Mindful
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Ethical Considerations for Marriage and Family Therapists

Introduction

The role of the marriage and family therapist (MFT) is to provide treatment for a wide range of clinical and relationship issues in the context of family structure. According to the American Association for Marriage and Family Therapy code of ethical principles, marriage and family therapists "are dedicated to advancing the welfare of families and individuals" (AMMFT, 2012). However, while clinical interventions are intended to promote the welfare of the family unit, they may also produce harmful consequences for some family members, therefore raising ethical and therapeutic dilemmas. Additionally, when professionals work with individual clients, they may face concerns related to confidentiality, informed consent, boundary violations, professional responsibility and competence, as well as other issues. Ethical standards are to be read, understood, and utilized as a guide for ethical behavior, with an understanding that development of standards is an ongoing process, and that every conceivable situation that may occur cannot be expressly covered (CAMFT, 2011). The MFT, however, must take reasonable steps to use their services appropriately and to maintain the standards of the profession.

"Ethical codes have been developed by mental health associations for the purpose of setting professional standards for appropriate behavior, defining professional expectations, and preventing harm to people who go to therapy. Mental health professionals have an obligation to be familiar with their professional code of ethics and its application to their professional services."

GoodTherapy.org, 2014

The Process of Pursuing Ethical Standards

According to Counselor magazine, there are certain assumptions that should be considered in the discussion of ethics (Counselor, 2012):

- Ethics is a continuous, active process in which all clinicians must engage.
- Standards (codes of ethics) are not cookbooks. They often tell us what to do but not always how to do it.
- It is the responsibility of the clinician, not the client, to set the boundary. And if a boundary is crossed, we should not blame the client or stigmatize them for the boundary crossing.
- Each clinical situation is unique. We must examine all of the relevant variables and factors that might affect our choices.
- Counseling is done by fallible human beings. We make mistakes. Wouldn't it be wonderful if we could admit our mistakes to one another? Sometimes the answers to what to do under what circumstances are elusive because sitting in front of you in a counseling session is a unique person with individual characteristics, needs and issues.

Furthermore, knowing that each situation and client is unique, therapists must seek "ethically correct" decisions based on the best interest of the client. The AAMFT Code of Ethics refers to the responsibility to advance the welfare of families and individuals through such practices as non-discrimination, informed consent, the avoidance of multiple relationships, and appropriate sexual conduct (AMMFT, 2012). Consider this example from the American Counseling Association's *Counseling Today* publication (Shallcross, 2011):

“Patrice Hinton Oswalt was flattered upon opening her e-mail and finding an E-vite to a client’s long-awaited graduation. Choosing whether to accept or decline the invitation was no simple decision.”

Oswalt recognized that engaging with the client outside of the office could have ethical consequences, and was especially concerned with maintaining trust. She states, “The counseling relationship is built on trust — clients trusting that they can be vulnerable and that their counselor will not take advantage of that openness. To earn this trust as counselors, we must be trustworthy, to prove our worth and integrity. These are standards of behavior that tie directly into our professional ethics.” Since Oswalt had addressed marital issues with her client and knew that she would likely see the husband and other family members at the graduation, she felt it was important to help her client see the big picture. As they discussed the situation further, the client realized that it was probably not a good idea for Oswalt to accept the invitation.

Although the above example may seem like a minor ethical concern, there is no way of knowing to what extent the clinician’s handling of the situation may impact the client, which reinforces the notion that such professionals must act with care and concern. Regardless of the professional organization, there is a reoccurring theme regarding the development and maintenance of ethical standards that protect both parties. According to the American Psychological Association, such a standard requires a personal commitment and lifelong effort to act ethically; to encourage ethical behavior by students, supervisees, employees and colleagues; and to consult with others concerning ethical problems (APA, 2010).

Boundary Crossings vs. Boundary Violations

As therapists strive to protect the welfare of their clients, they must recognize which actions may be perceived as boundary crossings or boundary violations. Jeffrey Barnett, professor in the Loyola University Maryland Department of Psychology, states, “most recent thinking is that there is a big difference between crossing a boundary and violating a boundary,” but one of the keys is maintaining objectivity. He goes on to say, “If it’s a conflict-of-interest situation or if I can’t remain objective, it’s probably not a good idea” (Shallcross, 2011). A boundary crossing is a deviation from classical therapeutic activity that is harmless, non-exploitative, and possibly supportive of the therapy itself. In contrast, a boundary violation is harmful or potentially harmful, to the patient and the therapy. It constitutes exploitation of the patient (Aravind, Krishnaram, and Thasneem, 2012).

Boundary crossings include casual encounters with clients outside of the therapeutic setting, sharing of personal information by the therapist, physical contact such as hugs or other forms of touching, or bartering for services. Boundary crossings are not all inherently unethical, and the AAMFT Code of Ethics and other major mental health professional association codes do not prohibit non-habitual boundary crossings (Adams, 2014). Most boundary violations are related to exploitive dual relationships, such as sexual contact with current or former clients. Sexual contact with clients is a fundamental violation of the professional-client relationship that undermines the therapeutic relationship and creates a range of psychological wounding to the client (Adams, 2014).

In the following vignette, a therapist is faced with a situation that addresses boundary issues:

Marianne is a divorced MFT who has been in practice for 14 years. One night when she is out with her girlfriends, she runs into a former client, Tommy. She first met Tommy about three years ago when he and his teenage son came to see her about relationship difficulties they were experiencing. Marianne worked with Tommy and Adam for approximately three months, until the relationship improved and all parties agreed to terminate therapy. Tommy has been divorced for four years. When they see each other at the restaurant, Marianne and Tommy talk briefly. She learns that Adam is away at college, and that he and Tommy have been doing well overall. She does not really think anything about it until he calls her the following week to ask her out to dinner. Marianne tells Tommy that she will have to think about it, and agrees to call him back later in the week. While Marianne feels some attraction toward Tommy and knows that it has been over two years since their last professional encounter, she also wants to think about all the ethical considerations that would come into play if she were to date and pursue an intimate relationship with Tommy.

While professional codes of ethics have specific guidelines for sexual intimacy with former clients, there are also other issues in this scenario that Marianne would want to consider, including:

Responsibility to clients-Is Marianne respecting the welfare of Tommy and Adam if she chooses to enter into a personal relationship?

