PETITION FOR THE RECOGNITION OF A SPECIALTY IN PROFESSIONAL PSYCHOLOGY

THIS PETITION gives guidance to the types and amounts of information necessary for a formal decision to be reached. Petitioning organizations may use additional pages where necessary. The petitioning organization is free to provide any additional material deemed relevant.

AMERICAN PSYCHOLOGICAL ASSOCIATION
750 First Street, NE
Washington, D.C. 20002-4242
(202) 336-5500

PETITION PACKAGE
Preamble

Family Psychology is a previously established specialty recognized by the American Psychological Association and its Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP). In 2016, Division 43 of APA officially changed its name from the Society of Family Psychology to the Society of Couple and Family Psychology. Couple and Family Psychology (CFP) is a specialty area of professional psychology practice characterized by a distinctive configuration of theories, models, and approaches for specified problems and populations. Couple and Family Psychology is unique in that it represents a paradigm shift from contemporary individualistic psychology to understanding human behavior, psychological assessment, and intervention based on a systemic perspective and model. The Specialty of Couple and Family Psychology conceptualizes human behavior in a matrix of reciprocal interaction between intrapersonal, interpersonal, environmental, and macro-systemic factors. The systemic knowledge base of Couple and Family Psychology provides for a unique focus on assessment, treatment, and consultation with the individual, couples, families, and other systems/subsystems and considers the important areas of:

1. The context in which various systems are embedded;
2. Identification of patterned interactions;
3. Accounts for developmental processes over the life span;
4. The centrality of issues related to diversity and culture.

The Specialty of Couple and Family Psychology is comprised of (a) core scientific foundations in psychology; (b) a basic professional foundation; (c) advanced scientific and theoretical knowledge germane to the specialty; and (d) advanced professional applications of this knowledge to selected problems and populations in particular settings, through use of procedures and techniques validated on the same.

Name of Proposed Specialty: **Couple and Family Psychology**

Please check one:

- [ ] Petition for Initial Recognition
- [ ] Petition for Renewal of Recognition
Criterion I. Administrative Organizations. The proposed specialty is represented by a specialty
council or one or more organizations that provide systems and structures sufficient to assure the
organized development of the specialty. **Commentary:**

1. Please provide the following information for the organization or specialty council submitting
the petition:

Name of organization or specialty council: **Couple and Family Psychology Specialty Council**
(CFPSC)

Address: c/o Frank R. Ezzo, Ph.D., ABPP, Chair. Cuyahoga County Domestic
Relations Court, 1 W. Lakeside Avenue Room 52
City/State/Zip: Cleveland, OH 44113-1083
Phone: (216) 443-8805 FAX: (216) 443-2056
E-mail address: frezzo@cuyahogacounty.us

Website of organization: **CFPSC does not have a website. Please refer to Council of Specialties in Professional Psychology Website: COSPP.ORG**

2. Please provide the following information for the President, Chair, or representative of the
organization or specialty council submitting the petition:

- **Name:** Frank R. Ezzo, Ph.D., ABPP, Chair CFPSC

  APA membership status: Fellow
  Address: 1 W. Lakeside Ave.
  City/State/Zip: Cleveland, OH 44113-1083
  Phone: (216) 443-8805 FAX: (216) 443-2056
  E-mail address: frezzo@cuyahogacounty.us

- **Coordinator of CRSPPP Application:** Thomas L. Sexton, Ph.D., ABPP

  APA membership status: Fellow
  Professor Emeritus Indiana University
  Address: 1221 South Dunn Street, Bloomington IN 47401
  Phone: (812) 369-7202
  E-mail: thsexton@mac.com

- **Co-Coordinator of CRSPPP Application:** Corinne Datchi, Ph.D., ABPP

  APA membership status: Fellow
  Assistant Professor & Clinical Coordinator
3. Please provide the following information for the organization or specialty council submitting the petition:

   Year founded: 1992  
   Incorporated? Yes _____ No_ X ____
   State incorporated __N/A__

4. Describe the purpose and objectives of the administrative organization or specialty council submitting the petition.

The Couple and Family Psychology Specialty Council (CFPSC) is the representative organization for the specialty of Couple and Family Psychology. The Couple and Family Psychology Specialty Council represents the following constituent organizations and interests: the Society for Couple and Family Psychology (Division 43 of APA); the American Board of Couple and Family Psychology (ABCFP), which is a specialty board of the American Board of Professional Psychology (ABPP); the Academy of Couple and Family Psychology (ACFP), which is comprised of all board certified specialists in Couple and Family Psychology of the ABCFP; and representatives from doctoral, internship, and postdoctoral programs.

The Couple and Family Psychology Specialty Council is responsible for the following functions: 1) facilitating communication and developing coherence and consistency of policies and procedures within Couple and Family Psychology; 2) promoting quality assurance of education, training, credentialing, and practice in Couple and Family Psychology; and 3) representing the specialty of Couple and Family Psychology to the Committee of Accreditation (CoA) and the Council of Specialties in Professional Psychology (CoS; Couple and Family Psychology Specialty Council Bylaws, 2005).

History of Couple and Family Psychology as a Specialty within APA

The Specialty of Couple and Family Psychology began with the formation of the Committee on Family Psychology Accreditation of Postdoctoral Training Programs (CFPAPTP) founded in February 1992. This committee was co-sponsored by the Academy of Couple and Family Psychology, the American Board of Couple and Family Psychology, and Division 43, the Society for Couple and Family Psychology (we are using the new name of Couple and Family Psychology, but in this history, the specialty was Family Psychology). The Committee was formed to coordinate the efforts within the specialty of Couple and Family Psychology and work in conjunction with the Interorganizational Council for the Accreditation of Postdoctoral Programs in Psychology (IOC). Following the recommendations of the IOC, this Committee was organized to have representatives from all the stakeholders in (Couple and) Family Psychology. Following the June 1996 IOC recommendation for the formation of an organization of postdoctoral training directors, the membership of the CFPAPTP was expanded with the addition of a subcommittee of representatives from Family Psychology.
Postdoctoral Training Programs. Following the 1996 recommendation from the IOC and with the approval of the three co-sponsoring organizations the Committee was renamed the Family Psychology Specialty Council (FPSC). In 2007, at the request of the Boards of the American Board of Couple and Family Psychology (ABCFP), Academy of Couple and Family Psychology (ACFP), and the Society for Family Psychology (Division 43), the Couple and Family Psychology Specialty Council (CFPSC) agreed to function as a liaison to promote the interaction and coordination of the CFPSC’s constituent groups. In 2015 the constituent groups voted to change the name of the Specialty Council to, Couple and Family Psychology Specialty Council (CFPS) in order to represent similar changes in each organization. The name on this petition represented that change.

The CFPSC meets annually in conjunction with the APA Convention and holds conference calls as needed. The chair of the CFPSC attends the annual Council of Specialties in Professional Psychology meeting held in the fall at APA offices in Washington, DC. Because the CFPSC is conceptualized as an umbrella organization representing a variety of membership groups within the discipline of Couple and Family Psychology, CFPSC’s membership exactly replicates these constituent groups. Thus, two individuals are appointed by the President of Division 43 to represent the division on the CFPSC. The representatives’ term of office is currently two years, with a maximum of two terms. Although it is not required that the division representatives be members of the Board, selected representatives attend Divisional Board meetings and the Annual Convention of the American Psychological Association, in order to facilitate the liaison function between the two groups. In addition, the American Board of Couple and Family Psychology (ABCFP) and the Academy of Couple and Family Psychology (ACFP) also select two members to represent their organizations, including the presidents of the respective groups. Finally, there are two representatives from the doctoral training programs and two from the postdoctoral programs. There are no dues and the budget for CFPSC is extremely modest and dependent on funding from constituent groups. Accordingly, in 2007 the Board of Division 43, as well as the boards of ABCFP and ACFP, approved a modest budget (to which all contributed and which was housed in the treasury of Division 43) to support the operating expenses of the CFPSC (e.g., conference calls and the annual CoS meeting).

Synergy of Couple and Family Psychology

The Specialty of Couple and Family is structured and organized around a synarchy of organizations. The Society for Couple and Family Psychology represents the specialty within the American Psychological Association. The Board of Couple and Family Psychology (ABCFP) is a part of the American Board of Professional Psychology (ABPP), which recognizes specialty practice in Couple and Family Psychology. The American Academy of Couple and Family Psychology represents the Board Certified Family Psychologists (www.familypsych.org).

1. Society for Couple and Family Psychology (Division 43 of APA)

The Society for Couple and Family Psychology is the representative body of Couple and Family Psychology in the American Psychological Association. Couple and Family Psychology integrates the understanding of individuals, couples, families and their wider contexts. The Society for Couple and Family Psychology seeks to promote human welfare through the development, dissemination, and application of knowledge about the dynamics, structure and functioning of families. The purposes of the Society for Couple and Family Psychology are:
a) To advance the contribution of psychology as a science and as a profession to understanding and helping families through basic and applied research, clinical practice, and scholarly contributions;

b) To promote the education of psychologists in matters of Couple and Family Psychology including the appropriate roles of psychologists in the field of Couple and Family Psychology; and

c) To inform the psychological, mental, and physical health communities, third-party payers, health management organizations, other appropriate institutions, and the general public about current research, educational and service activities, and the training and competence of Couple and Family Psychologists as clinicians, educators, supervisors, consultants, and researchers.

d) **American Board of Couple and Family Psychology**

The American Board of Couple and Family Psychology (ABCFP) is a member board of the American Board of Professional Psychology (ABPP). The ABPP oversees and authorizes the credentialing activities of thirteen specialty boards. The ABCFP is responsible for establishing criteria related to the definition and requirements for education, training, competencies, and the examination, which leads to Board Certification in Couple and Family Psychology. The ABCFP is governed by a Board of Directors who are certified in Couple and Family Psychology and are representative of the specialty on a national basis.

The Board, in association with the American Board of Professional Psychology (ABPP), is responsible for conducting Board Examinations in the specialty of Couple and Family Psychology, mentoring and training examiners, and awarding the Diploma in Couple and Family Psychology. Board Certification by ABCFP is intended to certify that the successful candidate has completed the educational training and clinical experience requirements of the specialty, including a practice sample and examination designed to assess the competencies required to provide quality services in the specialty of Couple and Family Psychology. The primary objective of the ABCFP Board Certification process is to recognize, certify, and promote competence in the specialty.

e) **American Academy of Couple and Family Psychology**

The Academy is devoted to the advancement of the specialty of Couple and Family Psychology in general and board certification in that specialty in particular. The Academy’s website describes how to obtain specialty certification through the American Board of Professional Psychology if you are a psychologist, and how to select a qualified Couple and Family Psychologist if you are a member of the public. Links to related websites are also provided.

The American Academy of Couple and Family Psychology is comprised of all psychologists who are board certified in Couple and Family Psychology by the American Board of Professional Psychology. Upon award of board certification in Couple and Family Psychology, an individual becomes a fellow of the Academy. The Academy of Couple and Family Psychology is involved in teaching and mentoring, promotion of the specialty of Couple and Family Psychology, and communication among board certified specialists.

The Couple and Family Psychology Specialty Council, therefore, is the CFP Synarchy comprised of the Society for Couple and Family Psychology, the American Board of Couple and Family Psychology, and the American Academy of Couple and Family Psychology.
Psychology, and the Academy of Couple and Family Psychology. Only these organizations contributed to the CRSPPP Renewal. Couple and Family Psychologists may hold memberships in other organizations such as: the American Association of Marriage and Family Therapy, the American Association of Sex Educators, Counselors, and Therapists, and the American Association of Family and Conciliation Courts.

Marriage and Family Therapists (MFTs) and Couple and Family Psychologists (CFPs) share a similar history and work in the same general domain of practice. Yet, while both work with couples and families, MFTs and CFPs are distinct and unique in practice and training. CFPs receive different training, work in different settings, and have different licensing requirements than MFTs. For these reasons, AAMFT has never been involved in any of the CRSPPP petitions for the recognition of Couple and Family Psychology as a specialty of Professional Psychology. While some Couple and Family Psychologists are also AAMFT members, membership in both professional organizations is not common, and MFTs are not qualified to achieve ABPP status, which is the highest level of clinical recognition as a Couple and Family Psychologist. In fact, the majority of MFTs are master’s level clinicians who follow the AAMFT Code of Ethics, not the APA code of Ethics, and whose training is based on the AAMFT Core Competencies, not those endorsed by the Psychology profession. In essence, the field of MFT has its own specific set of principles for training and practice which are separate from the principles of Psychology and Couple and Family Psychology in particular.

It is also important to note that Couple and Family Psychology is not defined by areas of interest shared with MFT, but by its distinct science and empirical foundations, its specialty competencies, and the professional organizations that represent the specialty. While there is overlap in knowledge, theories, and techniques, there are also some substantial differences between MFT and CFP practice and training standards (see sections below). MFT is population-focused, hence its emphasis on working with couples and families, while CFP emphasizes the use of a systemic lens and the use of psychological science to understand human behaviors and work with diverse systems, not only couples and families.

Additional Material: The Bylaws for the Couple and Family Psychology Specialty Council are provided in Appendix A. The Bylaws for the Society of Couple and Family Psychology are provided in Appendix B. The Bylaws for the American Board of Couple and Family Psychology are provided in Appendix C. The Bylaws for the Academy of Couple and Family Psychology are provided in Appendix D.

A summary of the structure, functions and administrate features of the Specialty Council are listed below.

<table>
<thead>
<tr>
<th>Name of Organization</th>
<th>Couple and Family Psychology Specialty Council</th>
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</thead>
<tbody>
<tr>
<td>Frequency of Meetings</td>
<td>Minimum of an annual meeting usually conducted at the APA Convention</td>
</tr>
<tr>
<td>Number of Meetings per year</td>
<td>Minimum of an annual meeting and teleconference meetings as needed</td>
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<tr>
<td>Membership size</td>
<td>Seven: Frank R. Ezzo, Bob Geffner, Tom Sexton, Michele Harway, Robert Welsh, Susan Regas, John Thoburn</td>
</tr>
<tr>
<td>Functions Performed</td>
<td>See bylaws Article II</td>
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<tr>
<td>How are decisions made</td>
<td>In accordance with Articles IV, VI, and VII of the Bylaws, meetings are conducted in accordance with the latest edition of Keesey’s <em>Modern Parliamentary Procedures</em>; votes may be conducted by mail, e-mail, or fax and amendments to the bylaws may be made by a two-thirds majority vote of the members of the Couple and Family Psychology Specialty Council.</td>
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<tr>
<td>Types of committees</td>
<td>In 2010 the Council of Doctoral Programs for Couple and Family Psychology and the Council of Internship and Residency Programs for Couple and Family Psychology were created and became constituents of the Couple and Family Psychology Specialty Council.</td>
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<tr>
<td>Dues Structure</td>
<td>There are no Dues, operating expenses are provided primarily by Division 43 and secondarily by the Academy of Couple and Family Psychology. The only recurring expense is the Chair’s attendance at the annual Council of Specialties meeting.</td>
</tr>
<tr>
<td>Names of Publications</td>
<td>There are no publications from the Couple and Family Psychology Specialty Council. Division 43 of APA (the Society for Couple and Family Psychology) publishes a newsletter, The Family Psychologist (see Appendix E), and the American Academy of Couple and Family Psychology publishes a Newsletter (see Appendix F). Two APA journals represent the specialty of Couple and Family Psychology: <em>The Journal of Family Psychology</em>® has been published bimonthly by the American Psychological Association since 1987. The journal’s purpose is to provide: “cutting-edge, ground-breaking, state-of-the-art, and innovative empirical research with real-world applicability in the field of family psychology. <em>Couple and Family Psychology: Research and Practice</em>® (CFP) first published in March 2012 is a scholarly journal publishing peer-reviewed papers representing the science and practice of family psychology. <em>CFP</em> is the official publication of the Society for Family Psychology (APA Division 43) and is intended to be a forum for scholarly dialogue regarding the most important emerging issues in the field, a primary outlet for research particularly as it impacts practice and for papers regarding education, public policy, and the identity of the profession of family psychology.</td>
</tr>
<tr>
<td>Website</td>
<td>There is no website for the Couple and Family Psychology Specialty Council. The following are the online addresses for the websites of Division 43 Society for Couple and Family Psychology, the American Board of Professional Psychology (links to American Board of Couple and Family Psychology), and the American Academy of Couple and Family Psychology:</td>
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| | |
Present a rationale that describes how your organization or specialty council provides systems and structures which make a significant contribution to the organized development of the specialty.

The Specialty of Couple and Family Psychology is represented by the Couple and Family Specialty Council through a diverse synergy of researchers, educators, practitioners, and theoretical leaders in the specialty. Serving as the umbrella organization, CFPSC pulls together many of the organizations in Couple and Family Psychology, and thus helps to organize the research, training, and policy elements of the specialty. Moreover, the Chair of CFPSC presents a report at the Division 43 Annual Board meeting, serves on the ABCFP Board, and is a member of ACFP, which further enhances communication. Most importantly, by design, the membership of the CFPSC includes members of each of the constituent groups providing a true collaboration and allowing for a more powerful voice for the discipline. Although each of the constituent organizations (Society for Couple and Family Psychology; American Board of Couple and Family Psychology; American Academy of Couple and Family Psychology) has a specific purpose, they provide a symbiotic network to support the growth and development of the specialty. Together, they facilitate education, clinical training, research, professional practice, board certification, and professional identity in the specialty of Couple and Family Psychology (Nutt & Stanton, 2008). The figure below illustrates the interrelationship of these organizations:
4. Signatures of officials representing the organization or specialty council submitting the petition:

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frank R. Ezzo, Ph.D., ABPP</td>
<td>Chair CFPSC</td>
<td>12/29/2016</td>
</tr>
<tr>
<td>Thomas L. Sexton, Ph.D., ABPP</td>
<td>Coordinator, CRSPPP reapplication</td>
<td>12/29/2016</td>
</tr>
<tr>
<td>Corinne Datchi, Ph.D., ABPP</td>
<td>Co-coordinator, CRSPPP reapplication</td>
<td>12/29/2016</td>
</tr>
</tbody>
</table>
Criterion II. Public Need for Specialty Practice. The services of the specialty are responsive to identifiable public needs

Commentary: Specialties may evolve from the professions’ recognition that there is a particular public need for applications of psychology. Specialties may also develop from advances in scientific psychology from which applications to serve the public may be derived.

1. Describe the public needs that this specialty fulfills with relevant references. Under each need specify the populations served and relevant references.

The specialty of Couple and Family Psychology fulfills the public needs for:

(1) Effective couple and family-based clinical assessments and interventions that target severe psychopathology and social problems such as juvenile delinquency, family violence, and addictions.
(2) Knowledge about the relational processes that influence the development, prognosis, and treatment of psychopathology.
(3) Knowledge about the effectiveness of family and couple-based clinical assessments and interventions with diverse populations in diverse settings.
(4) Mechanisms to transport effective family- and couple-based treatment models from university settings to community-based mental health agencies and the private sector.

The need for Couple and Family Psychology (CFP) stems from the clinical demand for couple and family-based interventions. Indeed, couple and family clinical issues are one of the most frequent referrals to psychological practitioners (Sexton et al., 2003). CFP interventions address a variety of clinical needs embedded within the individual, family and social context of familial relationships. These include, but are not limited to, family developmental needs, psychopathology, family and intimate partner violence, marriage and divorce, LGBT families, military families, juvenile delinquency, elder care, homelessness, family migration, and chronic illness. Research suggests that these and other clinical problems are best addressed through couple and family-based intervention programs (Carr, 2014; Datchi & Sexton, 2016; Sexton et al., 2013). Increasingly, Couple and Family Psychologists are employed in all kinds of private and public settings, in rural as well as urban and suburban communities (Datchi, Baglieri, & Catanzariti, in press). They also are gaining more acceptance in medical settings in the role of family systems medicine (Ruddy & McDaniel, in press).

Couple and Family Psychology research is critical to the success of Couple and Family Psychology practice in addressing the needs of the public. It produces knowledge that can be translated into treatment recommendations about what works best with whom under what conditions. The hallmark of Couple and Family Psychology is the emphasis on evidence-based practice, in particular, the development, testing and dissemination of empirically based clinical programs that target youth and adult problems in the context of couple and family relationships.

Couple and Family Therapy is only one component of the specialty of Couple and Family Psychology. The specialty also includes the development and testing of clinical tools for assessing family and couple functioning (e.g., Family Assessment Device, Family Environment Scale, Family Adaptability and Cohesion Evaluation Scale); consultation with broader systems such as school systems, primary
health care agencies, family businesses, and justice systems that affect the functioning of individuals, couples and families; and training and supervision of CFP practitioners in the context of the dissemination of multisystemic treatment programs nationally and internationally. Assessment, consultation, training, and supervision are interconnected with CFP practice: they are activities that address the public needs for faculty members that educate and supervise students in both research and clinical practice and for clinicians who are highly trained and skilled in treating families and couples as systems and sub-systems both to prevent pathology, treat existing pathology, and to help families and subsystems within the family become more functional. These factors are keys ways in which Couple and Family Psychologists differ from other family focused professions (e.g., social work, marriage and family therapy).

Significance of the public needs for the CFP specialty

Below, we list thirteen different areas of significant public needs that directly relate to the CFP specialty:

a) Divorce: The American Psychological Association reports that healthy marriages are a protective factor for couples’ mental and physical health and for children’s psychological, educational, and social outcomes. However, “About 40 to 50 percent of married couples in the United States divorce. The divorce rate for subsequent marriages is even higher.” (http://www.apa.org/topics/divorce/) Children and adults from divorced families have a higher risk of developing behavioral and emotional problems than their peers from intact families (Hetherington, Arnett, & Hollier, 1988). “Marital dissolution has reached epidemic proportions in the United States. We now know that separation and divorce have deleterious consequences to the mental and physical health of the spouses involved. These negative effects include increased risk for psychopathology; increased rates of automobile accidents (including fatalities); and increased incidence of physical illness, suicide, violence, homicide, and mortality from diseases” (Gottman, Ryan, Carrere, & Erley, 2002, p. 147). Emery and Dinescu (2016) provide an overview of demographics, boundaries of power in parent-child relationships during divorce proceedings, key emotional tasks in divorce, children’s feelings, new partner’s emotional challenges, and current thinking about family intervention in divorce and remarriage, among other topics. The Family Court Review, an interdisciplinary journal, contributes to leading dialogue in family court research, policy and practice. For example, Volume 54, Number 1 (January 2016) is a Special Issue on Mental Illness in the Family, and Volume 52, Number 2 is a Special Issue on Shared Parenting. Lebow (2015) discusses ways that a therapist best deals with the discussion of divorce during the course of treatment, and looks at the ways couple therapists can best help those who have decided to divorce.

b) Remarried stepfamilies: The US is a nation where the majority of families are divorced and remarried, and it is estimated that 1300 new stepfamilies are forming every day and that 10 to 20% of children in the US live in stepfamilies (The StepFamily Foundation; National Healthy Marriage Resource Center). These families have unique developmental and relational needs that couple and family psychologists are best equipped to address. Papernow (2015) summarizes the challenges in treating stepfamilies with special attention to diverse stepfamilies, LGBT stepcouples, African American stepfamilies, Latino stepfamilies, and older “recouplers.” Emery and Dinescu (2016) argue that all couple and family therapists must be familiar with
separation, divorce and remarriage, because these are common and often “wrenching” experiences for modern families.

c) Family violence: The U.S. Department of Health & Human Services Administration for Children and Families (2013) collected data on child maltreatment submitted voluntarily by all 50 states, the District of Columbia, and the Commonwealth of Puerto Rico. During FFY 2013, CPS agencies received an estimated 3.5 million referrals involving approximately 6.4 million children. The national rate of child fatalities was 2.04 deaths per 100,000 children. Child maltreatment research has recently indicated that parental difficulties and related family stressors increased the risk of maltreatment to all siblings. (Hamilton-Giachritsis & Browne, 2008). Between 1998 and 2002, violence inflicted on family members accounted for approximately 11% of all violent crimes committed in the United States. Approximately 3.5 million violent crimes against families were committed during that four-year period. Approximately 75% of all crimes against family occurred in or near the victim’s home (Bureau of Justice Statistics, 2005). The prevalence and characteristics of sexual violence, stalking, and intimate partner violence was reported by Black, Basile, Breiding, Smith, Walters, Merrick, Chen, & Stevens (2011) and further summarized in a Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report (2014). They conclude that there is a need for public health action because a substantial proportion of sexual violence, stalking, and intimate partner violence is experienced at a young age, consequently primary prevention of these forms of violence must begin early. The Journal of Family Violence, edited by Robert Geffner, a board certified specialist in Couple and Family Psychology, is a specialized journal that addresses multiple areas of family and interpersonal violence.

d) Substance abuse: Substance abuse has adverse consequences on family relationships and individual family members’ mental health (SAMHSA TIP 39, 2004, http://www.ncbi.nlm.nih.gov/books/NBK64258/): “Most available data on the enduring effects of parental substance abuse on children suggest that […] a parent’s alcohol problem can have cognitive, behavioral, psychosocial, and emotional consequences for children. Among the lifelong problems documented are impaired learning capacity; a propensity to develop a substance use disorder; adjustment problems, including increased rates of divorce, violence, and the need for control in relationships; and other mental disorders such as depression, anxiety, and low self-esteem.” Meta-analytic studies have demonstrated that drug-abusing patients show higher levels of abstinence when they receive family based treatment (Stanton & Shadish, 1997). These findings are similar with alcohol abusing clients (O’Farrell & Fals-Steward, 2001). McGrady and Epstein (2015) published a chapter on alcohol behavioral couple therapy, a research-based model for conceptualizing and treating individuals with alcohol problems and their partners.

e) Military families: “There are an estimated 23.4 million veterans in the United States, and about 2.2 million military service members and 3.1 million immediate family members. Cumulative lengths of deployments are associated with more emotional difficulties among military children and more mental health diagnoses among U.S. Army wives. Children of deployed military personnel have more school-, family-, and peer-related emotional difficulties, compared with national samples.” (SAMHSA, 2014, http://www.samhsa.gov/veterans-military-families ) Veterans and their families are
f) Lesbian and gay families represent a growing public need. “Unlike heterosexual parents and their children, lesbian and gay parents and their children are often subject to prejudice because of their sexual orientation that can turn judges, legislators, professionals, and the public against them, sometimes resulting in negative outcomes, such as loss of physical custody, restrictions on visitation, and prohibitions against adoption (ACLU Lesbian and Gay Rights Project, 2002; Appell, 2003; Patterson, Fulcher, & Wainright, 2002).” In 2005, the American Psychological Association’s Lesbian, Gay, and Bisexual Concerns Office published Lesbian and Gay Parenting, a document that summarizes the research and provides resources for psychologists (http://www.apa.org/pi/lgbt/resources/parenting.aspx). This document demonstrates the need for professional training that focuses on lesbian and gay parenting. Lesbian and gay families are routinely included in the research and practice of Couple and Family Psychology (Green & Mitchell, 2015; Macapagal, Greene, Rivera, & Mustanski, 2015). Goldberg (2010) provides a comprehensive overview of the research on same-sex parenthood. In addition, Couple and Family Psychologists are uniquely trained and well equipped to provide lesbian and gay families with services that address the psychological impact of contextual adversity.

g) Adoption: Goldberg and Smith (2013) focused on predictors of psychological adjustment among early placed adopted children with lesbian, gay, and heterosexual parents. Their findings revealed that a lack of parental preparation for the adoption and parental depressive symptoms, were associated with higher parent-reported levels of both externalizing and internalizing symptoms. Children’s adjustment did not differ by family type. Feldman, Price, and Rupel (2016) detailed the “Parent for Every Child” initiative, a federally funded recruitment program which targeted special needs youth who had been freed for adoption. Pace, D’Onofrio, Guerriero, and Zavattini (2016) summarized a single case study aimed at analyzing attachment outcomes, through long-term follow-up, both for the adoptive mother and her late-adopted son. Far, Flood, and Grotevant (2016) examined the roles of siblings in adoption outcomes and experiences from adolescence to emerging adulthood.

h) Sexual Dysfunction: Frank, Anderson, and Rubinstein (1978) found that 40% of men and 63% of women experienced a major sexual dysfunction and 50% of men and 77% of women reported minor sexual difficulties. The sample consisted of 100 non-clinical couples. Several researchers have estimated the incidence of sexual dysfunction to be much higher among clinical couples (Weeks & Nixon, 1991, pp. 12-13). A current list of seventy-eight resources and journals providing a comprehensive review of sexual issues can be found at the Kinsey Institute: (www.kinseyinstitute.org/resources/journals.html). Weeks and Gambescia (2015)
present a systemic paradigm for couple-based sex therapy called the “intersystem approach.”

i) **Physical health:** The integration of mental and physical health represents another need. Bridging the gap between mental and physical health by introducing a systems-based approach that unites physicians, psychologists, family therapists, social workers, nurses, counselors, and therapists of all theoretical orientations in working with families across a wide range of professional settings has been addressed by McDaniel, Doherty, and Hepworth (2014). For example, Kazak and Noll (2015) discuss the role of pediatric psychologists in clinical and research partnerships with pediatric oncology teams and clinical trials groups. While considerable resilience in families and children is seen, domains of vulnerability and areas of successful collaboration are highlighted along with future directions to alleviate late effects of cancer and its treatment. Similarly, the role of parental caregiving in pediatric chronic conditions such as asthma was studied by Silva, Carona, Crespo, and Canavarro (2015). They looked at negative (burdens) and positive dimensions (uplifts) that may support risk and protective processes that influence family adaptation. They conclude that a risk-resistance approach to family caregiving may contribute to operationalizing strength-based interventions in the context of pediatric asthma. Ruddy and McDaniel (2016) summarized the emerging field of medical family therapy which has developed in order to meet the needs of families whose medical and psychosocial issues are intertwined.

j) **Severe Psychopathology:** High Expressed Emotion in families with severe mental disorders is a well-established risk factor for relapse. Family-based psychoeducation has shown to reduce the number of hospitalization for bipolar disorder and schizophrenia (Miklowitz & Goldstein, in press). MacFarlane (2016) provided an overview of empirically supported family psychoeducation for severe mental illness that includes cognitive, behavioral, and supportive elements. Lebow (2014) has a chapter on “Specific Strategies for Specific Problems” that describes couple and family interventions for externalizing disorders in adolescents, conduct disorders, depression and anxiety, eating disorders, child sexual abuse, schizophrenia, substance use disorders, posttraumatic stress disorder, borderline personality disorder, and problems embedded in relationships such as intimate interpersonal violence, infidelity, sexual problems, and health problems. Datchi and Sexton (2016) summarized the scientific evidence supporting the effectiveness of family-based interventions for schizophrenia, bipolar disorder, depression, anxiety, eating disorders, childhood disorders, chronic medical illness, substance misuse, and youth behavior problems and violence.

k) **Aging Couples and Families:** As the baby-boomers become older, there is a growing and urgent need to understand the impact of aging on relationships in late adulthood. Jamila Bookwala (2016) has begun to address this need through an edited volume on couple relationships in the middle and late years. APA’s Committee on Aging has also highlighted the need for public policy, research, and interventions for older adult population. A Special Issue of the American Psychologist (June 2016) addresses “Aging in America: Perspectives from Psychological Science.” In particular, this special issue edited by Roberto and DiGiglio features family-focused articles on caregiving families (Qualls) and elder abuse (Roberto).

l) **Immigrant Couples and Families:** The topic of immigration has been one important

m) **Youth Violence** is the third leading cause of death for individuals age 15 to 24 (CDC, 2015). It is a significant social and public health concern that impacts families and communities. Research has shown the critical influence of the family on the development of adolescent antisocial behaviors (Steinberg, 2000): Youth violence emerges in the context of hostile and punitive parenting; low parental involvement and poor parental monitoring; and abusive, hostile, and conflict-ridden homes. Couple and family psychologists have played a leading role in the development of intervention and prevention programs for youth violence. The Center for the Study and Prevention of Violence at the University of Colorado Boulder has identified four blueprint, model programs for at risk youth and their families (http://www.blueprintsprograms.com/programs): Functional Family Therapy, Multisystemic Therapy, Multisystemic Therapy for Problem Sexual Behavior, and Treatment Foster Care Oregon. There have been many recent publications describing these programs and their outcomes (Bergström & Höjman, 2015; Datchi & Sexton, 2016; Schoenwald, Henggeler, & Rowland, 2016; Sexton, 2016).

2. **Describe how the specialty attends to public need**

The specialty of Couple and Family Psychology (CFP) is grounded in science to assess and identify the changing needs of a diverse public (e.g., clinical populations, mental health organizations, academic institutions, policymakers). There is a recursive interplay between research, theory, and practice in the delivery of CFP services. More specifically the CFP specialty attends to the public need in three important ways:

1) By developing, testing and implementing evidence-based assessments and interventions for a variety of populations and disorders identified above. Those interventions are described in a
number of publications that constitute the research literature in Couple and Family Psychology. Specific assessment and intervention strategies are described in more detail in Criterion IV. The Society for Couple and Family Psychology has created a set of guidelines for evidence-based practices (Sexton et al., 2007). In addition, Couple and Family Psychology intervention programs have been recognized as integral to state-of-the-art psychological practice in several domains including juvenile delinquency and substance use. For example, SAMSHA’s National Registry of Evidence-based Programs and Practices identifies nine (9) couple therapy interventions and forty-one (41) family therapy interventions. These can be found at: http://nrepp.samhsa.gov/SearchResultsNew.aspx?s=b&q=coupletherapy and http://nrepp.samhsa.gov/SearchResultsNew.aspx?s=b&q=familytherapy.

2) By training and supervising clinicians and graduate psychology students in the implementation of evidence-based couple and family-based interventions for diverse clinical problems.

3) By conducting intervention research in university and community-based settings, submitting the results of their investigation for peer review, and translating their findings into practice recommendations in the professional literature.

4) By being involved in APA governance (see paragraph below).

The development and testing of evidence-based CFP programs, the training and supervision of clinicians and students, and the dissemination of research findings are key mechanisms couple and family psychologists use to respond to the needs of the public.

Through their involvement in APA governance, couple and family psychologists can advocate for the multisystemic needs of individuals, couples and families, and call attention to the significant social issues of family violence, divorce, marriage, and parenting, among others. For example, the specialty of Couple and Family Psychology has a proud history of APA Presidents whose Presidential Initiatives responded to changes in public needs: (A) Susan H. McDaniel, Ph.D., ABPP (President-elect) -- Dr. McDaniel’s initiatives focus primarily on the integration of psychologists and psychological science into comprehensive health care. She plans to connect APA with other health care professional organizations to further this goal; in particular, to improve team functioning, encourage interpersonal education, reduce health disparities, and develop novel and effective payment models. (B) Nadine J. Kaslow, Ph.D., ABPP (2014 APA President): Dr. Kaslow’s theme was Uniting Psychology for the Future. She focused on three main initiatives during her presidency: (1) Opening Doors Summit: Facilitating Transitions from Doctoral Education to First Job, 92) Translating Psychological Science for the Public, and (3) Patient-Centered Medical Homes: How Psychologists Enhance Outcomes and Reduce Costs. (C) James H. Bray, Ph.D., ABPP (2009 APA President): Dr. Bray’s four major initiatives were: (1) Task Force on the Future of Psychology Practice, (2) Presidential Summit on the Future of Psychology Practice, (3) Task Force on the Future of Psychological Science Education, and (4) Task Force on Psychology’s Contributions to Ending Homelessness. (D) Gerald P. Koocher, Ph.D., ABPP (2006 APA President): Dr. Koocher’s two major initiatives were: (1) Promoting psychology as a means of building stronger families and strengthening immigrant families, (2) Strengthening the family of psychology with special attention to diversity and early-career psychologists. (E) Ronald F. Levant, Ph.D., ABPP (2005 APA President): Dr. Levant’s initiatives were: (1) Promoting Evidence-Based Practices, (2) “Making Psychology a Household Word”, (3) Promoting health care for the whole person, and (4) Enhancing diversity within APA.

Couple and Family Psychology is also well represented in the APA Public Interest Directorate with Amicus Briefs in the areas of adoption, custody, and marriage.
References


Hahlweg, K., Baucom, D. H., Grawe-Gerber, M., & Snyder, D. K. (2010). Strengthening couples and


The members of the specialty have also produced a number of videos that support graduate training and continuing education, and thus ensure that clinicians are informed about the latest developments in CFP best practice. The videos listed below also are relevant to Criterion VIII, Continuing Professional Development and Continuing Education. We have identified thirty-four (34) videos published by APA, on various clinical topics and treatment modalities:

a) Attachment-Based Family Therapy
b) Functional Family Therapy
c) Emotionally-Focused Treatment
d) Stepfamilies
e) Various theoretical models of couple and family therapy
f) Fertility  
g) Medical/physical problems  
h) Infidelity/affairs  
i) Older Couples and Caregiving  
j) Alzheimer’s Disease and Caregiver Family Therapy  
k) Adoption  
l) Sex Therapy  
m) Divorce  
n) Forgiveness

CFP’s consistent effort to assess and respond to public needs as this relates to training, research and policy is represented by the depth and breadth of the recent books in the area. These publications constitute a knowledge base that is current and relevant.


3. **Describe how practitioners in the specialty attend to public need and to issues of human diversity (research reports, needs assessment, market surveys, etc., are examples of some types of appropriate documentation). Evidence that the specialty is monitoring developments and has moved to meet identified emergent needs is also appropriate.**

The specialty of Couple and Family Psychology is embedded in science to assess and identify the changing public needs of the specialty and training and community policy work to bring those important findings to current individual, couple, family and community needs. In the Specialty, there is an active and recursive interplay with research, theory, and practice based on evidence based couple and family interventions. There are yearly updates of clinical intervention research findings and constant input on training and policy from the synarchy of members of the Specialty Council. A sampling of the literature in Couple and Family Psychology demonstrates a strong commitment to monitoring and identifying the most important and current issues of human diversity. A listing of references includes:


4. Describe what procedures this petitioning organization and/or other associations associated
with this specialty utilize to assess changes in public needs.

The science of Couple and Family Psychology plays a major role in assessing changes in public needs. It is represented by the sample of ongoing long-term research programs listed below. There are a variety of active research programs in Couple and Family Psychology that focus on critical social and clinical issues, that build on knowledge about couple and family processes that are linked to optimal individual and relational functioning, that evaluate CFP evidence-based treatment programs, and thus ensure that these interventions are adapted to the changing needs of the public.

Sample of active CFP research programs:

**Gonzalo Bacigalupe, EdD, MPH** oversees the activities of an international research team located in Boston and Bilbao, Spain. His team studies family health, e-Health, the impact of emerging technology on families, and immigration and transnational family processes.

**Annmarie Cano, PhD,** at Wayne State University, investigates how the quality of couple and family communication about chronic illness (specifically, chronic pain) relates to pain adjustment and relationship well-being. She is interested in emotional disclosure of illness-related distress and empathic responses to those disclosures.

**Cindy Carlson, PhD,** Professor and Chair, University of Texas at Austin, focuses on family assessment, family functioning, and the home-school relationship. Specifically, she evaluates (a) the effects of family and peers on the academic and social functioning of early adolescents and (b) the efficacy of family treatment for child and adolescent problems.

**Barbara H. Fiese, PhD,** at Family Resiliency Center, University of Illinois at Urbana-Champaign, investigates family factors that promote health and well-being in young children. Her work is conducted as part of the initiatives at the Family Resiliency Center with specific focus on childhood obesity prevention and the reduction of childhood hunger.

**Myrna L. Friedlander, PhD,** University at Albany/SUNY current work concerns therapeutic change processes in family therapy and verbal interaction and the therapeutic alliance in family therapy. In 2010 Dr. Friedlander and Laurie Heatherington, Ph.D. were jointly honored as recipients of the Distinguished Contribution to Family Systems Research award by the American Family Therapy Academy.

**Mary A. Fristad, PhD, ABPP,** Ohio State University, conducts clinical trials of psychosocial and nutritional interventions for children with mood disorders (depression and bipolar disorder). She is also part of the Longitudinal Assessment of Manic Symptoms (LAMS) study, a multi-site study following 707 children at risk for developing bipolar disorder.

**Kristina Coop Gordon, PhD,** University of Tennessee-Knoxville, focuses on the dark side of relationships (infidelity, aggression, betrayals) and, conversely, on relationship health (implementing a Relationship Check-up program to improve relationship health through primary care clinics, conducting couples-based programs to improve physical health).

**Erika Lawrence, PhD,** Arizona State University, studies the predictors, correlates, and consequences of relationship dysfunction, with special emphasis on intimate partner violence. She conducts basic longitudinal research and applied research with individuals, couples and families.
Valerie Stephens Leake, PhD, Radford University, studies family belonging, specifically validating a new measure of family belonging, the Family Belonging Scale-Revised.

Richard E. Mattson, PhD, Assistant Professor, Auburn University, investigates the antecedents to and developmental course of marital discord. His research also focuses on the measurement of variables relevant to relationship research. Secondary research interests include addictive behaviors, as well as their detrimental effects on relationship functioning (e.g., psychological abuse).

Shelley A. Riggs, PhD, The University of North Texas, is the Director of the Family Attachment Lab in the UNT Department of Psychology. She works with a team of graduate and undergraduate students to conduct research on psychological risk and resilience in relation to child/adult attachment and family processes across the lifespan, as well as relational trauma and loss.

Galena Rhoades, PhD, University of Denver is part of the Center for Marital and Family Studies at the University of Denver and her projects involve studies on the ways that people form, develop, and maintain romantic relationships as well as studies on the effectiveness of relationship education.

Thomas L. Sexton, PhD, ABPP, investigates the mechanisms of change in family therapy based interventions for adolescents with behavior problems. In particular, he studies Functional Family Therapy (Sexton, 2010) and its application in community based practice settings.

Louise Silverstein, PhD, Ferkauf Graduate School of Psychology, Yeshiva University, conducts qualitative research to illustrate the effectiveness of therapy informed by Bowen Family Systems Theory.

Gregory L. Stuart, PhD, University of Tennessee-Knoxville, conducts research on family violence across the lifespan, with a particular emphasis on the interface between substance abuse and intimate partner violence.

Melissa Sturge-Apple, PhD, Department of Clinical and Social Sciences in Psychology, University of Rochester, is part of the Rochester Center for Research on Families and Children. Her work focuses on examining process models of interparental discord, coparenting, parent-child relationships, and children's social and emotional development.

Criterion III. Diversity. The specialty demonstrates recognition of the importance of cultural and individual differences and diversity.
Commentary: The specialty provides trainees with relevant knowledge and experiences about the role of cultural and individual differences and diversity in psychological phenomena as it relates to the science and practice of the specialty in each of the following areas: i) development of specialty-specific scientific and theoretical knowledge; ii) preparation for practice; iii) education and training; iv) continuing education and professional development; and v) evaluation of effectiveness

1. Describe the specialty-specific scientific and theoretical knowledge required for culturally competent practice in the specialty, how it is acquired and what processes are in place for assessment and continued development of such knowledge.

Diverse couples and families are one of the fastest-growing populations in the US. Contemporary couples and families help their members with the issues that all Americans face when establishing their identities, including: racial and ethnic identity, gender and sexual orientation identity, religious and spiritual identity, identity intersections, and identity with context and systems (Kelly, in press). In addition, cultural competency for psychologists, commonly thought to be comprised of knowledge, skills, awareness, and dynamic sizing (Sue, Zane, Hall, & Berger, 2009), is essential towards accurate cross-cultural assessment of health and pathology, and the ability to tailor treatment to the diversity found in most families. Culturally competent treatment also helps couples and families to address structural disparities, discrimination, and intergenerational trauma, and incorporates the strengths and resilience often inherent in diverse couples and families, such as the parental socialization of a positive racial identity, religious coping, and extended family support.

