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## Therapist-initiated addiction assessment procedures of marriage and family therapists in the southwest United States

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THERAPIST-INITIATED ADDICTION ASSESSMENT PROCEDURES OF  
MARRIAGE AND FAMILY THERAPISTS IN THE  
SOUTHWEST UNITED STATES

by

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Bachelor of Arts  
University of Nevada, Las Vegas  
2007

A thesis submitted in partial fulfillment of  
the requirements for the

**Master of Science in Marriage and Family Therapy**  
**Department of Marriage and Family Therapy**  
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**University of Nevada, Las Vegas**  
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THE GRADUATE COLLEGE

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**Emire Olmeztoprak**

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**December 2010**

## ABSTRACT

### **Therapist-Initiated Addiction Assessment Procedures of Marriage and Family Therapists in the Southwest United States**

by

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The purpose of this study was to examine the addiction assessment procedures of marriage and family therapists. Addiction prevalence rates are growing therefore it is likely that marriage and family therapists will have clients affected by addiction. Undetected addictions can impede treatment and/or prevent the therapist from making appropriate treatment related decisions. Marriage and family therapists in Nevada, Arizona, and New Mexico were invited to complete a web-based survey containing a series of questions about their assessment procedures for addiction as well as a series of demographics questions. The data from the completed surveys was collected and analyzed. The data analysis focused on frequencies of answers as well as a comparison of the actual data with the expected data. The data analysis provided information that did not support either of the hypotheses. The results of this study showed the participants are routinely assessing their clients for addictions and are utilizing both formal and informal assessment techniques.

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## CHAPTER 1

### INTRODUCTION

Broekart, Soyez, Vanerpasschen and Vandervelde note “clinical psychologists, educators and social workers have always introduced their own qualitative methods of assessment, treatment planning, therapy and evaluation” (2001 p. 135). Commonly a biological, psychological, and social assessment is utilized in treatment. Assessments, however, can be conducted a variety of ways, either in person, on paper, through observation, or any combination. Topics included in the assessment may originate from clinical experience, training, and/or personal bias. According to Lavee and Avisar, “Clinical assessment is an essential part of any treatment both physical and mental” (2006 p. 233). Assessment not only helps to diagnose disorders, but also gives information on the impact of certain topics on one’s life.

While it is commonly accepted that assessments are a critical part of the therapeutic process, it is just as critical in addiction treatment. Addictive behaviors have potential to influence in some cases one’s physiology, but also psychological aspects such as the quality of life of the individual, satisfaction of interpersonal relationships, dynamics within a family or household, vocational performance and satisfaction, and potentially introduce legal and financial issues for the person engaging in the behaviors. The occurrence of these issues can influence treatment as it pertains to addressing the presenting problem, but also the issues associated with the addictive behaviors themselves. In either case, etiology of the problem is important to treating the presenting problem effectively. Lavee and Avisar state “the assessment enables the therapist to establish therapeutic goals and to plan modes of intervention” (2006, p. 234) as well as

point out “[assessment] enables an evaluation of the individual interpersonal and environmental factors that may exacerbate problems or hinder the couple’s recuperation and helps to identify internal and external forces that may affect outcomes” (2006, p. 233).

The challenge, however, is that therapists who may not initiate assessment for addiction may never uncover its presence, yet addictions of any sort (whether they be substance or process) have a significant impact on the family. The primary purpose of this study is to determine if marriage and family therapists (MFTs) are routinely initiating assessment of their clients for various addictions and to determine the means of their assessment procedures.

### Significance of the Problem

#### **Substance-Related Addictions**

As prevalence rates of addiction rise, mental health clinicians will undoubtedly see more clients affected by addictions. All helping professions including psychiatrists, psychologists, MFTs, social workers, clergy and counselors see a share of substance abusing clients (Gassman, Demone, & Albilal 2001). According to the National Substance Abuse Index (NSAI, 2006), the percentage of reported marijuana use in the United States in the past month by those ages 18-25 has steadily increased since 1979, reaching a peak in 2003. The percentage of reported cocaine use in the U.S. in the past month by those ages 18-25 has steadily increased since 1980, peaking in 2002. In addition, the NSAI (2006) reports:

from 1993 to 2003, the rate of treatment admissions for primary methamphetamine/amphetamine abuse increased from 13 to 56 admissions per

100,000 population aged 12 or older and the proportion of primary methamphetamine/amphetamine admissions referred to treatment by the criminal justice system increased from 36 percent in 1993 to 51 percent in 2003. (trends, meth treatment admissions trends section, bullets 1-3).

It is apparent that substance use and abuse, particularly methamphetamine/amphetamine use, is increasing in the United States.

Nevada has serious challenges when it comes to drugs and drug-related issues. Nevada is listed as a high drug trafficking area in the United States. Club drugs such as ecstasy, gamma hydroxybutyrate (GHB) and lysergic acid diethylamide (LSD) are common in Las Vegas nightclubs as well as in the commercial sex industry in Nevada (NSAI; 2006). It is also of importance to note an increase in marijuana “grow houses” in Las Vegas in 2001 (NSAI; 2006). In addition, drug arrests have increased from 180 drug arrests in 2001 to 207 in 2005 with a slight decrease in 2002 and 2003 (NSAI, 2006). Some of its specific challenges include methamphetamine use, crack, and heroin. Estimates about methamphetamine use in Nevada identify that it is the most prevalent and commonly abused drug. Cocaine is readily available in Southern Nevada whereas crack is more easily accessible in urban Northern Nevada (NSAI, 2006). Black tar heroin is available in Nevada, thought to enter Nevada by means of Mexican drug trafficking organizations.

Nevada is not the only state in the desert Southwest with challenges related to drugs. According to the NSAI (2006), Arizona’s substance issues are primarily related to drug trafficking by poly-substance trafficking organizations that bring drugs across the border from Mexico. Arizona is viewed as a “transshipment” location for cocaine that is

then spread throughout the United States. Crack cocaine is widely accessible in the Phoenix and Tucson areas (NSAI, 2006). Mexican black tar heroin is becoming a problem in Arizona, in particular in public schools in the Phoenix metropolitan area. Arizona has also experienced an increase in prescription opiate use, particularly Oxycontin (NSAI, 2006). Much like Nevada, methamphetamine is a concern in Arizona. Methamphetamine is both locally manufactured and smuggled in from Mexico. In addition, club drugs are readily available throughout the state and marijuana is easily accessible as well (NSAI, 2006). The NSAI (2006) also reports drug arrests are significantly higher in Arizona than Nevada, which is likely due to the high level of trafficking of drugs and drug money in Arizona. From 2001-2005 drug arrests were highest in 2001 with 1,799 arrests, decreased in 2002 and 2003 and climbed to 1,356 in 2005 (NSAI, 2006).

Similar to the substance issues in Arizona, New Mexico is also threatened by transshipments of drugs from Mexican poly-substance distribution organizations (NSAI, 2006). As a result, drugs are readily available in New Mexico. Cocaine is often transported through New Mexico resulting in an abundance of crack cocaine in urban areas and available throughout the state. The presence of heroin in the state has shown a steady increase over the last five years. Again, black tar heroin is the type available in New Mexico (NSAI, 2006). Methamphetamine is available in New Mexico, but is far less prevalent in this state than in Nevada or Arizona. According to the NSAI (2006), club drugs including ecstasy, ketamine, LSD, and GHB are widely available in the Albuquerque and Santa Fe areas. These drugs are commonly found at Raves, often held in remote areas of the state. Marijuana is the most prevalent drug in New Mexico. Drug

arrests in New Mexico from 2001-2005 reached a peak in 2004 with 690 arrests and were lowest in 2003 with 534 arrests (NSAI; 2006).