Professional integrity-Although it may be acceptable to consider having a relationship with a client after two years, it is a good moral decision? Would she be furthering her own interests at the expense of others?

Multiple relationships-Does entering into a personal relationship with Tommy violate the trust that was established in the professional relationship, and will the influential position that she had as the therapist carry over and create an unhealthy dependency?

Sexual Intimacy with Former Clients-According to the AAMFT Code of Ethics, "If therapists engage in sexual intimacy with former clients, or their spouses or partners, more than two years after termination or last professional contact, the burden shifts to the therapist to demonstrate that there has been no exploitation or injury to the former client, or their spouse or partner" (AAMFT, 2012). Can Marianne be assured that establishing a personal relationship with Tommy will not in any way exploit or cause injury to Tommy or Adam?

Seek assistance-Will Marianne seek consultation from other professionals to discuss this issue?

If, after considering the above factors, Marianne decides to date Tommy, the onus will be on her to demonstrate that there has been no undue harm to Tommy or Adam. Marianne should document the process and the appropriate precautions taken to establish that she has acted thoughtfully and with care.

"Therapists make every effort to avoid conditions and multiple relationships with clients that could impair professional judgment or increase the risk of exploitation. Such relationships include, but are not limited to, business or close personal relationships with a client or the client's immediate family."

AAMFT Code of Ethics, 2012

Multiple Roles

Roger has been seeing Leo, a popular 15 year old student-athlete for six months. Leo is grieving over the loss of his father, a 48 year old in the late stages of ALS. Leo was referred to therapy when he began to lose interest in school and sports, started experimenting with drugs and alcohol, and was feeling depressed and anxious. One day Leo comes to his session excited and animated because he has been invited to try out for a well-respected traveling basketball team. Roger becomes anxious when he realizes that Leo is trying out for the team that his own son is on. While he is happy for Leo and thinks this could be a very positive experience for him, he is concerned about the possibility of entering into a multiple relationship with Leo if he makes the team, as the team commitment will involve seeing each other outside of the office, traveling out of town for tournaments, and regular interactions.

In the above scenario, the issue of multiple roles/dual relationships is presented to Roger without any intent on his part to create the situation. As Dr. Stephen Behnke, APA Ethics Director, states, "Finding oneself in a multiple relationship is not necessarily a sign that one has engaged in unethical behavior. It may rather be a sign that one is fully engaged in the life of a community" (Behnke, 2008). Although Roger is contemplating what the best course of action is as he is faced with his professional, personal, and community role, he doesn't feel the need to process anything with Leo until he finds out if Leo has made the team. He knows that he and Leo have made positive steps toward dealing with Leo's grief and loss, and has no intention of abandoning Leo in the therapeutic process. He also knows that he must consider confidentiality and boundary issues if he is going to see Leo outside of the office.

In the article, Ethical Decision-Making and Dual Relationships, Jeffrey N. Younggren addresses dual relationships and states, "By answering the following questions in a step by step fashion a professional who is considering entering into a dual relationship will increase the likelihood that he or she will make the correct choice in the matter: a choice that is in the best interest of both the patient and the therapist" (Younggren, 2002).

- Is the dual relationship necessary?
- Is the dual relationship exploitive?
- Who does the dual relationship benefit?
- Is there a risk that the dual relationship could damage the patient?
- Is there a risk that the dual relationship could disrupt the therapeutic relationship?
- Am I being objective in my evaluation of this matter?
- Have I adequately documented the decision making process in the treatment records?
- Did the client give informed consent regarding the risks to engaging in the dual relationship?

If Leo gets selected for the traveling team, Roger will want to look at the above questions to help determine with Leo whether or not to continue therapy. It may be a great opportunity to empower Leo with some of the decision-making, such as how to manage the situation when they see each other away from the office. Roger will also want to consider how his own son may be impacted by the dual relationship. Finally, Roger may initially choose to continue to see Leo if he feels it is in Leo's best interest and is adhering to the AAMFT Code which states, "Marriage and family therapists continue therapeutic relationships only so long as it is reasonably clear that clients are benefiting from the

relationship" (AAMFT, 2012). When and if they determine that they should terminate therapy, Roger will make an appropriate referral.

"Informed consent is a legal procedure to ensure that a patient, client, and research participants are aware of all the potential risks and costs involved in a treatment or procedure. The elements of informed consent include informing the client of the nature of the treatment, possible alternative treatments, and the potential risks and benefits of the treatment."

About Education, 2014

Informed Consent

Although the term "informed consent" was not formally introduced until 1957 in a medical malpractice case, the concept has been evolving since the early part of the twentieth century. In 1914, Justice Benjamin Cardozo of the New York Court of Appeals stated, "Every human being of adult years and sound mind has the right to determine what shall be done with his own body," and this statement has served as the foundation for the principles of informed consent as we know them today (Aiken, 2009). The Board of Directors of the American Association for Marriage and Family Therapy requires that professionals obtain appropriate consent for services by using language that clients will feasibly understand and ensures that the client:

- has the capacity to consent
- has been adequately informed of significant information concerning treatment processes and procedures
- has been adequately informed of potential risks and benefits of treatments for which generally recognized standards do not yet exist
- has freely and without undue influence expressed consent
- has provided consent that is appropriately documented

Informed consent will likely be presented to the client in the form of an agreement signed by the client, the parent or guardian if the client is a minor, and the therapist. Integral parts of the agreement include what to expect from the therapeutic process, services offered, confidentiality factors and limits, practices relating to release of information, recordkeeping, fees, payment, and cancellation, and a summary of the professional credentials. In the article, *Informed Consent*, Nir Eyal reports that the rationale for informed consent revolves around protection of the client or participant's health and welfare, the guarantee of a right to personal autonomy, as a commitment to prevent abusive conduct, a format to promote and enhance trust, a means to assure self-ownership over oneself, a way to guard against arbitrary control by others, and an opportunity to preserve the client's sense of personal integrity (Eyal, 2012). For minors, the general rule is that they are incapable of giving informed consent, so marriage and family therapists will obtain permission from the minor's parent, guardian, or other legal representative before treating the child or adolescent. As part of the informed consent agreement, therapists will often have specific guidelines related to the minor's right to confidentiality,

including under what circumstances confidentiality will be broken (See Appendix A for Sample Adolescent Informed Consent Form).

