I would like to propose an additional topic to discuss during the upcoming OBLPCT public hearing. I am hoping the board would consider approving hours accumulated during the waiting period between applying for the associate's registration and its approval. Having hours counted during the waiting period means a faster path to licensure, higher salaries for clinicians, avoiding paying for supervision longer than necessary, the ability to apply for more loan forgiveness programs, and job retention. It would also be helpful to require documents to be added to the application directly before submitting to avoid delay in approval if one is missing.

Thank you,
[Anonymous]

From: Alex Du Toit
To: STASHEK LaRee * MHRA
Subject: Public Comment Regarding Proposed Rule Changes
Date: Tuesday, May 19, 2026 11:55:33 AM

You don't often get email from alexandradutoit@gmail.com. Learn why this is important

To Whom It May Concern,

I am writing in support of the proposed rule changes regarding examination failure and study plan requirements for licensure candidates.

I recently took the national MFT examination again and narrowly did not pass. I fully understand the importance of protecting the public and ensuring competent clinicians enter the profession. However, I also believe there is an important distinction between clinical competency and standardized test performance, especially for experienced clinicians who have already completed graduate education, supervision, and years of direct clinical work.

I earned my master's degree approximately 15 years ago and successfully completed all required supervised hours and training. Throughout my professional experience, I have worked extensively with individuals and families and have consistently received positive feedback regarding my clinical skills, professionalism, ethics, and ability to connect with clients. Despite this, I continue to struggle significantly with high-pressure, four-hour standardized examinations.

I know I am not alone in this experience. Many capable and compassionate clinicians experience test anxiety, processing difficulties, or challenges with lengthy standardized exams that do not necessarily reflect their ability to provide safe, ethical, and effective care to clients.

The emotional and financial impact of repeated exam failure can be devastating, particularly for older candidates, returning professionals, and those supporting families while trying to complete licensure requirements. In my own situation, I have put major areas of my life and career on hold while attempting to pass this examination, despite already demonstrating years of supervised clinical competency.

I appreciate that the Board is considering more supportive and less punitive approaches, including removal of the automatic one-year wait period and the addition of study plans. I would also encourage the Board to continue exploring **additional pathways that consider the full scope of a clinician's education, supervised experience, ethical history, and demonstrated professional competency — rather than relying so heavily on one examination score alone.**

Oregon, like many states, faces growing mental health needs and workforce shortages. Thoughtful flexibility and supportive remediation pathways could help retain experienced, compassionate clinicians while still protecting public safety.

Thank you for your time, consideration, and willingness to evaluate these important issues.

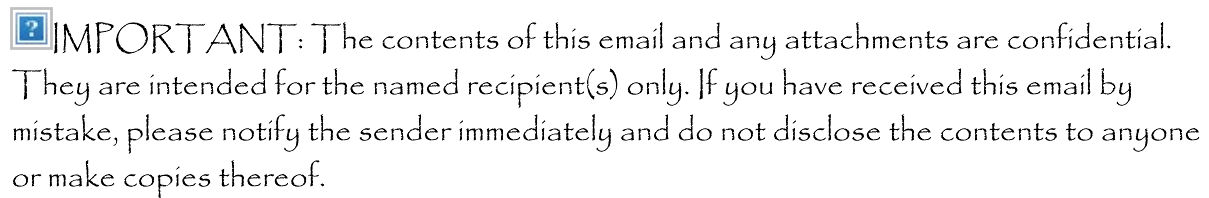
Sincerely,

Alexandra Du Toit
Bend, Oregon

(818) 941-7910

--
In gratitude,

~Alex~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From:	Alex Du Toit
To:	STASHEK LaRee * MHRA
Subject:	Fwd: MFT Examination Free Retest for - [Alexandra Du-Toit]
Date:	Wednesday, May 20, 2026 8:09:36 AM

You don't often get email from alexandradutoit@gmail.com. Learn why this is important

I wanted to forward the email I received yesterday from PTC and AMFTRB regarding the 2026 MFT National Examination Handbook and examination content outline issue.

After learning yesterday morning that I narrowly missed passing the examination by 10 points, receiving this notification was both surprising and emotional to process. I spent many months studying extensively using the handbook and examination outline that had been provided to candidates, and during the examination I remember feeling confused by portions of the content emphasis and weighting that did not fully align with what I believed I had prepared for.

While I appreciate that candidates are now being offered a free retake opportunity, I also felt this situation further highlighted the immense pressure and consequences attached to one lengthy standardized examination — especially for experienced clinicians who have already completed graduate education, supervision requirements, and years of clinical experience.

I wanted to share this additional information as the Board continues reviewing proposed rule changes regarding examination failure and remediation pathways. I believe this situation illustrates some of the real-world concerns many clinicians face regarding reliance on a single high-pressure examination as the primary gatekeeper for licensure.

Thank you again for your time, consideration, and willingness to review these issues thoughtfully.

Sincerely,

Alexandra Du Toit
Bend, Oregon

---------- Forwarded message ---------
From: **PTC Test Administration** <notices@ptcny.com>
Date: Tue, May 19, 2026 at 2:02 PM
Subject: MFT Examination Free Retest for - [Alexandra Du-Toit]
To: Alexandra Du-Toit <alexandradutoit@gmail.com>

Dear Candidate,

AMFTRB recently identified that an earlier/incorrect version of the examination content outline was inadvertently included in a prior version of the 2026 MFT National Examination Handbook for Candidates, which you may have used while preparing for the examination.

Although the six domains of practice assessed on the examination remained the same, the number of items within five domains were adjusted as a result of the most recent Job Task Analysis study.

That this accidental error occurred is regrettable. To ensure a fair and equitable testing experience, we are offering you the opportunity to retake the examination at no cost. This option to sit for the examination will

remain available through December 2026.

As you prepare for the examination, please review the 2026 examination content outline contained in the [2026 Handbook for Candidates].

To take advantage of this offer, please:

1. Request a new code from your state board.
2. Go to PTC - Testing Application Portal.
3. Select your preferred test window.
4. Complete the application using your new state code.
5. Use your prior PTC ID number in the coupon code field on the payment page of the application.
6. If there are any questions, please contact PTC.

Thank you.

CandidateID: P69081587

PTC Logo

Phone: 212-356-0660
www.ptcny.com/contact

Dated: 5/19/2026

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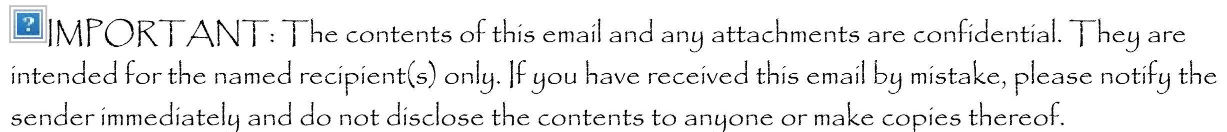
In gratitude,

~Alex~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From:	Michelle Fitz
To:	STASHEK LaRee * MHRA
Subject:	Public comment for OAR 833-020-0081
Date:	Tuesday, April 28, 2026 4:43:46 PM
Attachments:	Outlook-swikunf4.png

You don't often get email from michelle@healinghaven.net. Learn why this is important

Hello, I would like to support this passing:

Amend: Removes automatic
license denial and one-year wait period for licen-
sure candidates that fail the competency examina-
tion for a third time, and adds provision for study
plan after second failure.

Thank you,
Michelle

Michelle Fitz, LMFT, NCSP
She/her
Assistant Clinical Director & Therapist
The Healing Haven LLC
503-683-3223
Licensed in OR & WA

If you are experiencing an emergency or need immediate assistance, don't hesitate to get in touch with 911, go to your nearest Emergency Department, or call your local county or national crisis line:

Kaiser Emergency Psychiatric Services: 866-453-3932
Clackamas County Crisis & Support Line: 503-655-8585
Washington County Crisis Line: 503-291-9111
Multnomah County Crisis Line: 503-988-4888
Marion County PCC: 503-585-4949
National Suicide Prevention Line: 800-273-8255 or dial 988
Oregon Warmline (24/7 peer-to-peer): 1-800-698-2392

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If you have received this email in error, please call the therapist's name at the phone number and delete this copy from your system. Thank you for your cooperation.

From: Tam Werner-Fitz Gibbon
To: STASHEK LaRee * MHRA
Cc: Morgan Fitz Gibbon
Subject: Public Comments for Amending OAR 833-020-0081
Date: Wednesday, May 20, 2026 7:49:54 PM
Attachments: Licensing Exam Pass Rate Disparities in Marriage and Family Therapy.pdf

You don't often get email from tamara@rebelheartpdx.com. Learn why this is important

To the Oregon Board of Licensed Professional Counselors and Therapists,

We are writing as licensed members of the Oregon mental health workforce, clinical supervisors, and owners of Rebel Heart Therapy in Portland regarding the mandatory one-year wait period following a third AMFTRB or NBCC licensing exam failure. We are also writing specifically regarding the termination of Malik Campbell's associate license, #R7801. Malik is a skilled BIPOC queer clinician whose work has been especially important to BIPOC queer clients in our community.