The NSAI (2006) also provides the following statistics on drug rehabilitation and substance abuse treatment admissions in 2004. In Nevada, 10,797 people were admitted for substance abuse treatment or rehabilitation. The highest number of clients (3,122) was admitted for only alcohol use problems followed by methamphetamine use (2,558) and then alcohol and a secondary drug (1,355). In Arizona, 1,159 people were admitted to treatment or rehabilitation. The majority was also admitted for only alcohol use (1,359) followed by heroin (765) then cocaine administered by a method other than smoking (610). In New Mexico, 6,690 people were admitted to rehabilitation or treatment. Again, only alcohol use accounted for the majority of admits (2,188), followed by 742 admits for alcohol with a secondary drug, then heroin use (468).

### **Process-Related Addictions**

Bradley (1990) stated, “The factor common to all the conditions referred to as [process] addictions is that they consist of repetitive sequences of behaviors and that they are maladaptive” (p. 1417). Process-related addictions share the following characteristics with substance-related addictions: the behavior or process acts as an instrumental reinforcement, developmental of tolerance, withdrawal effects, produces a sense of euphoria which is followed by dysphoria, the behavior or process is an unconditioned stimulus, and the process or behavior can be triggered by various settings or states (Bradley, 1990). Like the substance-related addictions, process addictions (such as gambling, Internet use, porn and sex use, food, and shopping) also have a detrimental and significant impact on many facets of a client’s life, including relationship strain,

economic challenges, and overall diminishing of life satisfaction. For example, gambling addictive behaviors are attributed to an estimated 15 million people worldwide (Gambling Facts and Stats, n.d.) and are associated with antisocial behavior (Cunningham et al, 2007) and poorer general and mental health (Pietrzak et al. 2007). According to Pulford et al (2008), “Problem gamblers who do not seek help, therefore, continue to expose themselves and others to these significant, and potentially resolvable, harms.” (p. 20). Problem gambling affects an entire family psychologically, financially, emotionally, and may have irreparable effects of family relationships. Even after the problem gambling has stopped, the individual is often faced with resentment, anger and isolation from family members who may have suffered a loss of standard of living, credit ratings, savings, and overall income (Phillips, 2005).

Like the substance addictions, process addictions can be comorbid with other process addictions. For example, as Internet addiction becomes more common, the incidence of gambling addictions also increases (Griffiths, 2010). Individuals experiencing problem gambling are more likely to have affective disorders and/or substance related addictions (Phillips, 2005). In addition, sex and food addiction often accompany each other in that they are two vital aspects of human life where abstinence is not a possible goal (Powers, 2005).

### **Impact on the Family System**

Marriage and family therapists need to be aware of the presence of addictions due to the impact addiction has on the overall functioning of the family system. In families where one or more family members have an alcohol problem, for example, interpersonal distance is often a problematic area. Those experiencing the alcohol problem often

minimize the need for close relationships resulting in isolation and emotional unavailability to the family (Bowen, 1974). Theorists such as Bowen (1974) also discussed the cycle in which the emotional isolation can lead to more drinking leading to more isolation and therefore produces a cycle of isolation and increased alcohol consumption. Being raised in an environment where one or both parents experience problem drinking can create significant distress as evidenced in the accounts of children of parents with alcohol problems and adults who reflect on their childhood with parents with alcohol problems (Rafferty & Hartely, 2006). In addition, Rafferty and Hartely (2006) note disharmony including the presence of an alcohol problem in the family of origin is a determining factor in negative developmental outcomes.

Dundas (2000) discusses the repercussions of problem drinking on the family, outlining that the family's experience of their interaction patterns may be very different than an observer (counselor). Family members may be unable to ask for or receive support from each other, yet at the same time be extremely dependent on each other, which appears very contradictory and confusing (Dundas, 2000). Further, children of parent(s) experiencing problem drinking fear escalation of conflicts and loss of control when interacting with the person(s) experiencing problem drinking (Dundas). Children describe placating parents in order to avoid such conflicts, physical distancing from the parent(s) or family, and cognitive distancing when physical distancing is not possible. There may also be intrusive interactions with the parent(s) experiencing the drinking problem including the parent(s) seeking high levels of contact with the child, a lack of consideration for the child's perspective, and the parent(s) infringing upon the child's peer relationships (Dundas, 2000).

Orford et al (2005) point out that there is a significant amount of empirical literature produced on the effects of alcohol problems on the family system and very little to explore the impact of other forms of addiction on the family. In fact, the majority of research and literature considering addiction and family surrounds fetal drug exposure and the family of origin factors that lead to adolescent substance use. This may be in part due to the fact that primary health care providers are not trained in recognizing or treating family problems particularly as they relate to addiction (Orford et al, 2005). In order to address the lack of attention to the family, Orford et al (2005) suggests that a means of assessing the needs of concerned and affected family members that can be used in a practical manner must be in place.

With the impact of addiction on the family, it is clear that treatments not sensitive to the presence of an addiction could include contraindicated treatment or interventions that perpetuate unhealthy interaction patterns, unhealthy family dynamics, addiction behavior and/or enabling of the individual with addiction issues. For example, problem-drinking results in harmful effects on the family, but can also result in positive adaptive family characteristics therefore reinforcing the problem drinking behaviors (Jacob & Leonard, 1988). In effect, a therapist unaware of the presence of the addiction could be praising and encouraging patterns (or sometimes teaching patterns) that perpetuate the context for the addiction, thus rendering the treatment ineffective. For example, family, couple or individual problems could intensify or manifest as a result of the addiction. Progress could be delayed, impeded or contraindicated.

Therefore, regardless of the addiction, successful intervention for alcohol and drug problems depends in part on assessment. If an assessment procedure is faulty or



incomplete then treatment is likely to suffer as a result (Gassman, Demone, & Albilal, 2001). Attention to and assessment for a wide variety of addictions is critical to a marriage and family therapist's treatment protocol, yet few clinicians use formal assessment instruments (Lavee & Avisar 2006). According to Bray (1995), "Despite the development of good family measures, family oriented practitioners do not regularly make use of standardized or formal family assessments in their practice."

The unrecognized presence of addiction can have ethical implications for the therapist. Code 3.11 of the American Association for Marriage and Family Therapists (MFTs) states "MFTs do not diagnose, treat, or advise on problems outside the recognized boundaries of their competencies" (AAMFT, 2002). Without additional training and/or certification, MFTs may not be qualified to treat addiction as the presenting problem for their clients. If a therapist is unaware of the presence of addiction, the therapist could find him or herself in an ethical bind. For example, a therapist may come to find out several months into treatment they have been dealing with an addiction case they are not qualified to treat. Once into the course of treatment but not able to address the addiction, therapists then must weigh issues of potential client abandonment with conducting the appropriate standard of care. Viable options could include referrals to additional treatment, or referral and termination of treatment. In addition, if a therapist proceeds with treatment without addressing the addiction issues, treatment may be compromised. In short, a therapist who does not make appropriate referrals or acknowledge the presence of an addiction would not be practicing in the best interest of the client nor the appropriate standard of care.

