

THE DEVELOPMENT OF CORE COMPETENCIES FOR THE PRACTICE OF MARRIAGE AND FAMILY THERAPY

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In response to a series of national policy reports regarding what has been termed the “quality chasm” in health and mental health care in the United States, in January 2003, the American Association for Marriage and Family Therapy convened a task force to develop core competencies (CC) for the practice of marriage and family therapy (MFT). The task force also was responding to a call for outcome-based education and for the need to answer questions about what marriage and family therapists do. Development of the CC moves the field of MFT into a leading-edge position in mental health. This article describes the development of the CC, outcomes of the development process for the competencies, and recommendations for their continued development and implementation.

Over the last decade and a half, a number of national task forces have issued a series of critical reports, reform recommendations, and policy statements regarding what has been termed the “quality chasm” in health and mental health care in the United States (e.g., Committee on Quality of Health Care in America, 2001; Pew Health Professions Commission, 1993; President’s New Freedom Commission on Mental Health, 2003; U.S. Department of Health and Human Services, 1999). This chasm is defined as the gap between the treatment patients deserve and the care that they actually receive (Committee on Quality of Health Care in America, 2001, p. 1). The many factors that contribute to this gap include disconnections between the best available scientific clinical evidence and the models and protocols applied by healthcare and mental health professions (Committee on Quality of Health Care in America, 2001; U.S.

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Department of Health and Human Services, 1999); between the efficacy of clinical protocols and the health and mental health disparities in outcomes across cultural, racial, and ethnic lines (Smedley, Stith, & Nelson, 2003; U.S. Department of Health and Human Services, 2001); and between the knowledge found in health and mental health professions' education programs today and the skills new physicians and therapists need tomorrow to improve quality of care (Hoge et al., 2005; Pew Health Professions Commission, 1993; President's New Freedom Commission on Mental Health, 2003).

To address this chasm, the Committee on Quality of Health Care in America (2001) articulated that delivery systems must be designed to provide "safe, effective, patient-centered, timely, efficient, and equitable" care (pp. 7-8) that serves the needs of patients, including their needs for participation, and care that is respectful of their values. These systems must also use scientific knowledge and assist clinicians in developing the resources they need to provide consistent and safe evidence-based care.

A major challenge in accomplishing these goals is bringing about change in health and behavioral healthcare educational systems so that the new workforce is prepared to practice a system of care that is safe, effective, patient-centered, timely, efficient, and equitable. To this end, the Committee on Quality of Health Care in America (2001) recommended a multidisciplinary summit meeting of leaders within the health professions to develop strategies for restructuring clinical education and assessing implications of educational changes for credentialing organizations, funding, and educational programs.

In the mental health arena, a multidisciplinary group that took up this charge was the Annapolis Coalition on Behavioral Health Workforce Education (Annapolis Coalition), which launched a major initiative on behavioral health workforce competencies to help prepare students with the knowledge base and clinical decision-making skills they will need if the quality chasm is to be closed (Hoge et al., 2005). The final report (Annapolis Coalition, 2006a) outlined seven core strategic goals plus objectives and action steps for reaching those goals. Goal 4 specifically addresses issues of education and training (increase the relevance, effectiveness, and accessibility of training and education; Annapolis Coalition, 2006b). Within this goal are seven objectives, including the development of core and focused competencies for mental health professionals, implementation of competency-based curricula, adoption of evidence-based training methods, the use of technology to increase the effectiveness and access to training, launching a national initiative to ensure that all behavioral health professionals develop competencies in diagnosing and treating substance abuse and co-occurring disorders, educating prospective students about best practices in training, and identifying and implementing strategies to "support and sustain newly acquired skills in practice settings" (Annapolis Coalition, 2006b, p. 6).

OUTCOME-BASED EDUCATION AND CORE COMPETENCIES

An important element in this discussion is the recent paradigm shift from input-oriented education to outcome-based education (OBE). This shift aims to close the gap between the current focus in educational programs on the courses, hours of training, and other activities that have been assumed to produce competently trained individuals on the one hand, and the knowledge and skills that those individuals actually obtain and can demonstrate on the other hand (cf. Hoge, Huey, & O'Connell, 2003). This shift to OBE in mental health fields parallels changes in higher education in general that have been taking hold in the United States since the early 1970s.

The knowledge and skills of a particular profession constitute the *core competencies* (CC) of that profession and are the primary targeted outcomes of OBE. As defined by Marrelli, Hoge, and Tondora (2004), a core competency is a "measurable human capacity that is required for effective performance" (p. 4). Marrelli and colleagues suggested that clients and the public in general will be best served when professionals can demonstrate abilities and skills

rather than completion of training courses, supervised experiences, and the successful passing of national professional examinations. Although it may seem obvious, assumptions that certain kinds of educational and experience requirements produce competence may be misguided. OBE seeks to turn those assumptions upside down and focus on knowledge and skill-based outcomes, helping trainees translate their coursework and supervised experiences into skills and competencies.

Critics of OBE raise several concerns. First, Manno (1995a, 1995b) suggested that the outcomes and related behavioral objectives are often vaguely worded, making it difficult to accomplish, measure, and evaluate the outcomes. Second, Manno suggested that outcomes typically and logically are delineated by communities of interest. Therefore, the outcomes may be more influenced by the values and perspectives of those communities than by the skills necessary for competent practice as determined by the recipients of the skills. For example, marriage and family therapy (MFT) values systemic practice and careful attention to the complexities of group dynamics. This value may obscure required abilities to recognize other influences on client families' presenting problems and therapists' ability to attend to them.

Third, Solway (1999) suggested that OBE limits teachers' creative abilities and talents by focusing their attention on outcomes rather than on processes. A logical extension of this argument suggests that outcome-focused education may prevent educators from attending to important and unique needs of students. For example, many are aware of potentially negative consequences such as teachers' "teaching to the test" rather than assisting students' development of critical thinking skills.

A final concern is the need for tools to assess outcomes and competencies. It is relatively easy for educators to measure students' accomplishments through test grades and essay assignments. However, in some fields, including MFT, many of the required skills are vague and not easily articulated or measured. Traits and skills such as personality characteristics, values, beliefs, attitudes, and motivations are not easily taught or objectively assessed. However, traits and skills such as theoretical knowledge, social skills, and techniques are more easily taught.

