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ORIGINAL PAPER

Couple and Family Therapy Within the Current Pan-Canadian Context

Alan McLuckie · Robert Allan · Michael Ungar

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Abstract Canadians take numerous approaches to couple and family therapy due in part to Canada's diversity of people and geography, as well as the influence of the health care context, a central facet of our national identity. Tracing back to Nathan Epstein, the founder of family therapy in Canada, there continues to be a strong tradition of couple and family therapy within Canada which has international reach. Formal training in family therapy, as well as couple/marital therapy occurs largely outside of the scope of degree granting programs and university settings. The American Association for Marriage and Family Therapy has a strong presence in Canada, with six divisions across the country. Popular models of practice for Canada's couple and family therapists include cognitive-behavioral therapy, solution-focused therapy, narrative therapy, emotionally-focused therapy, and Bowenian/inter-generational therapy. A growing number of training opportunities are becoming available across Canada, and the practice of couple and family therapy is becoming institutionalized as one of the core competencies for professions such as psychiatry. In this article, we examine the context of family therapy in Canada by examining its history, the unique accreditation standards, qualifications and organizations associated with family therapy, the relationship between couple and family therapy, and future directions for this field of practice.

Keywords Couple therapy · Marital therapy · Family therapy · Canada

Introduction

Canada is an expansive and diverse country bordered on three sides by oceans and to the south has one of the longest unprotected borders in the world with the United States of

A. McLuckie (✉)
School of Social Work and Department of Psychiatry, Dalhousie University, Mona Campbell Building, 3201-1459 LeMarchant Street, PO Box 15000, Halifax, NS B3H 4R2, Canada
e-mail: alan.mcluckie@dal.ca

R. Allan · M. Ungar
Resilience Research Centre, School of Social Work, Dalhousie University, 6420 Coburg Road, PO Box 15000, Halifax, NS B3H 4R2, Canada

America. Due to Canada's diversity of people and diversity of geography, it should not be a surprise that Canadians take numerous approaches to couple/marital and family therapy (CFT[1]). In this article we examine the context of family therapy in Canada by examining its history, the unique accreditation standards, qualifications and organizations associated with family therapy, the relationship between couple and family therapy, and future directions for this field of practice.

Canada is the second largest country in the world by land mass and has a population of approximately 35 million people. Relative to its geographic size, Canada is sparsely populated, with two thirds of the population residing within 100 miles of the border with the United States. Much of that population lives in, or near, large urban centres such as Toronto, Montreal, Vancouver, Ottawa, Calgary, and Halifax. As a federation of 10 provinces and 3 territories, Canada has a historical link to British and French traditions, reflected in its two official languages, English and French. The histories and influence of Canada's Indigenous peoples, including First Nations, Métis and Inuit are also woven into the fabric of Canada. As a country, Canada also prides itself on its commitment to human rights and being one of the most multicultural and religiously diverse countries in the world.

Central to Canadian identity is also a national commitment to publically funded universal health care. First introduced in the province of Saskatchewan in 1946, the right to public health care was championed by politician, Tommy Douglas, who is remembered as the 'Father' of Canadian health care. Since the passing of the Medical Care Act in 1966, followed by the passing of the Canada Health Act in 1984, Canadians have viewed comprehensive universal publically funded health care as a basic human right. Interestingly, the history of family therapy in Canada is closely intertwined with Canada's commitment to health care. Opened in 1823, The Montreal Medical Institution, which is now the Faculty of Medicine at McGill University, awarded the first medical degree in Canada in 1833. It is at this same institution over a century later that our story begins with another physician who came to be known as the founder of Family Therapy in Canada.

