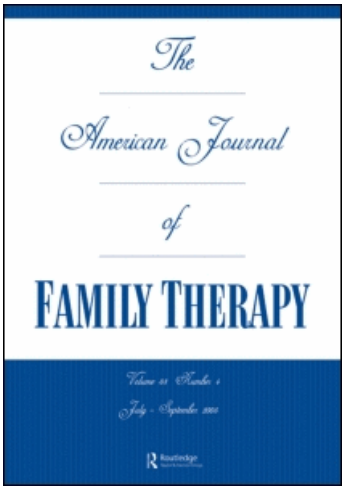

The American Journal of Family Therapy
Publication details, including instructions for authors and subscription information:
http://www.informaworld.com/smpp/title~content=t713722633

Comparison of the Family Therapy Educational and Experience Requirements for Licensure or Certification in Six Mental Health Disciplines

D. Russell Crane[a]; Aaron L. Shaw[a]; Jacob D. Christenson[a]; Jeffry H. Larson[a]; James M. Harper[a]; Leslie L. Feinauer[a]
[a] Marriage and Family Therapy Program, School of Family Life, Brigham Young University, Provo, Utah, USA

Online publication date: 13 October 2010

To cite this Article Crane, D. Russell , Shaw, Aaron L. , Christenson, Jacob D. , Larson, Jeffry H. , Harper, James M. and Feinauer, Leslie L.(2010) 'Comparison of the Family Therapy Educational and Experience Requirements for Licensure or Certification in Six Mental Health Disciplines', The American Journal of Family Therapy, 38: 5, 357 — 373
To link to this Article: DOI: 10.1080/01926187.2010.513895
URL: http://dx.doi.org/10.1080/01926187.2010.513895

The American Journal of Family Therapy, 38:357–373, 2010

ISSN: 0192-6187 print / 1521-0383 online
DOI: 10.1080/01926187.2010.513895

Routledge
Taylor & Francis Group

Comparison of the Family Therapy Educational and Experience Requirements for Licensure or Certification in Six Mental Health Disciplines

D. RUSSELL CRANE, AARON L. SHAW, JACOB D. CHRISTENSON, JEFFRY H. LARSON, JAMES M. HARPER, and LESLIE L. FEINAUER

Marriage and Family Therapy Program, School of Family Life, Brigham Young University, Provo, Utah, USA

In a review of literature on clinical licensure programs and certified mental health disciplines, no studies specifically compared didactic methods and clinical training standards for family-based interventions. Consequently, consumers and insurers of these services have no basis from which to evaluate the relative competency of each of the mental health disciplines in providing family-based interventions. This study used content analysis to examine the amount of family based training that is required by six core mental health disciplines (Clinical Psychology, Psychiatry, Psychiatric Nursing, Professional Counseling, Marriage and Family Therapy, and Social Work) in each of the 50 United States. Results indicate that a marriage and family therapist is required to have three times more family therapy coursework than any other professional mental health discipline. Also, before becoming licensed a marriage and family therapist, must complete 16 times more face-to-face family therapy hours than a mental health professional from any other discipline. Implications for consumers and practitioners are discussed.

Family therapy is becoming the preferred mode of mental health treatment for many disorders and a viable treatment option for many others (Sexton, Alexander, & Mease, 2004). For example, specialization in Child and Adolescent Psychiatry of the American Board of Psychiatry and Neurology (2005)

Originally presented as a doctoral dissertation to the same department by the second author, under the direction of the first.

Address correspondence to D. Russell Crane, Marriage and Family Therapy Program, School of Family Life, Brigham Young University, 257 TLRB, Provo, UT 84602. E-mail: RussCrane@byu.edu

notes that family members' participation in the treatment and assessment of adolescents, children, and infants is important to positive outcomes in a clinical setting.

Other institutions and studies have also found family therapy helpful to adolescents and children. Parent Management Training (PMT) is an effective treatment for childhood behavior disorders such as oppositional defiant disorder and conduct disorder (Kazdin & Weisz, 1998). In addition, for adolescents presenting with eating disorders lasting fewer than three years, family therapy has been shown to be more effective than individual treatment (Campbell & Patterson, 1995).

Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment (SAMHSA/CSAT, 2009) has also released treatment guidelines supporting family therapy as an effective treatment modality for adolescent clients (SAMHSA/CSAT, 2009). These policies were released in a Treatment Improvement Protocol (TIP), designed to help treatment providers improve their services to youth. The TIP states that the efficacy of family therapy has been documented extensively, and effective treatment of the adolescent almost always involves the family—particularly treatment for substance-using adolescents who are normally the most difficult to help (SAMHSA/CSAT, 2009).