Diversity is a central feature in the theoretical, research, and clinical practice core areas of Couple and Family Psychology. As a specialty practice, CFP views diversity in general, and family diversity more specifically, as typically described around the structural characteristics of race, ethnicity, and sexual orientation emphasizing and understanding of the unique characteristics and unique processes of diverse groups.

It is a specialty founded on the principles of systems theory, with the family as a system being of most central focus. The premise of practice in this specialty, which distinguishes CFP from other specialties, is that family dynamics play a vital role in the psychological functioning of individuals and family members within nuclear and extended families. Within APA, the Office of Ethnic Minority Affairs and the Socioeconomic Status Office punctuates the importance of these areas in general, and specifically to families. For example, the Socioeconomic Status Office underscores family well-being and stability as being correlated to SES. At a macrosystemic level, representing the specialty of CFP’s systemic epistemology, the Socioeconomic Status Office identifies ways in which SES affects our society, such as communities segregated by SES, race, and ethnicity. African American children are three times more likely to live in poverty than Caucasian children. American Indian/Alaska native, Hispanic, Pacific Islander, and Native Hawaiian families are more likely than Caucasian and Asian families to live in poverty.

At the broadest level, Couple and Family Psychologists recognize ethnic and cultural differences between families, as well as similarities among families of all backgrounds. The practice of couple and family psychology takes into consideration the family’s history and current environment (e.g., family history, ethnic culture, community, school, health care system, and other relevant sources of support or difficulty). Couple and Family Psychologists strive to understand issues presented by persons to be served not only from the perspective of the presenter(s) of a problem, but as well through
understanding the contexts in which these issues have developed or are maintained, including the family system (see Criterion II, APA Office of Ethnic Minority Affairs); gender (Falicov, 2016, Brock, Kroska, & Lawrence, 2016); aging (see Criterion II); socioeconomic status (Bessa, Eldemire, & Pleth-Suka, 2015; Beach, Lei, Brody, Kim, Barton, Dogan, & Philbert, 2016); issues related to physical and mental disabilities (Harry, MacDonald, McLuckie, Battista, Mahoney, E., & Mahoney, K., 2016; Berry, Elliott, Grant, Edwards, & Fine, 2012); and acculturation (see immigration in Criterion II).

Couple and Family Psychology also integrates diversity at an even more unique and core level that permeates the specialty’s research, training and practice. Systems approaches provide a basis for identifying common relational processes that exist in all families, regardless of culture or structure. A process and functional (how systems function) focus across the boundaries of systems provides a more effective and client centered match to treatment than the traditional focus on group characteristics (Patterson & Sexton, 2013). Such a functional perspective offers a path to retain the uniqueness of individuals and to gain more universal understanding of how families function and change. Systems principles give substance to the process dimension of families and thereby bridge the gap across various family types. Systems principles view the relationship between elements of a system as more important that the elements individually (the concept of nonsummativity—see Watzlawick, Weakland, Fisch, & Erickson, 1974). The synergy between elements across systems helps promote innovation, new perspectives and ideas, and development of new ways of practicing that can link research, practice, and knowledge of the unique family forms that currently exist in the world. General Systems Theory involves a set of analogous descriptors that were originally applied to biology, and later ascribed to physical and social systems (von Bertalanffy, 1968). Systems theory as applied to couple and family psychology can include the following: organization, wholeness, family rules, homeostasis, feedback loops—negative and positive, subsystems, boundaries, and open and closed systems (Goldenberg & Goldenberg, 2012). More recent articulations of systems principles illustrate its value in understanding the mechanisms of treatment as well as providing a unifying perspective for psychological thinking (Magnavita, 2006). Focusing on these connections and common relational processes among groups incorporates core systems principles as part of the central architecture on which to embrace the growing diversity that couple and family psychologists face (Patterson & Sexton, 2013).

The CFP models for understanding diversity have evolved over time, including the ways in which the specialty of Couple and Family Psychology translates and applies diversity to treatment and research with couples and families. The seminal work of McGoldrick, Giordano, and Garcia-Preto (2005) provides a wealth of knowledge on culturally sensitive practice with families and individuals from over 40 different ethnic groups. Yet, knowledge about diversity issues in CFP is rapidly changing and evolving. More recently Killian’s (2016) chapter on Couple Therapy and Intercultural Relationships and Lebow’s book on family therapy integration (2014) emphasize the importance of clinicians to be aware of where they are anchored in beliefs and how their own set of beliefs interfaces with those of family members within the context of cultural values. In research, the identification of moderator variables related to diversity has been addressed in a number of studies and is summarized in a chapter by Brock, Kroska, and Lawrence (2016). Choosing which references to include to represent the current state of the art in CFP is a difficult process because knowledge about diversity issues in CFP is rapidly changing. The references we cite include research and theory from diverse fields of psychology, rather than just classic texts commonly used in MFT training programs.

As a result of the principles of systems theory, diversity is one of the core competencies adopted by each of the synarchies of the Specialty. These principles are represented in the various documents that
describe the specialty, its training and its benchmarks: 1) Family Doctoral Guidelines, 2) Family Postdoc Guidelines, and 3) Education and Training Guidelines: A Taxonomy for Education and Training in Couple and Family Psychology. Respect for Individual and Cultural Diversity is a Foundational Competency developed by the Assessment of Competency Benchmarks Work Group convened by the APA Board of Educational Affairs in collaboration with the Council of Chairs of Training Councils. The Foundational Competency of Respect for Individual and Cultural Diversity is reflected in the three documents listed above and contained on the COSPP web site.

Diversity is integral and integrated into the specialty of Couple and Family Psychology, and is not segmented as an afterthought. Diversity encompasses many groups such as Age, Developmental and Acquired Disabilities, Religion, Ethnicity, Socioeconomic status, Sexual orientation, Indigenous heritage, National origin, and Gender (Hays, 2009). Bringing overlooked and marginalized groups and their strengths into consideration enables the broadening of norms. Research on universals and their culturally specific manifestations, such as research suggesting that the universal need to belong in families is manifest with nuclear families in the U.S., and with extended families and families of choice by diverse groups (Smith, Spillane, & Annus, 2006). There are a number of other examples in couples and families, such as with variations in attachment across cultures that changes our theories on how attachment operates (Keller, 2013; Rothbaum, Weisz, Pott, Miyake & Morelli, 2000; van Ijzendoorn & Sagi-Schwartz, 2008), and the data from persons with schizophrenia within Latino families that broadened our conception of the role of families and emotion in addressing schizophrenia (Lopez, Kopelowicz & Canive, 2002). Inclusion of multiple groups also shows many similarities in content and process across groups, such as how Family Stress models operates similarly across African American, Latino, and White families (Conger, Conger, & Martin, 2010), and data showing some similarities as well as cultural variations across Latino and White couples in paths of Gottman’s Cascade Model (Parra-Cardona & Busby, 2006).

Couple and Family Psychologists must exercise caution in asserting that because there is a focus on family systems there is also a focus and understanding of diversity. Understanding family systems, unique to the specialty of Couple and Family Psychology, makes strides in the direction of diversity by including important contexts, yet there is a continued need to adequately address diversity (Kelly, Bhagwat, Maynigo, & Moses, 2014; Kelly & Boyd-Franklin, 2009).

REFERENCES


Brock, R.L., Kroska, E., & Lawrence, E. (2016). Current status of research on couples. In Sexton and


2. Describe how the specialty prepares psychologists for practice with people from diverse cultural and individual backgrounds (e.g., through coursework, supervised practice, continued professional development, etc.) and how competence is demonstrated.

Diversity is an integral and critical area of Couple and Family Psychology practice and training. Diversity competence is developed through coursework, continuing education, and supervised practice. Stanton & Welsh (2011) have operationalized diversity competence in Couple and Family Psychology, and identified competency benchmarks specific to diversity issues in psychological practice. These competency benchmarks fall into three domains: Knowledge, skills, and attitudes. The ABPP, the Society for Couple and Family Psychology, and the Academy of Couple and Family Psychology use these benchmarks to define and verify expertise in the specialty of Couple and Family Psychology. In particular, the American Board of Couple and Family Psychology recently adopted the CFP competencies described by Stanton and Welsh (2011) and included specific diversity questions in the examination for CFP board certification.

Diversity is a foundational competence with a knowledge and experiential component, behavioral anchors, and specific ways in which it is measured (Stanton & Welsh, 2011). The operationalization of diversity competency benchmarks allows for assessment and monitoring in training. The table below offers information about the specific diversity competency benchmarks in Couple and Family Psychology, its behavior and assessment methods.
| Domain and Essential Component | Knowledge | | Skills | | Attitudes |
|--------------------------------|-----------|--------------------------|--------------------------|--------------------------|
|                                | - Self and others shaped by ICD & context | • Knowledge of factors that contribute to individual and societal perceptions about individual and cultural diversity factors in others | • Conduct culturally centered CFP assessment, intervention, consultation, teaching, supervision, and research | • Commitment to perennial development |
|                                | - Understand the individual, interpersonal, and contextual factors that shape perception of ICD factors in others | • Awareness through cultural self-assessment about CFP specialists’ perceptions of others that are different from their own | | • Promote multiculturalism with CFP |
|                                | - Understand the factors that shape the cultural experiences of others | • Knowledge of cultural diversity elements in couples and families, including normal family cultural patterns, worldviews and values, and macrosystemic factors | | • Commitment to serving marginalized couples and families |
|                                | - Knowledge of the CFP literature for working with multicultural clients | • Knowledge of factors that contribute to intracultural variations between family members and their contexts, including identity models, acculturation difference, and multiple identities | | |
|                                | | • Knowledge of the major theoretical and empirical contributions to providing CFP clinical services to multicultural populations | | |
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Graduate Psychology training programs with an emphasis on or major area of study in Couple and Family Psychology have integrated the above diversity competencies into their coursework and research activities. In these programs, graduate students are introduced to diversity issues through the study of theory and through supervised practice. The mission and diversity statements of these programs provide additional evidence that the development of diversity competence is a core aspect of education and training in Couple and Family Psychology:

- **Azusa Pacific University**: Diversity is one of seven core competencies identified in the curriculum.

- **Alliant University (all campuses)**: The goal is to educate students to work in a multicultural/international world with a focus on multicultural and international communities and issues.

- **Palo Alto University**: One goal of the program is to train “culturally competent clinical psychologists.”

- **University of Southern California**: “…program offers considerable opportunities to conduct research and clinical work with a wide range of economic, cultural, and racial backgrounds.”

- **Fielding Graduate University, Santa Barbara**: One goal of the program is to: “demonstrate knowledge of cultural and individual diversity and individual differences.”

- **Pepperdine University**: “…emphasis on clinical application and sensitivity to multicultural context and individual differences.”

- **University of California Santa Barbara**: One aspect of the Mission is: “…strives to be recognized for excellence and innovation in research that fosters the psychological well-being and social equity of all people, especially vulnerable populations.”

- **Argosy University (all campuses and programs)**: “…firm commitment to training students to provide psychological services to diverse populations.”

- **University of Northern Colorado**: Part of the program philosophy is: “…psychologists work with individuals and systems from many different backgrounds, cultures, and lifestyles…emphasizes the needs for diverse populations in order to produce graduates who are sensitive to cultural, ethnic, gender, and lifestyle concerns in both language and action.”

<table>
<thead>
<tr>
<th>Culturally Centered Perspective</th>
<th>Commitment to Advocate for Policies That Promote Equity for Marginalized Couples and Families</th>
<th>Commitment to Intervene in Oppressive Macrosystems</th>
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<tr>
<td>Demonstrate commitment to social justice</td>
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</table>
University of Denver, Psy.D. Program: A goal identified in training is: “…developing and challenging doctoral students to become ethical, multicultural-oriented competent psychologists is the purpose of this program.”

University of Florida, Counseling Psychology: “…training model promotes science and practice that consider individual, developmental, multicultural, and contextual perspectives and that emphasize human strengths with attention to aspects of psychopathology.”

Nova Southeastern University Ph.D. and Psy.D. Programs: “…employ skills in evidence based assessment and intervention techniques for effective and meaningful service to diverse individuals, groups, and communities.”

Carlos Albizo University: “Mission…is to train culturally competent clinical psychologists at the doctoral level with a special emphasis on the training of minorities, particularly Hispanics, with the necessary competencies to provide services to individuals and families.”

Adler Institute: “The University embraces diversity in the broadest sense, including, but not limited to, race, ethnicity, culture, gender, sexual orientation, age, nationality, language, disability, socioeconomic status, education, religious/spiritual orientation, political perspective, and intellectual viewpoint.”

Ball State: “…this emphasis is reflected in our faculty’s expertise in behavioral medicine, family psychology, gifted and talented populations, and multicultural counseling…we are proud to support a diverse student population, including international students.”

University of Indianapolis Psy.D.: “…respect for individual and cultural diversity…are consistent across the curriculum.”

University of Massachusetts Amherst: “In research and practice, we appreciate and consider issues of diversity in terms of culture, socioeconomic status, ethnicity, gender, age, sexual orientation, and other individual differences.”

University of Missouri Columbia Clinical Psychology: “Diversity is a reality in the world and in our American society. MU values this diversity because it is inherent in our institutional values of respect, responsibility, discovery, and excellence. Valuing diversity grows out of respect for others and for self, despite our differences. Honoring diversity is required in order for us to carry out our institutional responsibility and moral obligation to all the citizens of Missouri. Being open to diversity is essential for discovery because what we ourselves know is not all that is. Welcoming diversity is integral to achieving excellence, since without it our own views and opinions are not challenged and honed.”

Seton Hall University Counseling Psychology: “Because counseling psychologists work in increasingly diverse settings, the program is committed to training multiculturally sensitive and competent professionals. Creating such sensitivity and competency mandates attention to the cultural diversity of the student body and faculty, the practicum experience, the composition of course syllabi and lectures, and the program’s professional seminar content. The Ph.D. in Counseling Psychology program embraces the traditions of the discipline, which is visible in the curriculum. This includes training in supervision, vocational and career development and
vocational assessment, as well as a respect for diversity…students have selected multicultural studies…The program offers two unique international training experiences in Trinidad…”

- **Chestnut Hill College**: A listed program goal is: “To foster respect for human diversity and to enable students to work effectively with individuals from diverse cultural backgrounds.”

- **University of Houston**: “We focus on multiple goals during training including developing competencies in…Awareness of and sensitivity to individual and cultural differences…We encourage applications from those with a diverse individual and/or cultural background. Houston is the most ethnically diverse large city in the country and UH is the 2nd most diverse Tier 1 Research University. We take great pride in this diversity and the supportive environment it offers our students. During the last eight years, fully a third of our successful applicants have contributed to our individual and cultural diversity.”

- **University of North Texas Counseling Psychology**: One identified goal of training is: “Increase understanding and appreciation of individual and cultural diversity and their fundamental relevance to the science and practice of psychology… Training emphasizes acquisition of counseling skills through exposure to specific educational experiences according to the positive developmental perspective held by the faculty. The program’s approach is based on a scientific framework that stresses commitment to empirical, objective, and typically nomothetic evaluations of theory and technique without devaluing the uniqueness of individuals, their experiences, or perspectives.”

- **Our Lady of the Lake Psy.D. Counseling Psychology**: Objective 1.4 states: “Students demonstrate multicultural competence.” There is also a program for graduate students with conversational proficiency in Spanish who may elect to obtain a certificate in Psychological Services for Spanish Speaking Populations.”

3. **Describe how the specialty is monitoring developments and has moved to meet identified emergent needs and changing demographics in training, research, and practice (e.g., through research, needs assessment, or market surveys).**

The Specialty has taken a number of initiatives to help monitor developments and to identify important trends in diversity theory, practice and research. For example:

a) **The APA Presidential Task Force on Enhancing Diversity** was created by the 2005 APA President, Ronald F. Levant, Ed.D., MBA, ABPP who is a board certified specialist in Clinical Psychology and Couple and Family Psychology.

b) The Society for Couple and Family Psychology created two awards that acknowledges distinguished and outstanding contributions in diversity: **Carolyn Attneave Diversity Award** acknowledges special contributions to the promotion of diversity in couple and family psychology or special contributions to the lives of diverse families; **Florence Kaslow Distinguished Contribution to International Family Psychology Award** was created to acknowledge Dr. Florence Kaslow’s longstanding and outstanding contributions to couple and family psychology around the world.

c) The American Board of Professional Psychology, Board of Trustees Diversity Committee reported findings in the Winter 2012 Specialist publication of the “Getting to Know You”
survey. They concluded that the demographics of ABPP are similar to the APA membership, they are predominantly white, heterosexual and more earned Ph.D.s than other degrees with Psy.D’s higher with ABPP and Ed.D. for APA. ABPP members tend to be older and have fewer women. APA has more women. In both groups, ethnic minorities are underrepresented. ABPP respondents report slightly higher frequency of “impairment” than APA members that report “disability,” perhaps the result of ABPP’s chronological maturity. ABPP specialists less frequently endorse a particular religious affiliation compared to the American public. The results of the survey suggested a call for action on the part of ABPP membership to actively encourage a greater diversity of licensed psychologists to pursue specialty certification.

d) In the 2014 spring issue of The Family Psychologist, now past Vice President of Public Interest and Diversity, Joseph Cervantes, used his address to suggest that the Society for Couple and Family Psychology create a subspecialty with competency guidelines in ethnic and cultural diversity, that can be housed as a separate or part of the existing Board Certification in Couple and Family Psychology.

e) The Specialty has ongoing initiatives to monitor and assess the importance of diversity in training programs. For example, Shalonda Kelly, Vice President for Public Interest and Diversity addressed the diversity demographics in the Society of Couple and Family Psychology through an ongoing survey of training programs (see template below). Table T: Couple and Family Training Programs that Address Diversity summarizes the results of this survey.

<table>
<thead>
<tr>
<th>Program Name and Contact</th>
<th>Training level (e.g. grad students, internship, postdoc)</th>
<th>Couple/Family Areas (e.g. families, couples, youth, all) and specific specialties (e.g. teen dating)</th>
<th>Diversity Areas and specific specialties (e.g. race, SES, LGBT, gender, religion, etc.)</th>
<th>Theoretical Orientation(s)</th>
<th>Research and/or Practice?</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXAMPLE:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grad School of Applied &amp; Professional Psychology (GSAPP)</td>
<td>Graduate Students</td>
<td>All</td>
<td>Multicultural concentration covers all areas, plus faculty specialties in African American couples and families</td>
<td>CBT, Family Systems, Emotionally Focused Therapy</td>
<td>Both</td>
</tr>
</tbody>
</table>
ADDITIONAL REFERENCES


Family Psychology (pp. 112-128). Oxford, United Kingdom: Blackwell Publishing.


Criterion IV. Distinctiveness. A specialty differs from other recognized specialties in its body of specialized scientific knowledge and professional application.

Commentary: While it is recognized that there will be overlap in the knowledge and skill among various specialties in psychology, the petitioning organizations must describe the specialty in detail to demonstrate that it is distinct from other recognized specialties in the knowledge and skills required or the need or population served, problems addressed and procedures and techniques used.

1. Identify how the following parameters differentiate and where they might overlap with other specialties. Describe how these parameters define professional practice in the specialty.

A. Description of the Specialty.

Couple and Family Psychology (CFP) is a specialty area of professional psychology practice characterized by a distinctive configuration of theories, models, and approaches for specified problems and populations. Couple and Family Psychology is unique in that it represents a paradigm shift from contemporary individualistic psychology to understanding human behavior, psychological assessment, and intervention based on a systemic perspective and model. The Specialty of Couple and Family Psychology conceptualizes human behavior in a matrix of reciprocal interaction between intrapersonal, interpersonal, environmental, and macro-systemic factors. The systemic knowledge base of Couple and Family Psychology provides for a unique focus on assessment, treatment, and consultation with the individual, couples, families, and other systems/subsystems and considers the important areas of:

1. The context in which various systems are embedded;
2. Identification of patterned interactions;
3. Accounts for developmental processes over the life span;
4. The centrality of issues related to diversity and culture.
5. The family life cycle

Couple and Family psychology is a specialty in professional psychology that is focused on the emotions, thoughts, and behaviors of individuals, couples, and families in relationships and in the broader environment in which they function. Systems approaches provide a basis for identifying common relational processes that exist in all families, regardless of culture or structure. A process and functional (how systems function) focus across the boundaries of systems provides a more effective and client centered match to treatment than the traditional focus on group characteristics (Patterson & Sexton, 2013). Such a functional perspective offers a path to retain the uniqueness of individuals and to gain more universal understanding of how families function and change. Systems principles give substance to the process dimension of families and thereby bridge the gap across various family types. Systems principles view the relationship between elements of a system as more important that the individual elements. The systemic perspective of CFP places an important emphasis on contextual conceptualization of behavior and developmental progression that interacts with individual, interpersonal, and environmental factors. In order to understand pathology and healthy/adaptive behavior there is a need to include a developmental perspective, including an awareness of family history, changing social definitions of the family unit, life span issues, and current personal, family, or environmental circumstances (see Sexton & Stanton, 2015). For example, what may be healthy and
adaptive behavior in one particular context and developmental stage, could be considered pathological and maladaptive in a different context or individual and family developmental stage. See Carter and McGoldrick’s second edition of The Changing Family Life Cycle: A Framework for Family Therapy (1989).

Couple and Family Psychology is a complex area of research and practice that has, and continues to evolve over time. While unique and different, each generation of theory and treatment model is based on the common core of systems thinking. It is this epistemological core that is the unique foundation of CFP and the basis upon which the more specific current models of clinical practice are built. Our focus here is on the current evolution of systems thinking and the very unique models of treatment that distinguish the profession. (Sexton & Stanton, 2015)

Reference


a) Populations

CFP specialists work with individuals, couples, families, and broader environmental systems, such as schools, medical clinics, and business organizations. Even when the individual is the identified client, CFP conceptualizes assessment and interventions from an interpersonal, systems perspective. While the settings of CFP are diverse, the focus is distinctive: The emphasis is on relational systems. For example, in working with families, the entire family is viewed as a single emotional unit, comprised of smaller subsystems. One family member may be symptomatic, but the family as a system contributes to the maintenance of pathology, and more importantly, can contribute to the health of one identified symptomatic family member. CFP is not characterized narrowly by a particular population served. Rather, it is defined by its systems perspective from which problems and developmental issues are addressed (Stanton, Sexton, & McDaniel, 2016; Family Psychology Specialty Council, 2009). CFP specialists work in a variety of contexts such as hospitals, clinics, independent practice, schools, colleges and universities, business, government, judicial systems, and other organizations.

The populations served by CFP specialists are not a distinguishing factor between CFP and other mental health professions. What is unique about CFP is its systemic focus and the assessment and intervention methods that originate from that perspective. These CFP-specific methods are used to understand and treat diverse populations with various clinical problems in a wide range of settings. In other words, with regard to the population parameter, there is a substantial overlap with other professions because populations are not a defining parameter of the CFP specialty.

b) problems (psychological, biological, and/or social that are specific to this specialty):

Similar to the population parameter discussed above, the practice of Couple and Family Psychology is not limited to a particular set of problems, but rather, the distinctiveness of the specialty is based upon the unique epistemological perspective (Systems Theory) from which Couple and Family Psychologists think about a problem and work with their clients to solve the problem and restore optimal individual and family functioning. Couple and Family Psychology addresses a broad array of clinical problems as well as relational problems. The distinctive and
overarching specificity of CFP is the systemic epistemology in which problems are addressed. Couple and Family psychologists work with a wide range of client populations who present with a variety of clinical issues (Bray & Stanton, 2009; Thoburn & Sexton, 2015). The problems addressed by CFP as a specialty also represent an overlap with other specialties. However, Couple and Family Psychologists are uniquely trained in relationship issues, and how family relationships and problems recursively interact, influencing problems/symptoms by either mitigating the impact of problems or exacerbating the problems/symptoms.

Individually oriented, linear theories of psychological functioning historically emerged from a medical model that focused on deficits and disease. Couple and Family Psychology, in contrast, considers the human family (and other groups) as a naturally occurring system, similar to other systems that exist in nature, such as the solar system, an ant colony, or a biological cell. Like these other natural systems, a family is seen as a “whole,” composed of interrelated parts, with processes that regulate its functioning. Although families can differ in terms of values, personalities, etc., the same fundamental relationship processes organize all family systems. Therefore, the relationship patterns that exist in seriously dysfunctional families, e.g. those with a schizophrenic member, are conceptualized as exaggerated versions of the same processes that are present in all families. Thus, a natural systems orientation is a non-pathologizing theoretical framework that allows Couple and Family Psychologists to approach human functioning from a strengths-based perspective.

This strength-based perspective enables Couple and Family Psychologists to avoid pathologizing the individual and blaming the family. In contrast to the more distant, “expert” role assumed by other psychological specialists, Couple and Family Psychologists join with all members of a family as partners in collaborative problem-solving.

From a family systems perspective, the thoughts, feelings, and behaviors of each family member both reflect and contribute to what is happening in the family as a whole. A Couple and Family Psychologist examines the meaning of a presenting problem in terms of both the individual’s psychological functioning, and also in relation to the emotional functioning of the entire family system. For example, a child’s acting out behavior at school might reflect a child’s difficulty adjusting to a new school, and may also be related to the parents’ marital problems. From a systems perspective, if the underlying marital issues are not addressed, even the most effective plan to improve the child’s behavior probably will not be effective.

Couple and Family Psychologist’s systemic way of working is that presenting problems are assumed to be related to both the interactional patterns within the current family context, and also to relationship patterns that have been passed down historically across the generations. This multigenerational transmission process operates so that individuals internalize family patterns relating to significant attachment figures and managing anxiety, e.g. in terms of longings for closeness or distance; seeking or avoiding conflict; and underfunctioning or overfunctioning. Thus, Couple and Family Psychologists explore family of origin issues with each adult member of a family, across at least three generations.

A family systems approach also can be used with an individual who is not currently living either with his/her family of origin, or with a new family of choice. Because relationship patterns and strategies for managing anxiety are internalized within the intrapsychic structure of each individual family member, multigenerational family of origin work is effective in helping an individual, as well as a family, develop more adaptive coping strategies. Thus, a family systems approach is not defined by the number of people in the consulting room, but rather is a broad theoretical
framework for understanding human behavior.

When working as consultants in broader environmental contexts, Couple and Family Psychologists also use a multigenerational, systemic focus. In this context, the historical perspective explores prior generations of the organization and prior efforts to solve the organizational problem. However, the theoretical assumptions that govern natural systems functioning also apply to work in these organizational settings. For example, a Couple and Family Psychologist might work with a specific school to improve the collaborative partnership between families and school personnel. In exploring the historical context, the Couple and Family Psychologist might discover that the district superintendent fired a beloved principal and replaced him/her with a principal unknown to the teachers. The conflict between parents and teachers might actually be mirroring the sense of distrust between the principal and the teachers. Thus, the first step in improving the family-school climate might be to help the teachers mourn the loss of their prior principal and establish a relationship with their new leader. Therefore, the entire system – children, parents, teachers, and administrative staff would be included in the problem-solving process.

Thus, Couple and Family Psychologists work with:

- Individuals who have relationship issues (or whose individual issues affect their relational functioning), but whose intimate others are unavailable (e.g., a student whose parents are out of town) or whose intimate partner refuses conjoint therapy. Individuals experiencing relationship problems stemming from trans-generational processes.

- Couples and families who struggle with daily functioning, substance abuse, mental health, and youth behavior problems. A couple and family psychologist is able to “enrich or improve the functioning of non-clinical or normal couples … to treat dysfunctional couples” (Weeks & Nixon, 1991, p. 13) (or to help couples adjust to problems of living).

- Couple and family psychologists treat individuals and couples from all socioeconomic status backgrounds as well as traditional and nontraditional couples at various stages of life (e.g., dating, premarital, marital, gay and lesbian, separated, divorced, interracial, interethnic, and interreligious).

- Couple and family psychologists work with larger systems such as communities and organizations to help with problems in functioning and communication (e.g., family owned businesses, school consultation, consultation with agency personnel, church consultation).

The research literature illustrates the range of clinical problems successfully addressed by couple and family-based interventions (Sexton, Datchi, Evans, LaFollette, & Wright, 2013):

1) Alcohol and drug abuse
2) Youth problem behavior/behavior problems
3) Parental sensitivity
4) Depression
5) Hyperactivity
6) Parenting and Parent-child conflict
7) Speech disorders
8) OCD
9) Anxiety
10) Developmental disorders
11) Schizophrenia
12) Bipolar Spectrum Disorders
13) Family relationships
14) Sexual, physical, or verbal abuse
15) Medical issues
16) Deviant sexual behaviors
17) Suicide
18) Family relationships
19) Couple relationship dissatisfaction
20) General mental health
21) Intimate partner violence
22) Infidelity
23) Pathological gambling

c) procedures and techniques

Couple and Family Psychologists have a distinctive set of procedures and techniques that are built on a multigenerational, systemic perspective that are not used by other specialties. CFP pursues interventions that understand the complexity and reciprocity of real-life problems and makes the specialty amenable to interventions in complex systems, including couples, families, larger social systems, and organizations. CFP specialists approach clients’ lives and difficulties with an underlying assumption that families can and should solve problems together. The systemic model of intervention holds that even when the outcomes are equal between conjoint and individual solutions to problems, there is intrinsic value in involving family members in solving problems. Such involvement often improves the individual’s problems, and the improvement recursively reverberates throughout the entire family system.

Couple and Family Psychology has a number of specific and distinctive evidence based programs for a wide variety of clinical issues that are commonly used in communities and health care systems. Each of these models is grounded in systemic thinking and based on empirical knowledge, which is a unique feature of the CFP profession. In fact, the integration of systems thinking and psychological science is unique and specific to our Specialty. These unique, systemic, and often evidence based approaches represent the current state of the art in Couple and Family Psychology. CFP treatment models are widely practiced in community settings and have had an important positive impact on the wellbeing of individuals, couples, families, and communities. Some of these evidence-based systemic models focus on external systems (Multisystemic Therapy) while others focus more on internal systemic processes (e.g., Emotionally Focused Couple Therapy). Some (e.g., Functional Family Therapy) target both external and internal systems. The move from broad theory to specific clinical models is one that has occurred across other specialty areas of professional psychology, as psychological knowledge grows and evolves. However, compared to other specialties of professional psychology, CFP uses systemic principles in addition to evidence-based models to guide the delivery of treatment services.

Like all psychological interventions, those used by Couple and Family Psychologists are built on common factors similar to all effective treatments. In a common factors approach, there is a primacy of the therapeutic relationship: an emotionally charged confiding relationship with a helping person, a healing context, a rationale that provides a plausible explanation for the client’s problems and how to resolve those problems, and a procedure that involves active participation of client and therapist and is believed by both to be a means of restoring healthy functioning. Unique factors common to Couple
and Family Psychologist identified by Lebow (2014) are: Therapeutic alliance ruptures, the person of the therapist, goal setting, engaging positive but realistic expectancies, attending to the stages of change, and feedback.

2. In addition to the professional practice domains described above, describe the theoretical and scientific knowledge required for the specialty and provide references for each domain as described below. For each of the following core professional practice domains, provide a brief description of the specialized knowledge that is required and provide the most current available published references in each area (e.g., books, chapters, articles in refereed journals, etc.) While reliance on some classic references is acceptable, the majority of references provided should be from last five years and should provide scientific evidence for the theoretical and psychological knowledge required for the specialty.

Note that in addressing Criterion IV, Section 2, for continuity we have developed tables for each domain that provides an aggregate response to Sections 2 and 3. The tables are divided into three sections: Competency Domain and Essential Component, Behavioral Anchors, and Assessment Methods. The tables are then followed by the identification of professional practice activities with descriptions of how they overlap and differentiate from other specialties.

The distinctiveness of the CFP specialty in regard to its theoretical and scientific knowledge is best described by its unique theoretical perspective, the related scientific knowledge and the related core competencies that illustrate the unique nature of Couple and Family Psychology. The treatments and interventions of family and couple clinicians are the activity/action by an interventionist in a therapeutic context for the purpose of helping the client. Treatment interventions range from singular discrete actions to comprehensive treatment programs and models that represent increasing levels of comprehensiveness and specificity: (a) A technique (single activity with narrow range of desired outcome), intervention; (b) Intervention (techniques that might go together to have a desired outcome); (c) Treatment program/model (comprehensive treatment program with theoretical principles, clinical change process, change mechanisms, adherence measures). Those techniques, interventions, or treatment models with the highest level of specificity are most likely to be able to be replicated and therefore have a higher probability of producing clinically reliable outcomes. Sexton and colleagues (2011) describe systematic criteria for organizing and understanding the core elements of CFP knowledge and research and the ways in which they translate into clinical practice (Guidelines for Classifying Evidence-Based Treatments in Couple and Family Therapy).

Science has always been a central part of family therapy. Research by early pioneers focused on the efficacy of both couple and family interventions from a systemic perspective (Pinsof & Wynne, 1995). This early work established family therapy as an effective and clinically useful approach to treatment. In the ensuing decades, the research agenda broadened from answering initial questions of outcome (i.e., establishing whether it works in general) to assessing more specific applications of family therapy with specific clinical problems in specific settings. The result of these decades of research is a strong, scientific evidence base for the effectiveness of family therapies (Sexton, Alexander, & Mease, 2003; Sexton, Datchi, Evans, Lafollette, & Wright, 2013; von Sydow, Beher, Schweitzer, and Retzlaff, 2010; von Sydow, Retzlaff, Beher, Haun, & Schweitzer, 2013; Sprenkle, 2002, 2012). Outcome research for couple and family therapy has drawn from meta-analyses that combine results across large client groups and individual outcome studies conducted in local communities with diverse clients in realistic clinical settings. In addition to these outcome research efforts, process research studies have identified the change mechanisms that underlie positive clinical outcomes that are both common
across methods and specific to certain approaches.

The research in family therapy has evolved to the point that some now identify it as family intervention research (FIR; Liddle, Bray, Levant & Santisteban, 2002), a type of family research that focuses on the change process, attempting to find what therapeutic interventions and/or treatment programs are most effective in helping families change. Sexton, Hanes, and Kinser (2009) defined intervention research as “a systematic approach to understanding the practices, their outcomes, and the varying moderating and mediating variables that may affect the success or failure of different clinical interventions” (p.165).

**Distinctive Theoretical Foundations:** What distinctively defines and unifies the specialty is the unique theoretical foundation: systems thinking. Systems Theory highlighted the place of social context and interaction in understanding human behavior, particularly in regard to couple and family dynamics (Sexton & Stanton, 2015, Stanton, Sexton, & McDaniel, 2015) and served as the primary defining theoretical feature of CFP. Systems Theory marked a shift away from intrapsychic analysis to a focus on how reciprocal influences between elements in a system or individuals in relationships mediated and maintained current behavior. In its broadest terms, “systems” are defined as a complex set of interacting and interrelated components together with the relationship among them that permit identification of a boundary making process. Systems theory is frequently seen as synonymous with couple and family psychology. Sexton & Stanton (2015) describe this core differentiating feature of systems theory as one that is unique in that (1) perceives behavior and mental/emotional symptoms to be within the context of the social systems people live in; (2) focuses on interpersonal relations and interactions, social constructions of realities, and the recursive causality between symptoms and interactions; (3) includes family members and other important persons (e. g. teachers, friends, professional helpers) directly or indirectly through systemic questioning, hypothesizing and specific interventions; and (4) appreciates and utilizes clients’ perspectives on problems, resources and preferred solutions.

The distinctiveness of Couple and Family Psychology is represented by the overarching theme and influence of a systemic epistemology:
psychologists apply the knowledge of a systemic epistemology that transcends just couple and family interventions. The application of systemic thinking to individual psychotherapy is as important for the specialty. The connection, interdependence, and interrelatedness of systems suggest that all systems are networks of individual organisms that organize and nest within each other (Capra, 1996). In addition, we all interact and are embedded within a context of complexity that includes natural, political, cultural, economic, and other macroscopic or environmental elements.

In addition, CFP is unique in that a number of the current core treatment approaches are designated by numerous bodies as evidence based treatments.

**Distinctive Core Competencies.** The distinctive characteristics of the Foundational and Functional Competencies for Couple and Family Psychology lies within the paradigm shift from a linear thought process to a systemic epistemology that conceptualizes human behavior in a manner that integrates intra-individual, interpersonal, environmental, and macrosystemic elements. This promotes an awareness of ecological context and environmental factors and their impact on individual, social, and group behavior (Robbins, Mayorga, & Szapocznik, 2003; Stanton, 1999; Sexton & Stanton, 2016).

The unique theoretical and scientific knowledge is operationalized using the system of competencies in Couple and Family Psychology (Stanton & Welsh, 2011). Couple and Family Psychology advocates a systemic approach to the core competencies, core theoretical perspectives, and practices similar to those defined by professional psychology (N. J. Kaslow, 2004; N. J. Kaslow, Celano, & Stanton, 2005; Stanton & Welsh, 2011). The competencies movement in psychology achieved prominence in 2002 at the Competencies Conference where core competencies were identified and conceptualized as part of a developmental progression in the education and training in psychology. Couple and Family Psychology quickly joined this movement, noting developmental pathways toward competence in its petition for recognition as a specialty by the Council for Recognition of Specialties and Proficiencies in Professional Psychology, and initial specification of the particular manner in which Couple and Family Psychology understands and develops the core competencies in an article in *Family Process* in 2005 (N. J. Kaslow, et al., 2005). The article concluded with a challenge to the specialty to be “more formally organized in accord with the core competencies” (p. 348) in order to develop more competent couple and family psychologists. Subsequent articles detailed various aspects of the couple and family psychology competencies (Celano, Smith, & Kaslow, 2010; Michele Harway, Kadin, Gottlieb, Nutt, & Celano, 2012, Stanton & Welsh, 2011).

The American Board of Couple and Family Psychology (ABCFP) collaborated in an ABPP-related project that began in 2009 to complete a specialty book series on ABPP specialties with Nezu & Nezu (in press), as the series editors. As part of this series, Stanton and Welsh (2011) developed the text, *Specialty Competencies in Couple and Family Psychology*. As draft chapters were completed, they were reviewed by ABCFP board members in order to ensure consistency with ABCFP standards and requirements. Following the design of the series, the book addresses functional (“common practice activities provided at the specialty level of practice,” p. vi) and foundational (“core knowledge areas that are integrated and cut across all functional competencies to varying degrees,” p. vi) competencies. It provides an introduction to couple and family psychology and covers the functional competencies of conceptual and scientific foundations, assessment (case conceptualization and assessment), intervention, consultation, family forensic psychology competency, supervision of couple and family psychology, teaching couple and family psychology, as well as the foundational competencies of ethical and legal competency, diversity, interpersonal interaction, and professional identity as a couple and family psychologist (Stanton & Welsh, 2011). This text is now used by ABCFP to orient
candidates for board certification and the board examination was restructured in 2012 to align with the knowledge, skills, and attitudes related to the core competencies identified in the book. These core competencies include both foundational and functional competencies represented as attitudes, behaviors, and knowledge. According to Stanton and Welsh (2011) the core competencies include:

- **Foundational Competencies**
  1. Professional Identity as a Couple and Family Psychologist
  2. Ethical and Legal Competency
  3. Diversity Competency
  4. Interpersonal Interaction Competency

- **Functional Competencies**
  1. Conceptual and Scientific Competency
  2. Case Conceptualization Competency
  3. Assessment Competency
  4. Intervention Competency
  5. Consultation Competency
  6. Supervision Competency
  7. Teaching Competency

The Society for Couple and Family Psychology suggests that Couple and Family Psychologists further specify these competencies in the following areas:

- **Natural Systems Theory.** Using a systemic perspective means that the family psychologist must understand how natural systems work: how systems regulate themselves, change and resist change. Understanding the family as a unit requires a familiarity with other naturally occurring supraorganisms.

- **Family Strengths.** Acquiring the history of a relationship or family, its problems, strengths and goals is essential to understanding systems and how to intervene. The interviewing technique is used in theory building, research and treatment.

- **Family Evaluation/Research.** Competence is needed in couple and family assessment that goes beyond individual measures and test batteries. A couple and family psychologist should be able to construct new tests or use current instruments to measure family functioning, carry out validation studies, and administer and interpret test results. Evaluating how a family functions requires the ability to assess relationship patterns in both current functioning and in prior generations. The ways in which a family manages emotional closeness, distance, and conflict are central to the work of a family psychologist. Understanding how relationship patterns are transmitted across generations also is essential.

- **Marital/Couples Therapy and Parenting Issues.** A couple and family psychologist should know theories of marital interaction, marital evaluation, and marital therapy and their relationship to parenting. The couple and family psychologist should have the skills to use this knowledge to help couples change.

- **Family Therapy.** A couple and family psychologist would have a knowledge of theories of family interaction, family evaluation and family therapy. The skill to use this knowledge to effect change in families would be essential.
f) **Sex Therapy.** A couple and family psychologist would have knowledge of normal and abnormal sexual functioning, be able to evaluate sexual functioning, and the principles and programs used in treating sexual problems.

g) **Family Diversity.** Couple and family psychologists must recognize ethnic and cultural differences between families, as well as similarities among families of all backgrounds. Developing multicultural sensitivity is a long-term process that requires an awareness of one’s own racial, ethnic, and class identity, as well as one’s unconscious biases. It also is essential for family psychologists to be aware of the way in which gender and the unequal power relations between men and women construct family structures and family relationships.

h) **Family Law.** Couple and family psychologists must be familiar with law and regulations regarding such issues as custody and visitation; child, spouse, and elderly abuse; and ethical relationships with attorneys. If planning to engage in active courtroom work, the couple and family psychologist must be trained in forensic family psychology.

i) **Outcome & Process Research.** Couple and family psychologists must be familiar with systems-based process and outcome research and relevant statistical analyses. Paradigms that analyze family and/or group interactions are necessary. Sociological research also may be relevant to family and larger systems research.

j) **Family Violence.** Couple and family psychologists must be skilled in assessing and treating all types of abuse and violence and its impact on individuals, families and larger systems.

**References**


Nezu, A.M., & Nezu, C.M., (Eds.), (in press). *Oxford University Press Series on Specialty Competencies in Professional Psychology* (currently involves 13 volumes in the series). New York,
3. **Identify professional practice activities associated with the specialty in each of the following domains and how they differentiate and where they might overlap with other specialties.**

**A. ASSESSMENT:**

The most prominent difference between traditional assessment of individuals and CFP assessment is the philosophy of science that underlies both approaches to assessment. Individual assessment is based on a linear Cartesian philosophy of science, while couple and family assessment is based on a nonlinear systems theory. Furthermore, CFP specialists view evaluation and treatment as reciprocal and as an ongoing process throughout the course of treatment. CFP specialists not only assess pathology, but we place an emphasis on the individual’s strengths and resiliency that are incorporated into treatment planning and interventions.

CFP assumes that sets of categories exist along continua by which families and larger systems can be assessed to be healthy and functional or unhealthy and dysfunctional. Assessment also may describe types of dysfunction. Various schools of thought in Couple and Family Psychology view problems
through their own theoretical perspectives. Some focus on the structure of the family or group, while others focus on sequences that maintain symptoms. Others look at variables such as communication, patterns, cohesion, affection, etc. Assessment of families or groups from a systems perspective may include clinical interviews; family-oriented instruments, projective techniques such as KFD and family TAT; semi-structured approaches such as the family genograms, Beavers-Timberlawn Scale; FACES IV; and lifestyle analysis and birth order.