History of Family Therapy in Canada

Nathan Epstein, one of Canada's most distinguished psychiatrists, introduced family therapy to Canada and left an indelible legacy on the field internationally. Many of this country's leading figures in the field and the institutions that they established to train the next generation of Canada's couple and family therapists can be traced directly to Epstein. Influenced by his training with Nathan Ackerman, Epstein began working with families in the 1960s as psychiatrist-in-chief at the Jewish General Hospital in Montreal. In this environment, Epstein incorporated psychoanalytic theory into family therapy, and for the first time in the history of the Jewish General Hospital established the practice of linking hospital-based psychiatric programs with community-based social agencies. This practice remains firmly established in Quebec's model of mental health care delivery today (Kutcher et al. 2010). It was during his time at McGill that Epstein studied the family of

[1] It is worth noting that the majority of programs and services refer to themselves as providers of couple and family therapy, not marital and family therapy. The University of Guelph's MSc in Couple and Family Therapy changed its name over 10 years ago to better reflect the bias of the field. New legislation regulating the profession in Quebec (Bill 21) regulates couple and family therapists, and the Jewish General Hospital program is named the Couple and Family Therapy Training Program.

origins of McGill students which led to his Family Category Schema and, in collaboration with Norman Wesley, the publication of the influential book *The Silent Majority* (Wesley and Epstein 1969). This focus on family work at McGill also set the stage for Epstein to develop the Family Assessment Device (FAD) and the Family Assessment Measure (FAM), a version (Skinner et al. 1995) of which is still widely used in family therapy. While the Jewish General Hospital and McGill's Department of Psychiatry and School of Social Work all played foundational roles in developing CFT in Canada, the Université de Montreal was and continues to be pivotal for training French language couple and family therapists.

Later, Epstein moved to become Chair of the Psychiatry program at McMaster University in Hamilton, Ontario where he brought with him many of his colleagues practicing family therapy, resulting in McMaster becoming the centre for family therapy in the 1970s. Although his work would later be refined at Brown University, it is during his time in Hamilton that Epstein and his colleagues developed the foundation for The McMaster Model of Family Functioning (Epstein et al. 1981, 1983).

At about the same time in 1969, a young psychiatry resident named Karl Tomm was studying at the University of British Columbia struggling to understand the needs of a 14 years old girl who had been admitted to hospital because she was running away from home (Collins 2009). Tomm consulted with Epstein who was visiting from McMaster and was so inspired by Epstein's systemic approach that he left the University of British Columbia to finish his residency training at McMaster (Collins 2009; Tomm 2012, personal communication). There, Tomm studied with Epstein practicing under the supervision of Solomon 'Sol' Levin, another pioneer in Canadian family therapy (Collins 2009) who helped develop The McMaster Model (Epstein et al. 1978). Tomm returned home to Calgary, and in 1972 began a Family Therapy Training Program at Foothills Hospital (Collins 2009) where he is currently the Director. The Family Training Program associated with the University of Calgary's Department of Psychiatry and School of Social Work continues to offer nationally and internationally renowned training in family therapy.

Tomm was highly influential in bringing second order perspectives of CFT to Canada and is well-known for his early work in the area of relational-based interviewing and circular questioning, including "internalized other" conversations (Tomm 1988). This shift away from Epstein's confrontational style and objective stance with families towards a constructivist approach, learned while training in Milan, allowed Tomm to share the Milan approach to family therapy with Canadians (see Selvini-Palazzoli et al. 1980). The biggest shift in Tomm's approach, which would have a fundamental and lasting impact on the landscape of family therapy in Canada, came after meeting with Michael White in the mid-1980s.

Following a chance encounter while presenting in Adelaide, Australia, Tomm and White developed a close friendship and a collaborative working relationship that introduced White's social constructionist ideas and model of Narrative Therapy to a North American audience. Through this relationship, Tomm's new social constructionist ways of thinking fully took shape including his work on healing interaction patterns (HIPs) and pathologizing interactions patterns (PIPs) (Tomm 1991).

