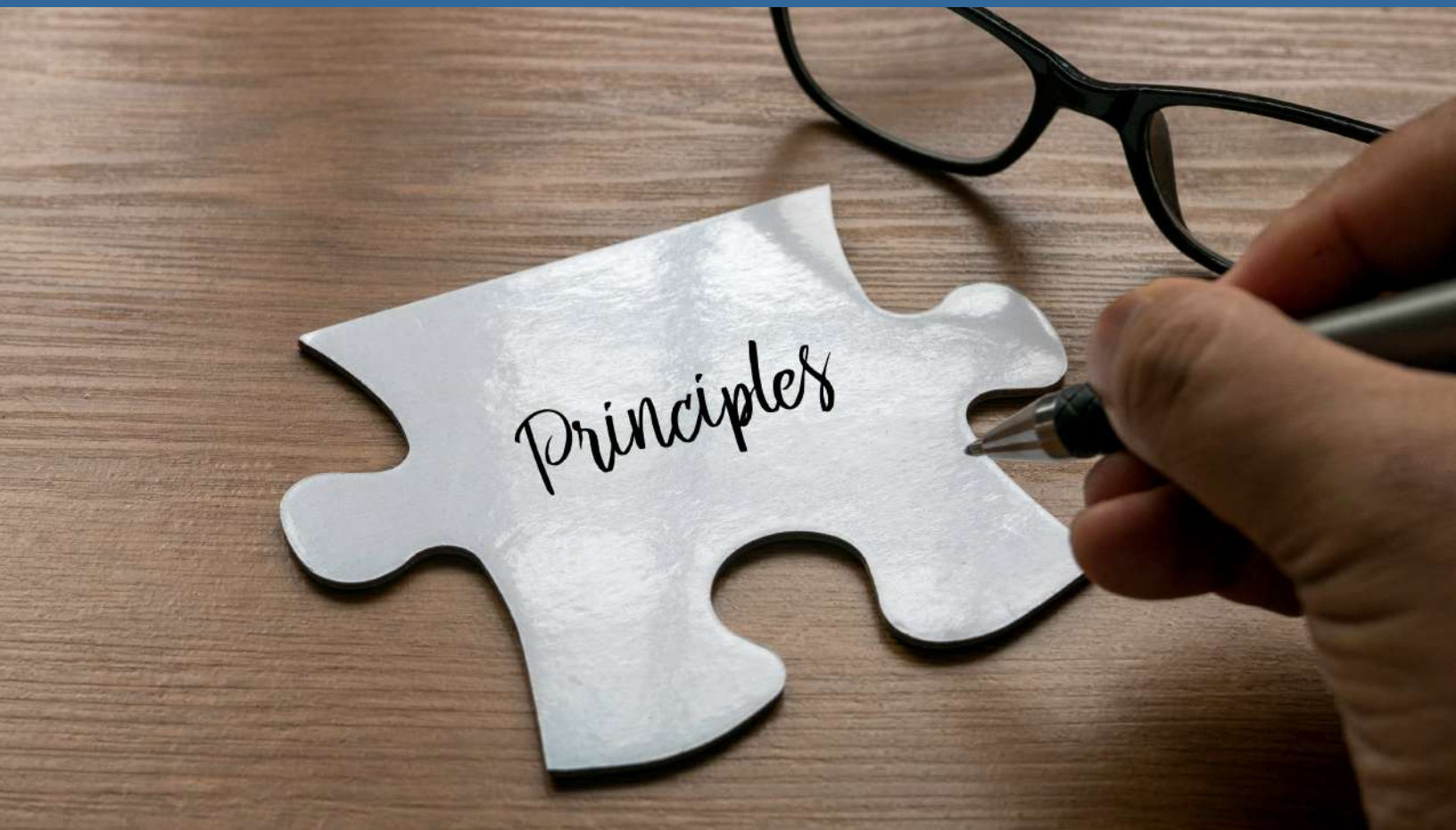
Mindful
Continuing Education

Ethics 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. While clinical interventions are intended to promote the welfare of the individuals and the family unit as a whole, they may also produce harmful consequences for some family members, therefore raising ethical and therapeutic dilemmas. When professionals work with clients in a therapeutic setting, they may face concerns related to confidentiality, informed consent, boundary violations, professional responsibility and competence, as well as other issues.