Confidentiality

Marriage and family therapists have an ethical and professional obligation to safeguard information that was shared during therapeutic interactions. Confidentiality issues often become complicated when the client is a minor or when the therapist is seeing more than one person in a family or unit and must protect the confidences of each individual. The AAMFT Code directs therapists to disclose the limits of confidentiality, to obtain written consent to release client information, and to maintain confidentiality in non-clinical activities such as teaching, writing, consulting, and research. In addition, the protection of client records and electronic information is addressed as well as the maintenance of confidentiality while consulting with colleagues or referral sources (AAMFT, 2012). While each state may have specific laws pertaining to therapist-client confidentiality, general exceptions to maintaining confidentiality are related to child, elder, or dependent adult abuse, legal mandates, or the threat of harm to self or others. Informed consent agreements and disclosure statements often outline the legal and professional obligation to keep all patient information in the strictest confidence. Lisa Stull, MS, LMFT includes the following policies in her disclosure statement (Stull, Lisa, 2014).

Confidentiality Statement: Generally speaking, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. There are several exceptions to confidentiality which include: (1) I am required to report any suspected incident of child abuse or neglect to law enforcement; (2) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (3) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder; (4) I am required to report any suspected threat to national security to federal officials; and (5) I may be required to disclose treatment information when ordered by a court.

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding by or against you. If you initiate litigation and your mental status becomes an issue, the defendant may have the right to obtain the psychotherapy records and my testimony. In couples and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon.

Even with a clear philosophy related to disclosing confidential information, therapists are often faced with dilemmas pertaining to whether or not they are obligated to violate confidentiality. The following case study from The Family Journal: Counseling and Therapy for Couples and Families illustrates a counselor's struggle with the client's right to confidentiality versus the obligation to a greater societal concern (Watts, 1999).

A counselor recently began working with a couple having difficulties in their marriage. The husband is a medical doctor and his wife, a certified public accountant (CPA), runs the business aspects of his practice. During the past 5 years, the couple has lived lavishly and, consequently, developed financial problems. They entered counseling stating that the presenting problem was anger and conflict stemming from their financial difficulties. In a recent session with the couple, the wife shared that about

a year ago her husband purposely and terminally overmedicated an elderly patient. The elderly patient was the stepmother of the wife, and because of a recent death, the wife is the lone benefactor of a large insurance policy. The counselor believes the fundamental problem in the couple's relationship is guilt over their conspiracy to terminate the life of the elderly stepmother—especially given the fact that the forthcoming insurance policy payment will cover their debts. However, the counselor is wondering whether she has an ethical or legal responsibility to contact the authorities and report the situation.

Questions for the counselor to consider may include:

- Since this would be considered past criminal activity, is there a duty to report?
- Does the counselor believe that the doctor and/or his wife may be capable of doing something similar in the future to another individual, or was this an isolated incident?
- Is there an exception to reporting past criminal activity since this incident involved elder abuse?
- Should she seek consultation from a supervisor, knowledgeable colleagues, an attorney, or all of the above?
- Should the counselor encourage her clients to turn themselves in to the authorities?

As is often the case for counselors and therapists, there is no clear-cut, black or white answer to the conflict that is faced in this scenario. After consulting with others, speaking further with her clients, and making a decision, the counselor should document the action taken and the rationale for doing so.

Confidentiality with Minor Clients

In the March/April 2012 issue of The Therapist, several professionals presented and responded to vignettes illustrating possible ethical/legal issues in therapy, including the following (The Therapist, 2012).

Susie (a 16-year-old) and Susie's parents came in to discuss treatment with LMFT Mark. MFT Mark reviewed his standard informed consent with both Susie and her parents, including a section on confidentiality which briefly mentioned reasons for a breach of confidentiality, including "harm to self."

After the third session, Susie admitted to LMFT Mark that she was sexually active with a few different people in her high school, and that she smoked pot on weekends. LMFT Mark determined that this did not rise to the level of "harm to self" worthy of a breach of confidentiality but instead he would work with her clinically. After the fifth session, she told LMFT Mark that she had been —cutting, but never near an artery. LMFT Mark again determined not to breach confidentiality. After the seventh session, Susie told LMFT Mark that she had been drinking heavily, and had started blacking out at parties, waking up in strange beds (clearly having had sexual intercourse). LMFT Mark decided to tell Susie's parents about the drinking and blackouts.

The ethical issue that seems to be of greatest concern in this vignette is Susie's level of self-harm and the risk of greater future harm. Although risky sexual behavior is dangerous, the therapist may not be able to justify breaking confidence. One professional pointed out that she would not likely do so, "unless I felt the client was risking consequences such as acquiring the HIV virus through highly risky behavior, and was unwilling to change her behavior." However, the clinician also stated that the cutting behavior definitely met the threshold of self-harm and warranted parental involvement. Another clinician went on to say, "Given the facts stated in this vignette, the nature of Susie's cutting is unclear.

Nonetheless, because there are multiple, serious risk factors described, including heavy use of alcohol by the client with reported blackouts along with high risk sexual behavior, the therapist would have to consider the possible need to disclose confidential information to Susie's parents, as a protective measure" (The Therapist, 2012).

Common practice would dictate that Mark could have sought consultation from peers and supervisors before making a decision to talk to the parents. It would also be important for Mark to involve Susie in the process of informing her parents, and to determine the best way for the parents to buy into a more intense treatment plan to help Susie, rather than seeing a need to punish her for the behaviors.

"Competence equals professionalism; therefore, incompetence cannot be tolerated. It is the responsibility of all professionals to maintain standards and to report any deviation in those standards. Loyalty and beneficence cannot be allowed to blur reality."

