THE QUESTION of Competence

COBALT STOCK/GETTY IMAGES

JOHN K. MILLER, PHD

It wasn't that the question wasn't answerable. It was answerable but the answer went on and on and you never got done." (Pirsig, 1991, pg. 159)

In the spring of 2003, I was asked to offer testimony at our state capitol before a senate policy committee that was considering Oregon Senate Bill 806. As the then president of the Oregon Association for Marriage and Family Therapy, I was happy to argue in support of the bill that would grant vendorship (legislative authority to have our services reimbursed by private insurance) for licensed marriage and family therapists. A cadre of colleagues added their voices to advocate for the bill and at the end of our testimony, I was confident we would gain the support of the committee. My optimism faded as I heard the testimony of the various factions testifying against the bill. One of the main arguments of the opponents was that family therapists were simply not competent. Although most of the committee members seemed to see the critique for what it was, veiled name-calling, they did not allow the bill to move forward. Had these senators and committee members been swayed by the argument that we were not competent? As a professor, supervisor, and clinician, I became intrigued with this and other questions. How is competency defined? Who decides what counts as competent practice? How do we measure competence, and how do we teach it to new therapists?

Although more commonly accepted today, when first introduced, the orientation to competence over intelligence was groundbreaking. Many now accept the notion that there is a gap between what we test for as educators and the skills necessary to actually help our clients.

How Do We Decide What Counts as Competence?

A few months later, I learned of the AAMFT's newly formed Core Competency Task Force, organized to help define core competencies for the profession. I soon became a member of the Task Force and set out with my colleagues to answer some of the questions I had been considering. The aim of the task-force was to define the domains of knowledge and skill for each area of practice in family therapy, to articulate the minimum standard of practice to operate as a licensed MFT, with the ultimate goal being to improve the quality of service we offer. The work was not easy. One initial dilemma I could see was not simply defining the core competencies, but deciding where to *stop* describing what should be considered core competencies. Crunching down the complex and sophisticated practice of family therapy into discrete categories of competence proved to be arduous work. Initially the

Core Competency Steering Committee produced over 250 "core" competencies, but by December of 2004, had edited the number down to 128. As I perused the competency literature across other professional disciplines, I could find no theoretical basis for describing a single rubric for defining competence. Each professional organization that adopts a competency orientation must make some fundamentally subjective decisions regarding where to draw the line for what counts as the minimum "core" standard of competency. This was the initial and most critical job of the AAMFT Competency Steering Committee.

The Gap Between Academic Success and Competence in the Real World

In 1973, David McClelland helped define the competency movement in the US by publishing an article in *The American Psychologist*, arguing that traditional exams alone are not sufficient to predict whether or not people would be good at their jobs in the real world, and that instead of testing for intelligence, we should be oriented to assessing for competence. Although more commonly accepted today, when first introduced, the orientation to competence over intelligence was groundbreaking. Many now accept the notion that there is a gap between what we test for as educators and the skills necessary to actually help our clients. In a recent text by Skovholt and Jennings (2004), *Master Therapists: Exploring Expertise in Therapy and Counseling*, the authors explore examples of expertise in practice and offer evidence for ways to close the gap. The premise of the text and the research that supported it was that one way to begin to assess competence in the real world is to begin with studying people who seem to have expertise in their work. Distilling out these qualities of expertise to inform how we teach competent practice is one creative method to close the gap.

Overcoming the Barriers to the Competency Movement

As with all change, there is unintended consequence for taking a purposeful action in any new direction (Merton, 1936). While many advantages of developing core competencies for the profession are self evident, we must also address the common barriers and pitfalls as we move forward. One hazard of the competency movement in family therapy is the unintended effect of limiting or hampering the professional autonomy, innovation, and creative practice of the individual practitioner. As the core competencies are further developed and defined, could we eventually find ourselves in a profession where any given clinical situation has an articulated "correct" and competent response? What effect would this have on the next generation of innovators? The concept of ***equifinality*** (Berttalanffy, 1950) offers us some guide to answer these questions by challenging the notion that there is any one specific path to competent practice. Instead, the concept of equifinality tells us that there are many possible paths to conducting competent practice in family therapy. Many different origins can lead to the same positive result. This does not mean that we should give up on defining and implementing the core competencies.

The core competency movement is here to stay. Every profession from accounting to neurology has developed and codified core competencies for their respective fields (Platt, Miller, Bruun, & Todahl, 2004).

The Delicate Balance Between Training for Competency and Allowing for Innovation

The core competency movement is here to stay. Every profession from accounting to neurology has developed and codified core competencies for their respective fields (Platt, Miller, Bruun, & Todahl, 2004). As we move forward as educators, supervisors, and clinicians, we can avoid the common pitfalls and barriers to quality practice as we strive for balance between standardization and innovation. The following are some strategies to help maintain this balance:

- Read and understand the core competencies. If the core competencies are to be useful for the field, all practitioners must become familiar with the document
- Keep in mind that the competence model of professional development is a continuing dialogue versus a destination or conclusion. The core competencies are a living work and require the membership to read them and offer feedback for them to grow and remain relevant. The competencies will be reviewed and modified at regular intervals
- Avoid a "one size fits all" orientation to training students and therapists. Instead, seek to promote creativity and innovation in practice while also maintaining the standards set down by the profession
- Recognize and avoid circularity

between the standard and the practice, commonly known as "teaching to the test." Moving forward with the core competencies means educators will need to find creative ways to measure student success relative to the competencies, while also embracing their unique styles and skills

- Steer clear of "either/or" descriptions pitting core competencies against innovative practice. The core competencies were designed to allow the maximum leeway for innovation and creativity in practice
- Teach to "expertise" versus mere "competence." The competencies were designed as the minimum standard for a professional to operate as a licensed marriage and family therapist. While we should ensure our students and supervisees are operating at the minimum, we should strive for them to develop beyond mere competence…to strive for expertise
- Design teaching and evaluation goals with the "end in mind." This concept implies that we should ultimately look at client outcomes as we consider the competence of any given student. This involves creating strategies where client feedback informs supervisee evaluations ❍

JOHN K. MILLER, PHD, is a licensed marriage and family therapist and is the program director of the Couples and Family Therapy Program at the University of Oregon. Miller is an AAMFT Clinical Member and an Approved Supervisor.

REFERENCES

BERTTALANFFY, L. (1950). An outline of general system theory. *British Journal of the Philosophy of Science*, 1, 134-165.

MERTON, R. (1936). The unanticipated consequences of purposive social action. *American Sociological Review*. Volume 1, Issue 6. pg. 894-904.

McCLELLAND, D. (1973). Testing for competence rather than "intelligence." *American Psychologist*, vol. 28, 1973, pp.1–14.

PIRSIG, R. (1991). *Lila: An inquiry into morals*. Bantam Books, New York.

PLATT, J. Miller, J., Bruun, E., & Todahl, J. (2004). *Competencies across disciplines*. The AAMFT Annual Conference Presentation.

SKOVHOLT, T. & Jennings, L. (2004). *Master therapists: Exploring expertise in therapy and counseling*. Allyn & Bacon, New York.