Marriage and family therapists recognize that ethical decision-making principles may be based on higher standards for their conduct than legal requirements and that they must comply with the highest standard. Marriage and family therapists act with integrity and truthfulness, ensure fairness and non-discrimination, and promote the well-being of their clients/patients within the larger society. Marriage and family therapists avoid actions that cause harm and recognize that their clients/patients control their own life choices.

Marriage and family therapists should be familiar with models of ethical decision-making and continuously develop their skills to recognize when an ethical conflict exists. Marriage and family therapists utilize consultation and stay current with the relevant research and literature about these processes. Furthermore, MFTs reflect on ethical issues that arise within their practice and within the context of their legal responsibilities, ethical standards, and personal values, and develop congruent plans for action and resolution (CAMFT, 2020).

The AAMFT Code of Ethics includes core values and ethical standards. Core values are aspirational in nature, and are distinct from ethical standards. These values are intended to provide a desirable and expected framework within which marriage and family therapists may pursue the highest goals of practice. Ethical standards, by contrast, are rules of practice upon which the marriage and family therapist is obliged and judged (AAMFT, 2015).

The core values of AAMFT (2015) embody:

1. Acceptance, appreciation, and inclusion of a diverse membership.

2. Distinctiveness and excellence in training of marriage and family therapists and those desiring to advance their skills, knowledge and expertise in systemic and relational therapies.
3. Responsiveness and excellence in service to members.
4. Diversity, equity and excellence in clinical practice, research, education and administration.
5. Integrity evidenced by a high threshold of ethical and honest behavior within Association governance and by members.
6. Innovation and the advancement of knowledge of systemic and relational therapies.

The Process of Pursuing Ethical Standards

Ethical standards are relevant to the professional activities of all marriage and family therapists. According to AAMFT (2022) these standards encompass:

- **Responsibility to Clients** - Marriage and family therapists advance the welfare of families and individuals and make reasonable efforts to find the appropriate balance between conflicting goals within the family system.
- **Confidentiality** - Marriage and family therapists have unique confidentiality concerns because the client in a therapeutic relationship may be more than one person. Therapists respect and guard the confidences of each individual client.
- **Professional Competency and Integrity** - Marriage and family therapists maintain high standards of professional competence and integrity.
- **Responsibility to Students and Supervisees** - Marriage and family therapists do not exploit the trust and dependency of students and supervisees.
- **Research and Publication** - Marriage and family therapists respect the dignity and protect the welfare of research participants, and are aware of applicable laws, regulations, and professional standards governing the conduct of research.
- **Technology-Assisted Professional Services** - Therapy, supervision, and other professional services engaged in by marriage and family therapists take place over an increasing number of technological platforms. There are great benefits and

responsibilities inherent in both the traditional therapeutic and supervision contexts, as well as in the utilization of technologically-assisted professional services. This standard addresses basic ethical requirements of offering therapy, supervision, and related professional services using electronic means.

- **Professional Evaluations** - Marriage and family therapists aspire to the highest of standards in providing testimony in various contexts within the legal system.
- **Financial Arrangements** - Marriage and family therapists make financial arrangements with clients, third-party payors, and supervisees that are reasonably understandable and conform to accepted professional practices.
- **Advertising** - Marriage and family therapists engage in appropriate informational activities, including those that enable the public, referral sources, or others to choose professional services on an informed basis.

Each situation and client is unique and therapists should continuously refer to the code of ethics for direction in ethical decision making. While we know there is not a one size fits all decision making model in behavioral health, it is important to explore ethical standards and potential conflicts in practice. The following example from Counseling Today (2018) illustrates how ethical dilemmas may arise unintentionally.

A clinician attended a client's graduation party. She had worked with this client for months as he dealt with the ending of his marriage, the loss of his 20-year career and the decision to go back to college to begin a new life. The graduation party was a celebration of the long road they had traveled together as clinician and client. It was a small party consisting almost exclusively of relatives. Even though the clinician stayed only a short time, the client introduced her as someone who had helped him through hard times. Subsequently, she was met with questions about her relationship with the client, whether they were dating and other awkward speculations. Because of the way he introduced her, she could not clarify her relationship with the client. Her decision to attend the party was made with the best of intentions but clearly involved ethical considerations that should have been contemplated.

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 recurring theme regarding the development and maintenance of ethical standards that protect both parties.

Reflection Question

What is a situation where you referred to the code of ethics for guidance? Can you think of a situation where you should have referenced the code of ethics and/or addressed the issue in supervision?

