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For educating marriage and family therapy (MFT) students, there has been an increasing emphasis on their ability to demonstrate a series of core competencies as identified by the American Associate for Marriage and Family (AAMFT) (Nelson et al., 2007). This type of therapist education from outcome-based education (OBE) fosters the characteristics or worldview associated with educational institutions and the profession. At the most general level, OBE is education or socialization into the professional MFT worldview. As a corrective to this, there is a need to seek this moral character in a Christian worldview which emphasizes a metanarrative informed by the Bible as well as Christian tradition. Therefore, moral character must be identified and developed in a Christian moral community. This Christian moral education and participation in moral community encourage Christian virtues such as faith, hope, and love.

Overview and Brief Statement of Purpose

This article seeks to describe the challenges and opportunities for integrating Christian principles into the education of marriage and family therapy (MFT) students. First, the article will begin by reviewing the relevant MFT literature on training and education, especially the relatively recent adoption by the American Association for Marriage and Family Therapy's (AAMFT) Commission on Accreditation for Marriage and Family Education's (COAMFTE) of outcomes based education and the development of core competencies that are used in MFT education programs. Second, the role of transcendence will be introduced. One issue with the identification of core competencies as the AAMFT has done entails identifying the highest, or macrosystem level (Bronfrenbrenner, 1979), which informs the values embedded in them. The core concern here is the AAMFT's adoption of hyper-individualistic perspectives without considering other perspectives (Doherty, 1995). Finally, implications will be developed for incorporating Christian virtues into the education of MFT students.

Education as Socialization

An important approach to thinking about the adoption of outcomes based education (OBE) and specifically the American Association of Marriage and Family Therapy's (AAMFT, 2004) core competencies is utilizing the social construction of reality. Berger and Luckmann (1967) distinguish between two, sometimes competing, socialization forces. Primary socialization concerns the processes involved in developing an identity as a member of a particular social group. "Primary socialization creates in the child's consciousness a progressive abstraction from the roles and attitudes of specific others to roles and attitudes in general" (Berger & Luckmann, 1967, p. 132). In other words, primary socialization is the internalization of the first or initial worldview for the child.

Secondary socialization refers to an educative process that occurs after the child has internalized his or her initial worldview. "Secondary socialization is the internalization of institutional or institution-based 'subworlds'" (Berger & Luckmann, 1967, p. 138). Individuals learn a new worldview when they enter into new institutions, i.e., school. These new institution-based worlds may be compatible with the primary worldview the individual learns from his or her parents. On the other hand, secondary socialization may be subversive toward the primary worldview. For example, a child learns how his or her parents complete their parental roles. In school, the child learns about parents in general. From the perspective of MFT education, the child learns the

primary experience and understanding of how mothers and fathers act. In MFT programs, students learn how mothers and fathers ought to act.

One may think of the common stock of MFT knowledge as the metanarrative for the discipline. This metanarrative provides the ethos for knowledge, values, and practice skills as well as an orientation toward alleviating human distress. Part of this metanarrative is the characteristics that describe adherents of this narrative, such as kinds of actions, beliefs, values, epistemology, views of evil and suffering, ways of alleviating suffering, and cosmology (Fancher, 1995; Frederick, 2009). From this perspective, OBE moves toward inculcating a MFT narrative (character) into its practitioners and students. MFT education becomes the process of socializing students into the MFT worldview. By transitioning to OBE, the focus changes from faculty disseminating information to students' ability to demonstrate specific types of behaviors or actions. Further, educational assessment provides a measure for evaluating students' level of assimilation into the profession as well as faculty's ability to demonstrate the necessary outcomes.

For MFT students, this emphasis follows on their ability to demonstrate a series of core competencies as identified by the AAMFT (AAMFT, 2004; Nelson et al., 2007). For the case of marital and family therapy, OBE fosters the critical skills, knowledge, values, and worldview associated with MFT (Gehart, 2009; Nelson & Smock, 2005). At the most general level, OBE is education or socialization into the professional MFT worldview.

To identify the core competencies needed for being a marriage and family therapist, the AAMFT created a committee to identify the skill sets and knowledge necessary to master the field (Nelson et al., 2007). They have also identified the needed behavioral or observational outcomes that demonstrate these competencies among students. That is, to prevent a loss of perspective on the field, the AAMFT created a transcendent community to identify the objectives necessary for MFT education. To state it another way, the AAMFT has identified their transcendent values through these competencies that constitute the core curriculum for MFT education.