Others report that children and adolescents are not the only populations to benefit from family therapy. Goldstein and Miklowitz (1995) found family therapy to be effective in the treatment of schizophrenic disorders. Also, Clarkin, Carpenter, Hull, Wilner, and Glick (1998) found support for treating adults with bipolar depression using family therapy. Baucom et al. (1998) found couples therapy to be effective when the wife in a marital relationship is depressed due to factors related to the marital relationship. Family therapy has also been shown to be superior in effectiveness over individual therapy in achieving sobriety (Corder, Corder, & Laidlaw, 1972). Additionally, Pinsof and Wynne (1995) found family therapy to be more cost effective than standard inpatient treatment when working with adults.

Not only are family-based interventions efficacious in terms of treating presenting disorders, they are also deemed helpful in their prevention. The Office of Juvenile Justice and Delinquency Prevention (OJJDP) released a series of clinical bulletins supporting the need for family-based intervention to help resolve the problem of delinquency. One bulletin states, "effective delinquency prevention efforts must involve the family, and should incorporate family strengthening" (Office of Juvenile Justice and Delinquency Prevention, 1994).

Family therapy has also been recommended in the treatment of substance abuse who have been infected with HIV. CSAT released another TIP on this topic which states that the therapeutic setting of marriage and family therapy is positioned to help with risk-reduction in a population not yet identified as substance abusers or HIV-infected (SAMHSA/CSAT, 2009).

In summary, it seems family therapy is not only becoming a viable treatment option for a wide range of disorders, but in some cases, it is becoming the preferred mode of mental health treatment for many issues. As shown above, several studies and institutions have shown support for the efficacy of these family-based interventions.

Core Mental Health Professions and Crossover Care

The U.S. Department of Health and Human Service's Bureau of Health Professions identifies clinical psychology, clinical social work, marriage and family therapy, psychiatry, and psychiatric nursing specialty as the five core mental health professions (Bureau of Health Professions, 2004). For the purposes of this study, professional counseling was also included because it is one of the major providers of services in the United States. These six disciplines are all nationally regulated professions with professional organizations, training accreditation standards, and strict licensing requirements.

Perhaps not surprisingly, advocates of the different mental health disciplines often debate whether or not a particular mental health provider is as capable of providing the same level of care as their peers from other mental health care disciplines. One important question that arises from this is whether all mental health professionals have the necessary training to provide competent family therapy? This question merits further exploration. Family therapy is a specialized treatment modality, and also a licensed mental health profession. Therefore, an untrained practitioner may not be prepared to provide an expected minimum standard of care. A provider of marriage and family therapy must learn to navigate complex relational interactions and balance many different therapeutic alliances that are not prevalent when treating an individual client. Because family therapy is often more complicated than individual treatment modalities it necessitates unique training and treatment approaches. From an ethical standpoint of providing competent treatment, it is logical that a mental health provider should be required to obtain sufficient and specific training in an area such as family therapy before being allowed to offer such therapeutic services.

In defining standards of care, state legislatures give credence to the fact that family therapy is not simple. The Georgia State Legislature definition of family therapy (Ga. Comp. R. & Regs. r. 135-1-.01) is a comprehensive definition of this complex treatment modality. Marital and Family therapy is defined in Georgia State Licensure Law as:

> Evaluating and treating emotional and mental problems and conditions, whether cognitive, affective or behavioral, resolving intrapersonal and interpersonal conflicts, and changing perception, attitudes and behavior; all within the context of marital and family systems. Marriage and family

> therapy includes, without being limited to, individual, group, couple, sexual, family and divorce therapy. Marriage and family therapy involves an applied understanding of the dynamics of marital and family therapy systems, including individual psychodynamics, the use of assessment instruments that evaluate marital and family functioning, designing and recommending a course of treatment, and the use of psychotherapy and counseling. (Ga. Comp. R. & Regs. r. 135-1-.01)

As suggested in this definition, the ability to provide competent family therapy is not encapsulated in a simple set of skills. Family therapy is a complex process. In order to ensure that all mental health practitioners who offer family therapy are competent to provide such services, it would be important to discover the amount of training expected of practitioners and regulated by the individual states.

Fortunately for clients and practitioners, state legislatures have made some important strides in establishing competency and accountability for providers of mental health services so as to protect consumers from providers who practice outside their "area of competence." Both licensure laws and training program accreditation standards have been helpful in establishing minimum qualifications across the various mental health disciplines. Though licensure laws and accreditation are not guarantees, clients can be reasonably confident that if the individual is licensed in their mental health discipline, the practitioner will at least have a minimum level of competence in mental health practice in their profession. However, this minimum level of competence may not extend to specific areas of mental health service, including family therapy. The problem also remains that the general public, not understanding the different requirements for licensure, becomes confused about who is qualified to provide family therapy when seeking help from a mental health provider.

