AN EXAMINATION OF COUNSELOR TRAINEE EXPERIENCES COMPARED WITH MARRIAGE FAMILY THERAPY SCOPE OF PRACTICE

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Abstract

of

AN EXAMINATION OF COUNSELOR TRAINEE EXPERIENCES COMPARED WITH MARRIAGE FAMILY THERAPY SCOPE OF PRACTICE

by

Heather M. Mummaw

The Marriage and Family Therapy (MFT) training program at Sacramento State includes a practicum course in which students work as therapist trainees as part of the requirements for the Master’s degree and MFT licensure. Neither a review on the client records nor an evaluation of the practicum portion of the students’ training had ever been performed. Therefore, the current project conducted a records review of demographic and therapeutic variables for 440 cases, representing seven years’ worth of client records. Descriptive analyses were conducted and subsequently discussed in relation to the training requirements, standards of practice, and core competencies of the MFT profession. Results indicated the practicum course provides training in some of the MFT core competencies, although several shortcomings were also present. The information provided in this study may contribute to future training of MFTs by assisting degree programs to plan practica that facilitate the development of the MFT core competencies.

_______________________, Committee Chair
Marya Endriga, Ph.D.

_______________________
Date
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# TABLE OF CONTENTS

| Acknowledgments | .......................................................... | v |
| List of Tables | .......................................................... | vii |
| List of Figures | .......................................................... | viii |

## Chapter

1. **HISTORY AND OVERVIEW OF THE AGENCY** .................................................. 1
2. **LITERATURE REVIEW** ................................................................................... 4
   - History of MFTs in the United States ............................................................. 9
   - History of MFTs in California ....................................................................... 11
   - Recent BBS and MFT Practice Changes .......................................................... 14
3. **METHOD OF ANALYSIS** ................................................................................ 20
4. **RESULTS** ..................................................................................................... 26
5. **DISCUSSION** ................................................................................................. 35
   - Limitations .................................................................................................... 44
   - Suggestions for Future Studies and Changes in Clinic Documentation Policies .............................................................................................................................................................................. 46
6. **References** .................................................................................................. 49
LIST OF TABLES

<table>
<thead>
<tr>
<th></th>
<th>Table 1 Age of Clients Seen as a Function of Number of Clients and Session. 29</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Table 2 Demographics of Clients Seen in the Practicum Clinic………………… 31</td>
</tr>
</tbody>
</table>
LIST OF FIGURES

<table>
<thead>
<tr>
<th></th>
<th>Figure Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Figure 1 Age of Clients Seen in the Clinic</td>
<td>28</td>
</tr>
<tr>
<td>2</td>
<td>Figure 2 Google Map of Client Zip Codes</td>
<td>33</td>
</tr>
</tbody>
</table>
Chapter 1

HISTORY AND OVERVIEW OF THE AGENCY

The Marriage and Family Therapy (MFT) training program in the Psychology Department at California State University, Sacramento is one of four specializations in the graduate program for a Master of Arts degree in Psychology. The other specializations include Applied Behavior Analysis, Industrial/Organizational, and Doctoral Preparation. The MFT program is known as the Counseling Psychology option and satisfactorily meets the educational requirements as laid out in Section 4980.37 through Section 4980.41 of the Business and Professional Code of California, Chapter 13, Article 1, regulating the licensing of Marriage and Family Therapists by the State of California (California State University, Sacramento, 2010).

This program is a 60 unit program and follows a strict list of required courses with no elective course options. There is also a Graduate Handbook which the Psychology Department has published and revises each year. The handbook presents extensive information about the MFT program and a Recommended Course Sequence is included. In Year Two of the program, it is suggested that the students enroll in PSYC 400, Practicum in Counseling and Psychotherapy. In this course, students work in the Psychological Services Center as therapist trainees, seeing clients from the community under supervision by a tenure-track faculty member who a licensed clinician and the instructor for the course. To enroll in the practicum course, students must have successfully completed coursework in professional issues and child abuse, theories and techniques, pre-practicum, advanced psychopathology and either family therapy,
counseling of multicultural groups, or child therapy. The practicum class usually contains no more than eight students and the students and the instructor meet weekly for at least two hours of supervision. This corresponds to the California Board of Behavioral Sciences’ (BBS) requirements for MFT experience, which requires that no more than eight supervisees can be in a supervision group and that group supervision must be provided in either one two-hour session or two one-hour segments (BBS, 2009).

The Psychological Services Center clinic is located on the second floor of Amador Hall and includes a waiting room, a small office where the files are stored, a library, four therapy rooms, and a group therapy room. In the back of the clinic is storage for the electronic equipment used to audio/visually record the sessions. Each therapy room includes a camera so that the student therapists may record their sessions to play back in supervision to obtain feedback from the supervisor and peers. The student therapists destroy the videotapes at the end of each semester for confidentiality purposes.

Psychological Services Center is a cost-free clinic and potential clients are referred to the clinic by either word-of-mouth or advertising done by the Clinic Director. Potential clients call the clinic’s confidential phone line and leave a message. A Clinic Coordinator (who is also a graduate student in the MFT program) then does a phone intake and fills out a Request for Counseling form. The supervisor/instructor then screens these forms and assigns clients to the student therapists. Clients determined to be too difficult for student therapists are appropriately referred to other counseling centers. Student therapists usually hold a case load of one to three clients per semester.
Client records are kept in a locked file cabinet located in the secured office of the clinic. Only current students in the practicum course, the instructor/supervisor, the Clinic Coordinator, and the Clinic Director have access to these files. They are filed/organized by semester and by student therapist and there are approximately 15 years of records currently stored in the clinic.

A records review has never been conducted on these records. Therefore, faculty who teach in the Counseling Psychology program and the Psychology Department’s Clinical Committee that monitors the program have little to no summarized, concrete data about the clients seen in the clinic. To date, there has been no evaluation of the practicum portion of the students’ training. Obtaining this data can provide valuable information to the Sacramento State Psychology Department, its faculty, administrators, and other beneficiaries. Specifically, it can provide interesting statistical and demographic information about the client base; it can provide interesting correlational information about the clients, therapy, therapists, etc.; and it can provide information about whether or not the experience provided to the student therapists is meeting the training standards for the MFT license.

The purpose of this study is to examine data from client records in the aforementioned MFT training clinic, provide basic descriptive statistics and compare the data with the standards of training and scope of practice for MFTs. The information resulting from this study can be used to improve current MFT training that is conducted in the Psychological Services Center clinic.
Chapter 2

LITERATURE REVIEW

The California Board of Behavioral Sciences (BBS) is the licensure board that regulates the practice of Marriage and Family Therapists (MFTs) for the state of California. It is one of the 50 state boards regulated under the Association for Marital and Family Therapy Regulatory Boards, an organization of governmental jurisdictions dedicated to the licensure and regulation of marriage and family therapists (AMFTRB, 2010).

The BBS defines the practice of marriage, family and child counseling as “that service performed with individuals, couples, or groups wherein interpersonal relationships are examined for the purpose of achieving more adequate, satisfying, and productive marriage and family adjustments. This practice includes relationship and pre-marital counseling” (BBS, 2010, p. 10). The BBS also defines the application of principles and methods of marriage and family therapy. These include, but are not limited to, “the use of applied psychotherapeutic techniques, to enable individuals to mature and grow within marriage and the family, the provision of explanations and interpretations of the psychosexual and psychosocial aspects of relationships, and the use, application, and integration of the coursework and training required by Sections 4980.36, 4980.37, and 4980.41” (BBS, 2010, p. 10). Each of these sections of the regulations go on to define the educational requirements and training for marriage and family therapists and eligibility requirements for sitting for the licensing exam.
The regulations on education requirements strictly identify the qualifying degrees, accreditation requirements of educational institutions, and the required coursework and training. The degree requirement for MFTs include a doctoral or master’s degree in marriage, family and child counseling, marriage and family therapy, psychology, clinical psychology, counseling psychology, or counseling with an emphasis in either marriage, family, and child counseling, or marriage and family therapy. The degree program should “be a single, integrated program primarily designed to train marriage and family therapists and shall contain no less than 48 semester or 72 quarter units of instruction. This instruction shall contain no less than 12 semester or 18 quarter units of coursework in the areas of marriage, family, and child counseling, and marital and family systems approaches to treatment” (BBS, 2010, p. 17).