Michael White's work (see White and Epston 1990) inspired many couple and family therapists within Canada, many of whom provided training to the next generation of family therapists. Judith Myers-Avis, whose clinical practice in narrative therapy and feminist practice with couples and families, is highly regarded (see Avis 1996, 1998, 2006a, b) helped develop the Ontario Association of Marriage and Family Therapy and, at the University of Guelph, one of only two programs accredited by AAMFT's Commission on

Accreditation for Marriage and Family Therapy Education (COAMFTE), an approved Master's level training program. At the Hinks-Dellcrest Centre in Toronto, a training program affiliated with the University of Toronto, James 'Jim' Duvall (see Duvall and Beres 2007) and Karen Young (see Young 2008; Young et al. 2008; Young and Cooper 2008) were also influenced by narrative models, as well as brief models of family therapy. On the west coast, Tomm and White's legacy is being carried on by Stephen Madigan (see Madigan 2011), another leader in the field of CFT training from a narrative perspective.

Other leaders in the field that may have been influenced by Tomm's work but offered their own unique contribution to family therapy include Arnold Slive, Nancy McElheran and Harry Park of Calgary, who developed single session models of engagement that continue to be the gold standard for walk-in counseling/mental health clinics working with young people and families (see Slive and Bobele 2011; Slive et al. 1995, 2001, 2008). Other leaders in the field of CFT, such as Sue Johnson (1996, 1998, 2008), are also Canadian. Greenberg (2003) focused their attention on experiential clinical approaches to mending couple and family relationships (Johnson and Greenberg 1985, 1987). Johnson is currently the Director of the Ottawa Couple and Family Therapy Institute and the International Centre for Excellence in Emotionally Focused Therapy. Greenberg is the Director of the Emotion Focused Therapy Clinic affiliated with York University in Toronto. Both Johnson and Greenberg continue to be leading figures in the training of couple and family therapists in Canada, as well as internationally.

On Canada's east coast, the Atlantic Child Guidance Centre (ACGC) was established in the late 1950s out of a perceived need for community-based child and adolescent mental health services. This newly incorporated organization collaborated with the IWK Health Centre (a women's and children's teaching hospital in Halifax) to have ACGC provide a relatively wide range of community-based child and adolescent mental health services in the greater Halifax-Dartmouth area. In the mid-1990s the Nova Scotia government required the IWK, the Nova Scotia Hospital, and the ACGC to merge child and adolescent mental health services. The result was a "Tri-facilities" service, which in turn led to the IWK taking over all child and adolescent mental health services and the closure of the ACGC (W. Hollett, personal communication, February 23, 2012).

More recent contributions to family therapy that originate on the east coast include work by Ungar (2008, 2011, 2012), who has been introducing a Social Ecological Approach to counseling that builds on research on resilience by himself and Walsh (2006) who recently retired from the University of Chicago. When seen altogether, there is evidence of a tremendous amount of work being done across Canada that has influenced the field of CFT internationally.

The Challenges and Opportunities to Family Therapy Within the Canadian Context

Challenges and Opportunities Presented by the Health Care System

The year 2012 marked the 50th anniversary of universal publically funded health care (i.e., Medicare) in Canada. While there has been a long-standing commitment to public health care, the role of CFT within this system has taken many forms across Canada. Couple and family therapists are integrated most strongly into the public health systems in geographic regions where graduate and post-graduate CFT training programs are available and well-respected within the health care community. The Jewish General Hospital in Montreal is a strong example of how family therapy work is recognised and revered in the health care

system. The Jewish General Hospital has a separate family clinic and a CFT training program with a 40-year history, the oldest of its kind in Canada. The presence of CFT in Montreal is further enhanced by CFT training and services provided by the Argyle Institute and the Université de Montreal.