Boundary Crossing Versus Boundary Violation

Boundary violations and boundary crossings, while different, should both be considered while assessing conflicts of interest. Boundary violations are unethical and harmful to clients. They happen when therapists are involved in exploitative relationships such as sexual contact with a client or an inappropriate business transaction.

Boundary crossings are not unethical and can be therapeutically helpful. Examples include: flying in an airplane with a patient who suffers from a fear of flying, having lunch with an anorexic patient, making a home visit to a bedridden elderly patient, going for a vigorous walk with a depressed patient, or accompanying clients to a dreaded but medically essential doctor's appointment to which they would not go on their own. Boundary crossings should be implemented according to the client's unique needs and specific situation. It is recommended that the rationale for boundary crossings be clearly articulated and, when appropriate, included in the treatment plan. (Zur, 2021).

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, is it 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, “Sexual intimacy with former clients or with known members of the client’s family system is prohibited” (AAMFT, 2015).

Exploitation - 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?

Reflection Question

While the previous code of ethics stated that if two years had passed since therapy or professional contact and a therapist could demonstrate there was no harm, injury or exploitation of entering into a sexual relationship with a former client or family member then it was permissible. When the code was updated in 2015 it was changed to no sexual contact allowed with previous client or family members. Do you agree or disagree with this change? What could be some positives and negatives to this no sexual contact ever rule versus the previous two year rule?

Multiple Relationships

The code of ethics states: marriage and family therapists are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, 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. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists document the appropriate precautions taken (AAMFT, 2015).

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 between Leo and Roger's son.

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. 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. Multiple relationships that do not cause impairment, risk exploitation, or harm are not unethical and often, especially in rural communities, inevitable and unavoidable (Zur, 2018).

Every dual relationship and situation is unique and requires careful consideration. The following questions are helpful to consider in any professional/client relationship where there is potential for dual or multiple relationships (NLASW, 2018):

- Is the dual relationship avoidable or unavoidable? If unavoidable, what steps can be taken to minimize risk?
- What is the nature of the professional relationship? Does the context of practice make a difference?
- Is the relationship having an impact on one's objectivity and decision-making?
- Whose needs are being met by the dual relationship? Clinician or client?
- Is this creating a blend between one's personal and professional life? Does this result in a conflict of interest (actual or perceived)?
- Could client confidentiality be compromised?
- Are exceptions being made for one client? If so, why?
- What policies, standards, or ethical values are applicable to the situation?
- How might this dual relationship be perceived by one's work colleagues, employer, or community members?
- Are there cultural elements that need to be considered?
- What options are available for addressing 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, or may feel that he needs to adhere to NASW ethical standards which state, "protecting clients' interests may require termination of the professional relationship with proper referral of the client." When and if they determine that they should terminate therapy, Roger will make an appropriate referral.

Zur (2021) Identifies multiple types of dual relationships which include:

A social dual relationship is where a therapist and client are also friends or have some other type of social relationship. Social multiple relationships can be in person or online. Having a client as a Facebook 'friend' on a personal, rather than strictly professional basis, may also constitute social dual relationships. Other types of therapist-client online

relationships on social networking sites may also constitute social dual or multiple relationships.

A professional dual relationship is where a psychotherapist or counselor and client are also professional colleagues in colleges or training institutions, presenters in professional conferences, co-authoring a book, or involved in other situations that create professional multiple relationships.

A special treatment-professional dual relationship may take place if a professional is, in addition to psychotherapy and counseling, also providing additional medical services, such as progressive muscle relaxation, nutrition or dietary consultation, Reiki, etc.

A business dual relationship is where a therapist and client are also business partners or have an employer-employee relationship.

A communal dual relationship is where the therapist and client live in the same small community, belong to the same church or synagogue and where the therapist shops in a store that is owned by the client or where the client works. Communal multiple relationships are common in small communities when clients know each other within the community.

An institutional dual relationship takes place in the military, prisons, some police department settings and mental hospitals where dual relationships are an inherent part of the institutional settings. Some institutions, such as state hospitals or detention facilities, mandate that clinicians serve simultaneously or sequentially as therapists and evaluators.

A forensic dual relationship involves clinicians who serve as treating therapists, evaluators, and witnesses in trials or hearings. Serving as a treating psychotherapist or counselor as well as an expert witness, rather than fact witness, is considered a very complicated and often ill-advised dual relationship.