Core competencies for marriage and family therapists (MFTs) are defined in this article as "a collection of the basic or minimum skills that each practitioner should possess in order to provide safe and effective care" (Graves, 2005, p. 15). In forming the list of CC for MFTs, the AAMFT was aware that MFT training is a developmental process and that the definition of "competent" could range from "novice therapist-in-training" to "master therapist." The AAMFT determined that the CC would be defined for those who are eligible to enter independent practice (eligible for state licensure), which often occurs about 2 years after graduation. Currently, this point in the career of an MFT is evaluated chiefly by a supervisor's subjective observation and determination and by passing a comprehensive examination covering knowledge related to the field. The result, of course, is that different supervisors have employed different standards of competence, yielding uneven quality in licensure candidates.

Medical fields have been working toward standards of competence for some time. Medicine has worked to establish CC for all physicians and for different specializations within medicine (Institute of Medicine, 2003). Curricula are designed around outcomes, and training techniques are customized for each specialization (Graves, 2005). In mental health, efforts to establish CC have been less focused. Rather than developing core or general competencies, the American Psychological Association and the National Association of Social Workers have developed competencies for a few specialty areas such as drug treatment, working with couples and families, and working with clients from diverse cultural backgrounds (e.g., Dittmann, 2003; Kaslow, 2002).

Maki (2004) pointed out that learning is a "multidimensional process of making meaning" rather than simply one of "ingesting information" (p. 1). It is reasonable to assume, then, that

students and trainees will learn in different ways from each other and in different ways for themselves, depending upon what is to be learned. By extension, it is clear that educators will need to develop multiple methods for helping MFTs to learn the skills and knowledge required for competent practice. Herein lies both the challenge and the blessing: Until we have valid and reliable tools for assessing competence, we must rely on traditional methods of both teaching and assessing. Developing a list of CC for MFTs is a first step in a recursive process that will eventually shape the list, inform educational processes, and determine assessment strategies.

Taking a leadership role, the AAMFT, a key member of the Annapolis Coalition, became one of the first mental health organizations to meet the challenge of preparing the next generation of behavioral healthcare professionals by developing a set of clinical competencies for marital and family therapists.

THE CHARGE

In January 2003, the AAMFT Executive Director convened a task force to develop CC for the field of MFT. The chief charge was to develop an outline and overview of domains of knowledge and skills that define the entry-level skills necessary for independent practice (licensed at the master's level) as a marriage and family therapist.

The final product was to be relevant to accreditation bodies, educators, trainers, and regulators. It was expected that a model would define knowledge domains and skill levels as well as define characteristics that predispose one to success as a marital and family therapist. The competencies would be based on what actually occurs in clinical practice, on ecologically valid clinical research, on what is known about evidence-based family therapies, and on the emerging trends in family therapy and broader behavioral health theory. Attention would also be paid to the interface between MFT and the broader behavioral health delivery system, including the bridge between pharmaceutical and biological and/or genetic issues, and the knowledge and skills MFTs need in relation to these domains. This article describes the process of developing the list of competencies, outcomes of the process, and recommendations for use and further development of the list.

TASK FORCE MEMBERSHIP

In January 2003, a steering committee for the CC task force was appointed by the AAMFT Executive Director. The members of the steering committee included the authors of this article. The primary inclusion criteria for members included published or presented work on the topics of training, supervision, and education in MFT. Two members (Alexander and Johnson) were selected because of their expertise and experience with evidence-based models of therapy, which require specific skills sets of clinicians. Three were chosen because of their experience as trainers and supervisors in accredited programs (Nelson, Chenail, and Crane); one of these also had experience with investigations of skills sets (Nelson). Finally, one member (Schwallie) was chosen for her experience with regulatory processes. It was hoped that this diversity of experience would result in a thorough and comprehensive list of competencies.

William Northey from the AAMFT staff was assigned to facilitate the work of the task force. In addition to the steering committee, 50 MFTs who were experienced in training, supervising, and educating MFTs were invited to join the task force (see Table 1 for a complete list of task force members). These clinicians represented diverse perspectives and were actively engaged in the training of MFTs. All of the task force members were contacted by e-mail, provided with an explanation of the project, and given a copy of the Executive Director's charge.

Table 1
AAMFT Core Competencies Task Force Members; Beta Test Group Members

Steering committee	Task force	Task force (cont.)	AAMFT staff	Beta test group
Alexander, James	Almeida, Rhea	McCollum, Eric E.	Northey, William F.	Alliant International University (MA, PsyD)
Chenail, Ronald	Anderson, Stephen A.	McDaniel, Susan H.	Bowers, Michael	Christian Theological Seminary (MA)
Crane, D. Russell	Bacigalupo, Gonzalo	Mead, D. Eugene	Gautney, Karen	St. Mary's University (PhD)
Johnson-Douglas, Susan	Bean, Roy	Miller, John	Bergman, David	Saybrook Graduate School (MA)
Nelson, Thorana S.	Becvar, Dorothy S.	Nazario, Andres		Southern Connecticut State University (MS)
Schwallie, Linda	Briggs, Kathleen	Prest, Layne A.		University of Akron (PhD)
	Carr, Alan	Rambo, Anne H.		University of Oregon (MEd)
	Carter, Cindy	Sells, Scott P.		Utah State University (MS)
	Cornille, Thomas A.	Sexton, Thomas L.		
	Gale, Jerry	Smith Lamson, Angela		
	Gehart, Diane R.	Smith, Thomas A.		
	Haddock, Shelly	Sprenkle, Douglas H.		
	Harkness Hodgson, Jennifer	Stewart, Kenneth L.		
	Heimke, Karen B.	Szapocznik, Jose		
	Hirschhorn, Debby Schwarz	Todahl, Jeffrey		
	Huff, Barbara	Verset, James		
	Johnson, Carl	Vetere, Arlene		
	Johnson, Lee	Wampler, Karen		
	Ketring, Scott	Wampler, Richard		
	Landau, Judith	Watson, Marlene F.		
	Leahy, Maureen	Wetchler, Joseph L.		
	Lebow, Jay	White, Mark		
	Lee, Robert E.	Williams, Lee		
	Marsh, Diane	Woodside, Blake		
		Zarski, John J.		