One of the purposes of this study was to determine the amount of training in family therapy required (as codified in state laws, rules and regulations) prior to providing such service to the public. This was done with a content analysis of the educational and experience requirements in family therapy through examination of licensure requirements of each of discipline in each state in the United States. Two sources were examined first licensure requirements and rules and regulations for each state license and second, the national accreditation standards for academic and post-degree training that are referenced in state legislation in lieu of specific state requirements.

Overview of Typical Licensure Requirements

To be licensed as a marriage and family therapist (MFT) it is required to have a master's degree in MFT or a related field, and at least two years of post-degree supervised clinical experience. Most frequently, the supervision

requirements for MFTs are 200 hours of supervision for every 1,000 hours of clinical practice, of which at least 100 of those hours must be face-to-face clinical supervision (Hartley et al., 2002). In order to become approved supervisors, MFT professionals are required to complete a 30 hour course of supervisor training plus 2 years and 200 hours of supervision of supervision (American Association for Marriage and Family Therapy, 2007).

In order to obtain licensure as a psychologist (P), one must possess a doctorate in clinical or counseling psychology and have completed typically 2 years of clinical supervision. One of those years may be done during the PhD or PsyD training, and the other may be completed after graduation (Hartley et al., 2002).

In order to obtain a license as a clinical social worker (SW), one must have either a doctorate or a master's degree in social work, plus 2 years of post-degree supervised clinical experience. In addition, some of the states specify exactly how many hours of supervision are required to be face-to-face.

The licensed professional counselor (LPC) generally must have at least a master's degree in counseling or a related field, and 2 years of post-degree clinical supervised experience. The 2 years of clinical experience usually translates into 2,000 to 3,000 hours of experience, some of which is face-to-face (Hartley et al., 2002).

In order to become a psychiatrist (MD), an applicant must first become a licensed physician, and then be certified by a national medical certifying board. Usually this board is the American Board of Psychiatry and Neurology, a member board of the American Board of Medical Specialties (American Board of Psychiatry and Neurology, 2007). An example of the requirements for board certification is found in the eligibility requirements from the American Association of Physician Specialists (AAPS). Under these requirements, an applicant must have an unrestricted license to practice medicine in the United States and territories, have completed a 3–4 year residency from an American Psychiatric Association or an American Osteopathic Association (AOA) accredited residency program, and submitted a record of their "medical school experiences and degrees earned" (American Association of Physician Specialists, 2010). The American Board of Psychiatry and Neurology also requires their applicants for board certification meet similar certification requirements such as completion of an MD or DO degree from an accredited school of medicine or osteopathy. Their applicants must also complete four years of medical residency with three of those years in the specialization of psychiatry (American Board of Psychiatry and Neurology, 2004).

The Bureau of Health professions defines a psychiatric nurse (RN) as a registered nurse who is either "certified by the American Nurses Association as a psychiatric and mental health clinical nurse specialist." Or, it defines a psychiatric nurse as having a master's degree in nursing with a specialization in psychiatric/mental health and 2 years of supervised clinical experience.

In either case, the psychiatric nurse must be licensed to "practice as a psychiatric or mental health nurse specialist, if required by the state of practice" (Bureau of Health Professions, 2005). In order to be certified by the American Nurses Association as a psychiatric and mental health clinical nurse specialist, an applicant must "hold a currently active registered nurse license in the United States or its territories; hold a master's or higher degree in nursing; have been prepared in the area of practice for which they have applied for certification through a master's program or a formal postgraduate master's program in nursing; have graduated from a program offered by an accredited institution granting graduate-level academic credit for all of the coursework that includes both didactic (coursework) and clinical (face-to-face therapy) components, and a minimum of 500 hours of supervised clinical practice in the specialty area and role" (American Psychiatric Nurses Association, 2003).

As a public policy issue, state licensure laws, rules, and regulations are in place primarily to protect consumers. Because of the differences between scopes of practice, licensure assures mental health care consumers a minimum standard of care within each mental health discipline. Therefore, it behooves states to guard against crossover care between disciplines where professionals are not trained to perform to an acceptable standard. For example, many states have created laws that do not allow psychologists to perform the functions of psychiatrists such as prescribe medication (Hartley et al., 2002).

As an additional measure of protection for mental health care consumers, the licensure laws of each state require the supervisor of the person being licensed to be in the same profession and at the same level of licensure that the applicant is seeking (Hartley et al., 2002). This provides further protection to the general public, ensuring that mental health professionals will have had sufficient supervised clinical experience in their discipline.