A supervisory relationship inherently involves multiple roles, loyalties, responsibilities, and functions. A supervisor has professional relationships and duty not only to the supervisee, but also to the supervisee's clients, as well as to the profession and the public.

A sexual dual relationship is where therapist and client are also involved in a sexual relationship. Sexual dual relationships with current clients are always unethical and often illegal.

A digital, online, or internet dual relationship that takes place online on social networking sites, such as Facebook or Twitter, or on blogs, chats, or LinkedIn between a clinician and client encompasses a unique dual or multiple relationship. These relationships can be professional (i.e., on LinkedIn or Facebook pages), social (i.e., Facebook or other social networking sites), or other types of multiple relationships that take place on chats, Twitter, blogs, etc.

While many of the above examples of dual relationships could be viewed as unavoidable, and may fail to violate the codes of ethics of many professional associations (does not cause impairment, exploitation or harm) the one dual relationship that all groups agree is unethical is having a sexual relationship with a client. Not only is it unethical, but it is also illegal in many states.

Informed Consent

Marriage and family therapists obtain appropriate informed consent for therapy and related services and use language that is reasonably understandable to clients. When persons, due to age or mental status, are legally incapable of giving informed consent, marriage and family therapists obtain informed permission from an authorized person, if such substitute consent is legally permissible. The content of informed consent may vary depending upon the client and treatment plan; however, informed consent generally necessitates 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; and has provided consent that is appropriately documented (AAMFT, 2015).

Polychronis (2020) explains informed consent as a process to walk clients through. His identified steps include:

- Determination of Client Capacity
- Disclosure About What Happens in Sessions
- Disclosure About Evidence-Based Information
- How to Disclose Information
- Establishing Consent

He also establishes the importance of client autonomy throughout the process. This standard is included in the code of ethics: “Marriage and family therapists respect the rights of clients to make decisions and help them to understand the consequences of these decisions. Therapists clearly advise clients they themselves have the responsibility to make decisions regarding relationships such as cohabitation, marriage, divorce, separation, reconciliation, custody, and visitation” (AAMFT, 2015).

Informed consent paperwork should be signed by a capable adult, but when adults do not have the capacity to give informed consent for themselves a legal guardian may sign for them. For minors, a parent or guardian may need to legally give informed consent. The age of consent for minors varies by state and for what services one is able to give consent, so marriage and family therapists should be aware of their state requirements for legal age and competence to give informed consent for self.

Since most informed consent forms focus on in-office procedures, therapists providing telehealth should seek additional informed consent around telemental health services.

Per the AAMFT code of ethics, therapist must: determine that technologically-assisted services or supervision are appropriate for clients or supervisees, consider professional, intellectual, emotional, and physical needs; inform clients or supervisees of the potential risks and benefits associated with technologically-assisted services; ensure the security of their communication medium (AAMFT, 2015). See Appendix A for a sample of a telemental health informed consent form.

Reflection Question

What are considerations that might impact a client's capability of understanding informed consent?

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, 2015). 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.

The practice management software, Simple Practice, has the following confidentiality statement recommendation in their forms for psychotherapy.

> *Confidentiality Statement: The session content and all materials relevant to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/ persons. Limitations of such client held privilege of confidentiality exist and are itemized below:*
>
> 1. *If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.*
> 2. *If a client threatens grave bodily harm or death to another person.*
> 3. *If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.*
> 4. *Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.*
> 5. *Suspected neglect of the parties named in items #3 and # 4.*
> 6. *If a court of law issues a legitimate subpoena for information stated on the subpoena.*
> 7. *If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.*

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Reflection Questions

Informed consent forms should minimally cover situations when confidentiality will no longer be kept. Therapists can make them as detailed or broad as necessary to fit their practice situation and population. What information would you include in your informed consent that is not listed above?

Confidentiality with Minor Clients

GoodTherapy explores some of the complications with confidentiality and minor clients. In many jurisdictions, minors are not considered developmentally able to consent to treatment, so parents are expected to consent on their behalf. Thus, minors do not have the same confidentiality rights that most adults have. In some states, minors 13 or older have comparable or identical rights to seek health care (including mental health care) and to have their privacy protected as adults. A lack of confidentiality can interfere with the therapeutic relationship and children may be reluctant to disclose information to a therapist if they know their parents will eventually learn about the shared information. To promote trust with the minor in therapy, many clinicians seek the permission of the clients' parents to keep the conversations confidential. Even when parents do not agree to confidentiality, therapists will not typically reveal details about their discussions in therapy. Instead, they will give information about broad treatment goals and progress (GoodTherapy, 2020).