COMPETENCY DEVELOPMENT

The development of the CC began with several brainstorming conference calls between Northey and the steering committee. Northey had assembled pertinent resources to guide the steering committee, including information from the Association of Marital and Family Therapy Regulatory Boards (AMFTRB) Candidate Handbook (Association of Marital and Family Therapy Regulatory Boards, 2002), the Center for Substance Abuse Treatment (1998), and the CC for psychiatry (Scheiber, Kramer, & Adamowski, 2003). Other documents reviewed included (a) California MFT Regulatory Board Validation Reports and Task Analyses; (b) an MFT National Examination preparation course; (c) The American Board of Psychiatry and Neurology Core Competencies; (d) Association of Psychology Postdoctoral and Internship Centers (2002) Workgroup on Competencies; and (e) Regulatory Bodies for Professional Psychologists in Canada (2001; see Appendix A for complete list of resources). Nelson also provided information to the steering committee from the Basic Family Therapy Skills project (e.g., Figley & Nelson, 1989) and the Basic Skills Evaluation Device (BSED; Nelson & Johnson, 1999). During steering committee discussions, the format and structure of competencies were determined. Specifically, six domains and five subdomains were identified. The six primary domains are Admission to Treatment; Clinical Assessment and Diagnosis; Treatment Planning and Case Management; Therapeutic Interventions; Legal Issues, Ethics, and Standards; and Research and Program Evaluation. The subdomains identified for each domain are Conceptual Skills, Perceptual Skills, Executive Skills, Evaluative Skills, and Professional Skills (Nelson and Johnson, 1999).

The first four primary domains reflect the developmental trajectory by which clients enter a therapeutic system. The latter two domains capture the importance of ethical and legal issues in the practice of MFT as well as the value that research and evaluation play in the delivery of effective services. Each domain was 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.

The subdomains were included to more effectively organize the presentation of the competencies. These subdomains are an amalgamation of previous work that has been proposed to help MFT educators and supervisors. Tomm and Wright (1979) articulated a theoretical typology for the education of therapists that included conceptual, perceptual, and executive skills. Cleghorn and Levin (1973) proposed a similar model. A list of skills in these areas was derived from the work of Figley and Nelson (1989). The additional subdomains, skills, and an evaluative device were developed by Nelson and Johnson (1999). The subdomains were defined 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.

After reviewing the documents and deciding on a format for the competencies, members of the steering committee each independently wrote as many items as they could think of in each domain and subdomain. This assignment resulted in a list of 273 items. As expected, many of the items overlapped. Many committee members addressed skills at multiple levels and/or multiple domains. The items were deconstructed and skills were revised and placed into subdomains of the highest level of complexity. For example, item 3.3.9 (“Assist clients in obtaining needed care while navigating complex systems of care”) requires that therapists know what systems of care are, how to access them in their own communities, etc.—skills that require conceptual and/or perceptual skills as well as executive or evaluative skills. Thus, conceptual skills were considered the least complex and executive and evaluative the most complex. Items were placed in only one subdomain, even when they could conceivably fit into more than one. This step also helped clarify the items and reduce redundancies. The resulting list consisted of 126 items.

Feedback Process

In July 2003, the competencies were copyedited and then sent to members of the task force for review. Feedback ranged from minor editing suggestions to major revisions and additional items. Some of the feedback was philosophical in nature and some of the additions were considered more complex or advanced than would be deemed a *core competency*, one appropriate for a newly independent practitioner. The resulting modification of the competencies resulted in a total of 133 competencies (Draft B).

Draft B was made available to the general membership of the AAMFT and was the basis for a series of workshops at the 2003 AAMFT Annual Conference in Long Beach, California. Requests for feedback were sent to the total membership of the AAMFT through announcements at the Long Beach Conference, in the June/July issue of *Family Therapy Magazine*, and on the AAMFT members’ homepage of the AAMFT Web site. Members who had provided e-mail addresses and members of existing AAMFT discussion lists (e.g., supervisors, program faculty, supervisors, and site visitors) were invited to view the competencies and offer feedback through e-mail.

Approximately 75 AAMFT members responded to the request for feedback and offered numerous suggestions, most of which were similar to those provided by the task force. Much of the feedback was positive in nature (e.g., one person wrote, “Overall, the core competencies are very thorough and seem very comprehensive. The committee obviously put a lot of thought into them”), and also ranged from general suggestions (e.g., “Include more on cultural competence” or “The language is very modernist”) to very specific (e.g., “Add ‘larger system’ to the competency on who should attend therapy”). Some of the feedback was generated by groups of faculty or students who had been given the competencies by their faculty to review as part of a class project.

Based on the feedback, the CC were once again modified. New items could not be redundant with existing items and had to be judged as a minimal and core competency rather than an advanced skill. New items were placed in the appropriate subdomain of greatest complexity.

Some items were revised for content or clarity. Some items were judged advanced rather than minimal and were deleted. This revision resulted in a list of 140 items (Draft C).

Draft C was sent for feedback to the California Association for Marriage and Family Therapists (CAMFT), the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), the AMFTRB, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Center for Mental Health Services (CMHS), all of the major behavioral health associations (e.g., APA, NASW, the American Counseling Association, American Psychiatric Association, National Alliance for the Mentally Ill, NAADAC [The Association for Addiction Professionals], National Mental Health Association, National Association of State Mental Health Program Directors, National Association of State Alcohol/Drug Abuse Directors, Children and Adults with Attention-Deficit/Hyperactivity Disorder [CHADD], Clinical Social Work Federation, the American Managed Behavioral Healthcare Association, the California Board of Behavioral Health, and the Director of the California Department of Mental Health and other potentially interested stakeholders [see Appendix B for complete list of stakeholders]). The majority of these stakeholders did not provide specific feedback on the CC. One organization, the American Academy of Child and Adolescent Psychiatry, requested that it be allowed to provide the competencies to other groups in its organization. The CMHS suggested that we include competencies on recovery and risk as well as protective factors that impact behavioral health. A letter of support for the project was received from the American Managed Behavioral Healthcare Association, which did not suggest modifications but pledged support for the project, stating that the competencies reflected the skills and training preferred by behavioral healthcare companies.

Feedback from these groups was incorporated into Draft D, which contained 139 CC. Concomitantly, to ensure that the competencies encapsulated the essential issues in the current behavioral health system, they were systematically evaluated relative to the extant MFT and behavioral health reports. Specifically, they were compared to the AMFTRB Practice Domains (AMFTRB, 2002), the Committee on Quality of Health Care in America's (2001) *Crossing the Quality Chasm* aims for improving healthcare delivery, the Surgeon General's report on mental health (U.S. Department of Health and Human Services, 1999), the PNFC goals for improving the behavioral health system (President's New Freedom Commission on Mental Health, 2003), and SAMHSA's Priorities (Substance Abuse and Mental Health Services Administration, 2005).