Aikens, 2009

Professional Competence and Integrity

Physicians Ronald Epstein and Edward Hundert (2002) define professional competence as, "The habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" (AMA Review, 2002). For marriage and family therapists, such competence is maintained by pursuing new knowledge and maintaining professional standards through education, training or supervised experience and by adhering to applicable laws, ethics, and professional standards (AAMFT, 2012). Marriage and Family Core Competencies were developed by AAMFT to improve the overall quality of services provided to clients in therapy. Competencies that fall under the domain of professionalism include (AAMFT, 2004):

Professional Subdomain:

- Understand the legal requirements and limitations for working with vulnerable populations.
- Complete case documentation in a timely manner and in accordance with relevant laws and policies.
- Develop, establish, and maintain policies for fees, payment, record keeping, and confidentiality.
- Utilize consultation and supervision effectively.
- Monitor personal reactions to clients and treatment process, especially in terms of therapeutic behavior, relationship with clients, process for explaining procedures, and outcomes.
- Advocate with clients in obtaining quality care, appropriate resources, and services in their community.
- Participate in case-related forensic and legal processes.
- Write plans and complete other case documentation in accordance with practice setting policies, professional standards, and state/provincial laws.
- Utilize time management skills in therapy.
- Respect multiple perspectives.

- Set appropriate boundaries, manage issues of triangulation, and develop collaborative working relationships.
- Articulate rationales for interventions related to treatment goals and plan, assessment information, and systemic understanding of clients' context and dynamics.
- Maintain client records with timely and accurate notes.
- Consult with peers and/or supervisors if personal issues, attitudes, or beliefs threaten to adversely impact clinical work.
- Pursue professional development through self-supervision, collegial consultation, professional reading, and continuing educational activities.
- Bill clients and third-party payers in accordance with professional ethics, relevant laws and policies, and seek reimbursement only for covered services.
- Contribute to the development of new knowledge.

Professional Misconduct

Margie is a marriage and family therapist in a small town who has been practicing for seven years. One night, her husband, who is a police officer, comes home from work and tells Margie that their mutual friend Sally, also a psychotherapist, has been arrested after a DUI accident. Apparently Sally was coming home from a party and lost control of her car, driving into an unoccupied restaurant downtown. Sally suffered only minor injuries, but a breathalyzer test indicated that her blood alcohol content (BAC) was well over the legal limit. In addition, there was enough damage done to the restaurant that it will have to be closed for several days.

Margie is very concerned about her friend and colleague. She immediately begins to think about her responsibility to the profession as well as her desire to help Sally. According to her professional code of ethics, she must comply with applicable laws to report alleged unethical conduct. Specifically, AAFMT states that marriage and family therapists respect the rights and responsibilities of professional colleagues, but also that therapists are in violation of the Code if they are convicted of a felony, are convicted of a misdemeanor related to their qualifications or functions, engage in conduct which could lead to conviction of a felony, or a misdemeanor related to their qualifications or functions (AAMFT, 2012). Although Margie does not yet know the outcome of any criminal procedures that Sally will face, she believes that Sally's actions could be in violation of the Code.

Margie decides that she will give Sally some time and then speak to her about her concerns. She will recommend to Sally that she contact their professional organization herself for guidance. If Sally chooses not to, Margie will wait to see what the outcome of the criminal proceedings will be, and then will contact the organization to see what her responsibility is. She will be following AAMFT procedures for filing a complaint, if that is what she is directed to do (See Appendix B). Margie will also speak to a colleague for guidance and document her actions.

Professional Boundaries in Supervisorial Relationships

When MFTs serve as supervisors to other professionals or students, they are expected to maintain the same standard of professionalism they exhibit as therapists. Most codes of conduct address the need to avoid exploitation while in the supervisorial role and to act in a way to establish and preserve trust. They also discuss maintaining confidentiality, ensuring that supervisees provide professional services,

being aware of cultural diversity issues that may impact the relationship, and enhancing their own supervisorial skills to remain effective. The following vignette from SAMSHA's *Treatment Improvement Protocol (TIP) Series* illustrates the role of the supervisor as a monitor of ethical and professional standards for clinicians, with the goal of protecting the welfare of the client (SAMSHA, 2009).

Stan has provided clinical supervision for Eloise for 2 years. He's watched her grow professionally in her skills and in her professional identity. Lately, Stan's been concerned about Eloise's relationship with a younger female client, Alicia, who completed the 10-week IOP 2 months ago and participates weekly in a continuing care group. Alicia comes to the agency weekly to visit with her continuing care counselor. She also stops by Eloise's office to chat. Stan became aware of her visits after noticing her in the waiting room on numerous occasions. Earlier in the day, Stan saw Eloise greet Alicia with a hug in the hall and commented that she will see Alicia "at the barbecue." Stan is aware that Alicia and Eloise see each other at 12-Step meetings, as both are in recovery. Eloise feels she is offering a role model to Alicia who never had a mother figure in her life. Eloise expresses no reservations about the relationship. Stan sees the relationship between Eloise and Alicia as a potential boundary violation.

As Stan addresses Eloise's relationship with Alicia, he will be focusing on helping her address boundary issues, transference and countertransference, and integrating a process of ethical decision making into her clinical skills. When he initially discusses the dual relationship that Eloise may be entering in with Alicia, she replies that she knows better than to sleep with her clients, borrow money from them, hire them for odd jobs, or take them on trips, but she doesn't feel that attending a barbeque where a client will be is inappropriate. Stan then reminds Eloise how a dual relationship can create an abuse of power in a relationship and that an important goal for Alicia in recovery is to achieve a sense of autonomy and make decisions on her own. Stan also acknowledges Eloise's questions and observations and focuses on how, in general, to make ethical decisions about the nature of a relationship with a client or a former client, and what's not professionally appropriate.

Stan remembers to be sensitive to the power differential between supervisor and supervisee while speaking with Eloise, but also wants to help her realize how her actions impact her professional integrity, Alicia's treatment and recovery, Stan as the supervisor, and the reputation of the agency. Eloise appears to be open to the feedback, and in the end agrees to rethink the relationship with Alicia and to develop strategies for making ethical decisions in the future.

Responsibility to Research Participants

MFT's and other professionals who work with research participants must adhere to the same ethical principles that they practice with clients, supervisees, students, and in other capacities. These include protecting the participants and seeking advice from other qualified professionals when needed, receiving informed consent and being aware of diminished consent, allowing participants to freely decline or withdraw from participation, and maintaining the confidentiality of research data (AAMFT, 2012). Please see the AAMFT Code of Ethics or other professional codes for more information.

