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Training Marriage and Family Therapists in Formal Assessment: Contributions to Students' Familiarity, Attitude, and Confidence

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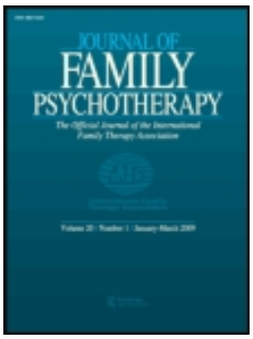

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Training Marriage and Family Therapists in Formal Assessment: Contributions to Students' Familiarity, Attitude, and Confidence

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Studies suggest that few practicing marriage and family therapists use formal assessments and even fewer use systemic assessments. Given the potential value of formal assessment to both clinicians and clients, we surveyed current marriage and family therapy students (N = 91) about their familiarity, attitude, and confidence in training with assessment. Experience using assessments predicted familiarity. Having a supervisor that valued assessments predicted familiarity and confidence in training. The number of courses taken in assessment was not predictive of familiarity, attitude, or confidence. Implications for training and future research are discussed.

KEYWORDS assessment, feedback, supervision, therapist training

INTRODUCTION

Careful assessment is imperative in the diagnosis and treatment of clients in psychotherapy. Research on using formal or standardized assessments to monitor and improve client outcomes has found significant benefit in using formal assessment measures to return treatment information to both clinicians and clients (Lambert et al., 2001). Similarly, the Commission on the Accreditation of Marriage and Family Therapy Education (COAMFTE) has

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identified clinical assessment and diagnosis as one of the domains essential for clinical competency (AAMFT, 2004). Many of the 26 competencies in this area focus specifically on clinicians' knowledge and appropriate use of formal assessment strategies. Only a minority of marriage and family therapists (MFTs), however, report using formal assessments during treatment, and the assessments that they report using are typically focused on individual pathology (Boughner, Hayes, Bubenzer, & West, 1994; Lavee & Avizar, 2006). Given the potential value of assessment to clients and the mandate for MFTs to demonstrate competence in assessment, we conducted a study that examined the degree to which assessment is taught in marriage and family therapy training programs and whether particular elements of those programs predict trainees' familiarity, confidence in their training, and attitudes regarding formal assessment techniques.

REVIEW OF LITERATURE

Importance of Formal Assessment

Cromwell, Olson, and Fournier (1976) outlined a conceptual model of why formal assessment is critical to the practice of marriage and family therapy. They contended that assessment helps therapists discover family needs prior to treatment, supply information throughout treatment, and provide an objective measure of progress during and after treatment. Though each of these needs are commonly served by informal assessments, formal assessment can provide a degree of perceived objectivity that may be valuable as therapists make and communicate treatment decisions (Floyd, Weinand, & Cimmarusti, 1989). Bagarozzi (1989) aptly noted that formal assessment is indispensable in school psychology and individual psychology. Assessment in those fields is used to help therapists treat clients and provide referrals and information to other professionals. MFTs could potentially provide family or systemic assessments and thus, fill an important role in the broader mental health field. Such assessments may also be useful for improving understanding of systems concepts inside and outside the profession of marriage and family therapy (West, 1988). Better understanding of individual assessments may also better position MFTs to work with other mental health professionals and in managed care settings.

Cromwell and colleagues (1976) also noted that assessment is an avenue through which MFTs can use and participate in research. Though their article was written three and a half decades ago, the division between researchers and clinicians is still a common theme in the literature (Crane, Wampler, Sprenkle, Sandberg, & Hovestadt, 2002). Howard, Moras, Brill, Martinovich, and Lutz (1996), for example, contend that using assessment in therapy can contribute to "patient-focused research" (p. 1059). In this paradigm, each client is treated as an individual research study such that the clinician uses

the feedback from formal assessments to uncover what will help a particular client in a particular context. Clinicians could try new techniques or ideas and receive relevant, personalized feedback, rather than relying solely on intuition to guide treatment and their own clinical development (Floyd et al., 1989).

In addition to the benefits available to clinicians, formal assessments may also be valuable to clients. When shared directly with clients, systemic assessments may help clients adopt a systemic perspective and understand their family dynamic better. This may be instrumental in then finding solutions to problems (West, 1988). Research has also shown that directly providing clients with regular feedback about their progress can improve treatment outcomes (Lambert et al., 2001). Therapist use of and competence with formal assessment measures is critical to the process of feedback.