The core competencies for Couple and Family Psychology in the area of assessment and their assessment methods are described below (Stanton & Welsh, 2011)

<table>
<thead>
<tr>
<th>Competency Domain and Essential Component</th>
<th>Behavioral Anchor</th>
<th>Assessment Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge: (A) Foundational Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(A.1) Understands nature of CFP assessment methodology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(A.2) Understands the scope of CFP evaluation methods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(A.3) Understands the measurement and psychometrics of CFP assessment instruments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Applies a systematic paradigm to CFP assessment and understands the distinction between CFP assessment and traditional psychological assessment</td>
<td>• ABPP Examination</td>
<td></td>
</tr>
<tr>
<td>• Understand the range of CFP assessment methods</td>
<td>• Coursework or CE</td>
<td></td>
</tr>
<tr>
<td>• Demonstrates knowledge of the appropriate uses and misuses of CFP assessment methods</td>
<td>• Self-Evaluation</td>
<td></td>
</tr>
<tr>
<td>• Awareness of psychometrics that constitute the various CFP assessment instruments, including strengths and weaknesses of using the tools in diverse contexts</td>
<td>• Peer Consultation</td>
<td></td>
</tr>
<tr>
<td>• Demonstrates the ability to select and use common CFP measurement instruments appropriate to the client’s</td>
<td>• Client Feedback</td>
<td></td>
</tr>
<tr>
<td>• Publication and presentation in scholarly venues</td>
<td>• Peer review and consultation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Consultation or supervision feedback</td>
<td>Same as above</td>
</tr>
<tr>
<td>assessment procedures appropriate to CFP</td>
<td>sociocultural context</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>-----------------------</td>
<td></td>
</tr>
<tr>
<td>(B.2) Demonstrates the ability to apply assessment methods to case conceptualization</td>
<td>• Demonstrates the ability to apply individual assessment instruments to CFP context</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Demonstrates the ability to use CFP assessment methods to arrive at a description and explanation of individual and systemic problems that informs treatment planning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Demonstrates the ability to communicate assessment findings in verbal and written feedback</td>
<td></td>
</tr>
<tr>
<td>Attitudes</td>
<td>• Values assessment as part of the therapeutic process</td>
<td></td>
</tr>
<tr>
<td>(C) Assessment Perspective</td>
<td>• Values critical thinking, integration of information, and clear presentation of results</td>
<td></td>
</tr>
<tr>
<td>Demonstrates a client-centered assessment perspective</td>
<td>• Committed to lifelong learning in the area of assessment</td>
<td></td>
</tr>
</tbody>
</table>

**Differences & Similarities with other Specialties**

- *Common Overlapping Areas:*
  1) Awareness of Psychometric Properties of Instruments
  2) Selection and use of Instruments for specific needs of clients
  3) Competency in administration and interpretation of Instrument
  4) Use of Instrument to assist in problem formulation
  5) Use of Instrument to assist in Treatment Goals
• Differences:
  1) Application of systemic case conceptualization
  2) Application of Instrument to assist in problem formulation and strength-based formulation of the case
  3) Formulation of hypotheses about interactions between individual factors, interpersonal relationships, and contextual factors
  4) Application of Assessment for Systemic Treatment Goals

SELECTED REFERENCES FOR ASSESSMENT DOMAIN


**Common Self-Report Instruments and Constructs Assessed in Couple and Family Psychology that demonstrate its uniqueness and difference from other specialties are described in the table below.**

<table>
<thead>
<tr>
<th>INSTRUMENT</th>
<th>CONSTRUCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centripetal/Centrifugal Family Style Scale (Kelsey-Smith &amp; Beavers)</td>
<td>Dependency needs, styles of adult conflict, proximity. Social presentation. Verbal expression of closeness, aggressive/assertive behaviors, expression of positive/negative feelings, internal scapegoating, global family style</td>
</tr>
<tr>
<td>Colorado Self-Report Measure of Family Functioning (Bloom)</td>
<td>Cohesion, expressiveness, conflict, intellectual-cultural orientation, religious emphasis, organization, family sociability, external locus of control, family idealization,</td>
</tr>
<tr>
<td>Instrument</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Conflict Tactics Scale (Straus)</td>
<td>Conflict reasoning, verbal aggression, violence</td>
</tr>
<tr>
<td>Dyadic Adjustment Scale (Spanier)</td>
<td>Dyadic satisfaction, dyadic cohesion, dyadic consensus, affective expression</td>
</tr>
<tr>
<td>Enriching Relationship issues, Communication, and Happiness (Olson)</td>
<td>Multiscale inventory assessing marital needs, concerns, problems</td>
</tr>
<tr>
<td>Family Adaptability and Cohesion Evaluation Scales IV (Olson, Tiesel, &amp; Gorall)</td>
<td>Family cohesion and adaptability</td>
</tr>
<tr>
<td>Family Assessment Measures-III (Skinner, Steinhauer, &amp; Santa-Barbara)</td>
<td>Task accomplishment, role, performance, communication, affective expression, affective involvement, control, values and norms</td>
</tr>
<tr>
<td>Family Emotional Involvement &amp; Criticism Scale (Shields, Franks, Harp, McDaniel, &amp; Campbell)</td>
<td>Expressed emotion, perceived criticism, emotional involvement</td>
</tr>
<tr>
<td>Family Environment Scale (Moos &amp; Moos)</td>
<td>Cohesion, expressiveness, conflict, independence, achievement orientation, intellectual-cultural orientation, active-recreational orientation, moral-religious emphasis, organization, control</td>
</tr>
<tr>
<td>Family Inventory of Life Events and Changes (McCubbin, Patterson, &amp; Wilson)</td>
<td>Intrafamily strains, marital strains, pregnancy and child bearing strains, finance and business strains, work-family transitions and strains, illness and family care strains, losses, transitions, legal strains</td>
</tr>
<tr>
<td>Global Assessment of Relational Functioning (Yingling, Miller, McDonals, &amp; Galewaler)</td>
<td>Problem-solving/interactional skills, family organization and structure, family attitudes of belonging</td>
</tr>
<tr>
<td>Marital Adjustment Test (Locke &amp; Wallace)</td>
<td>Marital satisfaction, cohesion</td>
</tr>
<tr>
<td>Marital Disaffection Scale (Kayser)</td>
<td>Loss of positive emotions toward spouse</td>
</tr>
<tr>
<td>Marital Satisfaction Inventory-Revised (Snyder)</td>
<td>Global distress, affective communication, problem solving, aggression, time together, disagreement about finances, sexual dissatisfaction, role orientation, family history of distress, dissatisfaction with children</td>
</tr>
<tr>
<td>McMaster Family Assessment Device (Epstein, Baldwin, &amp; Bishop)</td>
<td>Problem solving, communication, roles, affective responsiveness, affective involvement, behavior control, general functioning</td>
</tr>
<tr>
<td>Parenting Stress Index (Abidin)</td>
<td>Child adaptability, acceptability of child to parent, child demandingness, child mood, child distractibility/hyperactivity, child reinforces parent, parent depression, parent attachment, restrictions imposed by the parent</td>
</tr>
</tbody>
</table>
role, parental sense of competence, social isolation, relationship with spouse, physical health

Personal Authority in the Family System Questionnaire (Bray, Williamson, & Malone) Spousal intimacy, spousal fusion/individuation, nuclear family triangulation, intergenerational intimacy, intergenerational intimidation, personal authority

Premarital Personal and Relationship Evaluation Program (Olson) Identification of needs and concerns of premarital couples

Relational Assessment Measure for Same-Sex Couples (Burgoyn) Conflict resolution, cohesion, affection, sexuality, identity, compatibility, autonomy, expressiveness, social desirability

Self-Report Family Inventory (Beavers, Hampson, & Hulgus) Family health, conflict, family communication, family cohesion, expressiveness, directive leadership

Systematic Assessment of the Family Environment (Yingling, Miller, McDonald, & Galewaler) Organizational structure and interactional processes

B. INTERVENTION:

In addition to core professional training in individual-based interventions, Couple and Family Psychology requires training in a broad range of treatment interventions including, but not limited to: psychodynamic, structural, strategic, Bowenian, cognitive/behavioral, intergenerational, communication, psychoeducational, systemic, contextual, solution-focused, experiential, narrative, problem-solving, integrative models, and evidence based treatment programs. The distinctiveness of the specialty is noted by the table below outlining the Intervention Competency Domain and its behavioral and assessment markers.

<table>
<thead>
<tr>
<th>Competency Domain and Essential Component</th>
<th>Behavioral Anchor</th>
<th>Assessment Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td>Understand and capably utilize a systemic framework for specialty intervention</td>
<td>ABPP examination and Maintenance of Certification</td>
</tr>
<tr>
<td></td>
<td>Demonstrate advanced knowledge of specialty EBP</td>
<td>Ongoing status for practice through licensure</td>
</tr>
<tr>
<td></td>
<td>Understand common factors in CFP interventions</td>
<td>Continuing education in CFP interventions</td>
</tr>
<tr>
<td></td>
<td>Demonstrate advanced level of knowledge in the</td>
<td>Peer consultation and clinical case review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Client feedback</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-evaluation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consultation and supervision feedback</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>specialty interventions, including which interventions apply to particular treatment issues and/or populations</td>
<td>• Publication and presentation in peer reviewed venues</td>
<td></td>
</tr>
</tbody>
</table>

**Skills**
- Ability to accurately select, implement, and evaluate intervention

- Ability to review the case conceptualization, select prioritized intervention goals, and provide a rationale for the treatment plan that is understood and accepted by the client(s)
- Ability to select interventions appropriate to the issue/population
- Ability to demonstrate CFP common factors in treatment
- Ability to provide the intervention in a manner consistent with its theoretical and/or evidence-based formulation
- Independently evaluate treatment progress and outcomes
- Ability to modify the intervention to meet specific needs of clients and/or emerging circumstances during treatment
- Collaborate effectively with other treatment providers
- Seek consultation when needed to
In addition, there are distinctive clinical techniques commonly associated with couple and family psychology.

d) *Genogram:* A genogram is a diagram that illustrates at least three generations of the client’s family: spouse and children, if any; siblings; parents; and grandparents. Specific information about births, deaths, marriages, divorces, etc. is recorded on the diagram. In addition, important relationships also are depicted. The multigenerational genogram provides a relationship context within which the presenting problem and the current functioning of the family can be understood (see Guerin & Pendagast, 1976, Foley, 1984; McGoldrick, Gerson, & Petry, 2008). When working with families in larger systems, an organizational genogram reflects explicit and implicit power relationships and important events in the history of the relationship between the family (or families) and the organization. This broad perspective provides a systemic focus for the consultation.

e) *Circular Questioning:* Circular questioning is a technique in which the therapist asks each person in a family (or larger setting) a question about how another family member thinks or behaves. Each member is asked the same question successively. Members are invited to comment on the answers that other members have given. One member might be asked to predict how another member would respond. The prediction, then, can be compared with the other members’ actual responses. This technique illuminates coalitions, consensus, and conflict. All members of the system, then, are able to observe how each member affects other members. The interrelatedness of feelings and behaviors are reflected back to the family (or group). It becomes possible for individual members to begin to see the part they play in the functioning of others. For example, each family or group member could be asked why another family member thinks the family has come to treatment. The agreements and disagreements, the comments that some members make about the responses of others illuminate important forces which will become available for both change and resistance. In a family-school setting, both parents and school staff could be asked why the other feels efforts to work collaboratively in the past have succeeded or failed. Past misunderstandings or conflict can be given an opportunity to surface and be worked through more successfully. Prior successes can be underlined to provide hope for the future (see Fleuridas, Nelson, & Rosenthal, 1986; Palazzoli Selvini et al., 1980; Penn, 1982; Tomm, 1984).

f) *Enactment:* Enactment is a technique that enables the family or group to act out the presenting problem in the session. The Couple and Family Psychologist can observe the interactional patterns and begin to analyze how these patterns are sustaining the problem, even as the family or group attempts to solve it. Care must be taken not to allow conflict to escalate during this procedure. It
also is important for the Couple and Family Psychologist not to ally with any position but to maintain a neutral or multipartial stance. This technique also is appropriate for use in larger groups where conflict is high. For example, when there is a conflict between students and teachers, it is helpful to enact an example of student-teacher confrontation in a large family-school meeting. Enactment provides an opportunity for each constituency to feel heard by presenting their point of view. However, it simultaneously forces each constituency to hear the opposition’s viewpoint.

**g) Reframing:** Reframing refers to changing the meaning attributed to an act, person, or situation. When individuals, couples, or families present for therapy, they have often decontextualized the problem by attributing it to one person. In short, one member of the couple or family is seen as the identified patient. A Couple and Family Psychologist wants the couple or family to see how the problem is embedded within their system and causes pain to all members. To accomplish this goal, the Couple and Family Psychologist uses reframing to bring about a systemic definition of the problem. This process facilitates the couple or family becoming amenable for therapy. Reframing may bring about behavioral change in addition to a perceptual change or it may simply provide the foundation for the use of other systems oriented techniques. When working in a broader setting, reframing operates in a similar fashion to block the reciprocal blaming process that polarizes people and inhibits change. For example, parents and teachers often blame each other for the failure of a child to learn. A Couple and Family Psychologist might reframe a parent’s angry complaint about her child’s failure to learn as an expression of fear and concern for her child. The goal would be to enable the teacher to perceive the parent as anxious and worried, rather than aggressive and disrespectful. If the teacher could reframe his understanding of the parent, he could avoid the temptation to counterattack, and move toward the parent in a collaborative fashion (Sexton, 2010).

**h) Directives:** Couple and Family Psychologists are active and directive in their work. A directive is a request for behavioral change. There are two types of directives—linear and paradoxical. A linear directive is a common-sense request that systematically creates a change in the system in a step-wise fashion. The use of these techniques assumes a high degree of patient compliance. A number of these techniques include: attentive listening, interpreting, utilizing myths, metaphors, role playing and role taking, family conferences, etc. The second type of directive is paradoxical. A paradoxical directive is an indirect request for behavioral change and is based on the relational understanding of the interpersonal dynamics between the therapist and patient and/or family. The patient is expected to change without the therapist appearing to make such a request. These interventions are used after linear directives have failed and when the patient is non-compliant and symptoms are under voluntary control. A few of these techniques include: symptom prescription, symptom scheduling, symptom exaggeration, restraining, predicting relapses, prescribing relapses, prescribing no change, negative consequences of change, positioning, and making the symptom an ordeal.

**i) Family Sculpting:** Family sculpting allows a family member or a member of a larger system to recreate his/her view of the family or group in space and position by arranging persons in the room to represent the system. Body posture, relative positions, and any actions shown relate to group dynamics. The process allows for the examination of dimensions of closeness/distance and power within the family or organization (see Foley, 1984; Papp, Silverstein, & Carter, 1973).

**j) Family or Group Rituals:** Rituals are a way of organizing behavior. Shared rituals and traditions are important aspects of healthy families and organizations. Rituals enhance group identity and allow members to deal with transition such as loss, change, and growth. Family Psychologists work
to identify, enhance, or create new rituals for families and organizations (see Becvar & Becvar, 1993; Boscolo, Cecchin, Hoffman, & Penn, 1987; LaFarge, 1982; Nichols & Schwartz, 1991).

There are also a number of specific differentiating treatment programs that are common to Couple and Family Psychology. The table below describes a sample to illustrate the range and depth of treatment programs available in the specialty.

**Couple and Marital Treatment**

<table>
<thead>
<tr>
<th>Intervention Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broad Spectrum TX and Naltrexone for alcohol dependence</td>
<td>3 to 6 month manualized TX program utilizing CBT with naltrexone to treat adults with alcohol dependence</td>
</tr>
<tr>
<td>Child-Parent Psychotherapy (CPP)</td>
<td>Intervention for children who have experienced at least one traumatic event</td>
</tr>
<tr>
<td>Multi-Family Psychoeducational Psychotherapy</td>
<td>Group TX for couples and families of children and adolescents with a mood spectrum disorder</td>
</tr>
<tr>
<td>Prevention and Relationship Enhancement Program</td>
<td>Marital and relationship education intervention that teaches communication, working as a team, problem solving, managing conflicts, preservation and enhancement of commitment and friendship</td>
</tr>
<tr>
<td>Relapse Prevention Therapy</td>
<td>Behavioral self-control program</td>
</tr>
<tr>
<td>Solution-Focused Group Therapy</td>
<td>Strength based intervention for the TX of mental and substance use disorders</td>
</tr>
<tr>
<td>Alcohol Behavioral Couple Therapy</td>
<td>TX is based on intimate partner behaviors and couple interactions that can be triggers for drinking</td>
</tr>
<tr>
<td>Behavioral Couples Therapy for AoD</td>
<td>TX is based on the assumption that intimate partners can reward abstinence and reduce relationship distress resulting in less risk for relapse</td>
</tr>
<tr>
<td>Healing Our Women</td>
<td>Psychoeducational intervention for HIV positive women who have a history of child sexual abuse</td>
</tr>
<tr>
<td>Partners for Change Outcome Management System</td>
<td>A client feedback program for improving the TX outcomes of adults and children</td>
</tr>
<tr>
<td>Relationship Smarts Plus</td>
<td>Designed to help youth ages 14 to 18 gain knowledge about making good decisions about forming and maintaining healthy relationships</td>
</tr>
<tr>
<td>Teaching Students to be Peacemakers</td>
<td>A school-based program that teaches conflict resolution procedures and mediation skills</td>
</tr>
</tbody>
</table>
### Family Based Intervention

<table>
<thead>
<tr>
<th>Intervention Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent Community Reinforcement Approach</td>
<td>A behavioral intervention approach that seeks to replace environmental contingencies that have supported AoD with prosocial activities</td>
</tr>
<tr>
<td>AMIkids Personal Growth Model</td>
<td>A comprehensive approach for 10 to 17 year old youth adjudicated delinquent in lieu of incarceration or residential TX</td>
</tr>
<tr>
<td>Attachment-Based Family Therapy</td>
<td>TX for ages 12 to 18 that is designed to treat major depressive disorders, eliminate suicidal ideation, and reduce dispositional anxiety</td>
</tr>
<tr>
<td>Brief Strategic Family Therapy</td>
<td>Designed to prevent, reduce, and treat adolescent behavior problems, improve prosocial behaviors, and improve family functioning</td>
</tr>
<tr>
<td>Children of Divorce Intervention Program</td>
<td>A school-based intervention program for ages 5-14 who are dealing with the challenges of parental separation and divorce</td>
</tr>
<tr>
<td>CBT for Adolescent Depression</td>
<td>A developmental adaptation incorporating family systems to treat adolescent depression using classic cognitive therapy models</td>
</tr>
<tr>
<td>Cognitive Processing Therapy for PTSD</td>
<td>CBT therapy incorporating family systems used to treat older adolescents and adults with PTSD</td>
</tr>
<tr>
<td>Combined Parent-Child CBT: Empowering Families Who Are at Risk for Physical Abuse</td>
<td>A structured TX program for children ages 3-17 and their parents/caregivers in families where parents engage in a continuum of coercive parenting strategies</td>
</tr>
<tr>
<td>Community Reinforcement and Family Training</td>
<td>Intervention designed to help a concerned significant other facilitate treatment entry for an AoD treatment-refusing individual</td>
</tr>
<tr>
<td>Computer-Assisted System for Patient Assessment and Referral</td>
<td>A comprehensive assessment and services planning process for AoD</td>
</tr>
<tr>
<td>Emergency Room Intervention for Adolescent Females</td>
<td>A program for 12-18 year old girls admitted to the ER after a suicide attempt</td>
</tr>
<tr>
<td>Intervention Name</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Families and Schools Together</td>
<td>A 2-year multi-family group intervention based on social ecology theory, family systems theory, and family stress theory</td>
</tr>
<tr>
<td>Family Behavior Therapy</td>
<td>Family based TX aimed at reducing AoD in adults and youth with problems such as depression, AoD, family discord, school and work attendance, and youth conduct problems</td>
</tr>
<tr>
<td>Family Centered TX</td>
<td>A family preservation program for juvenile offenders and their families</td>
</tr>
<tr>
<td>Family Support Network</td>
<td>AoD TX for ages 10-18 that includes a family component, adolescent-focused CBT, and Case Management</td>
</tr>
<tr>
<td>Family Intervention for Suicide Prevention</td>
<td>CBT family intervention for ages 10-18 presenting in ER with suicidal ideation or after a suicide attempt</td>
</tr>
<tr>
<td>Functional Family Therapy</td>
<td>Family based intervention for ages 13-19 with AoD and delinquency, HIV risk behaviors, depression, or other behavioral/mood disorders</td>
</tr>
<tr>
<td>Living in Balance</td>
<td>Manual based intervention program emphasizing relapse prevention</td>
</tr>
<tr>
<td>Motivational Enhancement Therapy and CBT for Adolescent Cannabis Users and Other Substance Users</td>
<td>Brief intervention incorporating the family tested at four TX sites within the Cannabis Youth TX Study</td>
</tr>
<tr>
<td>Multi-Family Psychoeducational Psychotherapy</td>
<td>Group TX program for families of children and adolescents with depressive or bipolar spectrum disorders</td>
</tr>
<tr>
<td>Multidimensional Family Therapy</td>
<td>Multisystemic family-based outpatient or partial hospitalization program for AoD adolescents with comorbid mental disorders</td>
</tr>
<tr>
<td>Multisystemic Therapy (MST) for Juvenile Offenders</td>
<td>TX focuses on each youth’s social network that are contributing to antisocial behavior</td>
</tr>
<tr>
<td>MST for youth with Problem Sexual Behaviors</td>
<td>MST specifically targeted to adolescents who have committed sexual offenses and demonstrated other problem behaviors</td>
</tr>
<tr>
<td>Network Support TX for Alcohol Dependence</td>
<td>Manualized TX program to increase participation in AA, increase abstinent social network, increase self-efficacy, and improve coping strategies</td>
</tr>
<tr>
<td>Parent-Child Interaction Therapy</td>
<td>TX program for young children with behavior problems that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns</td>
</tr>
<tr>
<td>Program Name</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Parenting Wisely</td>
<td>Interactive, computer-based training programs for parents of children ages 3-18 based on social learning, cognitive-behavioral, and family systems theories</td>
</tr>
<tr>
<td>Parenting with Love and Limits</td>
<td>Combines group therapy and family therapy to treat children and adolescents ages 10-18 who have severe emotional and behavioral problems (conduct disorder, oppositional defiant disorder, ADHD,) and frequently comorbid depression, AoD, chronic truancy, destruction of property, domestic violence, or suicidal ideation</td>
</tr>
<tr>
<td>Partners with Families and Children: Spokane</td>
<td>Services to families with children under 30 months old at risk for child maltreatment</td>
</tr>
<tr>
<td>Real Life Heroes</td>
<td>Designed for use in child and family agencies to treat attachment loss, and trauma issues resulting from family violence, disasters, severe child maltreatment, and PTSD</td>
</tr>
<tr>
<td>Reinforcement-Based Therapeutic Workplace</td>
<td>Practical application of contingency management theory in the Workplace</td>
</tr>
<tr>
<td>Short-Term Interpretive Group Therapy for Complicated Grief</td>
<td>Intervention for adults who meet criteria for complicated grief</td>
</tr>
<tr>
<td>Solution-Focused Group Therapy</td>
<td>Strength-based group intervention for treatment of mental and AoD disorders that focuses on building solutions to reach desired goals</td>
</tr>
<tr>
<td>Surviving Cancer Competently Intervention Program</td>
<td>Intensive 1-day family group TX intervention designed to reduce the distress associated with PTS (D) symptoms in teenage survivors of childhood cancer and their parents/caregivers</td>
</tr>
<tr>
<td>Systematic Training for Effective Parenting</td>
<td>Skills training for parents dealing with frequently encountered challenges with their children that often result from autocratic parenting styles</td>
</tr>
<tr>
<td>Systems Training for Emotional Predictability and Problem Solving</td>
<td>Manual-based TX program for adults with Borderline Personality Disorder</td>
</tr>
<tr>
<td>The Seven Challenges</td>
<td>Designed to treat adolescents with AoD and other behavior problems</td>
</tr>
<tr>
<td>Treatment Foster Care Oregon, formerly known as Multidimensional Treatment Foster Care</td>
<td>Community-based intervention for ages 12-17 with severe and chronic delinquency and their families</td>
</tr>
<tr>
<td>Triple P—Positive Parenting Program</td>
<td>Multilevel system of parenting and family support strategies for families with children from birth to age 12 with extensions to families with children jags 13-16.</td>
</tr>
</tbody>
</table>
As noted in Section 1, many of these programs appear on the SAMSHA Evidence Based Practices List indicating strong research support and implementable programs. Couple and Family Psychology is well represented in this list. In addition to the SAMHSA resources, CRSPPP is also referred to previously cited works of Lebow (2014) that has chapters on Strategies and Techniques in Intervention, and Specific Strategies for Specific Problems. Sexton, Datchi, Evans, LaFollette, and Wright (2013) in the classic Bergin and Garfield’s Handbook of Psychotherapy and Behavior Change, 6th Ed. summarize empirically supported treatment in Couple and Family Psychology. Bray and Stanton (2009) also address Couple and Family Therapy treatment models for specific problems, as does Carr (2014) in two articles that review evidence based couple therapy, family therapy, and systemic interventions for adult-focused problems, and family therapy and systemic interventions for child-focused problems. These resources have all been cited earlier in the CRSPPP Renewal.

SELECTED REFERENCES FOR INTERVENTION DOMAIN


Carr, A. (2014). The evidence base for couple therapy, family therapy and systemic


Fishbane, M.D. (2013). Loving with the brain in mind: Neurobiology and couple therapy


68
New York: Guilford Press.


Wilson, J.D. (2014). Evidence-based couple/family treatment and intimate partner violence among veterans. 122nd American Psychological Association Annual Convention, Washington, DC.


Differences & Similarities with other Specialties

- **Common Areas:**
  1) Knowledge and application of evidence-based practices for specific problems and populations
  2) Importance of therapeutic alliance
  3) Importance of understanding alliance ruptures
  4) The personal qualities and characteristics of the therapist
  5) Goal setting
  6) Developing and implementing positive and realistic expectancies
  7) Attending to the stages of change
  8) Feedback

- **Differences between specialties**
  1) Maintaining a systemic epistemology
  2) Maintaining a relational frame and multisystemic focus
  3) Mixing individual, couple, and family session formats with specific attention to Informed Consent and Confidentiality parameters
  4) Managing sessions where a therapeutic alliance must be established with multiple people
  5) Engaging Positive Family Process
  6) The intensity and frequency of sessions varies more than individual treatment
  7) Creating structures that help families maintain treatment gains
8) Adapting to client culture and context that recursively interacts with systems and subsystems
9) Awareness of alliances in family systems

C. CONSULTATION:

Couple and Family Psychology requires the ability to consult with a wide range of clients regarding systemic issues and solutions to systemic problems. CFP requires knowledge pertaining to the functioning of systems in general, as well as characteristics of particular areas of concentration (e.g., schools, family business, primary medical care).

The unique focus of the Couple and Family Psychologist is represented by the competencies, related behavioral anchors and assessment points in the Table below.

<table>
<thead>
<tr>
<th>Competency Domain and Essential Component</th>
<th>Behavioral Anchor</th>
<th>Assessment Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Knowledge</strong></td>
<td>• Understand and capably articulate the application of systemic epistemology to consultation with individuals, groups, or organizations&lt;br&gt;• Demonstrate theoretical and scientific knowledge of consultation models in CFP and knowledge of the field in which the consultation is provided&lt;br&gt;• Demonstrate the understanding of roles, assessment methodologies, and intervention methodologies for CFP consultation</td>
<td>• Graduate course work assignments and exams&lt;br&gt;• Postdoctoral and/or postdoctoral applied assignments and evaluation&lt;br&gt;• Self-evaluation&lt;br&gt;• Supervision feedback&lt;br&gt;• Peer review&lt;br&gt;• Continuing education in CFP consultation&lt;br&gt;• Client feedback&lt;br&gt;• Publication and presentation in scholarly venues</td>
</tr>
<tr>
<td><strong>Skills</strong></td>
<td>• Ability to apply systemic orientation and research to conduct a needs assessment using</td>
<td>Same as above</td>
</tr>
<tr>
<td><strong>Knowledge</strong></td>
<td>• Ability to conduct effect CFP consultations, needs assessments, provide</td>
<td></td>
</tr>
</tbody>
</table>


reports and recommendations, conduct effective interventions | appropriate assessment methodologies and devices to provide focus to the referral questions
- Ability to prepare written and verbal reports that include cogent recommendations to address the referral question and the results of the needs assessment
- Ability to implement interventions based on organizational approval of recommendations using relationship skills
- Ability to demonstrate ethical and diversity competencies in consultation

**Attitudes**
- Value ethical and collaborative interaction and practice
- Independently value ethical practice that is culturally competent
- Value and adopt the role of consultant as part of the CFP specialty incorporating ethical and professional standards for consultation practice
- Value collaboration between the consultant and the client
- Value and respect individual and group diversity in consultation

| Same as above |
1) **Professional Practice Activities:** Couple and Family Psychologists may consult and/or be independent contractors in a variety of professional settings, but the most common are: Education and School-Based Consultation, Health Care Consultation, Family Forensic Consultation (Domestic Relations, Juvenile Court, and Probate Court), and Family Business Consultation.

2) **Education and School-Based Consultation:** Families and schools recursively interact to maximize socialization and education of students (Carlson, Funk, & Nguyen, 2009). CFP specialists share a foundation in systemic conceptualization with the specialty of school psychology, and there is overlap between the two specialties. CFP specialists provide assessment and interventions to enhance the quality of the home-school relationship with evidence that parental involvement in a child’s education, and parenting style are likely to result in better educational outcomes (Carlson et al., 2009). Carlson and Christenson (2005) provide an overview of consultation models designed to improve home-school collaboration. One model, EcoFIT, provides a family-centered approach to parental management of student behavior and addresses the social interactions around child behavior and child mental health (Dishion & Stromshak, 2009).

3) **Health Care Consultation:** McDaniel, Doherty, and Hepworth (2013) cited earlier in the CRSPPP renewal, describes in detail the field of medical family therapy with a focus on the impact of recent structural changes in health care on the role of the medical family therapist. They describe how medical and mental health providers can learn to speak the same language, whether they collaborate in outpatient therapy, co-location settings, community health centers, or fully-integrated health systems. They also take into account new advances in fertility treatments and genomic medicine, and assess the medical family therapist’s role in navigating conflicts that can arise in families dealing with these and similar issues. Mercer University has developed a Ph.D. and Psy.D. in Clinical Medical Psychology in response to the need for more psychologists collaborating with other healthcare providers to provide whole-person healthcare for patients. This program focuses on the interface between psychology, health, and disease. The program will be eligible to apply for APA accreditation in the 2016-2017 academic year.

4) **Family Forensic Consultation:** Family forensic psychology has been defined as “a special application of couple and family psychology and forensic psychology that provides expert-level services to families involved with the legal system, their attorneys, and the courts” (Welsh, Greenberg, & Graham-Howard, 2009, p. 703). Practice areas in Family Forensic Psychology was summarized in Welsh and Stanton, (2011), p. 135.

5) **Family Business Consultation:** Couple and Family Psychologists are uniquely qualified to provide consultation services to family businesses by virtue of their education and training in systems theory and family dynamics (Kaslow, 2006) cited earlier. Consultants function in the interface between three areas (circles): ownership/governance system, the business system, and the family system (Hilbert-Davis & Dyer, 2006). Consultants function in the interface between these three areas to create structures, develop processes, and produce policies and procedures that help manage systemic interaction between the three systems of family business.

**Commentary on Overlap and Differentiation in Consultation:**
- Couple and Family Psychologists and School Psychologists overlap in their consultative roles in schools. They may differ with different emphases on academic outcome criteria (School Psychologists) and the integration of the family system to achieve academic improvement (Couple and Family Psychologists).
• There is an overlap in health care consultation with other specialties such as, but not limited to, clinical, neuropsychology, pediatric psychology, geropsychology, and rehabilitation psychology. Couple and Family Psychology, however, provides a unique perspective on the role of the family in patient care. The importance of the family in medicine has also been recognized by the American Medical Association with a specialty in Family Medicine. Similar to Couple and Family Psychology, Family Medicine is concerned with the total health care of the individual and family, the scope of practice is broad, yet it is a precise discipline, integrating a unique blend of biomedical, behavioral, and social sciences.

• Family forensic psychology also overlaps with the obvious, forensic psychology. Other specialties such as clinical, counseling, and clinical child-adolescent psychology also may provide consultation in Family Forensic Psychology. The training, however, of a Couple and Family Psychologist provides a unique systemic epistemology perspective in the practice areas in domestic relations, juvenile, and probate courts.

• Family business consultation overlaps with Division 14, Society for Industrial and Organizational Psychology. The distinctive unique contributions, however, of Couple and Family Psychologists focus on the integration of the three circles defined by Hilbert-Davis and Dyer (2006).

SELECTED REFERENCES FOR CONSULTATION DOMAIN


**D. SUPERVISION:**

Supervision is a core component of training and ongoing clinical quality assurance. Supervision in Couple and Family Psychology requires a knowledge of a broad range of Couple and Family Psychology models/schools/techniques as well as the impact of issues of diversity (ethnic, gender, SES, sexual orientation, ability, etc.). Supervision is particularly important in CFP since multiple members of the system being treated can be overwhelming. Live supervision with a supervisory team observing behind a one-way mirror is a common and distinctive practice. The text by Todd and Storm (2014) has been recently cited as the definitive text for the systemic supervisor. Celano, Smith, and Kaslow (2010) focused on the intervention competency domain and provided an overview of eight essential components of couple and family therapy: developing a systemic formulation, forging a systemic therapeutic alliance, understanding family-of-origin issues, reframing, managing negative interactions, building cohesion/intimacy/communication, restructuring/parenting, and understanding and applying evidence-based couple and family therapy models. The authors conclude by addressing couple and family therapy competency within an integrative approach to supervision and provide a case illustration that depicts this process.

Supervision is a Functional Competency identified and incorporated as a core competency by the Assessment of Competency Benchmarks Work Group convened by the APA Board of Educational Affairs in collaboration with the Council of Chairs of Training Councils (June 2007). This competency is succinctly defined as the provision of supervision and training in the professional knowledge base and of the evaluation of the effectiveness of various professional activities. The distinctive nature of Couple and Family Psychology supervision is illustrated in the competency, behavioral anchors and assessment points noted in the table below.
<table>
<thead>
<tr>
<th>Competency Domain and Essential Component</th>
<th>Behavioral Anchor</th>
<th>Assessment Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Knowledge</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Knowledge of supervision in CFP specialty and knowledge of State or Provincial Board of Psychology’s requirements for supervision</td>
<td>• Knowledge of systemic concepts and theories applicable to teaching in a supervisory setting</td>
<td>• ABPP examination</td>
</tr>
<tr>
<td>• Demonstrate advanced knowledge of CFP competencies</td>
<td>• Knowledge of supervision models, theories, modalities, and research in CFP supervision</td>
<td>• Exemplary work performance</td>
</tr>
<tr>
<td></td>
<td>• Knowledge of theories, research, and methods to facilitate supervisee developmental progression in psychology competencies</td>
<td>• Self-evaluation</td>
</tr>
<tr>
<td></td>
<td>• Knowledge of foundational and, functional competencies, and ethics and diversity</td>
<td>• Ongoing supervision of supervision and consultation</td>
</tr>
<tr>
<td></td>
<td>• Knowledge of identified developmental markers and competency levels expected of supervisees at specific stages of training</td>
<td>• Peer consultation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Continuing education in supervision and CFP competencies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Formal written supervisee feedback and evaluation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Publication and presentation in scholarly venues regarding supervision</td>
</tr>
<tr>
<td><strong>Skills</strong></td>
<td></td>
<td>Same as above</td>
</tr>
<tr>
<td>• Provide effective CFP supervision</td>
<td>• Skilled at applying systemic concepts, modalities, and research to teach systemic thinking about CFP practice</td>
<td></td>
</tr>
<tr>
<td>• Application of systemic epistemology to CFP supervision</td>
<td>• Ability to teach CFP competencies in the context of supervision</td>
<td></td>
</tr>
<tr>
<td>• Ability to facilitate student development through CFP supervision</td>
<td>• Ability to form a supervisory alliance, maintain boundaries and power</td>
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</table>
differential, and accurately assess skills, developmental level, and training needs

- Provide effective feedback and monitor progress in a supportive manner
- Ability to identify and remediate problems of CFP competence

<table>
<thead>
<tr>
<th>Attitudes</th>
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</thead>
<tbody>
<tr>
<td>• Commitment to growth in self and supervisees</td>
<td>• Value self-evaluation and invite peer review and supervisee feedback regarding the supervision experience</td>
<td>Same as above</td>
</tr>
<tr>
<td>• Commitment to professionalism</td>
<td>• Commitment to providing and environment where supervisees can realize their professional and personal potential</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Commitment to displaying the highest levels of professionalism, including integrity, respect for others, and professional courtesy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Value ethical and legal specialty practice and ensure personal and supervisee compliance with all relevant laws and ethical standards related to supervision</td>
<td></td>
</tr>
</tbody>
</table>

**SELECTED REFERENCES FOR SUPERVISION DOMAIN**

Therapy, 40(3), 402-403.


Similarity and Differences with other Specialties: Supervision

Essentially, the overlap and differentiation in supervision has been incorporated above. The similarities and overlap occur with the Functional Competency of Supervision as defined by the Competency Benchmarks Work Group. The distinctive elements of supervision in Couple and Family Psychology are described by Lee and Everett (2004) with the specific knowledge base of systemic concepts essential for supervision in Couple and Family Psychology.

E. RESEARCH AND INQUIRY:

Couple and Family therapy is a distinct clinical process with a systemic focus that calls for complex research and statistical tools to capture the multidimensional and relational nature of therapeutic change. Despite the challenges of studying couple and family therapy, research has produced substantial evidence about the clinical utility of family-based programs (Sexton, Robbins, Hollimon, Mease, Mayorga, 2003; Sexton, Datchi, Evans, Lafollette, Wright, 2013; Sprenkle, 2012). Family therapy science has evolved from a focus on the efficacy and effectiveness of the broad modality of couple and family therapy to the study of specific interventions and treatment models and the mechanisms that produce positive outcomes in “real life” clinical settings. Current couple and family therapy intervention research focuses on the efficacy and effectiveness of well identified treatment techniques and intervention programs, the underlying processes of change and the factors that moderate the effects of treatment, in order to refine clinical protocols and improve practice. Research and Inquiry in Couple and Family Therapy requires skills in a variety of research methodologies and techniques including quantitative, qualitative, and meta-analytic approaches. More recently the scope of intervention science has expanded to include knowledge gained from translational studies about the implementation of treatment models in clinical settings and the better ways to match organizational and service delivery needs while replicating interventions and models with fidelity and producing consistently good outcomes (Datchi & Sexton, 2015).

The holistic approach of a systemic epistemology favors a broad definition of data and a range of methods to accumulate the data. Sexton, Hanes, and Kinser (2010) focus on the definition of research as a “systemic, inquiry-based, and knowledge-producing set of methods and skills” (p.166) for the purpose of neutralizing and setting aside the common tendency to distinguish or disparage quantitative or qualitative methods into separate camps. It is important for Couple and Family Psychology research to avoid reductionism in order to examine the complexity of human experience (Stanton, 2009). Goldenberg and Goldenberg (2013) conclude that outcome research, including both efficacy and effectiveness studies, having established that marital and family therapy are beneficial, has turned its attention to evidence-based practices—what specific interventions work most effectively with what client populations. Evidence-based family therapy is likely to become increasingly prevalent as efforts are under way to make healthcare delivery more effective and cost-efficient. Evidence-based practices in Couple and Family Psychology have been identified and already referenced in the CRSPPP Renewal (Lebow, 2014, Sexton et al, 2013). Gilgun (2009) discussed the importance of qualitative approaches to enhance theory-building and hypothesis-testing, rich descriptions of family phenomena, close analysis of texts, and items for various types of measurement tools and surveys. Qualitative research also offers family psychologists the opportunity for multi-method social research. Black and Lebow (2009) discuss systemic research controversies and challenges. They conclude that Couple and Family Psychology uniquely challenges conventional thinking, allowing for the development of new ideas and
improvements on existing methods. The weakness of this identity is, in itself, challenging and in some respects counter-intuitive, as this unique identity has some inherent risks of negating principles and thoughts that may advance the field. They saliently state that the specialty of Couple and Family Psychology needs to develop a both/and approach to research, epistemologies, and methodologies, rather than a reactionary either/or approach that may exclude the importance of a “both/and” approach to research.

Lebow (2015) discussed the diminishing funding available for family research. This is most pronounced in the U.S. where there is a focus on biological investigations, resulting in very little funding available for family research almost none for research on couple and family therapies. Lebow further states that the landscape for couple and family research is not totally desolate as is evidenced by the many journals that remain very active in publishing scientific areas of investigation. The White Paper published by Gordon, Rhoades, Atkins, Cordova, Doss, & Stanley (2015) highlight the high costs of relationship dysfunction in terms of health, mental health, and negative outcomes for children. Their White Paper proposes that Congress and the President encourage institutes to prioritize the science of intimate relationships, marriage, and interpersonal processes and related interventions to improve relationship outcomes.

Researchers also must be well-trained in various therapeutic models to ask relevant and useful research questions. As a core competency of Couple and Family Psychology, the unique knowledge, behavioral indicators and assessment points are listed in the table below.

<table>
<thead>
<tr>
<th>Competency Domain and Essential Component</th>
<th>Behavioral Anchor</th>
<th>Assessment Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Command of specialty epistemology,</td>
<td>• Demonstrate</td>
<td>• ABPP Examination</td>
</tr>
<tr>
<td>scientific knowledge, and scientific</td>
<td>advanced knowledge and capably articulate a systemic epistemology, including a systemic paradigm of key concepts, as well as the critiques and contemporary variations on a systemic orientation</td>
<td></td>
</tr>
<tr>
<td>methods (research design and</td>
<td>• Demonstrate advanced level of CFP scientific knowledge and scientific methods</td>
<td></td>
</tr>
<tr>
<td>statistical methods of analyzing data)</td>
<td>• Demonstrate advanced level of understanding regarding application of CFP epistemology and science to specialty practice</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ongoing status for practice through licensure and Maintenance of Certification through ABPP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Self-evaluation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Client feedback</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Peer review and consultation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Continuing education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Consultation or supervision feedback</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Publication and presentation in scholarly venues</td>
</tr>
</tbody>
</table>
### Skills
- Scientific foundation of CFP practice that incorporates the intentional inclusion of CFP concepts, scientific knowledge, and scientific methods in all aspects of the specialty activity
- Ability to think systemically and demonstrate systemic mental habits
- Ability to apply systemic orientation to all CFP competencies
- Ability to apply specialty knowledge and scientific methods to all CFP competencies

### Attitudes
- Maintain commitment to scientific contributions that independently value and apply CFP theory and scientific methods to specialty practice
- Awareness of epistemological options and ability to transition between paradigms in specialty practice
- Independent attitudes that demonstrate commitment to scientific values related to specialty practice
- Conduct self-evaluation and invite peer review of specialty practice (CRSPPP)

<table>
<thead>
<tr>
<th>SELECTED REFERENCES FOR RESEARCH AND INQUIRY</th>
</tr>
</thead>
<tbody>
<tr>
<td>In addition to the selected references listed here, the CRSPPP reviewers are referred to Criteria 2 where a sample of current research programs were identified that assist with the identification of public needs in the specialty of Couple and Family Psychology.</td>
</tr>
</tbody>
</table>


Comment on Overlap and Differentiation in Research and Inquiry: Sexton et al. previously cited identified four common markers in research: (a) scientific mindedness; (b) curiosity and openness (careful inquiry and nondefensive response to findings, even if they challenge existing knowledge); (c) recognition of ambiguity and the evolution of knowledge (knowledge is complex and dynamic, so clinicians must recognize the limits of current scientific knowledge while respecting and applying it); and (d) willingness to embrace the dialectical nature of science and practice (refusal to side with practice or science alone, but active pursuit of means for each to inform the other). The hallmark of Couple and Family Psychology research and inquiry is the capacity and ability of the specialty to apply systemic epistemology consistently and thoroughly to research questions.