The recognition of CFT within the health care system, achieved through a strong connection between training and service provision, is somewhat distinct to Montreal and is not typical of all parts of Canada. In some provinces such as Nova Scotia and Newfoundland, there is little or no recognition of CFT as an area of clinical expertise that requires specialised training beyond a general Master's degree in a mental health discipline. This contrasts with the United States where graduate schools and training programs offer specific graduate degrees in CFT. Where training in CFT is available in Canada, it tends to be offered through hospital settings (e.g., the IWK Health Centre in Halifax and the Children's Hospital of Eastern Ontario in Ottawa) or through programs affiliated with hospitals or university settings (e.g., Family Therapy Training Program at the University of Calgary or the Hincks-Dellcrest Family Centre in Toronto). There is renewed interest in family therapy within the health care system and the field of psychiatry in particular, since the Royal College of Physicians and Surgeons of Canada established a Child and Adolescent Psychiatry subspecialty (CACAP 2013), which requires psychiatry residents to have proficiency in family therapy and/or systems approaches to psychotherapy.

The lack of treatment and training centres can be attributed in part to how the provinces and territories structure their social service and health care systems. These systems are structured and funded in a manner that prioritizes individual-based interventions (e.g., one-on-one psychotherapy). Individuals can present for government funded services but not couples. When families are seen within government funded health care programs, they are treated in relation to the presenting concern of one family member, typically a child or adolescent. Other publicly funded services recognise the impact of families on treatment and may incorporate them into treatment plans, especially when Child Welfare services are involved as the referring agency.

Community-based, not-for-profit family serving organisations are one exception to the pattern of service the privileges one-on-one psychotherapy. These organizations typically integrate family therapy into community and health care programs. For example, Family Service Canada is a network of over 30 community organisations across eight provinces providing a range of CFT services, couple enrichment and family support programs. These organisations offer fee-for-service counseling on a sliding scale. They accept self-referrals and work collaboratively with government services. Family Service organisations have a long proud tradition in their respective communities of offering quickly accessible, affordable and effective services. For example, Family Service Saskatoon was established in 1931 and continues to offer CFT, as well as a range of group programs.

Challenges and Opportunities Related to Canada's Cultural Context

Canada is home to over 200 different ethnicities, two official languages, and over 600 First Nations communities with over 30 different languages. This cultural and linguistic complexity can sometimes be further magnified within a particular area or province. For couple and family therapists in Quebec, for example, an important ethical and therapeutic consideration is whether as a CFT, one should only see couples and families that speak one's first language, regardless of the therapist's ability to speak a second language.

One exceptional program that integrates culture into family therapy is The Hinton Friendship Centre in Alberta. The Hinton integrates Indigenous healing practices with

family therapy to create a holistic healing process involving spiritual, emotional, mental, and physical aspects for service users. Another exceptional program working to reflect the community diversity of service users is the Aurora Family Therapy Centre which partners with the University of Winnipeg's Master's program. It provides CFT in 30 different languages and works closely with settlement services for new immigrants. With approximately 15,000 newcomers to Manitoba each year, Aurora deals with a wide range of issues including, people from war torn countries and settlement camps, requiring a culturally sensitive delivery of CFT. For example, therapists at Aurora are more likely visit families in the family's homes and new Canadians are not required to sign consent forms if they have encountered oppression through completing such forms in their previous country.

An ongoing challenge in Canada is the limited availability of research and evidence-based CFT approaches for practice with new Canadian populations.

Challenges and Opportunities for Family Therapy Training

Formal training in family therapy, as well as couple/marital therapy occurs largely outside of the scope of degree granting programs. In Canada, there are no Ph.D. programs in CFT and only two Master's level programs fully accredited by COAMFTE. First established in 1979, and accredited with COAMFTE in 1989, the CFT program at the University of Guelph (U of G) in Ontario is a small but intensive program focusing on theory, research and practice offering a Masters in Science (M.Sc.) in Family Relations and Human Development. Although this two-year degree granting program is relatively small in capacity (4 faculty and 16 students enrolled annually), U of G's influence on CFT training extends well beyond its degree granting program through its Certificate Program in CFT Studies.