Use of Formal Assessment by MFTs

Boughner and colleagues (1994) provide a picture of MFTs' use of assessment. Of their sample of 598 practicing MFTs, only 33% reported using at least one assessment instrument. Consistent with the limited attention given to this clinical competence, no one has conducted a more up-to-date survey of assessment use by MFTs in the United States. Surveys of international MFTs report similar numbers as Boughner and colleagues. Lavee and Avisar (2006), for example, found that 27% of respondents from a sample of Israeli MFTs reported using formal assessment in their practice. Wynn, Myklebust, and Stensland (2005) also found that only 21.6% of Norwegian MFTs reported systematically using diagnostic instruments. They did find, however, that 66.2% of their sample reported referring patients out for testing. It is possible that referrals are more common in the United States as well, but were not reported in Boghner and colleagues survey.

Closer examination of Boughner and colleagues' (1994) results reveals an important trend related to the type of assessments used. Though there was some variability based on type of therapy, the most commonly used assessments were based on individual psychology. For each type of therapy (premarital, marital, family, divorce, and single parent), the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) and the Myers-Briggs Type Indicator (MBTI) were among the top three most commonly used assessments. Assessments rooted in a systemic worldview were rarely used. The only systemic assessment in the top three of any type of therapy was the Family Adaptability and Cohesion Evaluation Scales for family therapy, and this was used less frequently than the MMPI-2 and the MBTI. Thus, not only are MFTs not often using formal assessments, but when they do use them, they are doing so from an individually focused perspective, rather than a systemic perspective. On the other hand, Lavee and Avisar's (2006) sample of Israeli couple therapists reported using assessments that focused on the

relationship more often. Though the MMPI-2 was the second most often used assessment, it was the only individual focused assessment in the top five most used. It is not possible, however, to discern if this difference is because of the later date of the study, the different country or some other confounding variable.

Attitude Toward Formal Assessment

Lavee and Avisar (2006) found an overall negative attitude of formal assessment in couple therapists. Only 10% of the surveyed MFTs endorsed basing assessment on standardized measures. Likewise only 4.4% believed that formal assessments contribute to success in couple therapy. One positive attitude toward formal assessments comes from the question "If there had been a standardized assessment instrument that measured a meaningful component of the relationship I would have used it." Close to half of the respondents (49.7%) agreed with the statement, suggesting that therapists may be willing to use formal assessments in general, but that they are not familiar with instruments.

These findings are congruent with other studies of therapist attitudes. Boughner and colleagues (1994) found that 70% of their sample believed formal assessment were either not very important or not at all important. Anker, Dunkin, and Sparks (2009) anecdotally reported that therapists were skeptical of the formal feedback measure introduced in their study, believing that informal assessment would suffice. Wynn and colleagues' (2005) study of Norwegian therapists stands as an exception. They found a generally positive bias toward diagnostic testing, noting specifically that systemically oriented therapists were most likely to be interested in referring clients to testing. This coincides with Lavee and Avisar's (2006) finding that strategic-structural therapists were most likely to use standardized assessments.

Improving the Use of Assessments

Providing clinicians with information on assessment through professional literature is conceivably one way that assessment use among MFT may be improved (Boughner et al., 1994). The late 1980s and early 1990s saw a number of attempts in professional literature to review or list available assessments (Bagarozzi, 1989; Boen, 1988; Cromwell et al., 1976; West, 1988), develop systems for assessing specific aspects of marriage and family relationships (Bradbury, 1995; Floyd et al., 1989; Reichertz & Frankel, 1993; Snyder, Heyman, & Haynes, 2005), or discuss specific procedures of implementing assessment in practice (Bagarozzi, 1989; Floyd et al., 1989). Boughner and colleagues (1994) conducted a survey to compare this high

quantity of professional literature to actual assessment use among clinicians. They concluded that there is little connection between literature available and clinicians' use of formal assessment. Although there are significant limitations to their findings, they provide some evidence that reviewing assessments in the professional literature is not sufficient to increase use of assessments.

Alternately, training programs may be the best place to affect therapist use of assessment. As the source of clinician's initial and most intense learning, training programs may be uniquely suited to influence clinician's later attitudes and practices. Indeed, Lavee and Avisar (2006) found that MFTs that received any training in formal assessment are nearly five times as likely to use them compared to someone who is untrained. Unfortunately their analysis does not account for the amount or quality of training received.