F. PUBLIC INTEREST:

Couple and Family Psychology requires training in professional and research ethics and knowledge of
current national events that impact mental health. Active involvement with or knowledge of public policy implications for mental health also is encouraged. The specific competency, behavioral anchor and assessment points are described in the table below.

<table>
<thead>
<tr>
<th>Competency Domain and Essential Component</th>
<th>Behavioral Anchor</th>
<th>Assessment Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Knowledge</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Command and insight into the changing nature and needs of American and international couples, families, and systems</td>
<td>• Demonstrate advanced knowledge of CFP epistemology to the public needs of the evolutionary changes in understanding, assessing, treating, and research of couples, families, larger macrosystems, and the cultural context in which they are embedded</td>
<td>• ABPP Examination and Maintenance of Certification</td>
</tr>
<tr>
<td>• Command and insight into the global/international changing needs of couples, families, and systems</td>
<td>• Regularly and systematically review the American Psychological Association’s Public Interest Directory</td>
<td>• Self-reflection and evaluation</td>
</tr>
<tr>
<td>• Insight into the broader sociodemographic contexts in which couples, families, and other systems are embedded</td>
<td>• Review Annual Reports from the Committee on Children, Youth, and Families</td>
<td>• Peer review and consultation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Continuing education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Publication and presentation in scholarly venues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Contributions of Division 43, Society for Couple and Family Psychology’s Public Interest and Diversity Vice President and Committee</td>
</tr>
<tr>
<td><strong>Skills</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Utilization of Foundational and Functional Competencies to assess the changing needs of American and global/international couples, families, and systems</td>
<td>• Ability to think and apply CFP epistemology to the public needs</td>
<td>Same as above</td>
</tr>
<tr>
<td></td>
<td>• Ability to think and apply CFP epistemology to the prevention and treatment of mental illness</td>
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<tr>
<td>Ability to understand the changes and diversity in culture and norms with special attention to minority and underserved populations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Application of CFP epistemology to the needs of military families</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Application of CFP epistemology to major health problems</td>
<td></td>
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</tr>
</tbody>
</table>

**Attitudes**

- Value the role of CFP and its epistemology in addressing and protecting the public need and interest

**Same as above**

- Value the role of CFP and its epistemology in addressing and protecting the public need and interest

**SELECTED REFERENCES FOR PUBLIC INTEREST**


Center for Disease Control and Prevention: Injury Prevention and Control: Division of Violence Prevention-Intimate Partner Violence.  


Center for Divorce Education.  [www.divorce-education.com](http://www.divorce-education.com)
Couplet and Family Psychologists’ commitment to Public Policy is also demonstrated by the summarized nine areas and initiatives:

1) In Criterion II we cited former APA Presidents with Specialty Board Certification in Couple and Family Psychology. The CRSPPP reviewers are referred to that section for a description of their initiatives in the area of Public Interest.

2) Division 43, The Society for Couple and Family Psychology’s Board of Professional Affairs Committee from a meeting on 4/24/15 identified two topics that are relevant to the specialty of Couple and Family Psychology: (a) Master’s level practitioners; and (b) Integrated primary care. Given the changes taking place in managed care and the new role of private care centers, it is vital the Couple and Family psychology define what positions it will occupy in the new landscape of integrated patient care and advocate for the full integration of family assessment and interventions in treatment protocols.

3) A Division 43 White Paper identified the need for research funding: The Case for Funding Research on marriage, Cohabitation, and Interpersonal Processes (see Appendix M). This document is also relevant to the domain of Research and Inquiry.

4) Division 43 was invited to participate in a Think Tank event with The Family Systems...
Collaborative Group of the National Child Traumatic Stress Network. The purpose of Division 43’s involvement is to use our expertise to help trauma clinicians attend to systems issues and how we can help them obtain the necessary skills to accomplish this.

5) APA has Policy Statements and Resolutions Related to Children, Youth and Families in areas of; (a) Child and adolescent mental health and wellbeing; (b) International; (c) Child Abuse and Neglect; (d) Education; and (e) Violence.

6) APA has a Committee on Children, Youth, and Families as part of the Public Interest Directory, established in 1985 to ensure “…that children, youth, and families receive the full attention of the Association…in order that all human resources are actualized.”

7) Division 43, The Society for Couple and Family Psychology Board has a Vice President for Public Interest and Diversity.

8) The Couple and Family Psychology Specialty Council developed a brief Power Point presentation for the general public that explains the specialty of Couple and Family Psychology for the consumer of services (see Appendix P).

9) Divisions 43, 37, and 53, in 2013, received an Interdivisional Grant for: “Dissemination of Evidence-Based Practices for Children: Needs and Barriers at State and Local Levels”

Comment on Overlap and Differentiation in Public Interest:
As can be seen with APA’s Committee on Children, Youth, and Families, and other Policy Statements listed in item 5, there is an overlap of Public Interest topics with APA. This further illustrates the comment earlier that APA is a system and the systemic epistemology recursively reverberates through all the Divisions of APA. The specialty of Couple and Family Psychology, however, is differentiated by its exclusive focus on systems, and in particular the context of individuals in a system. Heldring (2009) in her chapter on Families and Public Policy recommends that the APA can help build a coalition to develop and issue a national report card on how policies are affecting families. She concludes that the U.S. government aims to support strong families, but does not provide the means, tools, protections, and opportunities to make this vision a reality.


G. CONTINUING PROFESSIONAL DEVELOPMENT:

After training that leads to a doctoral degree and professional credentials (licensure and specialty board certification), Couple and Family Psychologists engage in life-long learning through on-going continuing education. Both training programs and those offering CE must monitor current developments to keep training offerings timely and useful. The competency, behavioral anchor and assessment indicators are listed in the table below.

<table>
<thead>
<tr>
<th>Competency Domain and Essential Component</th>
<th>Behavioral Anchor</th>
<th>Assessment Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Knowledge</strong></td>
<td>• Demonstrate advanced knowledge, and enhanced foundational and functional competencies by</td>
<td>• Completion of APA Continuing Education Programs related to CFP specialization (14 CE programs identified)</td>
</tr>
<tr>
<td>• CFP specialists will maintain and expand upon CFP epistemology</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

87
### Skills
- CFP specialists will maintain skills and enhance skills in the foundational and functional competencies through continuing education activities.
- Complete the maintenance and acquisition of new clinical skills in CFP through the completion of CE activities.
- Demonstrate an understanding of the changing needs of the couples, families, and macrosystems through CE activities.

### Attitudes
- CFP specialists will maintain commitment to life-long learning in the foundational and functional competencies as they are applied to the specialty.
- CFP specialists will not practice beyond an area of competence and will recognize the need for remediation in areas requiring.
- The development or enhancement of existing or new competencies in CFP.
There is a rich set of professional continuing education activities that demonstrate the ongoing commitment to this core area. For example:

- Division 43 Clinical Practice Series: (a) Conversation with the Experts. On May 8, 2015, Robin Oatis-Ballew, Ph.D. discussed Couple and Family Psychology practice, managed care, and reimbursement-Challenges and Solutions; (b) Conversation with the Experts. August 6, 2015: “Therapy and the Use of the Internet,” Panel Discussion: Mary Gregerson, Ph.D., Eric Harris, Ed.D., J.D., & Joanne Broder Sumerson, Ph.D.
- American Board of Professional Psychology Maintenance of Certification; (3) American Board of Professional Psychology Workshops: May 27 –30, 2015: Florence Kaslow, Ph.D., ABPP presented “Divorce and Its Aftermath: Differential Impact on Each Member of the Family”
- Family Process Institute Webinar, e.g. June 12, 2015, Jill Freedman and Gene Combs presented on: “Narrative Therapy: Central Ideas and Practices;”
- 34 APA videos on subjects related to Couple and Family Psychology
- 14 APA CE Programs related to Couple and Family Psychology
- Continuing Education Programs with couple, family, and systemic orientations at the 2015 APA Convention:
  (a) Psychotherapy for Youth with Bipolar and Depressive Disorders
  (b) School wide PBIS---Bridging Multiple Systems
  (c) Application of Parent-Child Interaction Therapy with Specialized Pediatric Populations
  (d) Couple Therapy through Four Lenses
  (e) Technology-Mediated Interventions for Underserved Older Adults and Their Family Caregivers
  (f) A Quantitative Evaluation of New Fatherhood---Implications for Policy and Practice
  (g) PTSD Among Military Families---Contemporary issues
  (h) Intergenerational Conflict---Latino and Asian American Perspectives
  (i) Same-sex Couples’ Relationships in the Context of Legal Recognition---The CUPPLES Study
  (j) Theoretically Driven Approaches to Reducing Interpersonal Violence among Youth and Young Adults
  (k) Key Skills Demonstration from Two Intensive Outpatient Programs Focused on Children and Families
  (l) Implementation and Sustainment of Evidence-Based Practices for Children and Families
  (m) The Heavy Burden of Child Maltreatment---A Needed Dimensional and Developmentally Sensitive Approach
  (n) Refugees in International Settings---Interventions, Support, nd Group Work
  (o) Family Focus in Military and Veteran Systems of Care for PTSD
  (p) After Military Sexual Trauma---Understanding Individual and Family Outcomes and Barriers to Care
  (q) Intimate Partner Violence Research, Service Delivery, and Community Agency Collaboration
  (r) Lesbian and Gay Parent Families---Minority Stress, Gender Issues, and Children’s
Well-Being
(s) Intimate Partner Violence and HIV---Intersectionality and the Accumulation of Risk
(t) LGBTQ Youth Confronting Bullying, Foster Care, Homelessness, and Family Rejection---Intersections
(u) Couples Group Therapy---Video Presentations of Four Couples in One Group
(v) Family Therapy Across Cultures---When the Outsider is Invited In
(w) LGBTQ Reproductive and Family-Building Experiences---Invisible Groups and Understudies Topics
(x) Beyond Marriage---The Implications of LGBTQ Policy
(y) Family Sculpting with Children and Adolescents---Serving Dual Purposes for Therapy and Training
(z) Military-Connected Children and Families---Research Opportunities and Challenges

SELECTED REFERENCES FOR PROFESSIONAL DEVELOPMENT
Refer to APA Videos on Couple and Family Therapy cited earlier: total of 34 videos on Marriage and Family Therapy.

American Board of Professional Psychology. Maintenance of Certification.

American Psychological Association CE Programs: 14 search results for Families and Couples.


Comment on Overlap and Differentiation:
Psychologists in any specialty are committed to life-long learning. Couple and Family Psychologists’ professional identity evolves from a developmental process that entails progressive achievement of knowledge, skills, and competencies in the specialty. This occurs in stages of development, from doctoral education to internship to postdoctoral training or residency to all aspects of continuing professional development. Professional development also involves supervision for areas where more competency is needed. We support the ultimate recognition for specialty competency in Couple and Family Psychology with the completion of Board Certification through the American Board of Professional Psychology.

H. ANY RELEVANT ADDITIONAL CORE PROFESSIONAL PRACTICE DOMAINS.

Because of the unique nature of Couple and Family Psychology, ethical competencies are essential. The core ethical competencies, behavioral anchors, and assessment markers are listed in the table below.

<table>
<thead>
<tr>
<th>Competency Domain and Essential Component</th>
<th>Behavioral anchor</th>
<th>Assessment Methods</th>
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<tbody>
<tr>
<td>Knowledge</td>
<td></td>
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<tr>
<td>• Command of ethical and legal knowledge related to Couple and Family Psychology</td>
<td>• Understand the APA code of ethics as applied to CFP with awareness of limitations of the code when applied to work with couples and families</td>
<td>• ABPP examination and annual attestation of ethical and legal conduct</td>
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<td></td>
<td>• Understand the attendant ethics literature and applicable guidelines to CFP</td>
<td>• Maintenance of Certification</td>
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<td></td>
<td>• Awareness of the scope of family law relating to CFP area of practice</td>
<td>• Ongoing status for practice through licensure</td>
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<tr>
<td></td>
<td>• Understand common legal and ethical issues in CFP and demonstrate advanced knowledge of the literature regarding management of those issues</td>
<td>• Successful record of navigating ethical conflicts</td>
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<td></td>
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<td>• Self-evaluation</td>
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<td>• Student reviews</td>
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<td>• Peer consultation</td>
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<td>• Client feedback</td>
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<td>• CE in ethical and legal issues in CFP</td>
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<td>• Publication and presentation in scholarly venues regarding ethical and legal standards</td>
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<td>• Participation in consultation groups or ongoing supervision</td>
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<td></td>
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<td>• Service as ABPP examiner</td>
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<td></td>
<td></td>
<td>• Ethics consultation to other practitioners</td>
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</tbody>
</table>
### Skill
- Awareness and application of ethical decision-making model
- Intentional inclusion of relevant ethical and legal principles in all aspects in CFP
- Ability to articulate the ethical decision-making model used to reason through ethical dilemmas
- Ability to reasonably anticipate ethical and legal conflicts inherent in CFP practice
- Ability to identify, analyze, and proactively address legal and ethical conflicts during the course of providing couple and family services
- Professional writings, presentations, research, teaching, supervision, assessment, intervention, and consultation will represent efforts to include ethical principles and standards related to CFP

### Attitudes
- Commitment to ethical and legal development
- Strive to continually improve in ethical competency
- Evidence of continued development in the competency
- Ability to manage and avoid legal and ethical risks
- Take responsibility for continued professional development of knowledge, skills, and attitudes in relation to ethical-legal standards and policies relevant to CFP

There are a number of unique ethical challenges in Couple and Family Psychology. The APA Ethical Principles of Psychologists and Code of Conduct specifically addresses Therapy Involving
Couples or Families, 10.02. Behnke, (2004) stated that psychologists who work with children, adolescents, couples and families often include various configurations of individuals in their work. Psychologists will take reasonable steps to clarify: (1) which of the individuals are clients, and (2) the relationship the psychologist will have with each person: Limits of Confidentiality 4.02. Even in individual therapies, psychologists will sometimes include significant persons from the client’s life as is clinically indicated and in a limited manner. Including additional individuals in a therapy is a clinical decision that can be appropriate and helpful. Such determinations become problematic when individuals are not clear whether they are clients and do not understand the psychologist’s role. By virtue of Standard 10.02, psychologists will carefully think through their relationship with each of the people whom they involve in therapy. As with Standard 3.11 Psychological Services Delivered to or Through Organizations clarification of these issues follows from the psychologist first having considered how to organize and structure the services in the most clinically helpful manner. Furthermore, General Principle E, Respect for People’s Rights and Dignity exhorts the psychologist to respect the right of individuals to self-determination.

Change of Format (e.g. conducting limited individual sessions within the context of couple or family therapy) is a specific strategy in Couple and Family Psychology. While this is not inherently unethical, there are three major ethical issues that arise: Confidentiality, Responsibility, and Specific Iatrogenic Risks. Should there be full disclosure, partial disclosure, or no disclosure? This needs to be addressed from the onset with Informed Consent: responsibility to clarify from the onset of treatment the nature of the professional relationship with each of the persons involved. The Couple and Family psychologist must carefully consider and balance ethical considerations and clinical processes.

SELECTED REFERENCES FOR ETHICAL & LEGAL COMPETENCY


Criterion V. Advanced Scientific and Theoretical Preparation. In addition to a shared core of knowledge, skills and attitudes required of all practitioners, a specialty requires advanced, specialty-specific scientific knowledge.

Commentary: Petitions demonstrate how advanced scientific and theoretical knowledge is acquired and how the basic preparation is extended.

Specialty training is an essential component of Couple and Family Psychology. Built on the core and common principles of training as a Psychologist, Couple and Family Psychology focuses on the relational elements of each of the primary domains of psychological training. The core competencies of Couple and Family Psychology addressed in specialty training have been outlined in the sections above. The Taxonomy for Education and Training in Couple and Family Psychology (Appendix G) describes these elements. The criteria developed by Stanton & Welsh (2011), identified by Patterson and others (2009), and used as part of ABCFP certification specify in detail the competencies required of CFP practitioners at various levels. We also included a description of the role of psychopathology in Couple and Family Psychology. CFP has developed criteria that includes pathological as well as wellness models that extend beyond those applied to individuals. Evidence-based assessment tools that specify couple, parent-child, and family dysfunction have been developed by leading family psychologists (e.g., Pinsof, Sexton); they are unique to our specialty and are not included in the DSM or ICD. Specialty training is not required but is sought at the post-doctoral level. Specialty training in one or more areas is required for designations like ABPP.

Other organizations that work in related areas are not part of the specialization of Couple and Family Psychologists. For example, AAMFT (American Association of Marital and Family Therapy) AAMFT is a professional guild with its unique training requirements that are quite different from those described here. As noted above, the specific training requirements, different ethical codes, and differences in practice domains would make it impossible for AAMFT to be part of the core pathway for training CFP. While some psychologists may be involved in both AAMFT and APA, compared to MFTs, they have received advanced clinical preparation in Couple and Family Psychology based on CFP science and their training makes them eligible for ABPP certification. Advanced preparation in MFT does not qualify a professional to be eligible for the ABPP certification in CFP.

In addition to the information provided below, CRSPPP is also referred to the Council of Specialties in Professional Psychology web site (COSPP.ORG) under the specialty of Couple and Family Psychology where three documents addressing Criterion V. are listed: 1) Doctoral Training Guidelines, 2) Post-Doctoral training Guidelines, and 3) Education and Training Guidelines: A Taxonomy for Education and Training in Couple and Family Psychology. The Taxonomy is also contained in Appendix G.

The following additional evidence for this criteria is contained in the following appendices:

- APPENDIX G: TAXONOMY OF EDUCATION AND TRAINING FOR COUPLE AND FAMILY PSYCHOLOGY,
- APPENDIX H: AMERICAN BOARD OF COUPLE AND FAMILY PSYCHOLOGY ELIGIBILITY CRITERIA INCLUDING SENIOR TRACK,
- APPENDIX I: AGGREGATE DATA ON DOCTORAL PROGRAMS, PREDOCTORAL INTERNSHIPS, AND POSTDOCTORAL INTERNSHIPS/FELLOWSHIPS,
1. Specialty education and training may occur at the doctoral (including internship), postdoctoral or post-licensure levels. State the level of training of the proposed specialty.

Couple and Family Psychology is a doctoral level specialty that is focused on a systems view of families, relationships, and organizations. This specialty has a rich history, drawing upon traditional psychological theory as well as the multidisciplinary field of marital and family therapy. The training of Couple and Family Psychologists includes broad-based clinical and counseling skills as well as systems theory, and assessment and intervention from a systemic and multisystemic perspective. Didactic and experiential training is obtained at the graduate, internship and postdoctoral levels. Experience in clinical settings is obtained under supervision.

2. Training at the doctoral level is assumed to be primarily broad and general. If specialty training occurs in whole or in part at the doctoral level, describe that training. If there is specialty specific scientific knowledge that is typically integrated with aspects of the broad and general psychology curriculum [e.g., biological bases of behavior, cognitive-affective bases of behavior, individual bases of behavior, ethics (science and practice)] rather than taught as a freestanding course or clinical experience, specify how this integration occurs.

Specialty-specific advanced knowledge in Couple and Family Psychology relates primarily to understanding the properties of natural systems. However, this specialty-specific knowledge requires a solid foundation in the core scientific areas of psychology as a general discipline. Below we address the unique features of training in couple and family psychology in each of the core areas of doctoral training. These descriptions should be added to the core competencies of the field and education noted in the sections above.

a. Biological bases of behavior:

Natural systems are groupings of individual organisms which occur naturally in nature, e.g. the human family; a school; a larger community. Since these groupings are naturally occurring biological organisms, a Couple and Family Psychologist must have a solid grounding in the biological bases of behavior. Moreover, systems are composed of individuals whose behavior has a biological foundation. Understanding the principles of anatomy and physiology and the interaction between the biological, individual, family and environmental (social) variables as determinants of behavior, is essential. Specific areas which are most relevant to Couple and Family Psychology would be the effects of drugs and neuropsychological problems on family interaction, developmental disabilities and organically-based psychological problems. Also important would be the impact of chronic illness and/or long-term disability on the family. Current scientific knowledge of biological issues in parenting--both mothering and fathering--are essential to Couple and Family Psychology as are the biological components of sexuality and sexual dysfunction.
b. **Cognitive-affective bases of behavior:**

Since human beings organize their emotional experiences cognitively, a Couple and Family Psychologist must have a thorough understanding of the cognitive and affective bases of behavior. Complex interactions which happen in families and other groups are based upon prior learning and systems interventions are designed to lead to new learning. Understanding of basic operant and respondent conditioning as well as more complex social, cognitive, and information processing aid the Couple and Family Psychologist in conceptualizing problems and changing the course of behavior. Couple and Family Psychology requires understanding the scientific foundations of cognitions and affect and their impact on and interactions with larger systems beyond the individual. Communication research is particularly relevant.

c. **Social bases of behavior:**

A systemic perspective focuses on the reciprocal interaction of the individual and the group on the whole system. Thus, it is important for the Couple and Family Psychologist to have a strong background in individual development, as well as a thorough understanding of interpersonal dynamics and the social bases of behavior.

A family is a social system within a larger social system. It is important for the Couple and Family Psychologist to understand the principles governing social systems and their interaction. Since Couple and Family Psychology requires an understanding of the systemic (i.e., the reciprocal and historical), aspects of individual and group behavior and social interactions are a foundation of systems thinking applied to human beings. Therefore, a strong scientific foundation in the social bases of behavior is particularly critical for the Couple and Family Psychologist. Knowledge of social influence theory, attribution theory, attitude change, interpersonal attraction, small group interaction, family-of-origin dynamics, emotional triangles, underfunctioning and overfunctioning family systems, multigenerational transmission of relationship patterns, and impact of genograms as interventions are essential. Problems such as teen-age gangs, violence and abuse, parenting, adoption, and step-parenting, and school issues would be a few applications.

d. **Individual bases of behavior:**

The psychological functioning of the individual and the family or other social system is interactional. To understand the interaction requires a thorough grounding in the scientific bases of development, personality functioning, and individual psychopathology.

In addition, facing one’s own individual resistance to change helps the Couple and Family Psychologist avoid pathologizing clients. These experiences generate empathy for clients as they attempt to change. Taking a nonpathologizing stance while understanding individual and group psychopathology is essential in terms of joining with families and mobilizing their strengths. Working on one’s own family inspires humility in a Couple and Family Psychologist, and increases the probability that the psychologist will not judge the family or blame any members of the family for the behavior of other members. The ability not to blame any individual member(s) is the essence of achieving a systemic perspective. This fundamental emphasis on strengths/health in clients, whether they be individual clients, couples, families, or organizations, does not preclude or obviate the necessity/requirement for training in psychopathology, particularly from a biopsychosocial and systemic perspective. Kaslow, Celano, and Stanton (2005) state that training
in Couple and Family Psychology must require a paradigm shift from linear analysis of human behavior to conceptualizing human behavior in a fashion that integrates intraindividual, interpersonal, environmental, and macrosystemic elements. For example, prodromal, active, and remission stages of mental illness in a family member can be recursively influenced by expressed emotion in the family, and consequently addressed in treatment with a family-focused approach as described by Miklowitz and Goldstein (1997) in the treatment of bipolar spectrum disorders. The importance of evidence based assessment and intervention with specific pathology has been summarized and addressed in the previous sections of Assessment and Intervention. The training, specific to Couple and Family Psychology can occur at the doctoral level with courses and programs identified in Criterion VII, Internships and Fellowships also identified, and Continuing Education also identified in the Renewal Petition. Stanton and Welsh (2011) thoroughly address training in the specialty competencies, and Thoburn and Sexton (2016) also summarize training, supervision, and ethics in Couple and Family Psychology.

e. Ethics (science and practice):
Couple and Family Psychologists must be familiar with laws and regulations regarding such issues as custody and visitation, child, spouse and elder abuse; and ethical relationships with attorneys. If planning to engage in active courtroom work, the Couple and Family Psychologist must be trained in Family Forensic Psychology.

f. Research design, methodology, statistics:
The Couple and Family Psychologist must have skills in a variety of research methodologies and techniques including quantitative, qualitative and meta-analytic approaches to research. They must also be able to apply statistical as well as more qualitative approach to data analysis. Understanding of various therapeutic models will allow them to ask relevant and useful research questions. Moreover, Couple and Family Psychologists must be knowledgeable about systems-based process and outcome research and relevant approaches to data analysis. Research paradigms that analyze family and/or group interactions are necessary. Some aspects of sociological research may also be relevant to family and larger systems research.

g. History and systems:
Couple and Family Psychologists must be well versed in the philosophical and historical origins of the discipline of psychology and of the perspectives which have shaped contemporary psychology. Thus, they must have completed coursework that includes the various schools of thought associated with the field of psychology and the impact of these schools on contemporary practice in psychology. Within the context of history and systems, the history of Couple and Family Psychology may be seen as emerging from a synthesis of empiricism, systems thinking and clinical psychotherapy.

h. Measurement:
Competence is needed in couple and family assessment that goes beyond individual measures and test batteries. A Couple and Family Psychologist should be able to construct new tests or use current instruments to measure family functioning, carry out validation studies, and administer and interpret test results. Evaluating how a family functions requires the ability to assess relationship patterns in both current functioning and in prior generations. The ways in which a family manages
emotional closeness, distance, and conflict are central to the work of a Couple and Family Psychologist. Understanding how relationship patterns are transmitted across generations also is essential.

Couple and Family Psychology assumes that sets of categories exist along a continua by which families and larger systems can be assessed to be healthy and functional or unhealthy and dysfunctional. Assessment also may describe types of dysfunction. Various schools of thought in Couple and Family Psychology view problems through their own theoretical perspectives. Some focus on the structure of the family or group, while others focus on sequences that maintain symptoms. Others look at variables such as communication, patterns, cohesion, affection, etc.

Assessment of families or groups from a systems perspective may include clinical interviews; family-oriented instruments, projective techniques such as Kinetic Family Drawing (KFD) and family Thematic Apperception Test (TAT); semi-structured approaches such as the family genograms, Beavers-Timberlawn Scale; Family Adaptation and Cohesion Evaluation Scales (FACES); and lifestyle analysis and birth order (refer to Criterion IV section on Assessment).

i. Practicum:

Students in Couple and Family Psychology often have the opportunity to work in clinical settings that conceptualize cases systemically, or intervene with the family in some way.

j. Supervision:

Couple and Family Psychology requires skills in supervising/training others in developing Couple and Family Psychology knowledge and skills. This includes knowledge of a broad range of Couple and Family Psychology models/schools/techniques and the impact of issues of diversity (ethnicity, gender, SES, sexual orientation, ability, etc.). Supervision is particularly important in Couple and Family Psychology since multiple members of the system being treated can be overwhelming. Live supervision with a supervisory team observing behind a one-way mirror, or via co-therapy, is a common and distinctive practice of Couple and Family Psychology. Others who may be supervised by Couple and Family Psychologists include master’s and doctoral students or interns in Couple and Family Psychology, other mental health professionals, fellows or postgraduate trainees, master’s levels professionals in managed care settings, or psychologists undergoing re-specialization training.

k. Consultation:

Couple and Family Psychology requires the ability to consult with a wide range of clients regarding systemic issues and solutions to systemic problems. These may include consulting with schools regarding the needs of children in families, with attorneys regarding child custody and other family law matters, with primary care physicians, other health care providers, with community agencies and with psychiatrists or physicians regarding medication or hospitalization. The field also requires knowledge of functioning of systems in general as well as characteristics of particular areas of concentration (e.g., schools, family business, primary medical care). The curriculum includes attention to these issues.

l. Internship:
A typical one year full-time pre-doctoral internship with a Couple and Family Psychology emphasis should include a balance of clinical experiences and didactic offerings. The pre-doctoral internship needs to have an emphasis on the integration of theory and research into the practice of Couple and Family Psychology. In addition, the integration of theory, research, and practice in applied psychology generally and Couple and Family Psychology more specifically, needs to be central to the professional socialization of the pre-doctoral intern. Interns need to be provided with a diversity of clinical experiences in assessment and intervention with couples and families. In addition, the intern needs to have substantial opportunities for the systems assessment and treatment of individuals and interpersonal psychopathology and/or organizational problems. Both individual and group supervision need to be offered. One-way mirror, co-therapy, or videotape supervision are preferred over exclusive reliance on verbal case report. In addition to the core seminar topics important for interns, Couple and Family Psychology training at the internship level must include seminars in family and systems oriented work with individuals, couples, families, and groups. Such seminars may include topics as clinical assessments with diverse couples and families, theory-driven clinical interventions, family process and outcome research, etc. Live supervision family therapy seminars are highly recommended.

m. Other, including any additional specialty courses that do not fit the above categories:

Understanding the systemic nature of behavior is very difficult because we naturally experience other people’s behavior as emanating from a specific person or group of persons. Thus, achieving a systemic perspective is counterintuitive. Systemic principles can be taught at a beginning level through readings and classroom instruction. However, at a more advanced level, the student’s training must be more experiential. Two experiential training techniques that are used to provide advanced scientific and theoretical preparation to Couple and Family Psychologists are: work on the student’s own family of origin; and live supervision of work with families and/or larger systems.

Working on one’s own family of origin provides a concrete experience of such systems concepts as: emotional triangles; the underfunctioning/overfunctioning couple; and the multigenerational transmission of relationship patterns. Although psychoanalytic training also requires working on the self, family of origin work differs from the kind of work a psychoanalytic trainee might do. Family of origin work involves interviewing family and extended family members, rather than simply talking about these people in a therapist’s office. In family of origin work, the focus is on relationship patterns (rather than intrapsychic processes), e.g. pursuing and distancing; and managing the anxiety in a two-person dyad by triangulating a third person. This family research is then used to construct one’s own family genogram.

n. Other:

Other necessary scientific knowledge relates to process and outcome research in family therapy; family evaluation/assessment; legal issues regarding family law, child custody, child/spouse/elder abuse, confidentiality; ethics in Couple and Family Psychology; and supervision in Couple and Family Psychology. For example, in addition to work on one’s own family, beginning Couple and Family Psychologists need extensive supervision as they try to achieve advanced scientific and theoretical knowledge in their clinical practice. When working with a family, it is easy to become overwhelmed by the multiple members. Conflict can escalate, and members can be scapegoated. Because of the powerful nature of family systems, inexperienced family therapists can make things
worse, rather than better. Live supervision provides a safety net for the beginning family therapist and is more extensively used in Couple and Family Psychology than other specialties.

Live supervision involves a supervisor, and sometimes other students and colleagues, observing a session behind a one-way mirror. Clients are informed that this observation is occurring and usually are taken behind the mirror to see the room that the “team” will be in. In some training sites, the team is introduced to the family as well. The team might interrupt a session with a telephone call to the therapist, or through the use of “bug in the ear” technology, suggesting another line of questioning, or the team might send a message to the family directly. In this form of supervision, the “team” becomes a version of co-therapist. As a Couple and Family Psychologist becomes more experienced, supervision usually changes to videotapes of sessions. Again, direct observation of the ways in which a Family Psychologist loses his/her systemic perspective is provided by watching a videotape of self.

When Couple and Family Psychologists are working with larger systems, apprenticeship with an experienced Couple and Family Psychologist on-site replaces live supervision behind a one-way mirror. For example, in family-school consultation or collaboration with family practice physicians, training typically includes a year of observing more experienced Couple and Family Psychologists, and then working with the more experienced person as a co-consultant, similar to the way a co-therapist might work in a therapy session. The co-consulting provides a forum in which the beginning Couple and Family Psychologist can be given live supervision.

In summary, because of the difficulty in achieving a systemic perspective, and because of the number of clients with whom a Couple and Family Psychologist works, advanced training in this specialty requires more live supervision than is typical of most other fields of psychology. The development of this supervision model and research evaluating its effectiveness are critical to Couple and Family Psychology.

3. If specialty training occurs in full or in part during a formal postdoctoral program describe the required education and training and other experiences during the postdoctoral residency. Are there any doctoral level prerequisites beyond an APA-accredited degree in professional psychology required for postdoctoral training?

Postdoctoral training in Couple and Family Psychology is based on the premise that the doctoral resident holds a doctorate in professional psychology from a program that is accredited by APA/CPA or designated by ASPPB/National Register. It is assumed that the resident applicant has obtained a doctorate with a focus in clinical, counseling, or school psychology and has had some course work and pre-doctoral internship experience in family/child psychology. If an applicant has not obtained a doctorate with such a focus; first, he or she should be directed to a respecialization program. It is further assumed that the resident applicant has completed a pre-doctoral internship accredited by APA/CPA or approved by the Association of Psychology Postdoctoral and Internship Centers (APPIC). Each postdoctoral training program in Couple and Family Psychology will be responsible for determining criteria and procedures to assess an applicant’s competence in basic areas of applied psychology, either directly through the program or in some other acceptable academic/clinical forum whenever necessary. Supplementation of any existing deficiencies of the applicant may be required by the program as a condition of admission (Williams, Kaslow, & Grossman, 1994).
• A full-time postdoctoral residency (one or two years) or a part-time postdoctoral externship (two to four years) in Couple and Family Psychology is needed to consolidate mastery of the specialty. The nature and duration of the residency experience is determined in part by the nature and amount of prior training in Couple and Family Psychology (e.g., individuals who have had minimal pre-doctoral training in Couple and Family Psychology will require longer, more intensive postdoctoral training that will need to include clinical, didactic, and research training to remediate their deficiencies in Family Psychology education).

• In addition to ongoing weekly clinical supervision, preferably using a one-way mirror, videotape, and/or co-therapy, the following is a proposed model for postdoctoral training in Couple and Family Psychology (Williams, Kaslow, & Grossman, 1994). Training should be offered in (a) professional and ethical issues in Couple and Family Psychology, (b) marital and family systems theory, (c) assessment in Couple and Family Psychology, (d) couple and family intervention skills and strategies, (e) educational skills, (f) sex therapy, (g) family law, (h) family research, (i) supervision and consultation, and (j) management (administration).

4. If specialty training occurs in full or in part post-licensure, describe the required education and training during this training. Are there any doctoral level prerequisites beyond an APA-accredited degree in professional psychology required for post-licensure training?

As a specialty in Psychology, Couple and Family Psychology is represented in ABPP, the American Board of Professional Psychology. As noted above, the American Board of Couple and Family Psychology and the Academy of Couple and Family Psychology work together to promote post licensure education and training (see above).

Sub-Specialty Training

Sub-specialty areas of Couple and Family Psychology most often cited are: sex therapy, international family psychology, collaborative health care, and family forensic psychology. Advanced training in these areas usually occur through specialty programs or other institutes that specialize in these areas. For example, The Kinsey Institute provides advanced training in sex therapy, the International Academy of Family Psychology is a nonprofit worldwide scientific organization of academic and professional psychologists, primary care medical and surgical settings provide training in collaborative health care, and the Association of Family and Conciliation Courts (AFCC) provides training in family forensic psychology. It is important to clarify, however, that AAMFT and AFCC are multidisciplinary organizations, not exclusively organizations for psychologists. As with all psychologists, it is mandatory that “Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience” (Ethical Principles of psychologists and Code of Conduct, Section 2 Competence).

References


Criterion VI. Advanced Preparation in the Parameters of Practice. A specialty requires the advanced didactic and experiential preparation that provides the basis for services with respect to the essential parameters of practice. The parameters to be considered include: a) populations, b) psychological, biological, and/or social problems, and c) procedures and techniques. These parameters should be described in the context of the range of settings or organizational arrangements in which practice occurs. If the specialty training occurs at more than one level (e.g., doctoral, postdoctoral, post-licensure) please list the levels of preparation separately.

Commentary:

A) Populations. This parameter focuses on the populations served by the specialty, encompassing both individuals and groups. Examples include but are not limited to the following: children, youth and families; older adults; workforce participants and those who seek employment; men and women; racial, ethnic, and language minorities; gay, lesbian, bisexual and transgender individuals; persons of various socioeconomic status groups; religion; and those with physical and/or mental disabilities.

B) Psychological, Biological, and/or Social Problems. This parameter focuses on symptoms, problem behaviors, rehabilitation, prevention, health promotion and enhancement of psychological well-being addressed by the specialty. It also includes attention to physical and mental health, organizational, educational, vocational, and developmental problems.

C) Procedures and Techniques. This parameter consists of the procedures and techniques utilized in the specialty. This includes assessment techniques, intervention strategies, consultative methods, diagnostic procedures, ecological strategies, and applications from the psychological laboratory to serve a public need for psychological assistance.

The specialty of Couple and Family Psychology differs from other specialties in psychology because of the unique perspective from which Couple and Family Psychologists are trained to consider the biopsychosocial problems of their clients. Couple and Family Psychologists are trained to utilize key systemic concepts such as reciprocity, self-organization, complexity, adaptability, and social construction (Nutt & Stanton, 2008; See Appendix G). It is not so much that Couple and Family Psychologists treat different populations than other professional psychologists. Nor is it even that a Couple and Family Psychologist’s clients present with vastly different problems. Rather, the epistemology of the Couple and Family Psychologist differentiates him or her from the more traditionally trained professional psychologist. The Couple and Family Psychologist is trained to approach client issues from systemic and multisystemic perspectives. This perspective provides a vastly different conceptual model from which to view the complex presenting issues of families and their constituent members. Whether the client is a family, a couple, or a single member of a family, to the extent that the client’s presenting issue intersects with family or systemic functioning, a specialized conceptual model and related interventions are required. Consequently, a specialization in Couple and Family Psychology provides a unique perspective and approach to working with many of the same populations and problems treated by psychologists from other specialties.

The overarching theme distinguishing Couple and Family Psychology from other specialties that has been discussed in the CRSPPP Renewal is that the development of couple and family psychologists requires an epistemological transformation and achievement of core systemic competencies by following one of several educational and training pathways. As referenced earlier in the petition, the
specialty of CFP is not defined or characterized by the population treated or by the psychopathology addressed. CFP is a broad-based specialty that includes working with individuals, couples, families, family businesses, and family forensic work in a variety of contexts (school systems, primary healthcare, the justice system, and family business). Couple and Family Psychologists provide assessment and intervention to children, adults, couples, and families. CFP specialists provide supervision and consultation to various individuals and organizations and support effective program development and implementation through evaluative and basic research.

Traditional psychology has focused almost exclusively on the individual’s functioning and has virtually ignored the impact of the various systems within which an individual is embedded. By contrast, CFP requires that psychologists focus on the relational and contextual nature of an individual’s functioning. By understanding how small and large systems intersect, couple and family psychologists gain a broad understanding of human behavior. CFP look at the interactional system, the intergenerational system, the community system, and larger organizational and societal systems. Regardless of the number of clients being treated, the CF Psychologist conceptualizes problems in terms of systems. Psychological problems and their manifest symptoms are conceptualized in terms of the context in which the symptom was created, maintained, and influenced by others with whom the individual interacts. This epistemological perspective of the CF Psychologist is the differentiating hallmark from other psychologists. Consequently, the best education and training in Couple and Family Psychology will systemically develop student outcome competencies informed by a systemic epistemology.

Couple and Family Psychology recognizes the importance of a broad and general education in the science of psychology, the value of psychological assessment, intervention, consultation, supervision, ethics; with the epistemological paradigm shift to systems thinking. There are no separate doctoral programs in couple and family psychology (Clinical, Counseling and School Psychology dominate the training landscape) however; this does not represent a fatal flaw in training. Criterion VII will identify programs at the doctoral, internship, and postdoctoral training levels where the specialty competencies of CFP can be attained. A training program within the parameters of CFP should be consistent with key aspects of the specialty and include the following:

a) A paradigm shift from an intrapsychic and individual conceptualization to a systemic conceptualization.

b) In the systemic conceptualization there is: a focus on individuals, couples, families, and other systems as they operate within the various systems in which they are embedded.

c) Patterned interactions within and among these systems are identified in order to gain a comprehensive understanding of human functioning.

d) The client may be defined as an individual (whose presenting problems are considered within the larger systemic perspective) or any larger system (whether it is a couple, family, organization, or other type of system).

e) The types of problems being treated may not be different from those treated by other psychologists. What differs is the conceptualization of the problem as discussed above.

f) Couple and Family Psychologists are competent to treat the full spectrum of mental disorders, but they do so with special attention to the relational context of the disorders and their reciprocity between disorders and interpersonal contexts, whether clients are being treated as individuals, couples, families, or other group contexts.

g) The skills needed to be a couple and family psychologist include systemic case conceptualization, systemic assessment, and systemic approaches and techniques in individual psychotherapy, sex therapy, couples and marital therapy, family therapy,
psychoeducational strategies and divorce therapy. Couple and Family Psychologists have possess specialized skill and experience in assessment approaches and instruments that measure individual, couple, family, and broader system functioning.

h) Systemic conceptualizations also require special attention to ethical issues which must be dealt with somewhat differently that with more intrapersonal approaches.

1. Describe the advanced didactic and experiential preparation for specialty practice in each of the following parameters of practice:

   a. populations (target groups, other specifications):

   CFP specialists work with individuals, couples, families, and broader environmental systems, such as schools, medical clinics, and business organizations. CFP is not characterized narrowly by a particular population served. Rather, it is defined by its systems perspective from which problems and developmental issues are addressed (Family Psychology Specialty Council, 2009). CFP specialists work in a variety of contexts such as hospitals, clinics, independent practice, schools, colleges and universities, business, government and other organizations.

   b. problems (psychological, biological, and/or social (including symptoms, problems behaviors, prevention, etc):

   As noted above, Couple and Family Psychologists work with a wide range of clinical problems. Education and advanced training in these areas comes through advanced course work at the doctoral and post-doctoral level following the functional competencies noted in Criterion IV above.

   c. procedures and techniques (for assessment, diagnosis, intervention, prevention, etc.):

   An expansive list of the unique procedures of Couple and Family Psychology are noted in the Sections above. An updated version of a flowchart by Stanton and Nurse (2005) depicts the routes a psychologist may take to become a specialist is CFP (see Appendix O). Educational programs identified as having an Emphasis to Major Area of Study in Couple and Family Psychology approach the teaching of the core areas of psychology:

   1) Content in history and systems of psychology includes the history of couple and family psychology, systemic thinking, and the development of the specialty of couple and family psychology.
   2) Content on life-span human development considers both individual and family life-cycle development.
   3) Because multicultural and diversity issues strongly affect not only the individual but the systems, the program offers content in Multicultural issues and diversity, including each area of diversity defined in the APA CoA Guidelines and Principles of Accreditation such as gender and sexual orientation. Ideally, multiculturalism and diversity themes are reflected in each of the core and advanced content areas.
   4) Ethical and legal issues are studied and the special ethical and legal challenges which systemic work engenders are addressed (e.g., confidentiality considerations in couple and family therapy—change of format).
   5) Psychological measurement includes family and relational assessment along with more traditional psychological assessment tools.
   6) Content of research methodology considers the methodological approaches best suited
to the study of systems. Because qualitative approaches are particularly well suited to
the study of systems, the program includes qualitative research and qualitative data
analysis strategies in any content areas on research methodology.

In addition to academic training, a couple and family psychology doctoral program (Emphasis to
Major Area of Study) requires that students receive adequate and appropriate practicum experiences in
the specialty. The practicum must be integrated into the doctoral program and there must be sufficient
opportunity for discussion of the practicum in the educational program. The couple and family
psychology core faculty function as role models for students in the specialty area and the faculty
socialize students in the discipline of couple and family psychologists. Major faculty should be board
certified in Couple and Family Psychology through the American Board of Couple and Family
Psychology (ABPP) and as part of their socialization of students to the specialty, they should
courage students to participate in the ABPP Early Entry Option.