Figure 1 is a graphic representation of the context of MFT core competencies. The metanarrative rubric corresponds to the population of MFTs – educators, researchers, practitioners, and students. The goal of OBE education is to foster mastery – the ability to demonstrate competence – in most of the core competencies as identified by the AAMFT. From a narrative perspective, mastery is one's level of inculcation into the MFT worldview. As one embodies more and more of the MFT worldview, the more one is considered a "master" or is able to demonstrate mastery in the core competencies. OBE identifies core competencies (characteristics) deemed particularly important to the MFT profession. In identifying core competencies, therapist educators are able to identify the elusive construct "therapist mastery" and thereby specify certain competencies that therapists-in-training should be able to demonstrate. This is a noble goal that fosters a certain "therapist character" that transcends models, styles, and individual therapeutic preferences. This dovetails well with established research that relationship factors are the most important aspects of therapeutic outcome (Asay & Lambert, 1999; Duncan, Miller, & Sparks, 2004; Fancher, 1995; Johnson & Talitman, 1997; Johnson & Lebow, 2000; Maione & Chenail, 1999; Patterson, 1985). The ability of the therapist to have, maintain, and intervene in one's relationships is the primary tool for successful therapeutic outcome.

Figure 1. MFT Outcomes Based Education and the Core Competencies.

The six core domain areas of the core competencies represent the virtue level of the MFT worldview. In this area, MFTs are virtuous as they able to demonstrate "skills or knowledge that … are: a) Conceptual, b) Perceptual, c) Executive, d) Evaluative, and e) Professional" (AAMFT, 2004). The AAMFT has, therefore, clearly moved into the realm of education as socialization by identifying and adopting the core competencies in MFT education. Further, the critical implication of this move is to view the core competencies from a virtue ethics perspective (Dueck & Reimer, 2003).

Virtue Ethics and OBE

In line with Dueck and Reimer (2003), we argue that having an OBE perspective is not enough to create the necessary moral context to address the complexity of being a MFT. OBE is approaching the field from an encyclopedic tradition – competency is transcontextual and amoral. OBE identifies the content as well as the demonstrable outcomes by students in acquiring this information. By identifying core competencies that students must demonstrate, the AAMFT has actually cataloged their core values and characteristics. However, the moral and ethical context of their values has not been extended far enough. They have taken steps to ensure that the MFT community forms the context of transcendence in which MFT values are developed. However, the MFT community is not the ultimate or even penultimate source of moral and ethical transcendence (Doherty, 1995).

A poignant example comes from a case of ethnic diversity. An important issue (ethical) is the diversity of a client and its impact on the therapeutic process[i]. A clinical example may be that of an Asian graduate student. He initiates therapy with a Licensed Marriage and Family Therapist (LMFT) in California. The presenting problem is anxiety from the familial pressures he is beginning to experience as a result of pursuing an advanced degree. He is studying medicine at a major university in accordance with his parents' wishes. He meets a female student who is not Asian, and he begins courting her. His parents are intending to visit him in a month. If the LMFT adopts a classic Bowenian perspective, the client should be diagnosed as being fused with his family of origin, which is resulting in his symptom formation.

To briefly orient readers to the Bowen family systems theory model, there are eight concepts of Bowen family systems theory (Gilbert, 2006; Titelman, 1998): (1) differentiation, (2) triangles, (3) nuclear family emotional system, (4) family projection process, (5) emotional cut-off, (6) multigenerational transmission process, (7) sibling position, and (8) emotional process in society. Differentiation is the core focus for intervention, and it is considered the balance between the human drives for togetherness and individuality. Differentiation is also thought of as a hard core or solid self – those values and beliefs about the self that are non-negotiable and a pseudo-self which are those beliefs and values about the self that are mutable. The pseudo-self may also be thought of as a relationship derived self. Anxiety occurs as a result of perceived threats to togetherness.

Differentiation is also thought of as having levels. Intrapersonal differentiation is the separation of emotion and intellect and Interpersonal differentiation is the ability to maintain sense of self and contact with others. This is the critical area of therapeutic intervention. The goal of Bowen family systems theory is to increase levels of differentiation in order to reduce anxiety and foster the ability to maintain an "I" in relationship to "you".

Even when adopting a culturally sensitive therapy, i.e. one that honors filial piety and the close nature of Asian relationships (Jung, 1998; Lee, 2000; Lee & Mock, 2005; Searight, 1997), the core intervention and treatment goal will be to foster increasing levels of differentiation. Therefore, MFT competence acknowledges the role of culture and ethnicity; however, the core therapeutic goal is unchanged. The process of therapy is informed by culture, but the therapy goal is immutable. This ultimately devalues the culture of the client. From Dueck and Reimer's (2009) perspective, it does violence to the client's humanity by not respecting the client's own cultural resources for healing and wholeness.

