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Codes of Ethics and Medical Licensure in MFT

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Abstract
The role of the marriage and family therapist is to work with individuals, couples, and families towards client treatment. In particular, the therapist's understanding of the manner in which members of the family shape the mental health of one another requires that the marriage and family therapists in Oregon evaluate the families' development and roles (American Counseling Association, 2014). To be considered for licensure, it is expected that marriage and family therapists have doctoral degrees or master's degrees in this field. Therefore, the therapists ought to undergo a four-year undergraduate work to earn a Bachelor's degree in counseling. This step is followed by a graduate work that leads to a master's degree; culminating in doctoral (or PhD) work that enables one to earn a doctorate in counseling. Regarding the examination and experience for licensure as a family and marriage therapist in Oregon, it is expected that one chooses the intern method or the direct method. Regarding the direct method, individuals are expected to have an experience stretching to 2000 hours while the intern method, although demanding similar hours as the direct method, requires that at least 1000 hours are dedicated to the provision of therapy to couples and families (Anthony & Goss, 2009). Apart from gaining the field experience, licensure requires that individuals in Oregon sit for an examination. The exam that this state administers comes in the form of a computer-based test and is derived from the Professional Examination Service.

Keywords: Medical Licensure, MFT etc.

1 Introduction

It is expected that a licensee holds in confidence all the data obtained. Indeed, the information is secured during professional service provision. The safeguarding of client confidences is also expected to conform to the permission of law or rule. Hence, licensees are barred from using client confidences to the disadvantage of the latter. It is also expected that licensees and their professional associates (and even employees) do not disclose the clients' confidential information acquired during service provision; unless the law or rule dictates so (Anthony & Goss, 2015). In situations where the law or rule permits the disclosure of confidential data, it is expected that the client provides written informed consent. It is also worth noting that the licensee remains responsible for being awe of the federal and state regulations surrounding confidentiality, as well as the need to inform client groups regarding limits of confidentiality.

For individuals seeking licensure in marriage and family therapy (MFT), the American Association of Marriage and Family Therapist (AAMFT) states that it is the responsibility of therapists to disclose to client groups and other interested parties possible limitations of their confidentiality rights, as well as the nature of confidentiality. Indeed, the therapists are expected to engage clients in reviewing some of the situations that could prompt a request for confidential information, as well as legalized platforms through which the confidential data is likely to be disclosed (Ben-Zeev, Davis, Kaiser, Krzsos & Drake, 2012). To release client information, the guidelines advocate further for written authorization or disclosure only if the law permits in such circumstances. The therapist is also barred from disclosing data that operates outside or beyond the treatment context (unless written permission is obtained). When dealing with couples or families, it is also expected that the therapist

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does not reveal the confidence of one individual to another within the client unit; unless written permission is secured.

2 Methodology

From the perspective of the American Counseling Association (ACA), confidential data could be disclosed if the central objective is to protect the identified others or clients from foreseeable and serious harm (Consoli, Beutler & Bongar, 2017). Also, the disclosure could be done if legal requirements demand that the data is revealed. When in doubt, the guidelines suggest the need for counselors to consult other professionals; especially when dealing with end-of-life issues. It is also worth noting that counselors may disclose information when clients indicate that they have a life-threatening and communicable disease. Indeed, this suggestion is informed by affirmations that the rest of the parties could be at foreseeable and serious risk of contracting the same. However, ACA guidelines caution that the counselors ought to assess the clients' intent to disclose to third parties or the engagement in behaviors that prove harmful to the third party, upon which state laws are expected to be followed towards the disclosure of client disease statuses (Nichols, 2012).

3 Results and Discussion

The code of ethics that could be used to advocate for change is AAMFT, and the target profession is Marriage and Family Therapy. Indeed, the code states that there is a need for therapists to secure appropriate informed consent before engaging in therapeutic procedures. However, some situations (such as those involving an identified communicable or life-threatening disease) imply that the need for a therapist's intervention cannot be overstated. However, the code's provision that the intervention must be preceded by securing appropriate informed consent implies that if such a client declines to participate in a counseling process, the rest of the third parties might remain at risk of contracting the disease (American Counseling Association, 2014). Therefore, the proposed change is that AAMFT needs to be refined in such a way that it provides room for exceptional situations in which therapists could intervention without necessarily obtaining appropriate informed consent; especially if the primary motivation is to assure the safety of the remainder of the population.

