences may be attributed to the Ph.D. Marriage and Family Therapy Program at Brigham Young University, a program that was founded in the early 1970s and is considered by many to be one of the top programs in the country. Another related factor may be the emphasis that the Church of Jesus Christ of Latter-day
Saints places on education, a factor that could encourage more individuals to continue their education and receive a Ph.D. instead of stopping at the master’s level. Additionally, there are more males than females, on average, that have Ph.D.s, a factor that could help explain the higher number of Ph.D.s when combined with the higher frequency of males in Utah that work in the field of marriage and family therapy.

There are also some differences in professional identification, licensure status, and primary practice setting. The Utah data indicate that nearly 80% of clinical members identify themselves as MFTs, with 95% of them being licensed as MFTs, even though only 60% report that they received their degree specific to MFT. The data from the national study indicate that 61% use MFT as their professional identification and only 30% are licensed as such. The high degree of Utah MFTs who use MFT as their professional identification, and are licensed as such, could be an indication that MFTs are received with positive regard in this state by clients and third-party payers. In other words, practitioners who could use a different identification such as psychologist or social worker, based on their degree, may use the identification that lends them
the most credibility with clients. It is interesting to point out here that 26% of the clinical members reported they received their degree in the field of psychology but only 2.6% of practitioners identified themselves as such professionally.

In Utah, 55% of the clinical member sample reported being in private practice as their primary practice setting while the national study indicates 65% are in private practice. In Minnesota, 49% reported being in private practice. The differences in the Utah and national data for primary practice setting could be due to the two MFT programs in the state at Utah State University and Brigham Young University. This hypothesis is extrapolated from the fact that out of the 10 respondents who marked the "other" category as their primary practice setting, eight wrote in "university."

Practice Patterns

The client caseload data indicate that Utah MFTs are treating many difficult cases, according to therapist's perceptions, contrary to the stereotype that MFTs treat only mild relational problems. Respondents reported that 41% of their clients had severe to catastrophic problems and 45% had moderately severe problems. It must be kept in
mind, though, that the severity level of client problems is being assessed by the therapist; clients themselves may rate themselves differently as to the severity of their problems and clinicians could rate the severity of the problems differently based on their experience.

Even though MFTs have the stereotype of working only with couples or families, they are spending over half of their time performing individual therapy. This finding for MFTs in Utah is consistent with the results reported by Doherty and Simmons (1996). This finding is not surprising because it is usually individuals who present for therapy and it is often difficult to invite other family members to become involved in therapy. Also, some clients may prefer individual therapy. An element that was not addressed by this study was whether or not MFTs in Utah use a family systems approach when they work with individuals or if they are using more traditional individual approaches.

The most common presenting problems and DSM-IV diagnoses used as reported by Utah MFTs in this sample is very similar to those reported by Doherty and Simmons (1996) in their national study of 15 states. Marital problems, depression, anxiety, parent-adolescent problems, and other psychological problems were the identical most
common presenting problems by Doherty and Simmons (1996) although the order is somewhat different; Doherty and Simmons found depression to be the first most common problem. For DSM-IV diagnoses used, the depressive disorders, adjustment disorders, anxiety, and V-codes were the most common disorders reported in both studies. The high degree of missing data with DSM-IV diagnoses possibly reflects a general feeling among MFTs that individual diagnoses are not very useful in addressing problems as a family or relational problem, rather than an individual problem, except for insurance purposes.

The length of treatment reported by MFTs in Utah is lower than the results reported by Doherty and Simmons (1996) in their national study of 15 states. Utah MFTs reported a median of 8 sessions compared to a median of 12 sessions reported by Doherty and Simmons. The therapist fees reported by the two studies are very similar. Utah MFTs reported a mean fee of $73 and a median of $80 compared to a mean and median of $80 reported by Doherty and Simmons. The reasons for the differences in length of treatment are unclear.