Lest our postmodern friends think they are immune from such a critique, consider the following. One of the primary aspects of Asian culture is deference to authority. When seeking mental health counseling, Asians are looking for wisdom and expert advice (Jung, 1998; Lee, 2000; Lee & Mock, 2005). A hallmark of postmodern approaches to therapy is a one down or non-expert position of the therapist (Anderson & Goolishian, 1992). The postmodern therapist is painfully aware of his or her power to influence clients. This type of therapist takes great pains to foster in the client the sense that he or she is the expert of his or her own experience. Therefore, the postmodern therapist will not adopt an expert role. By acting in this manner, the postmodern therapist is actually imposing, albeit a postmodern, value upon the client. Again, the culture of the client is acknowledged in the context of the client's experience; however, the culture does not provide a core corrective to the therapist in his or her choice of treatment goal.

Moral Competence and MFT Training

The goal of MFT education is to foster mastery – the ability to demonstrate competence – in most of the core competencies as identified by AAMFT (see Figure 1). From a narrative perspective, mastery is one's level of inculcation into the MFT worldview. As one embodies more and more of the MFT worldview, the more one is considered a "master" or is able to demonstrate mastery in the core competencies. OBE identifies core competencies (characteristics) deemed particularly important to the MFT profession.

An essential component of OBE should be Doherty's Soul Searching (1995). Soul Searching provides an ethical critique of the primarily individualistic worldview contained in MFT theories. In this work, Doherty (1995) argues that therapists of all persuasions should foster moral and ethical responsibility by calling clients to make relationship-enhancing decisions. In this process, he develops three essential characteristics therapists should inculcate: (a) caring, (b) courage, and (c) prudence. This is an important step in moral philosophy for therapists who are held sway by the moral morays of modernity – whatever feels right is what I must do. This is a step from values to the language of virtues. However, seeking virtue in the community or in enhancing relationships (this is Doherty's highest authority) does not provide the moral foundation for transcendence that is required for the development of true virtues.[ii] This is especially evident in Doherty's (1995) discussion on personality. The personality of the therapist is the primary vehicle for therapeutic outcome; however, the personality of the therapist is subject to the values that constitute it. From his perspective, the personality to care for clients by having courage to address decision making with prudence becomes the primary vehicle of therapeutic intervention. It is possible as the therapist engages in moral therapy that a blind spot occurs where there is consonance between the morals of the community, the morals of the therapist, and the morals of the client.

In identifying core competencies, therapist educators are able to identify the elusive construct "therapist mastery" and thereby specify certain competencies that therapists-in-training should be able to demonstrate. This too is a noble goal that fosters a certain "therapist character" that transcends models, styles, and individual therapeutic preferences. However, competence does not necessarily create the moral climate necessary to create morally sound therapists, or to use

Doherty's (1995) concept – a morally sound therapeutic personality.

Implications of Core Competencies

Some of the implications for mastery and MFT training include the importance of developing the moral dimension of therapists. As Doherty (1995) argues, therapists do not explicitly offer moral perspectives to their clients directly. However, in striving to remain morally neutral, therapists often collude with the immoral activities of their clientele, especially in eschewing relationship obligations. Therefore, mastery over a domain of psychotherapy necessarily demands the moral and ethical integrity of the therapist. An emphasis that needs to be added to the AAMFT's list of competencies is moral competence.

A second implication is the need to seek this moral character in a Christian worldview which emphasizes a metanarrative informed by the Bible as well as Christian tradition. Therefore, moral character must be identified and developed in a Christian moral community. This moral community and its resulting character provide a foundation and stability to be courageous and challenge one to be ethically responsible. To foster this sense of moral character, therapists should be exposed to Christian moral and ethical philosophy. This moral education provides a context and language base to begin thinking morally about situations. Also, therapists should be encouraged to engage in religious and spiritual communities that have fostered and "supervised" the morality of their practitioners for centuries. Moral education and participation in moral community encourage Christian virtues such as faith, hope, and love (Hauerwas, 1981; Lee, 1998).