Post-doctoral Education and Training: Historically, most couple and family psychology education and
training was accomplished in family institutes (see Criterion VII). Alternatively, there are a variety of
continuing education programs that provide specialty training. ABPP occasionally sponsors
workshops, sometimes in conjunction with the APA Annual Convention. This can be and should be
enhanced with supervision from a board certified Couple and Family Psychologist in a structured
sequential training in the core competencies of the specialty.
Criterion VII. Structures and Models of Education and Training in the Specialty. The specialty has structures and models to implement the education and training sequence of the specialty. The structures are stable, sufficient in number, and geographically distributed. Specialty education and training may occur at the doctoral, postdoctoral, or both.

Commentary:

A) **Sequence of Training.** A petition describes a typical sequence of training, including curriculum, research, and supervision.

B) **History and Geographic Distribution.** A specialty has at least four identifiable psychology programs providing education and training in the specialty in more than one region of the country that are geographically distributed and which have produced an identifiable body of graduates over a period of years.

C) **Psychology Faculty.** Specialty programs have an identifiable psychology faculty responsible for the education and training of students and their socialization into the specialty. The faculty has expertise relevant to the education and training offered. Faculty may include individuals from other disciplines as appropriate. Specialty programs also have a designated psychologist who is clearly responsible for the integrity and quality of the program and who has administrative authority commensurate with those responsibilities. This psychologist has credentials of excellence (e.g., the diplomat from one of the specialty boards affiliated with the American Board of Professional Psychology, or status as a fellow of the American Psychological Association or the Canadian Psychological Association, or other evidence of equivalent professional recognition) and a record of scholarly productivity as well as other clear evidence of professional competence and leadership.

D) **Procedures for Evaluation.** Specialty programs regularly monitor the progress of trainees to ensure the relevance and adequacy of the curriculum and integration of the various training components. Attention focuses on the continuing development of the trainee's knowledge, skills, attitudes, and values. Formal performance based feedback is provided to trainees in the program.

E) **Admission to the Program.** Program descriptions specify the nature and content of the program and whether they are designed to satisfy current licensing and certification requirements for psychologists as well as whether or not graduates can satisfy the education and training requirements for advanced recognition in the specialty. Postdoctoral programs have procedures that take into account the trainees' prior academic and professional record. These programs design an education and training experience that builds upon the doctoral program and internship and the professional experiences of the postdoctoral residents as they prepare for meeting the guidelines of preparation for the specialty.

To address these issues we have conducted a comprehensive search and review of programs described below and in Appendices G, I, J, K, L, and M.

**Education and Training in Family Psychology**

A specialty must also be defined and distinguished from generic clinical, counseling, and school psychology programs or other specialties by the educational course work, practica experiences, internships, post-doctoral fellowships, and other post-licensure education and training completed to become proficient in a specialty area. Consequently, the Education and Training Guidelines: A
Taxonomy for Education and Training in Professional Psychology Health Service Specialties (2012) was developed by the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology and subsequently approved by the APA Council of Representatives. As cited above, the Couple and Family Psychology Specialty Council, as a constituent member of the Council of Specialties subsequently developed a Taxonomy of Education and Training for Couple and Family Psychology (see Appendix G).

Foundational and Functional competencies in Couple and Family Psychology have been cogently addressed by Stanton and Welsh (2011). In their book the Foundational Competencies consist of: Ethical and Legal Competency, Diversity Competency, Interpersonal Interaction Competency, and Professional Identity as a Couple and Family Psychologist. Functional Competencies involved: Case Conceptualization, Assessment, Intervention, Consultation, Family Forensic Psychology, Supervision in Couple and Family Psychology, and Teaching Competency in Couple and Family Psychology.

The next important goal was to identify specific doctoral programs, internships, and post-doctoral training programs with training experiences in Couple and Family Psychology. Division 43, The Society for Couple and Family Psychology conducted a survey from May to June 2013 resulting in aggregate data on doctoral programs, pre-doctoral internships, and post-doctoral internships/fellowships in Couple and Family Psychology (see Appendix I). The next step was to provide more specificity to the aggregate data by identifying internship and post-doctoral sites in Couple and Family Psychology. One methodology used was a survey to pre-doctoral internship program sites (see Appendix J). Another more complete list of pre-doctoral internships sites was created by Division 43 (see Appendix K). Finally, post-doctoral fellowship training sites were identified (see Appendix L). The methodology used correlates to the results of any empirical inquiry. A search of APPIC Internships with “Family” as the Key Word Search Parameter yielded 26 results while Post-Doctoral Programs using “Family Psychology” as the Key Word Search Parameter yielded 41 results. Another important resource for psychologists interested in training in Couple and Family Psychology is provided by training programs by the American Association of Marriage and Family Therapy (see Appendix M).

A search for doctoral programs in couple and family psychology for the CRSSPPP Renewal was also completed using different search parameters. The website http://apps.apa.org/accredsearch was used to collect information on programs in Couple and Family Psychology. Using “Family Psychology” as the Key Word Search Parameter yielded 332 results, while using “Family Systems Emphasis” as the Key Word Search Parameter yielded only 3 results. The disparate results using different, yet fundamentally similar search parameters necessitated a thorough search of the 384 APA approved doctoral programs on the website. The methodology involved reviewing each program, locating the curriculum, and identifying courses in Couple and Family Psychology. In some cases specialty clinics were also identified that contributed to educational experiences in Couple and Family Psychology. After courses were counted, programs were identified using the Taxonomy categories of: Experience, Emphasis, and Major Area of Study. The category of Exposure was excluded from this data because of the limited number of courses in Couple and Family Psychology that would not meet the threshold of specialty training. As with all data, we admit that there is also a certain amount of subjective interpretation, and where relevant, this will be addressed. A random variable, however, is a student’s dissertation topic, and research in Couple and Family Psychology could elevate any one of the following programs to a higher category of training as listed in the Taxonomy.
### Doctoral Psychology Programs offering experience, emphasis, or a major area of study in CFP

<table>
<thead>
<tr>
<th>Experience</th>
<th>Experience/Emphasis</th>
<th>Emphasis</th>
<th>Emphasis/Major Area of Study</th>
<th>Major Area of Study</th>
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<tbody>
<tr>
<td>Palo Alto-Stanford Psy.D. Consortium</td>
<td>U. of Northern Colorado</td>
<td>U. of California</td>
<td>Adler Institute (depending on access to courses in Couple and Family Therapy Program)</td>
<td>Palo Alto U.</td>
</tr>
<tr>
<td>U. of Miami Clinical Psychology</td>
<td>Wheaton College</td>
<td>Illinois School of Prof. Psychology, Chicago Campus</td>
<td>U. of Massachusetts-Amherst (depending on electives, practicum, &amp; Center for Research on Families and the Rudd Family Foundation Endowed Chair for Adoption Studies)</td>
<td>Fielding Graduate U., Santa Barbara</td>
</tr>
<tr>
<td>Georgia School of Professional Psychology at Argosy U.</td>
<td>Ball State U. Counseling Psychology</td>
<td>Minnesota School of Professional Psychology at Argosy</td>
<td>Minnesota School of Professional Psychology at Argosy</td>
<td>U. of Denver Psy.D.</td>
</tr>
<tr>
<td>Iowa State Counseling Psychology</td>
<td>Indiana U. Bloomington Counseling Psychology</td>
<td>U. of Missouri, Columbia, Clinical Psychology (depending on electives, practicum, and Family Assessment Lab)</td>
<td>U. of Missouri, Columbia, Clinical Psychology (depending on electives, practicum, and Family Assessment Lab)</td>
<td>U. of Florida Counseling Psychology (dependent on electives)</td>
</tr>
<tr>
<td>Midwestern U., Downers Grove Campus</td>
<td>U. of South Carolina Clinical &amp; School Psychology</td>
<td></td>
<td></td>
<td>Nova Southeastern U. Ph.D. &amp; Psy.D.</td>
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<tr>
<td>Western Michigan U. Clinical Psychology</td>
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<td></td>
<td>Carlos Albizo U. Psy.D. (depending on access to curricula in Marriage and Family Therapy)</td>
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<tr>
<td>Antioch U. New England</td>
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<td>Chestnut Hill College Psy.D. (depending on practicum)</td>
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<tr>
<td>U. of Albany Counseling Psychology</td>
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<td></td>
<td>U. of Houston Clinical Psychology</td>
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<tr>
<td>Alfred U. Psy.D</td>
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<td>U. of North Texas Counseling Psychology</td>
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<td>Case Western Reserve U.</td>
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<tr>
<td>U. of Akron Counseling Psychology</td>
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<tr>
<td>Indiana U. of Pennsylvania Psy.D.</td>
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<tr>
<td>Carlos Albizu U. San Juan Psy.D.</td>
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2. How are education and training programs in the specialty recognized? How many programs exist in the specialty?


Graduate Study in Psychology (American Psychological Association, 2007) primarily identifies clinical, counseling, and school psychology programs. Although there are no accredited programs in Couple and Family Psychology; education and training in Couple and Family Psychology at the doctoral level is addressed through specialty tracks and course emphasis. For this reason, we conducted the comprehensive review of APA Accredited Doctoral Programs in Clinical, Counseling, and School Psychology Programs that meets the requirements of the Taxonomy of Education and Training for Couple and Family Psychology above the category of Exposure.

Programs with an emphasis in Couple and Family Psychology are fundamentally recognized by an epistemological transformation and core systemic competencies. Traditional psychology has focused almost exclusively on the individual’s functioning, that ignores or limits the impact of the various systems within which the individual is embedded. By contrast, the paradigm shift in Couple and Family Psychology requires that psychologists focus on the relational and contextual nature of the individual’s functioning. In addition, by studying how small and large systems intersect, couple and family psychologists gain a broad understanding of human behavior. Couple and Family Psychology tracks/programs emphasis are attentive to the interactional system between couples, the intergenerational system in the family, the community system (including cultural groups), and other larger organizational and societal systems (groups, social organizations, businesses, agencies, schools). The core competencies in Couple and Family Psychology have been addressed in Criterion IV. Stanton, Harway, and Vetere (2009) conclude: “The best education and training in family psychology will systemically develop student outcome competencies informed by a systemic epistemology” (p. 131).

Education and training in Couple and Family Psychology should be consistent with the fundamental systemic epistemology and include the following:
a) A paradigm shift from an intrapsychic and individual conceptualization to a systemic conceptualization.

b) The systemic conceptualization focuses on individuals, couples, families, and other systems as they operate within the various systems in which they are embedded.

c) Patterned interactions within and among/between these systems are identified in order to gain a comprehensive understanding of human functioning.

d) The client may be defined as an individual (whose presenting problems are considered within the larger systemic perspective) or any larger system (couple, family, organization, school, family business, or other type of system).

e) The types of problems treated may not be different from those treated by other psychologists. What differs is the conceptualization of the problem from a systemic perspective that incorporates systemic/contextual/interactional contributions to the etiology and maintenance of the symptom and how these problems are embedded in and reciprocally influence the relational system of the client.

f) Family psychologists are competent to treat the full spectrum of mental disorders, but they do so with special attention to the relational context of the disorders and the reciprocity between disorders and interpersonal contexts, whether clients are being treated individually or in couple, family, or group contexts.

g) The skills needed to be a couple and family psychologist include systemic case conceptualization, systemic assessment, and systemic intervention approaches and techniques in individual, psychotherapy, sex therapy, couples and marital therapy, family therapy, and divorce therapy. Couple and Family Psychologists have knowledge, skill, and experience in assessment approaches and instruments that measure individual, couple, family, and broader system functioning.

h) Systemic conceptualizations also require special attention to ethical issues which must be dealt with somewhat differently than with more intrapersonal approaches. (Stanton, Harway, and Vetere. p.134).

3. Describe the qualifications necessary for faculty who teach in these programs. Describe the qualifications require for the director of such programs.

Doctoral programs with an emphasis in Couple and Family Psychology have a core faculty of psychologists who identify themselves as Couple and Family Psychologists and provide leadership to the emphasis in CFP. They are sufficient in number to meet the academic and professional responsibilities associated with the program. They have theoretical perspectives, and academic and applied experiences appropriate to the goals and objectives of a Couple and Family Psychology program emphasis. They demonstrate substantial competence in Couple and Family Psychology through recognized indicators such as psychology licensure; research, presentations, and publications related to CFP specialty; membership and service in the Society for Couple and Family Psychology (APA Division 43) and similar groups within the state associations; election as fellows of the APA Division 43; post-doctoral board certification in Couple and Family Psychology from the American Board of Professional Psychology; and/or other specialty-related recognitions. The Couple and Family Psychology core faculty function as role models for students in the specialty area and they socialize students into the discipline of Couple and Family Psychology. Other adjunct faculty who identify with Couple and Family Psychology and have expertise in the specialty area may augment the core faculty in the provision of education and clinical training in Couple and Family Psychology.
Faculty members who teach in recognized postdoctoral training programs in Couple and Family Psychology often have completed postdoctoral training in Couple and Family Psychology or family therapy. Their competence in the field of Couple and Family Psychology is demonstrated by board certification in Couple and Family Psychology from the American Board of Professional Psychology, election as a fellow of Division 43, service in Division 43 through governance or committee activities, or scholarly publications (including research reports) related to Couple and Family Psychology. Training directors for recognized postdoctoral training programs in Couple and Family Psychology have similar qualifications. Training directors for predoctoral internship programs usually do not have specific training or qualifications in Couple and Family Psychology, as the internship year serves the purpose of general clinical training in professional psychology. However, internship programs offering a major rotation in couples or family therapy usually include one or more faculty members with demonstrated competence in Couple and Family Psychology, as defined above.

If programs are doctoral level, what are the requirements for admission? Provide sample evaluation forms.

Azusa Pacific University has been a model program with an emphasis in Couple and Family Psychology. Appendix Q provides a comprehensive description of their program, including, but not limited to: Sequence of courses, admission requirements, and evaluation forms.

The Family Institute at Northwestern University represents a postdoctoral training program in Couple and Family Psychology. Appendix R provides the criteria for admission and sample evaluation forms.

Provide sample curriculum expected of model programs.

(See item 3. Above and Appendix Q.)
Criterion VIII. Continuing Professional Development and Continuing Education. A specialty provides its practitioners a broad range of regularly scheduled opportunities for continuing professional development in the specialty practice and assesses the acquisition of knowledge and skills.

Commentary: With rapidly developing knowledge and professional applications in psychology, it is increasingly difficult for professionals to deliver high quality services unless they update themselves regularly throughout their professional lives through continuing education mechanisms. A variety of mechanisms may be used to achieve these goals.

1. Describe the opportunities for continuing professional development and education in the specialty practice. Provide detailed examples, such as CE offerings that are available.

This has been addressed in Criterion IV, Section 3, Subsection E. Page 17 lists 14 clinical topics represented in 34 videos published by APA related to the specialty of Couple and Family Psychology. In addition to these videos, the APA Office of Continuing Education in Psychology has over 350 independent study programs. Using “Couple and Family” as a search criteria yielded 12 continuing education programs. At the 2016 APA Annual Convention, Florence W. Kaslow, Ph.D., ABPP and G. Andrew H. Benjamin, Ph.D., JD, ABPP conducted a 4 hour Continuing Education Program: “Divorce and Its Aftermath: Psychological Interventions Before and After the Breakup.”

Other resources for continuing education are: The American Association of Marriage and Family Therapy (AAMFT), the Kinsey Institute, the American Association of Sex Educators, Counselors, and Therapists, and the American Association for Family and Conciliation Courts. Many psychologists belong to these organizations, but they are not organizations specifically for psychologists. They are multidisciplinary organizations, and as such they are not part of the Couple and Family Psychology Synarchy, obviating their participation in the CRSPPP Renewal.

2. Describe the formal requirements, if any, for continuing professional development and education to maintain competence in the specialty.

One avenue for psychologists to gain the education necessary for Couple and Family Psychology specialization is through continuing education and supervision. To be effective, continuing education must reflect the same specialty foundations in systemic orientation, specialty scientific knowledge and evidence-based practices. The primary intent of continuing education as referenced by Stanton and Welsh (2011) is twofold: to provide specialty education not included in one’s doctoral education, and to ensure continuing competency through education in extant research and practice advances. Methods for continuing education include face-to-face education and distance education using technology delivery methods or literature review and examination.

The American Board of Professional Psychology has instituted a Maintenance of Certification (MOC) process for specialty certification. The MOC is the only formal requirement for the maintenance of competency in Couple and Family Psychology, and the other specialties represented by ABPP. A description from the ABPP website follows.

**ABPP Maintenance of Certification.** From 2006 to 2014, the American Board of Professional Psychology developed a method by which specialists could periodically engage in self-review to assure quality care and protection of the public consistent with the highest professional standards. ABPP Maintenance of Certification (MOC) is consistent with ABPP’s strategic objective to
“maintain the value of board certification.” Throughout its development, adoption and implementation MOC has been thoroughly publicized to all specialists, academies, and specialty boards. Maintenance of Certification (MOC) involves a process of self-examination and documentation of one’s continuing professional development since the last examination or review. MOC involves documenting the professional activities you routinely engage in that demonstrate your continuing professional development.

Specialists certified before January 1, 2015 may maintain their certification in one of two ways, by completing their Specialty Board approved MOC grid and narrative, or by waiving this requirement and still maintaining their certificate. Specialists certified after January 1, 2015 must successfully demonstrate Maintenance of Certification every ten years to maintain their ABPP board certified status.

With the support of the ABPP Board of Trustees the MOC Task Force assisted specialty boards and ABPP Central Office in preparing for full implementation, including assisting specialty boards craft their specific grids and narrative materials and assisting Central Office with development of documents and a model for implementation. The MOC Task Force collaborated with the ABPP Standards and Bylaws committees to revise respective manuals to incorporate Maintenance of Certification requirements.

3. Describe the minimum expectations, if any, for continuing professional development and education to maintain competence in the specialty.

Stanton and Welsh (2011) conclude that the specialty of Couple and Family Psychology recognizes that competency is not something achieved once, rather, competency entails an ongoing commitment to remain current in the specialty research and evidence-based practices that apply to professional practice. The most common method to maintain competence is through the completion of continuing education in the specialty. Because most states require continuing education for licensure renewal, this requirement may be met by completing continuing education in the specialty. To be effective, continuing education must be based on the same specialty foundations in systemic orientation, scientific knowledge and evidence-based practices. The primary intent of continuing education is: (a) to provide specialty education not included in doctoral education, and (b) to ensure continuing competency through education in recent research and practice advances.
Criterion IX. Effectiveness. Petitions demonstrate the effectiveness of the services provided by its specialist practitioners with research evidence that is consistent with the APA 2005 Policy on Evidence-based Practice.

Commentary: A body of evidence is be presented that demonstrates the effectiveness of the specialty in serving specific populations, addressing certain types of psychological, biological and social behaviors, or in the types of settings where the specialty is practiced. PLEASE NOTE: If the same article illustrates more than one of these items, it may be referenced under each applicable category. Evidence should include the most current available published references in each area (e.g., books, chapters, articles in refereed journals, etc.) While reliance on some on classic references is acceptable, the majority of references provided should be from last five years.

Identifying the “best” methods to help the diverse clients who seek clinical help has always been of critical importance to Couple and family Psychology. In the sections below we briefly summarize the current research on the effectiveness of Couple and Family Psychology clinical interventions on different populations, and clinical problems delivered in different settings. This is a significant body of research and, as a result, we focus on systematic reviews, meta-analysis and major recent individual studies to illustrate the support for CFP in each area. In many cases, these reviews support each of the sections below.

Efforts to help further focus CFP research and how to translate those findings into practice have been a significant process since the last CRSPPP Renewal Application. In an attempt to integrate effectiveness research and in an attempt to help more finely tune how clinicians use evidence-based interventions and understand evidence-based practice in Couple and Family Psychology, Guidelines for Classifying Evidence-Based Treatments in Couple and Family Therapy were developed out of an initiative of the Society of Family Psychology (in 2007). These Guidelines (Sexton, Gordon, Gurman, Lebow, Holtworth-Munroe, & Johnson, (2011) demonstrate the range, depth and breadth of the evidence for Couple and Family Psychology. They also serve as a foundation for future research into the effectiveness of the Specialty.

1. Provide at least five psychological manuscripts published in refereed journals (or equivalent) that demonstrate the efficacy of the specialty’s services for dealing with the types of clients or populations (including groups with a diverse range of characteristics and human endeavors) usually served by this specialty. Summarize and discuss the relevance of the findings of the studies, specify populations, interventions, and outcomes in relation to the specialty practice.


The authors considered 205 family studies and found positive the effects of CFP treatment on twenty-six distinct clinical problems, among which four emerged as the primary focus of the research: youth behavior problems (40%), general mental health (3.4%), parenting (4.4%), family relationships (3.9%), and schizophrenic symptoms
(3.4%). In their analysis, Sexton and colleagues (2013) found that 46% of the research (including studies of parenting programs) produced significant findings that support the effectiveness of family-focused interventions, 43.4% had mixed results, and 10.2% found that family-focused interventions did as well as the alternative treatment in the study. No studies reported iatrogenic outcomes. Found Couple therapy to be effective for:

a) **Relationship satisfaction.** The majority of general CT studies (11 or 25%) investigated the impact of CT on relationship satisfaction. Of these 11 studies, 7 (63.63%) found that CT

b) Produced significantly positive outcomes; 3 (27.3%) showed that CT’s effects on relation- ship satisfaction were moderated by clients’ initial level of distress.

c) **Alcohol and substance use/abuse** was a common topic of CT research with 12 studies (27.3%) investigating the effectiveness of various behavioral couple therapy programs. (See section on behavioral couple therapy for alcohol and drug use.)

d) **Infidelity** was the topic of five (11.4%) studies. CT is particularly successful in the treatment of intimate partner violence with four of these studies (80%) reporting significant positive outcomes.

e) **Intimate partner violence.** Two studies of BCT looked at the impact of treatment on physical aggression associated with substance use, but found no evidence of a significant, positive effect. The results provided preliminary evidence that DVCFT helped to reduce physical aggression and increase relationship satisfaction.

f) **General mental health and depression** were the focus of five (11.4%) studies. The research produced little evidence that CT was effective in the treatment of mental health issues with only one study yielding statistically significant outcomes. Likewise, CT appears to have a limited impact on depression with only one study yielding significant positive results and three reporting mixed results.

*Family Intervention programs effective for:*

a) **Child and Youth Behavior Problems.** The majority of the studies (75 or 33.8%) investigated the effects of family and parenting programs on clinical problems related to child and youth behavior problems. Twenty-five (33.3%) reported positive and significant outcomes; 35 (46.7%) found mixed results; 11 (15.6%) showed that FT and parenting interventions produced outcomes that were equal to another comparable treatment; and four (5.3%) produced no evidence of success. Both meta-analytic and individual studies support the effectiveness of FT and parenting programs with a broad range of child and youth behavior problems.

b) **Youth Substance Use/Abuse Problems.** Both meta-analytic and individual clinical studies indicated that family intervention programs could be successful with youth substance use/abuse problems. Of the 23 individual studies that analyzed the effect of an FT intervention on substance abuse, nine (39.1%) had significant and positive outcomes, 13 (56.5%) had mixed outcomes, and one
(4.3%) found the FT interventions to be no more successful than the comparison group. These results are consistent with the single meta-analysis (Smit, Verdurmen, Monshouwer, & Smit, 2008) that investigated the effect of family-based interventions, including family therapy, family psychoeducation, and parenting skills training, on alcohol consumption in participating youth. Results from the five relevant controlled studies suggest that family-focused interventions are effective ($ES = 0.25$)

c) **Youth Bipolar, Depressive Disorder, and General Medical Conditions.** Bipolar disorder is often viewed as an individually based clinical problem. However, this review found 12 individual studies investigating the role of parenting and family interventions with this disorder. Of these studies, six (50%) found significant and positive outcomes, five (41.6%) had mixed results and only one had outcomes equal to the alternative treatment. This would indicate that FT and parenting interventions are promising interventions for what is often viewed as an individual problem. Youth depression is also a clinical problem that is often viewed as an individual clinical issue. Of the nine studies of family and parenting interventions directed at youth depression, three (33.3%) were successful, three (33.3%) reported mixed results, two had outcomes no different than the alternative, and only one with no evidence of effectiveness. General medical conditions of youth are an area of increasing focus in the family intervention literature. Of the 12 studies (5.9%) in this area, all were either significantly positive (50%) or had mixed results (50%). These outcomes would indicate that family interventions are a promising intervention category for medically based problems for youth.


In a review the last decade of family and couple psychology research and, in particular, its efficacy across settings and populations the authors concluded that there was a range of diversity of effectiveness across a diversity of clients, a significant range of effectiveness for different clinical problems, and an emerging set of evidence about settings in which Couple and Family Psychology interventions are effective. In reviewing effective studies of Couple and Family Psychology study samples were, as in other specialties, racially White and non-Hispanic with the exception of family therapy research on conduct disorder, youth drug abuse, psychoeducation for major mental illness, and child/adolescent internalizing problems (Sprenkle, 2012). They found that most studies were done in community based studies. Most studies are transportability trials that report the outcomes of specific interventions in the community (Schoenwald et al., 2012). Evidence suggests that therapist adherence and alliance building are both significant predictors of therapeutic outcomes with the MDFT model (Hogue et al., 2006; Hogue et al., 2008). For example, studies of adherence in family based intervention programs have demonstrated that for efficacious programs to achieve success in community settings, the programs must be consistently delivered in a manner that adheres to the models’ specifications (Barnoski, 2004; Sexton, Sydnor, & Turner, 2003). Moreover, therapist adherence to a clinical intervention model is related to the distal outcomes such as adolescent re-offense rate and incarceration (Barnoski, 2004; Henggeler, et al., 1997; Schoenwald et al., 2000).

This review updates a similar paper published in the Journal of Family Therapy in 2001. It presents evidence from meta-analyses, systematic literature reviews and controlled trials for the effectiveness of systemic interventions for families of children and adolescents with various difficulties. In this context, systemic interventions include both family therapy and other family-based approaches such as parent training. The evidence supports the effectiveness of systemic interventions either alone or as part of multimodal programs for sleep, feeding and attachment problems in infancy; child abuse and neglect; conduct problems (including childhood behavioral difficulties, ADHD, delinquency and drug abuse); emotional problems (including anxiety, depression, grief, bipolar disorder and suicidality); eating disorders (including anorexia, bulimia and obesity); and somatic problems (including enuresis, encopresis, recurrent abdominal pain, and poorly controlled asthma and diabetes). Family therapy is also effective for a proportion of children and adolescents with anorexia, bulimia and obesity (Carr, 2013). Two trials of family therapy for bulimia in adolescence show that it is more effective than supportive therapy (Le Grange et al., 2007), and as effective as cognitive behavior therapy (Schmidt et al., 2007), which is considered to be the treatment of choice for bulimia in adults, due to its strong empirical support (Wilson & Fairburn, 2007).


This review presents evidence from meta-analyses, systemic literature reviews and controlled trials for the effectiveness of couple and family therapy for adults with various relationship and mental health problems. The evidence supports the effectiveness of systemic interventions, either alone or as part of multi-modal programs, for relationship distress, psycho-sexual problems, intimate partner violence, anxiety disorder, mood disorders, alcohol problems, schizophrenia, and adjustment to chronic illness.


This review presents evidence from meta-analyses, systematic literature reviews and controlled trials for the effectiveness of systemic interventions for families of children and adolescents with various difficulties. In this context, systemic interventions include both family therapy and other family-based approaches such as parent training. The evidence supports the effectiveness of systemic interventions either alone or as part of multi-modal programs for sleep, feeding and attachment problems in infancy; child abuse and neglect; conduct problems (including attention deficit hyperactivity disorder, delinquency, and drug abuse); emotional problems (including anxiety, depression, grief, bipolar spectrum disorders, and self-harm); eating disorders (including anorexia, bulimia, and obesity); somatic problems (including enuresis, encopresis, medically unexplained symptoms, and poorly controlled asthma and diabetes); and first episode psychosis.
Nowak and Heinrichs (2008) found Triple P (a family based parenting program) to significantly increase parenting skills and reduce child problem behavior of young children when compared to no treatment controls ($ES = .35$). For youth problem behavior, the magnitude of the effect appeared to be dependent on the type of outcome measure; maternal reports yielded larger effects ($ES = 0.42$) than independent observational measures ($ES = .18$). This corresponds to 71% improvement in the intervention group as measured by maternal report compared to only 59% improvement in the intervention group as measured by independent observers. Additionally, it is important to note that not all of the included studies were randomized controlled trials, and the effect size for the randomized controlled trials ($ES = .44$) was significantly higher than that of the nonrandomized controlled trials ($ES = .10$). With regard to the Triple P program, the individual approach to treatment ($ES = .43$) was found to be more effective than the group ($ES = .20$) and self-administered approaches ($ES = .23$), which indicates that about 72% of the individual intervention group improved compared to only 60% of the group intervention group and 62% of the self-administered intervention group.

Barbato and D’Avanzo (2008) reviewed eight randomized controlled trials of couple therapy and evaluated the relative effectiveness of CT compared to individual therapy and psychopharmacotherapy. Their meta-analysis showed that CT had a significant positive effect on relationship satisfaction ($d = .94$), but was not more effective than individual therapy in the treatment of depression. In other words, there was no evidence that reduction in relationship distress was associated with fewer mood symptoms. Using the findings of 12 controlled trials of behavioral couple therapy (BCT) for alcohol and substance use disorders, Powers et al. (2008) compared the outcomes of BCT to alternative treatment modalities (i.e., psychoeducation, individual and group therapy). The results of this meta-analysis showed that BCT was superior to the control conditions for alcohol and substance-related problems overall; it produced greater reduction in frequency of substance use ($d = .36$) along with fewer consequences ($d = .52$) and greater relationship satisfaction ($d = .58$). This meta-analysis also revealed that the relative efficacy of BCT was a function of time and outcome. Although BCT outperformed other conditions on measures of relationship satisfaction at both termination and follow-up, its positive effects on frequency and consequences of use were not greater than those of alternative treatments at termination. However, significant between-group differences were found at follow-up 3 months later, suggesting that relationship outcomes are an important factor in the reduction of problem drinking and substance use over time.
This article presents a meta-analysis of the effectiveness of a series of studies of Multisystemic treatment (MST). MST is a family- and home-based treatment modality that has been recognized by reviewers of empirically supported child and adolescent treatment to demonstrate sustained effectiveness in alleviating serious antisocial behavior in youths. The goal of this study was to estimate the overall effectiveness of MST in treating antisocial and associated behaviors in a variety of youth and family populations. The review included over 700 participants and results indicate a moderate effect size ($d = .55$) following treatment. Specifically, the reviewers found MST to be relatively effective in reducing both behavioral and emotional problems in individual family members, improving parent-youth relations, improving family relations, decreasing youth aggression toward peers, decreasing youth engagement with deviant peers, and reducing youth criminal activity (p. 416). Treatment effects were sustained for up to 4 years. The authors indicate that MST has been utilized across a range of client populations. For instance, evaluation of MST has been carried out in youth populations of serious and violent juvenile offenders, as well as comorbid populations (e.g., delinquency comorbid with substance abuse and/or pervasive emotional disturbance). While findings appear to be promising for the latter, more empirical support is necessary to make more definitive conclusions regarding its effectiveness with youth substance abuse problems or children and adolescents suffering from serious emotional disturbances.

2. Provide at least five psychological manuscripts published in refereed journals (or equivalent) that demonstrate the efficacy of the specialty's services for dealing with the types of psychological, biological, and/or social problems usually confronted and addressed by this specialty. Summarize and discuss the relevance of the findings of these studies, particularly their measures and outcome results.


Several family-based treatments of conduct disorder and delinquency in adolescents have emerged as evidence-based and, in recent years, have been transported to more than 800 community practice settings. These models include multisystemic therapy, functional family therapy, multidimensional treatment foster care, and, to a lesser extent, brief strategic family therapy. In addition to summarizing the theoretical and clinical bases of these treatments, their results in efficacy and effectiveness trials are examined with particular emphasis on any demonstrated capacity to achieve favorable outcomes when implemented by real-world practitioners in community practice settings. Special attention is also devoted to research on purported mechanisms of change as well as the long-term sustainability of outcomes achieved by these treatment models. Importantly, we note that the developers of each of the models have developed quality assurance systems to support treatment fidelity and youth and family outcomes; and the developers have formed purveyor organizations to facilitate the large-scale transport of their respective treatments to community settings nationally and internationally.
The goal was to evaluate whether Attachment-Based Family Therapy (ABFT) is more effective than Enhanced Usual Care (EUC) for reducing suicidal ideation and depressive symptoms in adolescents. This was a randomized controlled trial of suicidal adolescents between the ages of 12 and 17, identified in primary care and emergency departments. Of 341 adolescents screened, 66 (70% African American) entered the study for 3 months of treatment. Assessment occurred at baseline, 6 weeks, 12 weeks, and 24 weeks. ABFT consisted of individual and family meetings, and EUC consisted of a facilitated referral to other providers. All participants received weekly monitoring and access to a 24-hour crisis phone. Trajectory of change and clinical recovery were measured for suicidal ideation and depressive symptoms. Using intent to treat, patients in ABFT demonstrated significantly greater rates of change on self-reported suicidal ideation at post-treatment evaluation, and benefits were maintained at follow-up, with a strong overall effect size (ES = 0.97). Between-group differences were similar on clinician ratings. Significantly more patients in ABFT met criteria for clinical recovery on suicidal ideation post-treatment (87%; 95% confidence interval [CI] = 74.6-99.6) than patients in EUC (51.7%; 95% CI = 32.4-54.3). Benefits were maintained at follow-up (ABFT, 70%; 95% CI = 52.6-87.4; EUC 34.6%; 95% CI = 15.6-54.2; odds ratio = 4.41). Patterns of depressive symptoms over time were similar, as were results for a subsample of adolescents with diagnosed depression. Retention in ABFT was higher than in EUC (mean = 9.7 versus 2.9). ABFT is more efficacious than EUC in reducing suicidal ideation and depressive symptoms in adolescents.

This review of controlled studies of marital and family therapy (MFT) in alcoholism treatment updates the earlier review by O’Farrell and Fals-Stewart (2003). We conclude that, when the alcoholic is unwilling to seek help, MFT is effective in helping the family cope better and motivating alcoholics to enter treatment. Specifically, both Al-Anon facilitation and referral and spouse coping skills training (based on new findings) help family members cope better, and CRAFT promotes treatment entry and was successfully transported to a community clinic in a new study. Once the alcoholic enters treatment, MFT, particularly behavioral couple’s therapy (BCT), is clearly more effective than individual treatment at increasing abstinence and improving relationship functioning. New BCT studies showed efficacy with women alcoholics and with gay and lesbian alcoholics, and BCT was successfully transported to a community clinic, a brief BCT version was tested, and BCT was adapted for family members other than spouses. Future studies should evaluate the following: MFT with couples where both members have a current alcohol problem and with minority patients, mechanisms of change, transportability of evidence-based MFT approaches to clinical practice settings, and replication of MFT outcomes of reduced partner violence and improved child functioning.

This review presents evidence from meta-analyses, systematic literature reviews and controlled trials for the effectiveness of systemic interventions for families of children and adolescents with various difficulties. In this context, systemic interventions include both family therapy and other family-based approaches such as parent training. The evidence supports the effectiveness of systemic interventions either alone or as part of multimodal programs for sleep, feeding and attachment problems in infancy; child abuse and neglect; conduct problems (including childhood behavioral difficulties, ADHD, delinquency and drug abuse); emotional problems (including anxiety, depression, grief, bipolar disorder and suicidality); eating disorders (including anorexia, bulimia and obesity); and somatic problems (including enuresis, encopresis, recurrent abdominal pain, and poorly controlled asthma and diabetes). Family therapy is also effective for a proportion of children and adolescents with anorexia, bulimia and obesity (Carr, 2013). Two trials of family therapy for bulimia in adolescence show that it is more effective than supportive therapy (Le Grange et al., 2007), and as effective as cognitive behavior therapy (Schmidt et al., 2007), which is considered to be the treatment of choice for bulimia in adults, due to its strong empirical support (Wilson and Fairburn, 2007).


Family expressed emotion (EE) and communication deviance (or lack of clarity and structure in communication) are well-established risk factors for the onset of schizophrenia (McFarlane, 2006). In this review, psychoeducational interventions that aim to increase family members’ understanding of the major mental illness of a family member disorder and their ability to manage the positive and negative symptoms of psychosis. Prior reviews indicated that FPE was successful in postponing the recurrence of psychotic episodes and in reducing relapse rates by more than 50% compared to routine care (Sexton et al., 2003; McFarlane et al., 2003). Recent reports confirm the effectiveness of psychoeducational interventions as an adjunct to pharmacology in diverse cultural contexts, and define FPE as an evidence-based practice in the treatment of adult schizophrenia.


In this article, the author reviews evidence supporting the effectiveness of family interventions in the prevention and treatment of physical illness and physical disorders in a primary care setting. There is growing support for a collaborative and biopsychosocial approach to treat an individual by incorporating major family/support network, mental health providers, and medical providers in the process. This field has adopted a multisystemic approach that is consistent with the specialty of Family Psychology. This article details the family interventions used by the medical family therapy model (MedFT), into broad categories, namely, family education and support, family psychoeducation, and family therapy. The interventions are discussed in context of specific physical disorders, including childhood cancer, asthma, adult hypertension, diabetes, and various health behaviors (e.g., smoking, medicine adherence, diet), as well regards to specific populations (e.g., elderly, pediatric, adults). This article encourages couple and family therapists to collaborate with the medical field in order to provide often-
disregarded family and systemic perspective in the treatment process. The findings to date are promising, but Campbell underscores the importance of continued empirical research in this area in order to verify the powerful effect of family support in chronic medical treatments.


Youth in the study were high risk including: 85.4% that drug involved (high drug risk), high rates of reported alcohol use/abuse (80.47%), a range of other mental health or behavioral problems (27%), most had committed felony crimes (56.2%), 10.4% had adjudicated weapons crimes, gang involvement (16.1%), out of home placements (10.5%), running away from home (14.1%), and school dropout (46.39%). When compared to a no treatment control, FFT had a 31% reduction criminal behavior, a 43% reduction in violent recidivism. However, the positive effect of FFT was not universal. In fact, those therapists who delivered FFT with high fidelity (i.e. how it was designed) had the outcomes noted above. However, those who did not deliver the model with high fidelity, had outcomes that were worse than that with youth who received no therapy at all but instead were merely supervised by their probation officer. This finding would suggest that quality assurance and implementation plans are a critical feature in successful community implementation.


This article presents a meta-analysis of the effectiveness of Multisystemic treatment (MST) by examining the treatment outcomes across eligible MST outcome studies. MST is a family- and home-based treatment modality that has been recognized by reviewers of empirically supported child and adolescent treatment to demonstrate sustained effectiveness in alleviating serious antisocial behavior in youths. The goal of this study was to estimate the overall effectiveness of MST in treating antisocial and associated behaviors in a variety of youth and family populations. The review included over 700 participants and results indicate a moderate effect size ($d = .55$) following treatment. Specifically, the reviewers found MST to be relatively effective in reducing both behavioral and emotional problems in individual family members, improving parent-youth relations, improving family relations, decreasing youth aggression toward peers, decreasing youth engagement with deviant peers, and reducing youth criminal activity (p. 416). Treatment effects were sustained for up to 4 years. The authors note that youth antisocial behavior is a pervasive, complex, and growing social problem facing western systems of mental health, social welfare, and juvenile justice. The article draws attention to its prevalence, indicating that antisocial behaviors manifest in up to 15% of young people from the United States, United Kingdom, and New Zealand (p. 411). While many treatments are available, few have been able to produce sustainable effects at follow-up. Multisystemic treatment (MST) has been yielded promising results and demonstrating effectiveness across a variety of replications, problems, therapists, and settings.

This objective of this study was to examine the efficacy of two manual-guided treatments for adolescent drug problems: individual cognitive behavioral therapy (CBT) and multidimensional family therapy (MDFT). In a 2 (treatment) x 4 (time) repeated-measures intent-to-treat randomized design, data were gathered at a community-based drug abuse clinic at baseline, termination, 6- and 12-month follow-up. Youth clients were primarily male, African American, and from low-income single-parent homes. MDFT is a family-based treatment system that can be applied in a variety of settings (e.g., office-based, in-home, brief, intensive outpatient, day treatment, residential treatment). Therapists of MDFT work to simultaneously incorporate four interdependent domains that are congruent with Family Psychology: the adolescent domain, the parental domain, the interactional domain, and the extrafamilial domain. This study is significant because it provides added support for the beneficial effects of family-based interventions. Results revealed significant treatment effects in the MDFT group on substance use severity, other drug use, and minimal use. The authors emphasize the fact that youth and families treated with MDFT retained their treatment gains more effectively than those treated individually with CBT. This study encourages the incorporation of family therapy as well as a “systematic and fully comprehensive focus on social-ecological influences, particularly schools and juvenile justice” for the treatment of adolescent drug abuse (p. 1668).

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This article details the family interventions used by the medical family therapy model (MedFT), into broad categories, namely, family education and support, family psychoeducation, and family therapy. The interventions are discussed in context of specific physical disorders, including childhood cancer, asthma, adult hypertension, diabetes, and various health behaviors (e.g., smoking, medicine adherence, diet), as well regards to specific populations (e.g., elderly, pediatric, adults). This article encourages couple and family therapists to collaborate with the medical field in order to provide often-disregarded family and systemic perspective in the treatment process. The findings to date are promising, but Campbell underscores the importance of continued empirical research in this area in order to verify the powerful effect of family support in chronic medical treatments.

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This article examines the efficacy of psychosocial treatment by comparing a manualized family-focused psychoeducational therapy to an individual patient treatment for recently hospitalized bipolar, manic adult patients (ranging from 18-46 years of age). Patients were randomly assigned to one of the treatment groups, while all were treated concurrently with mood-stabilizing medications. Data were collected at baseline, in 3-month intervals during
treatment, and at a 1 year follow-up. Results indicate that the patients receiving family-focused treatment were less likely to be re-hospitalized between baseline and the follow-up. In addition, those receiving Family Psychology interventions comprising of psychoeducation, communication enhancement training, and problem-solving skills training experienced fewer mood disorder relapses over the 2-year study period. The authors endorse a comprehensive treatment approach to this mood disorder. Consistent with Family Psychology, this study emphasizes the role of family plays in treating individuals with bipolar disorder.

3. Provide at least five psychological manuscripts published in refereed journals (or equivalent) that demonstrate the efficacy of the specialty's procedures and techniques when compared with services rendered by other specialties or practice modalities. Summarize and discuss the relevance of the findings of these studies, particularly their measures and outcome results and the comparisons to other specialties or modalities.


The authors considered 205 family studies and found positive the effects of CFP treatment on twenty-six distinct clinical problems, among which four emerged as the primary focus of the research: youth behavior problems (40%), general mental health (3.4%), parenting (4.4%), family relationships (3.9%), and schizophrenic symptoms (3.4%). In their analysis, Sexton and colleagues (2013) found that 46% of the research (including studies of parenting programs) produced significant findings that support the effectiveness of family-focused interventions, 43.4% had mixed results, and 10.2% found that family-focused interventions did as well as the alternative treatments. Efficacy to when compared to alternative treatments was also established. No studies reported iatrogenic outcomes.


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individual counseling, group therapy, social skills training, vocational training, crisis stabilization, psychiatric evaluation, and/or intensive care. The findings suggest that youths and families treated with MST were functioning better than 70% of those treated by the comparison treatment programs.