A conundrum concerning fees is that associate members reported a higher average fee per session than did clinical
members, a situation that logically does not make sense considering that clinical members have been in practice much longer, have substantially more experience, and are more likely to be licensed. Looking more closely at the data helps to explain the puzzle. Two of the associate members have a Ph.D. or a Psy.D. in psychology and may be able to charge higher fees. Two of the associate members reported working for a state or community agency in which the agency may charge a high fee but the therapist is actually paid much less. Also, the associate member data were based on six respondents out of a population of 10 in which a few fees on the high end can dramatically affect the mean and median. Examining the data shows three answers in the $90-95 range and three answers in the $50-65 range. Additionally, therapists reported what their fee was not what they actually were receiving for payment. Therefore, in actual practice, it is doubtful that associate members are making more than clinical members.

Limitations

This study has several limitations that need to be discussed. First, the purpose of this study was to describe who MFTs are and what MFTs do in practice. Therefore, we
can make no assumptions as to the effectiveness of the services provided by MFTs. A study of this nature for Utah MFTs may be in order in the future, although Pinsof and Wynne (1995) have provided a comprehensive review of outcome literature. Second, this study relied solely on self-report survey data. Clinicians were asked to provide answers based on their general practices without relying on specific case data, leaving the possibility that data from actual cases may be different from the clinicians’ generalized answers. This could be especially problematic on questions that asked for estimates such as the average number of sessions needed to treat clients or the severity of clients’ presenting problems. This limitation should be minor because Simmons and Doherty (1995) found no major differences in their Minnesota study in which clinicians were asked to answer questions from their generalized practice and their three most recently closed cases.

Third, the population studied was MFTs who were members of AAMFT. There are licensed MFTs in the state who are not members of the Association. Therefore, it is possible that the whole population of MFTs in Utah would reflect different results. Future studies may want to include MFTs not affiliated with AAMFT to get a broader
picture of all MFTs in the state although there is no information that would suggest differences between members of AAMFT and nonmembers.

Fourth, considering the amount of missing data for some of the questions, especially DSM-IV diagnoses used and most common third-party payer, the questionnaire itself has several limitations that should be addressed if it is used in the future. After completing the research and reviewing the questionnaire, the question about the most common third-party payers was found to be confusing and should be removed or revamped for further usage. The missing data on the DSM-IV diagnoses usage may not be a problem with the questionnaire as much as a general feeling among MFTs that placing a diagnosis on an individual in a family system can be counterproductive to successful treatment.

Implications

Practice/Application

The findings of this study show that MFTs in this sample are, based on their training background, a qualified group of practitioners. They are providing cost effective and efficient treatment to clients who are presenting with serious relational and mental health problems. In actual
practice, clinicians can use this information in negotiations with HMOs and EAPs to market their practices by showing that MFTs in actual practice can provide cost effective treatment for many mental health problems. UAMFT can also use the information to make future decisions about the needs of MFTs in Utah and in advertisements by marketing the cost effectiveness and efficiency of treatment by MFTs.

Research

With this research we know what MFTs, in this sample, are doing in their various practices regarding the kinds of problems treated, according to their own reports. For future research it may be useful to study how MFTs treat the wide range of serious mental health and relational problems they report treating. If MFTs are treating problems efficiently, it could be very useful to find out what they are doing specifically that is helpful.

Additionally it may be useful and informative to investigate what MFTs are doing professionally in addition to providing therapy. For example, some MFTs are working with businesses and corporations to address relational problems in the workplace. Other MFTs are involved with divorce mediation and custody evaluations. To gain a more
comprehensive idea of what MFTs are doing, it could be beneficial to research the full range of professional activities.

**Policy**

With this research MFTs can show that they are treating a wide range of mental health problems. Therefore, there is no reason that MFTs cannot be included on provider panels to provide mandated therapy from the courts and other state agencies. The courts often mandate therapy in cases of domestic violence, sexual abuse, and other problems. MFTs are treating these problems and should therefore have the same reimbursement for providing these services as the other mental health professions.
REFERENCES


orientations of counseling and clinical psychologists: An objective approach. Professional Psychology: Research and Practice, 22, 133-137.


of who, what and how. *Journal of Sociology and Social Welfare*, 12, 186-204.


Who are they? What do they do? What do they practice?