U of G's program may be the best known COAMFTE training program for CFT in Canada, but it was not the first. In 1972, a training program was developed in Winnipeg, Manitoba to enrich the training of pastoral care and ordained ministry professionals. Drawing on their doctoral training in the United States that underlined the value of systems work and the need for specialized skills in CFT, three theologians developed The Interfaith Pastoral Institute which has grown over time into a Master's program at the Faculty of Theology at the University of Winnipeg. In 2004, a distinct program was started and housed within the Department of Graduate Studies at the University of Winnipeg, leading to a Master's in Marriage and Family Therapy (MMFT). The Interfaith Pastoral Institute, now called the Aurora Family Therapy Centre, continues to have a close relationship with the MMFT program at the University of Winnipeg.

Canadian University College, located in Lacombe, Alberta, also played an important role in CFT training in Canada. For many years, this small undergraduate institution, sponsored by the Seventh-day Adventist Church, offered an extension program from Loma Linda University in California. This program leading to a Master's in Science in Marital and Family Therapy was structured in a manner that allowed graduates to pursue clinical membership with AAMFT and/or pursue registration as psychologists with the Alberta College of Psychologists. This program is no longer accepting students and will be discontinued by Loma Linda.

In Canada, the vast majority of family therapy training is received via a combination of graduate level training in allied health disciplines (e.g., degrees other than an M.Sc. in CFT) and post-graduate supervision in a variety of counseling, health care and mental health settings. When taking stock of the degrees held by those practicing and/or

specializing in CFT, the Masters in Social work (MSW) is the most prominent with other prominent degrees including the Masters of Divinity (MDiv) (e.g., through Tyndale University College and Seminary), and the Masters in Counseling (e.g., through such programs as that offered by Acadia University in Nova Scotia) or a Master's in Counseling Psychology (e.g., the MEd community counsellor stream at the Ontario Institute for Studies in Education at the University of Toronto).

McGill's program has a long history of training excellence in family therapy, having been integral to Epstein's early pursuits related to family therapy training. This program continues to be a leader in family therapy education in Canada. After a decade long effort by teaching faculty, such as Sharon Bond, the School of Social Work at McGill with the support of the Department of Psychiatry at the Jewish General Hospital will soon launch a Master's Degree in CFT accredited with COAMFTE. The launching of this program comes as Quebec regulates the practice of couple and family therapy, the only province to do so at this point.

To date, few schools of social work or other departments of health professions have followed McGill's lead to develop programs specializing in CFT. This may be due to several factors including the rigorous requirements for COAMFTE programs, the huge resources required to run these specialized programs and the low number of students who can attend, all of which result in a fiscal imbalance. It is also likely that there are "turf" issues which lead social work, psychology and nursing programs to fear a reduction in their application/admission rates in an already competitive fiscally restrained climate.

It is important to note, however, that there is a changing climate in the education of social workers in Canada, which may have an influence on family therapy. Most schools of social work in Canada position themselves as teaching critical and anti-oppressive approaches to social work (see Baines 2011; Fook 2012), which tend to deemphasize CFT as core competencies within social work. Course work at these schools that does focus on social work with families seldom meets AAMFT requirements related to family therapy course work. Further problematic is that in many situations these family courses are taught as electives, resulting in many MSWs having minimal knowledge about families, systems, or models of family therapy. This likely has implications for graduates who wish to include family work in their scope of professional practice, as few will have the necessary theoretical foundation from which to develop their skills to work with families in a therapeutic capacity. Furthermore, without this course work new graduates from MSW programs in Canada will likely face a more daunting task of completing AAMFT requirements to become clinical fellows as they often need to take upwards of six additional Master's level courses, post-MSW, and receive extensive clinical supervision.