Available research provides some information about past practices in training assessment. Hines (1996) found that the MFTs included in his study reported that they had been sufficiently trained in marital and family assessment, but minimally trained in individual psychological assessment. Gold's (1997) survey of marriage and family counseling programs found that only 62.5% of programs required training in family assessment. Of those accredited by the American Association of Marriage and Family Therapy, 31.8% did not offer a class that covered family assessment and an additional 13.6% only included family assessment in a more general course on assessment. It may be that these percentages are even lower now that COAMFTE has shifted from input-based to output-based standards. As a result of this change the standard curriculum which required that programs teach "traditional psychodiagnostic categories, and the assessment . . . of major mental health issues" (COAMFTE, 2005b, p. 1), is now a guideline, rather than a requirement (COAMFTE, 2005a). New information on what is being taught in programs and what affects students' understanding of formal assessment can thus, play an important role in making attempts to improve assessment use throughout the profession.

THE CURRENT STUDY

With a view to discovering how training programs might more effectively train students in formal assessment, we surveyed current students of marriage and family therapy programs regarding their training in assessment. Our hypothesis was that programs which provide courses in assessment, that use formal assessments in their clinics or internship sites, and that use the results of assessment in supervision are most likely to produce clinicians that are familiar with formal assessments, have positive opinions about assessment, and feel confident in their training.

METHOD

Participants

Participants included 91 students in COAMFTE accredited graduate programs recruited via email. We sent an e-mail to all COAMFTE accredited marriage and family therapy program directors in the United States requesting that they forward an invitation for participation to all of their current graduate students. A follow-up invitation for participation was e-mailed two months following the initial e-mail. In total, 95 directors were e-mailed. Two messages were returned undeliverable. Two hundred ten students began the survey and 102 (48%) completed the entire survey. After removing cases for missing data, 91 participants had full data and were used in the analyses (43%). Our sample was predominantly female (84%) and enrolled in Master's level training programs (66%).

Procedure

Participants completed an online survey accessed through a hyperlink in the invitation e-mail. The survey included 38 questions on topics including participants' training in assessment, perceived usefulness of assessment, and the role of assessment in supervision. Participants were also asked about their preferred models of therapy, number of client contact hours, and other demographic information.

Measures

Familiarity

The familiarity score measured the degree to which the students felt they were familiar with formal assessment strategies and using the DSM for diagnosis. Students were asked to rate from 1 (very unfamiliar) to 4 (very familiar) whether they were familiar with formal assessment strategies for 14 topics. These topics included "mood disorders," "anxiety disorders," "couple functioning," "personality disorders," "session quality," and other topics. Students also rated their familiarity with the DSM and their ability to use it to assess clients. Four items about the DSM were rated from 1 (strongly disagree) to 4 (strongly agree). These 18 items were averaged to create a measure of familiarity that ranged from 1 to 4, with higher scores representing greater familiarity. Cronbach's alpha for this measure was .93. Additionally, two subscales were created. One consisting of five items measured students' familiarity with individual focused assessments (Cronbach's alpha was .83). One consisting of six items measured familiarity with systemic assessments (Cronbach's alpha was .87).

Positive Attitude of Formal Assessment

Students' responded to 12 items regarding their attitudes about formal assessment. These included items such as "are too time consuming," "benefit clients," "are too narrowly focused," and "help monitor client progress." Students rated each item between 1 (strongly disagree) and 4 (strongly agree). Items were reverse coded as needed to make higher scores represent more positive attitudes. The 12 items were averaged to create one scale of positive attitude toward formal assessment. Cronbach's alpha for this scale was .75.

Confidence in Training

Participant's responded to six items regarding their training in assessment. One item asked if participants felt, in general, that they had received adequate training, and the remaining five asked about training in assessment for psychological and relational problems, the purpose of assessment, potential uses of assessment, and evaluating the quality of assessment measures. Each item was rated from 1 (strongly disagree) to 4 (strongly agree). The items were then averaged to create a 1–4 scale. Cronbach's alpha for this scale was .85.

End of Program Training

Students responded to the question "I am confident that by the end of my program I will have all of the training in assessment that I will need," on a 1 (strongly disagree) to 4 (strongly agree) scale. The item was recoded into a dichotomous variable. Those that indicated that they disagreed or strongly disagreed were assigned a score of 0, and those that indicated that they agreed or strongly agreed were assigned a score of 1.

Frequency of Use

Participants were asked at what points during the therapeutic process they use formal assessments. Responses included "never," "prior to the first session," "during the first session," "on a fixed schedule," "every session," "at the last session," and "at a follow-up interview." Participants were given the option to indicate multiple answers. Answers were collapsed into three levels. The first group included those that described using assessment on a fixed schedule or every session. The next were those that used formal assessment measures, but not on a fixed schedule. The third group reported that they never used formal assessment measures. For analysis, two dummy variables were created, with those who never used formal assessment as the reference group.