Psychotherapy in Private Practice, 7, 135-150.
APPENDICES
Appendix A. Questionnaire
MARRIAGE AND FAMILY THERAPIST PRACTICE PATTERNS SURVEY
PART ONE

General Practice Patterns

1. Describe your practice setting. If you have more than one practice setting, check the one where you see the most clients as "1," the one with the next highest number as "2," and so forth.

   - private practice
   - state or community agency
   - private, non-profit agency
   - medical center (outpatient)
   - medical center (inpatient)
   - HMO
   - employee assistance program
   - Other (please specify):

2. What is your highest professional degree?

   - Ph.D.
   - M.A.
   - M.S.
   - M.S.W.
   - Psy.D.
   - Other (please specify): ____________________________

3. What field is your degree in? ____________________________

4. In what year did you receive your highest professional degree? ____________________________

5. Are you currently licensed or certified to practice by your state? □ Yes □ No

   List state: ____________________________

State __________
6. What licenses/certifications do you hold? (Check all that apply.)

☐ Marriage and Family Therapist  ☐ RN
☐ Psychologist  ☐ MD
☐ Social Worker  ☐ None
☐ Professional Counselor
☐ Other (please specify): ________________________________

7. What is your primary professional identification? (CHECK ONLY ONE.)

☐ Counselor (e.g., clinical mental health, rehabilitation, school, substance abuse, or vocational counselor)
☐ Marriage and family therapist
☐ Nurse (other than a psychiatric nurse)
☐ Physician (other than a psychiatrist)
☐ Psychiatric Nurse
☐ Psychiatrist
☐ Psychologist (e.g., clinical, counseling, or school psychologist)
☐ Social Worker
☐ Clergy
☐ Other (please specify): ________________________________

8. Are you an AAMFT Approved Supervisor?

☐ Yes  ☐ No

9. What is your current employment status?

☐ Full-time employed (at least 35 hours per week)
☐ Part-time employed (less than 35 hours per week)
☐ Student, intern, resident, trainee, or post-doctoral fellow/trainee
☐ Retired and not employed
☐ Not currently employed
☐ Other (please specify): ________________________________

10. (IF EMPLOYED) How many hours per week do you typically work for pay?

_____ hours per week

11. Are you currently seeking additional employment?

☐ Yes  ☐ No
12. How many different paid positions do you currently hold? ______ paid positions

13. Can you conduct therapy in any language other than English?
   □ no
   □ yes (please specify: ________________________________)

14. On average, how many clinical contact hours do you have per week?
   ______ clinical contact hours

15. How many cases are on your current active therapy caseload?
   ______ currently active cases

16. In which of the following time periods do you schedule clients? (Check all that apply.)
   □ Early mornings (before 8:00 a.m.)
   □ Evenings (5:00 p.m. or later)
   □ Saturdays or Sundays
   □ Weekdays (8:00 a.m. - 5:00 p.m.)

17. What is the typical interval between a client's request for therapy and the first session?
   □ One week or less
   □ One to two weeks
   □ Two weeks
   □ Two to three weeks
   □ Four weeks
   □ Four to six weeks
   □ Over six weeks

18. How many years post-training have you practiced marriage and family therapy?
   ______ years

19. With which of the following special populations do you consider yourself clinically competent to work? (Check all that apply.)
   □ Children
   □ Adolescents
   □ Elderly
   □ Gay
   □ Lesbian
   □ Physically impaired
   □ Racial/ethnic minorities
20. Which of the following do you consider yourself clinically competent to perform?
(Check all that apply)

- [ ] Individual child therapy
- [ ] Individual adolescent therapy
- [ ] Individual adult therapy
- [ ] Couple/marital therapy
- [ ] Family therapy
- [ ] Group therapy with children
- [ ] Other (please specify) ______ ______
- [ ] Group therapy with adolescents
- [ ] Group therapy with adults
- [ ] Sex therapy
- [ ] Hypnosis
- [ ] Biofeedback
- [ ] Psychological assessment/testing