The degrees obtained must be from a school, college, or university approved by the Bureau for Private Postsecondary and Vocational Education or accredited by the Commission on the Accreditation of Marriage and Family Therapy Education or a regional accrediting agency recognized by the U.S. Department of Education (BBS, 2010). The Commission on the Accreditation of Marriage and Family Therapy Education (COAMFTE) is probably the most common and most specific accrediting agency for the field of marriage and family therapy. The U.S. Department of Education has recognized the COAMFTE as an accrediting body for this field since 1978. It consists of nine commissioners, including seven professional members and two public members. The professional members must be senior marriage and family therapy educators or clinicians. Public members are not professional marriage and family therapy educators, supervisors,
or practitioners and represent the general public interest. Every effort is made to balance commission membership with regard to race, ethnicity, gender and geographic location. It must also balance academicians and practitioners as well as training contexts (master’s, doctoral, and post-degree) (AAMFT, 2002).

There are two sections of educational (coursework) requirements outlined in the current BBS regulations. One section is for those who will begin graduate study after August 1, 2012 or complete graduate study after December 31, 2018. The other section is for those who began graduate study before August 1, 2012 or will complete graduate study before December 31, 2018. For the purposes of this project, I will focus only on the latter section, as it applies to those individuals in the program at the time of this project.

The course work requirements include the following areas: leading theories of a variety of psychotherapeutic orientations directly related to marriage and family therapy, a marital and family systems approach for treatment; theories of marriage and family therapy and how they can be used to intervene therapeutically with couples, families, adults, children and groups; developmental issues and life events spanning from infancy to old age and their effect on individuals, couples, families and relationships. Coursework may include a focus on specific family life events and the psychological, psychotherapeutic, and health implications that arise within couples and families. This may include, but is not limited to, childbirth, child-rearing, childhood, adolescence, adulthood, marriage, divorce, blended families, step-parenting, and geropsychology; and finally, a variety of treatment approaches for children (BBS, 2010).
The degree program should contain no less than six semester or nine quarter units of supervised practicum in applied psychotherapeutic technique, assessments, diagnosis, prognosis, and treatment of premarital, couple, family, and child relationships, including dysfunctions, healthy functioning, health promotion, and illness prevention. This practicum should take place in a supervised clinical placement that provides supervised fieldwork experience within the scope of practice of a marriage and family therapist. For those enrolled in their degree program after January 1, 1995, the practicum shall include a minimum of 150 hours of face-to-face experience counseling individuals, couples, families, or groups and shall be considered part of the overall program unit requirement (BBS, 2010).

The regulations aim to provide “an integrated course of study and appropriate professional training, while allowing for innovation and individuality in the education of marriage and family therapists” (BBS, 2010, p. 18). Therefore, the degree program also must:

1) Provide an integrated course of study that trains students generally in the diagnosis, assessment, prognosis, and treatment of mental disorders.

2) Prepare students to be familiar with the broad range of matters that may arise within marriage and family relationships.

3) Train students specifically in the application of marriage and family relationship counseling principles and methods.
4) Encourage students to develop those personal qualities that are intimately related to the counseling situation such as integrity, sensitivity, flexibility, insight, compassion, and personal presence.

5) Teach students a variety of psychotherapeutic techniques and modalities that may be used to improve, restore, or maintain healthy individual, couple, and family relationships.

6) Permit an emphasis or specialization that may address one or more of the unique and complex array of human problems, symptoms, and needs of Californians served by marriage and family therapists.

7) Prepare students to be familiar with cross-cultural mores and values, including a familiarity with the wide range of racial and ethnic backgrounds common among California’s population, including, but not limited to, Blacks, Hispanics, Asians, and Native Americans. (BBS, 2010, p. 18)

In addition to these state regulations for qualifying for licensure as a marriage and family therapist, there are also professional organizations that regulate and set standards for the profession of marriage and family therapy. The national professional organization for the field of marriage and family therapy is the American Association for Marriage and Family Therapy (AAMFT). The state professional organization for marriage and family therapy is known as the California Association for Marriage and Family Therapy (CAMFT). CAMFT is independent of AAMFT and other professional organizations. Although the two are related in that they both represent professionals in the field of
marriage and family therapy, the AAMFT and CAMFT have somewhat different histories.

**History of MFTs in the United States**

Marriage and Family Therapy began as marriage counseling in the 1920s. It was part of the routine for physicians, especially obstetricians and gynecologists (OB/GYNs) who were just becoming established as a specialty in the field of medicine. By the 1930s marriage counseling was a recognized specialty. Many of the pioneers of the marriage counseling profession originated in California, or moved there once it was established. The AAMFT was originally based in California and began in 1942. California was the first state to license marriage and family counselors with legislation in 1963 that went into effect in 1964. California established a statewide association this same year called the California State Marriage Counseling Association (CSMCA). It later became the California Association of Marriage and Family Counselors in 1971 and then the California Association of Marriage and Family Therapists in 1979. It was one of three professional associations established from the AAMFT (Riemersma, 2007; Bowers, 2007).

In the early days of the profession, there were many training centers for marriage and family counselors but they provided post-graduate study for those with “qualifying graduate degrees” in the mental health field. Since there was no specific degree in MFT yet, one became qualified to practice based on specific courses and supervised experience. As more states began instituting regulations for the practice of marriage and family therapy, it became clear that both education and regulation would need to be
addressed in a more systematic manner. The AAMFT had been approving education programs up until this point, but then the AAMFT’s COAMFTE became recognized at the federal level as the accrediting agency for MFT education. Then in 1978, the recognition of the AAMFT’s COAMFTE by the U.S. Department of Health, Education, and Welfare made MFT recognized as an independent profession (Bowers, 2007). The AAFMT position stated,

> It is absolutely our intent to ensure that MFTs are regulated and that the public can have assurances that anyone who calls her/himself an MFT, family therapist, or any other logical derivative of that title, has the training which has become standard for marriage and family therapists, as reflected in AAMFT Clinical Membership (Bowers, 2007, p. 15).

After this point, through the 1980s and 90s, other states began regulation of MFTs and the AAMFT was working hard to differentiate the discipline of MFT from psychology, psychiatry, social work, nursing, and counseling.

Since the early 1980s, the model scope of practice for MFTs (which defines what MFTs can lawfully do when licensed) has been published by the AAMFT and has included the wording, “Marriage and family [sic] Therapy means the diagnosis and treatment of mental and emotional disorders, whether affective, behavioral, or cognitive, within the context of family systems” (Bowers, 2007, p. 16).

Two issues have risen about this MFT scope of practice: 1) whether they can treat individuals, or only families and couples, and 2) whether they can diagnose. The first issue has been addressed by pointing out that, for MFTs, it is not about how many people
are in the room (although the MFT profession is the only one that requires conjoint therapy as part of training), but about how the therapist conceptualizes problems and implements treatment. The second issue shows that opposition to this is mostly about trying to limit the MFT practice to non-reimbursable services (such as V codes in the Diagnostic and Statistical Manuals).

The AAMFT “firmly believes that the MFT license assists the public by helping them identify those professionals specifically trained to address mental and emotional processes in the context of relational systems—something that many surveys indicate is a primary issue when clients present for mental health care” (Bowers, 2007, p. 18).