According to the AAMFT Code of Ethics, therapists are expected to respect the autonomy of clients in relation to decision making. In particular, the guidelines state that the therapist needs to stretch beyond respecting these rights of clients and engage them in the understanding of the perceived consequences associated with the decisions made (Anthony & Goss, 2009). On the one hand, this section of the guidelines coincides with my value system regarding the importance of using client opinions as lead paths through which effective therapy could be provided. On the other hand, the specifications conflict with the expectation of the therapist regarding the central objective of the intervention, which involves bringing about changes in the lives of clients. For instance, the motivation behind offering therapy is to advice about relationships such as visitation, custody, reconciliation, separation, divorce, marriage, and cohabitation. Additionally, the code of ethics poses a dilemma in such a way that it does not specify the degree to which client autonomy in decision making should be tolerated (Anthony & Goss, 2015). Thus, the point at which the therapist needs to assume an active role and lead in the decision making process is yet to receive an in-depth analysis.

Both AAMFT code of ethics and the Oregon MFT Licensing Board exhibit several commonalities. For instance, both institutions the code of ethics division (in Oregon) states that licensees do not engage in or condone discrimination based on the client's socio-economic status, marital status, sexual orientation, religion, and race. Similarly, the division bars therapists from client discrimination relative to gender, national origin, ethnicity, disability, culture, color, or age (Ben-Zeev, Davis, Kaiser, Krzsos & Drake, 2012). In relation to AAMFT, the code of ethics state that therapists ought to offer professional assistance without discriminating clients based on factors such as those mentioned above. It is also worth noting that the code of ethics division in Oregon indicates that licensees ought to be aware of the influential positions they hold and avoid exploiting the dependency and trust of groups such as supervisees, employees, clients, and their students. Additionally, the division holds that licensees ought to avoid multiple relationships with client groups, especially those that threaten to compromise or impair professional judgment (or pose the risk of attracting exploitation). The relationships include sexual, personal, or business relationships with client groups. Similar to this

division, the AAMFT code of ethics states that therapists ought to avoid using their influential positions to exploit the clients' dependency and trust via practices such as sexual relationships. It is further notable that both institutions concur that privileged communication entails interactions among parties whereby the law acknowledges a protected and private relationship (Consoli, Beutler & Bongar, 2017). In particular, the privileged communication practice implies that issues that are discussed or communicated between the parties are expected to remain confidential; and that the communications' disclosure cannot be forced by the law.

4 Conclusion

Notably, an ethical dilemma is likely to arise if social work values come into conflict. On the one hand, there exists the obligation of the social worker to warn third parties or clients regarding a looming crisis of the possibility of harm. On the other hand, the issue of the client's right to privacy cannot be overstated. Therefore, a dilemma arises in such a way that the two values cannot be upheld simultaneously. Other scholarly observations contend that there exists a thin boundary between issues of legal obligations and responsibilities, and good clinical practice (Nichols, 2012). The eventuality is that the duty to warn tends to be prioritized at the expense of the right to privacy that the client is expected to enjoy. Hence, it can be inferred that the duty to warn or protect constitutes the therapist's responsibility to inform third parties or their authorities about a client's threat to other identifiable persons or themselves. Whereas a surface view suggests that the duty to earn could breach the confidentiality of clients, the central aim is to prevent harm from escalating. Regarding the limitations of the therapist's duty to warn, a therapist may only engage in the duty to warn if the patient or client has communicated actual threats involving physical violence against reasonably identifiable or identified victims. The eventuality is that the duty is achieved if therapists communicate the looming crises to victims and proceed to notify relevant law enforcement authorities regarding the threat (American Counseling Association, 2014). Therefore, the therapist engages in the duty to warn only if the threat has been communicated by the client, proceeding to communicate threats to target victims and relay the same information to law enforcement agencies or officers.

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