Advertising

In order to maintain professionalism, marriage and family therapists do not engage in any advertising practices that are inaccurate, deceitful, or that misrepresent them in any way. They must correctly represent their education, level of training, credentials, qualifications, areas of specialization, and professional affiliations. If any inaccurate information about the MFT is made by others, the therapist must correct the misinformation whenever possible. They must also ensure that their employees or supervisees maintain the same standard of honesty and accuracy when making any public statements or when representing themselves.

Financial Arrangements

Professional standards dictate that MFTs make financial arrangements with clients that are reasonable and that, according to the AAMFT Code, "conform to accepted professional standards". Therapists should have a clear statement about financial responsibility in their informed consent agreement or their disclosure statement, which may include session fees, charges for telephone conversations or other services if applicable, satisfactory forms of payments including policy on acceptance of insurance, fees charged for missed appointments, and the use of collection agencies or legal means to obtain missed payments. A statement about bartering for services should also be included, as this practice is generally not recommended because it has the potential to be exploitative and to distort the relationship. Finally, ethical practices regarding the withholding of records generally state that MFTs cannot refuse to release needed records due to lack of payment for past services.

More comprehensive information regarding research participants, advertising, or financial responsibilities can be found in the AAMFT Code of Ethics or within other professional codes.

Cultural competence is defined as "a developmental process that evolves over an extended period of time for which both individuals and organizations are at various levels of awareness, knowledge, and skills along the cultural competence continuum."

National Center for Cultural Competence, 2009

Cultural Competence

The United States is in the midst of a paradigm shift in service delivery that is heading toward true cultural competency, sensitivity, and diversity. Mental health professionals will not only need to become culturally and linguistically competent, but may also have to take on new roles in serving those at-risk and hard to reach underrepresented populations (Zagelbaum and Carlson, 2011). Clinically, cultural competence means having the self-awareness, knowledge, skills, and framework to make sound, ethical, and culturally appropriate decisions, but Western principles and concepts may be in opposition to values and beliefs of other cultures, which in turn creates ethical conflicts and dilemmas. In the following vignette, a therapist faces a situation where she suspects physical abuse, but upon further investigation

realizes that what she is seeing is the result of an Asian healing practice (American Occupational Therapy Association, 2011).

Janine is a Caucasian MFT who has been working with 13 year old Han, who is of Chinese decent, for several months. Han was referred to Janine because he was experiencing anxiety and symptoms of depression since his parents separated. Han is a quiet young man, and it has taken several sessions for him to begin to open up about his feelings. Janine is pleased with the progress they have made and sees that Han has had some symptom relief over the past few weeks, and appears to be happier than when she first met him. During the most recent session, however, Janine noticed that Han didn't seem like himself and he had some redness and light bruising on his upper arms. Han said that had been sick for about a week and was just beginning to feel better. When Janine inquired about the red marks, Han explained that his mother had taken him to a healer because his cold and fever would not go away, and the healer had rubbed oil on his back, shoulders, and upper arms with a coin. Janine asked if he was in pain during the procedure or currently, and Han replied that it hurt a little bit while the healer was working on him, but that he no longer had any pain. Janine learned from Han that he had been to the same healer several times over the past few years when he was sick, and he believed that it usually made him feel better. Janine and Han had discussed his parents' disciplinary practices in a previous session and he had reported that he remembered being spanked a few times as a child, but more recently lost privileges or the use of his phone and computer when he got in trouble. Janine never had a reason to suspect Han was being abused in any way.

Janine is now concerned with her position as a mandated reporter of suspected child abuse. Although she believes that Han is telling the truth, she did see obvious marks on his arms. Janine decides to do some research, and discovers that Han is talking about an Asian practice known as gua sha, or "coining" which is used to relieve muscle aches, muscle pains, nausea, abdominal pain, back pain, coughs, colds, fevers, and chills. Janine decides to talk to Han's mother and then to speak to her colleagues about the situation, but does not feel the need to file a suspected child abuse report at this time. She will thoroughly document her actions.

The above scenario illustrates the need for therapists to be culturally aware, but also to maintain what some refer to as "cultural humility", which acknowledges that we may never truly understand the experiences of another cultural group of which we are not members, but we will have a respectful attitude and approach toward different points of view (Zagelbaum and Carlson, 2011).

Conclusion

As it is inevitable that marriage and family therapists will face ethical dilemmas and predicaments, they have an obligation to themselves, their clients, and the profession to be prepared to make sound, thoughtful decisions. As they gain experience, knowledge, and skills, and are open to learning from others, they will surely learn to face such challenges with grace, confidence, and a sense that they are acting in a manner that is in the best interest of all concerned.

APPENDIX A: SAMPLE ADOLESCENT INFORMED CONSENT FORM

Source: Kraft, S. (2005). The Center for Ethical Practice.
Retrieved from http://www.centerforethicalpractice.org/Form-AdolescentConsent

Adolescent Informed Consent Form

* SAMPLE

Your Letterhead

Privacy of Information Shared in Counseling/Therapy:
Your Rights and My Policies

What to expect:

The purpose of meeting with a counselor or therapist is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to a counselor or therapist about these problems. Or, you may be here because your parent, guardian, doctor or teacher had concerns about you. When we meet, we will discuss these problems. I will ask questions, listen to you and suggest a plan for improving these problems. It is important that you feel comfortable talking to me about the issues that are bothering you. Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor or therapist. Privacy, also called confidentiality, is an important and necessary part of good counseling.

As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your written consent to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with me in a therapy session. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

>You tell me you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself.

> You tell me you plan to cause serious harm or death to someone else who can be identified, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform your parent or guardian, and I must inform the person who you intend to harm.

>You are doing things that could cause serious harm to you or someone else, even if you do not *intend* to harm yourself or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.

>You tell me you are being abused-physically, sexually or emotionally-or that you have been abused in the past. In this situation, I am required by law to report the abuse to the Virginia Department of Social Services.

>You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement *unless* the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.

<u>Communicating with your parent(s) or guardian(s):</u>

Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of — or would be upset by — but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian.