**History of MFTs in California**

Specific to California, many steps built the profession into what it is today. The effort to bring the MFT license to California began with Don Mulford, a Republican Assemblyman in Alameda County who co-authored Assembly Bill 2374 in 1963 to regulate marriage counselors. His interest in the bill was based on a personal experience in which his friend’s wife had gotten bad advice from a marriage counselor and suggested this legislation to Mulford. At that time, many people had the opinion that a marriage counselor should be qualified in another profession such as psychology, psychiatry, or social work. This view said that licensing the marriage counselors should be a specialty within existing licensing structures, and not a separate license. Yet the aforementioned AB 2374 provided for a marriage counseling license based on a master’s degree in one of the behavioral sciences and at least two years of supervised experience under the direction of someone with a similar degree and approved by the Director of Professional
and Vocational Standards. Opposition to this independent license was considerable, yet it was signed into law in July 1963, illustrating the importance of legislative action in the history of this profession (Riemersma, 2007).

In 1967, another significant challenge surfaced. The Little Hoover Commission (established to streamline state government efficiency) recommended that the license be abolished. This launched a major lobbying effort by the CAMFT to save the license. This effort was successful and it strengthened the organization and further stressed the need for MFCCs to become members of their professional organization. Up until the early 1970s, however, AAMFT membership was still only open to doctoral level professionals, which further strengthened the need for CAMFT specifically. Early CAMFT members viewed the AAMFT as “elitist” because of the doctoral level educational requirement for membership. This and the ways in which they viewed each other lead to some tension between the organizations, which still exists today. But by 1970, given that most marriage counseling was being done by master’s level professionals and the due to the declining number of members, AAMFT relaxed its membership qualifications to include master’s level applicants. AAMFT also began to get more involved in federal level legislation (Riemersma, 2007).

Through the next couple of decades, CAMFT was involved in sponsoring several bills that revised MFCC licensing, and better defined educational and supervisory requirements. Most of the bills were just that: revising many legal rights and protections, and revising educational and supervisory requirements. However, a few of them broke some major barriers (Riemersma, 2007).
One in particular was the move towards reimbursement by insurance companies. In 1980 the “freedom of choice” bill (AB 2211) passed and was viewed as the single greatest accomplishment to move the profession forward, although opposition was rampant. Those who disagreed with AB 2211 claimed that MFCCs were not qualified as psychotherapists, and could therefore not practice psychotherapy and diagnose mental disorders. Interestingly, California psychologists were going through this same battle against psychiatrists. One of the amendments that made this bill more acceptable to its opponents was that the MFCCs were admittedly not qualified to diagnose according to the medical model and so the amendment required physician referral (Riemersma, 2007).

Prior to 1980, most marriage counselors were exclusively in private practice. However, in 1980, CAMFT-sponsored AB 2210, aimed at limiting discrimination based on the type of license held, was signed into law and allowed MFCCs to work for the County Mental Health System. This also opened the door for more broad practicing options.

Another piece of legislation that was attempted many times but continued to fail, was trying to change the name of the professional from Marriage, Family and Child Counselor to Marriage and Family Therapist. The first attempt was in 1981 with AB 1762. The purpose of changing the name was to remove confusion about the education, training, and experience of these professionals, to more realistically describe the profession and what it does, and to clarify the right to practice psychotherapy. The opposition to this first bill came from other professional groups that claimed that if MFCCs referred to themselves as therapists, it would allow them to claim competence
outside of their scope of practice. At this time, all the other disciplines argued that MFCCs were not competent to practice therapy. It wasn’t until 1998 that this change happened, and the title now went along with what most of the rest of the country was calling marriage counselors (Riemersma, 2007).

**Recent BBS and MFT practice changes**

Some major changes have been occurring more recently in the field of MFT. First, the field has been moving towards a recovery model of treatment rather than a medical model. This model more closely ties into MFT theories and practice. Some elements of a recovery model include hope, meaning and purpose, coping, wellness, social functioning and social role, and social connectedness and relationships (Gehart, 2008). Rather than focusing on medical symptoms, this model focuses on psychosocial functioning. Partially out of this move toward a recovery model came the development of a list of core competencies. The primary reason for the development of MFT core competencies came from a recognized quality gap between the treatment patients expect and deserve and the treatment they actually receive (Nelson et al, 2007). Additionally, there has been a “paradigm shift from input-oriented education to outcome-based education” (Nelson et al, 2007, p. 418). “Accredited programs no longer demonstrate effectiveness by simply conforming to specific supervision ratios or total hours of experience; instead they must demonstrate student mastery of a well-defined set of competencies” (Gehart, 2010, p. 2).

In January 2003, the AAMFT created the Core Competencies Task Force which was charged with defining domains of knowledge and requisite skills in each domain that
comprise the practice of marriage and family therapy (Gehart, 2007). The final product would be relevant to accreditation bodies, educators, trainers, and regulators. The competencies they developed would be based on what actually occurs in clinical practice, on ecologically valid research, on what is known about evidence-based family therapies, and on emerging trends in family therapy and a more broad behavioral health theory. The AAMFT Executive Director appointed a steering committee of the following members: Thorana Nelson, Ronald Chenail, James Alexander, D. Russell Crane, Susan Johnson, and Linda Schwallie. Each person was appointed based on the different perspectives and experience they would bring to the table, thus ensuring a thorough and comprehensive list of competencies. Fifty MFTs were appointed to the task force along with William Northey, an AAMFT staff member, who was assigned to facilitate the work of the task force (Nelson et al, 2007).

The development of the competencies began with several brainstorming conference calls, using pertinent resources as guidance. During these discussions, the format and structure of the competencies were determined. Six domains, or content areas, and five subdomains, types of knowledge and skill within each domain, were developed through this process. The domains and subdomains include 128 competencies in total (Nelson et al, 2007). Each domain is defined as follows:

**Admission to Treatment** – All interactions between clients and therapist up to the point when a therapeutic contract is established.

**Clinical Assessment and Diagnosis** – Activities focused on the identification of the issues to be addressed in therapy.
Treatment Planning and Case Management – All activities focused on directing the course of therapy and extratherapeutic activities.

Therapeutic Interventions – All activities designed to ameliorate the identified clinical issues.

Legal Issues, Ethics, and Standards – All aspects of therapy that involve statutes, regulations, principles, values, and mores of MFTs.

Research and Program Evaluation – All aspects of therapy that involve the systematic analysis of therapy and how it is conducted effectively (Nelson et al, 2007, p. 422).

The subdomains were included to more effectively organize how the competencies were presented. They were identified as follows:

Conceptual Skills – What MFTs know. These skills demonstrate knowledge and familiarity with family therapy models and their concepts, system theories and thinking, and an awareness of the therapist as an agent of change.

Perceptual Skills – What MFTs perceive or discern. These skills provide for the interpretation of data through paradigmatic and conceptual lenses and tie theory or conceptual skills to what is happening in the client system.

Executive Skills – What MFTs do. These skills are the behaviors, actions, and interventions performed during the therapeutic process.

Evaluative Skills – How MFTs assess what they have done. These skills are the process of assessing and appraising the effectiveness of therapeutic activities and the therapist.
*Professional Skills* – How MFTs conduct therapy. These skills are the activities and attitudes of the therapist related to providing MFT, including professional development and identity (Nelson et al., 2007, pp. 422-423).

These core competencies can serve as a guide and a measurement tool for assessing trainees’ mastery of skills and knowledge gained through their training. The list of competencies was developed with independent practice in mind; therefore, it is reasonable to assume that these competencies will be introduced in graduate school and a beginning or moderate level of mastery will be reached by graduation (Nelson & Graves, 2010). Consequently, when it comes to the practicum experience, as part of an MFT’s training and education, it is expected that some of these core competencies will be introduced and practiced, so that mastery can be reached at a later time.