The following vignette explores maintaining confidentiality with minors and when there may need to be a determination to break confidentiality for safety reasons.

Sixteen year old Susie and her parents Susie came to the clinic to discuss treatment with LMFT Mark. 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. However, 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).

Reviewing this case through the lens of the code of ethics, once Mark determined there was harm to self and it was sufficient to break confidentiality with Susie and speak with her parents, he should be able to acknowledge that he had "disclosed to clients and other interested parties at the outset of services the nature of confidentiality and possible limitations of the clients' right to confidentiality" (AAMFT, 2015). 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. Mark should also be documenting all aspects that led him to not break confidentiality initially and what escalated to the level of harm to where he felt justified breaking that confidentiality.

Reflection Question

Do you agree with Mark's decision to bring in the parents when he did? Would you have done this sooner or waited longer? What pieces of the code of ethics will you document to support your decision?

Professional Competence & Integrity

Roberts & Termuehlen define professionalism as a multidimensional concept that encompasses ethics; relationships with one's patients, colleagues, and community; public policy; and self-awareness. They remind therapists that individuals who receive psychotherapeutic services place themselves in a vulnerable situation by allowing another individual to observe and evaluate their emotions, cognitions, attitudes, values, and behaviors. Mental health clinicians are expected to facilitate the growth and development of these individuals. This responsibility requires the valuing of the patient's autonomy and integrity, respect for the patient-clinician relationship and boundaries, appreciation of power differentials, continuous focus on the needs of the patient, and sensitivity to cultural diversity in the ecological context in which patients live and function (Roberts & Termuehlen, 2021).

The code of ethics states MFTs should maintain their competency through education, training, and/or supervised experience. They should ensure knowledge of and adherence to applicable laws, ethics, and professional standards (AAMFT, 2015). In addition to the code of ethics, AAMFT has established core competencies with the goal of improving services provided by marriage and family therapists (see the full list of 128 core competencies in appendix C).

Competencies that are included in the subdomain of professionalism include (AAMFT, 2015):

- Understand the legal requirements and limitations for working with vulnerable populations (e.g., minors).

- 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 the 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 sessions and other professional meetings.
- Respect multiple perspectives (e.g., clients, team, supervisor, practitioners from other disciplines who are involved in the case).
- 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

AAMFT (2015) defines the following as potential professional misconduct that could lead to termination of membership, termination of licensure or even criminal charges if members: are convicted of any 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; are expelled from or disciplined by other professional organizations; have their licenses or certificates suspended or revoked or are otherwise disciplined by regulatory bodies; continue to practice marriage and family therapy while no longer competent to do so because they are impaired by physical or mental causes or the abuse of alcohol or other substances; or fail to cooperate with the Association at any point from the inception of an ethical complaint through the completion of all proceedings regarding that complaint.

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, AAMFT 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, 2015). 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. Margie will also speak to a colleague for guidance and document her actions.

For instructions on how to file an ethical complaint with AAMFT and what steps are involved during their investigation, see Appendix B.

Professional Evaluations

Clear distinctions are made between therapy and evaluations. Marriage and family therapists avoid conflict in roles in legal proceedings wherever possible and disclose potential conflicts. As therapy begins, marriage and family therapists clarify roles and the extent of confidentiality when legal systems are involved. MFTs may perform forensic services which may include interviews, consultations, evaluations, reports, and assessments both formal and informal, in keeping with applicable laws and competencies. Those who provide expert or fact witness testimony in legal proceedings avoid misleading judgments, base conclusions and opinions on appropriate data, and avoid inaccuracies insofar as possible. When offering testimony as marriage and family therapy experts, they shall strive to be accurate, objective, fair, and independent. MFTs who provide forensic evaluations avoid offering professional opinions about persons they have not directly interviewed. Marriage and family therapists declare the limits of their competencies and information (AAMFT, 2015).

Professional Boundaries in Supervision

Marriage and family therapists who are in a supervisory role are aware of their influential positions with respect to students and supervisees, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships that could impair professional objectivity or increase the risk of exploitation. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists take appropriate precautions. Supervisors are expected to oversee their supervisee's professionalism and ensure that they are practicing within their level of competencies (AAMFT, 2015). The following vignette explores professional boundaries from a supervision perspective.

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 intensive outpatient program (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.