Even though state laws are in place to protect consumers and practitioners, laws, rules, and regulations do have limitations. Various mental health professionals are eligible to perform many of the same functions, as long as the professional is performing within the therapist's area of competence. This is known as the "within competence" section of the licensure laws. There are currently debates within the professions about which professions are allowed to perform what specify mental health practices. An example of this is the debate as to whether practitioners are allowed to perform "psychological testing" (Dattilio, Tresco, & Siegel, 2007). The inherent problem with this system is that it leaves room for the practitioner to determine, for themselves, if they are competent to practice any type of treatment.

Accreditation Requirements

National accreditation of educational programs is considered a second level of protection for both the general public and prospective students who are

considering advanced education in one of the mental health disciplines. Accreditation standards are designed both to help ensure the safety of the public, and ensure the effectiveness of practitioners (Bickman, 1999). According to the American Psychological Association (APA, 2003), the purposes of accreditation standards are to guarantee the public and academia that a particular educational program has a clear definition of what its goals are, and to establish conditions under which these goals can be reached.

Accreditation is designed to help promote greater effectiveness in the educational program it recognizes. While licensure is based on a standard of minimum knowledge and experience in each of the mental health disciplines, accreditation sets minimum standards for quality with which an educational program or institution educates students. In addition graduation from and accredited program is often a requirement for licensure (APA, 2003). In fact, it has been proposed that the main purpose of accreditation is guaranteeing a set of skills in an individual that are necessary for entering a supervised practice (Roe, 2002).

Purpose of This Study

Both licensure and accreditation standards have been helpful in establishing minimum qualifications for the mental health fields. However, the problem remains that the general public can become confused when seeking help from a mental health provider for family therapy services. They may incorrectly assume that every mental health professional has obtained the training necessary to provide a specific form of treatment. The variability of minimum standards for the different mental health fields make it virtually impossible for most consumers to know how qualified a practitioner is at providing one type of care or another.

In order to understand these issues, this study examined the didactic and clinical family therapy training requirements of all the major fields of mental health. This is important because most mental health providers practice within their state designated scopes of practice, which usually includes family therapy or counseling. Thus, it is important to assess their training in these areas. To date, no known study has been completed that compares the required family therapy training licensure requirements of the major mental health disciplines.

METHOD

This study first compared and contrasted the licensure standards from each mental health field included in this study. The term "licensing standards" refers to both the state licensing laws and the state rules and regulations associated with those licensing laws. The rules and regulations were used

to gather more specific information that was not detailed sufficiently in the state law itself.

Second, when a given state required a particular mental health discipline to have a degree from a specify professional accredited body in order to obtain licensure, this study first examined the rules and regulations and then referred to the organization's accreditation standards for additional information. Finally, in states where certification (rather than licensure) was the standard to practice, certification requirements were examined. These sources were then analyzed to discover the amount of training and clinical experience in family therapy that is required for licensure by each mental health field.

Coding Process

Five undergraduate students, who were either currently enrolled or graduates of a large western university, were recruited as content analysis coders. The coders were trained using a coding manual developed by the research team. The coders received minor compensation for their work on this project, or course credit.

The process of coding included readings, didactic instruction, an exam that covered the content of the training manual, and several practice coding exercises until the coders achieved consensus with each other and the criterion coder. In order to establish inter-rater reliability, the five reviewers independently reviewed the licensure requirements for 40 (of 200) randomly selected licensing laws and rules and regulations for the mental health disciplines. In order to maintain inter-rater reliability and control for coder "drift," the criterion coder randomly selected 10% of the licensure standards and accreditation standards and compared his coding to those of the initial coder. When inconsistencies were found, retraining was given until consensus was achieved.

For licensing requirements, the coders first reviewed the section of the licensure law and rules and regulations for hours of "clinical family therapy" and "family therapy didactic coursework". For the purposes of this study "clinical family therapy hours" were defined as any clinical hours required in which the licensee must conduct direct, face-to-face therapy with any combination of clients involving at least two family members present. The clinical family therapy hours were coded as 1 hour for each hour of clinical family therapy experience needed for licensure. Also, for the purposes of analyzing the content of the didactic coursework in family therapy, "family therapy courses" were defined as any course including the phrases, "family therapy," "family counseling," or "family systems," Each credit hour required was coded as 1 hour of family therapy didactic coursework by the reviewers. When a topic for a course was required by licensure, but not assigned a quantitative amount of credit hours required, the topic was coded as having

a value of 3 credit hours. In the instances when a degree from an accredited program was required by the licensing body, the requirements from the accreditation standards were coded second. All codes were based on consensus agreement.

Gathering Data and Information

The next task for this study was to gather the licensure requirements from each of the state licensure laws, rules, and regulations to discover the minimum family therapy training of licensees that is required. Every licensing law, rule, and regulation from each mental health field was gathered for analysis.