Given that it is not expected that these domains of knowledge and skills be mastered at the time of graduation, it is important to examine what areas of the competencies are at least introduced or where a trainee may be proficient at the time of graduation. One study by Nelson and Graves (2010) studied the opinions of AAMFT approved supervisors as to how well postgraduate trainees have mastered the core competencies. The study found that 12 of the 128 core competencies had a 66% response rating by the supervisors of either “good proficiency” or “mastered.” The top two competencies that were considered to be most widely mastered by trainees was competency “5.3.3: Inform clients and legal guardian of limitations to confidentiality and parameters of mandatory reporting” and competency “1.3.5: Obtain consent to treatment from all responsible persons” (Nelson & Graves, 2010, p. 6). Based on the 12 out of 128
competencies being either proficient or mastered, this means that only 10% of the competencies are adequately mastered by the time trainees graduate. Therefore, 90% of the competencies need to be further developed during the postgraduate training period, according to this study. Although this may seem meager, Nelson and Graves (2010) point out that this is actually an expected and reasonable result, given that it should not be anticipated that recent graduates have mastered all of the skills it takes to be an MFT; otherwise there would be no need for postgraduate training.

In the year 2010, several changes to the BBS licensure requirements went into effect. One of the most significant changes in relation to the types of clients trainees see is allowing for double counting of the first 150 hours of couples and family (150 hours will be counted as 300 towards the 500 hour total requirement). This incentive came out of a multi-year development in meetings of the BBS’ MFT Education Committee, Policy and Advocacy Committee, and the Board. Discussion began in December of 2007 when Carmen Knudson-Martin from Loma Linda University brought up that “she and others have concerns that people can get an MFT license but are not required to ever see families as part of their experience” (BBS, 2007, December, p. 9). She goes on to point out that “if it is not done in practicum it will be harder to do it any other time” (BBS, December, 2007, p. 9-10). Kathy Wexler from Phillips Graduate Institute added, “some interpretations of the recovery model do not support working with families” (BBS, 2007, December, p. 10). This conversation was continued in further meetings over the next several months and was eventually brought to the BBS Policy and Advocacy Committee meeting in October, 2008. Paul Riches, the Executive Officer of the BBS suggested this
committee begin to discuss the issue and to help develop a way to bring it to the Board to for addressing at that level. Also at this meeting Dr. Ian Russ, Chair of the committee, suggested making it an incentive, rather than a requirement, for gaining hours of experience in certain areas. Sponsorship of the change was presented to and approved by the Board at the May 2009 meeting. It was also during this meeting that the other changes to the licensure requirements were approved to be sponsored and these changes took effect in January 2010.

Based on the review of the educational requirements, licensure regulations, the history of the MFT profession, the MFT core competencies and some of the recent changes made by the BBS, it is expected that the data in the records in the Practicum clinic will show either consistencies or inconsistencies with these areas. More specifically, it is expected that some of the core competencies will be met by the student trainees in practicum, but that not all of them will be met or mastered. It is also expected that, based on the recent BBS committee meetings, there may be less experience working with families than with other types of clients; but before this study, it is unclear the level of experience actually gained in practicum. A portion of this study serves to quantify these unknown areas of training for the MFT students at Sacramento State.
This study was conducted at California State University, Sacramento from archival data comprised of client records from the Department of Psychology Psychological Services Center located in Amador Hall. The records were reviewed by the researcher and the following information about each client was collected and recorded: Gender, Age, Ethnicity, Zip Code, Marital Status, Number of Sessions, Client Type (Individual vs. Couple vs. Family), Therapist, Semester, Year, Returning Client (yes or no), DSM-IV-TR Diagnoses (intake diagnoses given by the therapist), and Termination Improvement Level (Greatly Improved, Moderately Improved, Slightly Improved, Remain the Same, or Deteriorated). This data was entered into a Microsoft Excel spreadsheet.

Seven total years of files were recorded (Fall 2003 – Spring 2010). Although there were approximately 15 years of records filed in the clinic, only seven years were recorded in this review because seven years is a standard retention period for medical and psychological records and because the files that were older than seven years were more inconsistently complete and it was more difficult to gather data on the variables. The files were originally filed in the cabinet by semester, so they were recorded by semester and the years are represented as academic years (2003-2004, 2004-2005, 2005-2006, etc). Fall semester was coded as 1 and Spring semester was coded as 2. When analyzing the data, Fall and Spring of the academic year were used to represent the data for that year.
(for example data from 1 of 2003 and 2 of 2004). Once all the records were recorded, the files were reorganized in the cabinet by name of client, alphabetical by last name. This re-organization served to help future student therapists and instructors find records for former clients.

All data recorded were based on information found in the client records either via client self-report or therapist-report on various forms used in a client record (i.e., request for counseling, therapist intake assessment, progress notes, client questionnaires, and termination summaries). If information was not found or determined from the available paperwork, the data were left blank and were coded as missing data. The researcher was careful to not make assumptions about a variable unless it was reasonably clear and the same result would be found by anyone else reviewing the records. The researcher observed that it was common for returning clients to have multiple records, filed separately. Even when the student therapist determined that the client was a former client, they did not always combine the files, which made it sometimes difficult to collect the data.

Gender was determined by either client self-report or therapist-report. Only female and male were options for the gender variable. The age recorded was the age of the client given at the commencement of therapy, even if the client’s age had changed by termination. Usually the age is first requested by the Clinical Coordinator during a phone intake and recorded on the Request for Counseling form, so this was primarily where it was found by the researcher.
There were nine ethnicities chosen as options based on U.S. Census ethnicity categories: White, Black/African-American, American Indian, Alaska Native, Asian, Native Hawaiian/Pacific Islander, Hispanic/Latino, Some other race, and Two or more races. Ethnicity information was retrieved from one or more locations, including the therapist’s intake under client demographics, the client questionnaire under the “ethnicity” field, or under the “ethnicity” field on the Termination Summary form. Whenever an ethnicity was only reported as a country of origin, the researcher estimated ethnicity by looking up what the primary ethnicity is in that country.

Marital status included Single, Married, Domestic Partner, Separated and Divorced. Marital status data was gathered from self-report of the client on the client questionnaire or the therapist intake assessment. The researcher chose Domestic Partner if the client self-reported as such, or self-reported that he/she lived with a romantic partner, regardless of the sexual orientation of the client. All child/minor clients were listed as “Single” even though their marital status was not usually a factor in the therapy. Therefore, for analysis purposes, they were dropped as “not applicable” and not included in the final analysis of marital status so that the numbers in the “Single” category were not distorted.

The Clinic Coordinator usually obtained zip codes during the phone intake interview as part of the address collected from the potential client. The researcher obtained zip code information from either the Request for Counseling form or the client questionnaire. Zip codes were then plotted on a Google (2010) map analyzed for
frequency. Frequency of each zip code was color coded on the map to show the distribution of the number of clients living in each zip code.

Number of sessions was determined based on therapist report or by the researcher counting of the number of sessions from progress notes or adding up therapist reported sessions on the termination summaries for returning clients. Client type was determined by therapist report on paperwork or by the researcher reviewing the records in the file. Therapist identifier, semester, and year were all determined based on the organization of files in the clinic. Returning client information was based on therapist-report, client self-report, or by discovery of a previous file by the researcher.

