

CREDENTIALING OF MARRIAGE AND FAMILY THERAPISTS

BY

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## INTRODUCTION

This report evolved from the efforts of the Kansas Association for Marriage and Family Therapy (KAMFT) to advocate for enactment of legislation to credential marriage and family therapists. The purpose of this report is to examine the complex issues surrounding state regulation of marriage and family therapists, and to serve as a resource guide for marriage and family therapists in other states who are undertaking a similar process.

Persons reading this report should keep in mind that the process of enacting regulatory legislation differs from state to state not only in terms of the lawmaking mechanism but also in regards to such political/economic issues as the relationships between the various mental health professions (e.g., social workers are more likely to support credentialing of MFTs if they themselves are seeking credentialing than if they are already regulated), as well as the current legislative sentiment regarding regulation in general. Therefore, the strategy utilized in advocating for credentialing of marriage and family therapists must be tailored to the particular conditions present in each state.

## THE NEED FOR REGULATION

There are two important reasons why marriage and family therapists (and other mental health professions) seek regulatory legislation. The first involves protection of the public from incompetent/unethical practitioners. The second involves legitimization/recognition of the profession of marriage and family therapy. A critical component of the attainment of parity with other mental health professions is the ability

to compete equitably. Eligibility for third party insurance reimbursement is related to status as a state regulated profession, and affects not only the economic well-being of marriage and family therapists, but also directly relates to the degree of access that consumers have to these practitioners.

#### Protection of the Public

Marriage and family therapy is a profession that requires a substantial body of knowledge and supervised experience in order to practice competently. Practitioners must also be trained in and be accountable to the highest standards of professional ethics. In the absence of regulation of marriage and family therapists, consumers are at risk of being harmed by unethical/incompetent practitioners because of the following problems:

1. No qualifications are required in order to practice marriage and family therapy. (Anyone, regardless of qualifications, may practice.)
2. There is no way for the consumer to identify qualified practitioners - to distinguish qualified from nonqualified.
3. There is no practical means of recourse for consumers should they be mistreated.
4. There exist no practice-related consequences for practitioner misconduct. A practitioner may legally continue to practice, no matter how unethically or incompetently he/she has practiced.
5. There exists no mechanism for requiring practitioners to educate their clients regarding client rights, practitioner

qualifications, unethical practitioner behavior, or procedures for reporting misconduct.

State credentialing could address each of these problems, by establishing minimum qualifications (involving knowledge, training, and supervised experience) that are required to practice and by providing for practice-related consequences for misconduct. The state's regulatory board would also be able to mandate education for consumers by regulated therapists regarding, client rights, unethical practices, procedures for reporting therapist misconduct, and the qualifications and responsibilities of a regulated practitioner. All therapists could also be mandated to report incompetent and unethical practice by their colleagues.

#### Economic Considerations

Most insurance companies/programs will only reimburse mental health professionals who are credentialed in the state in which they practice. Regulation, therefore, affects not only the ability to compete in the mental health market place, but also is related to the access that consumers have to professionals who are specifically trained to help them with their marital and family related problems.

There is a great need for the services provided by marriage and family therapists. There is a multitude of marital/family related problems plaguing our society. Americans are getting divorced at a higher rate than ever; if present trends continue, one out of every two present marriages will end in divorce. In addition, reports of physical and sexual abuse within families are at an all time high. Research suggests that marriage and family therapy is an effective treatment for many crucial problems facing America's families--such as family violence,

substance abuse, delinquency, and other serious disorders of childhood, adolescence and adulthood (Gurman, Kniskern, & Pinsof, 1986). Such problems often require treatment by a trained mental health professional, including marriage and family therapists. When marital and family problems are left untreated, or are treated by untrained or otherwise unqualified individuals, the consequences to marriage and family life can be adverse, detrimental or even result in more severe problems and dysfunction.

It is an empirically established fact that the majority of problems for which the help of mental health professionals is sought involve problems in marital and family relationships (Gurman, 1987). Unfortunately, consumer access to trained marital and family therapists is severely limited, due to restrictions within the systems for health care delivery and payment that are tied to statutory regulation. In states where there is no statutory means for identifying qualified practitioners, most health insurance programs will not reimburse marriage and family therapists for mental health services provided. Consumers may be forced with choosing between a licensed, reimbursable mental health professional (psychiatrist, psychologist, social worker) who may not be qualified to treat such problems or pay a marriage and family therapist out of their own pocket. Many people simply may not be able to afford this latter choice. Also, many employment settings will not hire marriage and family therapists because they are not reimbursable. Therefore, consumers may not have access to a practitioner trained to treat marital/family problems. Many community mental health centers, which in some locations are the only affordable source of mental health



services to low income families, will not hire marriage and family therapists. State credentialing, by enabling insurance programs to identify qualified practitioners, is an important first step leading to reimbursement of marriage and family therapists by health insurance programs, thereby expanding access to such practitioners by consumers.

#### METHODS OF STATE REGULATION

State credentialing identifies those individuals who have met minimum standards of education and training established by the state regulatory board. There are three levels of credentialing that have been traditionally used by states to regulate professions:

1. Title certification/Registration. This level of credentialing restricts use of a title, such as "certified marriage and family therapist." Non-certified individuals are permitted to use the title "marriage and family therapist," but not "certified marriage and family therapist."
2. "Pure" Certification/Registration. A more restrictive form of title protection. Restriction of title is extended to include "marriage and family therapist" whether or not it is accompanied by "certified" or "registered."
3. Licensure. This level of credentialing restricts practice. Only licensed individuals are permitted to practice the profession.

In addition to these levels of credentialing, other statutory means of protecting the public have also been employed:

- 1). Creation or extension of statutory causes of civil action, criminal prohibitions, and injunctive remedies.

Some states (e.g., Minnesota) have laws prohibiting sexual involvement between psychotherapist and client. Minnesota has also legislated that such activity can be a cause for civil action.

- 2). Regulation of non-credentialed psychotherapists.

Minnesota, in 1987, became the first state to pass a law requiring anyone practicing psychotherapy who is not state licensed or certified to file with a newly created Board of Non-regulated Psychotherapists, and list their level of education and training, so that consumers may have access to this information. In the event of misconduct, a therapist's right to practice can be revoked. The intent of this regulatory mechanism is to tighten existing loopholes which allow unethical/incompetent practitioners to avoid accountability by practicing psychotherapy under some unregulated title.

The relative advantages and disadvantages of each of the above methods of regulation will be assessed in a later section.

#### THE FUNCTIONS OF THE PROFESSION

In order to show a need for credentialing, evidence must be produced demonstrating that there is potential for harm to the consumer that is directly attributable to the functions of the profession. Preliminary to

a discussion of harm related to the practice of marriage and family therapy is a description of the functions of the profession.

Marriage and family therapist work primarily with couples and with whole families (parents with their children) to bring about changes in the way family members relate to each other. Dysfunctional family relationships (e.g. where marriage partners always fight or where children are scapegoated) give rise not only to much felt pain and misery, but also to individual symptoms (e.g. in adults, depression and somatic complaints; in children, school difficulties and inability to mature toward adulthood). Much of the work family therapists do is guided by family systems theory. The cornerstone of the theory is that the individual, however important in his or her own right, is a part of a larger social network which powerfully influences how members think, behave, and feel, and which patterns their relationships to form a whole system. The family system, then, is viewed as a unit wherein the behavior of each member affects and is in turn affected by the behavior of all other members. Individual problems and symptoms are seen as inadvertently serving a function for the family (e.g., a child's misbehavior may be functioning to take the parents' focus away from marital conflict), though often at great cost. The family relationship system often inadvertently functions to maintain symptoms and therefore is a powerful resource in the treatment of nervous and mental disorders (Russell, et al., 1983).

What ultimately distinguishes family versus individual psychotherapy is not the number of people in the room for a therapy session. Family therapy can be done with one person or a whole group of people present

(though typically more than one person is present). There are many psychotherapists trained in individual therapy who see couples or families in their practice, yet who have little or no training in family systems theory or therapy. What does differentiate family psychotherapy from individual psychotherapy is the application of what Kerr (1981) calls "systems thinking" to therapeutic practice.

Systems thinking means that individual behavior must be viewed within its context, i.e. the behavior is examined in terms of what happens before and after the behavior, in relation to which other people, in proximity to what other events, at what point in the family life cycle, as being similar and/or different to other nuclear or extended family relationships, and in terms of what function it may be serving for the family as a whole.

The family as a system may promote growth and well being, or conversely engender conflict and illness. Marriage and family therapists seek to help families to make constructive changes in the family system to produce better communications more effective problem-solving techniques, and to maximize the potential for growth and alleviate dysfunctional symptoms.

The viewpoint noted above is implemented by marriage and family therapists through specific helping procedures. Most therapy takes place in an office setting with routines similar to those practiced by psychiatrists, psychologists, social workers, and professional counselors. Clients typically present themselves for help when there is a marriage difficulty or a problem with a child. Usually, the couple or the whole nuclear family is seen together, and sometimes grandparents and

other relatives are asked to come. If individuals are seen, therapy is conducted from a systems perspective, i.e., the individual's problems are seen in relation to his/her familial and extra-familial context. Ordinarily the frequency of appointments is weekly or biweekly.

The KAMFT Application for Credentialing (1987) describes four general functions in the practice of marriage and family therapy: assessment, treatment, referral, and follow up. These are described below:

1. ASSESSMENT occurs on both an individual and family level. Assessment includes specification of the family's definition of the problem, the family's current patterns of interaction around the presenting problem, as well as family strengths and resources for addressing the problem. Assessment usually results in an understanding of how the problem is maintained or supported by the present family organization. Family members will be referred to physicians and/or psychologist for assessment of individual problems--e.g., hormonal imbalances, learning disabilities, inc.
2. TREATMENT involves psychotherapy (i.e., treatment of nervous, emotional, and mental disorders) based on principles of family systems theory and practice. It is characterized by involving family members in a variety of interactional tasks designed to restructure lines of authority, communication and access to one another. Typically treatment alters the family's flexibility (helping it to become either more flexible or more structured)

and/or shifts levels of connectedness within the various subsystems of the family.

As in any of the helping professions, marital and family therapists differ in theoretical orientation and in techniques employed. What most marriage and family therapies have in common are the following:

JOINING TECHNIQUES: Finding ways to get close enough to the couple or to the family to understand from the inside what is happening. Most therapists believe that rapport with the family is essential for effective intervention.

INTERVIEWING TECHNIQUES: The basic tool of all therapies is conversation with family members intended to elicit information about the nature of the family problem, the means used by the family to solve the problem, the role assigned to each family member, the rules governing behavior and thinking, family history, and so on. Individuals may be interviewed one at a time, or in a more random order depending on the strategy of the session. Great skill and sensitivity to family operations are needed, for instance, to make sure that all family members have a say and that certain ones are not left out or put down. Co-therapy (i.e., the use of more than one therapist in a therapy case and/or session)

is sometimes needed in working with complicated family processes.

ENACTMENT OR PRACTICE TECHNIQUES: Many therapists create opportunities for family members to work directly with each other to try new means of communication or new ways of dealing with problems. Such techniques require flexibility on the part of the therapist to facilitate client interaction and to challenge the dysfunctional aspects of family organization.

TASKS: Couples and families are encouraged to undertake prescribed tasks at home as part of the therapy. Such tasks may be straightforward and simple or indirect and more complicated. Skill is needed to devise tasks that fit the family and the goals of the treatment process.

3. REFERRAL: Marriage and family therapists are trained to refer the client to other professionals (e.g., psychiatrists, psychologists, social workers, professional counselors) when facing the following situations:
  - a) If there is difficulty or lack of clarity in client diagnosis, marriage and family therapists are trained to enlist the aid of other professionals to create a differential diagnosis in order to obtain a complete view of the clients within their context.

- b) If, during the course of therapy, the marriage and family therapist suspects or concludes that the clients' nervous and mental disorders contain significant components of pathology which are beyond the scope of the therapists expertise.
  - c) If, during the course of therapy, the clients' nervous and mental disorders are primarily within the province of the marriage and family therapist, but the clients' condition would be helped by supplementary assistance of other professionals.
4. FOLLOW UP. Couples or families are given the opportunity to return for follow up visits as needed, or are invited at specific intervals to return for a check up. Follow up procedures range anywhere from one session to occasional visits for a period of years. Research suggests that the effectiveness of this therapy does not seem to depend on the duration of treatment (Gurman and Kniskern, 1978; Gurman et al., 1986). Dramatic results are sometimes achieved in a matter of a few sessions, whereas in other cases it takes much longer to achieve improvement. Family approaches are effective because change in one member of the family can be responded to by other members and worked through with the therapist present. (pp. 9-11)

The paragraphs above have described the therapy function of the marriage and family therapy profession. In addition to this primary



therapy function, the KAMFT Application for Credentialing (1987) describes other functions which are an integral part of the profession:

EDUCATION. Educating students for the profession through formalized instructional programs is a major focus for some marriage and family therapists, especially in state university settings and in free-standing mental health institutions. Marriage and family therapy educators divide their time between directing programs, supervising students, and providing classroom instruction. Public education through workshops and seminars is a typical outgrowth of this educational function. Some therapists specialize in marriage or family enrichment programs, in workshops for divorced parents and their children, and in single parent families.

RESEARCH. Research is primarily done at the teaching and training centers around the state to arrive at increased knowledge of family and marital therapy practice, and to improve the quality of the profession.

OUTREACH. Many marriage and family therapists devote considerable time to court consultations (e.g., custody suits), community service (e.g., consultation with various human service organizations), and prevention (e.g., parent education groups). In these ways the special insights and experience of those practicing marriage and family therapy can be shared with others who have direct dealings with families through the legal system, the schools, the churches, and the state welfare and rehabilitation systems. (p. 12)

In summary, the practice of marriage and family therapy involves a distinct body of knowledge and skills. The consumer would benefit by being able to identify practitioners whose education includes such knowledge and skills.

#### UNREGULATED PRACTICE: THE POTENTIAL FOR HARM

To show a need for credentialing, evidence must be presented to demonstrate that the unregulated practice of marriage and family therapy poses a danger to the public. Kansas State law requires that such harm be "recognizable and not remote" and that "the evidence must be more than hypothetical examples or testimonials" (Kansas Statute 65-5003).

#### Research Evidence of Harm

Though research studies have shown psychotherapy in general and marriage and family therapy specifically to be highly effective in the treatment of mental health problems (Gurman and Kniskern, 1978b; Gurman et al., 1986), there is also evidence that some clients worsen over the course of therapy, and that some of this deterioration can be attributed to less than optimal therapist behavior. Lambert et al. (1976) defines deterioration due to therapy as a "worsening of the patient's symptomatic picture... that exceeds worsening expected from life stress, negative experience, or an ongoing process of deterioration" as well as "a lack of significant improvement when it is expected and even the acceleration of ongoing deterioration". Gurman and Kniskern (1978) point out that such a definition must be expanded when applied to marriage and family therapy, as progress and deterioration can't be evaluated solely by the status of one identified patient in isolation from the entire family context. It is not uncommon for the identified patient to show improvement, only to

see distress develop in other family members and/or relationships. Marriage and family therapists believe that any assessment of outcome must consider not only each individual but also every relationship in the family system. Deterioration as a result of either individual or marriage and family psychotherapy may involve the exacerbation of already existing symptoms or the development of new ones.

Research studies which have shown that deterioration/negative effects result from psychotherapy (both individual and marriage and family therapy) experiences include Bergin (1963, 1971), Bergin & Lambert (1978), Lambert et al. (1976), Strupp et al. (1977), Furrow (1980), Grunebaum (1985), and Gurman and Kniskern (1978). These studies suggest that less than optimal psychotherapy can precipitate deterioration in such forms as anxiety, depression, psychosis, phobias, excessive guilt, inability to trust, impaired social, occupational and familial functioning, psychosomatic disorders, withdrawal, hospitalization, divorce, lowered marital satisfaction, lowered self-esteem, criminal behavior, alcohol and drug abuse, suicide, and impaired ability to make use of subsequent therapy. These deterioration effects may represent the exacerbation of already existing symptoms or the development of new ones. Based on a comprehensive survey of over 200 marriage and family therapy studies, Gurman and Kniskern findings suggest that "approximately 5 to 10 per cent of patients or marital or family relationships worsen as the result of marital-family therapy" (p. 5), a figure which is consistent with the deterioration rates reported by the studies of individual therapy.

Therapist behavior has been causally linked with deterioration in both individual and marriage and family therapy (e.g., Strupp, 1977; Furrow, 1980; Gurman & Kniskern, 1978). Harm may be caused by either unethical behavior or incompetence on the part of the therapist (Van Hoose and Kottler, 1977).

Unethical Behavior. In any form of psychotherapy, marriage and family therapy included, the development of a healthy therapeutic relationship is considered crucial to a successful outcome. The therapist, by virtue of the trust placed in him/her by the client as well as by being perceived as an expert and authority, is in an extremely powerful position in relation to the client. Because of the disclosures made and vulnerabilities exposed to the therapist, the client is in a position of considerable risk. Any action on the part of the therapist which violates the trust placed in him/her may be harmful to the client. Therapists may take advantage of their clients through, for example, sexual involvement, excessive billing, or by inappropriately currying of favors such as free labor (Grunebaum, 1986).

The sexual exploitation of clients is perhaps the most widely publicized and one of the most harmful examples of therapist abuse. A relatively high proportion of psychotherapists have been found to engage in sexual contact with their clients. Kardener, Fuller, and Mensch (1973) found that 10% of male psychiatrists surveyed reported engaging in such contact, with 5% specifying sexual intercourse. A survey of PhD psychologists by Holroyd and Brodsky (1977) reported that 10.9% of males and 1.9% of females admitted having sexual contact with clients, with 5.5% of males and .5% of females specifying sexual intercourse. Holroyd

and Brodsky found that 80% of those who had intercourse reported doing so with more than one client. The damage to clients deriving from such activity has been well documented (Bouhoutsos et al., 1983; Bouhoutsos, 1985; Taylor and Wagner, 1976; Sonne et al., 1985). Bouhoutsos et al. found that 90% of those clients surveyed, who had been sexually involved with their therapists, sustained some type of damage including hospitalization (11%), suicide (1%), and personality negatively affected in some way (34%). Harmful effects to clients reported by the above studies include diminished ability to trust others, mistrust of one's own perception's of others, damaged self esteem, burdensome guilt and shame, exacerbation of already existing symptoms, diminished capacity for future involvement in intimate and/or sexual relationships, depression, deterioration of already troubled marriages, sexual dysfunction, estrangement from friends and family members, divorce, psychosis, suicide, hospitalization, inability to set limits in relationships with others, loss of motivation, overdependency on others, significant affective disturbance, impaired social adjustment, drug and alcohol abuse, and complication of the course of subsequent therapy.

Though unethical therapist behavior may lead to harm to the consumer in any form of psychotherapy, the very nature of marriage and family therapy suggests that ethical issues and practice associated with marriage and family therapy are much more complex than those involved with individual therapy (Morrison et al. 1982; Margolin, 1982; Hines & Hare-Mustin, 1978; Sider & Clements, 1982; Hare-Mustin, 1980). This complexity derives from the fact that the "client" in marriage and family therapy is usually more than one person. Harm to clients may occur as a

consequence of such issues as failure to realize that what is a good outcome for one family member may not be good for another family member or the family as a whole (Hare-Mustin, 1980; Sider & Clements, 1982; Morrison et al., 1982); confidentiality issues involving intra-family secrets and extra-family sharing of therapy related information (Karpel, 1980; Margolin, 1982; Hines & Hare-Mustin; Mariner, 1971; Morrison et al., 1982); revelations of child abuse (Lippett, 1985) or substance abuse (Rinella and Goldstein, 1980); privileged communication (Gumber & Sprenkle, 1981); decisions regarding when to insist on inclusion of absent family members in therapy (Hare-Mustin, 1980; Wilcoxon & Gladding, 1985); criteria for termination of therapy (Wilcoxon & Gladding, 1985); awareness of the impact of therapist values (Margolin, 1980; Morrison, 1982; Hare-Mustin, 1980; Seymour, 1982); and the issue of informed consent for each family member (Margolin, 1980; Morrison et al., 1982). Though many of these issues are similarly involved in individual therapy, the presence of more than one person in therapy introduces a complexity that calls for specialized training in marriage and family therapy.