Reflection Question

What strategies might Eloise implement in the future regarding ethical decision making and relationships with clients? If you were her supervisor, would you have done anything differently than Stan?

Research and Publication Standards

Marriage and family therapists respect the dignity and protect the welfare of research participants, and are aware of applicable laws, regulations, and professional standards governing the conduct of research. MFTs 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, 2015).

Professional Services and Technology

Prior to commencing therapy or supervision services through electronic means (including but not limited to phone and Internet), marriage and family therapists ensure that they are compliant with all relevant laws for the delivery of such services. Additionally, marriage and family therapists must: determine that technologically-assisted services or supervision are appropriate for clients or supervisees, considering professional, intellectual, emotional, and physical needs; inform clients or supervisees of the potential risks and benefits associated with technologically-assisted services; ensure the security of their communication medium; and only commence electronic therapy or supervision after appropriate education, training, or supervised experience using the relevant technology (AAMFT 2015).

Although the advantages of digitally communicating with clients are many and include client preference, client empowerment, increased therapeutic contact and enriching the therapeutic relationship, convenience, improved accessibility, and feelings of safety and reduced vulnerability, these must be balanced against identified risks. Known risks include threats to privacy and confidentiality, absence of formal training in digital or text-based counseling techniques by practitioners, unequal access based on socioeconomic status, misinterpretation of written messages, missed verbal and nonverbal cues, technology glitches, and access to computer-mediated communications by unauthorized and unintended recipients (Mattison, 2018). Therapists need to have a separate consent to treat or supervise utilizing technology assisted services (email, text, social media). See Appendix A for an example of a telehealth consent form. A telehealth consent form

should be signed in addition to the regular notice of privacy and/or consent form the therapist is using for in person sessions.

Reflection Question

If you offer telemental health, do you need to update your informed consent? Are there any updates you need to make to your social media account(s) or discussions you need to have with clients to set boundaries?

Financial Arrangements

AAMFT guidelines state that prior to entering into the therapeutic or supervisory relationship, marriage and family therapists clearly disclose and explain to clients and supervisees all financial arrangements and fees related to professional services, including charges for canceled or missed appointments; the use of collection agencies or legal measures for nonpayment; and the procedure for obtaining payment from the client to the extent allowed by law, if payment is denied by the third-party payor. Once services have begun, therapists provide reasonable notice of any changes in fees or other charges. Therapists give reasonable notice to clients with unpaid balances of their intent to seek collection by agency or legal recourse. When such action is taken, therapists will not disclose clinical information. Marriage and family therapists ordinarily refrain from accepting goods and services from clients in return for services rendered. Bartering for professional services may be conducted only if the supervisee or client requests it; the relationship is not exploitative; the professional relationship is not distorted; and a clear written contract is established. MFTs may not withhold records under their immediate control that are requested and needed for a client's treatment solely because payment has not been received for past services (AAMFT, 2015).

Advertising

The AAMFT code of ethics states that MFTs must accurately represent their competencies, education, training, and experience relevant to their practice in accordance with applicable law. MFTs ensure that advertisements and publications in any media are true, accurate, and in accordance with pertinent law. Wherever possible,

they correct false, misleading, or inaccurate information and representations made by others concerning the therapist's qualifications, services, or products (AAMFT,2015).

Using social media to promote oneself as a mental health influencer and for advertising is not addressed in most mental health professional code of ethics, including from AAMFT's Code. Triplett et al. (2022) explore some of the potential dilemmas facing a mental health influencer and a marriage and family therapist (MHI-MFT). Utilizing social media as a therapist means you are accepting the assumptions the public holds regarding this position of authority. Providing information to others via social media presents the need for professionals to critically evaluate how they interact with others online. Therapists are at risk of exposing details about their personal lives if they are not mindful of what they reveal on social media. While MHIs provide a benefit for their audiences by reducing stigma toward mental health concerns, it is important to consider that MHIs' motives may not be entirely altruistic. Social media provides a valuable platform to promote therapeutic services which potentially increases MHIs' income.

Scenarios where MHIs may risk having multiple relationships with a prospective client include if the MHI has initiated or responded to frequent direct messages with the follower or has met with the individual in person. Both these examples highlight how therapists may have initiated a non-therapeutic relationship with the prospective client, placing their therapeutic judgment—and in some states, their license—at risk. To prevent conflicts of interest, MHIs should maintain a professional boundary when using social media for professional and psychoeducational purposes. The use of personal accounts to connect with friends and seek business ventures allows therapists to continue using social media for personal purposes (Triplett et al. 2022).