Diagnostic information was used to obtain information about the presenting problem and to report the frequency at which certain diagnoses were given, are prevalent in the clinic, and to demonstrate what types of mental disorders student therapists have dealt with. This diagnostic information was based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; APA, 2000) 5-Axis diagnostic impressions by the therapist, as reported in the confidential intake. Each diagnosis was recorded as data and categorized into the various categories in the DSM (i.e., Mood Disorders, Anxiety Disorders, Personality Disorders, General Medical Conditions, etc.) even if there were multiple diagnoses on each axis. There were several occasions where multiple diagnoses were reported that fell into the same axis. There were instances when the student therapist did not record the diagnosis exactly as it would appear in the DSM (this was especially the case for Axis IV, Psychosocial and Environmental Problems). In these cases, the researcher chose the category in this Axis that best fit the description of the
problem given by the student therapist. Axis V (Global Assessment of Functioning) was not recorded as it did not provide relevant diagnostic information for “presenting problem.” Provisional diagnoses were recorded, but diagnoses to be ruled out or diagnoses that needed “further investigation” were excluded.

If a client was seen in multiple types of therapy, i.e., individual, couple, family, the researcher entered this information twice from both records because they resulted in multiple client records and may have provided different information for some variables. When clients returned to the clinic and saw the same therapist, the researcher used initial diagnostic information and ending termination improvement level obtained from the therapist rating on the Termination Summary Form. When clients returned to the clinic and saw different therapists, the researcher used the original intake for diagnostic information, but the current/most recent therapist for therapist information, semester seen, and ending termination information. The total number of sessions over all therapists and semesters were recorded and the fact that they were a returning client was also recorded. The only exception to this was when a client went for several semesters/years without being seen in the clinic; in these cases, the researcher only entered the more current, consecutive series of sessions.

No identifying data was stored with any of the above study variables. The researcher only collected data from client records while in the clinic office. The client records were then returned to the locked filing cabinet in the locked office of the clinic. Each case was assigned an ID number to ensure anonymity. The information linking study ID numbers with client names was stored in a separate locked cabinet and
destroyed at the conclusion of the study. No other individuals who have access to these client records had knowledge of this unique coding system. The researcher only used the coding system to access the files during the information recording process. The information about the client’s therapist was also recorded through a confidential coding system. The therapist was linked to the client only for determining the number of clients a student therapist has seen per semester. These procedures were reviewed and approved by the Psychology Department Human Subjects Committee on April 28, 2010 and it was determined that there was no risk to participants in this study.

Once all the data was collected and recorded from the client files, the data in the Excel spreadsheet was analyzed using various descriptive analyses. These analyses were then examined and interpreted based on the purpose of the study.
Several descriptive analyses were conducted on the data collected in the clinic. Data is described in terms of numbers of clients and sessions and categories of the variables are compared to one another. Data were recorded for seven years by semester and academic year and there were 440 client records reviewed and recorded in the clinic. The number of sessions clients were seen in the clinic ranged from one to 140 sessions. There were 65 total student therapists in the clinic during the seven years of recorded files. The distribution of sessions was examined and the client who was seen for 140 sessions was determined to be an outlier. The outlier was then omitted from the dataset. The mean number of sessions clients were seen in the clinic was 8.79 (SD = 9.39). The modal of number of sessions clients were seen in the clinic was one. The number of clients seen by the therapists varied. The most clients seen by a therapist was 20 and the least number of clients was two. The mean number of clients per therapist was 6.77 (SD = 3.10).

Overall, there were more clients seen in the spring semesters (n = 251) than in the fall semesters (n = 189). The year with the most clients was 2004-2005 (n = 90) followed by 2005-2006 (n = 89). The year with the lowest number of clients was 2003-2004 (n = 50). The highest mean number of sessions occurred in 2008-2009 (M = 11.60; SD =
10.26), followed by 2007-2008 ($M = 10.20; SD = 8.13$). The lowest mean number of sessions occurred in 2009-2010 ($M = 7.40; SD = 7.91$).

Whether or not clients returned to the clinic over multiple semesters was another variable. More clients did not return to the clinic ($n = 337$) than did return to the clinic ($n = 102$). Mean number of sessions for clients who did not return to the clinic was 5.74 and the mean number of sessions for clients who did return to the clinic was 20.27. There was only one client record where it was not clear whether they were a returning client.

Results showed that there were 282 females and 157 males seen in the clinic. There was only one client for which gender data was missing. The mean age of clients seen in the clinic was 35.64 ($SD = 14.84$). The age of clients ranged from six to 77 years old. When age was graphed on a histogram, age was represented as a normal distribution (see Figure 1). Age was then divided into age groups by decade (0-10, 11-19, 20-29, 30-39, 40-49, 50-59, 60-69 and 70-79). The highest number of clients were in age group 40-49 ($n = 101$). The least number of clients were in age group 70-79 ($n = 7$). The age group representing children (0-10) was low compared to the other groups ($n = 19$). The mean number of sessions in the 40-49 age group was 11.66 ($SD = 13.14$). The mean number of sessions in the 60-69 age group was 11.64 ($SD = 17.78$). There was missing age data for only two clients (see Table 1).

There were nine ethnicities chosen as options based on U.S. Census ethnicity categories (White, Black/African-American, American Indian, Alaska Native, Asian,
Figure 1. Age of the Clients Seen in the Clinic. Graph shows a normal distribution around a mean of age 35.64.
Table 1

*Age of Clients Seen in the Clinic as a Function of Number of Clients and Sessions*

<table>
<thead>
<tr>
<th>Age Group</th>
<th># of Clients</th>
<th>% of Overall Clients</th>
<th>Total # of Sessions</th>
<th>Mean # of Sessions</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-10</td>
<td>19</td>
<td>4.32</td>
<td>184</td>
<td>9.68</td>
<td>6.10</td>
</tr>
<tr>
<td>11-19</td>
<td>49</td>
<td>11.14</td>
<td>361</td>
<td>7.37</td>
<td>5.76</td>
</tr>
<tr>
<td>20-29</td>
<td>91</td>
<td>20.68</td>
<td>634</td>
<td>6.97</td>
<td>6.29</td>
</tr>
<tr>
<td>30-39</td>
<td>97</td>
<td>22.05</td>
<td>926</td>
<td>9.55</td>
<td>16.17</td>
</tr>
<tr>
<td>40-49</td>
<td>101</td>
<td>22.95</td>
<td>1178</td>
<td>11.66</td>
<td>13.14</td>
</tr>
<tr>
<td>50-59</td>
<td>63</td>
<td>14.32</td>
<td>543</td>
<td>8.62</td>
<td>6.79</td>
</tr>
<tr>
<td>60-69</td>
<td>11</td>
<td>2.50</td>
<td>128</td>
<td>11.64</td>
<td>17.78</td>
</tr>
<tr>
<td>70-79</td>
<td>7</td>
<td>1.59</td>
<td>39</td>
<td>5.57</td>
<td>3.82</td>
</tr>
<tr>
<td>Blank</td>
<td>2</td>
<td>0.45</td>
<td>15</td>
<td>7.50</td>
<td>6.36</td>
</tr>
</tbody>
</table>
Native Hawaiian/Pacific Islander, Hispanic/Latino, Some other race, and Two or more races). Only six of these ethnicities were identified in this sample (American Indian, Asian, Black/African-American, Hispanic/Latino, Two or more races, and White). There was missing ethnicity data for 42 of the client records recorded, which was about 10% of the data. It appeared that the highest number of clients seen in the clinic were reported as White \((n = 274)\) followed by Hispanic/Latino \((n = 61)\). It appeared that American Indian identified clients were the smallest group \((n = 2)\). Asian clients’ mean number of sessions was 13.00 \((SD = 11.20)\). American Indian identified clients’ mean number of sessions was 11.50 \((SD = 0.71)\). The mean of number of sessions of White identified clients was 9.63 \((SD = 10.48)\) (see Table 2).