Educators' Summit

An Educators' Summit (ES) was held July 15–18, 2004, in Reno, Nevada, where a group of more than 130 educators, policy makers, regulators, and other interested stakeholders met to consider the implications of the CC and to explore what it would mean for the field to move to an outcome-based educational and training system. Participants also discussed their perceptions of the competencies and the impact of an outcome-based orientation on licensing and certifying of MFTs. The summit featured a series of presentations by Peggy Maki, a Senior Scholar at the American Association for Higher Education and formerly its Director of Assessment, on outcome-based training and how to effectively assess outcomes (cf. Maki, 2004).

Maki previously had provided training to the COAMFTE. When asked to consult with the ES, she provided a copy of her not-yet-published book (2004) on assessing, which served as a guide for planning the ES. Feedback about Maki's helpfulness was significant. She informed participants about changes in higher education that pointed toward student-based learning and the need for organizations such as AAMFT to provide guidance in the form of CC. She also led the group through a vision of the process required to develop lists of competencies, develop assessment tools, revise lists, and help administrations embrace the concepts of OBE and student learning assessment. Finally, through exercises, she helped the group become more comfortable with the concept of competencies and the already-developed list.

Before the ES, participants were asked to go to the AAMFT Web site to code the competencies in terms of when they thought each competency should be taught, supervised, and assessed

in graduate MFT programs and/or postprogram completion experiences. Once at the ES, participants again reviewed and discussed the competencies, both within breakout groups and with the entire assembly in terms of (a) whether or not the competency was currently taught or supervised in their programs, (b) if the competency was taught/supervised, whether or not it was explicitly assessed, and (c) if the competency was taught/supervised and/or assessed, what tools were used in these processes.

As might have been expected, the ES participants converged on some ideas and diverged on others. It was affirmed that most of the CC skills were being learned by students in some fashion, but many disagreed about how the skills were being taught. It also became clear that participants were frustrated about the developmental trajectory for trainees' working with the CC. Some believed that the complete set of competencies could be mastered only after several years of experience and that expecting programs to teach them to the mastery level was unreasonable. Others believed that many competencies could reasonably be obtained in a typical graduate degree program.

Educator participants agreed that most of the skills were being addressed in some manner in their programs, although not to the level of mastery. Other skills were not as clearly addressed, and the wording of some skills was sufficiently confusing that participants suggested clarifications.

Participants decided to spend time assessing the manner of student learning for the competencies and did not address whether or how they were assessed. Conceptual skills were determined to be learned mostly in didactic courses through readings, lectures, and classroom or homework assignments. These skills were most easily assessed through observations of discussions, homework essays, course examinations, and theory-of-change projects. The participants did not reach agreement about where and how perceptual or executive skills were learned, primarily because of overlapping ideas about *experience* and *supervision*. That is, many thought that some skills could be learned only by experience (i.e., *doing*) and others thought that supervision was necessary (i.e., *instruction by supervisors*). However, other participants thought that supervision meant *experience guided by a supervisor*. Therefore, it was decided to pursue these ideas through other means at a later date.

The combination of ES exercises and presentations helped the participants provide feedback to the steering committee as to what might be missing from the competencies, what competencies might be combined, and what competencies might be eliminated. Most of the negative feedback from ES participants was oral and was not provided in writing after the meeting despite an invitation. Negative feedback seemed to come from the fact that, for many of the participants, this was the first time they had examined the CC carefully or in groups. Also, most of the initial concerns centered around this new way of thinking about objectives for MFT education (what students learn rather than what they are exposed to or required to do), and around uncertainty about expectations regarding the competencies. That is, participants wanted to know whether AAMFT was going to require graduate programs to teach all of the competencies at a master's degree level. Some were concerned about how the competencies would be incorporated into COAMFTE standards and how the competencies would be assessed.

Participants were reassured that (a) the steering committee believed that most of the competencies were already addressed in programs and would not require an entirely new design for graduate education, (b) the CC most likely would be incorporated into COAMFTE accreditation standards in some fashion, but the steering committee would not be dictating how that would occur, and (c) programs themselves would help develop the tools for assessing the competencies because it was believed that programs were already doing this, but not necessarily in a systematic or formal fashion. After this assurance, feedback took the form of suggestions for additional items, rewording of some items, and deleting some items. Positive feedback included appreciation to AAMFT for initiating and supporting the endeavor.

After the Summit, some participants began to think more clearly about how the competencies would be applied in their programs, leading to further valuable feedback. Participants

provided more than 100 suggestions for changes, ranging from editorial to a complete revision and restructuring of the list. All suggestions were considered using criteria similar to those used to evaluate feedback from the task force and the AAMFT membership. The result was a list of 128 items (Draft E, Appendix C). Much of the feedback focused on the need for clarity of meaning and the important role of cultural competence. Because these issues cut across the breadth of the competencies, the steering committee decided to incorporate them in concept through a revision to the preamble:

Although not expressly written for each competency, the stem “Marriage and family therapists...” should begin each. Additionally, the term “client” is used broadly and refers to the therapeutic system of the client/s served, which includes but is not limited to individuals, couples, families, and others with a vested interest in helping clients change. Similarly, the term “family” is used generically to refer to all people identified by clients as part of their “family system,” which includes fictive kin and relationships of choice. Finally, the core competencies encompass behaviors, skills, attitudes, and policies that promote awareness, acceptance, and respect for differences, enhance services that meet the needs of diverse populations, and promote resiliency and recovery. (Core Competencies, preamble)

The event also opened up conversations for the next steps of the CC project: researching the relationships between the competencies and therapist effectiveness, national and state MFT requirements and examinations, and COAMFTE Standards of Accreditation.

Core Competencies Relative to General Mental Health Skill

After finalizing the list, the steering committee examined each item regarding its relative position with regard to mental health skills in general. Each item was examined and rated as to whether it seemed to be a skill that fits mental health professionals in general, a skill that is unique to MFT, or a skill that is general to mental health but has a value added to it by MFTs. Ninety-nine percent of the items were agreed upon by a majority of the five raters. That is, all five agreed on the “mapping” of 75 of the items and four agreed on 41 items, for a total of 116 items agreed upon by at least four members of the group. Although this was an interesting and potentially useful way of looking at the competencies, a more systematic analysis may be necessary in the future to validate the findings of this relatively small group.