Incompetent Practice. Issues of therapist incompetence specific to marriage and family therapy include decisions on which family members to include in therapy. In a survey of 75 outcome studies of marital-family therapy involving almost 3000 cases, Gurman & Kniskern (1978) found that the deterioration rate when only one spouse was treated in marital therapy was twice that of the cases in which both spouses were included and the success rate was approximately one third lower. As a matter of fact, the success rate when only one spouse for a marital problem was treated was less than half (48%). Gurman and Kniskern also point out

evidence that the involvement of both parents (particularly the father) in family therapy strongly enhances the chances of a favorable outcome. A well-trained family therapist will make decisions based on such knowledge, thereby maximizing the chances of success and minimizing the risk of harm.

Harm to clients may result from a lack of understanding on the part of the therapist regarding the nature of family system functioning, which in turn may lead to ill-advised intervention. For example, an understanding of the effects and function of the "identified patient's" symptoms within the family system, as well as the way in which the family interactions may inadvertently maintain the symptoms, is essential for avoiding further harm to the family. For example, alleviation of symptoms in the identified patient may be accompanied by the development of symptoms in other family members and relationships (Russell et al., 1983). Gurman & Kniskern (1978) identify several studies (Arnold et al., 1975; Jackson & Weakland, 1961; Klein et al., 1975) which "demonstrate that either the siblings or parents of identified child and adolescent patients are 'worse' at the close of treatment, at times even when the identified patient has improved" (p.11). Kohl (1962) documents pathological reactions of marital partners to improvement of spouses. Based on such evidence, Goldstein (1984) points out the importance of a systemic view of problems: "the diagnosis of the identified patient should be secondary to the diagnosis of the systemic dysfunction... based on family level diagnoses" (p. 1). Gurman & Kniskern (1978b) reviewed every study (up to that date) which compared marital and family therapy with individual or group treatment of only the identified patient. In 22

(73%) of the thirty studies, marital-family treatment was found to produce superior results, with no differences found in the other seven studies. In a comparative review of family therapy failure case studies, Coleman (1985) found that one of the treatment factors most frequently associated with failure was "overlooking the systemic nature of the problem" (p. 362). Another example of a failure to employ a systemic analysis involves the concept of differential stages of the family life cycle. Haley (1963) points out that, when a therapist overlooks the contribution to the problem related to stress deriving from a normative family life cycle event (e.g., adolescence, departure of children from the home, retirement, etc.), an intervention may lead to more harm than not intervening at all. A final example of therapist action, resulting from lack of a systemic approach, which may lead to harm, is either implicit or overt side-taking with a member or members of a family (Zuk, 1972; Morrison, 1982; Hines & Hare-Mustin, 1978; Karpel, 1980).

Gurman & Kniskern (1978), in their comprehensive review of marital and family therapy research, identified several therapist factors which seem to be related to deterioration resulting from therapy: poor relationship skills (i.e., lack of warmth and empathy); confrontation of emotionally "loaded issues too early in therapy; a failure to provide structure or utilize an active style early in therapy; and a failure to intervene in potentially dangerous intra-family conflict - the authors speculate that a more forceful style may be required of the marriage and family therapist than of the individual therapist in order to deal with in-session conflict. Hines & Hare-Mustin (1978) also support the latter point.



Coleman (1985), in her comparative review of family therapy failures, found several therapist-related factors to be frequently associated with failure (ranging from continuing or worsening of presenting problems to psychosis and suicide): insufficient goal setting, inconsistency or contradictions between theoretical framework and applied interventions, theoretical oversights or admissions (failure to consider or deal with the contribution of e.g., family trauma, power issues, or intergenerational issues which affect the present; overlooking the role of the presenting problem; failure to pay attention to issues of motivation within the family (which family members are "the customers for change"); conflictual goals; and insufficient therapist-family alliance.

Though data is limited, research evidence suggests that more positive outcomes accrue to experienced marriage and family therapists than to inexperienced therapists (Gurman & Kniskern, 1978b; Coleman, 1985). The literature strongly supports not only the importance of training for the avoidance of harm in therapy but also the contention that training in individual therapy is no substitute for training in marriage and family therapy when it comes to working with couples and families (Margolin, 1982; Coleman, 1985; Gurman & Kniskern, 1978b, 1981; Gurman, Kniskern, & Pinsof, 1986).

#### Expert Testimony Regarding Harm

Expert testimony documenting harm related to the unregulated practice of marriage and family therapy can be submitted to support the need for credentialing.

The expert testimony (Appendix A), included by the Kansas Association for Marriage and Family Therapy (KAMFT) in their application

for credentialing, was submitted by a group of nationally known authorities (from both within and outside of Kansas) which includes not only marriage and family therapists but also members of related health professions such as psychiatrists, psychologists, and social workers. The eight experts, as a collective group, have held every national office in AAMFT, have served on AAMFT Judicial, Honors, Training, and Accreditation committees, include 7 AAMFT Fellows; have published in every reputable marriage and family therapy journal; include experience on university faculties, in private practice, hospitals, family therapy training institutes, and private clinics; and among them have over 150 years of experience as therapists.

The experts submitting testimony (see Appendix A for testimony and complete resumes.) were:

The American Association for Marriage and Family Therapy,  
submitted by Mark Ginsberg, PhD, Executive Director.

Candyce S. Russell, PhD, Professor and Chair, Marriage and  
Family Therapy Unit, Kansas State University;  
National Secretary of AAMFT.

Anthony P. Jurich, PhD, Professor of Marriage and Family  
Therapy and Clinical Director of the Marriage and  
Family Therapy Clinic of the Family Center, Kansas  
State University; Chair, AAMFT Organization of  
Training Directors.

Robert Beavers, M.D., President, AAMFT; Medical/Clinical  
Director, Willow Creek Hospital for Adolescents;

Clinical professor of Psychiatry, University of Texas, Health Science Center, Dallas, TX.

Eric McCollum, MSW, PhD, Faculty member, social worker, and marriage and family therapist, The Menninger Foundation.

Alan Gurman, PhD, Professor of Psychiatry, University of Wisconsin, clinical psychologist; Editor, Journal of Marital and Family Therapy.

Fred Piercy, PhD, Professor and Director of Training and Research, Marriage and Family Therapy Training Program, Purdue University.

Ralph Earle, PhD, President-Elect, AAMFT; President, Psychological Services, Ltd.; Director, Family Institute of Arizona.

Arthur Mandelbaum, MSW, Senior Consultant and former Director, Family Therapy Training Program, The Menninger Foundation.

Each of the experts asserted that the consumer is at risk of being harmed by the untrained/unethical practitioner. Examples of harm resulting from incompetent practice cited by those testifying include inappropriate guilt, exacerbation of marital violence, unnecessary break-up of marriages, trauma resulting from sexual exploitation, suicide, worsening of organically based symptoms, escalation of adolescent acting out behavior, and hospitalization or institutionalization which could have been prevented.

The experts attribute the harm to such practices as inaccurate assessment, failure to properly apply principles of family systems theory to treatment, failure to refer clients to other mental health professionals when necessary, and unethical behavior. Each expert directly associates such practice with lack of training.

Dr. Jurich included several case examples documenting harm, of which he has personal knowledge. In accordance with KAMFT's policy of assuring the confidentiality of clients as well as respecting the alleged offending practitioner's right to due process, the case examples have been disguised and neither client nor therapist is identified. Two of these case examples follow:

1. A male client in therapy with a marriage and family therapist wanted to talk about the guilt he felt about his wife's recent death. He had previously been seeing a clinical psychologist for a nervous condition. During the course of therapy, he had mentioned to the psychologist that the thing that made him most uneasy were his wife's threats of suicide. The client explained different situations which led to such suicidal threats by his wife. The psychologist, without ever asking to see the wife or hear her point of view, told the husband that these were manipulations and would be best handled if they were ignored. The wife proceeded to commit suicide. The husband was devastated. So was the psychologist. The husband reported the psychologist's apologizing to him for not seeing the wife's view clearly. The husband subsequently, specifically sought out a marriage and family therapist because he felt that he and

his wife should have come in together for marriage therapy before it was too late. He needed to do some grief work with his marital relationship after his wife's death. A family system's perspective might have made a difference in hearing her anguish and, perhaps, in preventing her death. Perhaps this is why some research has shown that family therapy is more effective than individual therapy with suicidal clients (Jurich, 1983).

2. Several years ago, a man, claiming to be a family therapist, became a member of a fundamentalist church and offered his services as a "Christian Family Therapist" to the congregation. An older couple, who had an unmarried daughter who was 26 years old, sought his advice as to how to help their daughter be more socially graceful "around men." After seeing the three of them in one family session, the therapist announced that he could work better with the young woman alone. After six sessions at \$30.00 each, the girl finally announced to her parents that the therapist had had sex with her in each of her previous six "therapy sessions" under the guise of "teaching her about how to get along with men." The parents were furious and wanted to take action against the therapist. However, since their daughter had consented, she was over the age of 18, and the therapist was slick enough to label his therapy in such a way as to not appear to be fraudulent, the parents were advised that they could not take legal action. Since the field of marriage and family therapy is not regulated and the therapist

was not a member of any professional organization, the parents had no recourse with the State or with the professions. The parents did expose him to the church elders and he was asked to leave. These parents sought a referral to a trained and ethical family therapist to continue work with the family over their daughter's original problem and, in addition, the new family problem caused by the therapist. Recently, when I checked with the therapist, to whom they had been referred, to see if he could get the family's permission to use this disguised version of their story for this testimony, he relayed some interesting information about the original unethical therapist. It seems that he had moved to another congregation in a neighboring state and proceeded to try to set up a practice in the same way. He did the same exact thing to another woman in that congregation! However, he also pulled the same scam on a 16 year old girl and is presently being prosecuted for statutory rape. If the profession of marriage and family therapy were regulated through licensure by the State, it would have been much harder for this individual to hurt these three women in this manner. Furthermore, if he had unethically injured the first woman, he could have been prevented from injuring the other two.

These experts are unanimous in their recommendation that licensure of marriage and family therapists would be the strongest possible means for protecting the public from harm by mandating minimum standards of education, training, supervised experience, and continuing education; and

by providing practice-related consequences and practical means of recourse for dealing with unprofessional conduct.

#### Consumer Testimony Regarding Harm

Some states (e.g., Kansas) may require testimony by consumers that have been harmed by practitioners of marriage and family therapy. Such a requirement poses an ethical dilemma to our profession. Ethical principles require that marriage and family therapists protect both the confidentiality of clients and the right of accused practitioners to due process. Documentation of specific case material would violate both principles. Even if a client were to volunteer to forego their right to confidentiality, it would still not be appropriate to disclose clinical material in a public setting (such as a legislative hearing) as alleged offending practitioners would not have a forum to defend themselves. Therefore, it is suggested that establishing harm via consumer testimony through use of the following two-pronged strategy:

- 1) Newspaper/magazine reports of harm to consumers by unethical and/or incompetent practitioners. This material is already a matter of public record.
- 2) Disguised case material which accurately represents actual harm to clients but protects both client and "counselor" by omitting names, location and family demographics. These self-imposed restrictions are consistent with the state and professional goal of protection of the consumer.

It is important to point out to state officials and legislators that it is very difficult to produce consumer testimony because in the absence of a mechanism for credentialing marriage and family therapists, there is no practical statutory means for consumers to file a complaint. The only

source of consumer testimony which is available is that which is a matter of public record (newspaper and magazine stories) and that which is available from clients of MFTs who have previously been abused by unethical/incompetent practitioners.

Newspaper/Magazine articles. The following summaries of articles document the harm that can befall the consumer when treated by an untrained marriage and family therapist:

McCall's May 1958, "Beware of Phony Marriage Counselors," by Norman Lobsenz. This was one of the first articles in a national magazine to expose the wide-spread exploitative practice of untrained and unscrupulous persons providing "marriage counseling." The article describes in detail numerous flagrant misrepresentations of qualifications on the part of "counselors". The author specifies treatment forms ranging from the merely innocuous to the outrageously noxious. For example, one "Doctor" guaranteed to clear up all marriage problems with a session on his special patented electrical machine. Details of a case in Chicago are given where a woman was directed to indulge in sexual relations outside of marriage in order to overcome her "sexual inhibitions." Several additional specific examples of the way in which this reporter discovered fraudulent practitioners damaging the lives of couples and whole families through the United States are documented.



CHICAGO DAILY NEWS, Sat.-Sun., November 8-9, 1975. "Marriage Counseling" A Growth Industry," by Sue Lindsay Roll. With more and more couples willing to pay good money to persons claiming to "save marriages," the field is "plagued by the same excesses... that befall any business experiencing an uncontrollable boom." Reporter Roll's investigation led her to the conclusion that the "marriage counseling business is inundated with a hodgepodge of charlatans, professionals, and gurus, all insisting that they can do the job. Everything from psychoanalysis to tarot card readers is available." One therapist contacted by reporter Roll in the Chicago area puts marital adversaries alone in a closet to reduce marital tensions by "screaming their heads off." Another, she says, prescribes extra-marital affairs. "Still another instructs his clients to remove their clothes, hold hands and gaze into one another's eyes, a costly and questionable exercise at \$50 an hour." She also found, "marriage counselors (who) rely on tea leaves and crystal balls as their sources of solutions." According to Illinois State Representative Henry Yourell (D-Oaklawn), "thousands of 'quacks' and 'phony marriage counselors' bilk the public out of more than \$750 million each year in Illinois alone." The legislator is further quoted by reporter Roll as stating that these people are "destroying marriages every day." Additional specific examples are given by the reporter of couples she contacted who had been victimized by fraudulent practitioners.

GOOD HOUSEKEEPING MAGAZINE, "The Shocking Story of Marriage-Counseling Frauds," May 1972. Along with safe and sensible suggestions for ways to pick a legitimate marriage counselor there are several shocking examples of fraudulent and damaging practice disclosed. In one instance a factory worker in Indianapolis decided it would be "fun" to hear people's problems, so he rented an office and proclaimed himself a "licensed" marriage counselor (there is no licensure for this profession in Indiana). Nevertheless, "he collected \$40 per session from unsuspecting couples who received worthless, potentially harmful advice." In Houston, TX, "another self-proclaimed counselor with no medical training advised women to undergo surgery to heighten and quicken their sexual reactions." The case of a young couple in "a small Eastern suburb" is detailed in which they were asked by the counselor to disrobe in his office and then "demonstrate publicly your affection for each other." They refused and consulted their lawyer, whose investigation showed that the counselor's background and degrees were fraudulent. However, no legal action could be taken since no law had been broken. This article quotes the chairman of the regulatory board for the California licensure of marriage and family counselors as saying that since licensure, the number of phony practitioners has been greatly reduced. The same results are reported for the state of Michigan. A middle-aged woman whose husband had

gradually withdrawn from emotional and sexual intimacy over the course of their twenty year marriage and whose children were grown and leaving the home became dissatisfied and increasingly depressed, with frequent crying spells. In desperation, she selected a therapist from the Yellow Pages under the heading "Marriage and Family Counselors" who had the largest ad and identified himself as a "psychoanalyst." He required \$500 in advance for a month of intensive individual therapy. The therapist prescribed sexually provocative literature and began to suggest "therapeutic sex" (i.e., with the therapist) as a means of enhancing marital sex. The woman's mental status deteriorated to the point where she required psychiatric hospitalization. Her two weeks of hospitalization included a negative reaction to the neuroleptic medication she was given and her fear of being placed in a state mental institution. These fears were exploited by the therapist after her release from the hospital (i.e., the same therapist she saw prior to her hospitalization). She continued to see this therapist over a three year period during which therapy usually consisted of sexual intercourse. She paid him \$5,000.00, including a loan to help him launch a bogus research project. When she read a newspaper article about a woman with a similar experience, only already being suspicious and angry about her experience, she decided to break away from the therapist and demanded the loan be repaid. He countered by threatening to tell her husband about her infidelity and to cooperate with him in having her

committed to the state hospital. She herself told her husband about the "therapy" and he filed for divorce. She was subsequently appropriately treated by a reputable professional.

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In the nation's first malpractice suit filed against the clergy, a Los Angeles family claimed that church counseling contributed to the suicide of a 24 year old family member in 1979. The family is claiming that the church acted negligently when it did not inform the parents of their son's depression and suicidal tendencies. The family is currently appealing a May 1985 Superior Court ruling which dismissed the suit on the grounds that the church was protected by the First Amendment requirement of separation of church and state. It is conceivable that family involvement in counseling may have prevented the man's death.

MANHATTAN MERCURY (5/20/83, 9/27/83, 12/6/83, 2/21/84).

A series of articles describe the exploitation of a 17 year old girl who was being "counseled" at the home of a 47 year old man with the permission of her parents. Riley County District Court documents charged that over the course of five separate sessions the man had "exhibited pornographic films to the girl, furnished her with intoxicating liquor, and engaged, with her consent, in oral copulation with her." Though there is no way of knowing what harm, if any, resulted to the girl, many

studies [see (37)] have documented the damage to clients connected with a sexual involvement with their therapist. One such study (Bouhoutsos, 1983) found that 90% of such patients sustained some type of damage.

Case Examples. The following case studies are based on consumers' personal accounts of their experience in therapy as personally related to another therapist in a subsequent therapy. State officials and legislators may be interested in knowing the credentials of the therapists submitting these accounts, in order to ascertain their qualifications to assess harm. For each of these cases, the therapist who submitted the case to KAMFT is a Ph.D. clinician located in Kansas with at least ten years of experience as a therapist. The case material has been disguised by omitting any information (e.g., names of clients and practitioners, location, and family demographics) which might make the case recognizable, in the interest of protecting the emotional well-being of the client, as well as the due process rights of the accused practitioner.

It is interesting to note that in some of these cases the practitioner had qualifications for practicing individual psychotherapy but lacked the requisite skills for marriage and family therapy. An individual therapist may expertly attend to the intrapsychic aspects of a patient's illness but miss the ways in which the individual's problems affect and are affected by other family members or even function as a finger in the dike of family conflict. In such cases the individual may feel supported and understood but not be helped to make needed changes in family relationships. Further, the sorts of chaos and pain arising from

family disturbances, particularly divorces and deaths, may leave a therapist who is untrained in family work unable to lend specific assistance. Skilled family therapy practice is equipped to ameliorate family crises, to identify relationship problems before they escalate, and to assist in making structural changes in family organization that decrease tension and violence. Even the most competent therapists trained in intrapsychic approaches may easily neglect these issues. More pointedly, the way that families are organized and the patterns of reciprocity characteristic of family functioning, unless properly understood and treated, may give rise to complications unforeseen by the well intentioned therapist who is untrained in family therapy.

The following cases (taken from the 1987 KAMFT Application for Credentialing), appropriately disguised, give the flavor of typical misguided efforts:

Case #1 A Kansas psychiatrist was treating a husband and wife for a relationship problem, but not conjointly. The husband had told the wife he discussed hunting with the psychiatrist. The wife, however, became convinced that the psychiatrist and her husband were discussing terrible things about her in her absence. She became increasingly paranoid, yet did not communicate her fears to her husband, and asked him for a divorce (which neither really wanted). She finally transferred, with her husband, to the second therapist, a psychologist who consulted with an experienced marriage and family therapist. Conjoint

therapy, a basic tool of marriage and family therapists, may very well have avoided this incident.

Case #2 A young Kansas mother sought advice from her priest because of the lack of sexual interest and activity by her husband. Her husband at that time was on active duty away from home. The priest, according to the woman, advised that sexual activities are a normal expectation in marriage, therefore her husband must have a deep seated problem and she was perfectly justified in seeking a divorce. All of this was done without the husband even being in town. She had already met with a lawyer by the time she came to a professional marriage and family therapist. It became rapidly clear that she didn't want a divorce and, on the husband's return, entered conjoint therapy. As it turned out, their "sexual" problem was largely a communication problem.

Case #3 A central Kansas couple with three children (ages 13, 11, and 8) sought marital counseling from a professional with a Ph.D. in counseling but no training in marriage and family therapy. He diagnosed the couple as being "too distant" and prescribed working on their relationship without the children. Under his guidance, the couple became so zealous in pursuing their marital relationship that they began to neglect the children, who began to

severely act out. This was encouraged by the counselor until Social Rehabilitation Services was called in by the neighbors. The counselor dropped the case. It took two years with a trained marriage and family therapist to repair the damage to the parent-child subsystem and to integrate into the whole family the gains the couple had made in their own relationship.