In this article, the authors review the current status of family-based treatment research. Family-based treatment is conceptualized as “any modality involving parents as essential participants in treatment” (p. 874). Studies of interest include those conducted in the past 10 years using randomized clinical trials, and they must have a family-based treatment focus. Surveying a range of recent empirical studies, this article examines a variety of clients, populations, and settings. The intention of the authors is to provide adequate evidence supporting a basic, systemic tenant of Family Psychology: “Treatment of children and adolescents is enhanced by attention to the family context of a child’s problem” (p. 874). Overall, this article provides various levels of support for Family Psychology interventions, as well as promising findings to encourage to future family-based treatment research.

Specifically, the authors review family-based treatments that encompassed a range of adolescent disorders, including depression, anxiety, anorexia and bulimia nervosa, conduct disorder, OCD, ADHD, and drug abuse. Many of the studies reviewed included comparisons between Family Psychology interventions and other specialty approaches. While some of the findings are promising in nature, many provide empirical support for including a family-based component in the treatment of children and adolescents. For instance, the authors underscore that family therapy has consistently demonstrated to be equal or superior to other modalities in reducing dropout, reducing drug use behavior, and diminishing associated problems with drug use. In addition, in a study investigating the effects of behavioral family systems therapy (BGST) as compared to ego-oriented individual therapy (EOIT) with youths suffering from anorexia nervosa, it was found that patients experienced greater weight gain and higher rates of resumption of menstruation when treated with the family-based treatment. Likewise, in treating depressed adolescents, researchers found that those families treated with attachment-based family therapy (ABFT) demonstrated more significant reductions in anxiety, hopelessness, and family conflict, as well as improved adolescent attachment. Further, the remission rate in adolescents treated with ABFT was 84%, compared to 36% in the control group. The authors contend that “engaging parents in the treatment process and reducing the toxicity of a negative family environment can contribute to better treatment engagement, retention, compliance, effectiveness, and maintenance of gains” (p. 872).


This objective of this study was to examine the efficacy of two manual-guided treatments for adolescent drug problems: individual cognitive behavioral therapy (CBT) and multidimensional family therapy (MDFT). In a 2 (treatment) x 4 (time) repeated-measures intent-to-treat randomized design, data were gathered at a community-based drug abuse clinic at baseline, termination, 6- and 12-month follow-up. Youth clients were primarily male, African American,
and from low-income single-parent homes. MDFT is a family-based treatment system that can be applied in a variety of settings (e.g., office-based, in-home, brief, intensive outpatient, day treatment, residential treatment). Therapists of MDFT work to simultaneously incorporate four interdependent domains that are congruent with Family Psychology: the adolescent domain, the parental domain, the interactional domain, and the extrafamilial domain. This study is significant because it provides added support for the beneficial effects of family-based interventions. Results revealed significant treatment effects in the MDFT group on substance use severity, other drug use, and minimal use. The authors emphasize the fact that youth and families treated with MDFT retained their treatment gains more effectively than those treated individually with CBT. This study encourages the incorporation of family therapy as well as a “systematic and fully comprehensive focus on social-ecological influences, particularly schools and juveniles justice” for the treatment of adolescent drug abuse (p. 1668).


This chapter presents a review of couple and family therapy (CFT) research with a focus toward specific clinical problems in particular treatment settings. The authors examine the broad, yet fundamental question: does couple and family therapy work? It is suggested through the survey of several studies over the last four decades that CFT has repeatedly demonstrated to be either as effective as or more effective than individual treatments when addressing problems associated with family conflict. CFT also yielded beneficial outcomes that were superior to no-treatment controls in about 65% of cases, as well as a producing both statistically and clinically effective outcomes when compared to no treatment. Furthermore, for some specific problems (e.g., drug abuse, depression, conduct disorder/oppositional defiant problems), couple or family therapy was demonstrated greater efficacy than did either individual or standard treatment. For instance, a comprehensive review of family-based interventions for both adolescent and adult drug abuse found family therapy to be more effective (as well as more cost-effective) than individual, peer, or family psychoeducational interventions. Many studies in this review incorporated diverse client populations, including Hispanic and Cuban families. Specifically, Functional Family Therapy (FFT) is a phasic, multisystemic family therapy intervention that has produced effective outcomes when working with “multiethnic, multicultural populations living in diverse communities” (p. 247). The authors also surveyed CFT used with wide range of specific clinical problems, including conduct disorder, risky sexual behavior, alcohol and drug abuse, delinquency, schizophrenia, anxiety, and depression. Specifically, parent management training (PMT), functional family therapy (FFT), and multisystemic therapy (MST) have been identified as three promising manual-based treatment approaches for managing adolescent externalizing behavior-disorders. In addition, a wide range of treatment settings for CFT were examined, including inpatient, outpatient, university setting, VA hospital, community setting, medical setting, home-based, and school based contexts. This chapter is significant because it provides a comprehensive overview of couple and family therapy that supports its effectiveness, as well as identifying methodological challenges and incorporating a fruitful discussion of specific change mechanisms by which therapists can achieve these gains.
This study evaluates the effectiveness of multisystemic therapy (MST), an evidence-based practice in the real-world mental health setting with juvenile justice involved youth and their families. MST is a family- and community-based intervention that aims to understand the functional basis of behavior problems. Over 90 youth were randomly assigned to MST or treatment as usual (TAU) services, and specific data were collected post-treatment. Results show that at the 18-month follow-up, the MST group yielded an overall recidivism rate that was significantly lower than the TAU group. In addition, the MST group, as well as significant improvement in functioning across time for home, community, and youth behavior toward others. MST therapists empower parents to “develop natural support systems and remove barriers to improve their effectiveness as parents” (p. 229). This article is consistent with Family Psychology in that it manages youth problem behavior by means of restructuring a youth’s ecology to foster prosocial development. The authors encourage replication of MST with similar externalizing behavior problems, in other populations, and within other contexts (e.g., schools, mental health facilities, child welfare).

This article examines the efficacy of psychosocial treatment by comparing a manualized family-focused psychoeducational therapy to an individual patient treatment for recently hospitalized bipolar, manic adult patients (ranging from 18-46 years of age). Patients were randomly assigned to one of the treatment groups, while all were treated concurrently with mood-stabilizing medications. Data were collected at baseline, in 3-month intervals during treatment, and at a 1 year follow-up. Results indicate that the patients receiving family-focused treatment were less likely to be rehospitalized between baseline and the follow-up. In addition, those receiving Family Psychology interventions comprising of psychoeducation, communication enhancement training, and problem-solving skills training experienced fewer mood disorder relapses over the 2 year study period. The authors endorse a comprehensive treatment approach to this mood disorder. Consistent with Family Psychology, this study emphasizes the role of family plays in treating individuals with bipolar disorder.

This research assessed the impact of a manualized multifamily group intervention that delivers a trauma-focused, skills-based treatment to families living in traumatic contexts. A total of 13 sites contributed data which included 103 families with a child age 6 to 17 years exposed to multiple traumas. Results of a linear mixed-model analyses indicated child posttraumatic stress disorder symptoms decreased post SFCR (as reported by both caregivers and children). Caregivers also reported significant reductions in their child’s behavior problems, healthier family functioning, and decreased parenting stress following completion of SFCR. Although
this article does not provide a comparative analysis of treatment and procedures, we include this research because there are few family-based interventions for children and caregivers affected by trauma, and even fewer for those impacted by multiple traumas and chronic stress.


The Moms’ Empowerment Program was tested with 181 mothers exposed to intimate partner violence assigned to 3 conditions: mother-plus-child received intervention (M + C), child-only received intervention (CO), and a wait list comparison group (CG). Women in the M + C condition showed the greatest improvement over time of the 3 conditions in both positive parenting and depression.


This research examined the effectiveness of 2 theoretically different treatments delivered in juvenile drug court – family therapy represented by multidimensional family therapy (MDFT) and group-based treatment represented by adolescent group therapy (AGT). During the court phase, youth in both treatments showed significant reduction in delinquency, externalizing symptoms, rearrests, and substance use. During a 24 month follow-up family therapy evidenced greater maintenance of treatment gains than group-based treatment for externalizing symptoms, commission of serious crimes, and felony arrests. The results suggest that family therapy enhances juvenile drug court outcomes beyond what can be achieved with a nonfamily based treatment.


This research examined whether Family Focused Therapy for Clinical High-Risk (FFT-CHR), and 18 session intervention that consists of psychoeducation and training in communication and problem solving, brought about greater reductions in perceived maternal criticism, compared to a 3-session family psychoeducational intervention. Perceived maternal criticism decreased from pre- to posttreatment for both treatment groups, and this change in criticism predicted decreases in subthreshold positive symptoms at 12-month follow-up. This study offers evidence that participation is structured family treatment is associated with improvement in perceptions of the family environment.


This study investigated the effect of Functional Family therapy on adult offenders’ mental health, family relationships, and risk of reoffending. The results showed that the participants who completed FFT experienced significant improvement in individual and relational
functioning and they reported fewer symptoms of distress, less family conflict, and higher levels of family cohesion and organization. The findings also indicated that the FFT group had significantly lower levels of criminogenic risk than offenders who received traditional probation services.

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This objective of this study was to examine the efficacy of two manual-guided treatments for adolescent drug problems: individual cognitive behavioral therapy (CBT) and multidimensional family therapy (MDFT). In a 2 (treatment) x 4 (time) repeated-measures intent-to-treat randomized design, data were gathered at a community-based drug abuse clinic at baseline, termination, 6- and 12-month follow-up. Youth clients were primarily male, African American, and from low-income single-parent homes. MDFT is a family-based treatment system that can be applied in a variety of settings (e.g., office-based, in-home, brief, intensive outpatient, day treatment, residential treatment). Therapists of MDFT work to simultaneously incorporate four interdependent domains that are congruent with Family Psychology: the adolescent domain, the parental domain, the interactional domain, and the extrafamilial domain. This study is significant because it provides added support for the beneficial effects of family-based interventions. Results revealed significant treatment effects in the MDFT group on substance use severity, other drug use, and minimal use. The authors emphasize the fact that youth and families treated with MDFT retained their treatment gains more effectively than those treated individually with CBT. This study encourages the incorporation of family therapy as well as a “systematic and fully comprehensive focus on social-ecological influences, particularly schools and juveniles justice” for the treatment of adolescent drug abuse (p. 1668).


This chapter presents a review of couple and family therapy (CFT) research with a focus toward specific clinical problems in particular treatment settings. The authors examine the broad, yet fundamental question: does couple and family therapy work? It is suggested through the survey of several studies over the last four decades that CFT has repeatedly demonstrated to be either as effective as or more effective than individual treatments when addressing problems associated with family conflict. CFT also yielded beneficial outcomes that were superior to no-treatment controls in about 65% of cases, as well as a producing both statistically and clinically effective outcomes when compared to no treatment. Furthermore, for some specific problems
(e.g., drug abuse, depression, conduct disorder/oppositional defiant problems), couple or family therapy was demonstrated greater efficacy than did either individual or standard treatment. For instance, a comprehensive review of family-based interventions for both adolescent and adult drug abuse found family therapy to be more effective (as well as more cost-effective) than individual, peer, or family psychoeducational interventions. Many studies in this review incorporated diverse client populations, including Hispanic and Cuban families. The authors also surveyed CFT used with wide range of specific clinical problems, including conduct disorder, risky sexual behavior, alcohol and drug abuse, delinquency, schizophrenia, anxiety, and depression. Specifically, parent management training (PMT), functional family therapy (FFT), and multisytemic therapy (MST) have been identified as three promising manual-based treatment approaches for managing adolescent externalizing behavior-disorders. In addition, a wide range of treatment settings for CFT were examined, including inpatient, outpatient, university setting, VA hospital, community setting, medical setting, home-based, and school based contexts. This chapter is significant because it provides a comprehensive overview of couple and family therapy that supports its effectiveness, as well as identifying methodological challenges and incorporating a fruitful discussion of specific change mechanisms by which therapists can achieve these gains.


In this article, the author reviews evidence supporting the effectiveness of family interventions in the prevention and treatment of physical illness and physical disorders in a primary care setting. There is growing support for a collaborative and biopsychosocial approach to treat an individual by incorporating major family/support network, mental health providers, and medical providers in the process. This field has adopted a multisystemic approach that is consistent with the specialty of Family Psychology. This article details the family interventions used by the medical family therapy model (MedFT), into broad categories, namely, family education and support, family psychoeducation, and family therapy. The interventions are discussed in context of specific physical disorders, including childhood cancer, asthma, adult hypertension, diabetes, and various health behaviors (e.g., smoking, medicine adherence, diet), as well regards to specific populations (e.g., elderly, pediatric, adults). This article encourages couple and family therapists to collaborate with the medical field in order to provide often-disregarded family and systemic perspective in the treatment process. The findings to date are promising, but Campbell underscores the importance of continued empirical research in this area in order to verify the powerful effect of family support in chronic medical treatments.


The aim of this article is to describe how Medical Family Therapy (MedFT) can be incorporated into inpatient psychiatric units. A subdiscipline of the Marriage and Family Therapy (MFT) discipline, MedFT is characterized by the involvement and collaboration of mental health professionals, medical professionals, and the ill individual’s family. MedFT is based on a systemic approach to medical problems and a biopsychosocial treatment of ill individuals and their families. This study is important because it provides major themes for MedFT therapists as they navigate through the pre-hospitalization, pre-session, session, and
post-session process. For instance, a guiding principle of the pre-session period is that “family stress and lack of support can contribute to hospitalization” (p. 170). In effect, this has created purpose for this MedFT session to expand the unit of treatment beyond the individual to include the identified patient’s major family or support system. Collaboration is at the core of each stage of MedFT in an inpatient psychiatric setting. In fact, of the 15 identified patient’s and their families, results indicate that the participants believed the single-session MedFT intervention was “focused, productive, and in a way, that would likely build on the work that was done” in session (p. 175).


This study evaluates a tiered, multilevel prevention program that promotes student adjustment and reduces risk within a public school setting. This investigation is consistent with Family Psychology tenets, in that it recognizes that “supporting caregivers’ behavior management skills and building a strong parent-child relationships” reduces adolescent externalizing behavior, such as substance use and problem behavior (p. 191). The program utilizes family-centered interventions and strategies that adequately address the needs of students in early adolescence (Grades 6, 7, & 8). Multiethnic students and families were randomly assigned to the intervention group or the control condition, and analyses were longitudinal in nature. While engagement levels were relatively low, the interventions yielded reduced initiation of substance use in both the at-risk and normal developing students by the first year of high school. The findings are promising as they support the value of Family Psychology treatment interventions, and the potential for family-centered services within the public school ecology.


The efficient operation of succession of family owned businesses plays a critical role in our national economic health. This study was built upon the Family Business Succession Model, which is based on family systems theory. The impact of owner characteristics, enterprise characteristics, business formalizing activities, family influence, access to resources, and external environmental conditions, all on the extensiveness of family business succession preparedness was assessed. These results were moderated by the generation of the business. With an exploratory and descriptive methodology, primary survey data were obtained from family business owners in Missouri, Illinois, and Kansas. Research results provide family business advisors with important insight for developing recommendations around improving the extensiveness of family business succession preparedness, provide important policy implications, and serve as a basis for additional theory development in family business succession planning.

Historically the schools have not been substantial employers of family therapy professionals. Yet, the issues of school violence and dropout prevention have raised awareness of the need to work with families as pro-social deterents. Since marriage and Family therapists are trained to work systemically and productively with families in many contexts, the next step is to provide new trainees with general and specific skills for working within the schools where they can activate and connect the resources in the family and in the school. This article describes an overview of how a district-wide family systemic program trains inexperienced therapists to work in the schools.


This study replicated the adverse childhood experiences (ACEs) Centers for Disease Control and Prevention (CDC) study with a low-income minority sample of primary care patients (N=801) at a community based healthcare center. A cross-sectional retrospective quantitative survey study was used to examine the association between participants’ reports of past childhood trauma and their current health care outcomes. Data were analyzed using binary logistic regression to evaluate the hypothesis that low income minority patients who reported more childhood trauma (abuse, neglect, household dysfunction, cumulative adverse childhood experiences [Aces]) would more likely be diagnosed with Type 2 Diabetes. The results suggested that the number of ACEs in the sample were considerably higher than the original CDC ACEs study, as almost 50% of patients surveyed reported 4 or more ACEs, confirming that trauma is central in an urban primary care setting. The findings have implications for family therapists, primary care providers, researchers, and policy makers to develop more collaborative approaches to primary care that better target the negative sequelae of ACEs.


The experience of parents in helping their children access and use mental health services is linked to service outcomes. Parent peer support service, based on the principles of family-centered care, is one model to improve parent experience and engagement in services. Little is known about how best to integrate this service into the existing array of mental health services. Integration is challenged by philosophical differences between family-centered services and traditional children’s treatment services, and is influenced by the organizational social contexts in which these services are embedded. This article describes an organizational and front-line team intervention that draws on research in behavior change, technology transfer, and organizational social context for youth with serious emotional disturbance. The two-pronged intervention: FAMILY (FCC and ARC Model to improve the Lives of Youth) is guided by evidence-based Availability, Responsiveness, and Continuity (ARC) organizational intervention, targeted primarily at program and upper management leadership and includes a family-centered care (FCC) intervention, targeted at front-line providers. The approach employs multilevel implementation strategies to promote uptake, implementation, and sustainability of new practices.
Researchers have advocated for a relational perspective to mood disorder treatment, and several promising treatments have been developed. However, few rigorous evaluations have been conducted within the Veterans Affairs (VA) system. Multifamily group therapy, an evidence-based practice for people living with schizophrenia, has recently been adapted for other psychological disorders with promising results. This article describes the first published evaluation of this treatment modality in the VA system for veterans living with mood disorders. Male veterans (n=101; 74 with major depression and 27 with bipolar disorder) and their family members participated in REACH (Reaching out to Educate and Assist Caring; healthy families), a 9 month, manualized, multifamily group treatment intervention adapted from McFarlane’s original multifamily group model. Both veterans and family members showed improvements in their knowledge about mood disorders, understanding of positive strategies for dealing with situations commonly confronted in mood disorders, and family coping strategies. Veterans also evidenced improvement in family communication and problem-solving behaviors, empowerment, perceived social support, psychiatric symptoms, and overall quality of life.

This study investigated the economics of multisystemic therapy for problem sexual behaviors (MST-PSB), a family based treatment that has shown promise with juvenile sexual offenders. The net benefit of MST-PSB over usual community services was calculated in terms of (a) the value to taxpayers, which was based on measures of criminal justice system expenses, and (b) the value to crime victims, which was based on measures of both tangible (e.g. quality of life loss, health care, damage and loss, lost productivity) and intangible (e.g. pain, suffering, reduced quality of life) losses. Every dollar spent on MST-PSB recovered $48.81 in savings to taxpayers and crime victims over an 8.9-year follow-up. The findings demonstrated that a family-based treatment such as MST-PSB can produce lasting economic benefits with juvenile sex offenders.

This special issue is replete with articles to improve family functioning, and decrease interparental conflict using collaborative law or mediation principles and strategies. Peacemaking is described as a set of values, personal attributes, goals, and behaviors that guide the principles of collaborative law and alternative dispute resolution. The goals go beyond avoiding litigation, and focus more on helping repair relationships and encourage and develop skills to manage future conflict.

In this thorough revision and update of their classic text, Medical Family Therapy: A Biopsychosocial Approach to Families with Health Problems (1992), the authors describe the impact of recent economic and structural changes in health care on the role of the medical family therapist. They describe how medical and mental health providers can learn to speak the same language, whether they collaborate in outpatient therapy, co-location settings, community health centers, or fully integrated health systems. They also take into account exciting new advances in fertility treatments and genomic medicine, and assess the medical family therapist’s role in navigating the unique conflicts that can arise in families dealing with these and similar issues.
Criterion X. Quality Improvement. A specialty promotes ongoing investigations and procedures to develop further the quality and utility of its knowledge, skills, and services.

Commentary: The public interest requires that a specialty provides the best services possible to consumers. A specialty, therefore, continues to seek ways to improve the quality and usefulness of its practitioners' services beyond its original determination of effectiveness. Such investigations may take many forms. Specialties promote and participate in the process of accreditation in order to enhance the quality of specialty education and training. Petitions describe how research and practice literatures are regularly reviewed for developments which are relevant to the specialty's skills and services, and how this information is publicly disseminated.

1. Provide a description of the types of investigations that are designed to evaluate and increase the usefulness of the skills and services in this specialty. Estimate the number of researchers conducting these types of studies, the scope of their efforts, and how your organization and/or other organizations associated with the specialty will act to foster and communicate these developments to specialty providers. Provide evidence of current efforts in these areas including examples of needs assessed and changed that resulted.

In accordance with the American Psychological Association’s (2009) “Criteria for the Evaluation of Quality Improvement Programs and the Use of Quality Improvement Data;” the specialty of Couple and Family Psychology strives to enhance the specialty through continuous evaluation of research and services provided by the specialty. Basic research as defined by the APA Dictionary of Statistics and Research methods (2014) states that: “basic research is research conducted to obtain greater understanding of a phenomenon, explore a theory, or advance knowledge, with no consideration of any direct practical application,” (p.21). Applied research “studies conducted to solve real-world problems, as opposed to studies that are carried out to develop a theory or to extend basic knowledge,” (p.12).

The Society for Couple and Family Psychology (Div. 43) fosters and supports scientific investigations through many avenues. APA initiated the publication of the Journal of Family Psychology in 1987, and Division 43 continues to publish research reports in the Division’s newsletter The Family Psychologist. Leaders of the Division co-sponsored a national conference on Marital and Family Therapy Outcome and Process Research at Temple University in May of 1995. The Society has a new Journal, Spring 2012, dedicated to the Specialty (Couple and Family Psychology: Research & Practice/Editor: Thomas L. Sexton). The successful networking ability of these leaders is evident in that the other sponsors were: APA’s Science Directorate, Division 42, Division 43, Philadelphia Child Guidance Center, University of Pennsylvania’s Department of Psychiatry, and Temple University’s Center for Research on Adolescent Drug Abuse. In addition, many members of Division 43 are academics who train graduate students in research and practice from a Family Psychology perspective.

There are additional APA Divisions and other professional organizations that promote research-based practice from a family systems perspective through journals, newsletters, conferences, and training: Division 37, Division 17’s special interest group on couples and families, the National Council on Family Relations, American Counseling Association’s International Association of Marriage and Family Counselors, the American Association of Marriage and Family Therapy, the American Family Therapy Association, the Association of Family and Conciliation Courts, National Association of Social Workers, family nursing associations, and family medicine associations.
The CRSPPP Renewal Petition is replete with research references pertinent to a variety of topics: evidence-based practices, special populations such as, but not limited to, military families, LGB&T families, diversity, and specific diagnoses. Sections in Criterion I of the Petition describes the purposes of the two APA Journals most relevant to CFP: The Journal of Family Psychology and Couple and Family Psychology: Research and Practice. A section in Criterion II lists Active Research Programs that are listed on Division 43, Society for Couple and Family Psychology’s web site. Many of these research programs have been responsible for the development and refinement of evidence-based practices in CFP.

The specialty of CFP fosters and communicates developments in quality of care and quality improvement through four primary avenues: 1) Division 43 has five (5) Listservs: a) Early Career Psychologists, b) Member Listserv, c) Announcement, d) Education and Training, and e) Relational Diagnosis, 2) The Family Psychologist Newsletter published by Division 43, 3) The Academy of Couple and Family Psychology’s Newsletter., and 4) Division 43 social media outlet: LinkedIn.

The member groups of the Specialty have not conducted systematic longitudinal membership surveys. Given that a number of programs with a CFP emphasis are APA accredited, we expect that these programs will now have to report the information you requested to comply with CoA requirements. At present, this information is not available, and there are no data on trainees’ attainment of specific CFP competencies. Our Council is promoting the use of this type of assessment in pre-doctoral and post-doctoral training.

The Appendices contain examples of the Family Psychologist and the Academy Newsletter.

2. **Describe how the specialty seeks ways to improve the quality and usefulness of its practitioners' services beyond its original determinations of effectiveness.**

As noted above, Couple and Family Psychology is represented by a synergy involving the Society for Couple and Family Psychology (a membership organization), the Academy of Couple and Family Psychology (board certified members) and the American Board of Couple and Family Psychology (ABPP, the Board that sets specialty requirements and criteria). The synergy allows for researchers, educators, specialty Board members and the Specialty examinations to be consistent with current research and trends in the field.

Couple and Family Psychologists, like other specialty areas, are committed to life-long learning. Item 1 above has already summarized how developments in CFP are accessed and reviewed. Throughout this CRSPPP Renewal we have identified research and books published since 2009 (the last CRSPPP Renewal) that punctuates the vitality and relevance of CFP. Information and recent developments are publicly disseminated through public access to: Division 43’s Web Site, COSPP Web Site, APA Web Site, and the ABPP Website.

The CRSPPP Renewal Petition also functions as a pathway to Quality Improvement. In part, it serves the purpose of a Self-Study to identify the specialties strengths and areas of needed improvement. The process of self-reflection is part of the **Foundational Competency of Self-Assessment and Reflective Practice** with a commitment to life-long learning, engagement with scholarship, critical thinking and respect for scientifically derived knowledge, with a commitment to further the development of the specialty of CFP. The Renewal Petition is developed by and approved by representatives of the
Synergy on the Couple and Family Psychology Specialty Council. Once approved the CRSPPP document is disseminated to the memberships to inform research, practice and training.

A search of the APA Web Site using Quality Improvement as the search criteria yielded 918 results. Refining the criteria to: a) Family Psychology as the search criteria yielded 534 results, and using Couple and Family Psychology as the search criteria yielded 110 results with 34 defined topic areas that covered: diverse populations, disorders, ethics, testing issues, marriage and divorce, HIV/AIDS, learning and memory, money, natural disasters, sex, SES, suicide, and workplace issues. A search of PsycNet from 2010 -2015 with quality improvement and family psychology as the search parameter yielded five results; quality improvement in couple and family therapy yielded 10 results, while quality improvement in systemic epistemology yielded no results.

There are also a number of specific Quality Improvement activities that illustrate the commitment to quality improvement implemented by both Division 43 and by the American Board of Professional Psychology, some of which have been previously summarized in the CRSPPP Renewal Petition:

a) Maintenance of Certification through the American Board of Professional Psychology (ABPP)

b) Continuing Education

c) ABPP Committee on Diversity

d) ABPP documents: a) “What Training Directors Can Do to Promote Interest in Board Certification Through ABPP Among Psychology Trainees,” b) ”What ABPP Can Do to Promote interest in Board Certification Among Psychology Trainees,” and c) What ABPP Can Do to Facilitate Public Recognition and Benefits of Specialty Board Certification.”

e) Division 43 partnering with Division 37 on Diversity (see pp. 36-37).

f) APA Presidential Task Force on Enhancing Diversity

g) Division 43 Surveys on Doctoral Programs, Internships, and Post-Docs (also relevant to item 4 below): The programs strong in couple and family psychology met three criteria: a) didactic or case presentations focused on couple and family psychology or systemic theoretical perspectives; b) Included at least one clinical rotation (>25 percent client contact hours) of couple/family therapy or systemic consultation supervised by a faculty member with demonstrated competence in family psychology; and c) employ at least one licensed faculty member with demonstrated competence in couple and family psychology as defined by ABPP certification, election as a fellow of Division 43, service in Division 43, and scholarly publications related to couple and family psychology. This survey used the 2012 Association of Psychology Postdoctoral and Internship Centers (APPIC) Directory which listed 127 (28 percent) of 457 APA-accredited internships as offering a major rotation in couples or family therapy. Emails were sent to the 127 internships and of the 59 who responded, 22 indicated that their program met all three criteria and provided names of faculty members with demonstrated competence in couple and family psychology. The 22 programs are listed on the Division 43 website.

The Couple and Family Psychology Synarchy does not have longitudinal outcomes of students in the internships and post-doctoral fellowships; however, aggregate data on internship and post-doctoral programs are available from the APA Education Directorate: Commission on Accreditation 2014 Annual Report. Additionally, and as noted above, APPIC is an excellent resource to search for programs with experience in Couple and Family Psychology by using “key words” in the search parameters such as “Couple and Family Psychology” (yielded 160 programs), and 381 programs with training opportunities in Couple and Family Therapy. “Community intervention” as a multi-systemic approach to treatment resulted in 473 programs. The APPIC website also lists: Program Descriptions, Internship Training Opportunities,
Treatment Modalities, Experience, and a Summary of Post Internship Employment Settings. This summary of Post Internship Employment Settings is the current best source of longitudinal data for internships.

h) Division 43 Membership Surveys have resulted in the development of topics for “Conversations with Experts”

i) The Academy of Couple and Family Psychology and Division 43 are collaboratively working on the recruitment of early career psychologists, particularly those working with marginalized and underserved populations

j) The Academy of Couple and Family Psychology will begin work on increasing the standard of training and expertise in family dynamics for child custody evaluators

k) The Couple and Family Psychology Specialty Council developed the Couple and Family Psychology Taxonomy for Education and Training in Professional Psychology Health Service Specialties (also relevant to item 4 below)

l) The American Board of Couple and Family Psychology in 2012 revised the Examination manuals resulting in a better user friendly experience for examiners and examinees.

m) 2013 Interdivisional Grant Program with Divisions 37 and 53: “Dissemination of Evidence-Based Practices for Children: Needs and Barriers at State and Local Levels.”

3. Describe how the research and practice literature are regularly reviewed for developments which are relevant to the specialty's skills and services, and how this information is publicly disseminated. Give examples of recent changes in specialty practice and/or training based upon this literature review.

Couple and Family Psychology has a long history of researchers who have periodically done systematic reviews of the research literature to identify what works and to translate those findings into formats for dissemination into training, practice and future research (addressed in prior sections of the CRSPPP Renewal). Systematic reviews of the CFP research literature are conducted at regular intervals (see Sexton et al., 2011; Datchi & Sexton, 2015, among others). These reviews shape the future research and practice of the Specialty. Public dissemination of these findings occurs in the Journals associated with the specialty.

Information and recent developments are publicly disseminated through public access to: Division 43’s Web Site, COSPP Web Site, APA Web Site, and the ABPP Website. Erika Lawrence, in her 2014 Division 43 President’s Address summarized three ways to increase the visibility and influence of Division 43: a) Increase efforts on key boards and committees, b) establish sustainable working relationships with members of key divisions and organizations, and c) sharing knowledge year-round. Similarly, Corinne Datchi in her first year (2014) as Vice President for Practice identified key words for her initiative as: “Interprofessional dialogue and partnerships,” (p. 7).

Reference:

The Family Psychologist (2014), Volume, 30 (1).
4. This criterion includes two components: one focusing on past activities around accreditation (X.4.a), and the other on future activities around accreditation (X.4.b).

For X.4.a, describe how the specialty has promoted and participated in the process of accreditation in order to enhance the quality of specialty education and training. Also, indicate how many programs in this specialty have been accredited at the doctoral and/or postdoctoral level.

After the CRSPPPP Renewal was completed in 2009, the synarchies began exploring through CoA, recognition of Couple and Family Psychology as a Developed Practice Area. After much discussion, exploration, and work, in February 2010 a decision was made to discontinue the process, and revisit Couple and Family Psychology as a Developed Practice Area in the future. This decision was made because of the strong emphasis in psychology on clinical, counseling, and school psychology programs. Additionally, it is perceived by many students that pre-doctoral and post-doctoral internship sites, as well as potential employers, prefer candidates from one of these established practice areas (Bray and Stanton, 2009; Stanton and Welsh, 2011). Consequently, there are no Doctoral Programs that are accredited in Couple and Family Psychology.

The Division of Couple and Family Psychology Task Force on Graduate Education in Couple and Family Psychology, however, made substantial progress in identifying doctoral programs that have a strong track or emphasis in couple and family psychology, (Bray and Stanton, 2009). The Task Force subsequently identified pre-doctoral internships and post-doctoral fellowships that emphasize couple and family psychology (see Appendix I, J, K, and L). As part of this current CRSPPPP Renewal, another comprehensive review of APA approved doctoral programs was conducted (see Criterion VII) using the Taxonomy of Education and Training for Couple and Family Psychology (see Appendix G).

For X.4.b, describe how the specialty will promote and participate in the process of accreditation in the future in order to enhance the quality and sustainability of specialty education and training. Also, explain how the future accreditation support activities will be consistent with the Education and Training Guidelines: A Taxonomy for Education and Training in Professional Psychology Health Service Specialties (see: http://www.apa.org/ed/graduate/specialize/taxonomy.pdf) and will be sustained (e.g., training CoA site reviewers with specialty expertise, sponsoring CoA self-study workshops, fostering the development or ongoing operation of a specialty training council, administrative agreements and protections, financial support, etc.). Explain how these activities will result in an increase in the number of specialty programs that are accredited at the doctoral and/or postdoctoral level.

The specialty is participating in the process of re-accreditation through this petition for the recognition of Couple and Family Psychology as a specialty within psychology, which was originally accredited by CRSPPPP in 2001. In addition, university-based members of Division 43 participate in the accreditation process in their own programs and as site team members to other training programs. Similarly, many clinically based members of Division 43 participate in the accreditation process for pre-doctoral internships and post-doctoral residencies.

Accreditation efforts will be promoted in the future by the development of competencies (Stanton & Welsh (2011). This document is consistent with the Taxonomy for Education and Training in Professional Psychology and Health Specialties. This was a significant document in that it is the first to bring a competency-based approach to training, supervision, and practice in Couple and Family Psychology.
Psychology. The competencies of Staton & Welsch (2011) serve as pathways for training programs to follow in developing and successfully maintaining Couple and Family Psychology training. Formal guidelines for doctoral education in Couple and Family Psychology have already been developed and are contained on the COSPP website. In large part, the CRSPPP Renewal is formatted and based on demonstrating the Foundational and Functional Competencies of the specialty and how these areas differentiate CFP from other specialties and proficiencies in professional psychology. Stanton and Welsh’s (2011) contribution to defining and describing Foundational and Functional Competencies in CFP have been incorporated throughout the CRSPPP Renewal.
Criterion XI. Guidelines for Specialty Service Delivery. The specialty has developed and disseminated guidelines for practice in the specialty that expand on the profession's general practice guidelines and ethical principles.

Commentary: Such guidelines are readily available to specialty practitioners and to members of the public and describe the characteristic ways in which specialty practitioners make decisions about specialty services and about how such services are delivered to the public.

1. Describe the specialty-specific practice guidelines for this specialty. Please attach. How do such guidelines differ from general practice guidelines and ethics guidelines? (In this context, professional specialty guidelines refer to modes of conceptualization, identification and assessment of issues, and intervention planning and execution common to those trained and experienced in the practice of the specialty. Such professional guidelines may be found in documents or websites including, but not limited to, those bearing such a title or as described in a variety of published textbooks, chapters, and/or articles focused on such contents.)

Steps in the development of practice standards began in 1991 when then Division 43 President Josephine Beebe commissioned a Task Force to create Specialty Guidelines for Family Psychology. The document was drafted and approved by the Division’s Board of Directors. It was sent out for comment and received wide support. The document was revised and presented for review to the APA board and committee structure (Gottlieb, Nutt, McDaniel, & Bodin, unpublished). The chair of the Task Force met with relevant boards and committees and was informed that the document would go no further within APA at that time because of the controversy over guidelines. The Division was disheartened and considered publishing the document nonetheless but subsequently chose to wait for a more favorable time. These guidelines have been revised (Dobbins & Watson, 2007), using the preferred term “Recommendations,” though this revision has yet to be reviewed and ratified by the various Couple and Family Psychology stakeholders. The problems encountered with this document did not prevent other important developments. First, a group representing the Division, Academy, and Board have been working on a model post-doctoral training curriculum. This work addresses two issues: 1) it further clarifies the skills that fall within the specialty’s domain; 2) it establishes standards by noting specific training requirements for various skills to be acquired. The second important development was the completion of a Periodic Comprehensive Review (self-study), a revision of the Examination Manual, and development of a Policy and Procedures Manual by the American Board of Couple and Family Psychology. The Board also recently established a committee to pursue the question of required ongoing continuing education for board certified Couple and Family Psychologists. The third development was the understanding that although Couple and Family Psychology has been recognized by CRSPPP as a specialty since the first CRSPPP petition, the specialty continues as an emerging specialty and development of practice standards will continue as an ongoing process. For example, recent national events have placed Couple and Family Psychology in the forefront of comprehensive political changes in health care delivery. Couple and Family Psychologists find themselves working in consultation and practicing and supervising in large health care organizations. These events require the specialty to continue to refine practice standards as we face new challenges and develop new roles.

APA has seventeen developed Guidelines for Practitioners. Of these seventeen Guidelines there is only one Guideline in a specialty area recognized by CRSPPP, the Council of Specialties in Professional Psychology, and the American Board of Professional Psychology; Specialty Guidelines for Forensic Psychology. In 2010, APA initiated a process for producing Clinical Practice Guidelines,
to provide research-based recommendations for the treatment of particular disorders. An Advisory Steering Committee for the Development of Clinical Practice Guidelines was appointed by the APA Board of Directors to oversee the process of guidelines development. Thomas L. Sexton, Ph.D., ABPP, the Coordinator of this CRSPPP Renewal Petition is a member of the Advisory Steering Committee. The development of Clinical Practice Guidelines (cpg’s) are intended to improve mental/emotional, behavioral, and physical health by promoting clinical practices that are based on the best available evidence. APA is committed to generating patient-focused cpg’s that are scientifically sound, clinically useful, and informative for psychologists, other health professionals, training programs, policy makers, and the public, (Hollon, Arean, Craske, Crawford, Kivlahan, Magnavita, Ollendick, Sexton, Spring, Bufka, Galper, & Kurtzman, 2014). The American Psychological Association (2015) in the American Psychologist published a policy document intended to assist the developers and users of “Professional Practice Guidelines.”

This reflects the need for Couple and Family Psychology and other specialties to develop both Guidelines for Practitioners and Clinical Practice Guidelines. We recognize this need and have started a discussion among the synarchies representing the specialty of CFP for the purpose of initially developing Guidelines for Practitioners to be followed by Clinical Practice Guidelines. For the purpose of clarification for consumers and others who access this CRSPPP Renewal, the difference between Guidelines for Practitioners and Clinical Practice Guidelines needs to be explained. Guidelines for Practitioners consist of recommendations to psychologists concerning their conduct and the issues to be considered in particular areas of practice. Guidelines are not definitive, but aspirational, and they are not intended to take precedence over the judgment of psychologists in general. In contrast, the mission of the Advisory Steering Committee for Clinical Practice Guidelines Development is to: improve mental, behavioral, and physical health by promoting clinical practices on the best available evidence, identify interventions that are effective and can be implemented in the community, and develop treatment guidelines that are scientifically sound, clinically useful, and informative for psychologists, other health professionals, training programs, policy makers and the public.

Although no formal Guidelines have been developed for APA; Division 43, Society for Couple and Family Psychology provides a statement about the specialty that is listed below. Bray and Stanton (2009) and Stanton and Welsh (2011) have been referenced throughout the CRSPPP Renewal as providing major contributions for practitioners on guidelines for education and practice of Couple and Family Psychology. CRSPPP is also referenced to previous sections for a summary of chapters relevant to the practice of Couple and Family Psychology in Bray and Stanton (2009). The development of evidence-based guidelines is not a novel pursuit to the specialty of CFP. Guidelines for the classification of evidence-based treatments in Couple and Family Psychology have been published by Sexton, Gordon, Gurman, Lebow, Holtsworth-Munroe, & Johnson, 2011). These Guidelines were designed to translate research into practice and practice into research in the Specialty of Couple and Family Psychology.

**REFERENCES**


Below, the Society for Couple and Family Psychology provides a description of CFP general practice guidelines primarily for the consumer.

Couple and Family Psychology Practice
(From the Division 43 Society for Couple and Family Psychology Website)

Couple and family psychology (CFP) practice is a recognized specialty in professional psychology based on the principles of systems theory. These principles set the specialty apart from other orientations that focus on individuals' intrapersonal and interpersonal experience. CFP practitioners understand clinical problems in the context of individuals' interactions with others (e.g., family members, peers, colleagues), communities and institutions (e.g., religious, school, workplace, local governments). They emphasize the complex reciprocal influence of person and context over the life course.

Couple and family psychologists work with individuals, couples, families, organizations and other social systems. They utilize treatment interventions that are founded on evidence-based knowledge of the individual, relational and environmental factors which support healthy functioning. They provide a variety of clinical services, including individual, couple and family assessment and therapy, consultation and clinical supervision. CFP practitioners work in diverse settings such as hospitals, outpatient clinics, and private practice.

For detailed information about CFP practice, we recommend the following texts:


2. How does the specialty encourage the continued development and review of practice guidelines?

As stated above, the synarchies of CFP have initiated discussions for the need to develop practice guidelines. Furthermore, research on evidence-based practices for specific disorders has already been addressed in the CRSPPP Renewal. A few additional resources are:


3. Describe how the specialty's practitioners assure effective and ongoing communication to members of the discipline and the public as to the specialty's practices, practice enhancements, and/or new applications.

a) Communication to members of the discipline: On-going communication to Couple and Family Psychologists regarding specialty practices, practice enhancements, and/or new applications are accomplished through multiple formats:

(1) Scholarly articles in peer reviewed journals and in particular The Journal of Family Psychology and Couple and Family Psychology: Research and Practice
(2) The Family Psychologist Newsletter for Division 43, Society for Couple and Family Psychology
(3) The American Academy of Couple and Family Psychology Newsletter
(4) Participation in Division 43 five (5) List Serves
(5) Effective communication among the synarchies. The specialty of Couple and Family Psychology has an effective collaborative process of recursive communication among the Society for Couple and Family Psychology, The Couple and Family Psychology Specialty Council, the American Board of Couple and Family Psychology, and the American Academy of Couple and Family Psychology (see page 13).
b) Communication to the Public: Providing on-going information to the public and consumer of Couple and Family Psychology services is provided by:

(1) The Academy of Couple and Family Psychology website
(2) The Council of Specialties in Professional Psychology Website
(3) The American Board of Couple and Family Psychology Website and Brochure
(4) Division 43, Society for Couple and Family Psychology Website

4. How does the specialty communicate its identity and services to the public?

This question was addressed above in subsection b, Communication to the Public.
Criterion XII. Provider Identification and Evaluation. A specialty recognizes the public benefits of developing sound methods for permitting individual practitioners to secure an evaluation of their knowledge and skill and to be identified as meeting the qualifications for competent practice in the specialty.

Commentary: Identifying psychologists who are competent to practice the specialty provides a significant service to the public. Assessing the knowledge and skill levels of these professionals helps increase the ability to improve the quality of the services provided. Initially practitioners competent to practice in the specialty may simply be identified by their successful completion of an organized sequence of education and training. As the specialty matures it is expected that the specialty will develop more formal structures for the recognition of competency in practitioners.

1. Describe the formal peer review-based examination process of board certification including its use of a review and verification of the individual’s training, licensure, ethical conduct status, and a peer assessment of specialty competence.

For all specialties a reevaluation of competencies, skills, and knowledge is essential. In Couple and Family Psychology, like all other specialties, this reevaluation happens in multiple ways. First, as part of continuing education required for licensure we all must interact with the current knowledge in the field allowing a period of reflection and reevaluation. Training programs, because of APA certification, use competency based measures to identify trainee’s skills and abilities. At the professional level formal methods of reevaluation occur at the level of the ABPP certification. ABPP has, across all specialization areas, started a Maintenance of Certification process to evaluate current skills for all Board Certified Couple and Family Psychologists. The Society of Couple and Family Psychology also has a fellow’s program allowing both recognition and a systematic evaluation of knowledge, and has established a CE program for increasing the CFP competence of its members. CFP leaders have also published articles encouraging members to select advanced CFP training by focusing on sequences of CFP Continuing Education courses rather than randomly taking unrelated workshops.