Supervisor Valuation

Participants were asked four questions about their supervisor's attitude about and use of formal assessments. These questions asked if supervisors valued formal assessments, required their use, asked supervisees about them, and used them to discuss clinical progress. Each item was rated from 1 (strongly disagree) to 4 (strongly agree). The four items were averaged to create a scale ranging from 1–4. Cronbach's alpha for this scale was .89.

Time in MFT Training

Students reported the type of program that they were currently in (Master's or Doctoral) and the percentage of the program that they had completed. We used these responses to create a measure of how much training they had received by assigning Master's students that had completed less than 50% a 1, Master's students that had completed more than 50% a 2, Doctoral students that had completed less than 50% a 3, and Doctoral students that had completed more than 50% a 4.

Number of Courses

Students responded to a question asking where they learned about assessment. Two options ("a required course" and "an elective course") were used to create a measure ranging from 0 to 2 of how many classes each student had taken about assessment.

Increase Use

Participants were asked to indicate which items from a list would increase their use of formal assessments and which would be the most likely to increase their use. Items included more training, better knowledge, shorter assessments, staff administration and scoring, and supervisor use. Students were also given the opportunity to write in additional ideas.

Strategy of Analysis

Means and standard deviations were calculated for all scale variables. Percentages were calculated for all categorical variables. A *t*-test compared familiarity with individual versus systemic assessments. The main analysis of the project used four regression analyses using familiarity, positive attitude of formal assessment, positive attitude of continuous assessment, and adequacy of training as the dependent variables. The independent

variables were the same in each of the analyses. In the first step for each analysis, gender, client contact hours, and time in MFT training were entered as control predictors. In the second step, the number of assessment courses the students had taken was added to the analysis. In the third step the frequency of use variables and the supervisor valuation variable were added to the analysis. Additionally, we conducted a binomial logistic regression analysis to predict student's beliefs about being adequately trained by the end of their program. The independent variables were the same as in the four main analyses, though frequency of use was recoded as a single variable with three levels (0 = never, 1 = non-regular, and 2 = regular).

RESULTS

Descriptive Statistics

Descriptive statistics for our sample can be seen in Table 1. Students reported being significantly more familiar with systemic assessments than individual assessments ($p = .003$). Most of the sample had some experience using formal assessment measures, with only 10% saying they never use them. Correlations between variables are presented in Table 2.

TABLE 1 Means, Standard Deviations, and Percentages of Study Variables ($N = 91$)

Sex		
Male	16%	
Female	84%	
Frequency of use		
Never	10%	
Not regularly	45%	
Regularly	41%	
End of program training		
Disagree	64%	
Agree	36%	
	Mean	SD
Time in MFT training	2.38	1.01
Client contact hours	466	496
Number of courses	0.93	0.59
Supervisor valuation	2.41	0.81
Overall familiarity	2.90	0.48
Individual familiarity	2.71	0.61
Systemic familiarity	2.83	0.60
Attitude of formal assessment	2.85	0.27
Confidence in training	2.84	0.51

TABLE 2 Correlation Matrix

	1	2	3	4	5	6	7
1. Client contact hours	–						
2. Time in MFT training	.60*	–					
3. Number of courses	.01	.04	–				
4. Supervisor valuation	−.19*	−.26*	.10	–			
5. Attitude of formal assessment	−.05	−.15	.00	.08	–		
6. Familiarity	.28*	.12	.12	.27*	.27*	–	
7. Confidence in training	.14*	.01	.15	.25*	.18*	.41*	–

Note. *$p < .05$.

Familiarity

Regression coefficients predicting familiarity can be seen in Table 3. In the first step, client contact hours were predictive of familiarity, indicating that students who had seen more clients were more likely to be familiar with formal assessment measures. Adding the number of courses taken in Step 2 did not significantly change the model, with an R^2 change of .014 (*ns*). Adding frequency of use and supervisor valuation in Step 3, however, resulted in an R^2 change of .183 ($p < .000$). A subset test of both frequency of use dummy variables indicated that frequency of use significantly predicts familiarity with formal assessment measures ($p < .05$). The significance values of the dummy variables indicated that both those who regularly and those who non-regularly use formal assessments felt significantly more familiar with formal assessment measures than those who never used them. Supervisor valuation also significantly predicted familiarity ($p < .05$), with greater valuation being associated with greater familiarity.