Reflection Question

Will you provide a disclaimer for the intended scope of your influence? What professional boundaries will you establish and how will you communicate the limits of your competency?

Cultural Competence

While the AAMFT code of ethics does not have a specific standard regarding cultural competence, it is important to acknowledge that the United States is constantly undergoing major demographic changes. The demographic shift is projected to continue

with increased diversity in our population. Diversity is more than race and ethnicity; it includes the sociocultural experiences of people inclusive of, but not limited to, national origin, color, social class, religious and spiritual beliefs, immigration status, sexual orientation, gender identity or expression, age, marital status, and physical or mental disabilities. Striving for cultural competence does not mean marriage and family therapists must face the impossible task of trying to understand every nuance of a person's culture. Instead, they must remain open to new cultural ideas, ask questions, and respond respectfully.

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.

Janine is a Caucasian MFT who has been working with 13-year-old Han, who is of Chinese descent, 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, Janine noticed that Han didn't seem like himself and he had some redness and slight 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 other times over the past few years when he was sick, and he expressed that it usually made him feel better. Janine had not suspected Han was being abused in any way, and when they had discussed his parents' disciplinary practices, she learned that he remembered being spanked a few times as a child, but more recently lost privileges and his phone or computer when he got in trouble.

Janine is immediately 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 speak to her colleagues about the situation, but she 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 the therapist to have awareness and cultural humility by engaging in critical self-reflection (understanding one's own bias and engaging in self-correction), recognizing clients as experts of their own culture, and committing to lifelong learning.

Reflection Question

Can you think of a time you had cultural humility, recognized the client as an expert on their culture, and learned from the client? Is there a population or culture you or your agency work closely with that you have limited knowledge of and could learn more about? If you, how would you go about educating yourself?

Conclusion

A code of ethics cannot guarantee ethical behavior or resolve all ethical issues or disputes. Rather, it sets forth standards to which professionals aspire and against which their actions can be judged. Ethical behavior should result from a personal commitment to engage in ethical practice and an attempt to act always in a manner that assures integrity.

By an enduring dedication to professional and ethical excellence, MFTs honor the public trust in the profession.

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Appendix A: Telehealth Consent Form

Example provided by: California Association of Marriage and Family Therapist (2020)

Telehealth Consent Form

I, [Name of Patient] (Patient) hereby consent to engage in Telehealth with [Therapist's Name, License] (Therapist).

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the [Informed Consent Form or Statement of Disclosures] I received from my therapist also apply to my Telehealth services.

2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.

3. I understand that miscommunication between myself and my therapist may occur via Telehealth.

4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.

5. I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.

6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.

7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

8. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.

9. I have discussed the fees charged for Telehealth with my therapist and agree to them [or for insurance patients: I have discussed with my therapist and agree that my therapist will bill my insurance plan for Telehealth and that I will be billed for any portion that is the patient's responsibility (e.g. co-payments)], and I have been provided with this information in the [Informed Consent Form or Name of Payment Agreement Form]

10. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

I have read and understand the information provided above, have discussed it with my therapist, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

[For conjoint or family therapy, patients may sign individual consent forms or sign the same form.]

_____ _____

Patient's Signature Date

_____

Patient's Printed Name

Verbal Consent Obtained Therapist reviewed Telehealth Consent Form with Patient, Patient understands and agrees to the above advisements, and Patient has verbally consented to receiving psychotherapy services from Therapist via Telehealth.

_____ _____

Therapist's Signature Date

Appendix B: An Overview of the AAMFT Ethics Complaint Process

Source: American Association for Marriage and Family Therapy January 2022

Retrieved from: https://www.aamft.org/legal_ethics/Ethics_Complaint_Process.aspx

The AAMFT Ethics Committee (hereafter, the Committee) has the ability to investigate ethical complaints made against AAMFT members. The complaint process is governed by the AAMFT Procedures for Handling Ethical Matters.

Initiating a Complaint

Complaints of unethical conduct must be initiated by someone with personal knowledge of the alleged behavior or by someone in a position to supply relevant reliable testimony or other evidence on the subject. Most of the complaints filed with AAMFT are filed by either current or former clients.

The Committee may also proceed on its own initiative when presented with sufficient allegations. Complaints initiated by the Committee are typically based on publicly available information from regulatory bodies and news sources. Whether initiated by an individual or the Committee, the complaint process is a paper review process.