Example: If you tell me that you have tried alcohol at a few parties, I would keep this information confidential. If you tell me that you are drinking and driving or that you are a passenger in a car with a driver who is drunk, I would not keep this information confidential from your parent/guardian. If you tell me, or if I believe based on things you've told me, that you are addicted to alcohol, I would not keep this information confidential.

Example: If you tell me that you are having protected sex with a boyfriend or girlfriend, I would keep this information confidential. If you tell me that, on several occasions, you have engaged in unprotected sex with people you do not know or in unsafe situations, I will not keep this information confidential. You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," in other words: "If someone told you that they were doing _____, would you tell their parents?"

Even if I have agreed to keep information confidential – to not tell your parent or guardian – I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

[You should also know that, by law in Virginia, your parent/guardian has the right to see any written records I keep about our sessions. It is extremely rare that a parent/guardian would ever request to look at these records.]

Communicating with other adults:

School: I will not share any information with your school unless I have your permission and permission from your parent or guardian. Sometimes I may request to speak to someone at your school to find out how things are going for you. Also, it may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, I will discuss it with you and ask for your written permission. A very unlikely situation might come up in which I do not have your permission but both I and your parent or guardian believe that it is very important for me to be able to share certain information with someone at your school. In this situation, I will use my professional judgment to decide whether to share any information.

Doctors: Sometimes your doctor and I may need to work together; for example, if you need to take medication in addition to seeing a counselor or therapist. I will get your written permission and permission from your parent/guardian in advance to share information with your doctor. The only time I will share information with your doctor even if I don't have your permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

* * * * *

Adolescent Consent Form
&
Parent Agreement to Respect Privacy

Adolescent therapy client:

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask your therapist at any time.

Minor's Signature _______ Date_____

* * *

Parent/Guardian:

Check boxes and sign below indicating your agreement to respect your adolescent's privacy:

/__/ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

/__/ Although I know I have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my adolescent's treatment.

/__/ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with her consultant/supervisor.

Parent Signature _____ Date_____

Parent Signature _____ Date_____

Therapist Signature _____ Date_____

***NOTE: This is a sample form, designed for training purposes.**
For use in your own setting, this form must be personalized
to reflect your own state's laws and your own actual policies about confidentiality.

Drafted for The Center for Ethical Practice
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Appendix B: AAMFT Complaint Process

Source: American Association for Marriage and Family Therapy
Retrieved from: http://www.aamft.org/iMIS15/AAMFT/Content/Legal_Ethics/Ethics_Complaint_Process.aspx

A Fair Process in a Difficult Situation

Marriage and family therapists are professionals who strive to provide the best services for their clients. Therapists are also human beings and on occasion tend to make unfortunate mistakes when rendering these services. The point at which the client perceives that they have been injured by the professional is when they may seek justice from an outside source, such as the courts or a licensing board and/or professional organization. This article will explain how an ethics complaint is processed by the American Association for Marriage and Family Therapy (AAMFT).

The AAMFT Procedures for Handling Ethical Matters is the official document that outlines the association's process for investigating ethics complaints against its members. An examination of these procedures indicates that it is primarily a "paper review" process. Complaints may be submitted by members of the AAMFT, non-members and the AAMFT Ethics Committee. In all but those cases that are filed by the AAMFT Ethics Committee, the complainant must have first-hand knowledge about the issue or be able to provide relevant testimony related to it.

The AAMFT Ethics Committee may initiate a complaint when presented with sufficient information indicating allegations that could constitute a violation of the Code of Ethics. According to the procedures, "When a member has been disciplined by another professional association or a regulatory board, or convicted of a felony, or misdemeanor related to his or her qualifications or functions by a court, it is the policy of the AAMFT Ethics Committee that the Committee will presume that such findings are correct and appropriate." However, the member is offered an opportunity to demonstrate evidence to overcome this presumption, through documentation that: (1) the investigative process was flawed and resulted in an incorrect outcome, and/or (2) that the action taken was too severe for the type of infraction.

Upon receipt of a complaint alleging violations of the AAMFT Code of Ethics ("Code"), ethics staff review for jurisdiction, filing deadlines, merit and precedent. For a case to proceed, complainants must waive therapist-client confidentiality and permit the use of their name and the provision of a copy of the allegations to the respondent member. All applicants and members are held to the Code, as are resigned members for a period of one year after resignation. If the complaint is judged to have merit under the Code, staff draft charges and present the case to the chair of the Ethics Committee for consultation and approval or modification. The Ethics Committee, usually acting through the chair, has the sole authority to make charges against members. Once the member is charged, the full investigative process is engaged and the complainant is notified. The member is required to address the allegations and present a defense within 30 days. If the member resigns in anticipation of, or during, the course of an ethics investigation, the Ethics Committee will complete its investigation. Any publication of action taken by the association will include the fact that the member attempted to resign during the investigation.

At any point in the process, the chair or full Ethics Committee may close the case for lack of merit or hold it in abeyance if the allegations appear to be more appropriately handled by another professional, civil or regulatory body.

When case materials are complete, the staff prepares and presents them to the Ethics Committee for deliberation. Only the full Committee can make a finding that a violation has occurred. "Preponderance of the evidence" is the standard of proof, and no members, complainants or witnesses attend Committee meetings, which are held each spring and fall. The Committee is composed of four Clinical Members and

two public members.

If the Committee finds the member in violation of the AAMFT Code of Ethics, the next step is to render an appropriate sanction based on the severity of the infraction. For the most serious violations, the Committee may recommend termination of membership with a permanent bar to readmission. As a sanction for lesser violations, the Committee may seek rehabilitation of the member by offering a "mutual settlement" in which the member agrees to mandated education, supervision, therapy, suspension or other actions. If the complaint has been filed against an applicant for membership, the Committee makes a report to the Standards Committee recommending that the application proceed or be denied. The Committee also issues warnings or reprimands as deemed appropriate. Members found in violation of the Code have the right to a hearing before the AAMFT Judicial Committee. If an appeal hearing is not requested, the Ethics Committee's findings and sanctions become final.