We fully understand and support the Board's responsibility to protect the public and uphold ethical standards within our profession. We appreciate that the Board is reconsidering whether prohibiting supervised practice for a year following a third examination failure is counterproductive to professional development. We do not believe the current rule meaningfully serves the public. We believe that allowing clinicians to continue supervised practice with an individualized study plan would be more effective in promoting clinical competence, ethical judgment, and fitness to practice.

As clinical supervisors, we are required to provide ongoing evaluation and formal review of associate clinicians. When there are concerns regarding ethics, clinical judgment, boundaries, professionalism, or client care, those concerns are documented and addressed directly through supervision and Board processes. Those systems exist precisely because they provide meaningful information about a clinician's actual work with clients.

Finding a skilled BIPOC queer clinician with lived experience and deep cultural understanding is particularly difficult in Oregon. According to OHA's April 2025 report, An In-Depth Look at Oregon's Licensed Behavioral Health Workforce, 2018–2024, "American Indian/Alaska Native, Asian, Black/African American, Native Hawaiian/Pacific Islander, and Hispanic/Latina/o/x providers are underrepresented in Oregon's licensed BH workforce with Mexican providers especially underrepresented at 2.6% of the BH workforce vs. 10.1% of Oregon's population." (OHA, 2025)

We are unable to find any publicly available data regarding representation of LGBTQIA+ mental health providers, but it is reasonable to assume that BIPOC LGBTQIA+ clinicians make up an even smaller group within Oregon's behavioral health workforce.

A recent analysis of mental health licensing exam pass-rate disparities found that exam outcomes were not explained simply by whether someone knew the material or had good test-taking strategies. Instead, the strongest predictors of not passing were factors such as attending an online program, having inadequate disability accommodations, and being Black. When the researchers removed online program delivery from the analysis, being Black became the strongest predictor of not passing the exam. (Lyness et al., 2025)

The study does not suggest that Black clinicians are less capable. Rather, it raises serious concerns that the current exam process may disadvantage some groups of clinicians in ways that are unrelated to their actual ability to provide safe, ethical, effective therapy. In plain terms, this means the exam results appear to be shaped by structural factors beyond individual clinical knowledge or effort.

We also believe it is important to acknowledge the inequities embedded in the accommodation process. Accessing the level of formal testing and documentation often required to obtain examination accommodations can cost thousands of dollars and may be inaccessible for many associates early in their careers. The ability to obtain accommodations should not depend on financial privilege.

These findings matter because the current rule attaches severe professional consequences to exam outcomes without accounting for racial disparities, disability access barriers, educational disruption, or the limits of standardized testing as a measure of clinical competence.

Removing someone from the profession solely because they did not pass a multiple-choice examination after three attempts does not inherently protect the public. In cases like Malik's, it exacerbates existing barriers to culturally competent and affirming mental health care for Oregon's BIPOC residents.

Malik Campbell is a passionate, ethical, and deeply committed clinician who has served many BIPOC queer clients in our Portland community. Malik's circumstances align with the three strongest predictors of not passing identified in Lyness et al.'s analysis: online program delivery, inadequate disability accommodations, and being Black. He attended Lewis & Clark's Marriage & Family Therapy program during the global pandemic, when the program transitioned online. He has experienced financial barriers to accessing formal evaluation for suspected dyslexia. He is also mixed race, including Black, which aligns with the racial disparity identified in the study. These factors may have contributed to Malik's testing outcomes, particularly given that each unsuccessful attempt was by a very small margin.

On March 18, 2026, his associate license was revoked after his third attempt at AMFTRB's licensing exam. The loss of a compassionate, intelligent, culturally responsive clinician like Malik has had a real impact. Many of his clients had built trusting therapeutic relationships with him over years, and the abrupt loss of that care has been painful and destabilizing. In this case, the public lost access to a valuable clinician, over thirty clients lost continuity of care, and our community lost a therapist who is deeply needed.

Additionally, Malik was informed by AMFTRB that his most recent examination is eligible for a retake due to identified issues with preparation materials and testing-related resources associated with that examination cycle. If the testing organization itself acknowledges sufficient concern to permit a free retake opportunity, it seems deeply unreasonable and unnecessarily punitive for that same examination attempt to trigger loss of licensure eligibility for a full year.

As clinicians who have directly supported Malik through supervision and consultation, we can attest that he is clinically skilled, thoughtful, ethical, receptive to feedback, and deeply invested in the wellbeing of his clients. He has consistently demonstrated strong therapeutic skills, ethical awareness, professionalism, and dedication to growth as a clinician. At no point have we had concerns that would suggest he poses a risk to the public. What we have observed instead is someone who sometimes struggles with aspects of reading comprehension and writing that are easily addressed by reasonable accommodations in the workplace and do not negatively impact his clinical work.

We urge the Board to replace automatic removal from supervised practice with individualized study plans and to create a reinstatement pathway for associates affected by the current rule. If the exam itself introduces barriers to entry into the field for clinicians of color and those in need of disability accommodations, amending OAR 833-020-0081 removes an additional barrier and seems like a necessary first step. Reinstatement would allow Malik to continue serving his clients, develop professionally under supervision, and contribute to a field that desperately needs clinicians like him. It would also allow him to work through an agreed-upon study plan while remaining in supervised practice. We truly believe he will continue to do meaningful and important work in the mental health field if given the opportunity.

Thank you for your time, consideration, and dedication to the mental health of all Oregonians.

Sincerely,
Tam Werner-Fitz Gibbon, LPC #C4497
Morgan Fitz Gibbon, LMFT #T1128
Owners, Rebel Heart Therapy

Portland, Oregon

—

Sources

Healthcare Workforce Reporting Program, An In-Depth Look at Oregon's Licensed Behavioral Health Workforce, 2018 - 2024 (2025). Retrieved May 20, 2026, from https://www.oregon.gov/oha/HPA/ANALYTICS/HealthCareWorkforceReporting/Oregons%20Licensed%20Behavioral%20Health%20Workforce%202018%20-%202025.pdf.

Lyness, K., Gehart, D., Hannigan, B., Birge, B., & Ross, S. (2025). Licensing exam pass rate disparities in marriage and family therapy: Using an analysis of predictive factors to inform a more equitable licensing exam process. Contemporary Family Therapy, 47(3), 401–415. https://doi.org/10.1007/s10591-024-09729-5

Tam Werner-Fitz Gibbon (they/them)
MS, LMHC, LPC
CEO, Rebel Heart Therapy
https://www.rebelheartpdx.com/

If you or someone you know is in crisis and needs immediate assistance in Oregon, you can contact the Oregon Crisis Line. The Oregon Crisis Line provides confidential and supportive services 24/7 for individuals who are experiencing a mental health crisis or emotional distress. Here's how to reach the Oregon Crisis Line:

Oregon Crisis Line: Phone: call 1-800-273-TALK (1-800-273-8255) or text "OR" to 741741

Suicide & Crisis Lifeline: 988

These contact options are available around the clock, and trained crisis intervention specialists are ready to listen, provide support, and help connect you to appropriate resources and services.

It's important to remember that seeking help during a crisis is a sign of strength, and you are not alone. The Oregon Crisis Line is there to assist and support individuals facing mental health challenges. If you believe someone is in immediate danger or experiencing a life-threatening emergency, please call 911 for immediate assistance.

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Contemporary Family Therapy (2025) 47:401–415
https://doi.org/10.1007/s10591-024-09729-5

ORIGINAL PAPER

Licensing Exam Pass Rate Disparities in Marriage and Family Therapy: Using an Analysis of Predictive Factors to Inform a More Equitable Licensing Exam Process

Kevin Lyness[1] · Diane Gehart[2] · Brian Hannigan[1] · Barrie Birge[1] · Sheiketha Ross[1]

Accepted: 20 December 2024 / Published online: 6 January 2025
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Abstract
This article describes the findings of a study that explored potential factors that influence the pass rate for those taking marriage and family therapy (MFT) licensing exams, both the national and California exams. An online, national survey was conducted to determine factors associated with passing the MFT licensing exams. The survey included measures of test anxiety, coping strategies, perceived stress, and experience of discrimination. The demographic results included patterns of racial and age disparities similar to those reported by the Association of Social Work Boards (2022), especially for Black respondents. Specific and readily implemented recommendations for making the current exams more equitable include (a) changing the phrasing of questions, (b) clarifying and reducing the scope of the content, (c) reducing the number of questions during the 4-hour period, and (d) ensuring adequate accommodations for disabilities.

Keywords Licensing exams · Marriage and family therapy · Pass rates · Racial disparities · Age disparities

Standardized examinations are a common step towards state licensure within the mental health professions: marriage and family therapy (MFT), clinical mental health counseling.

(CMHC), clinical social work (CSW), and psychology. Despite the significance of such tests in the profession, little has been explored around specific factors that contribute to one's likelihood of passing or failing (Caldwell & Rousmaniere, 2022). As educators and trainers in the field of family therapy for decades, we have heard about our students' experiences of struggle with the exam and were curious if there were specific factors that were related to passing and failing this exam.