After the licensure requirements were collected, the reviewers began analyzing the content of the requirements to discover the family therapy training requirements needed for licensure. Specifically, the areas within the licensure requirements that were examined were: (1) total clinical experience of the practice family therapy (in hours) needed to gain licensure; and, (2) total credit hours in family therapy didactic courses needed to gain licensure. All references to time (i.e., semesters or quarters) were converted into credit hours for comparison with other fields. One semester or one quarter of a given course was assigned the value of a 3 credit hour course for the purpose of this study.

When possible, hours of family therapy coursework and hours of clinical family therapy were separated from hours of couples' and individual therapy coursework and hours of clinical couples' and individual therapy.

Each hour of family clinical therapy or family therapy coursework a licensing standard requires was added to the overall total which contained information for all U.S. states. The total number of hours of family clinical therapy or family therapy coursework was then divided by the number of states who licensed each profession. This produced an average amount of hours of family clinical therapy or family therapy coursework required for each profession in the United States.

Analyzing Accreditation Standards

In order to gather the necessary accreditation standards for this study, the major accrediting bodies in each particular mental health field were identified. If the accrediting body was specified by state licensing standards, it was included in the analysis. If the accrediting body was not specified in the licensure standards, then it needed to be one recognized by the specific mental health profession as the governing accrediting body. The organizations included the Council for Accreditation of Counseling and Related Educational Programs (CACREP) for LPC, Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) for MFT, American Nurses Credentialing Center (ANCC) for psychiatric nursing, Accreditation

Council for Graduate Medical Education (ACGME) for psychiatry, the Commission on Accreditation (COAMFTE) for psychology, and Council of Social Work Education (CSWE) for social work. Standards and requirements for each accreditation body were obtained from each organization's web site.

RESULTS

Data Analysis

The mean number of clinical family therapy coursework hours from each mental health discipline were compared to determine the differences in the amount of family therapy clinical hours required for licensure. The median and range were also reported to demonstrate the spread of numbers examined. To determine the differences in the amount of family therapy coursework required for licensure the average number of credit hour in family therapy coursework from each mental health discipline were compared to each other. The mode, median and range were again reported below to demonstrate the spread of numbers analyzed for this study. Specific courses required in family therapy, as stated in the licensure, accreditation, or certification standards, were also noted and compared between the mental health fields. In some cases where the state requirements and/or accreditation requirement were not specific, 0 was recorded for that state. The requirements for psychiatry were particularly problematic as their laws rules and regulations and accreditation requirements were vague. Although MD's must complete a psychiatry residence, it was not clear what the training and experience requirements are.

Coursework Requirements

The first area examined in this study was the coursework required in family therapy in order to be licensed in each given mental health profession (Table 1). Within this area of examination, coursework was separated by keywords found in each title of the courses required for licensure.

The first courses examined in the study were courses required for licensure which had the phrase "family system(s)" as part of their title or course description. Under this heading, LPC licensees required the most amount of coursework, requiring, on average, .39 (*Mdn* = 0, *mode* = 0, *range* = 0–3) credit hours of coursework. Next, MFT licensees were required to have, on average, .30 (*Mdn* = 0, mode = 0, *range* = 0–9) credit hours of coursework. All other mental health professions examined in this study were not required to have any coursework with the phrase "family system(s)."

Another type of coursework examined in the study were courses required for licensure which had the phrase "family and/or couple(s)

TABLE 1 Mean Number of Required Credit Hours of Family Therapy Coursework by Mental Health Professions

Title of Course Includes the Following Phrase	MFT*	SW	LPC**	P	RN	MD
"Family System(s)"	.30	0	.39	0	0	0
"Family and/or Couple(s) System(s)"	.54	0	0	0	0	0
"Family Therapy/Counseling"	.78	0	.39	0	0	0
Marriage and Family Therapy/Counseling	1.32	0	0	0	0	0
Marriage, Couple(s) and Family Therapy/Counseling	.18	0	0	0	0	0
"Individual(s), Couple(s), and/or Family Therapy/Counseling"	.18	0	.52	0	0	0
Total Family Therapy Coursework	3.72	0	1.31	0	0	0

*Range = 0 to 9 hours.

**Range = 0 to 6 hours.

Note: MFT is marriage and family therapy, SW is social work, LPC is licensed professional counselor, P is psychologist, RN is psychiatric nurse, and MD is psychiatry.

system(s)" as part of their title or course description. Under this heading, MFT licensees were the only mental health profession to require this type of coursework. On average, MFT licensees are required to have .54 (*Mdn* = 3, *mode* = 0, *range* = 0–15) credit hours of coursework.