TABLE 3 Summary of Regression Analyses for Variables Predicting Familiarity ($N = 91$)

	Step 1		Step 2		Step 3	
Variable	B	SE B	B	SE B	B	SE B
Constant	2.9*	.28	2.8*	.29	2.2*	.32
Sex	−.04	.13	−.03	.13	.02	.12
Contact hours (/100)	.03*	.01	.03*	.01	.02	.01
Time in MFT	−.03	.06	−.03	.06	.02	.06
Number of courses			.10	.08	.06	.08
Regular use					.48*	.17
Not regular use					.41*	.156
Supervisor valuation					.15*	.06

Note. *$p < .05$; $R^2 = .08$ for Step 1; $\Delta R^2 = .01$ for Step 2; (*ns*), $\Delta R^2 = .18$ for Step 3; ($p < .000$). Not regular use and regular use are related dummy variables for frequency of use. Never use is the reference category.

TABLE 4 Summary of Regression Analysis for Variables Predicting Confidence in Training ($N = 91$)

	Step 1		Step 2		Step 3	
Variable	B	SE B	B	SE B	B	SE B
Constant	3.1*	.31	2.9*	.32	2.4*	.38
Sex	−.11	.15	−.10	.15	−.07	.14
Contact hours (/100)	.02	.01	.02	.01	.02	.01
Time in MFT	−.05	.07	−.06	.07	−.02	.07
Number of courses			.12	.09	.10	.09
Regular use					.03	.20
Not regular use					.04	.19
Supervisor valuation					.17*	.07

Note. *$p < .05$; $R^2 = .03$ for Step 1; $\Delta R^2 = .02$ for Step 2; (*ns*), $\Delta R^2 = .07$ for Model 3 (*ns*). Not regular use and regular use are related dummy variables for frequency of use. Never use is the reference category.

Confidence in Training

Table 4 includes results from a regression analysis predicting students' reports of the adequacy of their training in assessment. There were no significant predictors in Step 1 and Step 2. In Step 3, however, supervisor valuation was a significant predictor of confidence in training, indicating that greater supervisor use is associated with therapists feeling they have been adequately trained.

Attitude

There were no significant predictors of positive attitude toward formal assessment.

End of Program Training

Binomial logistic regression indicated that time in marriage and family therapy training was the only significant predictor of whether students believe they will have adequate training by the end of their program ($p < .016$, odds ratio = .461). To visualize the relationship between time in marriage and family therapy training and end of program training, we calculated the average rating on the end of program training item (before it was dichotomized) for each level of the time in marriage and family therapy training variable and plotted it (see Figure 1). The major difference was that those who had the least training (i.e., Master's students who had completed less than 50% of their program) were the most optimistic about receiving adequate training.

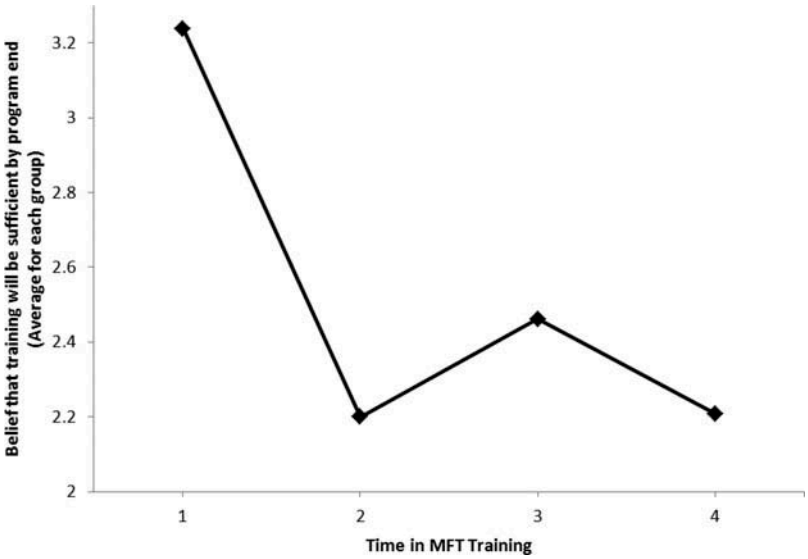

FIGURE 1 Belief That Training in Assessment will be Adequate by Program End According to Amount of MFT Training.