Currently, there are two clinical exams used for licensing marriage and family therapists: the "National Exam," overseen by the American Association of Marriage and Family Therapy Regulatory Boards (AMFTRB), and the California Clinical Exam, administered by California's Board of Behavioral Sciences (BBS). All states use the National Exam except California (AMFTRB, 2024; BBS, 2024). Many states add a supplemental part to cover their specific legal matters (AMFTRB, 2024; Caldwell et al., 2011). Both exams use a multiple-choice format, with four options (i.e., A, B, C, D) and rely heavily on vignette-based questions that require the exam candidate to apply professional knowledge. The national MFT exam has 180 questions, and California's Clinical exam has 170 questions.

This article describes the findings of a study that explored prominent factors that influence the pass rate for those taking the MFT licensing exams. Given limited research on the topic, this exploratory study aimed to identify possible connections between a wide range of factors, including demographics, university and fieldwork experiences, test anxiety, stress levels, coping strategies, and trauma history. Based on these findings, the discussion section includes

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Sheiketha Ross
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recommendations for exam improvement, including bridging age and racial pass rate disparities.

Current State of Research on Licensure Examinations

Research regarding factors that influence passing the MFT, CMHC, CSW, and psychologist examinations is limited, with much of the related literature being oriented towards other fields of health, law, and teaching professions (ABA, 2022; Allen & O'Dell, 2007; ASWB, 2022; Caldwell & Rousmaniere, 2022; Nettles et al., 2011). Below is a summary of relevant literature.

Family Therapy

Family therapy has minimal published research on its licensing exam. In 2011, Caldwell and colleagues conducted a study that examined whether students from schools accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) had higher exam pass rates than those from regionally accredited schools on the California licensing exams. They found that students who graduated from COAMFTE programs had significantly higher pass rates on the California exams than those who came from non-accredited programs. A potential difference may be that students with stronger traditional academic skills are accepted into the COAMFTE program (Caldwell et al., 2011).

One other article has looked specifically at the MFT licensure exam, though it is quite old at this point, using data from 1994 to 1996 (Lee, 1998). In that study, the author was able to examine actual total exam scores on the national exam in relation to questionnaire data gathered at the time the participant took the exam for over 1000 test takers over a three-year period. In that study, gender and age both affected scores, with women and younger respondents scoring significantly higher (Lee, 1998). The sample was over 90% White, with only 1.9% reported as Black. Lee reported that there was overall significant variability in scores by race, but the cell sizes were too small for meaningful group comparisons. Lee also found that 86% of this sample was taking the exam for the first time, with 10% taking it the second time, and 4% taking it for the third or more time, and that those who were taking the exam the first time scored significantly higher. In addition, test takers who had graduated more recently relative to taking the exam did better, and participants who used multiple preparation methods also scored significantly higher. Lee did not report pass rates for the exam, just total scores on the exam. One advantage of Lee's study is that the exam scores came from the testing service and the questionnaire was administered to those taking the exam directly, reducing response bias potential.

Counseling and Social Work

Regarding the exam for CMHC, one dissertation (Carr, 2016) was found that began to explore the presence of test-anxiety in students taking the National Clinical Mental Health Counseling Examination (NCMHCE). The CSW exam—governed by the Association of Social Work Boards (ASWB)—is more prominently written about, with Allen and O'Dell (2007) describing corollary, yet statistically insignificant relationships between passing the ASWB exam and being involved with a preparation course. More historically, Borenzweig (1977) concluded that neither age, sex, ethnicity, graduate school orientation, fieldwork, or supervisor credentials had any statistical bearing on passing the social work exam in California in 1977. Interestingly, the only statistically significant conclusion for Borenzweig was that people who passed were more likely to be in their own personal therapy than those who had failed.

Most recently, the ASWB (2022) published an in-depth analysis of pass rate data for their licensing exams. Their analysis included findings from test-takers from 2011 to 2021 on all five of their exams, with their clinical exam closest to licensing exams in family therapy, counseling, and psychology. They compared the "eventual pass rate" (p. 4) over the four-year period of 2018–2021 for all candidates taking the clinical exam based on gender, age, ethnicity/race, and primary language. Their analysis identified significant disparities based on age, ethnicity/race, and language but not gender. The eventual pass rate over a four-year period was 82.7% for women and 80.1% for men. In terms of age, they found that rates dropped significantly for older candidates. Over the four-year period of 2018–2021, pass rates varied by age as follows: 18–29 = 91.0%, 30–39 = 86.1%, 40–49 = 75.5%, 50 and over = 64.8%. A similar disparity in pass rates was found related to race/ethnicity: Black = 57.0%, Native American/Indigenous peoples = 73.5%, Hispanic/Latino/a = 76.6%, Asian = 79.7%, Multiracial = 86.6%, White = 90.7% (ASWB, 2022). The ASWB (2022) also found that candidates whose first language was English had an 83.4% pass rate, whereas 70% of candidates who spoke English as a second language passed.

In their discussion of age disparities, the ASWB (2022) identified factors such as increased family, financial, and professional responsibilities as a possible reason that older exam candidates may find it hard to prioritize exam preparation. Similarly, regarding racial disparities, they suggested that lower household income and wealth, educational inequities, and lower rates of health coverage as possible explanations. Additionally, they posited that stereotype

threat—an individual's fear that their test performance may confirm negative stereotypes—could also be a factor.

Psychology

The Examination for Professional Practice in Psychology (EPPP; Association of State and Provincial Psychology Boards, 2024) is the exam required for licensure as a psychologist. Sharpless (2019, 2021; Sharpless & Barber, 2013) has published several recent articles exploring factors that influence pass rates for the EPPP, including demographics and program characteristics. Sharpless has consistently found that minority racial status (especially being Black) is related to poorer pass rates on the EPPP.

Regarding program characteristics, Sharpless and Barber (2013) found that GRE scores, percentage of minorities in the program, and internship match rates were all predictive of pass rates for graduates, and they also found that those with PhDs passed the exam at higher rates than those with PsyDs. Chaparro (2020) also explored the effects of numerous variables (i.e., GRE scores, gender, program type, years to completion, etc.) on EPPP pass rates and found only admission rates of one's college/university to be statistically related to pass rates. As admittance rates decreased, pass rates increased (Chaparro, 2020). All other variables within Chaparro's work were unpredictive of passing the EPPP. In another study, Macura and Ameen (2021) spoke to pass rates for the EPPP and identified statistically significant relationships between passing the test and race (White psychologists had higher first-time pass rates), degree type, and institution accreditation status. Macura and Ameen (2021) also highlight anecdotal accounts of study material usage, study time, personal life factors (i.e., unexpected life events at time of exam), and challenges with test accessibility.

Racial Disparities

In their 2022 report, the ASWB (2022) concluded that systemic issues are likely related to ethnoracial differences in pass rates. They noted that historically marginalized groups often experience higher rates of socioeconomic hardship, higher poverty rates, inequities in educational resources, as well as lower rates of health coverage, wealth, and home ownership. These factors may affect exam candidates' access to preparation resources and time to study. Another possible contributing factor to pass rate disparities the ASWB identified was *stereotype threat*, defined as an individual's fear that their performance may reinforce preexisting negative stereotypes.

McWhorter (2022), a Black linguist at Columbia University, offered another explanation for ethnoracial disparities in exam pass rates. McWhorter believes that these disparities have an added dimension of social class, a factor identified as contributing to pass rates in this study. McWhorter cites a classic study in linguistics in which the language socialization of working-class Black families was compared to middle-class white families. In working class Black families, the conversations between parents and their children focused on practical problems: addressing problems in the real world with less reliant on book knowledge. In contrast, middle-class suburban parents engaged their children in conversations that involved "disembodied information-seeking," (para. 9) discussing facts for facts' sake with no direct real-world value. These linguistic differences have been observed across ethnoracial groups, meaning that White working-class families have patterns more similar to Black working-class families.

There have been several race-based critiques of licensure exams that are relevant here. Caldwell and Rousmaniere (2022) state:

> After more than 50 years of use, there remains no evidence that clinical exams in mental health care improve the quality or safety of that care. Absent such evidence, our reliance on these exams is built on trust, from professionals, policymakers, and the public…With ample evidence of racial disparity in exam performance, credible and longstanding criticisms that have not been adequately addressed, and potential conflicts of interest among boards serving as both exam buyers and sellers, that trust is not deserved. (Caldwell & Rousmaniere, 2022, p. 3)

Similarly, Kendi has said this:

> [T]oday, many Americans still imagine an achievement gap rather than an opportunity gap. We still think there's something wrong with the kids rather than recognizing the[re is] something wrong with the tests. Standardized tests have become the most effective racist weapon ever devised to objectively degrade Black and Brown minds and legally exclude their bodies from prestigious schools. (2020, para. 12)

The National Education Association subtitled their report on racism in standardized testing "From grade school to college, students of color have suffered from the effects of biased testing" (Rosales & Walker, 2021, p. 1). In discussing bias in teacher preparation programs Petchauer (2014) says: "Because African American test takers are roughly half as likely to pass basic skills exams on their first attempt compared to White test takers, this portion of the licensure exam is a key gatekeeper to the field and directly shapes the racial diversity of the profession." (p. 1).

Caldwell and Rousmaniere (2022) summarize the issue of race in licensure exams well:

> Clinical exams have been repeatedly shown to produce disparate outcomes on the basis of race and ethnicity. Rather than being passive recipients of existing disparities, evidence suggests that clinical exams add a unique layer of structural racism to the process of mental health licensure. Clinical exams also limit the mental health workforce by constraining licensure–a function that would make sense if there was evidence of their benefit, but without such evidence, only serves to reduce the supply and diversity of mental health care professionals available to serve the public. (p. 4)

There is a clear ongoing critique in the literature around race and racial bias in these exams, and our data contributes to that critique.