### Hypotheses and Definitions

This study specifically aims to answer the following research questions: are marriage and family therapists routinely initiating assessments of their clients for addictions; and what methods of assessment are they using? For the purposes of this study, “routinely” is operationally defined as endorsing some form of assessment on seven of the nine targeted areas of addiction as follows: illicit drugs, prescription drugs, alcohol use, pornography use, sex behavior, food behaviors, internet use, shopping behavior and gambling behavior. In this study, as outlined in the *Treatment Improvement Protocol 39*, the term assessment refers to some form of information collection regarding addiction behavior and history including but not limited to related concerns consisting of relationships, sexual history, mental health etc. (Center for Substance Abuse Treatment, 2004 p. 38).

## CHAPTER 2

### LITERATURE REVIEW

Over the past two decades, increasing importance has been placed on valid and reliable assessment in family therapy (Lavee & Avisar, 2006). Thorough standardized assessments provide a wide variety of information about clients that can guide treatment planning, hypotheses formation, lend insight into problem areas, etiology of problems, strengths, inform diagnosis and ensure important aspects of the case are not overlooked (Bray, 1995).

As helpful as standardized assessments can be, however, empirical literature devoted to them in the field of family therapy is minimal for two main reasons. First, marriage and family therapists generally classify themselves as “systemic therapists”, or therapists who are consider the process and interpersonal interactions in one’s life and evaluate the multiple contributions to the problem. Systemic therapists evaluate how families communicate and tracking patterns within then system in order to understand the context in which the problems arise (Corey, 2005). Systems theory is the cornerstone to marriage and family therapy and “describes the linked nature of individual’s lives as they exist together and in relation to the external environment” (Stelle & Scott, 2007, p. 46). This encompasses all aspects of the individual or family’s life, which includes addictions when present. Furthermore, every element of the system in turn affects another, which eventually disrupts the function of the system as a whole. Addiction is no exception. Stelle and Scott go on to say, “[addiction] problems should be conceptualized as a systemic problem with the family that potentially alters the structure and process of family dynamics.” (2007, p. 47).

Concepts underlying a systemic perspective include equifinality, multifinality, and circularity (de Shazer, 1985). Standardized assessments, on the other hand, tend to value content and the individual perspective, and do not have ways to attend to the core components of systemic process. Assessments typically offer little to no information on how multiple people behave and communicate, identify what roles they play within the system and therefore do not provide much information that gives insight into interaction patterns, family context, but rather provide factual information or interpretations of the individual. This is supported by Bray's (1995) report which states that many family therapists do not see how standardized assessments apply directly to their practice, thus undermining their use within treatment. Other practical issues regarding administration include the timing (do you do an exceptionally long session to do an assessment with each family member/partner?) and the structure (do you conduct the assessment individually or with family members/partner present?). To illustrate the point, in a chapter on evidence-based practice regarding substance abuse, Glicker (2005) suggests using the CAGE assessment to assess for substance abuse. The CAGE is an acronym for: cut, annoyed, guilty and eye-opener. Clinicians are instructed to ask clients the following questions:

- 1: Have you ever felt you should cut down on your drinking?
- 2: Have people annoyed you by criticizing your drinking?
- 3: Have you ever felt guilty about your drinking,
- 4: Have you ever had a drink first thing in the morning to get rid of a hangover?

While this method undoubtedly holds value, it is clearly aimed only at alcohol consumption and does not address anything related to the family or couple relationships.

Secondly, merely developing and testing and/or norming systemic assessments can be extremely difficult. Most practicing marriage and family therapists have completed their education with a master's degree as their terminal degree. In most programs at the master's level, there may only be 1-2 courses in research methodology, and minimal training, if any on psychometrics. Therefore, therapists at the master's level do not have the skills or training to develop a psychometric instrument, nor the adequate sample size to test or administer an assessment. Because assessments are typically oriented to individuals, there are few therapists who can manage data from multiple individuals on an assessment (either the second member of a couple or members of a family, who may all be at different developmental levels).

### **Challenges of Implementing Assessments**

Assessment in marriage and family therapy typically takes the following forms: client self-report, and observation (Bray, 1995). Client self-report is the most common form of assessment and observation is the primary method used in research and clinical assessment of families. The foremost problem to self-report is that client report is simply the client's perspective on the matter at hand and observational methods are open to clinician interpretation and bias (Bray, 1995). Besides therapists' beliefs that structured assessments do not have direct application to clinical practice, Bray (1995) reports assessment measures have been created in research contexts, are not directed towards clinical practice, and are confusing in the constructs measured. Specifically, researchers (who often develop assessment measures) use different names, labels and constructs than clinicians, but in reality are referring to the same thing. These factors contribute to the lack of utilization of formal assessment measures in family therapy.

There also seems to be little consensus on what a valid, reliable, and systemic assessment looks like and how it is conducted. According to Gassman, Demone, and Albilal, “one would expect specialists social workers and otherwise to ask standard questions about substance use and abuse [they] may not have the sensitivity training or organization support to assess their clients routinely for such problems” (2001 p. 137). Gassman, Demone, and Albilal (2001) surveyed master’s of social work students regarding the amount of training they received in the area of alcohol and drugs. They also asked students to rate their self-confidence in the area of addictions assessment. The authors found students who received more training in alcohol and drugs were more likely to serve clients with substance abuse problems, conduct substance related assessment and felt more confident in their ability to conduct an addictions assessment. This study suggests that clinicians do not feel they receive adequate training or support to conduct an addictions assessment. Based on typical training models, MFTs receive basic training in substance and addiction issues; therefore, family therapists are not always familiar with questions to ask or cues regarding substance use (The Center for Substance Abuse 2004, p. 42).

In addition to outsiders’ perspectives that addiction assessment procedures are subpar, the practitioners themselves may also be aware that their procedures are falling short. Broekart, Soyez, Vanerpasschen and Vandervelde report “[staff] was aware that they needed to change their professional approach [for assessment” (2001 p. 135). Lee Za, Dal-Yob, Cha and Arokiasamy (2008) also state, despite the identification of substance abuse dual diagnosis and mental health counseling as emerging practice, there is a lack of adequate training among professionals. Both of these examples indicate the

shortage of attention to the area of addiction assessment is related to a deficit in training and knowledge rather than a lack of recognition for the significance of assessment.

*Substance Abuse Treatment and Family Therapy: A Treatment Improvement Protocol (TIP 39)* is a comprehensive treatment guide for marriage and family therapists working with substance abuse published by the Substance Abuse Center, a division of the U.S. department of Health and Human Services substance abuse and mental health services administration (SAMHSA). The *TIP 39* directs family therapists on substance abuse treatment within the family context. This guide connects various family therapy theories with substance abuse treatment. In addition, *TIP 39* offers information on addictions within family, the impact of addictions, considerations for special populations, and potential policy and procedure problems that may arise when working with families affected by substance abuse.