Conferences and continuing education training programs, workshops and seminars are another typical route for helping professionals to acquire specialized training in CFT. Many of Canada's leading family therapists are active in offering training opportunities, which when combined with Canada's proximity to the United States and online options, results in endless opportunities for trainees. Unfortunately, these trainings can be an expensive proposition for new graduates limiting enrollment to those practitioners who are well resourced and potentially exclude a diverse group of helping professionals from the practice of CFT. Many family therapy centres also recognize their role in building capacity by offering training programs that supplement university programs. These include the Family Therapy Program in Calgary, Hincks-Dellcrest Centre, the University of Guelph's Centre for Open Learning and Educational Support, and the Ottawa Couple and Family Institute. These programs can offer a reduced cost option to access training, as volunteer

therapy services are offered in exchange for supervision in CFT, as the case is at Eastside Family Centre in Calgary Alberta.

The fact that most training in family therapy in Canada occurs post-graduation creates a Catch-22 for many interested in working with families. To engage in supervised direct practice with families requires a clinical counseling position, which can be very difficult to obtain without prior experience and training. The added challenge is to access good supervision, as many of the skilled family therapy supervisors have either limited capacity to provide training or provide this training within a private fee-for-service practice, which can be cost prohibitive to many helping professionals.

Challenges and Opportunities for Family Therapy Accreditation

Currently, Quebec is the only province or territory to license couple and family therapists, although other areas of Canada have been lobbying for this to occur (Beaton et al. 2009). Provincial regulation (i.e., Bill 46) allows qualified couple and family therapists (i.e., those with an MMFT and/or M.Sc. in CFT) in Quebec to join their colleagues in other regulated health professions (i.e., social work, nursing, medicine, and psychology) and practice CFT.

A similar process is currently underway in Ontario, where following the passing of provincial legislation (i.e., omnibus Bill 171; Psychotherapy Act 2207) a transitional council has been established in order to develop a regulatory College of Psychotherapists and Registered Mental Health Therapists. This new regulatory college is designed to provide oversight of all allied health professionals who were not previously regulated under the existing Health Professions Act (i.e. social work, psychology, nursing, medicine) and who want to include psychotherapy within their scope of practice. As the transitional council is still developing regulations for the Psychotherapy Act, there remains much uncertainty as to the specific impact the Act will have on the practice and profession of CFT. There is, for example, concern that family therapy will not be recognized as a protected title and practice specialization associated with specific training. Furthermore, although health care is under the jurisdiction of provincial and territorial governments to regulate, the formation of this new regulatory college in Ontario may have important implications elsewhere in Canada. Due to Canadian federal labour laws, when two regions of Canada have established regulations that shape or regulate employment practices, all provinces and territories must develop formal regulations to address the portability of credentials. Therefore, once established in Ontario, the College of Psychotherapists could regulated the act of CFT, which would mean that CFT would be legislated in Ontario and Quebec, thereby requiring other provinces and territories to recognized CFT as a distinct health care profession.

Challenges and Opportunities for Professional Organizations

In addition to the countless professional associations and regulatory colleges for the health professions, Canada has a long history of supporting associations specifically mandated for the professional needs of couple and family therapists. In the early days of CFT in Canada, Karl Tomm and several influential Canadian couple and family therapists created the Canadian Association for the Treatment and Study of the Family (CATSF). At the time of inception the board of CATSF decided to focus on capacity building related to CFT and to leave accreditation standards or training regulations to AAMFT. According to Tomm (personal communication), leaving the accreditation standards to AAMFT resulted in the demise of CATSF as the majority of couple and family therapists wanted to possess this

credential (i.e., clinical membership). To this day, Canadians are welcomed members of AAMFT through six regional associations: British Columbia, Alberta, Manitoba, Saskatchewan, Ontario and Quebec. At present, AAMFT members residing in the Atlantic Provinces (i.e., New Brunswick, PEI, Nova Scotia and Newfoundland) are members of the Quebec division of AAMFT. There are approximately 1500 AAMFT members across Canada (Beaton et al. 2009) which includes Clinical Fellow, Member, Pre-clinical Fellow, Associate Membership, Student Membership, and Affiliate Membership.