Psychological Testing Standards

Caldwell (2023) analyzed the current mental health licensing exams in terms of their adherence to industry standards for testing, specifically *Standards for Educational and Psychological Testing* established by the American Educational Research Association (AERA). Caldwell notes that mental health licensing exams fail to meet many of the required standards for fair and equitable testing. First, the exams do not meet the standards for *construct clarity*, which would require a clear description of what exactly is being tested. In stark contrast to testing norms, licensing exam test developers provide vague lists of general topics rather than clearly identifying the specific knowledge covered on the exam. Second, the author notes that these exams also fail to meet the standards of *construct validity–e*vidence that the test accurately measures what it says it measures–and *criterion validity*—the standard by which the scores are interpreted and used to make decisions. None of the licensing exam developers in mental health have taken reasonable efforts to assess whether these exams meaningfully assess a person's ability to be an effective, independent practitioner despite the use of these exams for decades to determine such readiness. The AERA standards also require that test developers ensure that their tests are *fair* to all test-takers, which most licensing exam test developers have ignored until recently. Finally, testing standards also require rigorous *statistical analysis* to ensure that individual exam items as well as the exam itself are not biased toward groups of test takers. However, developers of mental health licensing tests either ignore or downplay the importance of using statistical analysis to reduce test bias. Caldwell concludes that "the *overall structure* of these exams (primarily four-option multiple choice, with a single correct answer; often based on a very brief case vignette) is an inappropriate vehicle for performing and assessing 'knowledge' relevant to professional clinical practice" and recommends suspending licensing exams until the exams are able to meet the industry standards (p. 15; emphasis in the original).

Factors Influencing Examination Anxiety

A critical consideration when exploring exam pass rates is test anxiety. The consequences associated with test anxiety are far reaching and well documented, resulting in lower motivation (Elliot & McGregor, 1999), diminished cognitive ability, and reduced immune system function, which all lead to lower test scores, grades, and opportunity *(*Eysenk & Calvo, 1992, Sarason, 1988; Zatz & Chassin, 1983). Test anxiety has been found to affect females more than males (El-Zahhar & Hocevar, 1991; Speilberger, 1980; Zeidner & Nevo, 1993). Females may perceive test taking as more threatening, experiencing emotions such as fear, worry, and anger. Males may experience test taking as more of a "personal challenge" (Peleg-Popko, 2004, p. 649), using anxiety in a more productive way.

Research about specific factors affecting individuals taking the MFT licensing examination is sparse. However, becoming a licensed MFT takes an enormous commitment of time, energy, and resources. Although states have the final say in what is required to be a licensed practicing MFT (Lyness, 2020), the amount of work to become a clinician is significant. The overall stress of completing: eleven required courses, a specific amount of supervised client clinical hours, at least 1000 h of postgraduate clinical work and 200 h of postgraduate supervision, and a passed licensing exam is anxiety provoking (West et al., 2010). Test anxiety, a multidimensional issue, includes worrying about exams, lack of confidence in test performance, thinking about failure and the consequences. The emotional part of test anxiety includes feelings of "tension, apprehension, and nervousness towards [an] exam" with congruent somatic feelings experienced, such as "nausea, sweating and increased heart rate" (Sansgiry et al., 2005, p. 122). Also contributing to test anxiety is a student's perception of how difficult the study material is. Research to identify specific stressors that affect Doctor of Pharmacy students was done at two diverse universities, Howard University and the University of Houston (Sansgiry et al., 2005). Test anxiety has been negatively attributed to academic performance, academic competence, test competence, and time management (Sansgiry et al., 2005). An empirical study of test anxiety revealed that academic competence and test competence predictors were the most significant predictors of test anxiety (Sansgiry et al., 2005). At the University of Houston, students were

comfortable with their pharmacology classes. However, the study material given to the students for the exam and the amount of preparation time necessary may have increased test-taking anxiety (Sansgiry et al., 2005). This research is cited, along with earlier noted research on test anxiety in the counseling exam (Carr, 2016), to show that there may be a link between this anxiety and performance on important professional examinations like the licensure exams in MFT. Carr's study is the only study we could find that directly examined the link between test taking anxiety and professional licensure exams, but we felt this was an important variable to explore for the LMFT exams.

Stress, in general, is part of most academic and licensure testing. However, when stress becomes extreme, it leads to anxiety and ultimately impacts academic achievement. Student stress seems to be universal. A review of the study done by Kumari and Jain (2014) in India showed signs of stress that impact exam achievement is: insufficient or irregular sleep, feeling tired, isolated or sad, experiencing somatic conditions; upset stomach, restlessness, which all led to the inability to recall what the students have studied (Kumari & Jain, 2014). Addressing stressors: lifestyle (rest, nutrition, and time management), preparation of information before the test (date of exam, location of exam, content covered, paperwork required), while reducing catastrophic thinking ("there is no way I am going to pass this") and irrational thoughts ("I will hate myself if I fail") (Kumari & Jain, 2014) are all critical to reducing examination stress.

Another study researched undergraduate nursing students and the factors that influenced their examination anxiety. Once again, the researchers determined too much stress confuses, exhausts, and overwhelms students' test-taking ability. Three hundred and forty undergraduate nursing students (90.3% female) with a majority of 61% experiencing average amounts or no test anxiety, 25% with mild test anxiety, and 2% experiencing severe test anxiety were the sample (Vaz et al., 2018). The study looked at four factors impacting test anxiety: "learning process" (study habits, preparedness, course content, sleep pattern, motivation), "perceptions related to examinations" (confidence level, expectations, experience, test situation, health aspects, and recall), "learning patterns" (how students deal with challenging subjects, time management, revision), and "over expectations related to learning outcomes" (expectations of parents and student) (Vaz et al., 2018). The research showed that all four factors had a positive correlation (0.05) to examination stress. Perceptions related to examination and learning patterns had a moderate correlation (r=.655 and r=.368), and the least correlated factor was over expectations related to learning outcomes factor and had the weakest correlation (r=.017 and r=.132) (Vaz et al., 2018). Results from the study point to elements that contribute to stress; study habits, past experiences, health aspects, course content, test situation, motivation, self-concept, the expectation of student and parental pressure may impact examination anxiety.

There is some research that specifically looks at the role of coping with stress and test anxiety in professional examinations (see Amate-Romera & de la Fuente, 2021). We were interested in exploring whether specific coping strategies would be related to passing the LMFT exam, including exploring emotion-focused and problem-focused coping (Amate-Romera & de la Fuente, 2021; Tobin et al., 1989).

Context for Current Study

Minimal research exists on predictive factors related to exam pass rates on MFT exams specifically and mental health licensing exams more broadly. Both prior studies on MFT pass rates are well over a decade old, with one reporting on data from the mid 1990s (Caldwell et al., 2011; Lee, 1998). These studies identified the following factors related to passing the MFT exam: age, gender, COAMFTE-status of graduate program, number of exam attempts, and timing of exam relative to graduation. Significant variability was identified in scores by race, but the cell sizes were too small in the study for meaningful comparisons (Lee, 1998). More recently, the ASWB (2022) released a report indicating age and race disparities in their exam pass rates. Additionally, in a recent analysis, Caldwell (2023) determined that the current mental health licensing exams fail to meet industry standards for fair and equitable testing. Other research has indicated that text anxiety is a significant factor affecting general exam pass rates, affecting women more than men. In addition, coping factors in dealing with stress have been linked to test anxiety in professional examinations. Anecdotal information and the stories told to us as educators suggest that there may also be other significant barriers to passing the licensure exam and so in this exploratory study we sought to examine all of these factors and how they contribute to passing the licensure exam. Additional variables of interest from these more informal sources included overall levels of perceived life stress, experiences of discrimination, as well as several specific barriers, including those related to logistics around the examination process, adequacy of disability accommodations, and factors related to the Covid-19 epidemic. Our overall research question was to explore which of these factors was significant in predicting whether participants reported passing the LMFT licensure exam. While we had some directional hypotheses (e.g., that test anxiety would be negatively related to passing the exam) we approached the analysis in an exploratory fashion trying to identify significant factors reported by participants related to their reported passing of the exam.

Method

Sampling

Participants were recruited through convenience sampling via emails to program directors in accredited marriage and family therapy programs, via postings to social media, and via emails to email lists accessible to the authors. A second round of emails and postings was designed to recruit additional participants who had not passed the exam as our initial sample was overrepresentative of those who had passed. Data collection took place over about two-and-a-half months at the end of 2021 and start of 2022.

Procedure

We utilized SurveyMonkey (www.surveymonkey.com) as our online survey platform, and our survey was only available in English. The survey started with an informed consent document followed by demographics and measures. The research was approved by the university Institutional Review Board as an exempt study. It took respondents an average of 29 min to complete the survey.

Measures

We utilized four already established measures for several key constructs: test anxiety, coping strategies, perceived stress, and experiences of discrimination. We then added additional questions regarding other variables of interest and demographics. Each of these is described further below.