FURTHER DEVELOPMENT

During the ES, Maki stated that most groups take 10 years to implement CC and that it likely would take that long for the MFT CC. She qualified her statement by suggesting that there would be groups of “early adopters,” programs that, on their own, would use the competencies immediately and more quickly adopt them into their programs.

Given that the CC had yet to be implemented and “tested” in the real world, the AAMFT decided to support implementation by early adopters by creating a Beta Test Group (BTG). The BTG is made up of eight MFT training programs that are using the CC in their curricula (Table 1). Members of the BTG were provided with resources (e.g., meetings, opportunities to share curricula and assessment instruments, consultation) to implement the CC. Results of these meetings and consultations resulted in revisions of an instrument for supervision of master’s level graduate students (Beta Test Group, 2005; originally conceived by faculty at St. Mary’s University in San Antonio, TX); the development of a “Rubrics Cube” for mapping the competencies in terms of domains, subdomains, and items; a Web site for programs to use for exchanging ideas and tools in conjunction with the revised COAMFTE Standards (11.0); and plans for future research. In addition, the BTG began to get a sense for teaching the

competencies by mapping them against their existing program practices for when and how each competency was introduced to students (e.g., coursework, practicum, particular projects).

It is clear that there is much work yet to be done. The current draft of the competencies needs to be tested in programs and then revised with specific attention to the perspective of students in advanced training. It is probable that most programs already are teaching and training students toward the competencies. It is not clear, however, how supervisors of postgraduate trainees will view, use, and evaluate the CC and revise their practices based on their evaluations. Graves (2005) surveyed AAMFT-Approved Supervisors on their perspectives of the competencies, competencies which they thought were critical for trainees to have upon graduation and at what skill level, and how well they thought programs were preparing graduates toward those needed skills. Results suggest that supervisors clearly see good preparation for many of the competencies and a lack of preparation for others. In general, supervisors thought that graduates were not as well prepared as they would like them to be. Resolving these differences will require more understanding about what already is happening in graduate programs and postgraduate training, and more discussion among programs and advanced-training supervisors.

Programs and postgraduate supervisors, together with trainees, also will need to learn more about how each competency can best be learned. It is likely that many existing methods will be promoted and that new and varied methods will be developed. Given a perspective of OBE that focuses on student learning and outcomes rather than training-driven inputs, we need to pay more attention to individuals' learning styles and to develop methods that best match those styles.

Finally, methods need to be developed for assessing outcomes. The supervision instrument that is emerging from the BTG (Beta Test Group, 2005) is one potentially helpful tool, and some supervisors are already using it. Other instruments need to be developed to assist supervisors in assessing therapist competency at the more advanced level of the CC. The first author is beginning work on a broader instrument, similar to the BSED (Nelson & Johnson, 1999), that may be sufficiently flexible for both MFT graduate programs and for advanced training.

OTHER IMPLICATIONS

Policy

Work and time will help us determine how the CC can be implemented in graduate programs, advanced training, and regulatory activities (legislation and licensure). The competencies already are included in the latest revision of the COAMFTE Standards for Accreditation, Version 11.0 (Commission on Accreditation for Marriage and Family Therapy Education, 2005). In keeping with OBE principles, the revised standards have incorporated a paradigm shift from input-based to output-based education. Standards are more flexible in how they are used to educate students; programs may use the CC as one of the tools for implementing the standards and assessing outcomes. A new structure and items will help programs to systematically evaluate what they do and how they utilize institutional resources. Programs will be better able to assess where and how they teach different competencies or areas of competence, to evaluate the effectiveness of their practices toward student achievement, and to reduce resources in some areas while increasing them in others.

Graves (2005) made suggestions for how the competencies can be used in advanced training, including having trainees assess themselves for areas of accomplishment and areas needing work. Supervisors can use these assessments to systematically guide them in how they train to meet individuals' specific needs against a known standard.

The CC may be used by AAMFT, divisions of AAMFT, and other entities to demonstrate to third-party payers and other interested parties (e.g., government agencies) what MFTs are trained to do. Those who have worked with such entities know well the myths and questions that are asked about MFT, MFTs, and what we do. The CC may help develop and promote the field by providing better definitions of the scope and practice of MFTs' skills.

Practice

Perhaps the greatest initial boon the CC provides is the specificity with which the list gives guidance to training programs and supervisors of advanced trainees. Programs that have used the list (e.g., feedback from participants at the ES in 2004, BTG participants) report that although the list is somewhat daunting at first, both students and faculty appreciate its concreteness, which helps them know current levels of accomplishment and areas that need more training. Graves (2005) found that supervisors of advanced trainees also appreciated having a better tool for assessing trainees' skills and what work was needed before they would be ready for licensure. In time, tools will be developed to help programs and supervisors know how and at which stages of training the competencies are best introduced, learned, and evaluated.

Research

It is possible that in time the CC will assist research in many areas. Programs and those interested in advanced training will have a list and outcome measures for studying many aspects of MFT training, including program development, education and training methods, and assessment. Researchers will be interested in developing operational definitions of the competencies. These definitions will aid in studying what occurs in therapy that enhances therapeutic outcome for clients. We have some general and broad notions of common factors of effective MFT treatment (e.g., Blow & Sprenkle, 2001; Sprenkle & Blow, 2004; Sprenkle, Blow, & Dickey, 1999); however, the CC provide a level of specificity that allows for more clearly operationalizing and thus understanding what occurs in therapy that is helpful. Finally, researchers may be more able to address issues relevant to regulatory agencies, government policy and funding agencies, third-party payers, and others who are interested in mental health issues. These research activities, along with feedback from educators and supervisors, may illuminate what is missing in both MFT education and training and in MFT practice. That is, by knowing more about what educators *do*, we may be assisted in understanding better what we do *not* do or what we do not do well.

LIMITATIONS

This project is not without limitations, both in development and implementation. The initial list and revisions were developed by a certain group of steering committee members. Although efforts were made to ensure a diversity of thought and perspective relative to MFT practice, training, and context, the group was what it was (cf. Manno, 1995a, 1995b). The task force was more diverse in perspective and ethnicity than was the steering committee. Feedback about cultural competence was seriously considered and incorporated into several competencies, although not as a specific, singular competency. However, the competencies were clearly developed from a particular philosophical perspective (systems thinking), which was limiting.