Since 1995, all AAMFT clinical members automatically become members of the Registry of Marriage and Family Therapy (RMFT Canada), many of whom use the credential RMFT. The goal of the Registry is to promote the profession and practice of individual, CFT in Canada. The decision structure of this organization includes the presidents from each of the six Canadian AAMFT divisions. At present there are 840 clinical members of AAMFT residing in Canada who identify as being Registered Marriage and Family Therapists. They are distributed throughout Canada as follows: British Columbia (100), Alberta (85), Saskatchewan (12), Manitoba (56), Ontario (490), Quebec (82), New Brunswick (1), Nova Scotia (11), Newfoundland (1), and the Yukon (2).

Challenges and Opportunities Related to Models of Practice

A survey of AAMFT members in Canada by Beaton and colleagues in 2009 showed that of the 1406 AAMFT members who were registered that year (including student, affiliate, associate and clinical members), the majority of practitioners were female (71 %), Caucasian (84 %), heterosexual (88.8 %) and practicing with a Master's level of education (Beaton et al. 2009). Though the majority (60 %) of survey respondents reported their professional identification to be "couple/marital/family" therapy, only 27.4 % of their reported clinical time pertained to couple/martial therapy and only 12.1 % of their clinical time pertained to family therapy(Beaton et al. 2009). The largest amount of their clinical work was individual adult therapy (43.5 %). The most common presenting issues reported by survey respondents included couple/marital problems (55.1 %), depression (53.1 %) and anxiety (30.2 %). The most common therapeutic models used to address these and other presenting concerns were cognitive-behavioral therapy (38.6 %), solution focused therapy (38.5 %), narrative therapy (31.4 %), emotionally focused therapy (27.4 %), Bowenian/intergenerational therapy (21.7 %) and eclectic approaches to therapy (20.8 %) (Beaton et al. 2009). Tomm (personal communication) suggests that Narrative Therapy has become popular in Canada due to Michael White's influence and has been sustained to some degree by training centres such as Tomm's in Calgary and the Hincks-Dellcrest in Toronto. Sue Johnson (personal communication) indicates that Emotionally Focused Therapy has gained in popularity over the last few years due to the availability of training, but also due in part to the call by the public and by professionals for evidenced-based models of CFT.

It is important to note that affiliation with AAMFT is not necessarily an indication that someone is practicing CFT. Many helping professionals include CFT within their scope of practice but do not pursue AAMFT membership, especially when they did not graduate from a COAMFTE approved Master's program. Many individuals practice CFT with MSW, MDIV and MEd degrees. Furthermore, other helping professionals such as psychiatrists and psychologists may feel that dual affiliations with their regulatory colleges and AAMFT are unnecessary for career advancement, public perception of their expertise or insurability of their practice.

Psychiatrists such as Nathan Epstein and Karl Tomm have played, and continue to play, a key role in the practice of family therapy in Canada. Due to the nature of their training (bio-medical) and their typical place of employment (i.e., tertiary care hospital and/or medical setting), many psychiatrists practice at the intersection between family-based problems and mental disorders. This emerging resurgence in family therapy may be due in part to the Royal College of Physicians and Surgeons of Canada establishing Child and Adolescent Psychiatry as a subspecialty (CACAP 2013), bringing them in-line with their American counterpart. With this subspecialty, psychiatry residents are expected to develop proficiency in family-based therapy, resulting in resident training programs formalizing training and supervision programs in family therapy. Models of practice that are gaining traction among child and adolescent psychiatrists include Functional Family Therapy (Alexander and Parsons 1982), which has been shown effective for adolescent substance use and behavioural difficulties (Waldron et al. 2001; Waldron and Turner 2008), as well as the Maudsley Approach (see Lock et al. 2001) which has shown effectiveness for child and adolescent eating disorders (Eisler et al. 2000; Lock et al. 2006, 2010; Russell et al. 1987). There are also trends in adult psychiatry to include families within adult mental health treatment regimens (MHCC 2010, 2012). For example, aspirations to include families in a meaningful therapeutic way are being operationalized by mental health professionals and psychiatrists using such approaches as the Meriden Family Programme (see Froggatt et al. 2007).