Westside Test Anxiety Scale

The Westside Test Anxiety Scale (WTAS; Driscoll, 2007) is a short 10-item measure of test anxiety that has been demonstrated to be correlated with test performance and is a reliable indicator of impairment in test performance (Driscoll, 2007). The ten items are measured on a 5-point Likert-type scale (1 – *not at all or never true* to 5 – *extremely or always true*), and the overall score is an average of those scores (ranging from 1 to 5). The WTAS was designed to identify individuals who would benefit from an anxiety-reduction intervention to improve test performance.

Coping Strategies Inventory – Short Form

The Coping Strategies Inventory – Short Form (CSI; Tobin et al.,1989) is a 32-item measure of coping to manage stress. There are several ways to interpret the measure. The first is to look at 8 primary subscales or primary factors (Problem Solving, Cognitive Restructuring, Emotional Expression, Social Support, Problem Avoidance, Wishful Thinking, Self-Criticism, and Social Withdrawal). These can be combined into four secondary factors (Problem Engagement, Emotion Engagement, Problem Disengagement and Emotion Disengagement) and two tertiary factors (Engagement and Disengagement) (Tobin et al., 1989). We utilized the primary factors in our analyses.

Perceived Stress Scale

The Perceived Stress Scale (PSS; Cohen et al., 1983) is a short 10-item measure of respondents' perceptions of the amount of stress experienced in the past month. The items are measured using a 5-point Likert-type scale (0 – *never* to 4 – *very often*). Four of the items are reverse-scored, and the overall score is a total of the items, ranging from 0 to 40. In addition to perceived stress, we asked a few questions about history of trauma.

Everyday Discrimination Scale

The Everyday Discrimination Scale (EDS; Williams et al., 1997) is a short measure of 10 questions that get at experiences of discrimination as well as the attributed reason for that discrimination (including a wide range of possible reasons). The first nine items are measured on a 6-point frequency scale (1 – *never* to 6 – *almost everyday*) while the final item asks what the respondent believes is the main reason for experiences, with response items include ancestry or national origin, gender, race, age, religion, and so forth. The overall score is a sum of the first nine items.

Additional Measures

Our primary measure of exam success was the question "Have you passed the LMFT licensure exam?" (*yes* or *no*). We also asked how many times the respondent had taken the exam, with those answering "one" having passed the exam on the first try. With this information, we were able to know whether someone passed on the first attempt, passed on a subsequent attempt, or had not yet passed the exam, though for many analyses we simply used pass/not passed as the criterion variable. Respondents were also asked whether the exam was the national exam, the California exam, or both.

We asked a series of demographic questions, about age, ethnicity, gender, sexual orientation, marital status, income, and employment status. In addition, we asked about highest degree level, type of degree and subject area, and whether the program was accredited by COAMFTE (*yes/no/unsure*), as well as the location of the program (by state) and the delivery model (face-to-face, online, hybrid).

Respondents were also asked questions about challenges and barriers to successfully passing the exam. One question asked about whether the respondent struggled with test anxiety, with knowledge of the content of the exam, and/or with knowing the correct test-taking strategy for the exam, while another question about barriers to taking the exam (such as logistics, inadequate disability supports, language barriers, etc.). These were in the form of checklists where respondent checked off barriers or struggles that they had experienced. For some analyses, we looked at a count of the number of barriers reported. Finally, we asked some questions about exam preparation materials used and strategies and time put in to studying for the exam.

Results

Of the 340 people who started the survey, 317 submitted it. On average it took about 29 min to complete the survey. After accounting for missing data, we had 270 complete surveys. IBM SPSS Statistics (Version 26) was used to analyze the data.

General Exam Outcomes for Respondents

Overall, 78% had passed the exam (passed 1st attempt, $n=197$, passed on 2nd or subsequent attempt, $n=47$, not passed, $n=69$). Nearly 70% of respondents had taken the exam once while nearly 7% had taken the exam 4 or more times (the highest was 12 times). Regarding which exam was taken, 64.2% took the National exam, 31.9% took the CA exam, 3.8% took both. Pass rates were similar for those taking the national exam ($n=198$; 75.8% passed), the CA exam ($n=99$; 80.8% passed), or both ($n=12$; 91.7% passed) ($X^2(4)=3.02$, $p=.56$).

Demographics

The mean age was 43.46 ($SD=12.2$). Those who passed on the first attempt were significantly younger ($M=41.86$) than those who had not passed ($M=46.25$) (overall $F(2,309)=4.68$, $p=.01$, Tukey HSD post-hoc test $p=.03$). (The p value comparing passed on 1st vs. subsequent attempts was 0.07, and mean age of that group was 46.13).

The sample was 88% female, 11.7% male, and 0.3% gender queer. Gender identity was unrelated to pass rates ($X^2(4)=1.53$, $p=.82$). The reported sexual orientation in the sample was 86% straight, 5% bi, 3.5% lesbian, 2.5% queer, 2% something else, 0.6% gay, 0.6% preferred not to say. Reported sexual orientation was also unrelated to pass rates ($X^2(12)=11.63$, $p=.476$).

The sample was relatively middle class, with only 15% reporting incomes less than \$50k/year, and almost 22% reporting family income over \$150k/yr. Nearly 75% were employed full-time, with fewer than 6% not working. Income was related to pass rates ($X^2(12)=57.85$, $p<.001$), with those with higher income more likely to have passed on the first attempt and less likely to have not passed. Similarly, employment status was significantly related to pass rates ($X^2(4)=11.47$, $p=.02$), with those working part-time more likely to have passed on the first attempt and those not working for pay more likely not to have passed yet.

Regarding marital status, the sample was 60.8% married, 19.3% single, 10.8% cohabiting, and 9.2% divorced. Marital status was significantly related to pass rates ($X^2(6)=28.35$, $p<.001$), with married respondents being more likely to have passed on the first attempt than those reporting other marital statuses.

The sample was fairly diverse regarding race; 59.5% White ($n=187$), 13.9% Black ($n=44$), 12% Latino/a ($n=38$), 4.1% Asian American/Asian ($n=12$), 2.5% other race ($n=8$), 7.9% multiracial ($n=24$). Race was significantly related to passing the exam ($X^2(5)=38.34$, $p<.001$). The pass rates for each group were as follows: White, 87%, Black, 48%, Latino/a, 66%, Asian or Asian/American, 75%, other race, 63%, multiracial, 87.5%.

Regarding education, 86.7% had a master's degree, with 10.8% having a PhD, and 2.5% a professional doctorate. Regarding COAMFTE accreditation, 74.4% said yes, 17% said no, and 8.5% were unsure; 88.6% had degrees in C/MFT. Those with PhDs and professional doctorates were more likely than those with master's degrees to have passed on the first attempt ($X^2(4)=9.83$, $p=.04$), but graduating from a COAMFTE-Accredited degree program was unrelated (74.1% graduated from a COAMFTE program; $X^2(4)=8.37$, $p=.08$). Program delivery model was strongly related to pass rates, with students from online programs (37% passed, group $n=31$) being less likely to have passed the exam, while those from face-to-face programs (82% passed, group $n=244$) and hybrid or low-residency programs (82% passed, group $n=49$) were more likely to have passed ($X^2(2)=28.95$, $p<.001$). Because the face-to-face and hybrid programs had essentially the same pass rates, for later comparisons online vs. not-online was used. Programs were located in 38 states or territories and 4 other countries (but not Canada), and 36% of respondents went to CA graduate programs (next highest was KY and MN at 6% each).

Preliminary Analyses

We conducted a number of preliminary analyses exploring variables of interest. Self-reported hours of studying was significantly related to pass rates—those who studied

more were less likely to pass (probably because folks who knew they might struggle studied more but still struggled). There was also a small but significant positive correlation (r=.123, p=.032) between hours studying and number of times taking the test.

We asked if the respondents' programs had provided exam preparation training as part of the program (nearly 70% of programs did not provide this), but this was unrelated to pass rates (X^2 (4) = 7.13, p=.13). Nearly 93% of respondents reported using formal test preparation materials (and 20 of the 22 people who did not use formal test prep materials passed the exam on the first attempt, skewing the results such that using test prep materials was related to not passing the exam). Those who reported using test prep materials reported significantly *more* test anxiety than those who did not, likely indicating that those who are more anxious are more likely to use those materials ($t(309) = 2.50$, p=.013). A more useful measure looked at how useful respondents found the test prep materials, and unsurprisingly those who had not passed the exam were less likely to find the materials helpful (scale of 1 – *a great deal* to 5 – *not at all*) (oneway ANOVA $F(2, 287) = 18.43$, $p < .001$; $M_{(\text{passed 1st})} = 1.56$, $M_{(\text{passed 2+})} = 1.48$, $M_{(\text{not passed})} = 2.30$). *Kendall's Tau b* correlation was 0.228 ($p < .01$).