Increase Use

More than half of students (53.8%) reported that more training in how to use formal assessments and better knowledge of assessments would increase their use of formal assessments. More training was also most often indicated as the single most likely way to increase use. Supervisor use of assessments was only indicated by 2.9% of respondents as the most likely way to increase their use. Free responses indicated that learning information about value and efficacy, being given indications of how to use assessments with specific clients, and attending workshops or in-services would contribute to using formal assessments more often.

DISCUSSION

The results of this study provide an important view of the nature of formal assessment training in marriage and family therapy programs. Overall, the majority of students in our sample reported that they used formal assessments at some point in their work with clients, with many reporting that they collect formal assessments regularly. This is in contrast to reports from clinicians who report that they rarely use formal assessment measures (Boughner et al., 1994; Lavee & Avisar, 2006). Additional research will be required to determine whether current training practices are resulting in greater use of assessment or whether students use assessment while

training but then abandon the practice following graduation. According to their own self-reports, students have high familiarity, positive attitudes, and good confidence in their training in formal assessment. This is congruent with Hines (1996) finding that students are positive about the amount of training they receive in family assessment. Importantly, students reported being more familiar with systemic assessments than individual assessments. Compared to Bougher and colleagues' (1994) results, this suggests that use of systemic assessments has increased over time, though additional studies of practicing clinicians must be conducted.

One of the major contributions of this study to the literature on assessment is the effectiveness and preferred methods of training. It is intuitive that additional courses and information would increase familiarity and training in formal assessments. This is reflected in what students reported would be most helpful as well. However, our analysis did not support the idea that additional training is associated with attitudes, familiarity, or confidence in training in formal assessment as the number of courses taken was not a significant predictor of any of these.

Instead of traditional training efforts, the variables that were most predictive of familiarity and confidence in training were the students' frequency of use and their supervisor's valuation of formal assessment. The first finding supports the idea that experiential learning is of great value in clinical training. Our data is correlational, however, and should not be used for causal inferences. Having said this, it may be the case that by encouraging or requiring students to conduct assessments, programs can contribute to greater familiarity, thus improving student learning without significantly changing course loads or course content. Experimental research should be conducted to determine a causal link.

Our findings also stand as an indication of the value and importance of supervisors on supervisee training. Where supervisors may conceptualize their role more as focused on clinical development, our data suggests that they have the potential to affect student's training and professional development. By making assessment a part of the conversation in supervision, supervisors may help students come to value assessment. More importantly, they may be able to help students feel competent in their use of formal assessments. Wynn and colleagues (2005) found that college staff had the highest knowledge of assessment in their sample. Thus, increasing discussions of assessment in supervision may be a natural fit for university training clinics. This finding matches with Reese and colleagues (2009) finding that the use of client feedback in clinical training programs produced significantly better outcomes for those trainees that discussed their feedback with their supervisors versus those that received no feedback. Thus, both clients and students benefit when supervisors value assessment and use it.

Finally, one of the most interesting findings is that those who have just begun their marriage and family therapy training have the highest

expectations that they will have adequate training by the end of their program. It may be the case that students enter a training program expecting to receive adequate training in all aspects of marriage and family therapy practice, but are then disappointed to find that some aspects, such as assessment, are left out as they approach graduation. It may also be the case as students begin to learn about assessment, they realize that the topic is much broader and more difficult to master than they originally imagined. In either case, it seems that training programs can do more to help students set realistic expectations of training and then help them reach their expectations. It may also be the case that students' initially high expectations can be leveraged to encourage them to achieve more.

Limitations

There are several important limitations to our study that must be considered when interpreting the results. As has been mentioned, our study is correlational in nature and should not be used for causal inferences. Additional, experimental research should be conducted to validate the findings before the implications are adopted. Additionally, our sample has significant limitations. Program directors may have served a gatekeeping function in which only students in programs that were more engaged in assessment and research were given the survey. Similarly, only the students that are most committed to assessment may have begun and finished our survey. Thus, there may be a systematic bias in our results, perhaps making it appear that students are more familiar and competent with assessment than is actually the case.

Future Directions

There are several future directions and possible extensions of this project that will add to the field's understanding of training in formal assessment. Our research did not ask students about specific formal assessments. Additionally, our survey relied solely on student self-reports. While our method provided one important source of information, observational reports of student competence with specific assessments or assessment in general would be valuable in coming to understand the current state of marriage and family therapy training. Future studies should include other means of testing student knowledge and competence, such as case vignettes or actual case reviews. As was mentioned, experimental studies with training program changes should also be conducted to assess the practical utility of these findings.

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