*TIP 39* notes family therapy assessments often based on observation of family interactions. The areas of attention typically include family dynamics, triangulation, confrontation, and conflict. In addition, the observational assessment can be aimed at highlighting strengths, depending on theoretical viewpoint. The typical method of assessment in family therapy is rarely adequate for obtaining information relating to addiction (2004, p. 42). This suggests that a more formal assessment relating to addictions is potentially necessary and beneficial to treatment. MFTs should be trained in screening for substance abuse and be aware of the role that substance abuse plays in family dynamics (The Center for Substance Abuse, 2004, p. 42), which acknowledges the need for addiction related assessment training for MFTs as well as the significance of the assessment itself.

A study conducted by Schacht, Dimidjian, George, and Berns (2009) is of particular importance to this study. The authors examine the assessment practices of couple therapists as they relate to domestic violence and lend support to the design of the present study. The 2009 study employs a survey of 620 MFTs targeting their assessment procedures as well as a series of demographics questions. “The results of this study suggest the majority of couple therapists do not routinely engage in widely recommended domestic violence screening practices, which include screening all couples using standardized questionnaires” (Schacht, et al 2009, p. 55). Yet systemic therapists are trained to identify how multiple layers of a client’s context contribute to, alleviate, and otherwise influence their focus of treatment (Stelle & Scott, 2007). Hence, assessment aimed to uncover the presence of additions is imperative to family treatment because good systemic treatment will inherently likely affect the roles of the family and other elements of the context in which the problem is embedded. If the presence of addiction is detected within the assessment phase, such elements and potential challenges could be addressed directly.

Substance abuse and dependence including nicotine, illicit drugs and alcohol are commonly comorbid with a variety of mental health disorders (Swendsen, 2010). A 2010 study conducted by Swendsen et al examines at the results of the National Comorbidity Survey by utilizing a ten-year follow up design. The baseline data from the original survey was used as a comparison for current results. The participants repeated the survey approximately ten years later and the results of the two surveys were compared using multivariate logistic regression analysis and controlled for factors such as socio-demographic characteristics as a means to approximate associations of mental disorders



individually within the baseline, with first use, and age at follow up for each substance (Swendsen et al, 2010). Swendsen et al. (2010) found that behavior disorders and preexisting substance use were the strongest predictors of a transition from mental health disorders into comorbid substance abuse or dependence. In addition, mood and anxiety disorders had a high association with comorbid substance abuse or dependence (Swendsen et al., 2010).

The findings of Swendsen's study are consistent with previous research on mental health diagnosis and substance abuse or dependence. This substantiates the notion that there is a significant association between substance abuse and dependence and mental health disorders and furthermore confirms that mental disorders are a risk factor for substance use (Swendsen et al., 2010).

In addition, a study conducted by Feske et al (2007) found a correlation between borderline personality disorder in women and substance abuse and/or dependence. This study utilized a baseline design using the Structured Clinical Interview for *DSM-IV-TR* where participants were asked a series of questions over several interviews. Feske et al (2007) acknowledge that the random sample utilized in this study was rather small and may not generalize to the other populations and suggest further studies should be done on this topic.

The findings of these studies are directly tied to the importance of addictions assessment in treatment. The association of mental health disorders with addiction behavior suggests the majority of the clients treated by MFTs treat are at risk for addiction. Feske et al (2007) recommended that clinicians working with female clients suffering from borderline personality disorder take care to assess for addiction behaviors

in order to address both the personality disorder and substance use issues either concurrently in treatment or to refer to other sources to address the problems in a parallel. Addiction assessment is imperative to reveal the presence of addiction or of behaviors that could lead to addiction. This allows the therapist to address addiction issues at the appropriate level such as preventative psychoeducation, addictions counseling, or inpatient treatment depending on the severity of the addiction behaviors.

Given the intricacies and challenges to conducting addiction assessment within the field of marriage and family therapy comorbid with the significant problem of addiction in the desert Southwest, the purpose of this study was to evaluate the extent to which marriage and family therapists were assessing for addictions. Hypothesis 1 is that marriage and family therapists are not routinely initiating addictions assessments. Hypothesis 2 is that when they do assess, a majority of marriage and family therapists conduct their assessment through informal methods.

## CHAPTER 3

### METHODOLOGY

#### Participants

The participants of this study were licensed marriage and family therapists (MFTs) who are not dually licensed as licensed drug and alcohol counselors (LADC). LADCs were excluded because additional training and experience in the area of drug and alcohol counseling predisposes them to be more sensitive to and assess for the presence of addictions. In addition, MFTs who are also licensed drugs and alcohol counselors are more likely to be working in a practice that specializes in addictions treatment and/or issues. Therefore, addictions assessments are more likely to be part of the standard procedures of that practice.

Participants for this study were recruited by means of invitation (Appendix 1) to participate in the study. Therapist contact information was obtained using the Therapist Locator feature of the American Association of MFTs website. Participants were recruited from Nevada, Arizona, and New Mexico. Licensed MFTs chose to participate in the study at their convenience. Participants were not offered any kind of incentive or compensation for completing the survey.

#### Instrumentation

The present study and the survey instrument regarding therapist initiated addiction assessment procedures was based on a study on domestic violence assessment procedures of MFTs by Schacht, Dimidjian, George, and Berns (2009). The successful implementation of the survey instrument in the 2009 Domestic Violence Assessment study supports the design of the survey for this study. In addition, the methods of

recruiting were conducted in a comparable manner to the 2009 study. The success of the recruiting techniques for the Domestic Violence Assessment study produced a satisfactory number of participants, and supported the methods of recruitment for the addictions study.

The study utilized a web-based survey (Appendix 2) using QuestionPro software. The participants were provided with a web link to the survey, which they were able complete at their convenience. The survey included nine questions regarding the assessment procedures of the participants. I chose to ask questions about each area of addiction in order to account for differences in likelihood to assess for certain types of addiction. In addition, the survey included nine demographics questions. The specific demographics questions were chosen to reveal potential factors that influenced the likelihood of the participants to assess for addiction. Some the factors that may affect awareness of addiction include but were not limited to: type of practice, type(s) of degree(s) held, and number of addictions conferences attended per year.

Prior to beginning the survey, the participants were provided with an informed consent. Participants had to accept the terms of the informed consent before they could access the survey. By clicking on the “accept” option the participants were informed that they were “digitally signing” the informed consent document. The participants were informed that their “digital signature” indicated they read, understood, and accepted the informed consent document. These measures were in place to ensure all participants were aware of the risks and benefits of participating in this study. The participants were not able to access or view the survey questions until after they accepted the informed

consent to ensure the content of the survey did not influence their acceptance or decline of the informed consent.

Participants were required to answer all questions to reduce the amount of missing data. The data was collected directly from the survey program. The frequencies of each answer for each item regarding addiction assessment were collected. Data from the demographics portion of the survey was collected in terms of frequency of answers as well.

### Procedures

Participant selection was based on the targeted population. The participants were initially invited to take part in the study through email contacts provided on Therapist Locator. Therapists from Nevada, Arizona and New Mexico were invited to participate. Therapists were emailed an invitation to participate in the study that included a link to the survey. Therapists could then elect to participate complete the survey. This was done to obtain a variety of participants with different backgrounds and areas of expertise. In addition, it allows for participation of clinicians throughout the Southwest Region. This was done to obtain a random and diverse sampling of participants, which would increase the ability to generalize the results of the study. Participants were also recruited through subsequent methods when the Therapist Locator recruitment method was deemed inappropriate (for further discussion of this matter, see the Discussion section). I alternatively decided to advertise the survey on the Nevada MFT listserv, but its operations were also terminated within two weeks of posting the survey.