The initial format and structure for the CC is not the only possible format for conceptualizing them. Other formats may have been more useful or user-friendly and resulted in a smaller number of items or a better way of thinking about them. This format provided room for specificity as well as conceptual areas (domains) and levels of activity (subdomains), but is not very helpful for conceptualizing developmental levels of training. That is, although the list may be helpful for understanding and assessing MFT skill at the time of licensure, it may not be as helpful for guiding training up to that point; there may be a sequencing of skill learning that would be important to understand and incorporate into training. If this is the case, perhaps others will develop complementary ways of conceptualizing the CC or MFT competency.

The paradigm shift to OBE is not easily accomplished. Although some are able to easily perceive how the competencies are affected by this shift and how they will help bring about the shift in MFT education, it is possible that the level of specificity will reduce flexibility and result in programs' teaching to the competencies rather than using their own creativity and judgment about what students need to learn. Although the CC were developed through a rigorous process that

included many opportunities for feedback from many categories of stakeholders, we do not know what may be missing. Also, the CC were developed with a global picture of MFT practice in mind and may not be useful in local contexts, either for training or for practice. It would be a problem if the CC were used to narrow, rather than expand, the vision of MFT and its uses.

In terms of their use in regulatory arenas, the CC are a good idea but may not work well within the challenges of legislation and licensing. States and provinces have a wide diversity of form and function and little agreement about what MFT is, what MFTs do, how MFT and MFTs should or could be regulated, and how the public can best be protected in the context of MFT. Regulatory boards are varied in terms of composition, laws and rules are unique from state to state and province, changes are slow to make, and processes are usually very political. Although we hope that the CC will help with regulation and thus ensure both public protection and competent therapy, it is probable that unintended consequences will occur. For example, whenever any list is developed, questions are raised about what is not in the list and why it is not there. The specificity of the CC could be used to limit MFT practice. At present, it is not known how regulatory boards in the United States and Canada might use the competencies as part of a package of methods for evaluating basic competence for licensure, certification, or independent practice.

CONCLUSION

This article addressed the need for the field of MFT to focus on the gap between care that clients deserve and the care they actually receive. In order for MFT education and training to keep pace with current practices, which are rapidly outpacing us in terms of OBE, it is critical that MFT develop and implement clear skills that demonstrate MFTs' competency. Although licensing laws and the AAMFT clinical membership guidelines require educational and supervised experiences with individuals, couples, and families and require passing an examination (for those in licensed states), none of these requirements assesses actual competency, skill, or effectiveness at doing therapy. The development of the CC was intended to assist the field in determining what family therapists do, how skilled they are, how these skills may assist in leading to positive outcomes for clients in therapy, and how we can better understand the work that lies ahead. Although it is likely that the list of competencies will change over time, the current list is a rigorously developed foundation upon which the field can build. Educators, trainers, and researchers can use this list in endeavors toward improving family therapy education and practice and learning more about what therapists do that is most helpful to their clients.

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APPENDIX A

Documents Reviewed for Competency Development

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- Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* (Center for Substance Abuse Treatment, 1998)
- American Board of Psychiatry and Neurology (Scheiber et al., 2003)
- Association of Marital and Family Therapy Regulatory Boards Candidate Handbook (<http://www.amftrb.org>)
- Association of Psychology Postdoctoral and Internship Centers (2002) Workgroup on Competencies
- Behavioral Health Workforce Education Report from the Annapolis Coalition for Behavioral Health Workforce Education presented to the President's New Freedom Commission on Mental Health (Hoge & Morris, 2003)
- California Marriage and Family Therapy Regulatory Board Validation Reports and Task Analyses (Ferral, 2002)
- The Capable Practitioner*, a report commissioned by The National Service Framework Workforce Action Team of Great Britain (Lindley et al., 2001)
- Coaching Competencies from the International Federation of Coaches (IFC, 2003)
- Council on Linkages Competencies Project (CLCP, 2003)
- The Eight Counselor Skill Groups by the NADAAC Certification Commission (NADAAC, n.d.)
- The Institute of Medicine's *Crossing the Quality Chasm* (IIM, 2001)
- Marriage and Family Therapy National Examination Preparation Courses (Gagliardi et al., 2001)
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Mental Health: A Report of the Surgeon General (U.S. Department of Health and Human Services, 1999)

The Multisystemic Therapy Process Scale (Schoenwald et al., 2000)

The President's New Freedom Commission on Mental Health's *Achieving the Promise: Transforming Mental Health Care in America*

Regulatory Bodies for Professional Psychologists in Canada (2001)

Substance Abuse and Mental Health Services Administration (SAMHSA, 2005)

APPENDIX B

Stakeholders Sent Copies of the Core Competencies for Review

American Counseling Association

American Managed Behavioral Healthcare Association

American Psychiatric Association

American Psychological Association

Annapolis Coalition on Behavioral Health Workforce Education

Association for Marital and Family Therapy Regulatory Boards

California Association for Marriage and Family Therapists (CAMFT)

California Board of Behavioral Health

California Department of Mental Health

Center for Mental Health Services (CMHS)

CHADD (Children and Adults with Attention-Deficit/Hyperactivity Disorder)

Clinical Social Work Federation

Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE)

NAADAC, The Association for Addiction Professionals

NAMI

National Association of Social Workers

National Association of State Alcohol/Drug Abuse Directors

National Association of State Mental Health Program Directors

National Mental Health Association

Substance Abuse and Mental Health Services Administration (SAMHSA)

APPENDIX C

AAMFT Core Competencies, Draft E, May 2004

Number	Subdomain	Competence
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Domain 1: Admission to Treatment

1.1.1	Conceptual	Understand systems concepts, theories, and techniques that are foundational to the practice of marriage and family therapy
1.1.2	Conceptual	Understand theories and techniques of individual, marital, couple, family, and group psychotherapy