21. Which kinds of disorders do you consider yourself clinically competent to work with?
(Check all that apply)

- [ ] Psychoactive substance use disorders
- [ ] Anxiety disorders
- [ ] Adjustment disorders
- [ ] Dissociative disorders
- [ ] Schizophrenic disorders
- [ ] Personality disorders
- [ ] Post-traumatic stress disorder
- [ ] Attention deficit hyperactivity disorder
- [ ] Oppositional defiant disorder
- [ ] Mood disorders
- [ ] Somatoform disorders
- [ ] Sexual disorders
- [ ] Other psychotic disorders
- [ ] Eating disorders
- [ ] Phobias
- [ ] Conduct disorder

22. What percentage of your current adult caseload falls into the following educational categories? (Total should equal 100%.)

- [ ] % less than high school degree
- [ ] % high school degree
- [ ] % some college
- [ ] % college degree
- [ ] % post-graduate degree

100% TOTAL
23. If you examine your current therapy caseload, what percentage of your clinical hours do you spend in the following? (Total should equal 100%.)

___% Individual adult therapy
___% Individual child or adolescent therapy
___% Couples therapy (includes couples groups)
___% Family therapy (includes family groups)
___% Group therapy
100% TOTAL

24. What is your (or your agency's) fee per session for the following? If you use a sliding scale, give the range.

$ ___ Individual therapy
$ ___ Couple therapy
$ ___ Family therapy
$ ___ Group therapy

25. IF YOU DO PRIVATE PRACTICE, do you charge reduced rates to some clients?

☐ yes ☐ no (IF NO, skip to question 26)

IF YES, what percentage of clients on your current therapy caseload receive reduced fees?

___% 

IF YES, what was the average reduced fee? $ ___

26. IF YOU WORK FOR AN AGENCY, does your agency charge reduced rates to some clients?

☐ yes ☐ no (IF NO, skip to question 27)

IF YES, what percentage of clients on your current therapy caseload receive reduced fees?

___% 

IF YES, what was the average reduced fee? $ ___

27. Do you do offer pro bono or free services to some clients?

☐ Yes ☐ No

IF YES, how many cases are you currently treating pro bono? __________ cases
28. What percentage of the clients on your current therapy caseload have third party coverage under government programs, such as:

- ___% Medical assistance/Medicaid
- ___% Medicare
- ___% CHAMPUS
- ___% Federal Employee Health Benefits Program (FEHBP)
- ___% Other government programs (please specify):

29. How many of your outpatient clients have been hospitalized for a psychiatric disorder in the past 12 months? ______

If you had clients who were hospitalized, how many were:

- ______ children (10 and under)
- ______ adolescents
- ______ adults

30. What percentage of the clients on your current caseload are on a psychotropic medication? ______%

31. What percentage of the clients on your current caseload also see another health professional for MENTAL HEALTH treatment? ______%

Of these, what percentage see a:

- ___% psychiatrist
- ___% social worker
- ___% psychologist
- ___% marriage and family therapist
- ___% another mental health professional
- ___% medical physician (for mental health treatment)
- ___% other (please specify): ______

100% TOTAL

32. What percentage of your current clients (excluding groups) do you see:

- ___% more than once a week
- ___% weekly
- ___% bi-weekly
- ___% every three weeks
- ___% monthly
- ___% less than monthly

100% Total
33. What is the average or median number of sessions of treatment for clients in your practice? (Half your clients would have fewer than this number of sessions and half more.)

____ number of sessions

34. What percentage of clients receive treatment for:

____ % 1-10 sessions
____ % 11-20 sessions
____ % 21-30 sessions
____ % more than 30 sessions

100% Total

35. What are the five most common presenting problems that you treat? Start with 1=most common, 2=next most common, etc.

____ marital/couple difficulties
____ parent-adolescent conflict
____ drug/alcohol abuse
____ work difficulties
____ depression
____ anxiety
____ child behavior problems
____ school problems
____ child abuse
____ domestic violence
____ sexual abuse
____ other adult psychological problems
____ other child psychological problems
____ chronic mental illness
____ other (please specify):
36. In terms of severity of problems, what percentage of your current caseload consists of the following:

___% none
___% mild problems
___% moderate problems
___% severe problems
___% extremely severe problems
___% catastrophic problems
100% Total

37. What are the five most common DSM-III-R or DSM-IV diagnoses you use in your practice? Start with the most frequent. If possible, list both the name and number of the diagnosis.