The next type of coursework examined were course requirements with the phrase "family therapy" or "family counseling" in the title. Under this heading, MFT licensees are required on average to have .78 (*Mdn* = 0, *mode* = 0, *range* = 0–12) credit hours of coursework. Next, LPC licensees were required to have, on average, .391 (*Mdn* = 0, *mode* = 0, *range* = 0–6) credit hours of coursework. No other discipline was required to have any coursework in this coding category.

Courses required for licensure which had the phrase "couple(s) therapy" or "couple(s) counseling" as part of their title or course description were the next group of courses examined. Under this heading, MFT licensees were the only mental health profession examined in this study to require coursework. On average, MFT licensees are required to have .42 (*Mdn* = 0, *mode* = 0, *range* = 0–15) credit hours of coursework.

Next the phrase "marriage and family therapy" or "marriage and family counseling" as part of their title or course description were considered. Under this heading, MFT licensees were the only profession to require this coursework. On average, MFT licensees are required to have 1.32 (*Mdn* = 0, *mode* = 0,, *range* = 0–18) credit hours of coursework.

Finally, courses which had the phrase "individual(s), couple(s), and/or family therapy" or "individual(s), couple(s), and/or family counseling" as part of their title or course description were considered. LPC licensees required the most amount of coursework, requiring, on average, .523 (*Mdn* = 0,

mode = 0, *range* = 0–24) credit hours of coursework. Next, MFT licensees were required to have, on average, .18 (*Mdn* = 0, *mode* = 0, *range* = 3–6) credit hours of coursework. No other discipline was required to have any coursework in this area.

In summary, MFT licensees are required to have an average of 3.72 (*Mdn* = .42, *range* = .18–4.9) credit hours of family therapy coursework in order to gain a license. On average, LPC licensees are required to have 1.304 (*Mdn* = .391, *range* = .391–.523) credit hours of family therapy coursework in order to obtain a license in professional counseling. Finally, no other discipline was required to have any coursework in family therapy.

Clinical Experience Requirements

The second major area examined in this study was the hours of direct, face-to-face therapy experience required in family therapy required for licensure (Table 2).

The first area of therapy hours examined were hours which had the phrase "family and/or couple(s) therapy" or "family and/or couple(s) counseling" in the description of the hours required for licensure. Under this heading, MFT licensees are required, on average, to have 349 (*M* = 250, *mode* = 0, *range* = 0–2000) hours of direct, face-to-face therapy with clients. Next, LPC licensees were required to have, on average, 21.74 (*M* = 0, *mode* = 0, *range* = 0–1000) hours of direct, face-to-face therapy with clients. All other mental health professions examined in this study were not required to have any hours with the phrase "family therapy" or "family counseling" as part of the title or description to be licensed.

The final area had the phrase "individual and/or couple(s) and/or family therapy" or "individual and/or couple(s) and/or family counseling" in the description of the hours required for licensure. Under this heading, LPC licensees are required on average, to have 1558.09 (*M* = 1000, *mode* = 0, *range* = 0–8,500) hours of direct, face-to-face therapy with clients. Next, MFT licensees are required to have, on average, 1274.6 (*Mdn* = 1250, mode = 0, *range* = 0–3150) hours of direct, face-to-face therapy with clients. SW

TABLE 2 Mean Number of Hours Required of Face-to-Face Therapy Experience for Licensure in Each Mental Health Profession

Type of Therapy	MFT	SW	LPC	P	RN	MD
Family and/or Couple(s) Therapy	349	0	21.74	0	0	Unknown
Individual and/or Couple(s) or Family	1274.6	578.57	1558.09	795.5	500	Unknown
Total	1623.6	578.57	1579.83	795.5	500	Unknown

Note: MFT is marriage and family therapy, SW is social work, LPC is licensed professional counselor, P is psychologist, RN is psychiatric nurse, and MD is psychiatry.

licensees are required to have, on average, 578.57 (*Mdn* = 0, mode = 0, *range* = 0–3000) hours of direct, face-to-face therapy with clients. RN licensees are required to have 500 hours of direct, face-to-face therapy with clients. Psychologist licensees are required to have, on average, 795.5 (*Mdn* = 0, *mode* = 0, *range* = 0–4000) hours of direct, face-to-face therapy with clients. This project was unable to find any face-to-face therapy experience requirements for psychiatrists.

DISCUSSION

The results that marriage and family therapists are expected to have more coursework and clinical experience in family therapy than the other professions were not surprising. However, it was surprising that only MFTs and LPCs were *required* to have *any* coursework or supervised clinical experience in this form of psychotherapy. This outcome was unexpected given that previous research has found that providing family therapy is a common practice among all six of these mental health disciplines (Crane & Payne, in review).