Case #4 A young Kansas woman with a difficult ten year old child sought help from a psychiatrist because of fears that she might abuse her child. The psychiatrist chose to see the child individually, excluding the mother. The mother was quite frustrated in seeking meetings with the psychiatrist. She felt that his lack of contact with her was unwarranted; and she was quite angry about his refusal to include her in the treatment process. She subsequently left therapy and sought help from a minister who was willing to see both her and her child. After several months of therapy, the case was terminated to the mutual satisfaction of all parties. The refusal of the psychiatrist to include the mother in therapy may have eventually resulted in the mother abusing the child. The mother, did in fact take the child out of therapy without his symptoms being



elevated. Fortunately she did find another therapist.

Case #5 A Kansas farm couple had approached a psychiatrist about their son's violent reaction to their discipline. Despite efforts of the parents to visit with the psychiatrist, the psychiatrist would only see the boy in individual therapy, with no further input from the parents. The boy was heavily sedated by the psychiatrist to the point where both parents became alarmed at his listlessness (he was described by his parents as being a "Zombie in school"). They withdrew their child from therapy with the psychiatrist and sought help from a family therapist. The family therapist dealt directly with the parents' unrealistically high expectations regarding their son's behavior, and they were given training in more age appropriate disciplinary techniques. With this increased understanding, the child ceased to react violently and returned to an age-typical pattern of behavior.

Case #6 In a recent Kansas custody case, each parent's lawyer had engaged a psychologist to give expert witness as to that parent's fitness to take custody. The judge complained that neither psychologist seemed to have a firm understanding of the "total picture" of the family. They seemed to "view the family as a

collection of individuals instead of as a whole." Therefore, he asked the couple to seek out a marriage and family therapist who could give them a more complete picture of their situation. The family therapist, by focusing on the needs of all family members in the context of a family group session, was able to mediate the situation. After four weeks of family therapy, the divorced couple settled their custody battle outside of court in an atmosphere of mutual cooperation.

These illustrations demonstrate that even highly skilled therapists who are not knowledgeable about marital and family dynamics may unwittingly increase family difficulties instead of correcting them.

#### Harm Documented by Legal Precedents, Financial Awards, and Judicial Rulings

There does not seem to be an easily accessible source of documentation of legal precedents, financial awards, or judicial rulings regarding harm attributable to psychotherapy in general and marriage and family therapy in particular. The fact that there is relatively little mention in the media of such precedents, awards, or rulings compared with the relatively frequent incidence of deterioration due to therapy reported in the body of outcome research may be an indication of the inadequacy of civil litigation as a practical means of consumer recourse for dealing with therapist malpractice. This conclusion would concur with findings by those (Bouhoutsos, 1985) who report that incidents of client-therapist sexual involvement are typically under-reported.

Cummings and Sobel (1985) do report that the American Psychological Association Insurance Trust indicates that there was a marked increase in all malpractice claims against covered psychotherapists in the three years prior to the study (1982-1984), especially in the area of sexual exploitation. A total of 726 malpractice claims had been filed against licensed psychologists between 1976 and 1984. Though only 104 of these cases involved sexual malpractice, the actual judgements in these cases exceeded all other judgements by twofold.

#### Statistics Documenting the Incidence of Harm

Some states (e.g., Kansas) may request statistics documenting the number of incidents involving harm to consumers of marriage and family therapy. In their comprehensive survey of over 200 studies of marital and family therapy, Gurman & Kniskern (1978) found that "approximately 5 to 10 per cent of patients or marital or family relationships worsen as the result of incompetent/unethical marital-family therapy" (p. 5). This is consistent with the deterioration rates reported for individual intrapsychic therapy (Bergin, 1963, 1971; Lambert et al, 1976). In addition, studies (Kardener, Fuller, and Mensch, 1973; Holroyd and Brodsky, 1977) have shown around 10% of the therapists surveyed admitting sexual contact with clients, with 80% having done so with more than one client.

Aside from these studies (generated by practitioners of the discipline), it is important to note that it is very difficult to estimate the numbers of clients harmed specifically by marriage and family therapists. Even if statistics regarding numbers of complaints made to and disciplinary action taken by state regulatory agencies are

available, such numbers would under-represent the actual number of cases, because clients significantly under-report therapist misconduct (Bouhoutsos, 1985). However, it is significant to point out that even these statistics are unavailable in states that have no credentialing mechanism for marriage and family therapists. A credentialing process establishes a state regulatory board to hear complaints against therapists, and this is the means by which such statistics are generated.

The situation in Kansas is illustrative of this problem. The Kansas Behavioral Sciences Regulatory Board reports a total of 147 complaints within the period between July 1, 1980 and January 1, 1987, with the number of complaints increasing substantially over the past three years. Mary Ann Gabel, Executive Director (personal communication, 1987), reports that "the Board seldom has knowledge of the credentials of nonregulated persons against whom complaints are filed. The majority of the complaints filed against non-regulated persons are in the nature of violations of social work or psychology statutes wherein the person is alleged to be practicing in those areas restricted to licensees". It follows that there is obviously no recourse (via the board) for filing of complaints dealing with abuses (other than those within the areas of practice restricted to licensed practitioners) against unregulated practitioners (including marriage and family therapists).

Although the Kansas Attorney General's office does not compile statistics regarding complaints against unregulated practitioners, a 1984 letter on the subject from Acting Deputy Attorney General Brenda L. Hoyt (personal communication) reports 25-35 complaints per year against

unregulated persons calling themselves "counselors" or "therapists". She goes on to say:

The most common complaint made against these persons -- perhaps half of the complaints -- was that the counselor or therapist either made sexual advances to the client or actually engaged in sexual conduct with the client. Because the counselor was not licensed by the state in any manner and the client was 16 years of age or older, the client rarely had any legal recourse available beyond hiring a private attorney to file a malpractice action. Other complaints have involved a "therapist" who managed his client's money; ineffective or inappropriate treatment which subsequently required the clients to seek intensive treatment from another source to handle problems aggravated by the initial "treatment", and "counselors" misrepresenting their credentials and attempting to deal with clients whose mental conditions required a more extensively trained person.

The section in boldface in the above quote highlights a compelling reason for state licensure of marriage and family therapists; i.e., the lack of availability of any practical means of recourse for consumers harmed by practitioners.

The AAMFT Committee on Ethics and Professional Practices reports approximately 40 active cases pending against AAMFT members for alleged violations at any one time (see Appendix C). The Committee completes

action on approximately 80 cases every year, most of which involve allegations of a serious nature, such as sexual misconduct and fraudulent billing. It is important to point out however, that the Committee has jurisdiction only over AAMFT members, and, consequently, has no way of estimating the amount of misconduct by non-members.

#### KNOWLEDGE REQUIRED TO PRACTICE MARRIAGE AND FAMILY THERAPY

One criterion that must be met to show a need for credentialing is that there is an identifiable body of knowledge that is required to competently practice the profession. There must be evidence that authorities in the field recognize the body of knowledge as that expertise necessary to practice marriage and family therapy. It must also be demonstrated that the public will benefit by being able to identify those practitioners who have this level of training, upon initial entrance to the profession and on a continuing basis. Legislators will also want to know that formal training programs are available within the state.

The body of knowledge germane to the profession of marriage and family therapy is reflected in the AAMFT membership requirements (AAMFT, 1986):

**Educational.** Completion of a master's or doctoral degree in marital and family therapy from a regionally accredited educational institution, or an equivalent course of study and degree, as defined by the Board of the American Association for Marriage and Family Therapy (AAMFT).

Interpretation: Meeting the educational qualifications consists of completion of a course of study substantially equivalent to the following:

- Human Development (3 courses minimum). Course content must include human development, personality theory, human sexuality, psychopathology, behavior-pathology.
- Marital and Family Studies (3 courses minimum). Course content must include family development and family interactional patterns across the life cycle of the individual as well as the family. Courses may include the study of: family life cycle; theories of family development; marriage and/or the family; sociology of the family; families under stress; the contemporary family; family in a social context; the cross-cultural family; youth/adult/aging and the family; family subsystems; individual, interpersonal relationships (marital, parental, sibling).
- Marital and Family Therapy (3 courses minimum). Course content must include communications; family psychology; family therapy methodology; family assessment, treatment and intervention methods; overview of major clinical theories of marital and family therapy such as: structural, strategic, transgenerational, experiential, object relations, contextual, systemic.

- Research (1 course minimum). Course content must include research design, methods, statistics, research in marital and family studies and therapy.
- Professional Studies (1 course minimum). Course content must include professional socialization and the role of the professional organization, legal responsibilities and liabilities, independent practice and interprofessional cooperation, ethics, and family law.
- Clinical Practicum (1 year minimum) 500 hours of face-to-face contact with individuals, couples, and families for the purpose of assessment and intervention.

This course of study may be completed in a master's or doctoral degree program or subsequent to a graduate degree.

**Clinical.** Completion of at least 1,000 hours of direct clinical contact with couples and families. Typically, the final 500 contact hours are accumulated after completion of the degree program.

Interpretation: This clinical experience involves at least 1,000 hours of direct clinical contact with couples and families and 200 hours of supervision of that work, at least 100 of which shall be in individual supervision. This supervision must be provided by AAMFT Approved Supervisors or supervisors acceptable to the Membership Committee.



Personal. Endorsement by two Clinical Members of the Association, attesting to suitable qualities of personal maturity and integrity for the conduct of marital and family therapy.

The body of knowledge outlined above has been recognized by The Commission on Accreditation for Marriage and Family Therapy Education, 1717 K Street, N.W., Washington, D.C., which has been designated by the U.S. Department of Health, Education and Welfare as the sole accrediting body for marriage and family education and training programs since May, 1978. This designation was most recently reaffirmed by the U.S. Department of Education in 1985.

The body of knowledge outlined above is also recognized in the credentialing laws of each state which currently credentials MFT's: California, Utah, North Carolina, New Jersey, Massachusetts, Nevada, Michigan, Florida, Connecticut, Georgia, Rhode Island, South Carolina, Tennessee, Washington, Minnesota and Wyoming.

#### Accreditation

In addition to the issue of whether there are formal training programs in marriage and family therapy within the state, legislators may be interested in knowing that these training programs are of high quality. They may want to require that credentialed practitioners graduate from accredited marriage and family therapy programs. It should be pointed out that this would be an unrealistic requirement. Because the profession of marriage and family therapy is an emerging one, there are still relatively few accredited programs. The Commission on Marriage and Family Therapy Education currently accredits forty training

programs nationwide (17 Masters Degree, 9 PhD, and 14 non-degree). Another relevant issue is that the profession of marriage and family therapy counts among its ranks individuals who have degrees not only in marriage and family therapy, but also those from fields such as psychiatry, social work, psychology, clergy, counseling, and education who have received additional training in family therapy. This is consistent with a desire among marriage and family therapists to be inclusive rather than exclusive, to seek cooperation rather than competition with other mental health professions. A statute credentialing marriage and family therapists, therefore, must provide for alternatives to graduation from an accredited marriage and family therapy program that spell out requirements comparable to those of an accredited program.

#### Grandparenting

Credentialing statutes specify minimum levels of education, supervised training, and experience required of a certified/licensed practitioner. Many competent individuals, however, who have been practicing marriage and family therapy for years would not be able to meet the exact requirements specified in the statute (e.g., equivalent to those required by AAMFT) because when they were in school, coursework in marriage and family therapy did not exist. The aim of credentialing legislation is to screen out those practitioners who are not qualified, not those who are. Therefore, almost all credentialing statutes contain a provision for "grandparenting", so that those individuals who entered the profession before the current "state of the art" qualifications were established, may still be permitted to practice. The trick, however, is

to establish requirements for grandparented practitioners that will screen in qualified individuals and screen out those who are not qualified. The following is a suggestion for how grandparenting might be handled:

1. Educational Requirements: an appropriate graduate degree, related to the discipline of marriage and family therapy, from an accredited institution so recognized at the time of granting such degree.
2. Experience Requirements: at least five (5) years of clinical experience in the practice of marriage and family therapy, and either:
  - a. membership in, or certification by, an appropriate professional organization, as defined by the state regulatory board
  - or
  - b. documentation of a level of training, supervised experience, competency, and integrity equivalent to that required for membership in a professional organization, as determined by the state regulatory board.

This issue is similar to that of accreditation, in that the state board regulating MFTs would need to establish standards equivalent to those required of graduates of accredited MFT programs for those individuals who have graduated or who will graduate from non-accredited programs. It should be noted that grandparenting is a "one-shot", time limited process. After a specified amount of time, all new entrants into

the profession will have to meet the "state of the art" standards (which will be updated on an ongoing basis) in order to be credentialed.

#### Marriage and Family Therapy Examination

Ideally, a state credentialing process would be able to provide assurances not only of practitioner training but also of competence. Most states, therefore, require that individuals who seek to be licensed/certified in one of the mental health professions first pass an examination. National examinations have been developed by the American Psychological Association, the National Association of Social Workers, and the American Association for Counseling and Development for their respective professions. Many state regulatory boards adopt these national exams or develop their own exams.

Currently, there is no national exam for marriage and family therapy. However, on October 22, 1987, the Association of Marital and Family Therapy Regulatory Boards (AMFTRB) was officially incorporated. The membership of AMFTRB is made up of representatives of each of the regulatory board from states that currently credential MFTs. A major goal of AMFTRB is to develop a national examination for marriage and family therapy. At a meeting in October, 1987, according to AMFTRB President, Carl F. Johnson, the board of directors voted to make a request for a written proposal from each of three companies who had expressed interest in developing a national examination for marriage and family therapists. The three companies are:

1. Assessment Systems, Inc. (ADI), Philadelphia, PA. This is the same firm that has developed the national examination for social workers.

2. Educational Testing Services (EST), Princeton, NJ. The same company that administers the Scholastic Aptitude Test (SAT) and Graduate Record Examination (GRE).
3. Professional Examination Service (PES), New York, NY. This firm has developed the national examination for psychologists.

These companies, as part of their proposal, would guarantee to perform a job analysis, i.e., a behavioral analysis of what skills are involved in the performance of the profession of marriage and family therapy. At that point, an examination development committee, made up of experts in the field and regulatory board representatives, would generate test items, keyed to the job analysis. Each of the three companies are offering to bear the entire cost of the exam development, as they are confident of eventually recouping their expenditures from the exam takers.

The board has tentatively set May 1, 1988 as a target date for accepting a proposal from one of the three companies. The goal is to have the examination in place by January 1, 1990.

A question that arises in regard to all such examinations is whether such tests really measure competence. Many experts (Bouhoutsos, 1985) maintain that at most, these exams measure only relevant knowledge, which is a far cry from the ability to competently apply that knowledge. California requires an oral exam as requirement for licensing both psychologists and marriage and family therapists. It would seem that an oral exam administered by expert clinicians would come much closer to measuring competence than would a standardized, multiple-choice written exam. As part of an oral exam, applicants could be asked to submit a

videotape of a therapy session that would be one of the bases for the evaluation of competence. Problems related to utilization of an oral exam include the high expense of administration as well as greater vulnerability to charges of subjective bias. In spite of these limitations, marriage and family therapists may want to seriously consider the inclusion of an oral component to an examination.

### Continuing Education

Most credentialing statutes seek to provide consumers an assurance not only of initial (entry-level) ability, but also of continuing ability. This is accomplished by establishing minimum standards of continuing education.

The same question arises in regard to continuing education as that discussed earlier in terms of an exam, namely, how well does continuing education correlate with continuing competence? Perhaps what is needed is a re-certification process, every specified number of years, in which practitioners would need to demonstrate their current competence, perhaps through an oral evaluation centered around a video-tape of a therapy session. Such a mechanism would be a more valid assessment of competence than attendance at continuing education offerings, and might also save time and expense for rural practitioners. Individual practitioners would bear the responsibility for remaining competent and up-to-date enough to pass the periodic re-certification evaluation.

The American Association for Marriage and Family Therapy approves continuing education offerings. To qualify for approval, these offerings

must deal specifically with theory, research, or practice related to family functioning and family therapy. AAMFT members are asked to voluntarily submit a record of their continuing education activities each year. These continuing education activities should total 150 hours over a three year period with at least 30 of these hours being officially approved by AAMFT. It should be stressed that AAMFT does not mandate continuing education for its members. At the present time, the Association is not in a financial position to do the record keeping. In addition, the Association has heard feedback that continuing education requirements tend to put a severe strain on practitioners living in rural areas, who must travel long distances to attend workshops, at a considerable sacrifice of time and money.

Nevertheless, the goal of providing consumers with some assurance of continued competence is an important one, and one that marriage and family therapists will almost certainly have to be addressed should a credentialing statute be sought.

#### Opposition Arguments

Because credentialing is related to reimbursement, efforts to credential mental health professions have traditionally led to "turf battles" among the various disciplines. Those who are already credentialed often attempt to exclude those who are not. Marriage and family therapists need to be prepared to respond to a variety of arguments that the opposition can be expected to raise.

Opponents of MFT credentialing may seek to claim that marriage and family therapy is a subspecialty of other professions (e.g., psychology, social work), a modality of psychotherapy, rather than a distinct

profession, and therefore should not be regulated as a distinct profession. As a "scare tactic", opponents often claim that credentialing of marriage and family therapists will open the door for other groups to seek credentialing, such as hypnotherapists, dance therapists, group therapists, art therapists, and primal scream therapists.

This argument may be dealt with by asking the question, what are the criteria for the recognition of a distinct profession?" Both Gurman and Kniskern (1981) and Brown-Standridge (1986) cite Carlfred Broderick for identifying the following criteria for identifying a distinct profession: a) "self awareness and the identity of a body of experts", b) a set of skills requiring advanced training and established standards of performance," and c) "a recognition of this body of experts and the utility of their expert service by the larger society." (Brown-Standridge, p.5) I will deal with these criteria one at a time:

a. Self-awareness and the identity of a body of experts.

An identifiable historical development of a discipline is characteristic of a profession.

Marriage and Family Therapy has itself evolved from two distinct developments in psychotherapy, marriage counseling, which emerged in the 1920's, and family therapy which began to come into its own in the 1950's. (AAMFT, 1985). The American Association of Marriage Counselors was formed in 1942. The fields of marriage counseling and family therapy formally merged in 1970 with the formation of the American



Association of Marriage and Family Counselors (AAMFC). The name was changed to the American Association for Marriage and Family Therapy (AAMFT) in 1978. AAMFT currently has approximately 14,000 members throughout the United States and Canada.

- b. A set of skills requiring advanced training and established standards of performance. The body of knowledge relevant to marriage and family therapy has been discussed earlier in this section. What distinguishes marriage and family therapy from the other mental health professions is its grounding in family systems theory. As Brown-Standridge (1986) puts it, "It is this epistemological lens that is distinctively different from the theoretical underpinnings of the established mental health profession. Technique derived from systems model is also quite different from the pioneering efforts of early marriage and family counselors who simply were trying to find out if greater headway could be made if more family members were added to the session room" (p. 136).

AAMFT has established standards of education, training, supervision and experience for members of the profession; as well as a code of ethics. The Commission on Accreditation for Marriage and Family Therapy Education has established standards for

training programs in marriage and family therapy and accredits such programs. Presently there are 40 accredited marriage and family therapy training programs in the U.S., all of them are either advanced degree programs or post-graduate non-degree programs.

- c. A recognition of this body of experts and the utility of their expert service by the larger society.

Because government functions as the representative of "the larger society", governmental recognition is characteristic of a distinct profession.

Currently, 16 states have enacted legislation regulating marriage and family therapy as a distinct profession. In 1978, the Commission on Accreditation for Marriage and Family Therapy Education was recognized by the U.S. Department of Health, Education, and Welfare as "the official agency designated to establish standards for certification of training programs in the field of marriage and family therapy (Broderick and Schrader, 1981, pp. 31-32). In arriving at this decision, an advisory board was appointed to determine, among other matters, whether marriage and family therapy was indeed a distinct profession. The results of a Division of Eligibility and Agency Evaluation (DEAE) report, requested by the advisory committee, was that marriage and family therapy is indeed "a distinct,

integrated discipline" (See DEAE report in Appendix B).