The Specialty of Couple and Family Psychology is represented by the ABPP Couple and Family Psychology Board which sets criteria for and examination procedures to ensure specialty competencies in board certification. It is important to note that the ABPP Couple and Family Board criteria and examination procedures are based on the Stanton & Welch (2011) criteria that is identified above. This provides a unique nexus in the specialty between training, practice, and Board Certification. The ABPP examination is comprehensive, focusing on current research and practice methods. There is an early career, regular and senior track for certification. Appendix H previously referenced in the CRSPPP Renewal Petition describes the American Board of Couple and Family Psychology Eligibility Criteria.

If this is a new petition for recognition describe a) current methods by which individual practitioners can secure an evaluation of their knowledge and skill and be identified as meeting the qualifications for competent practice in the specialty and b) efforts to establish a formal peer review-based examination process of board certification including a detailed plan and timeline.

NOT APPLICABLE: THIS IS A RENEWAL PETITION.
1. Describe how the specialty educates the public and the profession concerning those who are identified as a practitioner of this specialty. How does the public identify practitioners of this specialty?

The American Board of Professional Psychology’s website (ABPP.ORG) has a link to identifying board certified specialists in all the specialty areas represented by ABPP. A specific search can be done by specialty, name, or state.

2. Estimate how many practitioners there are in this specialty (e.g., spend 25% or more of their time in services characteristic of this specialty and provide whatever demographic information is available) and how many are board certified through the process decried in item 1

   a) See Appendix S for Division 43 Demographic Data
   b) Board Certified Specialists Data since 2009 are listed below

<table>
<thead>
<tr>
<th></th>
<th>Cert.</th>
<th>Not Cert.</th>
<th>Pass Rate</th>
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<tbody>
<tr>
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<td>100%</td>
</tr>
<tr>
<td><strong>2010</strong></td>
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<td>100%</td>
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<tr>
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<td>1</td>
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</tr>
<tr>
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<td>100%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>18</td>
<td>1</td>
<td>95%</td>
</tr>
</tbody>
</table>

Current ABPP’s in Couple and Family Psychology listed on ABPP.ORG

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Public Description:

An important component of the recognition process is to develop a public description of the specialty that can be used to inform the public about the specialty area. Please develop a **brief** description of the specialty by responding to the question below (total combined word limit for all five questions must not exceed 400 words). This provides the foundation for what will appear on the APA website upon recognition of the specialty and should be understandable to the general public (wording should not exceed an eighth-grade level). Descriptions will be edited for consistency to conform to the CRSPPP website standards.

1. Provide a brief (2-3 sentences) definition of the specialty.

2. What specialized knowledge is key to the specialty?

3. What problems does this specialty specifically address?

4. What populations does this specialty specifically serve?

5. What are the essential skills and procedures associated with the specialty?

Couple and family psychology is a specialty in professional psychology that is focused on the emotions, thoughts, and behavior of individuals, couples, and families in relationships and in the broader environment in which they function. It is a specialty founded on principles of systems theory, with the family as a system being the most central focus. The premise of practice in this specialty is that family dynamics play a vital role in the psychological functioning of family members. This applies to extended families as well as nuclear families. The practice of couple and family psychology takes into consideration as well as the family’s history and current environment (e.g., family history, ethnicity, culture, community, school, health care system, and other relevant sources of support or difficulty). Couple and family psychologists strive to understand issues presented by persons to be served not only from the perspective of the presenter(s) of a particular problem but as well through understanding the contexts in which these issues have developed and might be maintained.

**Within this framework couple and family psychologists might see:**

a) Individuals  
b) Couples  
c) Families  
d) Work Groups  
e) Communities groups of all kinds  
f) Organized systems

**Clinical problems that couple and family psychology addresses are:**

a) Relationship issues between individuals who are coupled  
b) Schooling problems of youngsters  
c) Behavioral problems of children or adolescents  
d) Parenting problems  
e) Adaptational challenges of caring for a family member with a serious psychological or chronic health problem  
f) Work-related problems with one or more adults in a family  
g) Managing the aging problem of a family member or relative
h) Problems in relationships between a sub-set of family members
i) Problems in communications between two or more persons
j) Relationship disturbances based on misperception
k) Individual problems and specifically how the problems affect family members, or how individual problems might be maintained by family members

**Typical procedures and techniques used by family psychologists may include as appropriate:**

a) Evidence based assessment and treatment
b) Systems interventions (including family therapy) from a wide away of emphases
c) Network therapy
d) Couples therapy
e) Group therapy and work group therapy
f) Consultation with external authorities such as school professionals, primary and chronic care physicians, juvenile authorities and the courts
g) Supervision of various workers concerned with resolving the presenting issues

The practice of couple and family psychology is not limited to a particular set of problems, but rather, the distinctiveness of the specialty is based upon the theory from which couple and family psychologists think about a problem and work with their clients to solve it. Couple and family psychology addresses the broad array of problems people face individually, as a couple, within a family, and other social systems.
Attachment A

Structures and Models of Education and Training in (name of specialty) Psychology

Doctoral Program

COMPLETE THE FOLLOWING FOR ANY EXAMPLE DOCTORAL PROGRAMS SUBMITTED IN CRITERION VII THAT ARE NOT APA ACCREDITED

NOT APPLICABLE: DOCTORAL PROGRAMS LISTED ARE ALL APA ACCREDITED
Attachment B

Structures and Models of Education and Training in (name of specialty) Psychology Postdoctoral Program

COMPLETE THE FOLLOWING FOR ANY EXAMPLE POSTDOCTORAL PROGRAMS SUBMITTED IN CRITERION VII THAT ARE NOT APA ACCREDITED

NOT APPLICABLE: POSTDOCTORAL PROGRAMS LISTED WITH DIVISION 43 SURVEY RE APA ACCREDITED.
END OF PETITION FORM
Appendix A
Bylaws Family Psychology Specialty Council
Bylaws of the
Couple & Family Psychology Specialty Council

Article I:
Name of Organization

The name of the organization is the Couple & Family Psychology Specialty Council.

Article II

Couple & Family Psychology Specialty Council Mission

The purpose of the Couple & Family Psychology Specialty Council shall be to:

1. Facilitate communication and development of coherence and consistency of policies and procedures within Couple & Family Psychology.

2. Promote quality assurance of education, training, credentialing, and practice in Couple & Family Psychology.

3. Represent the specialty of Couple &Family Psychology to the Committee of Accreditation and the Council of Specialties in Professional Psychology.

Article III:
Membership

1. The membership of the Couple & Family Psychology Specialty Council shall consist of at least one representative from each of three co-sponsoring organizations: the Academy of Couple and Family Psychology, the American Board of Couple and Family Psychology and Division 43-Society for Couple & Family Psychology. The organization of education and training directors in Couple & Family Psychology at the doctoral program level, the doctoral internship and postdoctoral residency levels shall have one representative each.

2. Each representative shall be appointed for a term of two years and may serve a maximum of two two-year terms. All appointments beginning January 1, 2000 shall be for two years.

3. Terms of representatives to the Couple & Family Psychology Specialty Council and officers thereof shall begin in January.

4. Representatives to the Couple & Family Psychology Specialty Council commit themselves to regular attendance at meetings that typically occur once a year at the APA Annual Convention. Teleconference meetings may be scheduled as needed. Appointment of a new representative may be
required by the Couple & Family Psychology Specialty Council in the case of insufficient participation by a representative.

5. The officers of the Couple & Family Psychology Specialty Council shall consist of a chair, vice-chair and secretary. Officers can be re-elected for a second two-year term under special circumstances. The vice-chair shall serve in the absence of the chair and perform tasks requested by the chair. The secretary shall take and distribute minutes of meetings within six weeks and shall help with furthering communications. Elections to office extend appointment to the end of service in that office, total service not to exceed six years.

Article IV: Meetings

1. Meetings shall be held at least once a year.

2. Meetings may be attended by liaisons and observers by invitation of the Family Psychology Specialty Council.

3. The Couple & Family Psychology Specialty Council may address business matters outside of the regularly scheduled meetings. Votes may be conducted by mail, e-mail or fax.

Article V: Representative to the Council of Specialties in Professional Psychology

Members of the Couple & Family Psychology Specialty Council shall elect the Couple & Family Psychology Representative to the Council of Specialties in Professional Psychology. The term of this Representative shall be three years, effective January 2003 and reelection for one consecutive term is possible.

Article VI: Rules of Order

The Couple & Family Psychology Specialty Council shall conduct its meetings in accordance with the latest edition of Keesey’s Modern Parliamentary Procedures.

Article VII: Amendments

Amendments to these Bylaws may be made by a two-thirds majority vote of the members of the Couple & Family Psychology Specialty Council. Mail ballots may be utilized providing a discussion of the matter had taken place at a prior meeting and allowing a twenty-day response.

Adopted August 2000
Amended August 2001 (10/16/01)
Amended September 2013 (09/25/13)
Amended April 3, 2015
Appendix B
Bylaws Society of Couple and Family Psychology
BYLAWS

SOCIETY FOR COUPLE AND FAMILY PSYCHOLOGY

Of the American Psychological Association

ARTICLE I:  NAME

1. NAME: The name of this organization shall be: Society for Couple and Family Psychology of the American Psychological Association.

ARTICLE II:  OBJECT AND MISSION

1. OBJECT: The purposes of this organization shall be:

   a) to advance the contributions of psychology as a science and as a profession to understanding and intervening with diverse couples, families, children, and other systems;
   b) to promote the education of psychologists in matters of couple and family psychology including the appropriate roles of psychologists in the field of family psychology; and
   c) to inform the psychological community, mental and physical health communities, third party payers, health management organizations, other appropriate institutions, and the general public, about current research, educational and service activities and the training of family psychologists as clinicians, educators, supervisors, consultants and researchers.

2. MISSION: Couple and Family Psychology integrates the understanding of individuals, couples, families and their wider contexts. The Society for Couple and Family Psychology seeks to promote human welfare through the development, dissemination, and application of knowledge about the dynamics, structure and functioning of families.

ARTICLE III:  MEMBERSHIP

1. CLASSES: There shall be three classes of membership in the Division: Fellows, Members, and Associate members. There shall also be a class of Student Affiliates. The requirements for these classes shall be as provided by the bylaws of the APA. In addition, there will be a class of Professional Affiliates and a class of Honorary Members, the requirements for which are described below.

2. ELIGIBILITY:

   a. Fellows: Members nominated to become Fellows in the Division must provide to the Fellows Committee evidence of unusual and outstanding contributions in an area of family psychology
   b. Members and Associate Members: Members and Associate members of the APA admitted to Division membership will be admitted in the same status held in the APA. Associate members may not vote or hold office, but shall be entitled to all rights and privileges not specifically denied them in these Bylaws. Associate members shall achieve voting privileges after five consecutive years in the status of Associate membership.
c. **Student Affiliates**: Graduate or undergraduate students taking courses in psychology are eligible to become Student Affiliates of the division and of APA. Consistent with APA bylaws, Student Affiliates are not Members of the Division and may not vote or hold office apart from that of Student Representative to the Division Board.

d. **Professional Affiliates**: The minimum requirement for acceptance to Professional Affiliate status in the Division shall be a doctoral degree (e.g., Ph.D., M.D., J.D., D.Min) or its equivalent. Professional affiliates need not have joined APA. Consistent with the APA bylaws definition of Affiliates, Professional Affiliates are not Members of the Division and may not vote or hold office.

e. **Honorary Members**: Honorary members may be selected by the Board of Directors in recognition of extraordinary contribution(s) to the field of Family Psychology.

3. Voting in the Division shall follow the criteria established in the Bylaws of the American Psychological Association. All Members and Fellows shall have the right to vote and hold office.

4. The minimum membership dues are set by the Council of Representatives and are paid to the Division by the Association from the members’ annual dues payments. Additional dues or assessments may be imposed by vote of The Board of Directors of the Division.

**ARTICLE IV: OFFICERS**

1. The Officers of the Division shall be the President, President Elect, Past President, Vice Presidents (4): Practice, Public Interest and Diversity, Science, and Education; Secretary, and Treasurer, who shall assume their duties January 1 of the year following their election to that position.

2. The **President** shall be a Member or Fellow of the Division who has just completed his/her term of office as President Elect and shall serve for one (1) year. The President shall be the Chairperson of the Board of Directors and the Executive Committee of the Board, and shall perform all usual and customary duties of a presiding officer including those specified in the Policies and Procedures Manual. In the event that the President fails to serve his/her term for any reason whatsoever, the Past President, if available, shall succeed to the unexpired remainder thereof. If the Past President is unavailable, the Board of Directors, at its discretion, may fill the President’s unexpired term by selecting the President Elect or, if unavailable, a previous Past President.

3. The **President Elect** shall be Member or Fellow of the Division, elected for a term of one (1) year. The President Elect shall be a member of the Board of Directors with vote and shall perform the duties that are usual and customary for a vice president. The President Elect shall also serve as Chair of the Nominations and Elections Committee.

4. The **Past President** shall be the most recently retired President of the Division and shall serve as a member of the Board of Directors with the right to vote.

5. The **Secretary** shall be a Member of the Board of Directors with the right to vote, perform all usual and customary duties of a Secretary including those specified in the Policies and Procedures Manual.
6. The Treasurer shall be a Member or Fellow of the Division elected for a term of two years. The Treasurer shall be a member of the Board of Directors and Executive Committee with vote and shall perform all the usual and customary duties of a Treasurer including those specified in the Policies and Procedures Manual.

7. In the case of death, incapacity, or resignation of any officer except the President or Past President, the vacant office shall be awarded to the defeated candidate for the position who was, at the time of the most recent past election, the runner up for the office in question. If the runner up declines to serve or is for any reason unavailable, the elected members of the Board of Directors shall, by majority vote, elect a successor to serve the remainder of the unexpired term.

8. The means for filling a vacancy in the office of President is specified in Article IV, Section 2 of these Bylaws above. In the case of death, incapacity, or resignation of the Past President, such vacancy shall remain through the balance of the year in which it occurs.

ARTICLE V: BOARD OF DIRECTORS

1. There shall be a Board of Directors of the Society for Family Psychology. Its membership shall consist of the following persons:

   a. The nine (9) Officers of the Division as specified in Article IV, Section 1 of these Bylaws.

   b. Representative(s) elected to the APA Council of Representatives as specified in Article V, Section 2 of these Bylaws.

   c. A Student Representative, who shall be appointed by the President Elect and serve as a member of the Board, with vote. The Student Representative shall assume office at the same time as the President Elect becomes President, and shall serve during that President’s term of office. The Student Representative shall be a Student Affiliate of the Division. In addition to standard reimbursement for non-convention board meetings, the Student Representative shall have all reasonable expenses to attend the convention reimbursed up to $1,000, which may include registration, lodging for three nights, airfare, ground transportation, and meals.

   d. An officer or the Executive Director of the American Board of Couple and Family Psychology (ABCFP) shall serve as an ex-officio Member of the Board without vote, at the expense of ABCFP.

2. APA COUNCIL REPRESENTATIVE(S): The Division shall elect each year that number of Representatives to APA Council necessary to fill vacancies created by the ending of the terms of incumbent Council Representatives and/or vacancies created by changes brought about by the yearly APA apportionment ballot. Consistent with APA Bylaws, any Representative to APA Council must be a Member or Fellow of the Division and are ordinarily elected for a three (3) year term. The Representatives to APA Council shall perform those duties required of Council Representatives as specified in APA’s Bylaws and Rules of Council and the Division
43 Policies and Procedures Manual. The Division’s Representatives to APA Council shall be members of the Board of Directors with the right to vote. They shall be responsible for informing the Board of Directors of significant action taken by APA Council.

a. Representatives to APA Council shall assume office in accordance with APA procedure and shall maintain office until their successors are seated.

b. In the case of death, incapacity, or resignation of any Representative to APA Council the vacant office shall be awarded to the defeated candidate who was, at the time of the most recent past election, the runner up in the election for Council seats. If the runner up declines to serve or is for any other reason unavailable, the Board of Directors by majority vote shall elect a successor to serve the unexpired term.

c. If the Division loses one or more of its seats on APA Council as a result of that association’s annual reapportionment, and if the loss cannot be offset by the ending of a term or terms of outgoing Representatives, then the seat will be given up from among those elected most recently, in reverse order of their election.

3. VICE PRESIDENTS: There shall be four Vice Presidents: Practice, Public Interest and Diversity, Education, and Science. Two (2) shall be elected at a time, each for a two (2) year term. The Vice Presidents shall be members of the Board of Directors with vote. Vice Presidents shall be responsible for generating and coordinating initiatives in the Vice President’s area, liaison activities involving the corresponding APA Board and Directorate, oversight of the functions and budgets of the Committees and Task Forces which have been assigned to their area, as well as any other duties or functions specified in the Policies and Procedures Manual. In the case of death, incapacity, or resignation of any Vice President, the vacant office shall be awarded to the runner up candidate. If there was a tie for runner-up the Board shall select one to serve. If a runner up declines to serve or is for any reason unavailable, the Board of Directors shall, by majority vote, elect a successor to complete the unexpired term.

4. DUTIES: The duties of the Board of Directors shall be the usual and customary duties for a Board of Directors including those specified in the Policies and Procedures Manual.

5. MEETINGS: Each member of the Board of Directors present at the meeting shall have one vote, and no member may vote by proxy. The Board of Directors is authorized to adopt and publish rules and codes for the transaction of the business of the Division in accordance with these Bylaws. The Board may also conduct business via conference call and email, including submitting, discussing, and voting on motions.

6. EXECUTIVE COMMITTEE: There shall be an Executive Committee of the Board of Directors. The Executive Committee shall be composed of the President, President Elect, Past President, Secretary, and Treasurer. The Executive Committee shall conduct such affairs of the Division between meetings of the Board of Directors as may be needed to implement or prompt decisions of the Board of Directors. During the interval between meetings of the Board of Directors, the Executive Committee may act on matters it deems urgent provided it does not exceed Divisional budget allocations or set new policy. Rules governing the functioning of
Executive Committee are specified in the Divisional Policies and Procedures Manual. Should the Executive Committee declare there to be an emergency requiring immediate action, an email ballot may be taken on such emergency matters from the full Board of Directors. Board members shall be provided minutes of the Executive Committee in a timely fashion after the approval of such minutes.

7. **COMMUNICATIONS**: Actions of the Board of Directors shall be communicated to the membership through *The Family Psychologist*, and may also be communicated on the listserv, through special mailings, and at the annual membership meetings.

8. **PARLIAMENTARY PROCEDURE**: Except as otherwise specified in the Bylaws or Policies of the Division, the parliamentary authority for Division 43 shall be the latest edition of Ray E. Keesey’s *Modern Parliamentary Procedure*. Where Keesey is silent, the latest edition of Robert’s *Rules of Order Newly Revised* is the parliamentary authority. The President shall appoint a parliamentarian.

**ARTICLE VI: COMMITTEES, TASK FORCES & BOARD(S)**

1. The Committees of the Division shall consist of such Standing Committees (referred to as “Administrative Committees”) as may be provided by these bylaws, and such special committees (referred to as “Divisional Services Committees”), task forces, and board(s) as may be established by the Board of Directors. Committees, task forces, and board(s) shall function as specified in the Divisional Policies and Procedures Manual. Committee, Task Forces, and board(s) chairs are appointed by the President with advice and consent of the Board of Directors and serve the pleasure of the President. Each Chairperson’s term of office expires at the end of the President’s term and Chairpersons must be reappointed or replaced by the next President. All committees, board(s), and task forces will report in writing to the Board of Directors as specified in the Divisional Policies and Procedures Manual. The President or Board of Directors may request a report from any Committee, Task Force, board(s), or other divisional component at any time with a reasonable advance notice.

2. **ADMINISTRATIVE COMMITTEES**: The Administrative (or standing) Committees shall be: Awards, Bylaws, Fellows, Finance, Membership, Nominations and Elections, Program. There shall be a Publications Board.

   a. **Awards Committee**. The Awards Committee is chaired by the immediate Past President and shall recommend to the Board such awards and recommendations as reflecting and furthering the aims and purposes of the Division. The Awards Committee shall perform all the usual and customary duties of an Awards Committee as specified in the Divisional Policies and Procedures Manual.

   b. **Bylaws Committee**. The Bylaws Committee shall periodically review and recommend to the Board of Directors changes to enable the Division to function more effectively. The Bylaws Committee shall perform all the usual and customary duties of a Bylaws Committee as specified in the Divisional Policies and Procedures Manual.

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1 Note: The EC is referred to but not described in the Policy & Procedures Manual. At one time, Council Representatives and the ABCFP representative (without vote) were members of the EC. The EC would hold meetings to plan budget, etc.
c. **Fellows Committee.** The Fellows Committee shall recruit, receive, review and recommend nominations and applications for Fellowship in accordance with the Divisional Policies and Procedures Manual and of the APA and shall perform all the usual and customary duties of a Fellows Committee.

d. **Finance Committee.** The Finance Committee shall consist of the President Elect, the Treasurer, one affiliated Board member and two other members of the Division, nominated by the President and approved by the Board. The President shall appoint as Chair of the Finance Committee one of its members other than the Treasurer. The Finance Committee shall perform all the usual and customary duties of a Finance Committee as specified in the Divisional Policies and Procedures Manual.

e. **Membership Committee.** The Membership Committee shall recruit, receive, and recommend applications for membership and represent their recommendations to the Board. The members of the Membership Committee shall perform the usual and customary duties of the Membership Committee such as those specified in the Policies and Procedures Manual.

f. **Nominations and Elections Committee.** The Nominations and Elections Committee shall ordinarily consist of the President Elect, the more recently elected of the Secretary or Treasurer, and one member of the Division (chosen by the President). No one serving on the Nominations and Elections Committee may run for office that year. A conflict of interest may be handled by not running for office that year or by resigning from the Nominations and Elections Committee. The Nominations and Elections Committee shall conduct nominations and elections following APA policy and the Divisional Policies and Procedures Manual.

g. **Program Committee.** The Program Committee shall solicit, evaluate, and select scientific and professional program proposals submitted for presentation at the APA’s Board of Convention Affairs following the Divisional Policies and Procedures Manual.

h. **Publications Board.** The Publications Board shall develop and supervise all publications of the Division and recommend policy regarding such publications and shall perform all the usual and customary duties of a Publications Board including those specified in the Divisional Policies and Procedures Manual. The Publications Board shall include, with vote, the Editor(s) of *The Family Psychologist*, the President, Treasurer, plus another member appointed by the President.

**ARTICLE VII: ACTIVITIES**

1. The annual meeting of the Division shall take place during the annual convention of the APA, and in the same locality for the transaction of business, the presentation of scientific papers and awards, and the discussion of professional matters in the field of the Division’s interest. The Division shall coordinate its programs with, and participate in, the program of the Association.

2. An additional annual Board Meeting will be held as called by the President or a majority of the
Board. Conference calls of the Executive Committee shall be held at least quarterly, with others held by the Board and Executive Committee at their discretion. All calls are open to members.

3. The Nominations Chair of the Division, directly or through the APA Central Office, shall notify new members of the Division of their election in a timely fashion.

4. The Division may publish *The Family Psychologist*, a journal or other material to disseminate news, or for other purposes; coordinate divisional participation in the APA political process and answer the substantive needs of the members.

**ARTICLE VIII: AMENDMENTS**

1. Amendments to these Bylaws may be proposed by a majority vote of the Division’s Board of Directors or by petition of 10 percent of the Division’s voting members. Bylaws amendments are ratified and implemented upon a 2/3 majority of those division members voting in a mail or electronic ballot. Bylaws amendments may also be adopted and implemented by the Division’s Board if there are no more than two votes opposed. The President shall appoint a By-laws and Policy & Procedures Revision Committee as needed, but no less than every five years. The next revision is due in 2016.

**ARTICLE IX: SUBORDINATION**

1. In case of conflict the APA and the Division 43 Bylaws; the former shall be followed.

**ARTICLE X: DISSOLUTION**

1. In the event of the dissolution of the Division, any assets remaining following satisfaction of the Division’s debts and obligations shall be conveyed or distributed to the APA.

**ARTICLE XI: POLICIES AND PROCEDURES MANUAL**

1. There shall be a Division 43 Policies and Procedures Manual. It is intended that Division 43 policy and procedure not contained in the Division’s Bylaws be included in the Division’s Policies and Procedures Manual.

Approved November 2003
Edited January 2005 and July 2005 (nse)
Reformatted February 2008 (whw)
Revised and approved, August 2008 (whw)
Revised and approved, September 2011 (gkh)
Appendix C
Bylaws American Board of Couple and Family Psychology
Constitution and Bylaws of the
American Board of Family Psychology

Article I:
Name of the Organization

The name of the organization shall be the American Board of Family Psychology (ABFamP), hereafter referred to as the board. Unless decided otherwise by a majority vote of members of the organization, ABFamP is, and will remain, an affiliated Board of the American Board of Profession Psychology (ABPP).

Article II:
Purpose

Section 1. The Board shall provide a service to the profession of psychology, to other professionals and to the public by granting an ABFamP Diploma which is Board Certification to qualified psychologists who evidence advanced, specialized expertise in the practice of family psychology.

Section 2. The Board may grant Board Certification to those psychologists who successfully complete the Board’s professional, peer-based evaluation of their competence in the specialty area of family psychology.

Section 3. Diplomas authorized by the Board shall be issued jointly with ABPP and holders of such Diplomas shall be considered to have been awarded said Diploma jointly by ABFamP and ABPP.

Article III:
Composition and Responsibilities of the Board of Directors

Section 1. The Board of Directors shall consist of ten members. Each member of the Board of Directors shall be an ABPP Board Certified Diplomate in good standing with the Academy of Family Psychology, ABPP and with the Board.

Section 2. The nomination and election of the Board of Directors shall be carried out according to the procedures specified in Article VI.

Section 3. The composition of the Board of Directors may be changed by a two-thirds vote of the Board of Directors.

Section 4. A member of the Board of Directors may be removed for cause by a two-thirds vote of the Board of Directors. Appropriate causes for such action may include, but not be limited to, activity or behavior by a Board member that is judged by the Board to be contrary to the stated purpose or objective of the Board. If a member misses three consecutive, called meetings of the Board of Directors, he or she shall be removed automatically from office unless their absence is excused by a majority vote of the Board of Directors.

Section 5. The responsibilities of the Board of Directors shall be to:
A. Establish policies and procedures and to supervise the implementation of said policies and procedures regarding the examination process for ABFamP Board Certification,
B. Review and revise policies and procedures as needed,
C. Review, evaluate and approve application of candidates. Candidates who fail examinations may appeal Board decision through the ABFamP Appeals committee if there is just cause to do so,
D. Establish and supervise the activities of examination committees,
E. Review and revise requirements for applications including those regarding education, training, experience and supervision,
F. Establish standing and/or ad hoc committees, and
G. Maintain ongoing communications with and make recommendations to the ABPP Board of Trustees regarding matters within its purview.

Article IV:
Officers

Section 1. The officers of the Board shall be the members of the Board of Directors. The Board of Directors shall be composed of the: President, Past-President, Vice President, Secretary, Treasurer, Representative to the Board of Trustees (ex officio), two Regional Examination Chairs and four additional Representatives who are members at large and are elected by those ABPP Diplomates eligible to vote.

Section 2. The President shall be elected to serve a term of two years. The Past-President shall serve a term of two years, following a two-year term as President. The Secretary and Treasurer shall be elected to serve terms of two years elected in alternating years. Board members elected to serve as representative to the ABPP Board of Trustees shall serve a term of four years. Members may serve no more than two, full successive terms in the same office. Their service may be extended to a maximum of six years if they were previously elected to the Board to fill an unexpired term of a former Board member.

Section 3. Any officer may be removed from office for cause by a two-thirds vote of the Board of Directors [see Article III, Section 4]. If a vacancy on the Board of Directors is created due to death, resignation, or removal, the President may appoint, with the advice and consent of the Board of Directors, a member to serve until the next regular election, or call a special election to fill the unexpired term according the Article VI, Section 4.

Section 4. Duties of Officers

A. The President shall preside at all meetings of the Board of Directors. The President shall: be the chief executive officer of the Board and insure that all directives of the Board of Directors are implemented; with the approval of the Board of Directors, appoint members to committees; prepare and submit an Annual Report of the Board’s activities and affairs; and perform other duties as may be required by the Board of Directors. When deemed appropriate by President, non-members of the Board, may be appointed as committee chairs or members.

B. The Vice-President shall preside in the absence of the President at all meetings of the Board of Directors. The Vice-President shall function as interim President if the President is incapacitated or, for any valid reason, is
unable to function as President for a short period while in office. The Vice-
President shall be considered as “President-Elect” so the Board of Directors
can have a planned, orderly succession of office, although it will be an option
of the Board of Directors to elect whomever it deems the best suited candidate
for President. The Vice-President shall not automatically ascend to the office
of President.

C. The Secretary shall: keep or cause to be kept minutes and records of all
meetings of the Board of Directors and Executive Committee; and notify
members in writing of the time and location of meetings of the Board of
Directors at least two months before regularly held meetings. This can be
done in conjunction with ABPP staff.

D. The Treasurer shall have the general oversight of all Board finances and cash
flow data. The Treasurer shall work with the President and the Board and the
Treasurer of the BOT of ABPP in planning annual budgets and tracking all
income and expenditures. All requests for expense reimbursement will be
sent to the Treasurer on the ABFamP Expense Reimbursement Sheet who
will then sign the expense voucher form and forward it to the ABPP Central
Office for payment. All questions will be resolved in consultation with the
President.

E. The Past President shall serve as Chairperson of an annual Nominating
Committee. (It shall be understood that this person cannot run for office
in the present election year so as to avoid any conflict of interest.) If said
person is not available, the President can appoint someone else to serve as
Nominating Committee Chair.

F. The Representative to the ABPP Board of Trustees (BOT) shall be an
ex officio member with vote of the ABFamP Board of Directors. The terms of the
Representative and alternate will be for four (4) years to coincide with
established terms of the BOT. The next Representative and alternate terms
begin in 1998 and change every four years thereafter. The Representative
to the ABPP Board of Trustees shall: attend all meetings of the ABPP BOT;
represent the interests of the Board at such meetings; and report to the
Board actions and proceedings of the ABPP Board of Trustees.

G. All Board Members shall serve on committees and perform functions as
requested by the Board or by the President. The members at large shall:
attend all regularly scheduled Board meetings, serve on Board Committees
and chair a committee if asked to do so. They shall be available to serve on
a minimum of two examination committees per year.

Article V:
Committees

Section 1. There shall be an Executive Committee comprised of the President, Past-President, Vice-
President, Secretary, Treasurer, and Representative to the ABPP BOT.
The duties of the Executive Committee shall be to act on behalf of the Board in between regular
meetings of the Board of Directors and recommend items for the Annual Meeting.

Section 2. The Credentials Review Committee shall consist of Diplomates in good standing and a Chair (who shall be a member of the Board of Directors) appointed by the President who shall review and evaluate the credentials of applicants.

Section 3. The President may establish ad hoc committees and task forces, and appoint members at his or her discretion. These committees shall automatically be terminated at the end of the Annual Meeting unless reappointed by the President.

Article VI:
Nominations and Elections

Section 1. Based on the ABPP-BOT guidelines, nominations to the ABFamP Board are generated from the Academy of Family Psychology ABPP membership list of members in good standing (dues are paid up) by an ABFamP Nominations Committee. The Nominations Committee shall be chaired by the Past-President of the ABFamP, or someone designated if he/she cannot so serve, with additional committee member appointed by the President. The call for nominations to the Board will be mailed to all members in good standing by the Academy of Family Psychology who are Board Certified in Family Psychology by ABPP. The persons receiving the most nominations, and who have agreed to serve, shall have their names placed on a ballot.

Section 2. The Nominations Committee will implement the Call for Nominations by mailing a Nomination Form to all Academy of Family Psychology members in good standing by April 1st annually. Nominations must be postmarked no later than May 15th annual to be valid. ABFamP Board members will be mailed a ballot to vote on the slate of Nominees which will be due no later than June 10th annually. By June 30th annually, the newly elected member will be contacted by the President or Nominating Committee chairperson and invited to attend the annual meeting at APA in August to provide overlap between old and new Board members for an orderly transition of Board responsibilities. [No provision for email.]

Section 3. The President may call a special election to fill a vacancy on the Board of Directors at his or her discretion.

Section 4. The Board shall elect its own officers as openings occur, and from a slate of nominees produced by the ABFamP Nominations Committee from the Academy of Family Psychology membership list of ABPP Diplomates in good standing. Preferably they will have already served at least one term as member of ABFamP.

Article VII:
Meetings

Section 1. Regular meetings of the Board shall be held twice a year if possible. The Annual Meeting shall be held in conjunction with the Annual Convention of the American Psychological Association. The Mid-year meeting can be held in conjunction with Division 43 or other relevant groups. Additional meetings may be scheduled as required.

Section 2. Special meetings of the Board of Directors may be called by the President, or upon written
request to the President, by at least one-third of the members of the Board of Directors. Written notice, email or courier mail of the time of the special meetings and an agenda shall be sent to each member of the Board of Directors not less than seven days prior to a special meeting. The President shall determine the location of special meetings and may include a telephone conference call.

Section 3. A majority of the members of the Board of Directors shall constitute a quorum for the transaction of business. Except as otherwise stated, the majority vote of a quorum shall be sufficient to pass upon any business of the Board.

Section 4. The Board of Directors shall be authorized to carry on necessary business of the Board by mail ballot, email or phone conferences between meetings. In such instance, it shall require a majority vote of the members of the Board of Directors to pass upon any business.

**Article VIII:**
**Liabilities of the Board**

The Board of Directors, as a Specialty Board of ABPP, and its officers and committee chairs shall be afforded the same liability protection as members of the ABPP BOT.

**Article IX:**
**Amendments**

Alterations or amendments to these Bylaws may be made by at two-thirds vote of the members of the Board of Directors provided that all members of the Board of Directors have been notified in writing or by confirmed e-mail of proposed changes not less than twenty-one days prior to the date of action.

**Article X:**
**Subordination**

In case of conflict between these Bylaws and the Constitution and Bylaws of ABPP, the latter shall be followed.

Revised September, 2005
Appendix D
Bylaws Academy of Couple and Family Psychology
BY-LAWS
THE AMERICAN ACADEMY OF COUPLES AND FAMILY PSYCHOLOGY
(Academy of Family Psychology)

ARTICLE I – PURPOSE

The purpose of this organization shall be to advance Family Psychology as a psychological science, and also to promote and enhance family welfare. Specifically, it shall:

a) Support the research and expansion of the database of Family psychology;
b) Enhance communications among its members;
c) Provide continuing education programs;
d) Disseminate information to the public about the specialty of Family Psychology;
e) Support the functions of the American Board of Family Psychology as an affiliated Board of the American Board of Professional Psychology;
f) Provide a voice for the specialty of Family Psychology within the profession of psychology;
g) Recommend and help to implement policy decisions within the specialty.

ARTICLE II – MEMBERSHIP

Section 1: Current holders of board certification shall automatically become members upon notification of successful completion of requirements for certification. No additional application shall be necessary. There shall be three classes of members, active, retired, and affiliates.

Section 2: Active members shall have all rights and privileges of membership including the right to vote and hold office.

Section 3: Active members may become retired members upon retirement from less than halftime employment.

Section 4: Psychologists may become affiliate members if they are considering becoming active members. They do not have the right to vote and hold office.

Section 5: Membership in the Academy may be terminated by receipt of written notice of voluntary withdrawal, for non-payment of dues and other mandatory fees, or for cause. Other than non-payment of fees, cause for termination of membership shall include: conviction of a felony, revocation or suspension of the member's license to practice psychology, revocation of membership in the American Psychological Association for ethical violation, or revocation of membership from any other professional organization in a related discipline due to a violation of professional ethics.

ARTICLE III - DUES AND FINANCES

Section 1: The fiscal year of the Academy shall begin on July 1st.

Section 2: The annual dues shall be determined by the Board of Directors. Section 3 Special assessments may be approved by majority vote of the Board of Directors. Section 4 Dues are payable in advance of the first day of the membership year. Section 5 Members who fail to pay their dues within thirty (30) days of the their renewal date shall be notified by the Academy and, if payment is not made within the next thirty (30) days, may, without further notice or hearing, be dropped from the rolls and denied all rights and privileges of membership. The Board of Directors may extend the time for payment of dues and continuation of membership privileges for good cause.
ARTICLE IV - BOARD OF DIRECTORS

- Section 1: The Academy is a volunteer organization, and officers shall receive no compensation for their services; they may, however, be reimbursed for expenses to the extent approved by the Board. The Board of Directors shall be the chief governing body of the Academy and shall have full power and authority over the affairs and funds of the Academy within the limitations set by the Articles of Incorporation and these Bylaws. All members of the Board shall be Members of the Academy in good standing.

- Section 2: The Board of Directors shall consist of seven members. Five members will be officers of the Board, and there shall be two Members-At-Large.

- Section 3: Terms of office of the Board of Directors shall be for a two year term, with the exception of the directors serving in the Presidential sequence who serve as President-Elect, President, and Past-President during the course of three years. No person shall serve in any capacity for more than two consecutive terms on the Board of Directors. Board Members shall rotate their terms of office so that they occur in different years.

- Section 4: All votes require a majority of the quorum with a quorum defined as four of the seven board members.

- Section 5: Replacements or vacancies for any position on the Board of Directors may be filled by a majority vote of the Board after being nominated by the Nominations Committee Chair.

- Section 6: The Board of Directors shall meet via conference call or in person at least quarterly, as set by the President of the Board. The approved minutes of the Board of Directors meetings shall be posted by electronic means to membership.

- Section 7: All meetings shall be governed by the most current edition of Keesey's Rules of Order.

- Section 8: Any member in good standing of the Academy may attend a Board of Directors meeting to present business to the Board. The Board also may have executive sessions.

- Section 9: The Board shall establish standing committees as necessary to perform regular and necessary functions of the Academy. The President may establish task forces or designate consultants, as necessary, for special purposes. Task forces or consultants shall exist for one year unless reauthorized by the President. The Chair of each task force shall choose committee members and submit them to the Board for approval.

ARTICLE V – OFFICERS

- Section 1: The officers of this Academy shall be the President, President-Elect, Past President, Secretary and Treasurer.

- Section 2: The President shall be the principal officer of the Academy and shall preside at all meetings. The President will represent the Academy in order to best further its interests, and shall perform other duties as prescribed by the Board of Directors.

- Section 3: The President-Elect shall succeed the President at the conclusion of the latter's term of office, assume and perform the duties of the President in the absence or incapacity of the President, and perform such other duties as prescribed by the Board of Directors.
• Section 4: The Past-President shall be responsible for chairing the Nominations Committee for selecting new Board members and Officers.
• Section 5: The Secretary shall be responsible for recording minutes of Academy meetings, and shall perform such other duties as prescribed by the Board of Directors.
• Section 6: The Treasurer, in collaboration with the Board of Directors, shall preserve all funds of the Academy, shall deposit them in the name of the Academy in such financial institutions as directed by the Board of Directors, shall have authority to sign checks and drafts of the Academy for disbursement of funds as prescribed by the Board of Directors, shall monitor and record all money received and paid out, shall provide reports, shall supervise the preparation of budgets for approval by the Board of Directors, shall ensure that the federal 501(c)(3) tax return is filed in a timely manner, and shall perform such other duties as prescribed by the Board of Directors.

ARTICLE VI – MEMBERS

• Section 1: General meetings of the Academy shall be held no less than once yearly at the annual convention of the American Psychological Association or convened by technological means.
• Section 2: Special meetings may be called by majority vote of the Board of Directors.
• Section 3: Extraordinary general meetings of the Academy must be called at the request of ten (10) percent of the Full Members of the Academy who have filed such request with the President in writing. Such extraordinary general meetings shall be for the purpose of bringing items of business before the membership and only those items of business can be considered at such a meeting. Fourteen (14) days’ notice must be given to members prior to such an extraordinary general meeting. If the item is approved, the item must be submitted to the entire voting membership. Section 4 Upon petition of 10% of the Full Members in good standing, a request for a vote of the voting Members of the Academy upon any matter (but not involving an amendment to the Bylaws) may be addressed to the Board of Directors, who shall present the matter covered by the petition, if it is consistent with the Articles of Incorporation and these Bylaws, to the voting Members of the Academy for a vote. The Board of Directors shall take such action as may be necessary to implement the result of any such vote.

ARTICLE VII – ELECTIONS

• Section 1: The members of the Board of Directors shall be elected directly by the majority of the Members who voted.
• Section 2: Any member in good standing may run for and hold office. Within ninety days before the end of the fiscal year, for each Board position whose term is lapsing, the Chair for the Nominations Committee shall select with the approval of the President at least two members to run for the positions. The Nominations Chair shall have the Secretary e-mail on a nominations ballot the two candidates to members which shall be returned within the following week. There shall be provision on the ballots for write-in votes. Election ballots will then be e-mailed to members no less than forty-five days before the end of the fiscal year and be returned within thirty days. The Secretary will count the votes, and inform the President of the outcomes. The nomination results of President will notify the winners and losers, and then officially announce the results to the membership. Ballots will be saved for an inspection for forty-five days.
ARTICLE VIII – AMENDMENTS

These Bylaws may be amended, repealed or altered, in whole or in part, by a three-quarters vote of the Board of Directors (five of seven Directors), by the majority vote of the Members at the annual meeting, or by a majority vote of the Members who respond to an e-mail vote.

IX – INDEMNIFICATION

- Section 1 No current or former officer, Board of Director, consultant, or employee of the Academy shall be personally liable to the Academy or its members for monetary damages for any conduct in that position; provided, however, that this section shall not eliminate or limit liability for acts or omissions that involve intentional misconduct or a knowing violation of law for any transaction from which the person will receive a benefit in money, property, or services to which he/she is not legally entitled.
- Section 2 Each Board member, consultant, and employee shall be indemnified by the Academy against all expenses reasonably incurred by him/her in connection with an action, suit or proceeding to which he/she may be a party defendant or with which he/she may be threatened by reason of his/her being in the above position, or by reason of having acted pursuant to a resolution of the Board of Directors, but a Board member shall not be indemnified for any matter for which he/she is held liable for gross negligence or misconduct in the performance of his/her duties. The right of indemnification under this article shall not exclude any other right to which a Board member may be entitled nor restrict the Academy's right to indemnify or reimburse a Board member in a proper case even though not specifically provided.
- Section 3 The Academy may maintain insurance, at its expense, to protect itself and any such officer, Board member, consultant, employee or agent of the Academy or another corporation, partnership, joint venture, trust or other enterprise against any such expense, liability or loss, whether or not the Academy would have the power to indemnify such person against such expense, liability or loss under the law.

XI – DISSOLUTION

The Academy shall use its funds only to accomplish the objectives and purposes specified in these Bylaws and no part of the funds shall be distributed to the members of the Academy other than for reimbursement of authorized expenses. On dissolution of the Academy, any funds remaining shall be distributed to one or more regularly organized professional societies or qualified charitable, educational, scientific or philanthropic organizations selected by the Board of Directors.
Appendix E
The Family Psychologist
Volume 30 #3 Fall 2014
Volume 31 #2 Summer 2015
To open click on the cover page
GAINING Visibility

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- All you need to know, you learned from family psychologists. pg 4
- Announcing the Next Clinical Practical Series. pg 9
- Interview with Mark Stanton on the success of our journal. pg 22
- Dr. Frank Ezze explains the Family Psychology Specialty Council. pg 18
- Interview with family psychologists in hospital settings. pg 6
123rd Annual Convention
Couple and Family Psychology
at the APA Convention

Toronto | August 6-9
Metro Toronto Convention Centre

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- CFP Relevant Symposa and Events at the Convention pg 28
- Interview with the Author of Invisible Chains pg 16
- Stay informed about the Hoffman report pg 25
- The Synergy of CBT and Family Systems pg 19
- The story behind the Society's forthcoming NEW name pg 12
- The benefits of Couple Group Therapy pg 9
The American Academy of Couple and Family Psychology

Volume 15, Issue 2

December 2014

Intervention and assessment in Couple & Family Psychology, embracing the total family system including individuals, couples, families, and the intergenerational system.
Appendix G
Taxonomy of Education and Training for Couple and Family Psychology
**Subscript 1:** A full-time postdoctoral residency (one or two years) or a part-time postdoctoral externship (two to four years) in CFP is needed to consolidate mastery of the specialty. The nature and duration of the residency experience is determined in part by prior experience and training in CFP.