A marriage and family therapist is required to have three times more family therapy coursework than any other discipline. However, the average amount of the family therapy training required by LPCs may be inflated as a result of a few states requiring many times the amount of family therapy training than the vast majority of the states examined in the data.

Another important finding of this study is the amount of family therapy clinical experience hours required for licensure for the different mental health professions. A person applying to become licensed in marriage and family therapy would have to prove that they have had, on average, 349 hours of direct, face-to-face therapy experience with families. The only other profession to require *any* family therapy hours was the professional counselor (LPC), where the requirement for licensure was about 22 hours of clinical experience. On average MFT licensee would have to complete 16 times the amount of supervised, direct, face-to-face family therapy as the nearest other mental health profession.

One is left to wonder how those who have no required training or supervised clinical experience can competently provide this service. This would be analogous to mental health providers who provide hypnosis without receiving any training with that form of treatment.

However, several caveats need to be discussed. First, it should be noted that mental health professionals may receive family therapy training outside of their regular training curriculums. In fact, some even obtain additional training in family therapy after having received their degree. This is most often done by attending professional workshops and seminars, which rarely involve intense training or supervision of workshop participants. Professionals may also seek additional training through post-degree educational programs

that are accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE). The current study was not able to analyze the extent to which mental health professionals seek extracurricular classes in marriage and family therapy. Future research should focus on the type and quality of post-degree and workshop/conference family therapy training that non-MFT mental health professionals who advertise that they provide family therapy typically receive.

It is also possible that specific universities go well above and beyond the minimum education and experience requirements established in state regulations or accreditation standards. There may be additional coursework and experience requirements, including family therapy. Analysis of such training is outside the scope of the current analysis but would be a valuable inclusion in a future study.

The language surrounding the practice of mental health care often includes the terms "competence" and "scope of practice." It is important to distinguish between these. Competence is an elusive term. It typically refers to a sort of measure of one's ability to perform a skill. However, few psychotherapy skill sets are easily measured. As a result, states seem to have adopted the use of politically influenced "scopes of practice" to define what licensed professional are allowed to do. It is unlikely that state legislatures know the differences between the training of the different mental health professions. In the absence of true competency measures of specific skill sets among the different professions, legislators and policy makers have to rely on their own best judgment often based on testimonies from professionals in different clinical disciplines. In addition, it is entirely possible that the providers own interpersonal skills are the most important issue. Unfortunately, until these skills are measured and the results codified in licensure law or accreditation standards, consumers will have very little direct evidence of a practitioners skills. Hopefully, given the constraints of the contents of licensure laws, the results of this study can provide information to legislators, policy makers, and insurers.

Limitations

As with any research, there are a number of limitations to this study. First is that licensure laws and accreditation standards are somewhat fluid and change over time. As a consequence, the results of the current study would likely differ from one time to another.

Second, given that the coders were undoubtedly familiar with the purpose of the study, it is possible that they were subject to research bias. Although training was conducted, coding assignments were randomly assigned and there were a number of reliability checks, the coders may or may not have influenced the study through their expectations. However, given

the magnitude of the different outcomes, it is unlikely that research bias influenced the outcomes.

Perhaps the largest limitation of this study is the vague nature of the licensure laws and accreditation standards themselves. Often these laws only vaguely outline the requirements for licensure. In addition, clinical experience requirements are often not delineated. For most of the professions, the licensee may have spent 2 years performing intensive direct, face-to-face family therapy. Or, on the other hand, they may have spent 2 years doing testing, paperwork, or individual therapy. In coding these requirements, most states and professions were given the benefit of the doubt and given credit for direct, face-to-face therapy in the final category of therapy hours under the heading of "Individual and/or Couple(s) or Family Therapy." Thus, the broadest possible category and was used for therapy hours that were undetermined. Because the requirements in this final category were so vague, no valid conclusions can be drawn from these specific results. This was also the case with the entire profession of psychiatry. Because the licensure of a psychiatrist is determined by one national licensing body, there was only one set of licensure standards that could be examined. Unfortunately, these licensure standards were another good example of extremely vague requirements.

Summary

In summary after examining family therapy requirements in six mental health professions, only two are required to have any type of specialized training in providing family therapy. The licensure laws for the marriage and family therapist require the licensee to have three times the family therapy coursework and up to 16 times the amount of family therapy supervised experience as the nearest mental health profession (LPCs). Legislatures, licensing boards, accreditation organizations, insurers, and the public may value from knowing these results in a variety of ways that hopefully will increase their awareness of the specialized nature of family therapy training and practice.