Marriage and family therapy, therefore meets the criteria for a distinct profession. Even assuming, for the sake of argument, that marriage and family therapy is instead a subspecialty of other professions, the public would still be left unprotected if this argument is used to reject credentialing of marriage and family therapists. In some states (i.e., Kansas) licensure/certification as a psychologist or social worker requires a degree specifically in that discipline. A large number of marriage and family therapists do not have degrees in already credentialed disciplines. For example, 70% of the membership of KAMFT are currently unregulated, as are those practitioners with much less training. The bottom line, then, is that whether or not marriage and family therapy is seen as a distinct profession, there are many individuals practicing marriage and family therapy, both qualified and unqualified, who are currently unregulated in the absence of credentialing legislation, and consumers remain at risk.

#### EFFECT OF REGULATION ON THE COST OF HEALTH CARE

As much as any other issue related to credentialing, legislators will be interested in determining the impact of regulation on the cost of health care to the public.

By itself, there is no hard evidence that state credentialing of marriage and family therapists would have a measurable impact on the cost of health care. However, credentialing may have an indirect effect on the cost of health care to the public. Credentialing would provide for

the identification of qualified marriage and family therapists. This, in turn, may make it practical, at some point in time, for marriage and family therapists to be reimbursed by insurance companies. Should this occur, there may be a positive impact on health care costs, related to the resulting increased freedom of choice available to the consumer in selecting a practitioner.

First of all, widely accepted empirical literature in health policy and economics suggests that a "cost-offset" phenomena exists for mental health coverage. The "cost-offset" concept refers to the fact that the use of traditional and expensive medical services is found to decrease when appropriate mental health services are included within health benefit plans. Numerous studies show a decrease from 5% to 80% in medical service use following appropriate and well-managed mental health treatment (Jones & Vischi, 1979; Cummings & Vandenboss, 1981; Schlesinger et al, 1983; Mumford et al, 1981; McGuire, 1981; Mumford et al, 1984; Holder & Blose, 1985; Taintor et al, 1982; Turkington, 1987; Seagraves, 1980).

Seagraves (1980) summarizes a wealth of studies which have shown that problems treated by marriage and family therapists, such as marital stress, separation, and divorce have a profound impact on health and medical utilization. For example, Seagraves points out that it has been found that hospital admissions are generally highest for separated and divorced individuals. In fact, admission rates for the divorced have been reported to be from 6-10 times greater than the rate for married individuals. Evidence also suggests that divorced individuals have the highest hospital admission rates for many diagnostic categories, the

highest rates of alcoholism and suicide attempts, and four to five times as great a utilization of outpatient psychiatric services as their married counterparts. Further, it has been reported that almost 50% of those who seek medical or psychiatric help in times of crises have a serious marital problem as an etiological factor. Bloom, Asher, and White (1978) described evidence suggesting that marital disruption is linked to a wide variety of physical and emotional disorders. It would seem that access to treatment by a marital and family therapist for such individuals would be extremely important, as well as leading to a decrease in medical costs via a cost-offset effect.

Richard Frank (1982), a well known and highly respected health economist, reports that when consumer freedom-of-choice is enhanced, "competition in the market for psychotherapy resources will be intensified, which will lead the market to allocate resources more efficiently. Gains in allocative efficiency arising from increased competition are often characterized by decreases in the price of services" (p. 87). Frank found, for example, that in states where freedom-of-choice laws (which require insurance companies to reimburse specific credentialed mental health professionals in addition to physicians) have been enacted, "fees for psychiatrists' services will be about 9% lower than in states that have not adopted such legislation" (p. 94).

It must be emphasized that increased freedom of choice adds no new benefit to an established health insurance program. Rather, it enables consumers to secure services for treatment of mental and nervous disorders from competent marriage and family therapists. At the same

time, increased freedom-of-choice can serve to reduce health care expenditures.

It is significant to note that while increasing competition does expand the pool of reimbursable providers, it does not subsequently lead to greater utilization of mental health services, according to several studies (United States Office of Personnel Management, 1986; Frank, 1982; McGuire, 1981). Rather than greater utilization, there is a substitution of service delivery, usually accompanied by a decrease in fees.

The fact that marriage and family therapists generally charge lower fees than other licensed mental health professionals, even in states where marriage and family therapists are credentialed (Psychotherapy Finances, 1986), is evidence that greater public access to marriage and family therapists will help serve to reduce health care costs. By its very nature, marriage and family therapy is cost-effective. Marriage and family therapists treat family members conjointly. The cost of treating several family members at the same time is lower than the cost of treating each family member individually. The relative effectiveness of marriage and family therapy can also serve to lessen health care expenditures. Gurman and Kniskern (1978) report that, in the treatment of a marital problem, treatment involving both spouses is significantly more effective than individual therapy with only one spouse. Effective treatment lowers financial costs as well as emotional and social costs. In conclusion, it seems that, in terms of holding down the costs of health care (not to mention therapeutic efficacy), the public would be best served by maximizing access to marriage and family therapists.

Credentialing of marriage and family therapists could be an important first step towards that goal.

Finally, it must be stated that even if there were to be an increase in health care costs, the increased protection of the public would be well worth it. As the report of the state of Minnesota's Advisory Task Force on the Regulation of Psychotherapists (1986) puts it, "It is an insult to say to clients that it would not be cost effective to the State to protect them from abuse. Injured clients could end up paying a huge and lifelong emotional price for their victimization" (p. 24).

EFFECT OF REGULATION ON AVAILABILITY OF  
MARRIAGE AND FAMILY THERAPISTS

Legislators are also concerned with the impact of credentialing on the availability of needed services to the people in their state. It is important to impress on legislators the critical need for marriage and family therapy to be available to the public.

The Need for Marriage and Family Therapy

A glance at statistical evidence of trends in marital and family-related problems demonstrates the need for marriage and family therapy services, as well as a need for credentialing to assure to the greatest extent possible that these services are provided by qualified practitioners. Statistical evidence from the state of Kansas will be used to illustrate this point. The following statistics were taken from the Kansas Statistical Abstract (1982) and the FBI Crime Index (1982). Although the 26,137 marriages performed in 1981 represented a 5.2% increase over the number performed in 1980, the number of divorces and annulments also increased to 13,737 in 1981. Between 1971 and 1981 in the state of Kansas, marriages increased 16% and divorces increased 46%. These divorces included at least one minor child in 58.2% of the divorcing families. In 1981, 13,737 divorces and annulments left 13,820 minor children in broken homes. Forty percent of all the marriages begun in Kansas in the 1980's will be expected to end in divorce. Marital and family problems are on the rise in the state of Kansas.

The adolescents in today's Kansas families are also under stress. In 1981, out-of-wedlock births to Kansas residents reached 5,086. This is the highest number ever recorded in a single year in Kansas. These



births represented 12.3% of all live births in 1981—a record high. Kansas juvenile court referrals totaled 22,784 in 1980, with 2,275 juveniles incarcerated in Kansas institutions. One out of every five Kansas boys and girls who enter into high school drop out before graduating. Every year, 2,500 Kansas adolescents run away from home. Among youths in Kansas who are 29 years or younger, 563 died of violent deaths in 1980 (65 from suicide and 62 from homicide), with suicide being the second leading causes of Kansas deaths in the 12-24 age group. These statistics are indicators of stress among today's Kansas youth and their families. In a state where one violent crime occurs every 69 minutes and 38 seconds, 39% of the victims of murder and non-negligent manslaughter in Kansas in 1981 were family members of their murderer. Of the total number of murder and non-negligent manslaughters in the state of Kansas in 1981, husbands killed wives in 12.1% of the cases, wives killed husbands in 6% of the cases, parents killed their child in 2.7% of the cases, children killed their parents in 3.4% of the cases, and other family killings (such as ex-spouses and common law spouses) totaled 2% of the cases. Add to this a statewide suicide rate of 11.3 per 1000 population in 1981 (ranking suicide the eighth leading cause of death in Kansas) and the picture of family stress can be painted in violence and death among family members.

These statistics point out a great social need. Family therapists can be a key professional resource to help families cope.

#### Impact of Credentialing on Availability of MFTs

By itself, there is no evidence that state credentialing would have any significant effect on the availability of marriage and family

therapists in rural and urban areas in Kansas. There is, however, the potential for state credentialing to have an indirect effect.

Availability of marriage and family therapists to consumers in both rural and urban areas is significantly restricted due to the current systems of health care delivery in Kansas. Should state credentialing provide a way of identifying competent practitioners, it is conceivable that marriage and family therapists may at some point be designated as eligible for insurance payments. This would greatly enhance the availability of marriage and family therapists to consumers.

In the absence of credentialing (and consequent non-reimbursability), employment opportunities for marriage and family therapists, unless they also happen to hold licensure in another mental health profession (i.e., psychiatrist, psychologist, social worker), are bleak. Many mental health facilities, such as community mental health centers and hospitals, cannot afford to hire marriage and family therapists, as insurance companies will not pay for their services. Marriage and family therapists are forced to look elsewhere for employment (often out of state). The state of Kansas, for example, is in the peculiar position of investing tax dollars into marriage and family therapy training programs at both Wichita State University and Kansas State University, only to put many of the graduates in the position of having to look outside Kansas for employment in a state which permits the public a more equitable access to marriage and family therapists. This results in a waste of public funds as well as in a "brain drain". The current climate also discourages marriage and family therapists from other states from moving to Kansas. For example, in the spring of 1987,

Kansas State University offered a faculty position to an outstanding applicant from another state. The applicant turned down the position because her spouse, also a marriage and family therapist with a PhD, found the employment climate for marriage and family therapists in Kansas to be unfavorable, especially in comparison to his present state of residence.

In many remote, rural communities, the public's only access to mental health services is via a regional or local community mental health center. Typically, these facilities do not hire marriage and family therapists because insurance companies will not pay for their services. In such communities, therefore, consumers do not have any access whatsoever to the services provided by a marriage and family therapist. Even in large population centers, low-income individuals frequently depend on community mental health centers for low cost services, and therefore may also lack access to a practitioner trained specifically in marriage and family therapy. The overall effect, then, of credentialing followed by payment of insurance benefits for marriage and family therapy, would be to open up employment opportunities for marriage and family therapists which in turn would provide for greater availability of needed services to the public.

An example of how the current lack of credentialing indirectly restricts access by consumers to marriage and family therapy services is the situation at a clinic at a University in Kansas which serves both rural and urban populations. Clients with health insurance from most insurance companies cannot get payment if they wish to receive treatment from any of the three professors associated with the clinic, who are all

AAMFT approved supervisors with national reputations in the field of marriage and family therapy. These same consumers, however, could receive insurance payments if they were seen by one of the two doctoral students with masters degrees in social work, who, incidentally, are receiving supervision from the MFT faculty! Another example of consumers being denied access to a competent practitioner under current conditions is that a university MFT professor was hired as a consultant for the Southeast Area SRS Department for training their foster parents in coping with level 5 and 6 children and adolescents in foster care. However, if any of these foster families should need family therapy, the state of Kansas will not reimburse this professor for providing family therapy himself because he is not licensed. He can train the provider but cannot deliver the service himself! Such absurd scenarios, in which consumers are denied access to services provided by extra-qualified practitioners, will hopefully become a thing of the past should credentialing of marriage and family therapists provide a way of identifying qualified practitioners, which may in turn, eventually lead to reimbursement for their services by insurance companies and state agencies.

#### Opposition Arguments

Representatives of other mental health professions may argue that there is already sufficient access to practitioners trained in marriage and family therapy via already licensed professionals. For example, in Kansas, the major opposition to credentialing of marriage and family therapists comes from an organization representing private practice psychologists. They claim that the vast majority of psychologists have ample training in marriage and family therapy. That argument does not

hold up in the face of the evidence. For example, Cooper, Rampage, and Soucy (1981) report that only 15 out of 102 clinical psychology programs surveyed required even one course in family therapy. Ribordy (1987) reports that in a study by Ganahl et al. (1985), 34% of psychologists surveyed were doing family therapy, yet these practitioners reported "little formal training" (p. 205). In her own study of one clinical psychology program, Ribordy (1986) found that only 14% of graduates went on to do formal post-graduate training in family therapy, though 54% reported doing family therapy and 60% were practicing marital therapy. Alan Gurman, who is a clinical psychologist and professor of psychiatry, as well as a leading authority in the field of marriage and family therapy, reports that "in point of fact, most psychologists and psychiatrists receive minimal, and often no formal training in marital and family therapy". (See Appendix A).

Even if there were enough already credentialed practitioners adequately trained in marriage and family therapy, the consumer is not served by having a state established monopoly restrict his/her freedom of choice, as is the case when marriage and family therapist are effectively prevented from becoming reimbursable. A marketplace in which all legitimately qualified mental health practitioners were allowed to compete equitably would serve the public interest. This will not happen so long as credentialing (and reimbursability) is restricted to an elite class of practitioners.

## SCOPE OF PRACTICE

The language defining the scope of practice of the profession is a key item in the credentialing statute. It is commonly the item of contention between marriage and family therapists and other mental health professions who oppose their credentialing efforts. The reason for the controversy is that the wording of the scope of practice definition may affect the right of marriage and family therapists to claim reimbursement from insurance companies. Some already reimbursable mental health professionals aggressively oppose the credentialing of marriage and family therapists (as well as other professions) in order to restrict competition (though few will admit publicly that this is the reason).

KAMFT decided to propose the scope of practice language that was included in the 1987 version of the AAMFT model bill. AAMFT recommended usage of this wording in order to put marriage and family therapists in the best possible position to become eligible for third party insurance reimbursement. KAMFT decided to use the strategy of admitting to state officials and legislators that reimbursability was a major reason for seeking credentialing, and that reimbursability was not only in the interest of MFTs, but also in the interest of the consumer, whose access to MFTs is severely restricted in the absence of reimbursability. The language reads as follows:

### AAMFT Model Bill

The scope of practice of marriage and family therapy involves the rendering of professional marital and family therapy services to individuals, family groups, and marital pairs, singly or in groups, whether such services are offered

directly to the general public or through organizations, either public or private, for a fee, monetary or otherwise. Marital and family therapy is defined as the diagnosis and treatment of nervous and mental disorders, whether cognitive, affective, or behavioral, within the context of marital and family systems. Marital and family therapy involves the professional application of psychotherapeutic and family systems theories and techniques in the delivery of services to individuals, marital pairs, and families for the purpose of treating such diagnosed nervous and mental disorders.

Examples of scope of practice language utilized in other states:

Minnesota (1987) (Statute 148 B.29) and Utah (1984) (Statute 58- 39-3):

"Marriage and family therapy" means the process of providing professional marriage and family psychotherapy to individuals, married couples, and family groups, either singly or in groups. The practice of marriage and family utilizes established principles that recognize the interrelated nature of the individual problems and dysfunctions in family members to assess, understand and treat emotional and mental problems. Marriage and family therapy includes premarital, marital, divorce, and family therapy, and is a specialized mode of treatment for the purpose of resolving emotional problems and modifying intrapersonal and interpersonal dysfunction.

South Carolina (1985) (Statute 40-75-90):

"Marital and family therapy" means a specialized field of psychotherapy which recognizes the importance of marital and

family relationships in understanding and treating emotional and mental problems. It centers primarily upon the family system, marital and similar relationships, parent-child relationships, sibling relationships, and other family relationships. It involves the disciplined application of specific principles, methods, and techniques associated with marital and family relationships for the purpose of resolving emotional and mental problems, resolving interpersonal conflict, improving personal functioning, and improving interpersonal relationships. It includes, but is not limited to, premarital, marital, couple, sexual, divorce, and family psychotherapy.

Georgia (1984) (Statute 43-7A-3):

"Marriage and family therapy" means that specialty which centers primarily upon family relationships and the relationship between husband and wife and which includes, without being limited to, premarital, marital, sexual, family, predivorce, and postdivorce issues. This therapy also involves an applied understanding of the dynamics of marital and family systems, along with the application of psychotherapeutic and counseling techniques for the purpose of resolving intrapersonal and interpersonal conflict and changing perception, attitudes, and behavior in the area of marriage and family life.



For the purposes of reimbursability, the phrase "diagnosis and treatment of nervous and mental disorders" is the key language in the Model Bill wording. Words like "emotional" and "mental" are important to include; "diagnosis", "disorders", and "psychotherapy" are also helpful, but not quite as critical, according to the AAMFT national office. Therefore, of the examples given, the wording in the Model Bill would be preferable to the wording in the Minnesota, Utah, and South Carolina statutes, which, in turn, is preferable to the language used in the Georgia law.

#### Opposition Arguments

In Kansas, the wording in the proposed MFT bill was vigorously opposed by the most vocal opposition, the Kansas Association of Professional Psychologists (KAPP), an organization representing private practice PhD psychologists. KAPP has historically opposed the credentialing efforts of every other mental health profession in the state, and has aggressively fought to exclude language from the scope of practice which would allow for reimbursability. The premise of KAPP's argument is that other professionals (including MFTs) are not qualified to "diagnose and treat nervous and mental disorders." They attempt to prove this by pointing out that the training of an MFT differs from that of a psychologist.

In blunting this argument, it is necessary to use a two pronged strategy: 1) To demonstrate that the scope of practice language accurately reflects the training and practice of a marriage and family therapist and 2) To expose the psychologists' opposition for what it is: blatantly self-serving.

1) In support of the Scope of Practice Language

The difficulty involved in this task should not be taken lightly. The lay public (including state officials and legislators) while not being at all familiar with family therapy, is very familiar with the view of human functioning implicit in the medical model. Therefore, when psychologists attack the scope of practice language by pointing out that MFT training includes little or no emphasis on the DSM-III, MFTs' face an uphill battle in educating state officials and legislators to realize that such an argument is irrelevant. In other words, the psychologists attempt to set the rules for the game by establishing their own training as the standard for doing psychotherapy. It is important that MFTs not allow the game to be played on that particular field.

MFTs can immediately point out that it is the Commission on Accreditation for Marriage and Family Therapy Education (not a group of private practice psychologists in Kansas) that has received the official sanction of the U.S. government to set the standards of training for the field of family therapy. KAMFT secured a letter (see Appendix D) from Dr. Kenneth Hardy, Executive Director of the Commission on Accreditation. In the letter, Dr. Hardy states, "I want to unequivocally assure you that the educational standards set forth by the Commission on Accreditation for Marriage and Family Therapy Education reflect the body of knowledge and experience that the Commission deems necessary to practice marital and family therapy, as defined in the proposed scope of practice delineated in the KAMFT application."

To underscore this point, Dr. Hardy cites the 1988 Manual on Accreditation:

"Within the context of marital and family systems, students will learn to diagnose and treat dysfunctional relationship patterns, and nervous and mental disorders whether cognitive, affective, or behavioral."

It is then important to explain how the use of the phrase "diagnosis and treatment of mental and nervous disorders within the context of marital and family systems" accurately describes the practice of marriage and family and how the training of an MFT prepares him/her to so practice. The following discussion is the explanation used by KAMFT to educate state officials and legislators:

**"Emotional and Mental Disorders"**

Before we document that MFTs have the training to treat "nervous and mental disorders," it is important to explain what is meant by this concept of "nervous and mental disorder." The American Psychiatric Association has developed a system of diagnosing mental health problems, The Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III) that is based on the traditional medical model of diagnosing disease. Each of the "nervous and mental disorders" listed in the DSM-III describes, categorizes, and labels a particular symptomatic picture. This is a system of diagnosis that, though the standard in the medical field, is far from being universally accepted within the mental health field as a whole. However, insurance companies, which have only relatively recently extended health coverage to include mental health, have taken what they are familiar with, i.e., the medical model, and

require therapists to submit a DSM-III diagnosis of a "nervous and mental disorder" in order to be reimbursed. Hence, the importance of including this language in the scope of practice.

It is important to make it clear to state officials and legislators that family therapists have no great love for the term, "nervous and mental disorders." It is not the way MFTs choose to conceptualize the problems that individuals and families experience. Family therapists tend to view the DSM-III system, which utilizes a medical model of physical illness to describe mental and emotional dysfunction, as an attempt to fit a square peg into a round hole. Though certain other professionals may find the medical mold useful, it just doesn't fit for MFTs. Family therapists feel that this penchant to label people may in some instances have some undesirable effects, and there is some research which supports this view (Farina, Fisher, Getter, and Fischer, 1978). Family therapists are not alone in this opinion, as many other mental health professionals, among them some psychologists and psychiatrists, share this view.