Due to the method of recruitment through the Association for Marriage and Family Therapy affiliation, there is the possibility that the sample may not be

representative of the general population. Affiliation with the association could result in a sample that is more likely to be active in the professional community and may be more likely to have more exposure to literature, education, or training surrounding addictions issues than those who are not part of the professional organization.

### Analysis

In order to determine if MFTs are assessing their clients for addictions I examined the frequency of each response to each survey item. The Statistical Package for the Social Sciences version 17 (SPSS) was utilized in order to perform a chi-square for each survey item to compare the expected number of responses for each item with the actual number of responses from the survey. “A chi-square tests for goodness of fit uses sample data to test hypotheses about the shape or proportions of a distribution. The test determines how well the obtained sample proportions fit the population proportions specified by the null hypotheses” (Gravetter & Wallnau, 2005 p. 456).

This provided information to determine whether my hypotheses that MFTs are not assessing all their clients for addictions and that they are using informal assessment techniques if they are assessing for addictions in their practices was supported. In addition, the data was analyzed in search of potential factors that could influence the likelihood of the participants to assess for addiction. Some the factors that may affect awareness of addiction included but were not limited to: type of practice, type(s) of degree(s) held, and number of addictions conferences attended per year. The data was also analyzed to reveal factors that could contribute to the likelihood of therapists to assess for a particular addiction behavior over another.

## CHAPTER 4

### RESULTS

#### Demographics

The survey was distributed to 211 MFTs via email. A total of 24 participants completed the survey, resulting in a response rate of 11.37%. Twenty-six of the people who did not complete the survey at least viewed it, and 29 participants ultimately began the survey, with 24 completing it. The completion rate was 82.76%.

Participant ages ranged from 31 to 74 years with a mean age of 45.9 years. 8 of the participants reported residing and practicing in Nevada, while 10 reported residing in New Mexico, and 6 reported residing in Arizona. Years in practice ranged from 1 to 37 with a mean of 11.7 years in practice. The average weekly caseload of participants ranged from 4 to 40 with a mean of 20.3 cases per week.

Tables 1 through 3 display demographics data collected from the survey. The tables serve to compare various demographic factors and potentially provide information regarding the propensity for MFTs to initiate addiction assessments.

Table 1 Type of Practice and CEUs

Type of Practice	Average Number of Addiction Related CEUs in past year
Private practice	5.25
Within a private clinic	20.3
Within a government agency	12
Within a non-profit agency	5
Within a college setting	16
Within a school setting (grades k-12)	6

Table 1 compares the type of practice participants reported working in with the average number of addiction related continuing education credits participants reported receiving during the last calendar year. Participants were able to select all types of practices in which they work. Twenty participants reported working in private practice, three reported working in a private clinic, 3 reported working within a government agency, 3 reported working within a non-profit agency, 1 reported working within a college setting, 1 reported working in a school setting, zero reported working within a hospital setting, and zero participants reported working in another type of practice.



Table 2 Degrees Held and Years in Practice

Degree Held	Average Number of Years in Practice
Master: Marriage and Family Therapy	10.2
Master: Counseling	15
Master: Counseling Psychology	11.6
Master: Other	8.5
Doctoral: PhD Psychology	8
Doctoral: PsyD Psychology	5
Doctoral: Marriage and Family Therapy	8
Doctoral: Other	37

Table 2 compares the degrees held by the participants with the number of years in practice. In this particular survey item, participants were asked to select all that apply to account for participants who hold multiple degrees. Seventeen participants reported having a master level degree in marriage and family therapy. Two participants reported having a master level degree in counseling. Four participants stated they have a master level degree in counseling psychology. Zero participants reported having a master level degree in social work, and two participants reported having another type of master level degree. Other types of master's level degrees included secondary education, art therapy, and psychology and human relations.

One participant reported having a doctoral level degree in psychology (PhD) and one participant reported having a doctoral level psychology degree (PsyD). One

participant reported having a doctoral level degree in marriage and family therapy. One participant stated they had another type of doctoral level degree. Other types of doctoral degrees included family studies.

Table 3 Types of Practice and Average Caseloads

Type of Practice	Average Weekly Caseload
Private practice	19.2
Within a private clinic	33.3
Within a government agency	4
Within a non-profit agency	13
Within a college setting	28.5
Within a school setting (grades k-12)	25

Table 3 compares type of practice with average weekly caseload. Participants were asked to report their average weekly caseload. No distinction was made for participants who may work in multiple settings. Based on the data collected in this survey participants working in a private clinic have the highest weekly caseload whereas participants working in a government agency have the lowest weekly caseload.

#### Hypothesis Testing

In the present study, I was interested in examining whether MFTs in the Southwest United States were routinely assessing for addictions. My first hypothesis is

MFTs are not routinely initiating addictions assessments. My second hypothesis is MFTs who are assessing for addiction are utilizing informal methods of assessment.

A chi-square was used to evaluate whether there were significant differences in the number of therapists using particular assessment procedures. The significance level used was  $p < .05$ . I assumed that the procedures people were using would be equally distributed among the participants. In other words, I assumed that each assessment strategy would be used equally among the participants. In addition, I assumed that each type of addiction would be assessed equally.

The frequency data (Tables 4-12) suggest that therapists are more likely to use both informal and formal assessment procedures in their practice. Specifically, more therapists reported that their assessment procedures involved both interview and paperwork procedures were used in their assessment procedures. Below are the tables representing the frequencies along with the chi-square data.<sup>1</sup>

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<sup>1</sup> Blank cells in the “Expected” and “Residual” cells were the result of no observations in that category; therefore, SPSS did not divide the probability among those choices.

Table 4 Alcohol Use

Describe your assessment procedures for alcohol use.			Expected	Residual
a. I do not assess	0	0.00%		
b. Included in initial paperwork	0	0.00%		
c. In person interview	5	20.83%	6.0	.0
d. Inventory separate from initial paperwork	0	0.00%	6.0	6.0
e. B and C	<b>12</b>	<b>50.00%</b>		
f. C and D	5	20.83%	6.0	-1.0
g. B and D	0	0.00%		
h. B C and D	2	8.33%	6.0	-5.0
i. None of the above	0	0.00%		
<b>Total</b>	<b>24</b>			

For assessing alcohol usage, half of the participants reported that they used a combined assessment of initial interview paperwork and through the in-person interview (n = 12). Other popular assessment procedures included the combination of in person interview and another formal assessment, solely an in-person interview (n = 5 for both). The  $\chi^2 = 7.814$  (df = 3, p = .0293), indicating that there was significant difference between the frequency of assessment methods used.