REFERENCES

Accreditation Council for Graduate Medical Education. (2003). Retrieved October 6, 2003, from http://www.acgme.org/Media/dutyHours.asp

American Association for Marriage and Family Therapy. (2007). *Becoming an AAMFT Approved Supervisor*. Retrieved April 11, 2008, from http://www.aamft.org/membership/Approved%20Supervisor/AS_Becoming_AS.asp#Step%202:%20Training%20for%20the%20Approved%20Supervisor%20Designation:%20Meeting%20the%20Requirements

American Board of Psychiatry and Neurology. (2005). Welcome. Retrieved May 4, 2005 from http://www.abpn.com/

American Board of Psychiatry and Neurology (2007). *Child and Adolescent Core Competencies Chart 2.1*. Retrieved September 10, 2010, from http://abpn.com/downloads/core_comp_outlines/core_cap_2.1.pdf

American Psychological Association (2010). *About accreditation, what is the purpose of accreditation?* Retrieved September 10, 2010, from http://www.apa.org/ed/accreditation/about/about-accreditation.aspx?item = 6

American Psychiatric Nurses Association. (2003). Professional titling and credentialing for advanced practice registered nurse-psychiatric/mental health. Retrieved August 21, 2008 from http://www.apna.org/i4a/pages/index.cfm?pageid=3349

Baucom, D., Shoham, V., Mueser, K., Daiuto, A., and Stickle, T. (1998). Empirically supported couple and family interventions for marital distress and adult mental health problems. *Journal of Consulting and Clinical Psychology*, *66*, 53–88.

Bickman, L. (1999). Practice makes perfect and other myths about mental health services. *American Psychologist*, *54*(11), 963–965.

Bureau of Health Professions. (2004). *FY 2004 Preview: Health Professions Education and Training Funding Opportunities*. Retrieved June 30, 2004, from http://www.hrsa.gov/grants/preview/professions.htm

Bureau of Health Professions. (2005). *Definition and Eligibility of Providers*. Retrieved August 2, 2005, from http://bhpr.hrsa.gov/shortage/hpsaguidement.html

Campbell, T. L., & Patterson, J. (1995). The effectiveness of family interventions in the treatment of physical illness. *Journal of Marital and Family Therapy*, *21*, 545333.

Clarkin, J., Carpenter, D., Hull, J., Wilner, P., & Glick, I. (1998). Effects of psychoeducational intervention for married patients with bipolar disorder and their spouses. *Psychiatric Services*, *49*, 531–533.

Corder, B., Corder R., & Laidlaw, N. (1972). An intensive treatment program for alcoholics and their wives. *Quarterly Journal of the Study of Alcohol*, *33*, 1144–1146.

Crane, D. R., & Payne, S. H. (in press) Individual and family therapy in managed care: Comparing the costs of treatment by the mental health professions. *Journal of Marital and Family Therapy*. doi: 10.1111/j.1752–0606.2009.00170.x

Dattilio, F., Tresco, K., & Siegel, A. (2007). An empirical survey on psychological testing and the use of the term psychological: Turf battles or clinical necessity? *Professional Psychology: Research and Practice*, *38*(6), 682–689.

Ga. Comp. R. & Regs. r. 135-1-.01.

Goldstein, M. J., & Miklowitz, D. J. (1995). The effectiveness of psychoeducational family therapy in the treatment of schizophrenic disorders. *Journal of Marital and Family Therapy*, *21*, 361–376.

Hartley, D., Ziller, E., Lambert, D., Loux, S., & Bird, D., 2002 (October). State Licensure Laws and the Mental Health Professions: Implications for the Rural Mental Health Workforce. Portland, ME: Maine Rural Health Research Center.

Kazdin, A., & Weisz, J. (1998). Identifying and developing empirically supported child and adolescent treatments. *Journal of Consulting and Clinical Psychology*, *66*, 37–52.

Office of Juvenile Justice and Delinquency. (1994). Prevention Family Strengthening for High-Risk Youth. Juvenile Justice Bulletin: Office of Juvenile Justice and Delinquency Prevention.

Pinsof, W., & Wynne, L. (1995). The efficacy of marital and family therapy an empirical overview, conclusions, and recommendations. *Journal of Marital and Family Therapy 21*(4), 585–613.

Roe, R.A. (2002). What Makes a Competent Psychologist? *European Psychologist*, *7*(3), 192–202.

Sexton, T. L., Alexander, J. F., & Mease, A. L. (2004). Levels of evidence for the models and mechanism of therapeutic change in family and couple therapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behaviour change* (5th ed., pp. 590–646). New York: Wiley.

Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Prevention Enhancement Protocols (2009). *Family-centered approaches to prevention of substance abuse—What works*. Retrieved September 10, 2010, from http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book = hssamhsapep? = A14520

Thompson, B., & Hill, C. (1993). Client Perceptions of Therapist Competence. *Psychotherapy Research*, *3*(2), 124–130.