However, the realities of the mental health marketplace today require mental health professionals, including marriage and family therapists, to be familiar with the DSM-III system. Consequently, though this system is addressed in MFT training, it is not emphasized in our treatment. Diagnosis (we prefer to call it assessment) is essential to the practice of family therapy, but we do it differently.

It is important to demystify for state officials and legislators the concept of a "nervous and mental disorder" as utilized in DSM-III; to talk about what it is and what it isn't. Many lay persons, for example,

hear the phrase "nervous and mental disorders", and immediately get a picture of a crazy person in a hospital. There are over 250 nervous and mental disorders described in DSM-III, some of which describe symptomatic pictures of people who are very detached from reality, such as schizophrenics, but also many that could be used to describe people who function at a much more "normal" level. Some examples of this opposite extreme are "Adjustment Disorder" and "Oppositional Defiant Disorder".

A DSM-III nervous and mental disorder describes an individual's symptomatic picture, and it does so in terms that a lay person can understand. Marriage and family therapists consider the individual symptomatic picture of every family member to be an important, though not, by itself, sufficient, component of family diagnosis. An important distinction to make is that family therapists do value a description of the individual symptomatic picture, but not the arbitrary categorizing and labeling that is the hallmark of DSM-III. It is also important to point out that DSM-III does not describe etiology nor prescribe treatment. Assigning a diagnostic category does not dictate the treatment. There are as many ways to treat depression, for example, as there are schools of psychotherapy. The treatment is based more on the training and preference of the therapist than on the diagnostic category. Some individually-oriented therapists, for example, would utilize only one approach, e.g., psychoanalysis or behavior therapy, no matter what the diagnosis, in the belief that treatment must be grounded in a consistent theoretical orientation. Other therapists prefer to use multiple modalities. Similarly, some family therapists prefer to operate from only one theoretical stance, e.g., the Bowen intergenerational

approach, while others may choose to integrate, for example, intergenerational, structural, strategic, and behavioral approaches in their practice of family therapy.

In conclusion, the diagnostic system (DSM-III) used by proponents of the medical model, has little utility for family therapists. The most common use of the DSM-III for most MFTs is for affixing a diagnostic category on an insurance claim form so that their clients can afford to have access to them. It should be emphasized that MFTs have the requisite skills to assign such diagnostic categories. To do so requires an assessment of an individual symptomatic picture, which is already an important (though not sufficient) part of family diagnosis/assessment. The MFT will then refer to the DSM-III manual and find the diagnostic category which most closely fits the symptomatic picture in question. It is important to point out that the DSM-III system is not an exact science, whether administered by psychiatrist, psychologist, or MFT. If a particular client is examined separately by, for example, three different practitioners, it is quite possible that they will come up with three different diagnoses. A key point to be made is that an MFT will not base treatment on the DSM-III category that is placed on an insurance form. Treatment will be based, however, on an assessment that includes an evaluation of each individual's symptomatic picture (minus the categorization and the labeling). Equally critical to note is that family therapists, as other mental health professionals, are both trained and ethically bound to recognize the limits of their competence, and to refer to other professionals when a particular problem is beyond their level of training. To sum up, most family therapists use the DSM-

III only for description of symptoms on insurance forms, and have sufficient training to do so. More importantly, since the DSM-III plays no significant role in family assessment, training in DSM-III should not be used as the measuring stick for determining the ability of marriage and family therapists to "diagnose and treat mental and nervous disorders within the context of marital and family systems."

It is important to point out the compelling research evidence (summarized in Gurman, Kniskern, and Pinsof, 1986) which shows that marriage and family therapy has proved effective in assessing and treating the entire range of symptomatic pictures categories as nervous and mental disorders, among them psychosomatic disorders (e.g., eating disorders), conduct disorders, schizophrenia, substance abuse, affective disorders (e.g., depression), and anxiety disorders. Alongside this fact, it is important to note that many individuals with symptomatic pictures that fit the criteria of a "nervous and mental disorder" experience their difficulties within a marital or family context. Research shows that the majority of clients who enter psychotherapy describe problems of a marital or family nature (Gurman, See Appendix I; Veroff, Kulka, and Dorvan, 1981; Seagraves, 1980).

These, then, are the clients who seek the help of a marriage and family therapist, those who present with "nervous and mental disorders within the context of marital and family systems." Despite our dislike of the terminology, this language does, in fact, accurately represent our scope of practice. The choice of language is necessary to put MFTs in a position to become reimbursable.

## Family Assessment and Treatment

It is important to emphasize to state officials and legislators that the training of an MFT intentionally differs from the training of a psychologist, because MFTs do not assess and treat in the same manner that psychologists assess and treat. Though MFTs respect the methods of psychology, ours are based on a different paradigm. While many psychologists, for example, make extensive use of paper and pencil tests for assessment, family therapists prefer methods that are more interactive. Traditional individual psychotherapy generally has conceptualized assessment and treatment as separate parts of therapy. One hallmark of family therapy is an integration of assessment and treatment.

It is important to explain to state officials and legislators just what family assessment involves. Articles dealing with family diagnosis/assessment (e.g., Mandelbaum, 1976; Kerr, 1987) are available for this purpose. One can then document for state officials and legislators that the training of MFTs enables them to diagnose/assess families by referring to the Commission on Accreditation's manual and to curricula of MFT training program.

### 2. Exposing Opposition Arguments as Self-Serving

The opposition (e.g., psychologists) will attempt to portray their objections to MFT scope of practice language as purely an attempt to protect the public from inadequately trained professionals. They may be able to get away with this, because most legislators, though aware that battles over credentialing among the various mental health professions



involve turf-guarding and access to third-party insurances, are unaware of the link between scope of practice language and reimbursability. Some groups, (e.g., the professional counselors in Kansas) have decided not to make the link between scope of practice language and health insurance overt, for fear that they would appear to legislators as self-serving. KAMFT, however, decided to use the strategy of admitting self-interest, but pointing out how, in terms of the scope of practice issue, the public interest meshed with KAMFT self-interest, in that it enables the consumer to have access to practitioners trained specifically in helping people with marital/family related problems.

MFTs can point out that both sides, in debating the scope of practice language, are interested in their own self-interests and that there is nothing inherently wrong with various professional groups attempting to further their own interest. However, legislation must be enacted on behalf of the public interest, and it is up to the legislature to determine on which side of this issue the consumer's interest lies.

What is the personal stake that marriage and family therapists have in advancing this licensure proposal? It is the ability to compete equitably with other mental health professionals, in the best sense of the American tradition of equal opportunity. What interest do already licensed, reimbursable mental health professions have in opposing credentialing of currently non-credentialed groups such as MFTs? They stand to gain by restricting competition in the mental health field. In Kansas, for example, the Kansas Association of Professional Psychologists (KAPP), an organization whose membership consists of private practitioners (i.e., those psychologists who would have the most to gain

from restricting the ability of other professionals to practice), has opposed the credentialing efforts of every other mental health profession to date.

Such groups would have legislators believe that their only motive for opposing credentialing is to make sure that the consumer is being treated by a competent professional. Yet it is widely known within the mental health field that "turf battles" play a major role in the debate over regulatory legislation. In an article examining the pros and cons of licensure that appeared in the January 1981 issue of the American Psychologist (which, incidentally, is published by the American Psychological Association), Danish and Smyer summarize the discussion that has emerged around the issue of licensure from within the ranks of psychologists:

"Two dominant themes have emerged from the discussion: ensuring psychology's place within the third-party reimbursement system and excluding other professions (e.g., social work and marriage and family counseling) from the system." (p. 13). (Our emphasis).

Danish and Smyer (1981) also point out how ironic it is that psychologists, who have historically fought the medical establishment to gain the right to practice their profession, are now, in turn, attempting to exclude other mental health professions:

"Psychologists are well aware of the increased costs to the public when qualified care providers are denied equal opportunities. It is just such an argument that psychologists

have used in their fight to gain the right to be equal partners with psychiatrists in health care provision." (p. 17).

The authors also cite research to support their contention that such turf guarding is not in the best interests of the many people with mental health problems, who, they contend, are undeserved (p. 17).

The question may arise: wouldn't credentialing of marriage and family therapists create the same sort of monopoly that the psychologists have? We would like to point out that there is nothing in typical MFT legislation to prevent psychologists from practicing marriage and family therapy. The intent of MFT legislation is to be inclusive: one would be able to be credentialed without having a degree specifically in marriage and family therapy. In contrast, the law in Kansas regulating psychologists is exclusive: someone with a degree in marriage and family therapy (even a Ph.D.) cannot be licensed as a psychologist, even if they were to take additional course work in psychology. In fact, the only way to be licensed as a psychologist is to have a degree in psychology.

#### Confronting the Opposition Argument

It is important to make clear to legislators exactly what the premise of the opposition's argument is, and then to expose the fallacy behind it. It may be useful to examine the example of Kansas, where it was KAPP's contention that marriage and family therapists were not qualified to "diagnose and treat nervous and mental disorders within the context of marital and family systems." They maintained that a Masters degree in marriage and family therapy plus two years of supervised experience (the qualifications called for in the proposed KAMFT legislation) was not sufficient. To call the opposition's bluff in this

situation one can then ask if they think an individual is qualified to diagnose and treat nervous and mental disorders with a Masters degree in MFT plus 4, 6, 10, 20 years of experience? A Masters in Social Work (in Kansas, insurance companies are required to reimburse licensed social workers for treating such disorders)? A PhD in Family Therapy? Psychologists typically answer no. It may then be advantageous to point out that there are over 250 "nervous and mental disorders" described in DSM-III, some of which describe symptomatic pictures of people who are very detached from reality, such as schizophrenics, but also many that could be used to describe people who function at a much more "normal" level. Certainly marriage and family therapists must be qualified to treat some of these disorders. Typically, psychologists will answer that a person with a degree in marriage and family therapy is not qualified to treat any nervous and mental disorder.

The premise of the psychologists arguments thus becomes clear; that, in terms of non-physician practitioners, only a practitioner with a PhD specifically in psychology is qualified to "diagnose and treat nervous and mental disorders." It can be pointed out to legislators that one would have a hard time convincing the millions of people who have found relief from their suffering with the help of psychotherapists who happen to be marriage and family therapists, psychiatric nurses, clinical social workers, and professional counselors, of this claim.

Even more significantly, MFTs can point out that there is no empirical evidence to support the premise that practitioners with degrees in psychology are more effective. On the other hand, there is ample research evidence to show the efficacy of marriage and family therapy, as

well as individually/intrapsychically based psychotherapy, in treating an entire range of "nervous and mental disorders" (Gurman, Kniskern, and Pinosof, 1986). In other words, psychologists are effective and marriage and family therapists are also effective. In addition, the available research indicates that the risk of harm to the client is the same for all forms of psychotherapy (Gurman and Kniskern, 1978).

A relevant question to raise is that of who it is that should set the standards for a profession. Not only is it "common sense", but it is also the precedent that the experts in the particular field set the standards for the profession. MFTs can point out that the scope of practice language is supported by the Commission on Accreditation for Marital and Family Therapy Education (see Appendix D), which has been sanctioned by the federal government to set training standards for the field. Testimony from other experts in the MFT field, both from within and outside the state can also be presented. It should be stated that it is inappropriate for one profession to attempt to dictate standards of another profession.

The bottom line, however, is that if the only goal of the psychologists was to assure that individuals practicing psychotherapy were qualified, there must exist some level of training/experience that would so qualify someone with a degree in marriage and family therapy. Apparently, the position of the psychologists is that not even someone with a PhD in marriage and family therapy and 50 years experience is qualified to "diagnose and treat a nervous and mental disorder within the context of marital and family systems." It is important to clarify for legislators that MFTs are not saying that groups like KAPP have no

regard for the public's well-being. Surely they do. What does seem clear is that this is not the reason they oppose credentialing of other mental health professionals. It seems, however, that it is all too easy for them to justify their own self interest by rationalizing to themselves that they are the only ones qualified to help people with their problems.

It is important, in challenging such opposition, to convey a sense of respect for their profession, e.g., psychology, particularly because this attitude will likely contrast with the opponents' tactics. It is equally important, however, for MFTs to convey an attitude of respect for their own profession, and to refuse to be intimidated by the opposition. It can be very difficult to strike a comfortable balance. Many therapists would prefer to stay "above the fray", yet these issues can be a matter of professional survival, and ultimately are important to the well-being of our clients, who stand to benefit by having access to practitioners trained in marriage and family therapy.

It should be pointed out that under the terms of the legislation advocated by AAMFT, even licensure would have no effect on the scope of practice of members of the other established mental health professions (e.g., psychiatrists, psychologists, social workers, and psychiatric nurses). The legislation would not prevent these professionals from doing or advertising that they perform the work of a marriage and family therapy nature consistent with the accepted standards of their respective professions, as long as they do not use a title or description stating or implying that they are marriage and family therapists or counselors or that they are licensed to practice marriage and family therapy or

counseling. This will allow members of other disciplines to practice their profession while, at the same time, enabling consumers to identify practitioners who possess the level of training and experience recommended by the profession of marriage and family therapy.

#### LEVEL OF REGULATION

In order to evaluate an appropriate means of protecting the public, it may first be helpful to refer back to the problems associated with the lack of regulation of marriage and family therapists:

1. No qualifications are required in order to practice marriage and family therapy. (Anyone, regardless of qualifications, may practice.)
2. There is no way for the consumer to identify qualified practitioners - to distinguish qualified from non-qualified.
3. There is no practical means of recourse for consumers should they be mistreated.
4. There exist no practice-related consequences for practitioner misconduct. A practitioner may legally continue to practice, no matter how unethically or incompetently he/she has practiced.
5. There exists no mechanism for requiring practitioners to educate their clients regarding client rights, practitioner qualifications, unethical practitioner behavior, or procedures for reporting misconduct.

There are several possible courses of action for dealing with these problems. Each one will be evaluated for its efficacy in dealing with these concerns:

1. Rely On the Present System of Credentialing by the Private Sector (AAMFT)

A certification process (through AAMFT) is currently in place, yet the public is at risk of being harmed by unqualified therapists who do not meet certification requirements. Although it is correct that voluntary membership in AAMFT represents possession of a credential, attesting that the members have received a certain level of education and experience, membership in AAMFT is not an adequate substitute for state regulation. The strongest remedy available to the Association to discipline its members is revocation of membership. The offender is still free to practice and continue to harm consumers. State government, in contrast, has a greater arsenal of weapons to use in monitoring a profession. The state can, for example, levy fines for unprofessional conduct, impose criminal sanctions, or place limitations on the ability of a professional to practice. Moreover, state government exists to serve the public interest and, therefore, consumers may reasonably feel that a license or certification granted by a state is more meaningful than possession of a credential from a voluntary organization.

2. Rely on Supervision in Employment Settings to Provide Protection of the Public

In many employment settings, individuals who perform the marriage and family therapy related functions do not receive what can be



considered adequate clinical supervision. Even in those settings that are under the direction of other health care personnel, it cannot be assumed that the consumer will be adequately protected. A practitioner from another mental health profession might supervise a marriage and family therapist administratively but not clinically. A marriage and family therapist could only be responsibly supervised clinically by another marriage and family therapist.

3. State Regulation

- A. Statutory regulation that does not involve credentialing, such as the creation or extension of statutory causes of civil action and/or criminal prohibitions.

Several states have passed legislation prohibiting therapists from becoming sexually involved with their clients. Minnesota has one of the strongest such statutes. Not only does it prohibit sexual contact with a current client, but also with ex-clients within a period of two years subsequent to termination of therapy. In addition, any professional who has knowledge of sexual impropriety by a therapist is required to report the misconduct to the state regulatory board. Minnesota has also extended causes of civil action to include unethical conduct on the part of psychotherapists.

Statutory regulation, such as the actions listed above, would provide a means for dealing with unethical practice. The problem with relying solely on civil action and criminal prohibition is that the harm is being addressed after the fact, i.e., after the damage has already been done. Any individual

would be permitted to practice marriage and family therapy, regardless of his or her qualifications, and the consumer would have no way to differentiate between qualified and unqualified practitioners.

Public sophistication regarding marriage and family therapy is not high enough to help consumers cope with the nuances regarding the implications and consequences of insufficient or deficient training in marriage and family therapy training. Errors of omission are much more difficult to prove in court than are errors of commission.

Another major problem is that there would be no means of suspending or revoking the right to practice as a consequence of violating such statutes, in the absence of a mechanism to restrict practice (i.e., licensing). Violators of these statutes would be free to continue to practice and, potentially, to inflict further damage on their clients. Finally, recourse to the courts through such statutory causes of action would be ineffective because of time delay and financial cost to the consumer who has been harmed.

B. Certification/Registration (Title Protection)

Certification/Registration is a level of credentialing that restricts the use of the protected title (e.g., "marriage and family therapist") to certified/registered individuals.

Currently, twelve states regulate marriage and family therapists through registration/certification laws: Connecticut, Florida, Georgia, Massachusetts, Michigan, New

Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Washington, and Wyoming.

Certification/Registration statutes differ in the level of restrictiveness. Some certification statutes prohibit the use of a particular title, e.g., "Certified" (or "Registered") "Marriage and Family Therapist". The protected phrase is "certified marriage and family therapist" rather than the broader professional title ("marriage and family therapist"). Non-registered practitioners are still permitted to call themselves "marriage and family therapists".

Some states have certification/registration laws which are more restrictive in that they prohibit the use of a broader title, e.g., "Marital and Family Therapist". Some certification laws have the effect of making it difficult to practice the function covered by the law, and, therefore, resemble licensing laws. This occurs where a title is defined so broadly as to make it virtually impossible to advertise the performance of the function.

A certification/registration law would set minimum standards of education (including ethical training), experience, and supervision as a requirement for certification/registration as a marriage and family therapist. This would present the consumer with the opportunity to make an informed choice when attempting to select a qualified therapist. The public would also have some small degree of protection from unethical practitioners as the state

regulatory board would have the authority to suspend or revoke registration, though not to suspend practice.

Though state certification would establish minimum qualifications for marriage and family therapists certified under the act, this does not guarantee that the public would be knowledgeable about the qualifications associated with a certified professional. (This would especially hold true if, as in the Kansas professional counselors registration law, the statute were to only restrict the title of "certified marriage and family therapist" and still permit anyone to call themselves a "marriage and family therapist", "marriage counselor", etc.) Though an aggressive effort to educate the consuming public would help (and could be mandated by the regulatory board), it would still be expected that a sizeable amount of the public would not know the difference between a certified and uncertified marriage and family therapist and therefore be at greater risk of being treated by an incompetent and/or unethical practitioner.

The major problem not addressed by certification is that, although the state regulatory board would have the power to revoke the registration of an incompetent/unethical practitioner, such a person would still be permitted to practice as a marriage and family therapist (without the title: "registered"), thereby exposing the public to further risk.

- C. Licensure would not only restrict use of title but also the practice of marriage and family therapy to licensed

individuals. Four states currently require the licensing of marriage and family therapists: California, Minnesota, Nevada, and Utah.

A licensure statute establishes minimum qualifications in the areas of knowledge, training, experience and supervision which are required in order to practice. It provides for practice-related consequences (suspension and revocation of license) in the event of unethical or incompetent behavior as well as a practical form of redress for injured clients. The state regulatory board could also be empowered to mandate education of consumers by licensed therapists regarding client rights, unethical practices, procedures for reporting therapist misconduct, and the qualifications and responsibilities of a licensed practitioner.

The state of Minnesota's statute licensing marriage and family therapists mandates that knowledge of professional misconduct by regulated individuals be reported to the state regulatory board by the following:

- 1) Institutions. Government agencies, private agencies, hospitals, clinics, and other health care organizations are required to report to the board any adverse or disciplinary action (e.g., any revocation, suspension, or restriction of privilege to practice) taken by the institution against a regulated practitioner for conduct that might constitute grounds for adverse or disciplinary action by the board.

2) Professional Associations. Professional associations such as AAMFT would be required to report to the board any adverse or disciplinary action (e.g., revocation or suspension of membership) taken against a regulated individual.

3) Licensed Health Professionals. A licensed health professional is required to report to the board personal knowledge of any conduct (by a regulated individual) that he/she reasonably believes constitutes grounds for adverse or disciplinary action.

4) Insurers. Any insurer providing professional liability insurance to regulated individuals is required to submit to the board a report detailing all malpractice awards and settlements against regulated practitioners.