Marital status was divided into five groups: Single, Married, Domestic Partner, Separated, and Divorced and determined based on client self-report on the client questionnaire or therapist-report on the therapist intake assessment. Most of the clients were single \((n = 125)\). The next highest group was married \((n = 105)\) with the lowest number of clients being separated \((n = 17)\). The highest mean number of sessions was in the divorced group \((M = 11.13; SD = 13.16)\) and the least mean number of sessions was in the married group \((M = 7.42; SD = 6.66)\). There was missing marital status data for 15 of the clients, which was about 3% of the data (see Table 2).
Table 2

Demographics of Clients Seen in the Practicum Clinic

<table>
<thead>
<tr>
<th>Demographics</th>
<th># of Clients</th>
<th>% of Overall Clients</th>
<th>Total # of Sessions</th>
<th>Mean # of Sessions</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>282</td>
<td>64.09</td>
<td>2,524</td>
<td>8.95</td>
<td>11.22</td>
</tr>
<tr>
<td>Male</td>
<td>157</td>
<td>35.68</td>
<td>1,472</td>
<td>9.38</td>
<td>11.43</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>274</td>
<td>62.27</td>
<td>2,638</td>
<td>9.63</td>
<td>10.48</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>61</td>
<td>13.86</td>
<td>545</td>
<td>8.93</td>
<td>18.15</td>
</tr>
<tr>
<td>Black/African American</td>
<td>35</td>
<td>7.95</td>
<td>283</td>
<td>8.09</td>
<td>7.27</td>
</tr>
<tr>
<td>Two or More Races</td>
<td>16</td>
<td>3.64</td>
<td>162</td>
<td>10.13</td>
<td>7.56</td>
</tr>
<tr>
<td>Asian</td>
<td>10</td>
<td>2.27</td>
<td>130</td>
<td>13.00</td>
<td>11.20</td>
</tr>
<tr>
<td>American Indian</td>
<td>2</td>
<td>0.45</td>
<td>23</td>
<td>11.50</td>
<td>0.71</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>125</td>
<td>28.41</td>
<td>1,354</td>
<td>10.83</td>
<td>16.38</td>
</tr>
<tr>
<td>Married</td>
<td>105</td>
<td>23.86</td>
<td>779</td>
<td>7.42</td>
<td>6.66</td>
</tr>
<tr>
<td>Domestic Partner</td>
<td>60</td>
<td>13.64</td>
<td>486</td>
<td>8.10</td>
<td>8.46</td>
</tr>
<tr>
<td>Divorced</td>
<td>54</td>
<td>12.27</td>
<td>601</td>
<td>11.13</td>
<td>13.16</td>
</tr>
<tr>
<td>Separated</td>
<td>17</td>
<td>3.86</td>
<td>154</td>
<td>9.06</td>
<td>6.91</td>
</tr>
</tbody>
</table>
In order to describe the areas of residence from which clients come, clients’ zip codes were recorded and plotted on a Google (2010) map (see Figure 2). The map was color coded to represent the number of clients living in that zip code. Green = 30 or more clients, Yellow = 20-29 clients, Pink = 15-19 clients, Orange = 10-14, Purple = 5-9 clients and Blue = 0-4 clients. The zip code with the highest concentration of clients was in 95825 (Sacramento, CA). There were a few outlier zip codes, not represented visually on the local Sacramento region map. One client lived in 95603 (Auburn, CA), one client lived in 94533 (Fairfield, CA), one client lived in 95687 (Vacaville, CA), three clients lived in 95685 (Sutter Creek, CA), one client lived in 95350 (Modesto, CA), two clients lived in 95648 (Lincoln, CA), one client lived in 95695 (Woodland, CA), five clients lived in 95616 (Davis, CA), and four clients lived in 96822 (Honolulu, HI).

The Client-Type variable included Individual, Couple, and Family. Most clients appeared to have been seen in individual sessions (n = 337), followed by Couples (n = 82) and then Family (n = 21). The highest mean number of sessions occurred in family therapy (M = 11.33; SD = 5.70) followed by individual therapy (M = 9.48; SD = 12.42), then couples therapy (M = 7.02; SD = 5.86).

Several diagnoses on four of the five axes of the DSM-IV-TR were recorded. The most common diagnosis on Axis I was Mood Disorders (n = 114), followed by Other Conditions That May Be a Focus of Clinical Attention (n = 104). These included all those diagnoses that fall under that category, including V codes (e.g. Partner Relational Problem, Bereavement, Occupational Problem). Axis II was largely unrepresented, with only Paranoid Personality Disorder (n = 1) and Personality Disorder
Figure 2. Google map showing a plotting of the local (Sacramento region) zip codes of the clients seen in the clinic. The colors represent the number of clients at each zip code, using the following legend:

- Green (G): 30+
- Yellow (Y): 20-29
- Pink (P): 15-19
- Orange (O): 10-14
- Purple (P): 5-9
- Blue (B): 1-4

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NOS \( (n = 9) \) being diagnosed. Axis III, which only includes General Medical Conditions, had 107 of the clients receive that as a diagnosis. The highest diagnoses given on Axis IV was Problems with Primary Support Group \( (n = 214) \), followed by Occupational Problems \( (n = 109) \). The lowest diagnosed problem on Axis IV was Problems with Access to Health Care Services \( (n = 10) \).

Finally, the Termination level of improvement was recorded from the Termination Summary Form. The most common improvement level was Improved Slightly \( (n = 138) \) followed by Remained the Same \( (n = 119) \). The least common improvement level was Deteriorated \( (n = 10) \). The mean number of sessions for the Improved Greatly group was 13.17 \( (SD = 7.22) \). The mean number of sessions for Deteriorated was 11.70 \( (SD = 10.13) \). The mean number of sessions for Remained the Same group was 7.76 \( (SD = 12.30) \). There were 61 clients with missing termination level of improvement data. A pattern that appeared was for the number of sessions: termination level of improvement was left blank most often for clients seen for only one session. There did not appear to be any other patterns to the missing data for termination level of improvement.
Chapter 5

DISCUSSION

This is the first time the client records in the Psychological Services Center practicum clinic have ever been formally reviewed. Now that this data is available, it can be used to compare to the standards of training and scope of practice of the MFT profession. The results of this project now provide important information about the clients seen in the clinic for those interested parties. It provides valuable descriptive and demographic information about the clinic’s client base, it answers some of the questions about the training that graduate students are receiving in practicum, and can provide suggestions for the future of the MFT training program and practicum.

Seven years of client records were reviewed, resulting in 440 total records, which made for a good sample of the entire client record file and provided adequate general information about the practicum clinic’s client base. It was interesting that the modal number of sessions was one, which means that clients would discontinue therapy after the first intake session. Previous studies in numerous, diverse treatment settings, found that 23 – 45% of clients do not return after the initial intake (Garfield, 1994). Additionally, previous studies of premature termination in a training clinic show a rate of 77% (Callahan et al, 2009). It is not possible to know the reason behind a client who was only seen for one session, based on the data collected. The literature shows that there are numerous possible factors in premature termination that include client’s personal history, current difficulties, psychological functioning, and personality traits, role expectancies,
and effectiveness expectancies (Garfield, 1994; Callahan et al, 2009). Because of the high rate of premature termination in a training clinic, it has been identified as important to address premature termination with trainees. The training implication of this is that the trainees may be gaining valuable experience in initiating treatment, but may be receiving insufficient training in middle to late stage treatment (Callahan et al, 2009).

The data on the number of clients seen per therapist varied widely because several of the therapists stayed for more semesters than the typical two semester requirement; however, the mean number of clients seen by a given therapist of 6.77 which was consistent with the idea that most student therapists will see three clients each, for two semesters, resulting in six clients total. The data showing that there were more clients seen in the Spring semesters compared to the Fall semesters was consistent with trends observed by supervisors of the Practicum course (L. Berrigan, personal communication, Fall 2008).

There were almost twice as many females seen in the clinic as males. This is consistent with the literature which has shown that, as a group, men seek psychotherapy less often than women (Addis & Mahalik, 2003). Interestingly, the mean number of sessions was slightly higher for men than women, which suggests that in general, men stayed in therapy longer or attended more sessions than women.