Table 5 Illicit Drug Use

Describe your assessment procedures for illicit drug use.			Expected	Residual
a. I do not assess	0	0.00%		
b. Included in initial paperwork	0	0.00%		
c. In person interview	6	25.00%	6.0	.0
d. Inventory separate from initial paperwork	0	0.00%	6.0	6.0
e. B and C	<b>12</b>	<b>50.00%</b>		
f. C and D	5	20.83%	6.0	-1.0
g. B and D	0	0.00%		
h. B C and D	1	4.17%	6.0	-5.0
i. None of the above	0	0.00%		
<b>Total</b>	<b>24</b>			

Of the 24 participants, half reported they used both assessment items in the initial interview paperwork and through the in-person interview. The other assessment methods used were a combination of in person interview and another formal assessment (n = 5), and solely an in-person interview (n = 6). The  $\chi^2 = 10.333$  (df = 3, p = .016), indicating that the combined assessment procedure of both including it in the initial paperwork as well as assessing in an in-person interview was significantly more frequent than the other assessment procedures.

Table 6 Prescription Drugs

Describe your assessment procedures for prescription drug use.			Expected	Residual
a. I do not assess	0	0.00%		
b. Included in initial paperwork	2	8.33%	4.8	-2.8
c. In person interview	6	25.00%	4.8	1.2
d. Inventory separate from initial paperwork	0	0.00%		
e. B and C	<b>11</b>	<b>45.83%</b>	4.8	6.2
f. C and D	4	16.67%	4.8	-.8
g. B and D	0	0.00%		
h. B C and D	1	4.17%	4.8	-3.8
i. None of the above	0	0.00%		
<b>Total</b>	<b>24</b>			

Of the 24 participants, nearly half (11) reported they used both assessment items in the initial interview paperwork and through the in-person interview. The other assessment methods used were a combination of in person interview and another formal assessment (n = 4), and solely an in-person interview (n = 6). The  $\chi^2 = 12.083$  (df = 4, p = .011), indicating again that the combined assessment procedure of both including it in the initial paperwork as well as assessing in an in-person interview was significantly more frequent than the other assessment procedures.

Table 7 Gambling Behavior

Describe your assessment procedures for gambling behavior.			Expected	Residual
a. I do not assess	4	16.67%	4.8	-.8
b. Included in initial paperwork	4	16.67%	4.8	-.8
c. In person interview	<b>8</b>	<b>33.33%</b>	4.8	3.2
d. Inventory separate from initial paperwork	0	0.00%		
e. B and C	4	16.67%	4.8	-.8
f. C and D	4	16.67%	4.8	-.8
g. B and D	0	0.00%		
h. B C and D	0	0.00%		
i. None of the above	0	0.00%		
<b>Total</b>	<b>24</b>			

For gambling, the most consensus was again around the combined assessment of initial interview paperwork and through the in-person interview (n = 8). Other popular assessment procedures included the combination of in person interview and another formal assessment, solely an in-person interview, solely included in the initial paperwork. Four participants noted that they do not assess for this. The  $\chi^2 = 2.667$  (df = 4, p = .615), indicating that there was no significant difference between the frequency of assessment methods used.

Table 8 Shopping Behavior

Describe your assessment procedures for shopping behavior.			Expected	Residual
a. I do not assess	8	33.33%	4.8	3.2
b. Included in initial paperwork	1	4.17%	4.8	-3.8
c. In person interview	<b>9</b>	<b>37.50%</b>	4.8	4.2
d. Inventory separate from initial paperwork	0	0.00%		
e. B and C	3	12.50%	4.8	-1.8
f. C and D	3	12.50%	4.8	-1.8
g. B and D	0	0.00%		
h. B C and D	0	0.00%		
i. None of the above	0	0.00%		
<b>Total</b>	<b>24</b>			

For shopping behavior the most consensus was around in person interview only (n = 9). The next consensus was around not assessing for shopping behavior (n = 8). Three participants noted reported using a combination of included in initial paperwork and in person interview. Three participants also noted using a combination of in person interview and an inventory separate from initial paperwork. The  $\chi^2 = 10.167$  (df = 4, p = .038) indicating that the assessment procedure of in person in person interview was significantly more frequent than the other assessment procedures.



Table 9 Sex Behavior

Describe your assessment procedures for sex behavior.			Expected	Residual
a. I do not assess	1	4.55%	4.4	-3.4
b. Included in initial paperwork	1	4.55%	4.4	-3.4
c. In person interview	<b>12</b>	<b>54.55%</b>	4.4	7.6
d. Inventory separate from initial paperwork	0	0.00%		
e. B and C	5	22.73%	4.4	.6
f. C and D	3	13.64%	4.4	-1.4
g. B and D	0	0.00%		
h. B C and D	0	0.00%		
i. None of the above	0	0.00%		
<b>Total</b>	<b>22</b>			

Of the 22 participants that responded to this survey item, over half (n = 12) reported using an in person interview to assess for sex behavior. Five participants reported using the combined methods of included in initial paperwork and in person interview. Three participants reported using an in person interview and an inventory separate from initial paperwork to assess for sex behavior. One participant reported only using included in initial paperwork to as an assessment method and one participant noted that they do not assess for sex behavior. The  $\chi^2 = 18.909$  (df = 4, p = .001) indicating the assessment method of in person interview was significantly more frequent than the other methods of assessment.

Table 10 Pornography Use

Describe your assessment procedures for pornography use.		Expected	Residual
a. I do not assess	5 20.83%	4.0	1.0
b. Included in initial paperwork	1 4.17%	4.0	-3.0
c. In person interview	<b>12 50.00%</b>	4.0	8.0
d. Inventory separate from initial paperwork	0 0.00%		
e. B and C	3 12.50%	4.0	-1.0
f. C and D	2 8.33%	4.0	-2.0
g. B and D	0 0.00%		
h. B C and D	0 0.00%		
i. None of the above	1 4.17%	4.0	-3.0
<b>Total</b>	<b>24</b>		

Of the 24 participants half (n = 12) reported using an in person interview to assess for pornography use. The next consensus (n = 5) was around not assessing for pornography use. Three participants reported using the combined method of included in initial paperwork and in person interview. Two participants reported using the combined method of in person interview and an inventory separate from initial paperwork to assess for pornography use. One participant noted that they do not use any of the listed assessment procedures. The  $\chi^2 = 22.000$  (df = 5, p = .001) indicates the assessment method of in person interview was significantly more frequent than the other assessment procedures.

Table 11 Food Behavior

Describe your assessment procedures for food behavior.			Expected	Residual
a. I do not assess	5	20.83%	6.0	-1.0
b. Included in initial paperwork	0	0.00%		
c. In person interview	<b>13</b>	<b>54.17%</b>	6.0	7.0
d. Inventory separate from initial paperwork	0	0.00%		
e. B and C	4	16.67%	6.0	-2.0
f. C and D	2	8.33%	6.0	-4.0
g. B and D	0	0.00%		
h. B C and D	0	0.00%		
i. None of the above	0	0.00%		
<b>Total</b>	<b>24</b>			

Over half (n = 13) of the participants reported using an in person interview to assess for food behavior. Other popular assessment methods included not assessing for food behavior (n = 5), the combined method of included in initial paperwork and in person interview (n = 4), and the combined method of in person interview and inventory separate from initial paperwork (n = 2). The  $\chi^2 = 11.6667$  (df = 3, p = .009) indicates in person interview was significantly more frequent than the other assessment procedures.