(1) ____________________________________________
(2) ____________________________________________
(3) ____________________________________________
(4) ____________________________________________
(5) ____________________________________________

38. When you do couple or marital therapy, how do you generally code it for administrative or insurance reimbursement purposes?

☐ as individual therapy
☐ as couple therapy
☐ as family therapy
☐ other (please specify): ____________________

39. When you do family therapy, how do you generally code it for administrative or insurance reimbursement purposes?

☐ as individual therapy
☐ as couple therapy
☐ as family therapy
☐ other (please specify): ____________________
40. What percentage of your current therapy cases pay “out of pocket,” without third party reimbursement? ______ %

For those clients who pay “out of pocket,” what is the reason? (The total should equal 100%)

____% no third party coverage
____% third party payor doesn’t cover service
____% third party payor doesn’t cover provider
____% client has exhausted benefits
____% client chooses not to use third party benefit
100% Total

41. Do you have any affiliations with managed care organizations, such as HMOs, Independent Practice Associations (IPAs), Preferred Provider Organizations (PPOs), or Managed Mental Health Care Organizations

☐ Yes  ☐ No

☐ I am employed by such an organization

[IF YOU ANSWERED YES, COMPLETE QUESTION 42]
[IF YOU ANSWERED NO, SKIP TO QUESTION 43]

42. For the following kinds of managed care organizations, what is your number of affiliations and the number of your current clients enrolled in that organization:

<table>
<thead>
<tr>
<th>Organization</th>
<th>Number of Affiliations</th>
<th>Number of Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Maintenance Organization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent Practice Association</td>
<td></td>
<td></td>
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<tr>
<td>Preferred Providers Organization</td>
<td></td>
<td></td>
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<tr>
<td>Managed Mental Health Care</td>
<td></td>
<td></td>
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<tr>
<td>Other (specify):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL: ____________________  ____________________
43. Using the chart below, please indicate the following:

a) In the left hand column, list the third party payors carried most frequently by your clients. Start with the most frequent.

b) For each payor listed, please answer Y (yes) or N (no) to the following question: Does the payor reimburse for couples therapy under some circumstances?

c) If the answer to b) is no, stop. If the answer to b) is yes, please answer the next two questions:

1) Does the payor require a diagnosis for one partner, other than a v-code?
2) Does the payor require you to code the service as individual therapy with spouse present?

[IF YOU DO NOT KNOW THE ANSWER TO A QUESTION, PUT "DK" (FOR "DON’T KNOW) IN THE BOX.]

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
<td>(b)</td>
<td>(c)</td>
<td>(d)</td>
</tr>
<tr>
<td>Payor Name (Please spell out)</td>
<td>Reimbursement for couples therapy under some circumstances (yes or no?)</td>
<td>Require diagnosis for one partner other than a v-code (yes or no?)</td>
<td>Code as individual with spouse present (yes or no?)</td>
</tr>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>4.</td>
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<td>5.</td>
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<tr>
<td>6.</td>
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</tbody>
</table>
Questions 44 through 55 were developed by the National Institute of Mental Health (NIMH). These standardized questions will allow direct comparison with surveys of other professional groups.

44. For the last calendar MONTH, please indicate the TOTAL number of hours you worked in your primary paid position, the total number of hours you worked in your secondary paid position, and all other paid positions (if applicable). (If you did not spend any time in a specific activity, write "0" in the appropriate boxes.)