In response to the potential argument that this sounds like value imposition, there are two important caveats to remember. First, therapy and education is a transmission of one's values. This might be identified as the socializing effect of therapy and education (Berger & Luckmann, 1967; Fancher, 1995). That is, therapists and their clients have more similar values at the conclusion of therapy than at the beginning (Kelly, 1995). Therapy in this sense is a vehicle for the cultural transmission of norms and values. Therapy socializes (read educates) clients into a "better adjustment" which fosters a higher degree of value consonance between clients and the larger culture.

Second, spirituality and religion are wellsprings for seeking transcendence. Spirituality considers how an individual lives and practices transcendent beliefs. Spirituality may be concerned with a particular religious affiliation, but it need not. Walsh (1999) defines it this way: "Spirituality, an overarching construct, refers more generally to transcendent beliefs and practices" (p. 6). As such, spirituality is more concerned with lived, individual experiences. Spirituality, as a resource for clinicians, may connect one to a faith community and provide a subculture for understanding and explaining one's experience (Walsh, 1999).

The trend from a psychological perspective indicates that spirituality is important (Wulff, 1996), but it maintains the division between spirituality on the one hand and a specific religious tradition on the other (Richards & Bergin, 2000; Wulff, 1996).[iii] For the most part, spirituality is seen as encompassing religious preferences and practices. Also, a spiritual individual may not necessarily belong to a specific religious organization (Hoge, 1996).

The trend in psychology and family therapy to value the importance of individual choices and experiences (Downey, 1997) is important in understanding how psychology has become more accepting of spirituality. To begin with, "New Age" spirituality has offered an overabundance of choices for individuals who may be tired and abused by more traditional religious forms (Downey, 1997). The type of spirituality valued by psychotherapists and family therapists is highly individualistic.

The spiritual and religious dimension of existence is important for individuals, couples, and families' lives. Wuthnow (1996) estimates that some 60% of the American population seeks a small group to aid in spirituality. These small groups have purposefully avoided naming and identifying with specific denominational and religious institutions. However, these groups do encourage a broadly defined spirituality especially in the 12-step group. As evidenced in the family values debate (Lee, 1998), Christians and non-Christians alike share deeply engrained vales regarding the nature of the family. As Lee (1998) demonstrates, Christians have greater attitudinal commitment to the permanence of marriage, the importance of the family for childrearing, and the maintenance of a heterosexual, traditional family forms than non-Christians. However, this is not to say that non-

Christians do not adhere to similar family values to Christians. After all, Christians form a subculture compared to non-Christians, not an alien culture. The issue here is one of ordering these values. In this sense, spirituality is important for both religious and non-religious people, and as such becomes an important source for seeking transcendence that forms the context for competence.

Conclusions

Therefore, seeking competence or character is based on the need for identifying the core dimensions of a professional domain. OBE in marriage and family therapy is seeking this transcendence as far as it is concerned with educating future MFTs into mastery of core MFT competencies in the broader culture of MFTs from across the United States. Even from Doherty's (1995) important moral perspective, this transcendence is ultimately communicated through therapy (or socialization) that MFTs conduct and the supervision (or socialization) that MFT trainees receive in a way that emphasizes individuals over relationships. An important corrective to Doherty's (1995) moral critique of current MFT practice is the adoption of Christian virtues into the education of MFT students. This ties the character of the therapist into a transcendent moral and religious community which subverts the hyper-individualism associated with most, if not all, psychotherapy as currently conducted. Spirituality as conceived of as the search for ultimate meaning and transcendence (Fowler, 1995) should be included as a core competency for MFTs as it encourages individual participation in moral and ethical communities grounded in the Christian tradition.

See competencies 1.2.1, 1.31, 2.1.6, 2.3.7, 3.2.1, 4.1.1, 4.4.1, and 4.4.6 (AAMFT, 2004, core competencies).

See Girard (1979) Violence and the Sacred for an argument regarding the community's penchant for perpetrating violence on innocent victims.

Following Fowler's (1995) argument for distinguishing faith, belief and religion.

References

American Association for Marriage and Family Therapists. (2004). *Marriage and family therapy core competencies*. Retrieved from **www.aamft.org**

Anderson, H., & Goolishian, H. (1992). The client is the expert: A not-knowing approach to therapy. In S. McNamee & K. J. Gergen (Eds.), *Therapy as social construction* (pp. 25-39). Thousand Oaks, CA: Sage Publications.

Asay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 23-55). Washington, DC: American Psychological Association.

Berger, P. L., & Luckmann, T. (1967). *The social construction of reality: A treatise in the sociology of knowledge*. New York: Anchor Books.

Bronfrenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, MA: Harvard University Press.