We explored barriers experienced that may have interfered with taking the exam. We looked at this data a couple of different ways. First, we created an index that was a count of how many of the barriers were experienced (range 0 to 7, M = 1.25, SD = 1.34). This index was significantly related to pass rates, with those having not passed reporting significantly more barriers than those who has passed on the first or subsequent attempts ($M_{(\text{not passed})} = 2.03$, $M_{(\text{passed 1st})} = 1.01$ [$p < .001$], $M_{(\text{passed 2+})} = 1.13$ [p=.001]). We also used logistic regression (looking at the binary variable passed or not passed) to explore which of the barriers was most predictive of not passing the exam and found that only two barriers significantly predicted not passing while controlling for all the others. These were *inadequate disability accommodations* (OR = 4.71, p=.008) and *difficulty with logistics* (OR = 5.19, $p < .001$). One note is that African American respondents were more likely to report having difficulty with logistics ($X^2(1) = 10.05$, p=.002) and there was also a significant effect when looking at passing or not passing the exam ($X^2(1) = 21.10$, $p < .001$), where there was a significant difference in percentage of those reporting no difficulty with logistics by race (but the lack of logistical difficulties was more salient for non-Black participants, with 85.4% of non-Black participants who passed the exam reporting no logistical difficulties, but only 59.0% of Black respondents who passed reported no logistical difficulties—meaning that not experiencing logistical difficulties was more beneficial for non-Black respondents).

We also explored the role of trauma, focusing on a question that asked how much negative effect on current functioning the participant reported (from 1 = *a great deal* to 5 = *none*). Those who had passed the exam reported significantly lower effects from trauma than those who had not passed (M = 3.07 vs. 3.78, $t(285) = 3.96$, $p < .001$). This variable was also related to other study variables: WTA $r = -.224$**, ED $r = -.183$**, PSS $r = -.377$**. There were also significant correlations with almost all of the coping measures.

Primary Results

Logistic regression was chosen as the best analytic strategy to explore what best predicts passing the exam. While we also had a three-group classification (passed on 1st attempt, passed on 2nd or subsequent attempt, not passed), the relationship of nearly all of the predictor variables with this three-group classification was linear. While we could use discriminant function analysis, it is less robust, especially to unequal group sizes like we have here. Logistic regression also provides easy-to-understand odds ratios and each predictor shows how strong the effect is while controlling for all of the other variables and we felt it provides the best and most parsimonious analysis of the data.

To that end, the first step was to examine bivariate relationships, looking for significant relationships with the binary pass/not-pass variable. The everyday discrimination variable was eliminated due to very low correlations with study variables. We decided to include all of the coping strategies in the first regression analysis even though several showed low correlations with the primary outcome variable for theoretical reasons (variables that have theoretical similarity are often retained in hierarchical regression models at the first step).

The second step was to create a stepwise logistic regression. The first block included demographic variables (age, being Black vs. non-Black, family income, being married vs. non-married). Because the primary differences in preliminary analyses were between Black vs. non-Black and married vs. non-married respondents, these simplified dummy variables were used in the regression (in the second block we similarly used online vs. other delivery models). A second block included variables related to the testing (specific barriers related to logistics and disability accommodations, test anxiety, perceived stress, online delivery model, trauma effects, struggles with test content and test strategy). The third block included coping strategies.

The final step in the regression process was to simplify the model by eliminating variables with p values greater than 0.25 (trauma effects, social contact, prob avoidance,

and wishful thinking). Each step of the regression showed significant improvement in the model.

See table for final model results Table. 1.

The predictor with the largest odds ratio is coming from a program with an online delivery model (OR = 7.45), followed by inadequate disability accommodations (OR = 4.90) and being Black (OR = 3.30). Although struggling with test content and strategy both had relatively large odds ratios, they were not significant predictors of passing when controlling for these other variables.

One result of note is that one strong predictor of not passing the exam is being Black (OR = 3.30). We did several additional analyses to explore this result. There were no significant differences by race on any predictors of pass rates (e.g., text anxiety, number of barriers, perceived stress, etc.) except for family income and program delivery model. Black respondents had less income ($t(312) = 3.80$, $p < .001$), and were more likely to have attended online programs ($X^2(2) = 16.96$, $p < .001$), and each of these are predictors of lower pass rates. Further analysis of delivery model also shows a racial effect. More Black students went to online programs (24% of Black students vs. 6% for non-Black; overall $X^2(2) = 16.96$, $p < .001$) and Black students who went to online programs were less likely to have passed the exam than non-Black students at online programs (17.4% of non-Black students in online programs had not passed compared to 39.1% of Black students). In fact, if you remove delivery model from the regression analysis, being Black becomes the variable with the largest odds ratio predicting not passing the exam.

Table 1 Hierarchical logistic regression examining passing or not passing licensure exam

Predictor	B	SE B	Odds Ratio
Age	0.07**	0.02	1.07
Black	1.2*	0.58	3.30
Family Income	-0.45**	0.16	0.64
Not Married	0.56	0.45	1.75
Westside Test Anxiety	0.79**	0.29	2.19
Perceived Stress Scale	0.10**	0.04	1.11
Barrier: Logistics	1.19	0.64	3.29
Barrier: Inadequate Disability Accommodations	1.59*	0.74	4.90
Online Delivery Model (vs. F2F or Hybrid)	2.01**	0.71	7.45
Struggled with test content	0.77	0.48	2.16
Struggled with test taking strategy	0.89	0.50	2.44
Expressing Emotions	-0.55*	0.25	0.58
Self-Criticism	0.50*	0.22	1.66
Social Withdrawal	-0.73*	0.29	0.48
Constant	-6.65	2.15	

Notes: Overall model $X^2(15) = 131.96$, $p < .001$. Outcome variable coded 1 = *Passed Exam*, 2 = *Not Passed*

* $p < .05$, ** $p < .01$

Barriers: most did not show significant differences comparing Black to non-Black respondents. One exception was Difficulty with Logistics of the exam ($X^2(1) = 10.05$, $p = .002$). (Black respondents reported this difficulty 22% vs. non-Black 7.5%). However, follow-up analysis showed that Difficulty with Logistics was only significantly related to not passing exam for non-Black respondents, so even though they reported this barrier more often, it was less likely to affect their passing the exam. The pass rate for Black respondents was virtually identical when looking at the national exam (51% passed) vs. CA exam (50% passed). For non-Black participants, it was 81% passed for national and 84% passed for CA. So, the exam pass rates for Black respondents cannot be explained by differences in other variables (like test anxiety, coping strategies, stress, barriers, or difficulties, each controlled for in the analysis and not demonstrating any difference between Black and non-Black respondents). One key consideration, though, is program delivery.

Discussion

Recently, the AAMFT Diversity, Equity, and Inclusivity Oversight Committee (2024) published results from a membership survey with current demographics, though the response rate was only 1.5%, and it was a survey on diversity, so it is difficult to know how representative these results are. Regarding race, our results were comparable though the AAMFT sample was slightly more diverse (53% White, 11.5% African American, 6.4% Latinx/Hispanic, and 4.1% Asian/Asian American). Our respondents were more likely to be female (88% vs. 63.8% in the AAMFT sample). Our sample was significantly younger (58.2% of our sample was under age 45, compared to only 30.6% of the AAMFT sample) though this makes sense given we were targeting those who had recently taken the licensing exam. Our sample also consisted of more respondents with just a master's degree (86.7% compared to 66%), though again this makes sense given that the master's degree is the qualifying degree for licensure.

The data from this study closely parallel the findings from ASWB's 2022 exam analysis related to gender, age, and ethnoracial identity. Both studies (ours and the ASWB's) found no significant difference in terms of pass rate based on gender. Similarly, our study did not find differences based on sexual orientation. However, both studies found a significant difference based on age, as did Lee (1998) (Table 2).

In terms of ethnoracial identity, both our study and the ASWB data showed significant disparities, which is similar to research results on licensing exams in teaching, nursing, law, pharmacy, and social work (ASWB, 2022). In both

Table 2 Comparison of this study's age data and ASWEB 2022 data

Pass rate by Age	Current study of MFTs	ASWB 2022 (Clinical exam)
18–29	88.5%	91.0%
30–39	81.6%	86.1%
40–49	77.8%	75.5%
50+	70.7%	64.8%

Table 3 Comparison of this study's Ethnoracial identity data and ASWB 2022 clinical exam data

Pass rate by Ethnoracial identity	Current Study of MFTs	ASWB 2022 (Clinical Exam)
Black	48%	57%
Other race	63%	Not reported
Native American	No responses	74%
Latino/a/x	66%	77%
Asian/Asian American	75%	80%
White	87%	91%
Multiracial	88%	87%

this study and the ASWB study, Black identifying exam candidates had significantly lower pass rates compared with white candidates, followed by "other" race, Native American/indigenous, and Latino/a/x. Lee (1998) did not have enough minority respondents to meaningfully analyze group differences.

The consistency and parallel findings in the ASWB and current study reveal a concerning pattern, especially when licensing exams are considered within the broader context of formal, standardized exams. In contrast to most standardized exams such as the Scholastic Aptitude Test (SAT) in which Asian-American candidates often outperform all other candidates (Reglin & Adams, 1990), in both our study and the ASWB study, white candidates had an 11–12% higher pass rate than Asian-Americans, indicating that a different testing dynamic may be at play with licensing exams compared with traditional high-stakes college exams. At this time, McWhorter's (2022) explanation that points to specific linguistic skills due to social class enabling white children to develop more "disembodied, information seeking" (McWhorter, 2022, para. 9) abilities is the leading theory for why licensing exams have a distinct racial disparity pattern (Table 3.