Building on Opportunities and Overcoming Obstacles: Future Directions in Family Therapy

With more and more regions of Canada recognizing CFT as a distinct area of professional practice, we believe that CFT will continue to increase in popularity nationally. A growing number of training opportunities are becoming available across Canada, and the practice of CFT is becoming institutionalized as one of the core competencies for child psychiatrists. While our colleagues across Canada are optimistic about the future for CFT, they also note that CFT, and couple's therapy in particular, continues to be perceived as a luxury and family therapy more suited to preventing problems among children than an effective part of intensive tertiary level care after disorder is present.

Cognitive therapies continue to dominate the practices of even those professionals who are trained in CFT. In part, this disparity between the possible benefits of CFT and their perception as lacking an evidence base is due to a shortage of good research on their effectiveness being known to practitioners. Where such evidence exists, we found that practitioners had little knowledge of the results from outcome studies. There appears to be a need not only for increased training in CFT but also greater knowledge mobilization with regard to the effectiveness of CFT interventions with specific populations along the continuum from prevention to treatment.

Immediate challenges for the growth of CFT in Canada include the need for more specific licensure so that the profession stands apart for other forms of psychotherapy. While the establishment of professional bodies to oversee CFT and other clinical practices is a step forward, the practice of CFT risks being confused with other types of counseling unless it constitutes itself as a separate discipline. Portability of licensure between Canadian provinces and territories, as well as into the United States, would increase the attractiveness of the professional designation.

In Canada, there is also a tension among CFT professionals regarding the holding of licensure through US bodies like AAMFT. Many of those training couple and family therapists suggest that a Canadian licensing body for the profession may be more attractive to clinicians. Presently, most couple and family therapists carry dual designations, holding both their professional licence as a social worker, counselor, psychologist, nurse, clergy or psychiatrist, and an additional license as an RMFT, usually through membership with an American body. For the profession to stand alone in Canada, the profession may need to develop its own Canadian CFT associations and accreditation standards for programs nationally and regulation of the profession provincially.

The Canadian context also offers CFT unique challenges and opportunities. As a very large and sparsely populated country, with an emphasis on multiculturalism and bilingualism, Canada may be the perfect setting for innovation in online CFT and CFT with culturally diverse populations. Models for these approaches are still early in their development, with linguistic diversity and physical distance posing serious problems to practitioners who have rare skill sets (e.g., fluency in a second language or training in CFT with culturally diverse families) who want to reach as many clients as possible.

In other ways, advances to CFT in Canada mirror those in other countries. There is strong and growing attention to attachment oriented work (e.g., Circle of Security) and autism spectrum research and its application to family therapy. CFT with Aboriginal people is a growing area of concern among professionals nationally, and the country has produced some of the best work internationally on emotionally focused therapy (Johnson 1996, 1998, 2008), the McMaster Model (Epstein et al. 1981, 1983) and the application of research on resilience to systems-based clinical practice (Ungar 2011).

Conclusion

It is yet to be seen if the rich history of CFT in Canada is sustainable, growing, or to become part of other professional practice models. While we find evidence nationally for a robust community of clinicians using CFT and continuing to advance their training, it is unclear whether the field will stand alone or become a set of competencies applicable to many different professions. Competition between professions may further add to the problem of making CFT a separate profession as some social workers and psychologists, in particular, have suggested that CFT is part of their core professional practice. Regardless of the debates over professional identity, the practice of CFT is increasing across Canada. New populations with unique challenges are requiring the field to reconsider its core practices and develop new ones. This may help position Canadians once again as leaders in the field, the same position they have occupied periodically throughout the development of CFT.

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