Preliminary Review of Complaint

When a complaint is filed with AAMFT, AAMFT staff review the complaint materials for jurisdiction and completeness. In order for the complaint to be forwarded to the Ethics

Committee Chair, complainants must waive therapist-client confidentiality and permit AAMFT to use their name and forward a copy of the allegations to the member, if charged with a violation of the AAMFT Code of Ethics.

Determining Whether to Open a Case

Once the Chair receives the complaint materials, the Chair, in consultation with AAMFT's legal and ethics staff, determines whether the allegations, if proven factual, would constitute a violation of the Code. If so, a copy of the complaint materials and a charge letter are sent to the member for a response. If not, the case is closed.

With limited exceptions, when a case is opened based on a complaint that has been filed concurrently with a regulatory body, AAMFT's case will be held in abeyance.

Consideration by the Full Committee

Once all case materials are received, the case will be submitted to the full Committee at its next meeting. The Committee typically meets once annually. Only the full Committee can make a finding that a violation has occurred. If the Committee determines that a violation has occurred, the Committee will recommend an appropriate sanction based on the severity of the violation. In cases where the member has already been disciplined by a regulatory body, the Ethics Committee will presume that the findings of that body are correct and will move on to its discussion of appropriate sanctions.

For lesser violations, the Committee may require the member to take a certain number of continuing education courses or to practice under supervision for a period of time. For more egregious violations, the Committee may recommend the revocation or termination of membership. In cases where membership is terminated with a permanent bar to readmission, that fact will be published in AAMFT's Family Therapy Magazine once the Committee' s decision becomes final.

Appeal to Judicial Committee

After the Committee has made its decision, the member will be notified and given the opportunity to appeal the Committee's findings and recommendations to the Judicial Committee. The member must provide a written request for a hearing within 15 days after receiving notice of the Ethics Committee's findings and recommendations. If the member does not appeal within the allotted time, the Ethics Committee's decision becomes final.

Manner of Judicial Committee Hearing

The member may choose either an in-person hearing or a written review process. In-person hearings are typically held in Alexandria, VA before a Judicial Committee Panel. 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. The Judicial Committee panel is required to render its decision within 30 days of the hearing. If the member requests a written review process, the member and the Ethics Committee will provide written submissions to a Judicial Committee Panel, which will review the materials and render its decision within 30 days of the review.

Appeal to AAMFT Board of Directors

A member may make a final appeal to the AAMFT Board of Directors if the member believes that a procedural violation substantially impaired the member's ability to defend against the charges. The Board will review the appeal at its next scheduled meeting and will render a decision within 30 days of the meeting. The Board renders its decision based solely on the member's written statement and the response from the Judicial Committee or AAMFT's legal counsel.

Confidentiality of Ethics Matters

All information obtained by the Ethics Committee and all case proceedings are confidential with limited exceptions. At this time, termination of membership with a permanent bar to readmission is the only sanction that is routinely published in AAMFT's Family Therapy Magazine. In cases that involve a finding of no violation(s) and cases that involve lesser sanctions, typically the only notification is to the member and complainant. The Procedures permit AAMFT to provide a limited report on an ethics case to a regulatory body or another professional association upon request. If such a report is provided, a copy of the report is sent to the member.

How to Obtain a Complaint Packet

To obtain a complaint packet, you can send an email to ethics@aamft.org or contact AAMFT by phone at 703-838-9808.

Legal and Ethics Consultations

Your membership in AAMFT allows you access to various member benefits, including consultations with AAMFT's legal and ethics staff. All members of AAMFT are eligible to receive Ethical Advisory Opinions. Members in the following AAMFT membership categories are eligible for Legal Consultations: Pre-Allied Mental Health Professional Members, Allied Mental Professional Members, Pre-Clinical Fellow, and Clinical Fellow.

Code of Ethics

The AAMFT strives to honor the public trust in marriage and family therapists by setting standards for ethical practice as described in this Code. The ethical standards define professional expectations and are enforced by the AAMFT Ethics Committee.

Appendix C: Marriage and Family Therapy Core Competencies

American Association for Marriage and Family Therapy

Advancing the Professional Interests of Marriage and Family Therapists

112 South Alfred Street
Alexandria, VA 22314

Telephone: (703) 838-9808

Fax: (703) 838-9805

Website: www.aamft.org

Marriage and Family Therapy Core Competencies©

December, 2004

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 healthcare 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 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 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.
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.
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.

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