1.1.3	Conceptual	Understand the behavioral healthcare delivery system, its impact on the services provided, and the barriers and disparities in the system
1.1.4	Conceptual	Understand the risks and benefits of individual, marital, couple, family, and group psychotherapy
1.2.1	Perceptual	Recognize contextual and systemic dynamics (e.g., gender, age, socioeconomic status, culture/race/ethnicity, sexual orientation, spirituality, religion, larger systems, social context)
1.2.2	Perceptual	Consider health status, mental status, other therapy, and other systems involved in the clients' lives (e.g., courts, social services)
1.2.3	Perceptual	Recognize issues that might suggest referral for specialized evaluation, assessment, or care
1.3.1	Executive	Gather and review intake information, giving balanced attention to individual, family, community, cultural, and contextual factors
1.3.2	Executive	Determine who should attend therapy and in what configuration (e.g., individual, couple, family, extrafamilial resources)
1.3.3	Executive	Facilitate therapeutic involvement of all necessary participants in treatment
1.3.4	Executive	Explain practice setting rules, fees, rights, and responsibilities of each party, including privacy, confidentiality policies, and duty to care to client or legal guardian
1.3.5	Executive	Obtain consent to treatment from all responsible persons
1.3.6	Executive	Establish and maintain appropriate and productive therapeutic alliances with the clients
1.3.7	Executive	Solicit and use client feedback throughout the therapeutic process
1.3.8	Executive	Develop and maintain collaborative working relationships with referral resources, other practitioners involved in the clients' care, and payers
1.3.9	Executive	Manage session interactions with individuals, couples, families, and groups
1.4.1	Evaluative	Evaluate case for appropriateness for treatment within professional scope of practice and competence
1.5.1	Professional	Understand the legal requirements and limitations for working with vulnerable populations (e.g., minors)
1.5.2	Professional	Complete case documentation in a timely manner and in accordance with relevant laws and policies
1.5.3	Professional	Develop, establish, and maintain policies for fees, payment, record keeping, and confidentiality

Domain 2: Clinical Assessment and Diagnosis

2.1.1	Conceptual	Understand principles of human development; human sexuality; gender development; psychopathology; psychopharmacology; couple processes; and family development and processes (e.g., family, relational, and system dynamics)
2.1.2	Conceptual	Understand the major behavioral health disorders, including the epidemiology, etiology, phenomenology, effective treatments, course, and prognosis

2.1.3	Conceptual	Understand the clinical needs and implications of persons with comorbid disorders (e.g., substance abuse and mental health; heart disease and depression)
2.1.4	Conceptual	Comprehend individual, marital, couple, and family assessment instruments appropriate to presenting problem, practice setting, and cultural context
2.1.5	Conceptual	Understand the current models for assessment and diagnosis of mental health disorders, substance use disorders, and relational functioning
2.1.6	Conceptual	Understand the strengths and limitations of the models of assessment and diagnosis, especially as they relate to different cultural, economic, and ethnic groups
2.1.7	Conceptual	Understand the concepts of reliability and validity, their relationship to assessment instruments, and how they influence therapeutic decision making
2.2.1	Perceptual	Assess each client's engagement in the change process
2.2.2	Perceptual	Systematically integrate client reports, observations of client behaviors, client relationship patterns, reports from other professionals, results from testing procedures, and interactions with client to guide the assessment process
2.2.3	Perceptual	Develop hypotheses regarding relationship patterns, their bearing on the presenting problem, and the influence of extratherapeutic factors on client systems
2.2.4	Perceptual	Consider the influence of treatment on extratherapeutic relationships
2.2.5	Perceptual	Consider physical/organic problems that can cause or exacerbate emotional/interpersonal symptoms
2.3.1	Executive	Diagnose and assess client behavioral and relational health problems systemically and contextually
2.3.2	Executive	Provide assessments and deliver developmentally appropriate services to clients, such as children, adolescents, elders, and persons with special needs
2.3.3	Executive	Apply effective and systemic interviewing techniques and strategies
2.3.4	Executive	Administer and interpret results of assessment instruments
2.3.5	Executive	Screen and develop adequate safety plans for substance abuse, child and elder maltreatment, domestic violence, physical violence, suicide potential, and dangerousness to self and others
2.3.6	Executive	Assess family history and dynamics using a genogram or other assessment instruments
2.3.7	Executive	Elicit a relevant and accurate biopsychosocial history to understand the context of the clients' problems
2.3.8	Executive	Identify clients' strengths, resilience, and resources
2.3.9	Executive	Elucidate presenting problem from the perspective of each member of the therapeutic system
2.4.1	Evaluative	Evaluate assessment methods for relevance to clients' needs
2.4.2	Evaluative	Assess ability to view issues and therapeutic processes systemically
2.4.3	Evaluative	Evaluate the accuracy and cultural relevance of behavioral health and relational diagnoses

2.4.4	Evaluative	Assess the therapist-client agreement of therapeutic goals and diagnosis
2.5.1	Professional	Utilize consultation and supervision effectively
<i>Domain 3: Treatment Planning and Case Management</i>		
3.1.1	Conceptual	Know which models, modalities, and/or techniques are most effective for presenting problems
3.1.2	Conceptual	Understand the liabilities incurred when billing third parties, the codes necessary for reimbursement, and how to use them correctly
3.1.3	Conceptual	Understand the effects that psychotropic and other medications have on clients and the treatment process
3.1.4	Conceptual	Understand recovery-oriented behavioral health services (e.g., self-help groups, 12-step programs, peer-to-peer services, supported employment)
3.2.1	Perceptual	Integrate client feedback, assessment, contextual information, and diagnosis with treatment goals and plan
3.3.1	Executive	Develop, with client input, measurable outcomes, treatment goals, treatment plans, and aftercare plans for clients utilizing a systemic perspective
3.3.2	Executive	Prioritize treatment goals
3.3.3	Executive	Develop a clear plan of how sessions will be conducted
3.3.4	Executive	Structure treatment to meet clients' needs and to facilitate systemic change
3.3.5	Executive	Manage progression of therapy toward treatment goals
3.3.6	Executive	Manage risks, crises, and emergencies
3.3.7	Executive	Work collaboratively with other stakeholders, including family members, other significant persons, and professionals not present
3.3.8	Executive	Assist clients in obtaining needed care while navigating complex systems of care
3.3.9	Executive	Develop termination and aftercare plans
3.4.1	Evaluative	Evaluate progress of sessions toward treatment goals
3.4.2	Evaluative	Recognize when treatment goals and plan require modification
3.4.3	Evaluative	Evaluate level of risks, management of risks, crises, and emergencies
3.4.4	Evaluative	Assess session process for compliance with policies and procedures of practice setting
3.4.5	Evaluative	Monitor personal reactions to clients and treatment process, especially in terms of therapeutic behavior, relationship with clients, process for explaining procedures, and outcomes
3.5.1	Professional	Advocate with clients in obtaining quality care, appropriate resources, and services in their community
3.5.2	Professional	Participate in case-related forensic and legal processes
3.5.3	Professional	Write plans and complete other case documentation in accordance with practice-setting policies, professional standards, and state/provincial laws
3.5.4	Professional	Utilize time management skills in therapy sessions and other professional meetings