The age of the clients seen in the clinic normally distributed around a mean age of 35.64. This normal distribution would be expected, given the nature of the clinic and the therapy offered. Because the clinic is community-based, no-cost, and serves families, couples, individuals, and children, the variety of age would likely range from low to high
and cluster around the mean. The low number of clients in the child age group (0-10) indicates that student therapists are not getting sufficient experience counseling children in the Practicum course. As stated in the BBS requirements for practicum, child relationships is an area that is specifically addressed, along with generally learning a variety of treatment approaches for children. Luckily, many of the community placements for the other required hours of face to face client contact are with the child population. However, this also means that students are entering child-focused community placements with very little previous experience in counseling children.

The results for ethnicity were comparable to the ethnic representation in Sacramento County, based on census data. The student therapists are seeing mostly White clients and 69% of the population is White (U.S. Census Bureau, 2009). The second highest number of clients seen was Hispanic/Latino (20.5% of the area population) and the lowest percentage of population in the area that was also represented in the sample was American Indian/Alaskan Native (1.3% of the population). Given this data, it is not surprising that the highest population of clients in the clinic was White and the lowest was American Indian.

Although the ethnicity of clients seen in the clinic is generalizable to the population in the area, this is still concerning considering the need for cultural competence of therapists and for MFT trainees to gain experience in counseling cross-cultural groups. According to Sue and Sue (2008), it is projected that persons of color will become a numerical majority sometime between the years 2030 and 2050. Therefore, the area population percentages previously mentioned may be quickly changing, making
it that much more important for MFT students to have experience working with a variety of ethnicities.

The mapped zip codes of the clients showed that most of them lived very near the Sacramento State campus, indicating that the clinic primarily serves the needs of the local community; however, there also were clients from outside the immediate area of the campus clinic, such as those living in the suburban areas of Sacramento. This indicates that people might also be willing to travel a greater distance to receive the counseling provided at this particular clinic. This information may be used in future clinic planning; for example, to determine target areas for advertising and public service announcements or to gather local referral information for clients who are accepted for services at the clinic.

The client type variable indicates that student therapists primarily see individual adults as clients. This reveals a potential lack of experience in treating children, families, and couples in the experience gained in the practicum portion of graduate study. These results are consistent with the reasoning behind the recent legislation of allowing for double counting of hours for seeing couples and families. Of specific concern is the low numbers of family clients, since this was the lowest represented client-type. Since a strong focus for MFTs is to work with families, this lack of experience is concerning. Once again, this echoes what was said by members of the committees of the BBS, as discussed in the introduction, about the lack of experience working with families. This is especially concerning in light of the BBS committee statement about how difficult it is to
get experience working with families if it’s not done during the practicum (BBS, 2007, December).

The results of the DSM-IV-TR diagnoses showed a high degree of mood disorders, other conditions that may be a focus of clinical attention, general medical conditions and psychosocial and environmental problems such as problems with primary support group and occupational problems. The diagnoses of the clients did not indicate anything unusual or of concern except for the lack of reported Axis II diagnoses. This could indicate that the student therapists do not have enough knowledge from their coursework and experience about personality disorders to be able to recognize them in their clients. It could also indicate that a diagnosis upon intake is not enough time for student therapists to be able to recognize personality disorders in their clients that could be observed later in therapy. Additionally it indicates that student therapists might not be getting adequate experience in the area of personality disorders compared with other disorders. Generally speaking, it should be noted that the diagnoses given and recorded for this project were only diagnoses reported by the student therapist at the time of intake. This means that therapists only had one to two sessions with the client before needing to assign a 5-Axis diagnosis. It might have been interesting to see if the therapists would have given the same diagnosis or diagnoses upon termination or at least farther along in the therapy process.

The results of the therapist report of Termination Improvement Level in which clients received Slightly Improved ratings, on average, appear to be promising for the prognosis of the clients seen in the clinic and of the work being done by the student
therapists. However, it would be unwise to conclude that most clients actually improve slightly after receiving therapy in the Practicum clinic. First, this is therapist reported, so it does not include the view of the client as to how helpful therapy was for them and whether or not their therapy goals were met. There are no forms or other outcome measures that currently exist in the clinic to survey clients, either pre-treatment or post-treatment, about their effectiveness expectancies or their level of satisfaction with the therapy they received. Client feedback on the therapeutic process is important; it can improve therapeutic outcomes and reduce premature termination (Reese et al, 2010). An American Psychological Association (APA) task force has recommended that practitioners “routinely monitor patients’ responses to the therapy relationship and ongoing treatment” and that this helps avoid premature termination (Ackerman et al, 2001, p. 496). Secondly, the mean number of sessions was highest for Remained the Same, which might indicate that the therapists were marking this level as a possible neutral rating. Some probable reasons could include discomfort with committing to an improvement level or lack of knowledge or experience in evaluating treatment outcomes.

Finally, the construction of the Termination Improvement Level rating scale may have contributed to positive response bias on the part of the student therapist raters. The way the rating scale is currently designed, three of the response choices are positive (Greatly Improved, Moderately Improved, Slightly Improved), one is neutral (Remained the Same) and one is negative (Deteriorated). Having more positive choices might indicate a preference for showing that therapy resulted in positive outcomes, especially if student therapists are also reluctant to evaluate their client’s condition as “Deteriorated”
upon termination. Although the student therapists are presumably giving their ratings after considerable thought, the scale construction could still increase likelihood of response bias (Leong & Austin, 2006).

As stated before, not all the MFT core competencies are expected to be mastered during the graduate program and especially not in the Practicum; however, it is expected that some of them will at least be introduced in the Practicum. From a general standpoint, the data suggest that trainees are gaining experience in some of the domains of the core competencies. For example, in the domain of Clinical Assessment and Diagnosis, where activities are focused on the identification of the issues to be addressed in therapy (Nelson et al, 2007), the data suggest that student therapists are assigning 5-Axis diagnoses to their clients using the DSM-IV-TR and therefore learning about the issues that should be addressed in therapy and learning about diagnosis.

When considering the individual core competencies, it would be nearly impossible to determine the level of competency with some of them specifically without interviewing the student therapists or somehow otherwise evaluating his/her competence. There are a limited number of individual competencies that can be tied into the Practicum experience, based the data collected. One of them is core competency 4.4.3: Evaluate treatment outcomes as treatment progresses. Competency or a move towards competency can be determined from looking at the therapist-reported Termination Improvement Level variable, which is basically the MFT student’s evaluation of the treatment outcomes. Determining an improvement level shows the student therapist has at least some level of competency with evaluating treatment outcomes. Another one is under the domain of
Admission to Treatment, competency 1.3.1: *Gather and review intake information.* It was clear from a review of the forms and other documents in the client records that trainees had experience with gathering intake information. Another competency is under the domain of Clinical Assessment and Diagnosis, competency 2.3.1.: *Diagnose and assess client problems systemically and contextually.* It was clear from the records review that trainees gave clients a 5-Axis diagnosis at the point of intake, which was determined based on gathering a complete history of the client and his/her presenting problems. Finally, under the domain of Clinical Assessment and Diagnosis, competency 2.3.8.: *Elicit a relevant and accurate biopsychosocial history to understand the context of the clients’ problems.* Although this does not directly tie to one of the study variables, the intakes were examined as part of the records review and client intakes included biopsychosocial histories, which shows trainees are able to gather this information and report it in the client records.

Based on a more general review of the records and the researcher’s personal experience in Practicum, there are several of the competencies that are addressed in supervision and other aspects of the Practicum that are not reflected in the data collected from the records. Some of these include competencies in the domain of Admission to Treatment, such as 1.3.5.: *Obtain consent to treatment from all responsible persons.* This was clear from observation that informed consents were included in the client files. Another competency is 1.5.5.: *Draft documents required for treatment, including informed consent, release of information, and intake forms.* All these documents were
included in the files to which they were relevant and showed that trainees have experience drafting these forms.