If the member files an appeal with the Judicial Committee, the committee's chair appoints a Hearing Panel to conduct a hearing. At the hearing, the Ethics Committee chair presents the charges against the member and has the burden of proving these charges by a preponderance of the evidence. During the hearing, the Ethics Committee chair and the member may be assisted by counsel, present witnesses, cross-examine witnesses and make brief opening and closing statements. An audiotape is made of the hearing. The Hearing Panel renders a decision within 30 days, indicating whether or not a violation was found, and if a violation is found, ordering action to be taken. Since 1990, 25 ethics cases have been reviewed by the Judicial Committee. The last hearing was held in 1997.

A member may make a final appeal to the AAMFT Board of Directors if they believe that a procedural violation impaired their defense before the Judicial Committee Hearing Panel. The Board reviews the appeal at its next scheduled meeting and renders a decision based solely on the member's written statement and the response from the Judicial Committee or AAMFT's legal counsel. The Board renders a written decision within 30 days of the meeting. This decision may affirm the Judicial Committee's decision or order a new hearing. Since 1990, the AAMFT Board has reviewed three ethics cases. The last appeal to the Board was reviewed in 1994.

All information obtained by the Ethics Committee and all case proceedings are confidential with limited exceptions. At this time, termination of membership is the only sanction that is routinely made public. Sanctions that involve mutual settlements, warnings or reprimands remain confidential and the only notification is made to the complainant. The procedures permit AAMFT to provide a limited report on the case to a regulatory board or another professional association upon their request. At that time, the member is provided a copy of the report.

Appendix C
American Association for Marriage and Family Therapy (AAMFT)
Marriage and Family Therapy Core Competencies

The marriage and family therapy (MFT) core competencies were developed through a collaborative effort of the American Association for Marriage and Family Therapy (AAMFT) and interested stakeholders. In addition to defining the domains of knowledge and requisite skills in each domain that comprise the practice of marriage and family therapy, the ultimate goal of the core competencies is to improve the quality of services delivered by marriage and family therapists (MFTs). Consequently, the competencies described herein represent the minimum that MFTs licensed to practice independently must possess.

Creating competencies for MFTs and improving the quality of mental health services was considered in the context of the broader behavioral health system. The AAMFT relied on three important reports to provide the framework within which the competencies would be developed: *Mental Health: A Report of the Surgeon General*; the President's New Freedom Commission on Mental Health's *Achieving the Promise: Transforming Mental Health Care in America*; and the Institute of Medicine's *Crossing the Quality Chasm.* The AAMFT mapped the competencies to critical elements of these reports, including IOM's 6 Core Values that are seen as the foundation for a better health care system: 1) Safe, 2) Person-Centered, 3) Efficient, 4) Effective, 5) Timely, and 6) Equitable. The committee also considered how social, political, historical, and economic forces affect individual and relational problems and decisions about seeking and obtaining treatment.

The core competencies were developed for educators, trainers, regulators, researchers, policymakers, and the public. The current version has 128 competencies; however, these are likely to be modified as the field of family therapy develops and as the needs of clients change. The competencies will be reviewed and modified at regular intervals to ensure the competencies are reflective of the current and best practice of MFT.

The core competencies are organized around 6 primary domains and 5 secondary domains. The primary domains are:

1) **Admission to Treatment** – All interactions between clients and therapist up to the point when a therapeutic contract is established.
2) **Clinical Assessment and Diagnosis** – Activities focused on the identification of the issues to be addressed in therapy.
3) **Treatment Planning and Case Management** – All activities focused on directing the course of therapy and extra-therapeutic activities.
4) **Therapeutic Interventions** – All activities designed to ameliorate the clinical issues identified.
5) **Legal Issues, Ethics, and Standards** – All aspects of therapy that involve statutes, regulations, principles, values, and mores of MFTs.
6) **Research and Program Evaluation** – All aspects of therapy that involve the systematic analysis of therapy and how it is conducted effectively.

The subsidiary domains are focused on the types of skills or knowledge that MFTs must develop. These are: a) Conceptual, b) Perceptual, c) Executive, d) Evaluative, and e) Professional.

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

Domain 1: Admission to Treatment

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

Domain 2: Clinical Assessment and Diagnosis

Number	Subdomain	Competence
2.1.1	Conceptual	Understand principles of human development; human sexuality; gender development; psychopathology; psychopharmacology; couple processes; and family development and processes (e.g., family, relational, and system dynamics).
2.1.2	Conceptual	Understand the major behavioral health disorders, including the epidemiology, etiology, phenomenology, effective treatments, course, and prognosis.
2.1.3	Conceptual	Understand the clinical needs and implications of persons with comorbid disorders (e.g., substance abuse and mental health; heart disease and depression).
2.1.4	Conceptual	Comprehend individual, marital, couple and family assessment instruments appropriate

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

Domain 3: Treatment Planning and Case Management

Number	Subdomain	Competence
3.1.1	Conceptual	Know which models, modalities, and/or techniques are most effective for presenting problems.
3.1.2	Conceptual	Understand the liabilities incurred when billing third parties, the codes necessary for reimbursement, and how to use them correctly.
3.1.3	Conceptual	Understand the effects that psychotropic and other medications have on clients and the treatment process.
3.1.4	Conceptual	Understand recovery-oriented behavioral health services (e.g., self-help groups, 12-step

Number	Subdomain	Competence
		programs, peer-to-peer services, supported employment).
3.2.1	Perceptual	Integrate client feedback, assessment, contextual information, and diagnosis with treatment goals and plan.
3.3.1	Executive	Develop, with client input, measurable outcomes, treatment goals, treatment plans, and after-care plans with clients utilizing a systemic perspective.
3.3.2	Executive	Prioritize treatment goals.
3.3.3	Executive	Develop a clear plan of how sessions will be conducted.
3.3.4	Executive	Structure treatment to meet clients' needs and to facilitate systemic change.
3.3.5	Executive	Manage progression of therapy toward treatment goals.
3.3.6	Executive	Manage risks, crises, and emergencies.
3.3.7	Executive	Work collaboratively with other stakeholders, including family members, other significant persons, and professionals not present.
3.3.8	Executive	Assist clients in obtaining needed care while navigating complex systems of care.
3.3.9	Executive	Develop termination and aftercare plans.
3.4.1	Evaluative	Evaluate progress of sessions toward treatment goals.
3.4.2	Evaluative	Recognize when treatment goals and plan require modification.
3.4.3	Evaluative	Evaluate level of risks, management of risks, crises, and emergencies.
3.4.4	Evaluative	Assess session process for compliance with policies and procedures of practice setting.
3.4.5	Professional	Monitor personal reactions to clients and treatment process, especially in terms of therapeutic behavior, relationship with clients, process for explaining procedures, and outcomes.
3.5.1	Professional	Advocate with clients in obtaining quality care, appropriate resources, and services in their community.
3.5.2	Professional	Participate in case-related forensic and legal processes.
3.5.3	Professional	Write plans and complete other case documentation in accordance with practice setting policies, professional standards, and state/provincial laws.
3.5.4	Professional	Utilize time management skills in therapy sessions and other professional meetings.