<table>
<thead>
<tr>
<th>Activity Description</th>
<th>Primary Position</th>
<th>Secondary Position</th>
<th>All Other Positions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Hours per week</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Direct care (diagnostic, assessment, evaluation, medication prescription and management, treatment)</td>
<td></td>
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<tr>
<td>Clinical supervision of staff and trainees</td>
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<tr>
<td>Clinical/community consultation and prevention (not including direct care)</td>
<td></td>
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<tr>
<td>Educational activities (teaching of courses or professional workshops; curriculum development; or course evaluation)</td>
<td></td>
<td></td>
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<tr>
<td>Management and administration (policy or program development and review; personnel administration, recruitment; and budgeting)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research (basic and applied)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other activity not mentioned (for example, scholarly writing)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

11.
45. Using the DSM-III-R or DSM-IV diagnostic categories, during the last calendar year did you provide direct services to clients with: (Check all that apply.)

- Affective disorders (bipolar depression, major depression)
- Anxiety disorders
- Dually-diagnosed individuals (individuals with a mental health and substance abuse diagnosis, a mental health and mental retardation diagnosis, and a mental retardation and substance abuse diagnosis)
- Mental retardation and other developmental disorders
- Organic brain disorders and syndromes
- Personality disorders (e.g., borderline disorders, antisocial disorders)
- Schizophrenia and other major psychoses
- Substance abuse (alcohol or drug abuse or dependency)
- Other problems not listed above (for example, V code problems such as adjustment problems, family and/or relationship problems, academic problems)

46. During this same time period (past year), did you provide services to clients who were: (Check all that apply.)

- Children from birth to age 18 who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder that has resulted in functional impairment in family, school or community activities.
- Persons age 18 and over who currently or at any time during the past year have had a diagnosable mental, behavioral or emotional disorder that has resulted in functional impairment in one or more major life activities.

[These disorders include any mental disorder listed in DSM-III-R, DSM-IV, or ICD-9 with the exception of "V" codes, substance abuse disorders, developmental disorders including mental retardation and Alzheimer's related dementias, unless they co-occur with another diagnosable mental disorder.]

47. During the past year, to which of the following age groups did you provide direct services? (Check all that apply.)

- Children (individuals age 10 years or younger)
- Adolescents (individuals age 11-17 years)
- Adults (individuals who were 18-64 years)
- Elders (individuals age 65 years and older)
48. From which of the following racial or ethnic minority groups were clients to whom you provided direct services during the past year?

- American Indian/Alaskan Native
- Asian-American/Pacific Islander
- African-American
- Hispanic (Cuban, Mexican American, Puerto Rican or other Hispanic)
- Caucasian

Other (please specify): __________________________

49. During the past year, did you provide direct services to: (Check all that apply.)

- Females
- Males

50. What is your racial background? (Check all that apply.)

- Native American/Alaskan Native
- Asian or Pacific Islander
- African-American
- Caucasian
- Hispanic

Other (please specify): __________________________

51. Is your ethnic heritage Hispanic?  

- Yes
- No

52. Please provide the first five digits of the zipcode for your primary and secondary (if applicable) paid positions.

Primary paid position

Secondary paid position

53. Town/City and Zip Code in which you hold your primary paid position:

________________________

54. Your Date of Birth: _________________________

55. Sex (check one):  

- Female
- Male

THANK YOU!
Appendix B. Approval Letter
February 14, 1996

Thane Palmer
Family Life Center
493 North 700 East
Logan, UT 84321

Dear Thane:

This is a belated response to your request for the questionnaire, program and other materials that we have been using in our national survey of marriage and family therapists. Bill Doherty and I are pleased to share this material with you and hope that it will help you do a wonderful masters thesis project. However, we do request that you share your data with us at the end of the project so that we can enter it into our national data base. We've got 16 states thus far; Utah would make it 17.

On this disk you will find several files that should help you get started.

a:amftbh1 This is the codebook for the Part I survey. Print it out so you can become familiar with the variables.

a:amftpp1.sps This is the program for the Part I questionnaire. Right now it is in WordPerfect and will need to converted to SPSS (either SPSS-PC or SPSS for Windows) to make use of it. You will need to change the title, system file name, etc. from % to your own computer drive and title. The syntax was written for SPSS-PC so you might (or might not) have to tinker with it to get it to run in SPSS for Windows.

a:paycoup1.sps This program aggregates across all insurers to look at how often therapists estimated that insurers pay for couples therapy. Run this after you run a:amftpp1.sps.

a:sample.dat Here is a sample of what your data will look like when it is entered. To keep things consistent with our numbering, you can start with number 1820 or you can start with 1 thru X if it better meets your needs. If you start with #1, you will need to modify the column designation in the first part of the program.