Domain 4: Therapeutic Interventions

4.1.1	Conceptual	Comprehend a variety of individual and systemic therapeutic models and their application, including evidence-based therapies and culturally sensitive approaches
4.1.2	Conceptual	Recognize strengths, limitations, and contraindications of specific therapy models, including the risk of harm associated with models that incorporate assumptions of family dysfunction, pathogenesis, or cultural deficit
4.2.1	Perceptual	Recognize how different techniques may impact the treatment process
4.2.2	Perceptual	Distinguish differences between content and process issues, their role in therapy, and their potential impact on therapeutic outcomes
4.3.1	Executive	Match treatment modalities and techniques to clients' needs, goals, and values
4.3.2	Executive	Deliver interventions in a way that is sensitive to special needs of clients (e.g., gender, age, socioeconomic status, culture/race/ethnicity, sexual orientation, disability, personal history, larger systems issues of the client)
4.3.3	Executive	Reframe problems and recursive interaction patterns
4.3.4	Executive	Generate relational questions and reflexive comments in the therapy room
4.3.5	Executive	Engage each family member in the treatment process as appropriate
4.3.6	Executive	Facilitate clients' developing and integrating solutions to problems
4.3.7	Executive	Defuse intense and chaotic situations to enhance the safety of all participants
4.3.8	Executive	Empower clients and their relational systems to establish effective relationships with each other and larger systems
4.3.9	Executive	Provide psychoeducation to families whose members have serious mental illness or other disorders
4.3.10	Executive	Modify interventions that are not working to better fit treatment goals
4.3.11	Executive	Move to constructive termination when treatment goals have been accomplished
4.3.12	Executive	Integrate supervisor/team communications into treatment
4.4.1	Evaluative	Evaluate interventions for consistency, congruency with model of therapy and theory of change, cultural and contextual relevance, and goals of the treatment plan
4.4.2	Evaluative	Evaluate ability to deliver interventions effectively
4.4.3	Evaluative	Evaluate treatment outcomes as treatment progresses
4.4.4	Evaluative	Evaluate clients' reactions or responses to interventions
4.4.5	Evaluative	Evaluate clients' outcomes for the need to continue, refer, or terminate therapy
4.4.6	Evaluative	Evaluate reactions to the treatment process (e.g., transference, family of origin, current stress level, current life situation, cultural context) and their impact on effective intervention and clinical outcomes
4.5.1	Professional	Respect multiple perspectives (e.g., clients, team, supervisor, practitioners from other disciplines who are involved in the case)

4.5.2	Professional	Set appropriate boundaries, manage issues of triangulation, and develop collaborative working relationships
4.5.3	Professional	Articulate rationales for interventions related to treatment goals and plan, assessment information, and systemic understanding of clients' context and dynamics
<i>Domain 5: Legal Issues, Ethics, and Standards</i>		
5.1.1	Conceptual	Know state, federal, and provincial laws and regulations that apply to the practice of marriage and family therapy
5.1.2	Conceptual	Know professional ethics and standards of practice that apply to the practice of marriage and family therapy
5.1.3	Conceptual	Know policies and procedures of the practice setting
5.1.4	Conceptual	Understand the process of making an ethical decision
5.2.1	Perceptual	Recognize situations in which ethics, laws, professional liability, and standards of practice apply
5.2.2	Perceptual	Recognize ethical dilemmas in practice setting
5.2.3	Perceptual	Recognize when a legal consultation is necessary
5.2.4	Perceptual	Recognize when clinical supervision or consultation is necessary
5.3.1	Executive	Monitor issues related to ethics, laws, regulations, and professional standards
5.3.2	Executive	Develop and assess policies, procedures, and forms for consistency with standards of practice to protect client confidentiality and to comply with relevant laws and regulations
5.3.3	Executive	Inform clients and legal guardian of limitations to confidentiality and parameters of mandatory reporting
5.3.4	Executive	Develop safety plans for clients who present with potential self-harm, suicide, abuse, or violence
5.3.5	Executive	Take appropriate action when ethical and legal dilemmas emerge
5.3.6	Executive	Report information to appropriate authorities as required by law
5.3.7	Executive	Practice within defined scope of practice and competence
5.3.8	Executive	Obtain knowledge of advances and theory regarding effective clinical practice
5.3.9	Executive	Obtain license(s) and specialty credentials
5.3.10	Executive	Implement a personal program to maintain professional competence
5.4.1	Evaluative	Evaluate activities related to ethics, legal issues, and practice standards
5.4.2	Evaluative	Monitor attitudes, personal well-being, personal issues, and personal problems to ensure they do not impact the therapy process adversely or create vulnerability for misconduct
5.5.1	Professional	Maintain client records with timely and accurate notes
5.5.2	Professional	Consult with peers and/or supervisors if personal issues, attitudes, or beliefs threaten to adversely impact clinical work
5.5.3	Professional	Pursue professional development through self-supervision, collegial consultation, professional reading, and continuing educational activities
5.5.4	Professional	Bill clients and third-party payers in accordance with professional ethics and relevant laws and policies, and seek reimbursement only for covered services

Domain 6: Research and Program Evaluation

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| 6.1.1 | Conceptual | Know the extant MFT literature, research, and evidence-based practice |
| 6.1.2 | Conceptual | Understand research and program evaluation methodologies, quantitative and qualitative, relevant to MFT and mental health services |
| 6.1.3 | Conceptual | Understand the legal, ethical, and contextual issues involved in the conduct of clinical research and program evaluation |
| 6.2.1 | Perceptual | Recognize opportunities for therapists and clients to participate in clinical research |
| 6.3.1 | Executive | Read current MFT and other professional literature |
| 6.3.2 | Executive | Use current MFT and other research to inform clinical practice |
| 6.3.3 | Executive | Critique professional research and assess the quality of research studies and program evaluation in the literature |
| 6.3.4 | Executive | Determine the effectiveness of clinical practice and techniques |
| 6.4.1 | Evaluative | Evaluate knowledge of current clinical literature and its application |
| 6.5.1 | Professional | Contribute to the development of new knowledge |
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