Doherty, W. J. (1995). *Soul searching: Why psychotherapy must promote moral responsibility*. New York: BasicBooks.

Downey, M. (1997). *Understanding spirituality*. New York: Paulist Press.

Dueck, A., & Reimer, K. (2003). Retrieving the virtues in psychotherapy: Thick and thin discourse. *The American Behavioral Scientist*, 47, 427-440.

Dueck, A., & Reimer, K. (2009). *A peaceable psychology: Christian therapy in a world of many cultures*. Grand Rapids, MI: Brazos Press.

Duncan, B. L., Miller, S. D., & Sparks, J. A. (2004). *The heroic client: A revolutionary way to improve effectiveness client-directed, outcome-informed therapy* (2nd ed.). San Francisco: Jossey-Bass Publishers.

Fancher, R. T. (1995). *Cultures of healing*. New York: Freeman.

Frederick, T. V. (2009). Models of psychotherapy: Implications for pastoral care practice. *Pastoral Psychology*, 58(4), 351-363.

Fowler, J. (1995). *Stages of faith: The psychology of human development*. San Francisco: Harper.

Gehart, D. R. (2009). *Mastering competencies in family therapy: A practical approach to theory and clinical case documentation*. Belmont, CA: Brooks/Cole.

Gilbert, R. M., (2006). *The eight concepts of Bowen theory*. Falls Church, VA: Leading Systems Press.

Girard, R. (1979). *Violence and the sacred* (P. Gregory, Trans.). Baltimore, MD: The Johns Hopkins University Press.

Hauerwas, S. (1981). *A community of character*. London: University of Notre Dame Press.

Hoge, D. R. (1996). Religion in America. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 21-41). Washington, DC: American Psychological Association.

Johnson, S. M., & Lebow, J. (2000). The "Coming of age" of couple therapy: A decade review. *Journal of Marital and Family Therapy*, 26, 23-38.

Johnson, S. M., & Talitman, E. (1997). Predictors of success in emotionally focused marital therapy. *Journal of Marital and Family Therapy*, 23(2), 135-152.

Kelly, E. W. (1995). *Spirituality and religion in counseling and psychotherapy*. Alexandria, VA: American Counseling Association Press.

Jung, M. (1998). *Chinese American family therapy: A new model for clinicians*. San Francisco: Jossey-Bass Publishers.

Lee, C. (1998). *Beyond family values*. Grand Rapids, MI: InterVarsity Press.

Lee, E. (Ed.). (2000). *Working with Asian Americans: A guide for clinicians*. New York: Guilford Press.

Lee, E. & Mock, M. R. (2005). Asian families: An overview. In M. McGoldrick, J. Giordano, & N. Garcia-Preto (Eds.), *Ethnicity and family therapy* (3rd ed.) (pp. 269-289). New York: Guilford Press.

Maione, P. V., & Chenail, R. J. (1999). Qualitative inquiry in psychotherapy: Research on the common factors. In M. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 57-88). Washington, DC: American Psychological Association.

Nelson, T. S., Chenail, R. J., Alexander, J. F., Crane, D. R., Johnson, S. M., & Schwaille, L. (2007). The development of core competencies for the practice of marriage and family therapy. *Journal of Marital and Family Therapy*, 33, 417-438.

Nelson, T. S., & Smock, S. A. (2005). Challenges of an outcome-based perspective for marriage and family therapy education. *Family Process*, 44, 355-362.

Patterson, C. H. (1985). *The therapeutic relationship: Foundations for an eclectic psychotherapy*. Monterey, CA: Brooks/Cole.

Richards, P. S., & Bergin, A. E. (2000). Toward religious and spiritual competency for mental health professionals. In P. S. Richards and A. E. Bergin (Eds.), *Handbook of psychotherapy and religious diversity* (pp. 3-26). Washington, DC: American Psychological Association.

Searight, H. R. (1997). *Family-of-origin therapy and diversity*. Bristol, PA: Taylor & Francis.

Titelman, P. (Ed.). (1998). *Clinical applications of Bowen family systems theory*. Binghamton, NY: Haworth Press.

Walsh, F. (1999). Religion and spirituality: Wellsprings for healing and resilience. In F. Walsh (Ed.), *Spiritual resources in family therapy* (pp. 3-27). New York: Guilford.

Wulff, D. M. (1996). The psychology of religion: An overview. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 43-70). Washington, DC: American Psychological Association.

Wuthnow, R. (1996). *Sharing the journey: Support groups and America's new quest for community*. New York: Free Press.