Finally, I am sending you a hard copy of the questionnaire itself to xerox. One caveat: questions 30-35 refer to client questionnaires that we requested along with case reviews. You will not need these for your study and may wish just to cover them...
up when you xerox the survey. You’ll want to take references to these variables out of the program and codebook as well.

I hope that this will be helpful to you. You can reach me at 612-625-4225 or by e-mail at simm0007@gold.tc.umn.edu with questions. E-mail’s probably a better bet.

Please give my best to Thorana.

GOOD LUCK!!

Sincerely,

Debbie Simmons
Appendix C. Cover Letter
MEMORANDUM

TO: Thorane Nelson, Ph.D.
    Thane Palmer

FROM: True Rubal, Secretary to the IRB

SUBJECT: A Profile of Professional Activities and Clinical Practice Patterns of Marriage
         and Family Therapists in Utah.

April 26, 1996

The above-referenced proposal has been reviewed by this office and is exempt from further
review by the Institutional Review Board. The IRB appreciates researchers who recognize the
importance of ethical research conduct. While your research project does not require a signed
informed consent, you should consider (a) offering a general introduction to your research goals,
and (b) informing, in writing or through oral presentation, each participant as to the rights of the
subject to confidentiality, privacy or withdrawal at any time from the research activities.

The research activities listed below are exempt from IRB review based on the Department
of Health and Human Services (DHHS) regulations for the protection of human research
subjects, 45 CFR Part 46, as amended to include provisions of the Federal Policy for the

2. Research involving the use of educational tests (cognitive, diagnostic, aptitude,
achievement), survey procedures, interview procedures or observation of public behavior,
unless: (a) information obtained is recorded in such a manner that human subjects can be
identified, directly or through the identifiers linked to the subjects: and (b) any disclosure
of human subjects' responses outside the research could reasonably place the subjects at
risk of criminal or civil liability or be damaging to the subjects' financial standing,
employability, or reputation.

Your research is exempt from further review based on exemption number 2. Please keep
the committee advised of any changes, adverse reactions or termination of the study. A yearly
review is required of all proposals submitted to the IRB. We request that you advise us when
this project is completed, otherwise we will contact you in one year from the date of this letter.
January 8, 1996

Dear UAMFT Member:

Last fall I attended AAMFT’s Leadership Conference in Baltimore, including a presentation by Executive Director Michael Bowers on AAMFT’s Practice Patterns Survey. Michael expressed confidence in the data, and admitted that even he was somewhat surprised by the results. Did you know that 61% of AAMFT’s membership is female, a 10% increase since 1987? Or, that AAMFT members treat more Affective Disorders than psychologists?

The enclosed material is a study being conducted by Thorana Nelson and Thane Palmer through Utah State University. Their goal is to gain more information about the clinical practice patterns of Utah Marriage & Family Therapists. Information from the study will provide data about who we are and the kinds of problems we treat. This information will help us promote the quality services provided by our members, and achieve increased awareness and acceptability of the field of Marriage & Family Therapy in the state of Utah. It will increase MFTs’ leverage in negotiating treatment contracts with HMO’s, EAP’s, PPO’s and state government agencies.

The UAMFT Board voted to support the Utah Practice Patterns Survey. The data will also support specific goals outlined in the Strategic Plan, designed to increase visibility of UAMFT Members’ services and communicate more effectively with the public with legislators and other officials about the nature of our work. As President of UAMFT, I urge you to take time to complete the enclosed questionnaire. Results from the study will be reported in the fall newsletter.

We appreciate your contribution...an investment in UAMFT, in the research so desperately needed to thrive in a competitive mental health care market, and in our shared future as Marriage & Family Therapists.

Sincerely,

[Signature]

Beth Hughes, R.S., M.F.T. President