In the domain of Clinical Assessment and Diagnosis, an example of a specific competency addressed in the Practicum includes 2.3.4: *Apply effective and systemic interviewing techniques and strategies*. Not only are student therapists encouraged by the supervisor to look for certain factors during the clinical interview, but the consistency of the confidential intake shows that techniques and strategies are used in gathering information from the clients.

In the domain of Treatment Planning and Case Management, the trainees learn how to plan treatment and manage their case through both clinical supervision and experience in therapy. One example of a competency in this domain which trainees receive experience is competency 3.4.1.: *Evaluate progress of sessions toward treatment goals*. The trainees work closely each week in supervision with peers and the clinical supervisor to evaluate the progress of the sessions, by reviewing tapes of the therapy, discussing the case, and sometimes through case conceptualizations. Specifically, treatment goals are discussed and the progress is evaluated according to these goals.

Another example under this domain is competency 3.4.5.: *Monitor personal reactions to clients and treatment process, especially in terms of therapeutic behavior, relationship with clients, process for explaining procedures, and outcomes*. Practicum supervision encourages the trainees to think about and share their personal reactions to clients, including any countertransference that may be occurring. Trainees are also encouraged to
discuss reactions to how they feel the therapy is going, how the clients behave in therapy, their relationships with their clients and the progress of treatment.

Finally, the Therapeutic Interventions domain also includes some competencies with which trainees gain experience in Practicum. One of these is competency 4.3.1.: Identify treatment most likely to benefit clients for presenting clinical problem or diagnosis. This competency is developed both individually and through supervision. The trainee uses his/her educational knowledge to identify what types of treatments are available and which would be most beneficial to the client, depending on their presenting problem or diagnosis. Supervision is also used to improve this competency through consulting with peers and the supervisor to decide which might be the best treatment choice for a particular client’s problems.

Limitations

The limitations of this study are many. First, because this research was done on archival data that was not set up for research purposes, the information that could be gathered was limited. For example, it limited the scope of questions that could be addressed and the files provided little numerical information. Additionally, because of missing data, it was more difficult to accurately examine some of the variables. Related to this was a limitation of the use of descriptive statistics. While this is appropriate as a preliminary examination of the records, it limited the conclusions that could be made about the relationships among the variables.

Next, further data beyond the demographic information might have been interesting to research. For example, it might have been helpful to know the sexual
orientation of a client, whether the client had any disabilities, and what religious beliefs
the client may have held. This relates back to some of the core competencies, specifically
under the domain of Admission to Treatment where the therapist is expected to recognize
contextual and systemic dynamics. It also relates to the domain of Treatment
Interventions where the therapist is expected to deliver interventions that are sensitive to
these particular areas and needs of the client. In particular, in this study the researcher
noticed that GLBT (Gay, Lesbian, Bisexual and Transgendered) issues came up
somewhat regularly, so it might have been helpful to have collected some kind of data on
that factor. The previously mentioned background and identity information would have
also been interesting to know about the therapist to compare client characteristics with
therapist characteristics and to see how the characteristics of each might have affected
one another.

Finally, it would have been interesting to look deeper into some of the other
variables and factors that were examined, such as particular issues, diagnoses, presenting
problems, or crises. With diagnoses or presenting problems, it would have been
interesting to look at whether or not any of the student therapists used any assessment
tools, previous records from another therapist or general medical practitioner, or to see if
they use a genogram when looking at family dynamics. Some of these relate back to the
core competencies, specifically in the domain of Clinical Assessment and Diagnosis. If
these factors were researched more thoroughly, it might have been easier to assess the
level of competence the student therapist had in these areas of the core competencies. In
relation to crises, it would have been interesting to see if suicide assessment was properly
performed and documented, or the same for domestic violence or dangerousness to the self or others. Looking at this detail might have shown whether the student therapist was competent or approaching competency in these areas. Dealing with crises relates back, not only to the Clinical Assessment and Diagnosis domain of the core competencies, but also to the Legal Issues, Ethics, and Standards.

**Suggestions for Future Studies and Changes in Clinic Documentation Policies**

For the future, it would be helpful to regularly review the records of the Psychological Services Center practicum clinic for research purposes and improve the record keeping policies to make them more conducive for research. Such data would show further trends in the client base that continue to develop past the point of this study. Periodic reviews of clinic data would also contribute to the constantly changing MFT training climate and show areas of improvement from the shortfalls previously mentioned. As mentioned in the Methods section, there were times when there was missing data because of missing information in the file or because of multiple client records filed in the cabinet. If the records are going to be regularly reviewed, it would be good for the supervisor/instructor of practicum to ensure that forms are filled out by the student therapists consistently, properly and that they complete their files within a timely manner at the end of the semester. Also, the policies of record keeping from semester to semester and between instructors should be more consistent. Finally, it would be good if the instructor or Clinic Director were to come up with standards for how the files are kept and filed within the cabinet (i.e. have forms sorted in the same order in the file and
combine previous clients’ records with the current file). These practices might also help student therapists learn more about proper record keeping as part of their training.

Furthermore, if future studies like this are done in the context of evaluating MFT training, it would be advantageous, as discussed above, to further examine the data available through administering surveys or coding forms. To glean more information that is pertinent to the literature, interviews or surveys could be conducted on the student therapists, instructors/supervisors and, even more valuably, the clients themselves. Several previous studies of training programs and practica, including ones mentioned earlier, incorporated surveys of the clients or instructors/supervisors (Reese et al, 2010). An example of a way in which surveys might have been helpful is getting a more first-hand report of some of the factors in the therapy, such as opinions on the competence of the therapist or clients’ individual experience with the therapy process. Also, the more narrative portions of the file, such as the progress notes or intake reports could be subjected to thematic coding or content analysis, which would provide further information about the themes and content of therapy, but would also provide more data for doing further analysis. Additionally, doing more exploratory analyses would be interesting to test. For example, the data could be subjected to inferential statistics such as correlational analysis or between-subjects tests. While the purpose of current study was to describe the population of clients seen in an MFT training clinic, further studies should look more closely at the associations between the demographic variables and the therapy-related variables. For example, it might be interesting to look at the correlation between therapist and termination improvement level to see if a particular therapist rated their
clients as improved more often than not. Additionally, with more data, it might be easier to determine the extent to which other domains, subdomains, and individual competencies are addressed in Practicum. For example, if the intake reports or progress notes are coded for all the information they provide, it might be easier to determine whether trainees are gaining experience in the domain of Treatment Planning and Case Management. Another domain that could be comparable to the trainees’ experience if these documents had been coded is the domain of Therapeutic Intervention, as trainees may have indicated in their notes which interventions they were using with their clients. Overall, a more extensive examination of the records would provide more information about how well the practicum connects to the core competencies.

A study such as this serves to guide the faculty of the Psychology Department at Sacramento State in their curriculum development, program development, and specifically the teaching styles and learning outcomes of the practicum course. Further evaluation of this course and reviewing the records in the clinic will help assess whether or not any changes made have resulted in improvements on this stage of MFT training. Now that the records have been reviewed and analyzed for descriptive statistics, it highlights the areas that would be interesting and valuable to examine in future studies. Finally, using the information in this study as a tool, the future clinic procedures and documentation requirements could be more closely aligned with the competencies and training standards for MFTs.
REFERENCES


Board of Behavioral Sciences.(2007, December). Meeting minutes from the meeting of the Marriage and Family Therapy Committee.

Board of Behavioral Sciences. (2007, October). Meeting minutes from the meeting of the Policy and Advocacy Committee.

Board of Behavioral Sciences. (2009, May). Meeting minutes from the meeting of the Board.


Sacramento, CA. Retrieved from