5) Courts. Court administrators are required to report any judgements or findings that a regulated individual is mentally ill, mentally incompetent, guilty of a felony, or guilty of an abuse or fraud under Medicare or Medicaid.

The law also requires that license applicants who have previously practiced in another state report to the board any malpractice settlement/award or civil litigation related to misconduct by the license applicant. Another section of the statute provides that the board shall, at least annually, publish and release to the public a description of all disciplinary measures or adverse actions taken by the board. Such measures would greatly enhance the effectiveness of a licensure law.

Licensure addresses each of the problems associated with the lack of regulation: 1) Practice is restricted to individuals who have met established qualifications. 2) The public has a means for identifying practitioners who have minimum qualifications. 3) The consumer has a practical means of recourse for dealing with therapist misconduct through the filing of a complaint with the state regulatory board. 4) The state regulatory board can apply practice related consequences (i.e., revocation, suspension of license) in response to practitioner misconduct. 5) The state regulatory board can mandate that licensed practitioners educate clients regarding their rights.

Licensure would obviously not eliminate all harm. Studies (Gurman and Kniskern, 1978a) show that deterioration occurs in a percentage of cases even when trained practitioners are involved, psychotherapy not being an exact science. Unethical behavior occurs in spite of licensure. The hope is that through a combination of preventative measures and effective recourse, the amount of harm will be reduced.

#### CONCLUSION

The profession of marriage and family therapy, as other mental health professions, has a two-fold interest in credentialing legislation. Credentialing is seen as a means to protect consumers of marital and family therapy services. Credentialing is also seen as a way to advance the interests of MFTs, in that societal recognition will provide for an

equitable opportunity to compete in the mental health care market place. This latter goal dovetails with the interest of consumers who stand to benefit from increased access to practitioners trained in marital and family therapy. Licensure would provide the strongest measures for protecting the public.

Licensure, however, is not without its flaws. The debate within the profession of marriage and family therapy should include a frank evaluation of the disadvantages of licensure as well as a thorough and creative consideration of alternative possibilities for achieving the same goals.

The problem with licensure is that though the goal is to screen out unqualified practitioners, there is also the potential for excluding some competent practitioners as well. Licensure, by excluding non-members of the profession from practicing serves to create a state-enforced monopoly for members of the licensed profession. Though non-members may be able to get around the practice barriers, by using another title and by using differing words to describe their scope of practice, licensure makes it tougher to compete. This is particularly true when, as is currently the case, the system of payment for health care delivery is tied to state regulation. Marriage and family therapists know only too well the disadvantages of being shut out by this defacto monopoly. Not only do the practitioners suffer from this situation but also the consumer, who stands to pay higher fees and have access to non-licensed practitioners significantly restricted.

Marriage and family therapists must ask themselves if they want to "do unto others as has been done unto them." Pursuing a course of action



that would corner the market for family therapists would be inconsistent with the ecologically based principles of family therapy that place a high value on the openness and interrelatedness of social systems. The key is to be able to provide protection for the consumer without 1) keeping other qualified practitioners from earning a living and 2) preventing consumers from having access to competent individuals who are able to help them.

One point that must be kept in mind is that no one has a monopoly when it comes to knowing how to help people with their problems - the science of mental health is in its infancy. Therefore, it does not serve the public for there to be absolute monopoly in terms of the practice of mental health care. Relatedly, licensure laws have the potential for institutionalizing professional stagnation and discouraging creativity in the advancement of the field of mental health. The licensure process, by establishing standards of training based on a certain body of knowledge, carries with it the potential for "carving in stone" a certain worldview inherent in that body of knowledge, along with the associated practice methodology. New fields, such as marriage and family therapy, need to be not only permitted to develop by law but encouraged to develop. It is questionable whether licensure laws provide for such an environment.

If there are to be credentialing laws, the challenge is to make them as inclusive as possible while still providing protection. Current MFT regulatory statutes represent much of an improvement over those of traditional professions by virtue of allowing entry to the profession by practitioners with degrees from disciplines other than marriage and family therapy.

Another valid criticism of licensure is that it has not been very effective in dealing with unethical behavior on the part of therapists. Bouhoutsos (1985), for example, points out that sexual involvement between therapist and client goes largely unreported. She points out the need for a greater emphasis on preventative measures, i.e., education of both consumers and practitioners. One study (Bouhoutsos, 1983), for example, found that only about half of the clients surveyed who had been involved in such activity knew that it was considered unethical by the mental health professions. Mandatory consumer education informing clients of their rights could go far to making regulatory laws more effective.

Education aimed at the practitioner is another important component of prevention that might enhance the protection of consumers. Ethical training must not only be included in the curriculum of training programs (as called for by AAMFT and Commission on Accreditation guidelines), but must also be an ongoing subject for supervision. MFT supervisors must be proactive in this area, e.g., by acknowledging their own experiences with these issues. For example, it can be effective to let students know that they will be sexually attracted to clients (and vice versa) and to provide discussion on strategies to deal with these situations. Ongoing inservice training and support groups in employment settings should also be an important part of a practitioner's education Bouhoutsos (1985).

Some critics of licensure (Gross, 1978) note that the public views licensure as a measure of competence, and that this is misleading. Licensure does guarantee a minimum level of education and training, but this does not necessarily equate with competence. Most states require

passage of a written exam to measure competence. More likely such exams measure knowledge and not necessarily the competent application of such knowledge to psychotherapy. Perhaps a use of an oral exam designed to assess therapist skill would come closer to an evaluation of actual competence. A related problem is that only initial competence is typically evaluated. Provision for assessment of continuing competence would add even more credibility to a credentialing system. Though such solutions are time consuming and expensive they need to be closely considered by professions that are sincerely interested in "quality control".

Along with new ideas for protecting the public, the profession needs to actively encourage research. Competence, for example, can not be effectively assessed if there is not a reasonable understanding of the therapist behavior that leads to successful outcome.

#### An Alternative to Licensure

Minnesota has come up with a creative way of dealing with client protection that may provide a basis for eliminating the restrictiveness of licensure while still providing for recourse should a consumer be mistreated. A 1987 law requires that all non-regulated persons practicing psychotherapy file with the Board of Unlicensed Mental Health Service Providers. Each practitioner must list his/her qualifications and is required to distribute a "bill of rights" to all clients. The bill of rights encourages clients to report therapist misconduct to the Board, which has the right to revoke an individual's right to practice. Such a system provides for practice related consequences that were previously only available through licensure.

There is the potential for combining such a system with certification/registration of the established professions. Certification/registration would allow the consumer to identify practitioners with a certain level of training, but in contrast to licensure, would not prevent anyone else from practicing. Though this would allow unqualified, potentially incompetent people to practice, perhaps our current state of knowledge/research does not enable us to determine with enough certainty what training/education is necessary to practice competently. An intensive program of consumer education would increase the client's ability to make an informed choice. Practice related consequences would be available in the event of misconduct.

One intended benefit of such a system would be that it would be more conducive to cooperation among the mental health professions as opposed to the atmosphere of in-fighting that prevails when some groups are permitted a monopoly. If all of the mental health professions were certified/registered rather than licensed, there might be less incentive for turf-battling, since everyone would be permitted to practice. It seems, however, that such turf-guarding will continue, so long as the system of payment for health care delivery is tied to credentialing. It is important that the mental health professions begin to deal with this problem so that the short-term self interests of the professions do not continue to be advanced at the expense of the consumer's welfare. One first step might be a collaborative effort on the part of the various mental health professions to conduct research regarding the level and content of training associated with successful psychotherapy outcome. Not only would such research advance the science of mental health, but

these findings would help third party payers decide which professionals to reimburse.

In working towards protection of the public and advancement of the profession, marriage and family therapists need to keep an eye on the big picture. In making family therapy increasingly available to society, advocates should be guided by the same holistic principles that underlie the practice of the profession. As Brown-Standbridge (1986) has said, "acceptance of the new profession must be addressed via the very systemic principles which give it substance." (p. 141)

Though it will be important to pay close attention to such "big picture" issues, it is equally important not to minimize the significance of credentialing for the continued advancement of the field of marriage and family therapy. The profession will continue to develop only to the extent that marriage and family therapists are able to compete equitably with other mental health disciplines, and the key to such parity is statutory credentialing.

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APPENDIX A

EXPERT TESTIMONY IN SUPPORT OF KAMFT APPLICATION

Department of Psychiatry  
600 Highland Avenue  
Madison, Wisconsin 53792

(608) 263-

MEMORANDUM

TO: Behavioral Science Board, State of Kansas

RE: Testimony to the Technical Committee Hearing re: Application of the  
Kansas Association for Marriage and Family Therapy for  
Licensure of Marriage and Family Therapists

DATE: August 28, 1987

This note is written to lend the strongest possible support to the KAMFT proposal for the establishment of licensure for Marriage and Family Therapists in the State of Kansas. In offering such support, it is important that I emphasize that I am both a licensed clinical psychologist (Wisconsin) and a Professor of Psychiatry. These two professions are among those that typically do not endorse MFT licensure. Yet, the issue at hand is not one of professional territoriality, but of appropriate and effective patient care. In point of fact, most psychologists and psychiatrists receive minimal, and often no, formal training in marital and family therapy. This unfortunate fact exists alongside another empirically established fact that the majority of problems for which the help of mental health professionals is sought involve problems in marital and family relationships. For the consumer public to be well served in these areas of life, treatment needs to be provided by mental health professionals with formal, systematic and comprehensive academic and clinical education and training in the areas of relevance, i.e., marital and family relationships and marital and family therapy. Without question, professionals who would meet the stringent requirements for licensure as marriage and family therapists as proposed by the KAMFT, would qualify to provide appropriate and effective treatment.

I urge you respond positively to the KAMFT licensure proposal in the interest of enhancing the mental health welfare of the citizens of Kansas.

Sincerely,



Alan S. Gurman, Ph.D.  
Professor of Psychiatry  
and  
Editor, Journal of Marital and Family Therapy

ASG:bd

The American Association for Marriage and Family Therapy  
submitted by Mark Ginsberg, PhD, Executive Director.

AAMFT has long been established as the national professional association for marriage and family therapists in the United States and Canada. Founded in 1942, AAMFT has nearly 14,000 members and divisions in almost every state. The members of AAMFT have met rigorous educational and training standards which have been established as entry criteria into the profession of marriage and family therapy. The AAMFT clinical membership requirements help the public identify well-educated, skilled, and ethical practitioners of marriage and family therapy which, in turn, helps to serve the growing public demand for marital and family therapy services. AAMFT publishes the Journal of Marriage and Family Therapy, sponsors an annual conference, and has a committee that handles complaints of violations of code of ethics.



## American Association for Marriage and Family Therapy

August 18, 1987

Statement of the AAMFT regarding the application of the Kansas Association for Marriage and Family Therapy for the licensure of marriage and family therapists in Kansas

The American Association for Marriage and Family Therapy (AAMFT) strongly supports the advocacy efforts of our division, the Kansas Association for Marriage and Family Therapy, to pass regulatory legislation, in the public interest, to license marriage and family therapists. An important and compelling reason necessitating licensure of marriage and family therapists in Kansas is the serious risk of harm to consumers of marriage and family therapy services from untrained or unethical practitioners.

AAMFT has long been established as the national professional association for marriage and family therapists in the United States and Canada. Founded in 1942, AAMFT has nearly 14,000 members and a division in almost every state, including Kansas. The members of AAMFT have met rigorous educational and training standards which have been established as entry criteria into the profession of marriage and family therapy. The AAMFT clinical membership requirements help the public to identify well-educated, skilled and ethical practitioners in marriage and family therapy which, in turn, helps to serve the growing public demand for marriage and family therapy services.

Clinical members of AAMFT have completed specific post-graduate training in marriage and family therapy as well as extensive supervised clinical practice with couples and families. In an effort to advance the professional understanding of marriage and family behavior and the treatment of marriage and family dysfunction, the association publishes the widely respected Journal of Marital and Family Therapy. AAMFT also publishes a bimonthly newspaper, entitled the Family Therapy News. In addition, the Association sponsors an annual conference, with an attendance of approximately 4,000 marriage and family therapists, which brings together leading marriage and family therapists who participate in over 250 workshops, training institutes, seminars and symposia emphasizing the most recent developments in marriage and family therapy theory, technique, and research.

The services of marriage and family therapists are much in demand. Everyone is part of some family and none of us are immune from the problems associated with marriage and family life. Americans are getting divorced at a higher rate than ever; if present trends continue, one out of every two present marriages will end in divorce. In addition, reports of physical and sexual abuse within families are at an all time high. Consumer demand for, and interest in, marriage

and family therapy has steadily increased since the 1940s. Research suggests that marriage and family therapy is the most effective treatment for many crucial problems facing America's families--such as family violence, substance abuse, delinquency, and other serious disorders of childhood, adolescence and adulthood. Such problems often require treatment by a trained mental health professional, including marriage and family therapists. When marital and family problems are treated by untrained or otherwise unqualified individuals, the consequences to marriage and family life can be adverse, detrimental or even result in more severe problems and dysfunction.

Without state laws regulating the profession of marriage and family therapy, individuals experiencing serious marital and family problems, often are not informed about and able to make careful decisions on choosing a qualified therapist. Consumers are often unable to appropriately evaluate the credentials of persons holding themselves out as marriage and family therapists. In the absence of necessary state regulatory laws, inadequately trained mental health professionals pose special dangers for the public, and state regulation is, therefore, important both for providing consumers with information relevant to choosing a competent and appropriately trained marriage and family therapist, as well as providing a grievance process for consumers to bring appropriate legal action against fraudulent practice or for malpractice.

The fact that there exists a strong potential for harm to consumers who receive services from an untrained marriage and family therapist is a well established fact. Danger to clients can stem both from unethical and incompetent practice. The therapist, by virtue of both his or her relationship with a client and perceived expertise and authority, is in an extremely powerful position in relation to the client. Unfortunately, some mental health practitioners, fortunately a small number, have been known to use this influence to exploit their clients and cause harm. For example, there are, unfortunately, documented cases of therapists from virtually all of the mental health professions becoming sexually involved with clients, with serious, adverse consequences. Although regulation of marriage and family therapists by the state of Kansas does not, itself, guarantee that such cases would not exist, state regulation does provide a harmed party with an appropriate legal avenue for redress and an appropriate regulatory mechanism for the establishment of legally sanctioned ethical, educational and professional standards for the practice of marriage and family therapy in Kansas.

The very nature of marriage and family problems and marriage and family therapy places individual and family clients in a unique position. Ethical issues arise in marriage and family therapy which are, at times, different from those of individual therapy. Although harm from the violation of client confidentiality is a danger in all psychotherapies, in family therapy the therapist's client often is a family comprised of several individuals. Consequently, issues of confidentiality are very complex. Certainly more traditional issues of both confidentiality and privileged communication also are compelling issues for both consumers and practitioners of marriage and family therapy.

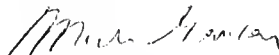


In addition, Kansans who are consumers of marriage and family therapy services are at risk when such services are not provided by appropriately trained professionals. The research literature in marriage and family therapy provides ample evidence of the fact that when incorrect interventions are applied or when the interventions of a marriage and family therapist are not properly applied, harm can result. It is unfortunate, but true, that health professionals, including marriage and family therapists, at times make errors. For example, when conducting marriage and family therapy, an untrained or inappropriately trained therapist easily can do harm either by not fully understanding or correctly using the "systems" concepts integral to marriage and family therapy or by making errors or using poor judgement regarding the use of a "systems" approach. The dynamics of marriages and of families are complex. Appropriate and effective treatment requires that when services are provided they are provided by adequately and appropriately trained persons. Without an assurance of the adequacy and appropriateness of the training of marriage and family therapists, through a state regulatory program, the citizens of Kansas are at risk for harm.

In conclusion, then, a strong potential for harm to consumers of marriage and family therapy exists. The probability of harm occurring is magnified when the practitioner lacks appropriate training and does not adhere to ethical and professional standards for practice. The requirement by the state of Kansas, through a state regulatory program, that individuals practicing marriage and family therapy possess a requisite level of training, supervision, and experience would help significantly to minimize the risk to the public. Therefore, AAMFT is strongly in favor of legislation, in the public interest, advocated for by our division, the Kansas Association for Marriage and Family Therapy, which would mandate the licensure of marriage and family therapists in the Kansas.

If I may be of further assistance, please do not hesitate to contact me.

Sincerely,



Mark Ginsberg, Ph.D.  
Executive Director

Candyce S. Russell, PhD.

Professor of Marriage and Family Therapy; Chair of the Marriage and Family Therapy Unit at Kansas State University, which runs both masters level and doctoral level AAMFT-accredited training programs; AAMFT approved supervisor, clinical member and Fellow; current national Secretary of the American Association for Marriage and Family Therapy (1985-1987); Teaching Associate and Visiting Professor, University of Minnesota. KAMFT: Board of Directors (1979-1983), Vice-President (1980-1981), President (1981-1982), Newsletter Editor (1983-1984), Legislative Committee (1984-present); Special Issue Editorial Boards: Family Relations (Farm Stress, Coping, and Adaptation) and Journal of Family Issues (Transition to Parenthood); Issue Editor: Journal of Psychotherapy and the Family (Circumplex Model of Marital and Family Systems); Special reader for: American Journal of Family Therapy and Journal of Marital and Family Therapy; Licensed Consulting Psychologist, State of Minnesota; Articles published in: Journal of Marital and Family Therapy, American Journal of Family Therapy, Family Process, Journal of Social Issues, Family Relations, Psychological Reports, and Journal of Marriage and the Family; Chapters in: Advances in Family Intervention, Assessment, and Theory (1979), New Perspectives in Marriage and Family Therapy: Issues in Theory, Research, and Practice (1983), Families in Trouble (1987); marriage and family therapist for 15 years and supervisor for 10 years; PhD from University of Minnesota (1975) and additional training in marriage and family therapy at the Menninger Foundation and the Philadelphia Child Guidance Clinic.



## American Association for Marriage and Family Therapy

CANDYCE S. RUSSELL Ph.D.  
Secretary

### TESTIMONY TO TECHNICAL COMMITTEE HEARING APPLICATION OF KANSAS ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY FOR LICENSURE OF MARRIAGE AND FAMILY THERAPISTS

The objective of this testimony is to establish the harm that may befall the consumer who obtains marriage and family therapy from an untrained, poorly trained and/or unregulated provider. Harm may result from: 1) inaccurate assessment, 2) lack of attention to how a change in one part of the family impacts other parts of the family, and finally, 3) unethical behavior that places the needs of the provider above those of the client family. Each of these three areas will be addressed below.

- 1) **Inaccurate assessment:** Competent treatment of the family system requires being able to identify redundant patterns of interaction which constrain the behavior of members of that system. Recognition of these patterns requires the clinician expanding his/her field of attention to the way parts interact (e.g. behavioral sequences) as opposed to what's going on inside the parts (e.g. cognitions, feelings, personality, defenses, etc.). Making the shift from a focus on the individual to a focus which includes the individual but also enlarges the context to interactional sequences requires careful training and, ideally, live supervision of family sessions. One of the most frequent errors in assessment is misinterpreting conflict within a family or marital relationship as too much distance when, in fact, the system is very reactive and in need of structured separateness. Such errors in assessment can result in escalation of conflict and increased domestic violence.
- 2) **Lack of attention to how a change in one part impacts other parts of the family:** A clinician trained in family systems theory will be aware that removing one symptom as a focus may not eliminate the problem if the "identified patient's" symptom has served an important function in the larger family system. For instance, if a child's behavior problem has served to distract his parents from marital stresses, a skilled family therapist will be prepared for increased marital conflict, symptoms in another child or depression in one of the spouses if the original "identified patient" improves. An untrained provider may terminate the family with the job only half done. Gurman (1978) reports a four per cent "deterioration" rate in published studies of marriage and family therapy outcome. These instances of deterioration may result from reverberation of change throughout the family system, with one symptom substituting for another.

An unskilled provider may also fail to prepare a client for the powerful "counter-moves" family members may make to resist changes (even healthy changes) which the client attempts to make. When a family has organized itself around an intrusive and persistent problem, improvement in the problem will confront the family with the dilemma of having to find a new way to respond to the "problem person" and to each other. A client who is not prepared for the family's "unappreciative" response may become discouraged and return to the original symptom or find a new one. For instance, a spouse who gives up drinking but finds his/her spouse to be increasingly distant may become depressed and return to drinking in response to the partner's lack of appreciation for his/her personal efforts at change. The couple should be prepared for this response and helped to gradually increase the closeness in their relationship (Kaufman, 1985).