Table 12 Internet Use

Describe your assessment procedures for internet use.			Expected	Residual
a. I do not assess	8	33.33%	6.0	2.0
b. Included in initial paperwork	0	0.00%		
c. In person interview	<b>13</b>	<b>54.17%</b>	6.0	7.0
d. Inventory separate from initial paperwork	0	0.00%		
e. B and C	1	4.17%	6.0	-5.0
f. C and D	2	8.33%	6.0	-4.0
g. B and D	0	0.00%		
h. B C and D	0	0.00%		
i. None of the above	0	0.00%		

Again, over half (n =13) of the participants reported using an in person interview to assess for Internet use. The next consensus (n = 8) was around not assessing for Internet use. Two participants reported using the combined assessment method of in person interview and inventory separate from initial paperwork. One participant reported using the combined assessment method of included in initial paperwork and in person interview. The  $\chi^2 = 15.667$  (df = 3, p = .001) indicates the in person interview was significantly more frequent than the other assessment methods for Internet use.

While the data suggests that there were differences among the groups, the findings are tentative because of the small sample size. For example, the minimum expected cell frequency for illicit drug was 6.0. That type of addiction had zero cells with expected frequencies less than five. For prescription drug use, gambling behavior and shopping behavior the minimum expected cell frequencies were 4.8. Five cells (100%) in each of these types of addictions had expected frequencies of less than 5.0. The minimum expected cell frequency for shopping behavior was 4.4. Five (100%) of the cells have expected frequencies that were less than five.

## CHAPTER 5

### DISCUSSION

#### Discussion of Results

The results of this study show that participants reported routinely using formal and informal methods to assess their clients for addictions therefore not supporting the first hypothesis or the second hypothesis. For substance-related addictions (alcohol use, illicit drug use, and prescription drug use) the majority of therapists reported assessing in their initial paperwork in combination with an in person interview. For process-related addictions (gambling, sex, pornography, shopping, internet use and food behavior) the majority of therapists reported assessing in an in person interview only. The second most frequently utilized method of assessment was a combination of an inventory separate from initial paperwork and in person interview. Between two and five therapists reported using this method of assessment for each type of addiction. Two therapists reported using a combination of initial paperwork, inventory and in person interview to assess for alcohol use and one therapist reported using that combination of methods to assess for prescription drug use.

The data suggests therapists are less likely to assess for process addictions, (gambling, shopping, food, sex, pornography, and internet use) with the exception of sex, behavior than substance related addictions. For example, eight of the participants reported they do not assess for shopping behaviors or Internet use. Five therapists reported they do not assess for food behavior or pornography use. Four therapists reported they do not assess for gambling behavior and one reported not assessing for sex behavior. None of the twenty-four participants indicated they do not assess for alcohol

use, prescription drug use, or illicit drug use. Further, most participants reported only assessing for process addictions during an in person interview and several reported not assessing for process addictions at all. Participants were least likely to assess for shopping behavior and internet use followed by food behavior and pornography use, then gambling.

The majority of participants reported using formal and informal methods of assessment for substance use related addictions and endorsed assessing for such addictions in the initial paperwork as well as an in person interview. The DSM IV-TR does not include these types of addiction in the section on dependence and abuse (American Psychiatric Association [DSM-IV-TR], 2000). Since the DSM IV-TR often guides treatment and treatment planning this frames process addiction outside of what typically comes to mind when speaking of addiction. There are currently no clear-cut diagnoses available for problem gambling, pornography addiction, sex addiction, food addiction, shopping addictions, or internet addiction. Phillips (2005) provided the following critiques of the DSM-IV TR diagnostic criteria for problem gambling: “They lack specificity, are not associated with a severity scale, no specifiers define the evolution of the problem, only one criterion deals with financial consequences, no specifications regarding the intensity, frequency, and duration of certain behaviors exist” (p.35). However, this may change in the future. One of the proposed changes for the DSM-5 is to include process addictions under the addictions category. So far, problem gambling is the only entry under process addictions (American Psychiatric Association, 2010). The current lack of attention to process addictions in the DSM IV-TR could be a contributing factor to the lower likelihood of therapists to formally and routinely assess for process

addictions. In addition, third party payers are unlikely to recognize and provide payment for treatment of process addictions (1996). This could be another contributing factor for the lack of attention to process related addictions.

Out of the six process addictions listed, therapists were most likely to assess for sex behavior by means of an in person interview. Due to the nature of the survey, context of the assessment was not accounted for. I would assume therapists who reported initiating assessment of sex behavior were not assessing within the context of addictions. Rather, I would think they were assessing for sexual satisfaction, frequency and desire as it relates to marital or couple relationships. In addition, despite the instruction to respond regarding assessment the therapist initiated without cue from the client, I assume that most therapists include assessment questions related to process addictions in the in person interview due to some sort of indication of a problem from the client.

### Limitations

This study has several factors to suggest the results may not generalize to the general population of MFTs. Primarily; the study has a very small sample size of 24. Participants were recruited through professional associations and then self-selected to complete the survey. The small sample of the population is due to the difficulties I experienced while attempting to obtain email addresses to distribute the survey. Some professional organizations were not willing to provide a list of member email addresses. Other organizations were willing to provide physical addresses for members for a fee but offered no assistance for distributing a web-based survey. Another organization offered to distribute the survey link to its members, however, there is little guarantee that the associations that were selected, followed through with emails to members. Furthermore,

some organizations failed to respond to requests for access to member contact information all together.

As a result of these difficulties, the recruitment method was altered. I then used the Therapist Locator service available on the AAMFT website. This method was a far more successful way to obtain contact information of AAMFT therapists. Many therapists, however, do not list actual email addresses on the site, rather they utilize a contact form that goes through a third party service to receive contacts from Therapist Locator. Therefore, there is no way to know if the therapists utilizing this type of contact actually received the survey link at all. In addition, during the recruitment and distribution phase, I received an email from an attorney associated with AAMFT stating soliciting research was an unacceptable use of the Therapist Locator service and requested that I cease distribution of the survey immediately (R. Smith, personal communication, August 9, 2010). These factors further limited access to the population.

In addition to the general difficulties in attempting to distribute the survey, there were factors that contributed to the limitations at the state level as well. For instance, there are 600+ MFTs in the State of Nevada, but only 210 were registered AAMFT members. This cut down the potential participant pool and many of the 210 registered members did not provide any contact information. The Nevada MFT listserv was shut down approximately two weeks prior to the distribution of the survey further limiting access to the population. Therefore, there was no way to really access the population.

While attempting to conduct this study I experienced a lack of willingness from professional organizations to participate or assist in the process and even resistance to the distribution of the survey. This is problematic for the field of Marriage and Family



therapy in that it does not perpetuate participation in research and at times hinders research in our growing field.

On the surface it appears there was a general resistance to participating in research. However it is possible that the resistance was to the topic of study. Therapists may have been reluctant to participate in a study that could have shown that MFTs are not conducting thorough assessments. In addition, the topic of addictions may not be valued in the professional organizations or by therapists. Another possibility is that MFTs do not feel that the topic of addictions is relevant to their practice because they perceive that they are not treating client who are experiencing addictions.