Domain 4: Therapeutic Interventions

Number	Subdomain	Competence
4.1.1	Conceptual	Comprehend a variety of individual and systemic therapeutic models and their application, including evidence-based therapies and culturally sensitive approaches.
4.1.2	Conceptual	Recognize strengths, limitations, and contraindications of specific therapy models, including the risk of harm associated with models that incorporate assumptions of family dysfunction, pathogenesis, or cultural deficit.
4.2.1	Perceptual	Recognize how different techniques may impact the treatment process.
4.2.2	Perceptual	Distinguish differences between content and process issues, their role in therapy, and their potential impact on therapeutic outcomes.
4.3.1	Executive	Match treatment modalities and techniques to clients' needs, goals, and values.
4.3.2	Executive	Deliver interventions in a way that is sensitive to special needs of clients (e.g., gender, age, socioeconomic status, culture/race/ethnicity, sexual orientation, disability, personal history, larger systems issues of the client).
4.3.3	Executive	Reframe problems and recursive interaction patterns.
4.3.4	Executive	Generate relational questions and reflexive comments in the therapy room.
4.3.5	Executive	Engage each family member in the treatment process as appropriate.
4.3.6	Executive	Facilitate clients developing and integrating solutions to problems.

Number	Subdomain	Competence
4.3.7	Executive	Defuse intense and chaotic situations to enhance the safety of all participants.
4.3.8	Executive	Empower clients and their relational systems to establish effective relationships with each other and larger systems.
4.3.9	Executive	Provide psychoeducation to families whose members have serious mental illness or other disorders.
4.3.10	Executive	Modify interventions that are not working to better fit treatment goals.
4.3.11	Executive	Move to constructive termination when treatment goals have been accomplished.
4.3.12	Executive	Integrate supervisor/team communications into treatment.
4.4.1	Evaluative	Evaluate interventions for consistency, congruency with model of therapy and theory of change, cultural and contextual relevance, and goals of the treatment plan.
4.4.2	Evaluative	Evaluate ability to deliver interventions effectively.
4.4.3	Evaluative	Evaluate treatment outcomes as treatment progresses.
4.4.4	Evaluative	Evaluate clients' reactions or responses to interventions.
4.4.5	Evaluative	Evaluate clients' outcomes for the need to continue, refer, or terminate therapy.
4.4.6	Evaluative	Evaluate reactions to the treatment process (e.g., transference, family of origin, current stress level, current life situation, cultural context) and their impact on effective intervention and clinical outcomes.
4.5.1	Professional	Respect multiple perspectives (e.g., clients, team, supervisor, practitioners from other disciplines who are involved in the case).
4.5.2	Professional	Set appropriate boundaries, manage issues of triangulation, and develop collaborative working relationships.
4.5.3	Professional	Articulate rationales for interventions related to treatment goals and plan, assessment information, and systemic understanding of clients' context and dynamics.

Domain 5: Legal Issues, Ethics, and Standards

Number	Subdomain	Competence
5.1.1	Conceptual	Know state, federal, and provincial laws and regulations that apply to the practice of marriage and family therapy.
5.1.2	Conceptual	Know professional ethics and standards of practice that apply to the practice of marriage and family therapy.
5.1.3	Conceptual	Know policies and procedures of the practice setting.
5.1.4	Conceptual	Understand the process of making an ethical decision.
5.2.1	Perceptual	Recognize situations in which ethics, laws, professional liability, and standards of practice apply.
5.2.2	Perceptual	Recognize ethical dilemmas in practice setting.
5.2.3	Perceptual	Recognize when a legal consultation is necessary.
5.2.4	Perceptual	Recognize when clinical supervision or consultation is necessary.
5.3.1	Executive	Monitor issues related to ethics, laws, regulations, and professional standards.
5.3.2	Executive	Develop and assess policies, procedures, and forms for consistency with standards of practice to protect client confidentiality and to comply with relevant laws and regulations.
5.3.3	Executive	Inform clients and legal guardian of limitations to confidentiality and parameters of mandatory reporting.
5.3.4	Executive	Develop safety plans for clients who present with potential self-harm, suicide, abuse, or violence.
5.3.5	Executive	Take appropriate action when ethical and legal dilemmas emerge.
5.3.6	Executive	Report information to appropriate authorities as required by law.

Number	Subdomain	Competence
5.3.7	Executive	Practice within defined scope of practice and competence.
5.3.8	Executive	Obtain knowledge of advances and theory regarding effective clinical practice.
5.3.9	Executive	Obtain license(s) and specialty credentials.
5.3.10	Executive	Implement a personal program to maintain professional competence.
5.4.1	Evaluative	Evaluate activities related to ethics, legal issues, and practice standards.
5.4.2	Evaluative	Monitor attitudes, personal well-being, personal issues, and personal problems to insure they do not impact the therapy process adversely or create vulnerability for misconduct.
5.5.1	Professional	Maintain client records with timely and accurate notes.
5.5.2	Professional	Consult with peers and/or supervisors if personal issues, attitudes, or beliefs threaten to adversely impact clinical work.
5.5.3	Professional	Pursue professional development through self-supervision, collegial consultation, professional reading, and continuing educational activities.
5.5.4	Professional	Bill clients and third-party payers in accordance with professional ethics, relevant laws and polices, and seek reimbursement only for covered services.

Domain 6: Research and Program Evaluation

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

Mindful
Continuing Education

"This course was developed from the document: Ethics for Marriage and Family Therapists – Patricia Hocking-Walker, Quantum Units Education (2014)."