## American Association for Marriage and Family Therapy

CANDYCE S. RUSSELL, Ph.D.  
Secretary

- 3) **Unethical behavior:** Providers who are untrained or who are not regulated are more likely to use their contact with their clients to work out their own unresolved issues or in other ways to focus on their own needs above those of the public (e.g. using client testimony to gain more business, engaging in dual relationships with clients, etc. Such behavior on the part of providers destroys the trust of clients and makes the development of future relationships appear all the more risky. Licensure would provide the state with a means of ensuring providers who misuse the public in unethical ways.

Candyce S. Russell, Ph.D.  
Professor

**Anthony P. Jurich, PhD**

Professor of Marriage and Family Therapy and Clinical Director of the Marriage and Family Therapy Clinic at the Kansas State University Family Center; AAMFT approved supervisor, clinical member, and Fellow; Director, Organization of Training Directors of the American Association for Marriage and Family Therapy; serves on AAMFT Judiciary Council; Associate Editor, Journal of Marriage and Family Therapy; author of 82 journal articles and book chapters; articles published in Journal of Marriage and Family Therapy, American Journal of Family Therapy, Journal of Marriage and the Family, The Family Coordinator, Family Relations, Journal of Early Adolescence, Adolescence, Family Issues, and Psychological Reports; co-author: Marital and Family Therapy; author: Moral Development of Adolescents; marriage and family therapist for 17 years; supervisor for 15 years; PhD from the Pennsylvania State University.



## Marriage and Family Therapy Unit

Department of Human Development and Family Studies  
Justin Hall  
Manhattan, Kansas 66506  
913-532-5510

9-1-87

### TESTIMONY TO THE TECHNICAL COMMITTEE HEARING THE APPLICATION OF THE KANSAS ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY FOR LICENSURE OF MARRIAGE AND FAMILY THERAPISTS

The purpose of this testimony is to help establish the need for the regulation of the field of Marriage and Family Therapy through licensure in the State of Kansas. The most compelling reason for licensure is to help prevent the harm to the public which is presently existant because of the unregulated practice of marriage and family therapy.

Trained marriage and family therapists work from a "systems theory" orientation in which the family is treated as the client and not simply the person whom the family has designated as the identified patient. In some cases there is an individual identified patient exhibiting symptoms which appear to have little family context and, upon further assessment, seem to be confined to the individual pathology of that person. In this case, the individual therapist and the systemic family therapist might come to the same conclusion that this client needs individual psychotherapy and the client will be referred to such a therapist (e.g., clinical psychologist, psychiatrist, clinical social worker). However, there are many times when the presenting problem and the identified patient are but a symptom of greater pathology within the family unit. In my 15 years as the Clinical Director of the Kansas State University Family Center, I have seen countless cases where a young adolescent boy or girl enters into the juvenile justice system for a misdemeanor or a Class D felony. The individual therapist agrees with the family in labeling the child "incorrigible" or "hard to handle." Often, this child demonstrates few delinquent tendencies but instead expresses worries about his or her parents' marital relationship and doubts as to whether the marriage will stay together if he or she does not "act up" in order to give the parents something upon which they can work together. Salvador Minuchin (1974) has expressed that, "the greatest gift which a parent can give to a child is a good marriage." These children did not receive such a gift. Because of his or her perspective, an individual therapist may never pick upon the cues or ask the questions which will lead to an exploration of these dynamics. To a family therapist, this would be one of his or her first lines of inquiry. How many of our state's youths, who are presently wards of the state, could have been treated with far less individual trauma and at less cost to the state, if marriage

and family therapy were licensed by the state to provide a state-regulated alternative to individual treatment?

Sometimes this lack of a family perspective can result in tragic consequences, as the following case example (appropriately disguised to assure confidentiality) makes clear. A male client in therapy with a marriage and family therapist wanted to talk about the guilt he felt about his wife's recent death. He had previously been seeing a clinical psychologist for a nervous condition. During the course of therapy, he had mentioned to the psychologist that the thing that made him most uneasy were his wife's threats of suicide. The client explained different situations which led to such suicidal threats by his wife. The psychologist, without ever asking to see the wife or hear her point of view, told the husband that these were manipulations and would be best handled if they were ignored. The wife proceeded to commit suicide. The husband was devastated. So was the psychologist. The husband reported the psychologist's apologizing to him for not seeing the wife's view clearly. The husband, subsequently, specifically sought out a marriage and family therapist because he felt that he and his wife should have come in together for marriage therapy before it was too late. He needed to do some grief work with his marital relationship after his wife's death. A family system's perspective might have made a difference in hearing her anguish and, perhaps, in preventing her death. Perhaps this is why some research has shown that family therapy is more effective than individual therapy with suicidal clients (Jurich, 1983).

Working therapeutically with families is more than working with a collection of individuals. These individuals have a history, expectations (both internal and external), and a way of relating with each other. Just like a chair is more than the sum of its parts, so too is a family more than a collectivity of individuals. As a therapist works with certain problems of certain family members, other problems may arise (symptom substitution) or other family members may take on more dysfunctional roles in an effort to protect the balance of the family system. In a recent case, a psychiatrist at a mental hospital asked a marriage and family therapist to do some family therapy with a family whose oldest teenage son was about to be discharged from the hospital, in preparation for their son's returning home. During a family session, the therapist asked each family member to explain to the family what it would mean to the other members of the family for the oldest son to return home. Following this pattern of "circular questioning," each family member gave the expected response of joy and happiness at the return of the first born son. However, the



youngest girl also remarked that she felt that Jim, the second oldest brother, would be most happy because if the oldest brother returned home, "Jim wouldn't have to act so bad as he did now." Within the context of family therapy, the family discussed their need for a "Scapegoat" who would "carry the sins of the family so that everyone else could be free." When the family therapist discussed this with the son's psychiatrist, he was surprised in that he had no idea that such a destructive family pattern existed in this family. He was aware of other problems but not that one. He had been limited to the single perspective of individual therapy, while the marriage and family therapist had the multiple perspective of family therapy. In this case, both perspectives were needed. It was agreed to delay the son's release until his family could work through these scapegoat issues. The son's integration back into the family was excellent. The lack of a trained marriage and family therapist, or the utilization of an untrained or poorly trained marriage and family therapist, would have left this family in dire need of additional help. Fortunately, the hospital psychiatrist knew how to contact a competent marriage and family therapist. In the absence of licensure, the consumer with far less knowledge of the helping system network, could easily be misled and make a poor choice.

Finally, without the licensure of marriage and family therapy, the public is at greater risk from unethical practitioners claiming to be marriage and family therapists. Approximately three years ago, a man, claiming to be a family therapist, became a member of a fundamentalist church and offered his services as a "Christian Family Therapist" to the congregation. An older couple, who had an unmarried daughter who was 26 years old, sought his advice as to how to help their daughter be more socially graceful "around men." After seeing the three of them in one family session, the therapist announced that he could work better with the young woman alone. After six sessions at \$30.00 each, the girl finally announced to her parents that the therapist had had sex with her in each of her previous six "therapy sessions" under the guise of "teaching her about how to get along with men." The parents were furious and wanted to take action against the therapist. However, since their daughter had consented, she was over the age of 18, and the therapist was slick enough to label his therapy in such a way as to not appear to be fraudulent, the parents were advised that they could not take legal action. Since the field of marriage and family therapy is not regulated and the therapist was not a member of any professional organization, the parents had no recourse with the State or with the professions. The parents did expose him to the church elders and he was asked to leave. These parents



sought a referral to a trained and ethical family therapist to continue work with the family over their daughter's original problem and, in addition, the new family problem caused by the therapist. Recently, when I checked with the therapist, to whom they had been referred, to see if he could get the family's permission to use this disguised version of their story for this testimony, he relayed some interesting information about the original unethical therapist. It seems that he had moved to another congregation in a neighboring state and proceeded to try to set up a practice in the same way. He did the same exact thing to another woman in that congregation! However, he also pulled the same scam on a 16 year old girl and is presently being prosecuted for statutory rape. If the profession of marriage and family therapy were regulated through licensure by the State, it would have been much harder for this individual to hurt these three women in this manner. Furthermore, if he had unethically injured the first woman, he could have been prevented from injuring the other two.

The State of Kansas needs to license marriage and family therapists in order to protect the public from the harm elaborated upon in this testimony.

Sincerely,



Anthony P. Jurich, PhD

/lf

Eric McCollum, MSW, PhD.

Faculty Member, Marriage and Family Therapy Training Program, the Menninger Foundation; marriage and family therapist and social worker, the Menninger Foundation; AAMFT Clinical Member and Approved Supervisor; has conducted training programs for marriage and family therapists both locally and in several other states; current Secretary, Kansas Association for Marriage and Family Therapy; PhD in marriage and family therapy, Kansas State University.

## CERTIFICATION OF MARITAL AND FAMILY THERAPISTS

The major reason for state government to regulate the members of a health profession is to protect the public. Regulation gives those who seek services from a certified professional the assurance that that professional person has met at least minimum standards of training and adheres to a certain standard of practice. This issue is particularly germane to the field of marital and family therapy (MFT). Currently, MFT is practiced by members of a number of health professions. Thus, the person seeking MFT services has no assurance that his therapist has had a specific course of training specifically in MFT. More likely, the practitioner either applies an approach best suited to individuals to families or tries to receive some family therapy training from brief training workshops. At times, this may be harmful. There is research evidence that using an individual approach when marital problems are the major concern can result in deterioration, not improvement, in the marriage. Certification would impose a standard of training which would insure that those who describe themselves as marital and family therapists have had adequate training to conduct such therapy.

State regulation would also help protect the public from unscrupulous or unethical practitioners. While there might be legal recourse if an individual were injured by the unethical behavior, a state regulatory body would have the ability to prevent that person from continuing in practice and potentially harming other people.

Finally, it is important to understand that the American family is undergoing a period of drastic change. Issues such as the high incidence of families in which there has been a divorce, the growing number of stepfamilies, the issues of medical remedies for infertility which create

dilemmas in family relationships (e.g. surrogate mothering) and certainly the issue of AIDS which promises to impact on family life, all demand that those who work with families be constantly reacting to a changing social milieu. Regulation of the practice of MFT could help insure that MFT practitioners are doing so by requiring continuing education for license renewal. Attempting to impose the structure of biological families on stepfamilies, for instance, can have harmful, not beneficial, effects yet this practice remains common among mental health professionals. Clearly, the requirement of continuing education would not guarantee that MFT practitioners would be up to date on every family issue but it would make it harder for an individual to operate in a vacuum, assuming that the reality of family life in the 1950's is the reality of the 1980's or 1990' or beyond.

*Eric S. McCallen MS*

W. Robert Beavers, M.D.

President, American Association for Marriage and Family Therapy (1986-present); Psychiatrist; Medical/Clinical Director, Willow Creek Hospital for Adolescents; Clinical Professor of Psychiatry, University of Texas, Health Science Center, Dallas, Texas; former Clinical Director, Southwest Family Institute, Dallas, Texas; Private Practice of Psychiatry, Dallas, Texas; Asst. Professor, Dept. Pharmacology, Univ. of Texas Health Science Center, 1957-60; Asst. Professor Psychiatry, Univ. of Texas Health Science Center, 1963-70; Research Consultant, Timberlawn Foundation, 1970-79; Clinical Assoc. Professor Psychiatry, Univ. of Texas Health Science Center, 1970-79; Executive Director, Southwest Family Institute, 1979-84; Advisory Committee to Commission on Accreditation, AAMFT, 1978-81; Supervision Committee, AAMFT, 1980-present; AAMFT Committee for Liason with AFTA, 1981; Task Force on Membership, AAMFT, 1981; Chairman, Commission on Supervision of Marital and Family Therapy, 1983-present; American Psychiatric Association, 1962-present; Dallas County Medical Society, 1964-present; American College of Psychiatry, 1972-present; American Family Therapy Association, 1978-present; Member, Editorial Board, Journal of Marital and Family Therapy, 1978-present; Reviewer, American Journal of Psychiatry, 1978-present; Advisory Editor, Family Process, 1979-present; Group for Advancement of Psychiatry, Family Committee, 1980-present; Member, Editorial Board, Journal of Divorce, 1982-present; Advisory Editor, Family Systems Medicine, 1982-present; National Board, American Family Therapy Association, 1982-present; Co-author, No Single Thread. A Study of Healthy Families, 1976; Author, Psychotherapy & Growth. A Family Systems Perspective, 1979; A Systems Model of Family Therapists, Journal of Marital and Family Therapy, July 1981; and numerous other articles and chapters on family issues.



## American Association for Marriage and Family Therapy

W. ROBERT BEAVERS, M.D.  
President

August 25, 1987

### STATEMENT IN SUPPORT OF THE KANSAS ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY'S APPLICATION FOR LICENSURE OF MARRIAGE AND FAMILY THERAPISTS IN KANSAS

I am writing in support of the efforts of the Kansas Association for Marriage and Family Therapy to secure licensure for marriage and family therapists in the State of Kansas.

As one who has been involved as a marriage and family therapist in a variety of settings - private mental health center (Willow Creek Adolescent Center), medical school faculty and private practice - I have had ample opportunity to observe first-hand how critical licensure is in protecting the public from harm at the hands of the untrained and inexperienced practitioner. In my position as President of the American Association for Marriage and Family Therapy, I have been gratified to see that our national association, through its state divisions, has successfully sought credentialing in fourteen states, a success that not only permits clients to have the freedom to select from a variety of competent mental health providers, but even more importantly protects them from the unqualified.

Perhaps the greatest difficulty in presenting my testimony lies in the term "harm" itself. This important term is not defined, and to supply a list of synonyms only begs the question of precisely what constitutes "harm to the public." Therefore, for purposes of this testimony, I will adopt the following definition:

"Harm" is to be understood as those actions or omission of actions on the part of the mental health practitioner which contribute to the lessening of the emotional, mental, physical, and relational well-being of the client(s).

We, who are physicians, have vowed at least to do no harm to our patients. Clearly, our hope as physicians is that our efforts contribute to the well-being of patients in such a way that they are able to resume a normal life. These goals are easily transferred to those who practice marriage and

family therapy. They too strive at the very least to avoid harm, and hopefully to improve the well-being of their clients.

To reduce the incidence of harm, and to increase the incidence of help, the state plays an invaluable role through the credentialing process. Harm can come to the unprotected public in a variety of ways, ranging from the serious to the critical.

For example, a person experiencing marital stress who confers with an unqualified provider may be encouraged to terminate the marriage, or endure it. Both recommendations portend serious and lasting consequences, and are not to be made lightly. In the hands of an incompetent practitioner, some marriages - such as those experiencing predictable life-cycle challenges - are dissolved needlessly, and others - such as ones where physical abuse is occurring - continue on in a fashion that is harmful to one or both partners. Death at the hands of an abusing partner is an extreme example of harm, as is family violence where serious and often fatal injuries occur.

Parents are another population who consult with marriage and family therapists. An unqualified therapist can harm a mother by intimating or stating directly that she is responsible for her child's misbehavior or problems. Such statements burden patients with needless guilt and prevent them from parenting effectively, to the detriment of the entire family.

Currently, we are aware of the dangers facing adolescents - teenage suicide, teenage substance abuse and addiction, teenage pregnancy and sexual activity. An unqualified therapist can harm adolescents and their families unintentionally by unwisely telling the parents of a "rebellious teenager" to "tighten down the screws." The harm from such "common sense" advice can increase the existing hostility, perhaps culminating in the adolescent escalating the self-destructive behavior.

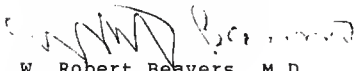
Of particular concern to me as a physician are those instances involving physical symptoms which may or may not be psychosomatic in nature. It is not at all unusual for those who sit in a therapist's office to mention physical symptoms - chest pains, headaches, dizziness, stomach aches, sleeplessness, appetite changes, weight loss, lack of energy. The unqualified therapist can induce enormous harm to the public at this juncture. If such a person tells those who come to them that their symptoms are "merely the result of stress", a serious medical problem may go undetected with varying degree of harm to the individual. Qualified therapists treat physical complaints seriously, and refer clients to physicians for a work-up to ascertain whether or not the symptoms have a physiological basis.

My closing example of the harm to which the public is exposed when credentialing is not in place has to do with the sexual involvement between mental health providers and clients. Qualified therapists, such as members of the KAMFT, subscribe to and are governed by a professional code of ethics. On the basis of this code, members are subject to peer review and disciplinary action. However, the strongest disciplinary remedy available to AAMFT is revocation of membership. Without state licensure, the therapist who victimizes a client may still continue to practice. Those who hold themselves out to be marriage and family therapists are not accountable to even a code of conduct, leaving the client in an unprotected position. Licensure ensures that greater protection is granted to the public since any sexual impropriety could result in revocation of the right to practice.

In summary, the public may be subjected to needless harm in the absence of state credentialing. Such harm ranges from burdensome emotional states such as inappropriate guilt, to increasing the likelihood of adolescent acting-out to exploitative sexual involvement, to life-threatening situations such as suicide or abuse.

By identifying qualified therapists and by institution of practice-related consequences for unethical/incompetent behavior, State licensure of marriage and family therapists would serve to lessen the risk of such harm to the consumer. I strongly support the enactment of such legislation.

Respectfully submitted,



W. Robert Beavers, M.D.  
President

WRB:kp



Ralph H. Earle, Ph.D.

President-Elect, American Association for Marriage and Family Therapy; Family psychologist and President of Psychological Counseling Services, Ltd.; Founding and present director of the Family Institute of Arizona; Chair, Board of Directors of Metropolitan University of the Southwest; Clinical Professor of Education-Arizona State University; Founding Director-interfaith Counseling Service, Scottsdale, AZ; Teacher and trainer for family practice physicians-Scottsdale Memorial Hospital; Founding Director-Community Counseling Center, Hacienda Heights, CA; Minister of churches in Dundee, Scotland; Winchester, MA; Las Vegas, NV; Hacienda Heights, CA; Member, American Psychological Society; Approved Supervisor AAMFT; Diplomate in Marital and Family Therapy-American Board of Family Psychology; Member, Academy of Family Mediators; Fellow, Lifetime Employee Assistance Society of North America; Present Member of AAMFT Honors Committee; Past Treasurer of AAMFT and member of National Board; Past President Arizona Association for Marriage and Family Therapy; Past member of Task Force on Membership and Legislative Issues; Past Chair of Arizona Licensing-Certification Committee for Marriage and Family Therapy; An organizer of the first Council of Divisional Presidents and a member of the first six regionally elected Divisional Presidents; Present liaison person for AAMFT and Division 43 (Family Psychology) of American Psychological Association; Past President Arizona Association of Sex Educators, Counselors and Therapists; Past member of Sex Counselors Certification Committee for AASECT; Past member of Ethics Committee for the American Association of Sex Educators, Counselors and Therapists; Leader in Private Practice Institutes; Member of the Advisory Council for American Arbitration Association; Past Chair of the Family Disputes Committee; Speaker at numerous seminars and training programs on the subject of family therapy; author of numerous book reviews and Journal Articles; Fellow of the American Association for Marriage and Family Therapy.



## American Association for Marriage and Family Therapy

RALPH H. EARLE, Ph.D.  
President-Elect

August 20, 1987

Committee for Hearing Applications  
Kansas Association of Marriage and Family Therapy

To Whom It May Concern:

I am writing as President-Elect of the American Association for Marriage and Family Therapy and also as psychologist who happens to be a marital and family therapist. I believe strongly that the state needs to establish and maintain standards of qualification and performance for persons who are in the practice of marriage and family therapy. It is essential for the protection of the public. There is no regulation of the activities of people who practice marriage and family therapy unless there is a state regulation for certification and/or licensing.

Certainly is it as essential that the field of marriage and family therapy be regulated as the field of psychology and/or psychiatry. Without such legislation, it is possible for anyone to "set up shop" and to deal with people's marriages - family stress situations - questions about such vital issues as whether or not abortion makes sense - parent-child relationships and other serious family concerns.