Coping Strategies

The CSI-SF secondary factors include Emotion-Focused Engagement and Emotion-Focused Disengagement (as well as Problem-Focused versions of both; Tobin et al., 1989). Three of the four Emotion-Focused scales were significant predictors in the final regression analysis, with two of those in expected directions (self-criticism positively predicts not passing the exam while emotional expression is associated with passing the exam). It was somewhat surprising that problem-focused coping strategies were not predictive of passing the exam, as might have been expected (see Amate-Romera & de la Fuente, 2021). What was interesting is that social withdrawal was associated with passing the exam (the fourth Emotion-Focused strategy is Social Contact, which was not a significant predictor of passing the exam). It may be that in this instance withdrawing from friends and others may be an adaptive strategy—perhaps reducing negative influences. Interventions focused on coping strategies may then focus on reducing self-criticism. These findings were significant in the regression analysis denoting that these coping strategies are significant predictors of passing the exam while controlling for the demographic and other factors.

Recommendations for Short-Term Adjustments to Licensing Exams

Licensing of family therapists is a complex ecosystem with multiple interlocking bureaucratic systems, including individual state licensing boards, state legislatures, exam creators and administrators, hundreds of universities, several professional organizations, and professional accrediting bodies. None of these systems makes changes quickly alone. Trying to make sweeping changes across multiple of these systems is a daunting task that will require higher levels of cooperation than we have typically seen in the past. Nonetheless, strategic modifications to existing exams and exam practices should be the first step in reducing disparities in exam outcomes. These modifications include:

Changing the Phrasing of Questions

Given McWhorter's (2022) explanation for racial disparities on mental health licensing exams that rely heavily on disembodied information, the use of over one hundred hypothetical scenarios to test a candidate's clinical skill appears to be contributing to ethnoracial disparities in pass rates. The ability to analyze disembodied scenarios unfairly favors those who have more experience with such linguistic exercises and has been largely attributed to the social class of one's family of origin. Vignettes never capture the richness and complexity of real-life clinical situations, and exam candidates tend to fill in the gaps of the vignette with their own clinical and personal experience, often introducing assumptions and issues that were not in the written vignette. To reduce the bias, test-writers should write exam questions that clearly and objectively measure the candidate's

knowledge of well-established principles without the use of hypothetical scenarios that easily introduce bias and cultural assumptions. It is interesting to note that the recent revision of the National Clinical Mental Health Counselor Exam takes the opposite approach: It offers much *longer* clinical vignettes than other mental health exams do, utilizing 11 case examples (NBCC, 2024). This may serve the same ends: It may reduce instances of examinees adding their own assumptions and biases into exam questions, though there is not yet evidence of this.

For example, California's current clinical exam outline includes the following sample question (BBS, 2024, p. 27):

> A therapist is currently involved in a contentious divorce and perceives his spouse as aggressive and unreasonable. The therapist begins meeting weekly with a colleague for consultation to prevent his feelings from impacting therapy with his clients. Three weeks later, a client who has been in ongoing therapy for symptoms of depression begins describing relationship difficulties that are similar to what the therapist is experiencing. Which of the following actions should the therapist take to manage the ethical issues involved in this case?

a. Provide continued treatment to the client and discuss the case with the colleague to monitor own feelings.
b. Utilize limited self-disclosure and reassure the client of the therapist's understanding to enhance therapeutic empathy.
c. Explain the potential for bias on the part of the therapist and refer the client to an alternate therapist to provide ongoing treatment.
d. Contain the therapist's own feelings and focus discussions on the client's depression to maintain consistency with established treatment goals.

This question is attempting to assess the candidate's knowledge related to ethical practice, specifically 3.3 of the AAMFT (2015) Code of Ethics:

3.3 Seek Assistance. Marriage and family therapists seek appropriate professional assistance for issues that may impair work performance or clinical judgment.

None of the four answers clearly and unambiguously align with the ethical standard. Instead, the candidate is expected to *apply* the standard to the vignette and the four answer options. However, many assumptions and leaps of interpretation need to be made, which is the most likely source of the current ethnoracial pass rate disparities. Consider the process of answering this question:

1. The first option involves continuing doing what he is already doing, which is discussing the case with a colleague. The problem with this response is twofold: (a) he is not doing anything new or different now that the client reveals he is in the same situation as the therapist, and (b) arguably talking with a colleague is not "seeking appropriate professional assistance." A colleague is likely to be a friend and biased and may or may not have sufficient clinical experience to be helpful. Professional assistance would more commonly be defined as a supervisor, personal therapist, or consultant.
2. The second answer involves providing limited self-disclosure to promote empathy, which some theories would support. Some therapists considered this an appropriate clinical response, but not all would agree. However, the question asks about managing the ethical issues in the case, and this response relates more to clinical issues.
3. In the third option, the therapist is going to great lengths to ensure crystal clear boundaries and avoid harming the client due to his personal issues. However, from the vignette, it is not clear whether he is impaired to the point of warranting a referral, which ultimately costs clients money and lost time and typically creates emotional distress.
4. The last option describes how the therapist manages the situation by not bringing up their personal issues and instead focusing on the presenting problem. Depending on the situation, this may be an appropriate direction.

An exam candidate who is familiar with the standard reads these four answers, there is no quickly identifiable correct answer that directly aligns with the standard. Instead, the candidate must sift through several options that each has some merit. To identify the correct answer, the candidate must notice in the stem that the question asks about what the therapist "should" do to manage ethical issues, which makes B and D less desirable because they primarily address clinical issues. This is the first place where candidates have more experience with "disembodied information" can catch the subtle linguistic distinction in the question.

Then the candidate is left deciding between A and C, with the former describing continuing to do what the therapist was doing before, which is talking with a colleague but not a typical form of "professional assistance," and the later moving in a very cautious and conservative direction, which is often the correct answer on licensing exams. The candidate is left to decide whether to go with an option that is less formal than the described in standard or a more conservative option based on the vignette. This is another point where experience and fluency with "disembodied information" benefits the candidate in weighing the pros and cons. This is

also an example of how knowing the ethical standard does not ensure answering the question correctly.

In contrast, shifting to a style of question that eliminates ambiguity and directly measures knowledge of clearly identifiable and agreed upon exam content would make it possible for all exam candidates to identify the correct answer. Using the above question as an example, a less ambiguous way to assess knowledge of the same ethical standard.

If a therapist is experiencing countertransference with a client, the ethical standards include the following guidance:

1. The therapist is instructed to seek professional assistance to help them address issues that may impair their judgment or performance.
2. The therapist is encouraged to use transparency and appropriate self-disclosure to communicate their empathy with the client's experience.
3. The therapist is required to immediately refer out all clients with whom they experience countertransference to ensure clear boundaries and avoid any possible harm.
4. The therapist is directed to redirect the session to focus on topics that are more comfortable for the therapist.

The correct answer (A) is much easier to identify when the question is phrased with a focus on factual knowledge and without applying the ethical standard to a hypothetical case.

Increasing Content Clarity of and Reducing the Scope of Content

The age disparity in pass rates that begins with candidates in their 30s in both the present study and the ASWB (2022) study is best explained by older students who typically have more family and work commitments and less time to study rather than age-related cognitive decline. Having more clearly defined and narrowly focused content to study would likely help reduce the current age disparities. In the course evaluations of an exam preparation program, candidates reported studying an average of 100 h, with many spending up to 200 h, in order to pass their exam on the first attempt, which equates to adding a part-time job to their regular workload: 10 h per week for 10 weeks or 5 h per week for 20 weeks (XXXX, personal communication).

As noted in Caldwell (2023), the MFT licensing exams fail to meet industry standards for construct clarity, which may be due to the field as a whole not having a clearly defined scope of required knowledge. Arguably, the closest approximation to a description of required knowledge for MFT licensure are the MFT Core Competencies. Published in 2004 by AAMFT, these competencies are a set of 128 statements about general areas of knowledge and skill to be an independently practicing MFT. However, to ensure their applicability over time and across contexts, these competencies do not name specifics, such as essential theories or areas of research. Similarly, the condensed version of these competencies proposed by Northey and Gehart (2019) does not list specific theories or areas of knowledge to increase its applicability. Similarly, the MFT accreditation standards (COAMFTE, 2023, Version 12.5) summarizes the required curriculum in nine broad areas of knowledge that does not define specific theories, practices, research, or areas of knowledge. Thus, the field does not have any readily agreed upon specific areas of knowledge for licensing boards to build their exams around.

To add further confusion to the exam content, the questions are initially drafted by *subject matter experts*, which the BBS simply defines as licensed MFTs in good standing and currently practicing, which is lower than typical academic standards for an expert. When developing items for the national exam, the AMFTRB has the questions written by experts then reviewed and revised by a second committee appointed by the board, for which the standards are again not clearly defined (AMFTRB, 2024; BBS, 2024). In sum, the level of competence of the persons writing exam questions is difficult to determine.