The following factors could affect the ability of the results of this study to generalize to the general population as well. Affiliation with professional organizations may predispose participants to be more involved with research, more apt to participate in research, and/or have more exposure to current issues surrounding addictions. In addition, MFTs who elected to complete the survey may already have an interest or awareness of addictions treatment, increasing their likelihood of completing the survey. Therapists who are routinely assessing for addiction may have an increased likelihood of completing the survey whereas those who are not assessing for addiction may have been more likely to drop out of the survey or elect not to complete it at all. Furthermore, MFTs who may have an affiliation with the University of Nevada, Las Vegas may be alumni of the Marriage and Family Therapy program, more likely to participate in student research from the University of Nevada, Las Vegas and may have received similar training and clinical experiences.

### Clinical Implications

Due to the limited number of responses it is not possible to determine if the results of this study are reflective of the general population. MFTs, however, must continue to seek training and education surrounding the assessment and treatment of addictions, as it is likely that they will encounter clients affected by addictions.

In the current economic state, programs in universities across the country are facing budget cuts and are being forced to eliminate classes. Unfortunately, best practices courses and substance abuse courses in marriage and family therapy programs are often among the first to go because they are not required as a part of COAMFTE accreditation. This means new therapists entering into the workforce may have even less training in the areas of addiction as well as less knowledge of effective and efficacious treatment modalities for addictions treatment with couples and families. The lack of training in these areas further places the responsibility of substance abuse assessment and treatment training on individual therapists and community agencies.

The economy may be affecting the number of therapists who are joining professional organizations as well. Some therapists may be able to belong to multiple professional organizations. However, in the current economic climate they may be choosing to only belong to the organization they identify most closely with rather than paying membership dues to several organizations. Therapists may also be electing not to join any professional organizations in order to avoid membership dues all together.

In addition, the resistance to research experienced during this project poses implications for clinicians. Based on my experiences in conducting this study it appears that professional organizations are somewhat unwilling to assist in the research process

and therapists are unwilling to participate in research regarding their practices. These barriers made it extremely difficult to conduct this study and next to impossible to access clinicians to collect data. The field of marriage and therapy would benefit greatly if the barriers to conducting sound research were reduced in order to foster an environment that encourages therapists to conduct their own research as well as participate in research of fellow therapists.

As a growing field marriage and family therapy needs to be contributing to research in mental health. A lack of current research limits MFTs' awareness of contemporary issues and innovative treatments in the field, thus forcing MFTs to rely on research conducted outside of the field. While research in psychology, counseling, social work and other related disciplines has a great deal of value, it often does not consider the unique issues of relational therapy.

#### Future Directions

The results of this study suggest therapists who elected to participate in the study are using both formal and informal assessment methods. Due to the limitations of this study more research must be conducted to determine the ability to generalize the results to MFTs throughout the United States. Replication of this study with more successful recruitment methods would be likely to yield different results than the present study.

As addiction rates increase it is imperative for MFTs to be aware of the best practices and effective methods for addiction assessment procedures in order to provide appropriate treatment for clients experiencing addictions. Continued research on addiction assessment procedures, co-occurring disorders, and comorbid substance abuse and dependence within marriage and family therapy would benefit the field.

## APPENDIX 1

### INVITATION TO PARTICPATE

Dear [Mr./Ms. Name]

I am a graduate student in the University of Nevada, Las Vegas Marriage and Family Therapy Department. I am conducting student research as part of my thesis. I would like to extend an invitation for you to complete a brief survey about some of your clinical work. Your responses are confidential and anonymous. The survey can be completed at your earliest convenience from any computer with Internet access. Please follow this link: <http://addictionassessmentsurvey.questionpro.com> to complete the survey.

I understand how valuable your time is and greatly appreciate your contribution to research in marriage and family therapy.

Sincerely,

Emi Olmeztoprak  
Marriage and Family Therapy Graduate Student  
University of Nevada, Las Vegas  
emi.olmeztoprak@cox.net  
702-580-7266

APPENDIX 2  
SURVEY INSTRUMENT

1. Describe your assessment procedures for alcohol use.
  - a. I do not assess
  - b. Included in initial paperwork
  - c. In person interview
  - d. Inventory separate from initial paperwork
  - e. B and C
  - f. C and D
  - g. B and D
  - h. B C and D
  - i. None of the above
  
2. Describe your assessment procedures for illicit drug use.
  - a. I do not assess
  - b. Included in initial paperwork
  - c. In person interview
  - d. Inventory separate from initial paperwork
  - e. B and C
  - f. C and D
  - g. B and D
  - h. B C and D
  - i. None of the above
  
3. Describe your assessment procedures for prescription drugs use.
  - a. I do not assess
  - b. Included in initial paperwork
  - c. In person interview
  - d. Inventory separate from initial paperwork
  - e. B and C
  - f. C and D
  - g. B and D
  - h. B C and D
  - i. None of the above
  
4. Describe your assessment procedures for gambling behavior.
  - a. I do not assess
  - b. Included in initial paperwork
  - c. In person interview
  - d. Inventory separate from initial paperwork
  - e. B and C
  - f. C and D
  - g. B and D

- h. B C and D
  - i. None of the above
5. Describe your assessment procedures for shopping behavior.
- a. I do not assess
  - b. Included in initial paperwork
  - c. In person interview
  - d. Inventory separate from initial paperwork
  - e. B and C
  - f. C and D
  - g. B and D
  - h. B C and D
  - i. None of the above
6. Describe your assessment procedures for sex behavior.
- a. I do not assess
  - b. Included in initial paperwork
  - c. In person interview
  - d. Inventory separate from initial paperwork
  - e. B and C
  - f. C and D
  - g. B and D
  - h. B C and D
  - i. None of the above
7. Describe your assessment procedures for pornography use.
- a. I do not assess
  - b. Included in initial paperwork
  - c. In person interview
  - d. Inventory separate from initial paperwork
  - e. B and C
  - f. C and D
  - g. B and D
  - h. B C and D
  - i. None of the above
8. Describe your assessment procedures for food behavior.
- a. I do not assess
  - b. Included in initial paperwork
  - c. In person interview
  - d. Inventory separate from initial paperwork
  - e. B and C
  - f. C and D
  - g. B and D
  - h. B C and D
  - i. None of the above

9. Describe your assessment procedures for internet use.

- a. I do not assess
- b. Included in initial paperwork
- c. In person interview
- d. Inventory separate from initial paperwork
- e. B and C
- f. C and D
- g. B and D
- h. B C and D
- i. None of the above

10. What degree do you have? Check all that apply.

- Master: Marriage and Family Therapy
- Master: Counseling
- Master: Counseling Psychology
- Master: Social Work
- Master: Other \_\_\_\_\_
- Doctoral: PhD Psychology
- Doctoral: PsyD Psychology
- Doctoral: Marriage and Family Therapy
- Doctoral: Other \_\_\_\_\_

11. How long have you been practicing as a licensed marriage and family therapist?

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12. What was your age on your last birthday?

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13. What is your average weekly caseload, in number of clients?

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14. With what types of client population(s) would you say you work?

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15. What type of practice do you work in?

- a. Private Practice
- b. Within a private clinic
- c. Within a government agency

- d. Within a non-profit agency
- e. Within a college setting
- f. Within a school setting (grades K-12)
- g. Other: \_\_\_\_\_

16. How long have you been practicing in Nevada, in number of years?

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17. In the last calendar year, how many addiction related CEU's did you receive?

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