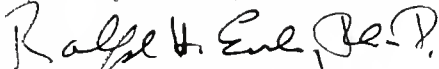
Marital and family therapy is designed as a professional application of marital and family systems theories and techniques and a diagnosis and treatment of mental and emotional conditions in individuals, couples, and families. Marital and family therapy is distinguished from marriage and family counseling by the presence of the mental or physical disorder in at least one member of the family or couple being treated. Without legislation for licensing (or certification), there is absolutely no regulation of the practices of people who get involved at points in people's lives where there is the most distress. There is great vulnerability in some stressful situations. At times there have been horrendous misuses of people's vulnerability. Again, when there is no regulatory body with a committee of ethics and power to enforce restrictions. Clients have no recourse in terms of any professional body in the field of marital and family therapy in the state.

Without licensing, there is no machinery for identifying qualified practitioners in the field of marriage and family therapy or for holding practitioners accountable for their actions. The Yellow Pages are an excellent means of identifying a plumber, but they provide little guidance for the consumer in selecting a marriage and family therapist. Licensure protects the public's right to be served by qualified therapists. Licensure provides the machinery for enforcing professional standards. The code of ethics for marriage and family therapy would be enforceable. The public's access to such services would be enhanced, as well as the assurance of a greater likelihood of competent practice.

Such licensure enables agencies in the state to offer the preventive development services best provided by professional marriage and family therapists. Regulation will enable the public to identify private practitioners with a greater assurance of competent services. Instances of incompetent or unethical practice would be dealt with through established procedures with resort to court action no longer being a consumer's only recourse.

Thus, I believe strongly in licensure (and/or certification) and have been active in this effort for approximately seventeen years.

Respectfully submitted,



Ralph H. Earle, Ph.D.

RHE:ct

**Fred P. Piercy, Ph.D.**

Director of Training and Research, and Associate Professor of Family Therapy, Family Therapy Doctoral Program, Purdue University, West Lafayette, IN; part-time private practice, Lafayette; Associate Professor of Marriage and Family Therapy Education, East Texas State University 1975-1982; Counseling Psychologist, Hunt County Family Service Center, 1977-1982; Family Therapist, University Counseling Center, East Texas State University (half-time), 1975-1977; Therapist, Outpatient mental health facilities at Ft. Benning, GA and Seoul, Korea, 1971-1973; Clinical Member since 1976; Approved Supervisor since 1978; Fellow, 1985; Journal of Marital and Family Therapy, Editorial Board member; Advisory Committee to the Commission on Accreditation, 1981-1986; AAMFT Elections Committee, 1982-1983; Chair, 1983; AAMFT Public Relations Committee, 1979-1981, Chair, 1981; Chair, AAMFT Accreditation site visits, 1980, 1981, 1983 and 1985; Site visit member, 1982; IAMFT (Indiana) Divisional Development and Membership Committee, Chair, 1985-1986; IAMFT Long Range Planning Committee, Chair, 1984; TAMFT (Texas) President-Elect, 1981-1982; TAMFT Board Member, 1979-1981; TAMFT Newsletter Editor 1977-1978; TAMFT Nominations Committee Chair, 1979; Member of the American Family Therapy Association, National Council on Family Relations, American Association of Counseling and Development, American Psychological Association (Division 43); Editorial Council Member, Journal of Psychotherapy and the Family; Editorial Board Member, Journal of Strategic and Systemic Therapies, Author of over 45 published articles and ten funded grants; editor of Family Therapy Education and Supervision (Haworth Press, 1985); co-author with Douglas Sprenkle and Associates, Family Therapy Sourcebook (Guilford, in press).

# PURDUE UNIVERSITY



MARRIAGE AND FAMILY  
THERAPY PROGRAM

Testimony to Technical Committee Hearing Application of KAMFT  
for Licensure of Marriage and Family Therapists

I would like to strongly support the marriage and family therapist licensure bill you are presently considering. Such a bill is both responsible and, in the long run, cost-effective. It will set into motion a procedure to assure that those persons practicing marriage and family therapy in Kansas are adequately trained to provide these important services. To do less is to jeopardize the public and to indirectly promote a dangerously poor quality of service throughout your state. (Presently many practitioners provide these crucial services with no supervised experience and no coursework in marriage and family therapy. This is simply unacceptable, and more than a little scary.)

I commend you in having the foresight to take this important step. Thousands of citizens of Kansas will benefit from this legislation.

Sincerely,

A handwritten signature in cursive script that reads "Fred P. Piercy".

Fred Piercy, Ph.D.  
Director of Training and Research

FP:ca

**Arthur Mandelbaum, M.S.W.**

Senior Consultant, Family Therapy Training Program, The Menninger Foundation (1981-present); Director, Family Therapy Training Program, The Menninger Foundation (1973-1981); Director, Social Work Services, The Menninger Foundation 91964-1973); Chief Psychiatric Social Worker, Children's Division, The Menninger Foundation (1952-1964); Faculty, Menninger School of Psychiatry (1952-present); Chairman, Topeka Chapter, National Association of Social Workers (1965-1966); served on the National Board of Psychiatric Social Work Section of the National Association of Social Workers; served on the Executive Board for the American Association of Psychiatric Clinics for Children; Secretary (1965-1966), President-Elect (1967-1968) and President (1969 and 1971), American Association for Children's Residential Centers; Chairman, Committee on Publications, National Association of Social Workers (1968-1975); Faculty, School of Social Welfare, Kansas University (1972-present); Visiting Faculty, Family Therapy Course, George Warren Brown School of Social Work, Washington University, St. Louis, MO (1975-present); Editorial Boards: Family Process (1977), International Journal of Family Counseling (1978), American Journal of Family Therapy (1978-present), Family and Child Mental Health Journal (1979, Aspen Family Therapy Collections (1980-present); Arthur Mandelbaum Award established for outstanding teacher of social work students in the post-masters degree training program of the Karl Menninger School of Psychiatry (1984); Honorary Doctor of Science Degree from Kansas State University for his contribution in the area of family therapy and the social sciences (1984); clinical member, approved supervisor, and Fellow of the American Association for Marriage and Family Therapy; social worker for over forty years; pioneer marriage and family therapist; author of 71 articles and book reviews.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE  
 OFFICE OF EDUCATION  
 BUREAU OF HIGHER AND CONTINUING EDUCATION  
 WASHINGTON, D.C. 20202

RECEIVED BY

MAY 30 1978

May 23, 1978

P.G.E. &amp; F., P.C.

Mr. Steven L. Engelberg  
 Price, Grove, Engelberg,  
 and Fried, P.C.  
 2033 M Street, N.W.  
 Suite 404  
 Washington, O.C. 20036

Dear Mr. Engelberg:

Enclosed is copy of the DEAE Staff Analysis of the petition by the Committee on Accreditation of the American Association of Marriage and Family Counselors for initial recognition as a nationally recognized accrediting agency. The U.S. Commissioner of Education's Advisory Committee on Accreditation and Institutional Eligibility will review it, along with the material which you have submitted, during its June 21-23, 1978 meeting. I hope the Analysis will be useful to you as representatives of the Committee on Accreditation prepare for their presentation before the Advisory Committee.

Best regards.

Sincerely yours,

John R. Proffitt  
 Director

Division of Eligibility  
 and Agency Evaluation

Enclosure

DEAE STAFF ANALYSIS OF THE PETITION OF  
THE COMMITTEE ON ACCREDITATION, AMERICAN ASSOCIATION OF  
MARRIAGE AND FAMILY COUNSELORS

June 21-23, 1978

BACKGROUND

The American Association of Marriage and Family Counselors, Inc., (AAMFC) was incorporated in the District of Columbia as a non-profit corporation in 1974. It is a rapidly growing organization with a current membership of over 5,500 professionals. A 1976 revision of the AAMFC by-laws changed the name of what was the Committee on Standards and Training, to the Committee on Accreditation. The new by-laws give the Committee final accreditation authority which the Committee relinquishes only when there is an appeal against one of its decisions. In cases of appeal, a hearing panel appointed by the AAMFC Board of Directors has final authority. The AAMFC formally organized its accreditation procedures, and published its first accreditation manual, in 1975. It published a slightly revised version of the manual in December, 1977. It is currently engaged in making a thorough revision of this manual. The Committee on Accreditation accredits graduate degree programs, and clinical training programs, in marriage and family counseling.

In 1976, the Committee on Accreditation submitted a petition for initial recognition only for its accreditation of graduate degree programs. This petition was reviewed by the Advisory Committee at its September 22-24, 1976 meeting. The Advisory Committee recommended denial of this petition and the Commissioner of Education accepted this recommendation.

Education in marriage and family counseling is interdisciplinary in character. The AAMFC reports that professional organizations in related disciplines have shown little interest in enlarging the scope of their accreditation to include marriage and family counseling. This is an important reason why the Association is doing its own accrediting.

Because marriage and family counselor training is interdisciplinary, Advisory Committee, at its September 22-24, 1976 meeting, questioned whether marriage and family counselor training is truly a discipline its own right. It appeared to the Committee at that time that already recognized accrediting bodies could, with slight expansions in scope provide the accreditation needed in the marriage and family counselor training field. In order to clarify this matter the Advisory Committee



directed the Division of Eligibility and Agency Evaluation to make a formal study for the purpose of determining whether marriage and family counselor training is a discipline in its own right, or whether it is, in reality, no more than an amalgam of other disciplines. In response to this mandate, the DEAE established a three-person panel of consultants. The panel's report is included with this analysis as Appendix A. Among other things, the panel, (1) concluded that marriage and family counselor training appears to be emerging as a distinct, integrated discipline, and (2) recommended that the Advisory Committee ask the AAMFC to substantiate the uniqueness of the marriage and family counselor field of study by means of a detailed analysis of the marriage and family counselor training programs already accredited by the Association's Committee on Accreditation. The Association submitted this analysis as a supplement to its current petition for recognition.

A DEAE staff person served as observer at a meeting of the Committee on Accreditation on March 12, 1978. His report is included as Appendix B.

**Arthur Mandelbaum, M.S.W., A.C.S.W., D.Sc.**

Supervision and Consultation  
for Professionals in  
The Practice of Marital  
and Family Therapy

August 27, 1937

Candice S. Russell, Ph.D  
Associate Professor  
Kansas State University  
Marriage And Family Therapy Unit  
Manhattan, Kansas 66506

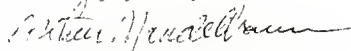
Dear Dr. Russell,

I am writing to express my concern about the absence of standards for many practitioners in the field of marriage and family therapy. Dealing with unhappy marital partners and with unhappy families is a most complex matter, demanding maturity, skill and knowledge of human behavior and development. There are too many practitioners in the field who lack the appropriate graduate degrees, who lack sufficient training and supervised experience.

One of the ways to deal with this problem and to protect consumers who come for help with their marriages, their roles as spouses, as parents, as adult children of aging parents, is to require the appropriate academic degrees, approved training, approved supervision of their work, and approved continuing education. All of this leads to great need for state licensing of practitioners, giving the public the reassurance and confidence, that the counselors and therapists they choose to work with, are qualified and approved by standards set by some state licensing board.

It is my hope that this will improve practice in the field of marriage and family therapy and help practitioners to strive for excellence and ongoing education and experience.

Sincerely yours,



Arthur Mandelbaum, M.S.W.,  
A.C.S.W., D.Sc.

Licensed Clinical Specialist  
State of Kansas  
Approved Supervisor A.A.M.F.T.  
Fellow of A.A.M.F.T.

1561 Westover Rd.  
Topeka, Kansas 66604  
913-272-8872

## CRITERIA SYNOPSIS

The American Association of Marriage and Family Counselors, and its Committee on Accreditation, have responded vigorously, and for the most part satisfactorily, to most of the deficiencies in compliance pointed out to them in the September 22-24, 1976 Advisory Committee meeting. They have presented satisfactory evidence that, though marriage and family counselor training can still be considered to be an emerging field, it is a distinct and integrated field. The Committee on Accreditation is making good progress toward interpreting the meaning of its accreditation standards in terms of minimum curriculum and program content requirements.

Now that the Committee has included accreditation of clinical training programs within the scope of the accreditation activities for which it seeks recognition, at least some of its accreditation will meet a need for providing eligibility for Federal educational funds, if it is recognized.

The Committee has come into compliance with six of the ten criteria with which the Advisory Committee found it not to be in compliance in 1976. It appears to be on the way to coming into compliance with the remainder of these criteria.

There is some reason for concern regarding the administrative support given to the Committee on Accreditation. For example, the Committee does not feel that it can require annual reports from accredited programs and clinical training centers because it does not have the personnel needed to process such reports. The Association has not identified in its financial statement a separate budget for its Committee on Accreditation.

While the Committee's preaccreditation standards appear to be properly related to its accreditation standards, its preaccreditation procedures do not appear to be properly related, since a self-study and a site-visit do not appear to be required as part of the preaccreditation procedure.

The Committee has begun to take steps toward assessing the validity and reliability of its accreditation standards. However, it has not indicated what it considers each of these two different terms to mean. Therefore, it is not clear how the activity it has begun will specifically assess both the validity and the reliability of its standards.

There is some question regarding the duties, and limitation of duties, of the Committee's site-visiting teams. There is evidence that these teams serve as consulting bodies to programs under review for accreditation to the extent that the adequacy of their evaluations could be adversely affected. It is not clear why the Committee on Accreditation has not reserved to itself the major responsibility for advising programs on the basis of strengths and weaknesses made known to it in program self-analyses and in team reports.

APPENDIX C

COMPLAINTS FILED WITH AAMFT ETHICS COMMITTEE



## American Association for Marriage and Family Therapy

August 14, 1987

Mr. James Beer  
2008 Stillman Drive  
Manhattan, KS 66502

Dear Jim:

Thank you for your telephone call today inquiring about the work of the AAMFT Committee on Ethics and Professional Practices. I staff the Ethics Committee, and am writing to you to report on the Committee's caseload, in order to support your work with your State legislature.

Our Association has a standing committee, the AAMFT Committee on Ethics and Professional Practices. One of the functions of this Committee (to quote from our Procedures for Handling Complaints of Violations of the Code of Ethics Principles for Marriage and Family Therapists, Section I.1.) "is to investigate complaints of violations of the Code of Ethical Principles for Marital and Family Therapists and, if violations are found, to take action by mutual agreement...or to propose disciplinary action."

At any one time, the Committee has approximately 40 active cases of complaints against AAMFT members for alleged violations of the Code of Ethical Principles for Marriage and Family Therapists. A few of these complaints involve more minor allegations, such as improper advertisement. Most of the cases, however, are more serious in nature, ranging from allegations about sexual misconduct, to fraudulent billing, etc. Over the course of a given year, the Committee completes action on approximately 80 cases.

If a formal complaint is received in accordance with our Procedures, and if, after notification of the AAMFT member and the investigation of the Ethics Committee, the Ethics Committee finds the member to be in violation of the Code, the Committee can recommend any of a number of actions, depending on the nature of the case: for example, that the member cease and desist, accept censure, be placed on probation and/or rehabilitation, be given supervision, education, and/or therapy, agree to revocation or suspension of the approved supervisor's status, termination of membership in the association, or any other action which the Committee deems appropriate.

However, the Committee has jurisdiction only over the Association's members, and cannot take action against non-members. Nor

does the Committee act as a civil court--its jurisdiction relates to membership in the Association.

I hope this information sufficiently answers your inquiry.

Please address any further questions regarding this matter to me, Steven Preister, Deputy Executive Director, the American Association for Marriage and Family Therapy, 1717 K Street, NW, Suite 407, Washington, DC 20006.

Sincerely,



Steven Preister  
Deputy Executive Director  
Staff to the Ethics Committee

Enclosure: Code and Procedures

cc: Frederick G. Humphrey, Ed.D., Chair, AAMFT Ethics Committee  
Steven L. Engelberg, AAMFT Legal Counsel

APPENDIX D

LETTER FROM COMMISSION ON ACCREDITATION IN SUPPORT  
OF SCOPE OF PRACTICE LANGUAGE



COMMISSION ON ACCREDITATION  
FOR MARRIAGE AND FAMILY THERAPY EDUCATION

American Association for Marriage and Family Therapy

neth V. Hardy, Ph.D.  
cutive Director

nne B. Kipnis  
ministrative Assistant

January 12, 1988

Henry Camp, Ph.D., Chair  
Technical Committee  
Bureau of Adult and Child Care Facilities  
Kansas Department of Health and Environment  
Landon State Office Building, 10th Floor  
900 SW Jackson  
Topeka, KS 66620-0001

Dear Dr. Camp:

The Kansas Association for Marriage and Family Therapy (KAMFT) has asked me to send you information regarding their application for licensure of marital and family therapists in Kansas.

I am the Executive Director of the Commission on Accreditation for Marriage and Family Therapy Education, recognized since 1978 by the U.S. Department of Education as the official accrediting body for marriage and family therapy education and training in the United States.

First, let me say that I strongly support KAMFT's application. Licensure of marital and family therapist in Kansas would protect the public by identifying qualified practitioners, by providing recourse to clients who have been harmed, and by mandating education of consumers.

It has been brought to my attention that the Technical Committee, in its preliminary report, has questioned whether "the scope of practice proposed by the applicant needs to be modified to actually fit the scope of educational requirements set by the accreditation commission."

I want to unequivocally assure you that the educational standards set forth by the Commission on Accreditation for Marriage and Family Therapy Education reflect the body of knowledge and experience that the Commission deems necessary to practice marital and family therapy, as defined in the proposed scope of practice delineated in the KAMFT application. My understanding is that the Technical Committee questioned whether marital and family therapists graduating with a degree from an accredited program were qualified to "diagnose and treat nervous and mental disorders."



There is a growing body of research which shows that marital and family therapy has been utilized to treat the entire range of nervous and mental disorders. And again, I want to assure you that the educational standards required by the Commission were designed to educate marital and family therapists to diagnose and treat nervous and mental disorders. Accredited marital and family therapy programs must provide coursework and training in individual and personality development in its normal and abnormal manifestations (Manual on Accreditation, page 11). The 1988 edition of the Manual on Accreditation states: "Within the context of marital and family systems, students will learn to diagnosis and treat dysfunctional relationship patterns, and nervous and mental disorders whether cognitive, affective, or behavioral." Furthermore, marital and family therapy students, enrolled in accredited programs, are required to complete 500 hours of direct clinical contact treating individuals, couples, and families with a diverse range of nervous and mental disorders.

It is important to point out that nervous and mental disorders are treated by marital and family therapists within the context of marital and family systems. The coursework and clinical training required in an accredited program provides students with the knowledge and experience necessary to do this work.

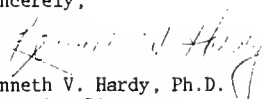
As you may know, the Kansas State program has been accredited since 1983. In examining the curriculum there, the Commission has found that the Kansas State program is in good academic standing and is in compliance with the current accreditation standards.

Finally, I want the Technical Committee to know that the Commission is prepared to assist in the development of the process of credentialing marital and family therapists in any way that the State deems helpful. We would be more than willing, for example, to help the State and/or KAMFT develop standards for determining the suitability of equivalent educational programs of study for those licensure applicants who have not graduated from accredited programs. Though it is an ultimate goal to have all programs accredited, the Commission recognizes that, realistically, this is a long-term rather than short term objective for our emerging profession. Until the time when programs are accredited on a widespread basis, therefore, there exists a need to provide for alternative methods of assuring quality in marital and family therapy education programs. The Commission is prepared to provide assistance in this matter.

I wish the Technical Committee the best of luck in your work with this important issue. Please let me know if I can be of help in providing any further information.

Thanks for your consideration.

Sincerely,



Kenneth V. Hardy, Ph.D.  
Executive Director

KVH/mr

CREDENTIALING OF MARRIAGE AND FAMILY THERAPISTS

by

JAMES ANTHONY BEER

B.S., State University of New York, 1982

AN ABSTRACT OF A REPORT

submitted in partial fulfillment of the  
requirements for the degree

MASTER OF SCIENCE

Marriage and Family Therapy

KANSAS STATE UNIVERSITY

Manhattan, Kansas

1988

#### ABSTRACT

The profession of marriage and family therapy, in the tradition of the established mental health profession, is currently pursuing statutory credentialing of the profession throughout the various states. The goal of credentialing is consumer protection and legitimization of the profession. This paper, based on the experiences of the Kansas Association for Marriage and Family Therapy (KAMFT) in pursuing regulatory legislation, surveys the primary issues relevant to the credentialing process. Different methods of regulation are evaluated in terms of implications for clients and for the profession, and alternative course of action are examined.