The BBS (2024) identifies 356 areas of content knowledge described over 25 pages of their exam handbook and specifically lists 19 different theories, several of which are listed as "general family systems theories," "general cognitive behavioral theories," "general postmodern theories," "general psychodynamic theories," and "general humanistic-existential theories" theories (p. 23–24). Similarly, the AMFTRB (2024) lists 106 clinical tasks, such as "practice therapy in a manner consistent with the philosophical perspectives found in systemic theory" (p. 17) as well as 70 general knowledge areas, such as "family studies and science," "models of marital, couple, and family therapy," and "individually based theory and therapy models" (p. 22). Even with the long lists of possible content, the exact theories, research, and practice standards that need to be studied is unclear. In sum, the scope of the MFT exams is arguably infinite, with the entirety of the knowledge foundation of multiple disciplines listed as "what to study."

The content of the MFT licensing exams could be clarified and narrowed to focus on the core knowledge necessary to protect the welfare of the public and render competent care by focusing on:

1. **Diagnosis**: Know how to assess and diagnose all mental health disorders in the DSM-5-TR that are within our scope of practice; know when to refer out for those outside of our scope of practice.
2. **Law and ethics**: Know how to use the the AAMFT code of ethics (CA and national exam) and CAMFT

code of ethics (CA) to protect clients and render professional care.

3. **Core MFT theories**: Know 8 of the foundational theories in the field, upon which newer approaches are built. Specifying the foundational theories rather than newer theories significantly reduces the costs of exam preparation. We recommend the following 8 theories due to their enduring influence in the field and centrality in most major theory textbooks in the field (Gehart, 2024; Gladding, 2018; Nichols & Davis, 2016):

- Strategic family therapy.
- Structural family therapy.
- Bowen intergenerational family therapy.
- Satir family therapy.
- Emotionally focused couple and family therapy.
- Cognitive-behavioral family therapy.
- Solution-focused therapy.
- Narrative therapy.

Reducing the Total Number of Questions

Anxiety was a significant predictor of passing the exam in this study, which is consistent with other studies on text anxiety (Eysenk & Calvo, 1992; Sarason, 1988; Vaz et al., 2018; Zatz & Chassin, 1983). One of the major sources of anxiety for licensing exams is time pressure. On the National MFT exam, candidates have 240 min to answer 180 questions, approximately 1.33 min per questions, while on the California exam they answer 170 questions in 4 h, approximately 1.3 min per question. Most questions require reading vignettes that are 200 words or more. Test-takers who have English as a second language, read slowly, experience stereotype threat, or become anxious for other reasons are likely to score lower for reasons other than their mastery of the content (ASWB, 2022).

Thus, another strategy for reducing racial and age disparities is to reduce the number of questions by 50% (90 on the national exam and 85 on the California) over the same 4-hour exam period. Reducing the time pressure will create more equitable testing conditions for candidates from diverse and working-class backgrounds, who speak English as a second language, who experience more test anxiety, and/or who may be older.

Accommodations

Inadequate disability accommodations were identified as one of the most significant predictors of passing the exam. These findings suggest that the exam testing sites may not be providing adequate accommodations for those with disabilities, which is concerning. The AMFTRB and BBS should do further investigation to determine how best to meet the needs of test-takers with disabilities.

Research Limitations

There are several important limitations in this study. First, and most importantly, this is self-report data from a convenience sample. There is no way to determine if there is significant response bias (perhaps participants in one racial or ethnic group who had not passed were more likely to respond that those from that group who had passed, skewing the results). In addition, this is correlational data and we cannot establish causality—we can only note that the variables are related in this data set. However, given how our data compares to other similar data, we feel that this is an important start in exploring these issues on the LMFT exams.

Conclusion

Like other mental health professions, the field of marriage and family therapy must critically examine its existing approach to licensing exams. Data from multiple studies indicate clear patterns of racial and age disparities that cannot be ignored. Although a long-term solution may move away from multiple choice exams altogether, all existing evidence demands immediate action. One clear implication is that we need data on the current exam. We believe that the AMFTRB and BBS must produce and publish exam performance data disaggregated by demographic factors, just as ASWB did. The AMFTRB and BBS can produce much higher quality data because they would not be reliant on convenience sampling, and this data is vital in understanding the factors that influence success on the exam. In addition, the current exams can be rapidly improved by (a) changing how questions are phrased, (b) clarifying and reducing the scope of the content, (c) reducing the number of items during the 4-hour period, and (d) ensuring adequate accommodations for disabilities.

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Author Contributions KL wrote the main draft including tables and figures, with BH, BB, and SR all contributing to the literature review and DG contributing to the discussion. Data collection was conducted by KL, BH, BB, and SR, with DG contributing research questions. All authors reviewed the manuscript.

Data Availability The dataset cannot currently be shared in order to protect the privacy of respondents.

Declarations

Competing Interests The authors declare no competing interests.

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From:	Irene Paul
To:	STASHEK LaRee * MHRA
Subject:	Comment on Amending OAR 833-020-0041
Date:	Tuesday, May 19, 2026 12:46:48 PM
Attachments:	Letter for Board .pdf

You don't often get email from irene@rebelheartpdx.com. Learn why this is important

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Irene Paul She/They
Clinical Director
MA, LPC , CADCI
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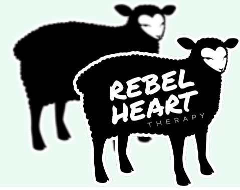


May 18, 2026

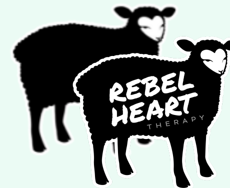
Oregon Board of Licensed Professional Counselors and Therapists
Re: Proposed Amendment to OAR 833-020-0081

Dear Board Members,

I am writing in my capacity as an LPC, Clinical Supervisor, and Clinical Director at Rebel Heart Therapy to express my support for revising the current regulation requiring associates to cease practice after a third unsuccessful attempt at the LMFT/LPC examination.

I support the proposed alternative of implementing a structured remediation and study plan, along with continued supervision and professional development, rather than requiring clinicians to immediately stop practicing. While examinations are an important measure of competency, a supportive pathway toward licensure better serves clinicians, clients, and the profession.

The current requirement creates significant disruption for both clinicians and the clients they serve. In many cases, testing performance may be impacted by factors such as learning differences or test-related anxiety, despite a clinician demonstrating strong ethical practice and competency in their clinical work. When supervisors, colleagues, and clients consistently regard a clinician as capable and effective, remediation and continued support are more constructive than professional displacement.



Allowing clinicians to continue practicing under structured supervision preserves continuity of care for clients while supporting professional growth and accountability. I respectfully urge the Board to adopt this revised approach to OAR 833-020-0081.

Thank you for your time and consideration.

Sincerely,

Irene Paul

Irene Paul, MA, LPC, CADCI
Clinical Supervisor & Clinical Director
Rebel Heart Therapy

From:	Kris Rieck
To:	STASHEK LaRee * MHRA
Date:	Friday, April 10, 2026 4:09:37 PM

You don't often get email from krieck2009@gmail.com. Learn why this is important

Re proposed rule making referenced in this email you sent out about " applicants must be actively engaged in a competency mastery plan to successfully pass Licensing Exam after 2nd or 3rd Failed Try"....

I wanted to thank the OBLPCT for shifting the focus away from passive waiting periods for License Exam takers into active learning engagement plans, which makes more sense.

Mental health needs in Oregon continue to expand and helping competent practitioners get licensed is good for Oregon Citizens. ☺

Thank you for creating this changed focus

Warm Regards,
Kristin Rieck MA, LPC -

Justice Rossman House
910 Capitol St NE
Salem, OR 97301
503-505-9168

Note: I am a Mandatory Reporter for Child Endangerment, including a child being present during Intimate Partner Violence. ___The Oregon Child Abuse Reporting # is 1-855-503-7233.

Hrs: M-F, 4 pm til 9 pm
CLOSED SAT & SUN

STASHEK LaRee * MHRA

From: Steffen Spear <steffen.spear@gmail.com>
Sent: Friday, May 1, 2026 9:07 PM
To: LPCT Board * MHRA
Cc: STASHEK LaRee * MHRA
Subject: Comment on Proposed Rule Making for Examination Failure

You don't often get email from steffen.spear@gmail.com. Learn why this is important

Hi Laree and Team,

I wanted to make a quick comment as per the email below. My name is Steffen Spear and I have been a patient at Rebel Heart Therapy since Oct 2022. I have been received treatment from an associate therapist, Malik Campbell, ever since. I've made a huge amount of progress with Malik over that time, surpassing 100 sessions with him several months ago.

I wasn't aware of Malik's provisional licensure status. I didn't know what the associate part of his title meant. To me, I was a happy patient, getting treatment for the symptoms of my clinically diagnosed depression and anxiety. In Mid April, Malik was affected by the Examination Failure ruling under upcoming consideration, which has affected my care at a very critical time in my life. I have recently gone through a divorce and other critical life changes which Malik was supporting me through. Though Rebel Heart has handled the situation very professionally and transferred my care to another therapist, this has represented a significant interruption in my care.

I ask whatever experts or professionals are reviewing this policy to consider those interruptions in care. Though I understand the importance of professional licensure in profession therapy practices, this policy ultimately interrupts the care of patients like myself. I ask that other disciplinary measures be considered which do not interrupt the important patient relationships which are already permitted under provisional licensure.

Thank you for your consideration. Please let me know if you have additional questions for me.

Thanks,
Steffen Spear
M. 706-587-2144
E. Steffen.Spear@gmail.com