*Italics in Post-Doctoral Fellowship Levels of Training:* Post-doctoral education and training in a specialty is by definition a major area of study requiring 80% or more of time spent in that specialty area but would allow for an exposure to other specialty areas. The italics in Emphasis, Experience, and Exposure represent post-doctoral experiences that are not a Major Area of Study in CFP but have sub-threshold levels of experience that can be documented for employers and consumers. The total percentage of time in the Levels of Training shall not exceed 100%.

**Subscript 3:** ABPP Specialty Board Certification: At the postdoctoral level of training many psychologists with training at the Emphasis level should qualify for CFP board certification candidacy. Most, if not all psychologists with training at the Major Area of Study level should qualify for CFP board certification candidacy. For specific information on three tracks for specific eligibility requirements access; abpp.org and click on Member Specialty Boards and select Couple and Family Psychology. Review the General Eligibility requirements and the Specialty Specific Eligibility Requirements.
Appendix H
American Board of Couple and Family Psychology Eligibility Criteria
Specialty Specific Eligibility Requirements

Applicants for certification in Couple and Family Psychology (CFP) may apply through one of three tracks. Each applicant is evaluated according to the requirements of the category in which she or he applies by a Specialty Evaluation Committee comprised of no less than three psychologists who are board certified in CFP; any variance from the requirements will be evaluated on a case-by-case basis by the Specialty Evaluation Committee.

Track 1: Doctoral Preparation for Eligibility in CFP
(This track is intended for individuals who completed a doctoral program that provided substantial education and training in CFP)

- An earned doctoral degree in professional psychology (e.g., clinical, counseling, or school) that meets the ABPP generic requirements with a prespecialty emphasis or track in CFP that includes a minimum of four specialty area courses and CFP practicum experiences;
- Completion of an APA or CPA accredited internship or an APPIC or CAPIC approved internship;
- Completion of a post-doctoral residency or one year postdoctoral practice (preferably with an emphasis on CFP) supervised by a licensed psychologist. A minimum of one hour a week of individual supervision for 48 weeks is mandatory. Additional supervision or consultation in the specialty is desirable.

Track 2: Post-Doctoral Preparation for Eligibility in CFP
(This track is intended for individuals who completed most of their education and training in CFP after their doctoral program)

- A doctoral degree from a program in professional psychology (e.g., clinical, counseling, or school psychology) that meets the ABPP generic requirements.
- Completion of one graduate course in Couple and Family Psychology or equivalent and at least 40 hours of continuing education (CE) in CFP. Continuing education must be completed in the specific areas of CFP competency. Satisfaction of this requirement or equivalency will be determined on a case by case basis. The CE activities must be completed within five (5) contiguous years (time frame from one to five years) prior to the ABPP application.
- Completion of an APA or CPA accredited internship or an APPIC or CAPIC approved internship;
- Completion of a post-doctoral residency or one year postdoctoral practice (preferably with an emphasis on CFP) supervised by a licensed psychologist. A minimum of one hour a week of individual supervision for 48 hours a year is mandatory. Additional supervision or consultation in the specialty is desirable.

Track 3: Senior Couple and Family Psychologist Eligibility
August 2011 Revision

Senior eligibility recognizes the accomplishments and contributions of those who have worked in the field of couple and family psychology for a minimum of 15 years after receiving their doctoral degree. Post-doctoral residencies count toward this 15 year total.
In order to qualify for application under the senior track, every senior candidate must demonstrate having a professional identity as a couple and family psychologist, in addition to meeting the generic qualifications required by ABPP. Candidates may demonstrate professional identity in the specialty by submitting a concise summary of evidence, using the illustrative examples provided below as guidance for the type of evidence desired.

Evidence of Professional Identity as a couple and family psychologist: (for example)
- Conceptual competency in systemic epistemology (ability to use systems theory to inform CFP)
- Fellow status in the APA Society for Family Psychology
- Completion of an education or training program in CFP
- Supervised experience in CFP
- Continuing education in CFP
- Membership and service in a CFP organization
- Presentations on CFP at professional conferences
- Documented systematic and sustained engagement in social policy, programs, and legislation on behalf of CFP

The senior track is reserved for psychologists who have made substantial, recognized contributions to the field and demonstrated competence in CFP. If the applicant is deemed not to meet all requirements for senior track eligibility, he/she will be advised to seek certification via Track II.

*Passing Stage I (Achieving candidacy)*

Upon favorable review and verification of the candidate’s credentials by the Specialty Evaluation Committee, the ABPP central office will notify the candidate of acceptance (or rejection). Favorable review means the candidate moves on to Stage II, at which point the ABPP office will provide the candidate with the name and contact information of the CFP examination coordinator. The examination coordinator will initiate contact with the candidate to continue into Stage II. Mentors are available to help candidates advance through the transition from Stage I to Stage II, including the development of the practice sample. The examination coordinator will facilitate contact with the chair of the Academy mentoring committee.

*Steps in moving from Stage I to Stage II:*

1. After passing stage 1, the ABPP central office will notify the candidate and provide contact information for the CFP examination coordinator.
2. The examination coordinator contacts the candidate. August 2011 Revision
3. The examination coordinator connects the candidate up with the mentoring coordinator from the Academy.
4. The examination coordinator appoints an examination committee chair.
5. The candidate submits his or her work sample and fee to the ABPP central office. The ABPP central office will forward the work sample to the examination committee chair.
Appendix I
Aggregate Data on Doctoral Programs, Pre-doctoral Internships, & Post-doctoral Fellowships
An invitation to complete the survey was sent by email to 61 School Psychology programs, 69 Counseling Psychology programs and 227 Clinical Psychology programs. A total of 100 psychologists responded.

The most common program offered is the PhD. Nine respondents also reported offering an EdS program in addition to their PhD, MA or MS programs. All 100 respondents reported that their programs are APA-accredited.

In response to the question, “Does your graduate program have Family and/or Couple Psychology courses?” 82% reported having at least one course in these areas:
Many of the 16 “Other” responses indicate that there is much focus on couple and family psychology in the curriculums, and most of these responses might be included in the category “An Emphasis”. An emphasis in family and/or couple psychology (i.e., strong inclusion of family psychology in the curriculum, clinical training in the specialty, and specialty faculty):

The most common response to the question, “What family and/or couple psychology courses do you offer regularly?” was “Family Psychotherapy”.

![Bar chart showing course offerings]

- **Family Psychotherapy**: 51
- **Couple Psychotherapy**: 31
- **Sexuality and Sex Therapy**: 12
- **Family Assessment**: 7
- **Systems Theory**: 20
- **None of These Courses**: 24
Twenty-one of the respondents reported having a sexuality course in their curriculums. Twenty-eight noted that there are Family, Couple or Sexuality courses required. Of the 28, only 13 specified which courses are required:

When asked, “How many faculty members in your program are family psychologists?”, 59% of the respondents reported at least one family psychologist on the faculty.

![Pie chart showing the distribution of the number of family psychologists in the respondents' programs.]

Over half the respondents (n = 51) said it would be helpful for Division 43 (Society for Family Psychology) to provide them with resources for training their students.
Pre-doctoral Internships

An invitation to complete the survey was sent by email to 464 APA-accredited Internships/Postdoctoral programs. A total of 101 psychologists who responded to the survey reported being affiliated with a pre-doctoral internship. Thirteen of these had also reported being faculty members in a clinical psychology, counseling psychology or school psychology program. Ninety-five reported that their internships are APA- accredited.

In response to the question, “How much training in Family Psychology does your pre-doctoral internship offer?”, only 12% reported having a major rotation in Family Psychology and 6% reported having a major rotation in Couple Psychology.

![Graph showing distribution of training in Family and Couple Psychology](image-url)
Only a quarter of the respondents reported that their internships offer training in Sexuality/Sex Therapy:

- 47% reported no, none
- 27% reported no, very little
- 25% reported yes, somewhat
- 1% reported yes, it is a significant component

Of those who said their internships did not offer training in Sexuality or Sex Therapy, four respondents commented on related trainings:

<table>
<thead>
<tr>
<th>Comment</th>
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<tbody>
<tr>
<td>We do teach about sexuality issues in teens with developmental disabilities but not actual therapy...</td>
</tr>
<tr>
<td>We have a fair amount of training and experience in working with individuals who identify as LBGTQ, but none in sex therapy.</td>
</tr>
<tr>
<td>Training in sexual minority issues (e.g., GLBT), but not sexuality per se</td>
</tr>
<tr>
<td>major rotation in sex addiction treatment</td>
</tr>
</tbody>
</table>

When asked, “How many of your training faculty or supervisors are family psychologists?”, 56% of the respondents reported having at least one family psychologist on the training faculty.

- 29% reported one
- 15% reported two
- 7% reported three
- 4% reported four
- 1% reported five
- 44% reported none

Over half the respondents (n = 58) said it would be helpful for Division 43 (Society for Family Psychology) to provide them with resources for training their students.
Postdoctoral Internships/Fellowships

In addition to the invitation to complete the survey that was sent by email to 464 APA-accredited Internships/Postdoctoral programs, 14 emails were sent to postdoctoral programs that were not affiliated with pre-doctoral internships. A total of 45 psychologists who responded to the survey reported being affiliated with a post-doctoral internship or fellowship. Five of these had also reported being faculty members in a clinical psychology, counseling psychology or school psychology program, and 34 had also reported being affiliated with a pre-doctoral internship. Ten (22%) reported that their internships or fellowships are APA accredited.

In response to the question, “How much training in Family Psychology does your pre-doctoral internship offer?”, only 11% reported having a major rotation in Family Psychology and 4% reported having a major rotation in Couple Psychology.

When asked, “How many of your training faculty or supervisors are family psychologists?”, 63% of the respondents reported having at least one family psychologist on the training faculty.
Forty percent of the respondents (n = 18) said it would be helpful for Division 43 (Society for Family Psychology) to provide them with resources for training their postdocs.
Appendix J
Pre-doctoral Internships
### Appendix: Family and Couples Pre-Doctoral Internship Sites

| Program Name | Program Type | Children | Adults | Family | Couples | Assessment | Therapy | Child Therapy | For More Information | Contact Information | Program Website Address | Program Director | E-mail Address | Phone Number | Contact Website | Other Notes |
|--------------|--------------|----------|--------|--------|---------|------------|---------|--------------|----------------------|----------------------|----------------------|------------------|----------------|--------------|--------------|---------------|-------------|
| Arkansas State University | APA | YES | YES | YES | YES | YES | YES | YES | YES | http://www.uark.edu/psychology/clinical-internship/ | Amanda Baker, Ph.D. | amandabaker@uark.edu | (501) 575-6396 | Department of Psychology | 200 intervention hrs & 100 assessment hrs required |
| Arizona State University | APA | YES | YES | YES | YES | YES | YES | YES | YES | http://www.asu.edu/psychology/education/internships/ | Adrianne B. Leach, Ph.D. | adrianne.leach@asu.edu | (480) 965-1200 | Family Therapy | 200 intervention hrs & 100 assessment hrs required |
| Arizona State University | APA | YES | YES | YES | YES | YES | YES | YES | YES | http://www.asu.edu/psychology/education/internships/ | Maria Verde, Ph.D. | maria.verde@asu.edu | (480) 965-1200 | Child Therapy | 200 intervention hrs & 100 assessment hrs required |
| Arizona State University | APA | YES | YES | YES | YES | YES | YES | YES | YES | http://www.asu.edu/psychology/education/internships/ | Jennifer Macias, Ph.D. | jennifer.macias@asu.edu | (480) 965-1200 | Family Therapy | 200 intervention hrs & 100 assessment hrs required |
| Arizona State University | APA | YES | YES | YES | YES | YES | YES | YES | YES | http://www.asu.edu/psychology/education/internships/ | Debra L. Smith, Ph.D. | debra.smith@asu.edu | (480) 965-1200 | Family Therapy | 200 intervention hrs & 100 assessment hrs required |
| Arizona State University | APA | YES | YES | YES | YES | YES | YES | YES | YES | http://www.asu.edu/psychology/education/internships/ | Karla A. Martinez, Ph.D. | karla.martinez@asu.edu | (480) 965-1200 | Family Therapy | 200 intervention hrs & 100 assessment hrs required |
| Arizona State University | APA | YES | YES | YES | YES | YES | YES | YES | YES | http://www.asu.edu/psychology/education/internships/ | Kevin M. Smith, Ph.D. | kevin.smith@asu.edu | (480) 965-1200 | Family Therapy | 200 intervention hrs & 100 assessment hrs required |
| Arizona State University | APA | YES | YES | YES | YES | YES | YES | YES | YES | http://www.asu.edu/psychology/education/internships/ | Laura E. Vazquez, Ph.D. | laura.vazquez@asu.edu | (480) 965-1200 | Family Therapy | 200 intervention hrs & 100 assessment hrs required |
| Arizona State University | APA | YES | YES | YES | YES | YES | YES | YES | YES | http://www.asu.edu/psychology/education/internships/ | Melissa R. Wright, Ph.D. | melissa.wright@asu.edu | (480) 965-1200 | Family Therapy | 200 intervention hrs & 100 assessment hrs required |
| Arizona State University | APA | YES | YES | YES | YES | YES | YES | YES | YES | http://www.asu.edu/psychology/education/internships/ | Sandra L. Young, Ph.D. | sandra.young@asu.edu | (480) 965-1200 | Family Therapy | 200 intervention hrs & 100 assessment hrs required |
| Arizona State University | APA | YES | YES | YES | YES | YES | YES | YES | YES | http://www.asu.edu/psychology/education/internships/ | Walter J. Zietlow, Ph.D. | walter.zietlow@asu.edu | (480) 965-1200 | Family Therapy | 200 intervention hrs & 100 assessment hrs required |
| Arizona State University | APA | YES | YES | YES | YES | YES | YES | YES | YES | http://www.asu.edu/psychology/education/internships/ | William J. Zink, Ph.D. | william.zink@asu.edu | (480) 965-1200 | Family Therapy | 200 intervention hrs & 100 assessment hrs required |
| Arizona State University | APA | YES | YES | YES | YES | YES | YES | YES | YES | http://www.asu.edu/psychology/education/internships/ | Yvonne A. Zuvic, Ph.D. | yvonne.zuvic@asu.edu | (480) 965-1200 | Family Therapy | 200 intervention hrs & 100 assessment hrs required |

*Note: The above table represents a subset of the total family and couples pre-doctoral internship sites. For a complete list, please refer to the APA internship database or contact the respective programs directly. Requirements vary by program, so it is important to review specific program details and assess whether they align with the individual's academic and career goals.*
Appendix K
Internship Sites from Division 43 Web Site
Internships in Family Psychology
From Society for Couple and Family Psychology Web page

Internship: A typical one year full-time predoctoral internship with a family psychology emphasis should include a balance of clinical experiences and didactic offerings. The internship needs to have an emphasis on the integration of theory and research into the practice of family psychology. In addition, the integration of theory, research, and practice in applied psychology generally and family psychology more specifically, needs to be central to the professional socialization of the predoctoral intern. Interns need to be provided with a diversity of clinical experiences in assessment and intervention with couples and families. In addition, the intern needs to have substantial opportunities for the systems assessment and treatment of individuals and interpersonal psychopathology and/or organizational problems. Both individual and group supervision need to be offered.

Internships that are strong in family psychology training are those that meet the following three criteria:
Include didactic or case presentations focused on family psychology or systemic theoretical perspectives;
Include at least one clinical rotation (>25 percent client contact hours) of couples/family therapy or systemic consultation supervised by a faculty member with demonstrated competence in family psychology; and 
Employ at least one licensed faculty member with demonstrated competence in family psychology. Demonstrated competence in family psychology is defined by board certification in family psychology from the American Board of Professional Psychology, election as fellow of Division 43 (Society of Family Psychology), service in Division 43 through governance or committee activities, scholarly publications (including research reports) related to family psychology and/or completion of postdoctoral training in family psychology (CRSPP Report, 2010).
The 2012 APPIC Directory lists 127 (28 percent) of 457 APA-accredited internships as offering a major rotation in couples or family therapy. (The number of APA-accredited internships offering a minor rotation in couples or family therapy is 325, or 71 percent.) Of those APA-accredited internships offering a major rotation in family therapy, only some are considered strong in family psychology training according to the above criteria.

Emails were sent to 127 internship training directors in February and March 2012 to determine if their internships met the three criteria above. Of the 59 who responded, 22 indicated that their program met all three criteria and provided names of faculty members with demonstrated competence in family psychology. These 22 programs are listed below by state.

Arizona
Southern Arizona Psychology Internship Center (SAPIC)
504 W. 29th Street, Tuscon, AZ 85713
Telephone: (520) 838-3993
Fax: (520) 838-5604
Director of Training: Mayday Levine-Mata, PsyD
Faculty Members with Demonstrated Competence in Family Psychology: Ed Lovejoy, PhD

California
Children’s Institute, Inc.
711 South New Hampshire Avenue
Los Angeles, CA 90005
Telephone: (213) 385-5100 Ext. 1812
Fax: (213) 383-1820
Director of Training: George Bermudez, PhD
Faculty Members with Demonstrated Competence in Family Psychology: George Bermudez, PhD

Western Youth Services
23461 South Pointe Drive, Suite 220
Laguna Hills, CA 92653
Telephone: (949) 855-1556
Fax: (949) 951-2871
Director of Training: Katie Devlin, PhD
Faculty Members with Demonstrated Competence in Family Psychology: Kathleen Devlin, PhD and Thomas Sexton, PhD

Delaware
Delaware Division of Prevention and Behavioral Health Services/Terry Children’s Psychiatric Center
10 Central Avenue
New Castle, DE 19720
Telephone: (302) 256-5601
Fax: (302) 577-3187
Director of Training: Aileen Fink, PhD
Faculty Members with Demonstrated Competence in Family Psychology: Marsali Hansen, PhD

Florida
Citrus Health Network
4175 W. 20th Avenue
Miami, FL 33012
Telephone: (305) 825-0300 Ext. 2080
Fax: (305) 826-3039
Director of Training: Dianne Rosen, PhD
Faculty Members with Demonstrated Competence in Family Psychology: Jesus Perez, PsyD

Georgia
Emory University School of Medicine
Grady Health Systems, Dept. of Psychiatry
80 Jesse Hill Jr. Drive Atlanta, GA 30303
Telephone: (404) 616-4807
Fax: (404) 616-3241
Director of Training: Carol Webb, PhD, ABPP
Faculty Members with Demonstrated Competence in Family Psychology: Marianne Celano, PhD, ABPP and Nadine Kaslow, PhD, ABPP

Medical College of Georgia/Charlie Norwood VA Medical Center
#1 Freedom Way
Augusta, GA 30904
Telephone: (706) 733-0188 Ext. 7735
Fax: (706) 731-7190
Director of Training: Alex Mabe, PhD
Faculty Members with Demonstrated Competence in Family Psychology: Bernard Davidson, PhD and Alex Mabe, PhD
Illinois
Ann & Robert H. Lurie Children’s Hospital of Chicago
225 E. Chicago Avenue
Chicago, IL 60611
Telephone: (312) 227-3427
Director of Training: Karen R. Gouze, PhD
Faculty Members with Demonstrated Competence in Family Psychology: Karen Gouze, PhD and Richard Wendel, PhD, LMFT

Kansas
University of Kansas Medical Center
Department of Psychiatry and Behavioral Sciences
3901 Rainbow Boulevard
Kansas City, KS 66160
Telephone: (913) 588-6401
Fax: (913) 588-1310
Director of Training: Edward E. Hunter, PhD, ABPP
Faculty Members with Demonstrated Competence in Family Psychology: Edward E. Hunter, PhD, ABPP and Teri Smith, PhD

Kentucky
Lexington VA Medical Center (DOC,149KB)
1101 Veterans Drive (116A-4 LD)
Lexington, KY 40502
Telephone: (859) 233-4511 Ext. 3443
Fax: (859) 281-3919
Director of Training: Christiane Schneider, PhD
Faculty Members with Demonstrated Competence in Family Psychology: Steven E. Hansel, PsyD

Louisiana
Southeast Louisiana Veterans Health Care System
Mental Health Service (116)
P.O. Box 61011
New Orleans, LA 70161
Telephone: (504) 571-8295
Fax: (504) 571-8126
Director of Training: Michelle Hamilton, PhD
Faculty Members with Demonstrated Competence in Family Psychology: Frederic J. Sautter, PhD

Maryland
Kennedy Krieger Institute
Johns Hopkins University School of Medicine
720 Aliceanna Street, 2nd floor
Baltimore, MD 21202
Telephone: (443) 923-7491
Fax: (443) 923-7507
Director of Training: Jennifer Crockett, PhD
Faculty Members with Demonstrated Competence in Family Psychology: Gina Richman, PhD and Tana Hope, PhD

**Minnesota**
Canvas Health
7066 Stillwater Boulevard North
Oakdale, MN 55128
Telephone: (651) 777-5222
Fax: (651) 251-5111
Director of Training: James V. Wojcik, PhD
Faculty Members with Demonstrated Competence in Family Psychology: James V. Wojcik, PhD and Dean Gorall, PhD

**New Jersey**
University of Medicine and Dentistry of New Jersey
183 South Orange Avenue
P.O. Box 1709
Newark, N.J. 07101
Telephone: (973) 972-5573
Fax: (973) 972-6976
Director of Training: Beata Geyer-Beaudoin, PhD
Faculty Members with Demonstrated Competence in Family Psychology: Sueli Petry, PhD

**New York**
Albert Einstein College of Medicine – Montefiore Medical Center
111 East 210th Street
Bronx, NY 10467
Telephone: (718)920-5024
Fax: (718) 798-1816
Appendix L
Post-doctoral Training Programs
Appendix M
AAMFT Training Programs
**California**
Bethel Seminary (MA)
Dr. G. Keith Olson
Administrator and Lead Faculty
6116 Arosa Street
San Diego, CA 92115-3902
Phone: (619) 325-5200
Fax: (619) 325-5237
Email: gk-olson@bethel.edu
Website: http://seminary.bethel.edu/programs/bssd/mft/
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: May 01, 2014
Renewal Date: November 01, 2015

**Colorado**
Denver Family Institute (PDI)
Ms. Misti Klarenbeek-McKenna
Program Director
7200 East Hampden Avenue
Suite 301
Denver, CO 80224
Phone: 303-456-0600
Fax:
Email: mistikmckenna@msn.com
Website: http://www.denverfamilyinstitute.org
Facebook:
Program on Probation**: Post-Degree
Program Type: Campus-Based
Self-Study Due Date: October 01, 2018
Renewal Date: November 01, 2019

Program on Probation - A program with deficiencies may be awarded accreditation with stipulations provided they can be corrected within a specified period of time. COAMFTE will specify "stipulations" that must be addressed in an interim report, due at a time determined by COAMFTE, or by an interim site visit to be conducted at a time determined by COAMFTE. Programs that fail to clear stipulations in their first year of carrying stipulations will be placed on probation for a period of time not to exceed one year. Programs that fail to clear all stipulations within the two year period may have their accreditation revoked. (COAMFTE Accreditation Manual: Policies and Procedures)

**Colorado**
Regis University (MA)
Dr. Jennifer Cates
Program Director
Division of Counseling and Family Therapy
Rueckert-Hartman College for Health Prof
Broomfield, CO 80021
Phone: (303) 964-6071
Fax: (303) 635-1363
Email: jcates001@regis.edu
Website: http://www.regis.edu/RHCHP/Academics/Degrees-and-Programs/Graduate-and-Doctorate-Programs/MA-Marriage-and-Family-Therapy.aspx
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2016
Renewal Date: November 01, 2017

**Colorado**

Colorado State University (MS)
Dr. Toni Zimmerman
Associate Professor
Department of Marriage and Family Therapy
119E Gifford Building
Fort Collins, CO 80523
Phone: (970) 491-6922
Fax: (970) 491-7975
Email: toni.zimmerman@colostate.edu
Website: http://www.hdfs.cahs.colostate.edu
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2017
Renewal Date: November 01, 2018

**Connecticut**

Connecticut, University of (MA)
Dr. Shayne Anderson
Assistant Professor and Director MFT Programs
Human Development and Family Studies
Unit 2058, 348 Mansfield Road
Storrs, CT 06269
Phone: (860) 486-1659
Fax: (860) 486-3452
Email: shayne.anderson@uconn.edu
Website: http://www.familystudies.uconn.edu/graduate/MFT.html
Facebook:
Program Accredited with Stipulations*: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2018
Renewal Date: May 01, 2019

Program Accredited with Stipulations - The Commission will award initial accreditation or renewal of accreditation to programs evidencing substantial compliance with accreditation standards. Initial accreditation shall be granted for a period not to exceed five (5) years. Renewal of accreditation shall be granted for a period not to exceed six (6) years (Shorter periods of accreditation may be awarded at the discretion of the Commission). A program with deficiencies may be awarded accreditation with
stipulations provided they can be corrected within a specified period of time. COAMFTE will specify "stipulations" that must be addressed in an interim report, due at a time determined by COAMFTE, or by an interim site visit to be conducted at a time determined by COAMFTE. (COAMFTE Accreditation Manual: Policies and Procedures)

Connecticut
Central Connecticut State University (MS)
Dr. Ralph Cohen
MFT Program Director
1615 Stanley St
Department of Counseling & Family Therapy
New Britain, CT 06050-4010
Phone: (860) 832-2122
Fax: (860) 832-2145
Email: cohenr@mail.ccsu.edu
Website: http://www.ccsu.edu/MFT
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: May 01, 2014
Renewal Date: May 01, 2015

Connecticut
University of Saint Joseph-(MA)
Dr. Michele Parker
Chair & Program Director
Department of Counseling & Family Therapy
1678 Asylum Avenue
West Hartford, CT 06117
Phone: (860) 231-5321
Fax: (860) 231-5774
Email: mparker@usj.edu
Website: http://www.sjc.edu/content.cfm/pageid/2973
Facebook:
Program Accredited with Stipulations*: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2018
Renewal Date: May 01, 2019

Program Accredited with Stipulations - The Commission will award initial accreditation or renewal of accreditation to programs evidencing substantial compliance with accreditation standards. Initial accreditation shall be granted for a period not to exceed five (5) years. Renewal of accreditation shall be granted for a period not to exceed six (6) years (Shorter periods of accreditation may be awarded at the discretion of the Commission). A program with deficiencies may be awarded accreditation with stipulations provided they can be corrected within a specified period of time. COAMFTE will specify "stipulations" that must be addressed in an interim report, due at a time determined by COAMFTE, or by an interim site visit to be conducted at a time determined by COAMFTE. (COAMFTE Accreditation Manual: Policies and Procedures)
Connecticut
Southern Connecticut State Univ. MFT
Dr. Paul Levatino
Program Director
MFT Program Davis Hall Room 020
501 Crescent Street
New Haven, CT 06515
Phone: (203) 392-6414
Fax: (203) 392-6441
Email: levatinop1@southernct.edu
Website: http://www.southernct.edu/academics/schools/health/academic-programs/marriagefamilytherapy/
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2015
Renewal Date: May 01, 2016

Connecticut
Fairfield University (MA)
Dr. Rona Preli
Program Director
Grad. School of Educ/Allied Profession
CNS 102
Fairfield, CT 06430
Phone: (203) 254-4000 x2475
Fax: (203) 254-4119
Email: rpreli@mail.fairfield.edu
Website: http://www.fairfield.edu/gseap/mamft_index.html
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2018
Renewal Date: November 01, 2019

Connecticut
Connecticut, University of (Ph.D.)
Dr. Shayne Anderson
Assistant Professor and Director MFT Program
Human Development & Family Studies
Unit 2058, 348 Mansfield Road
Storrs, CT 06269
Phone: (860) 486-1659
Fax: (860) 486-3452
Email: shayne.anderson@uconn.edu
Website: http://www.familystudies.uconn.edu/graduate/MFT.html
Facebook:
Program Accredited: Doctoral
Program Type: Campus-Based
Self-Study Due Date: April 01, 2018  
Renewal Date: May 01, 2019

**Florida**  
Nova Southeastern University (MS)  
Dr. Anne Rambo  
Chair, Program Director  
SHSS Dept. of Family Therapy  
3301 College Avenue (Maltz Building)  
Fort Lauderdale, FL 33314  
Phone: (954) 262-3002  
Fax: (954) 262-3968  
Email: rambo@nova.edu  
Website: http://shss.nova.edu/programs/family_therapy/ms/index2.htm  
Facebook:  
Program Accredited: Masters  
Program Type: Campus-Based  
Self-Study Due Date: October 01, 2019  
Renewal Date: November 01, 2020

**Florida**  
Nova Southeastern University (PhD)  
Dr. Martha Marquez  
Chair, Program Director  
SHSS Dept. of Family Therapy  
3301 College Avenue (Maltz Building)  
Fort Lauderdale, FL 33314  
Phone: (954) 262-3056  
Fax: (954) 262-3968  
Email: martmarq@nova.edu  
Website: http://shss.nova.edu/programs/family_therapy/phd/index.htm  
Facebook:  
Program Accredited: Doctoral  
Program Type: Campus-Based  
Self-Study Due Date: October 01, 2015  
Renewal Date: November 01, 2016

**Florida**  
Florida State University (PhD)  
Dr. Wayne Denton  
Program Director  
Interdiv. Doctoral Prog in Fam. Therapy  
240 Sandels Building,  
Tallahassee, FL 32306-1491  
Phone: (850) 644-3217  
Fax: (850) 644-3439  
Email: wdenton@fsu.edu  
Website: http://www.chs.fsu.edu/fcs/mft/  
Facebook: http://www.facebook.com/fsumft
Program on Probation**: Doctoral
Program Type: Campus-Based
Self-Study Due Date: April 01, 2018
Renewal Date: May 01, 2019

Program on Probation - A program with deficiencies may be awarded accreditation with stipulations provided they can be corrected within a specified period of time. COAMFTE will specify "stipulations" that must be addressed in an interim report, due at a time determined by COAMFTE, or by an interim site visit to be conducted at a time determined by COAMFTE. Programs that fail to clear stipulations in their first year of carrying stipulations will be placed on probation for a period of time not to exceed one year. Programs that fail to clear all stipulations within the two year period may have their accreditation revoked. (COAMFTE Accreditation Manual: Policies and Procedures)

Georgia
Georgia, University of (PhD)
Dr. Jerry Gale
Director of MFT Program
Dept of Child and Family Development
MFT Program, 123 Dawson Hall
Athens, GA 30602
Phone: (706) 542-4821
Fax: (706) 542-4489
Email: jgale@uga.edu
Website: http://fcs.uga.edu/cfd/mft/index.html
Facebook:
Program Accredited: Doctoral
Program Type: Campus-Based
Self-Study Due Date: April 01, 2015
Renewal Date: May 01, 2016

Georgia
Valdosta State University (MS)
Dr. Kate Warner
Program Director
1500 North Patterson St.
Valdosta, GA 31698
Phone: (229) 293-6264
Fax: (229) 293-6265
Email: kwarner@valdosta.edu
Website: http://www.valdosta.edu/mft/
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2018
Renewal Date: May 01, 2019

Georgia
Mercer University- Macon (MFT)
Dr. Bowden Templeton
Georgia
Mercer University- Atlanta (MFT)
Dr. Bowden Templeton
Program Director
Dept of Psych and Behavioral Science MFT
655 First Street
Macon, GA 31207
Phone: (478) 301-4077
Fax: (478) 301-5337
Email: templeton_gb@mercer.edu
Website: http://medicine.mercer.edu/Academics/Degree%20Programs/mft
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2015
Renewal Date: May 01, 2016

Illinois
Family Institute at Northwestern Univ-MS
Dr. Douglas Breunlin
Program Director - MSMFT Program
Bette D. Harris Center
618 Library Place
Evanston, IL 60201
Phone: (847) 733-4300 x214
Fax: (847) 733-0390
Email: d-breunlin@northwestern.edu
Website: http://www.family-institute.org/
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2017
Renewal Date: May 01, 2018

Alabama
Auburn University-(MS)
Dr. Thomas Smith
Director - MFT Program
Human Development and Family Studies
203 Spidle Hall
Auburn, AL 36849
Phone: (334) 844-4478
Fax: (334) 844-1924
Email: smitht8@auburn.edu
Website: http://www.humsci.auburn.edu/hdfs/ms-mft.php
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2017
Renewal Date: May 01, 2018

Arizona
Northcentral University (MA)
Dr. Lisa Kelledy
Program Director
8667 E. Hartford Drive
Scottsdale, AZ 85255
Phone: 928-771-6871
Fax: (928)759-6257
Email: lkelledy@ncu.edu
Website: http://www.ncu.edu
Facebook:
Program Accredited: Masters
Program Type: Online/Distance-Based
Self-Study Due Date: October 01, 2016
Renewal Date: November 01, 2017

California
Alliant International University- San Francisco (MA)
Dr. Marcia Michaels
Site Director
San Francisco Location
One Beach Street, Suite 200
San Francisco, CA 94133
Phone: (415) 955-2141
Fax: (415) 955-2178
Email: mmichaels@alliant.edu
Website: http://mft.alliant.edu
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: November 01, 2018
Renewal Date: November 01, 2019
California
Alliant International University- San Diego (MA)
Dr. Marianne Miller
Site Director
San Diego Location (Main Campus)
10455 Pomerado Road
San Diego, CA 92131-1799
Phone: (858) 635-4878
Fax: (858) 635-4585
Email: mmiller@alliant.edu
Website: http://mft.alliant.edu
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2018
Renewal Date: November 01, 2019

California
San Diego State University (MS)
Dr. Brent Taylor
Program Director
Dept of Counseling and School Psychology
5500 Campanile Drive
San Diego, CA 92182-1179
Phone: (619) 594-3871
Fax: (619) 594-7025
Email: btaylor@mail.sdsu.edu
Website: http://edweb.sdsu.edu/csp/programs/mft/mft.htm
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2015
Renewal Date: May 01, 2016

California
San Diego, University of (MA)
Dr. Todd Edwards
Associate Professor and Director
Marital and Family Therapy Program
5998 Alcala Park
San Diego, CA 92110-2492
Phone: (619) 260-5963
Fax: (619) 260-6826
Email: tedwards@sandiego.edu
Website: http://www.sandiego.edu/mft
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2015
Renewal Date: November 01, 2016

**California**
Loma Linda University-(Ph.D.)
Dr. Mary Moline
Program Director
Dept of Counseling and Family Science
Griggs Hall Room 202
Loma Linda, CA 92350
Phone: (909) 558-4547
Fax: (909) 558-0417
Email: mmoline@llu.edu
Website: [http://www.llu.edu/science-technology/cfs/phd-mfam.page](http://www.llu.edu/science-technology/cfs/phd-mfam.page)
Facebook:
Program Accredited: Doctoral
Program Type: Campus-Based
Self-Study Due Date: October 01, 2016
Renewal Date: November 01, 2016

**California**
Alliant International University- Irvine (MA)
Dr. Raji Natrajan-Tyagi
Site Director
Irvine, Orange County Location
2500 Michelson Dr. Bldg. 400
Irvine, CA 92612-1548
Phone: (949) 812-7456
Fax: (949) 833-3507
Email: rnatrajan@alliant.edu
Website: [http://mft.alliant.edu](http://mft.alliant.edu)
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2018
Renewal Date: November 01, 2019

**California**
Alliant International University- Irvine (PsyD)
Dr. Raji Natrajan-Tyagi
Site Director
Irvine, Orange County Location
2500 Michelson Dr. Bldg. 400
Irvine, CA 92612-1548
Phone: (949)812-7456
Fax: (949)833-3507
Email: rnatrajan@alliant.edu
Website: [http://mft.alliant.edu](http://mft.alliant.edu)
Facebook:
Program Accredited: Doctoral
Program Type: Campus-Based
Self-Study Due Date: October 01, 2018
Renewal Date: November 01, 2019

**California**
Alliant International University- San Diego (PsyD)
Dr. Marianne Miller
Site Director
San Diego Location (Main Campus)
10455 Pomerado Road
San Diego, CA 92131
Phone: (858) 635-4878
Fax: (858) 635-4585
Email: mmiller@alliant.edu
Website: http://mft.alliant.edu
Facebook:
Program Accredited: Doctoral
Program Type: Campus-Based
Self-Study Due Date: October 01, 2018
Renewal Date: November 01, 2019

**California**
Alliant International University- Los Angeles (PsyD)
Dr. Norma Scarborough
Site Director
Los Angeles Location
1000 South Fremont Avenue, Unit 5
Alhambra, CA 91803
Phone:
Fax:
Email: bcaldwell@alliant.edu
Website:
Facebook:
Program Accredited: Doctoral
Program Type: Campus-Based
Self-Study Due Date: October 01, 2018
Renewal Date: November 01, 2019

**California**
Chapman University (MA)
Dr. Brennan Peterson
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Dept of Psychology, MFT Program
One University Drive
Orange, CA 92866-2150
Phone: (714) 744-7915
Fax: (714) 997-6780
Email: bpeterson@chapman.edu
Website: http://www.chapman.edu/SCS/HLS/MAMFT.asp
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2018
Renewal Date: May 01, 2019

California
Loma Linda University (DMFT)
Dr. Winetta Bake-Oloo
Program Director
Dept of Counseling and Family Science
11063 Campus St., Griggs Hall Room 202
Loma Linda, CA 92350
Phone: (909) 558-4547
Fax: (909) 558-0417
Email: wbaker@llu.edu
Website: http://www.llu.edu/science-technology/cfs/imastersdmftmfmfam.page
Facebook:
Program Accredited: Doctoral
Program Type: Campus-Based
Self-Study Due Date: April 01, 2017
Renewal Date: May 01, 2018

California
Hope International University (MA)
Dr. Susan Hastings
Chair, Dept. of Psych and Counseling
Marriage and Family Therapy Program
2500 E. Nutwood, Ste 212
Fullerton, CA 92831
Phone: (714) 879-3901
Fax: (714) 681-7226
Email: shastings@hiu.edu
Website: http://www.hiu.edu/academics/grad/mft/
Facebook:
Program on Probation**: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2018
Renewal Date: November 01, 2019

Program on Probation - A program with deficiencies may be awarded accreditation with stipulations provided they can be corrected within a specified period of time. COAMFTE will specify "stipulations" that must be addressed in an interim report, due at a time determined by COAMFTE, or by an interim site visit to be conducted at a time determined by COAMFTE. Programs that fail to clear stipulations in their first year of carrying stipulations will be placed on probation for a period of time not to exceed one year. Programs that fail to clear all stipulations within the two year period may have their accreditation revoked. (COAMFTE Accreditation Manual: Policies and Procedures)
California
Alliant International University- Sacramento (MA)
Dr. Tatiana Glebova
Site Director
Sacramento Location
2030 West El Camino, Suite 200
Sacramento, CA 95833
Phone: (916) 561-3214
Fax: (916) 565-2959
Email: tglebova@alliant.edu
Website: http://mft.alliant.edu
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2018
Renewal Date: November 01, 2019

California
Alliant International University- Sacramento (PsyD)
Dr. Tatiana Glebova
Site Director
Sacramento Location
2030 West El Camino, Suite 200
Sacramento, CA 95833
Phone: (916) 561-3214
Fax: (916) 565-2959
Email: tglebova@alliant.edu
Website: http://mft.alliant.edu
Facebook:
Program Accredited: Doctoral
Program Type: Campus-Based
Self-Study Due Date: October 01, 2018
Renewal Date: November 01, 2019

California
Alliant International University- Los Angeles (MA)
Dr. Norma Scarborough
Site Director
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Phone: (626) 270-3383
Fax: (626) 284-0550
Email: nscarborough@alliant.edu
Website: http://mft.alliant.edu
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
California
Loma Linda University (MS)-MFT Program
Dr. Mary Moline
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Dept. of Counseling and Family Sciences
Griggs Hall Room 209
Loma Linda, CA 92350
Phone: (909) 558-4547
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Email: mmoline@llu.edu
Website: http://www.llu.edu/science-technology/cfs/msmft.page
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2017
Renewal Date: May 01, 2018

Illinois
Northern Illinois University (MS)
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School of FCNS
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Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: November 01, 2014
Renewal Date: November 01, 2015

Indiana
Purdue University-Calumet (MS)
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Associate Professor and Program Director
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Fax: (219) 989-2777
Email: mftprogram@purduecal.edu
Website: http://webs.purduecal.edu/mftp/
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2016
Renewal Date: November 01, 2017

Indiana
Christian Theological Seminary-(MA)
Dr. Suzanne Coyle
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1000 West 42nd Street
Indianapolis, IN 46208
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Website: https://inside.cts.edu/ics/Admissions/Master_of_Arts_in_Marriage_and_Family_Therapy.jnz
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2018
Renewal Date: May 01, 2019

Kansas
Friends University -- Lenexa Site-(MS)
Dr. Christopher Habben
MSFT Lenexa Site Director
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Email: chabben@friends.edu
Website: http://www.friends.edu/academics/family-therapy
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2017
Renewal Date: May 01, 2018

Kansas
Kansas State University (PhD)
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Email: sstith@ksu.edu
Website: http://www.humec.ksu.edu/fshs/mft-phd.php
Facebook:
Program Accredited: Doctoral
Program Type: Campus-Based
Self-Study Due Date: May 01, 2014
Renewal Date: May 01, 2015

Kansas
Kansas State University (MS)
Dr. Sandra Stith
Program Coordinator
Marriage and Family Therapy Grad Program
101 Campus Creek Complex
Manhattan, KS 66506-7500
Phone: (785) 532-4377
Fax: (785) 532-6523
Email: sstith@ksu.edu
Website: http://www.humec.ksu.edu/fshs/mft-grad.php
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: May 01, 2014
Renewal Date: May 01, 2015

Kansas
Friends University-(MS)
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2100 W. University Avenue
Wichita, KS 67213
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Fax: (316) 295-5115
Email: susan_dutcher@friends.edu
Website: http://www.friends.edu/academics/family-therapy
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2017
Renewal Date: May 01, 2018

Kentucky
Louisville Presbyterian Theol. Sem. (MA)
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Kentucky
Kentucky, University of (MS)
Dr. Ronald Werner-Wilson
Program Director
MFT Program-Dept of Family Studies
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Lexington, KY 40506-0054
Phone: (859) 257-7750
Fax: (859) 257-3212
Email: ronald.werner-wilson@uky.edu
Website: http://www.ca.uky.edu/kes/index.php?p=77
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2015
Renewal Date: November 01, 2016

Program on Probation - A program with deficiencies may be awarded accreditation with stipulations provided they can be corrected within a specified period of time. COAMFTE will specify "stipulations" that must be addressed in an interim report, due at a time determined by COAMFTE, or by an interim site visit to be conducted at a time determined by COAMFTE. Programs that fail to clear stipulations in their first year of carrying stipulations will be placed on probation for a period of time not to exceed one year. Programs that fail to clear all stipulations within the two year period may have their accreditation revoked. (COAMFTE Accreditation Manual: Policies and Procedures)

Kentucky
Louisville, University of (MSSW)
Dr. Emma Sterrett
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Kent School of Social Work
Seminar Center / Shelby Campus
Louisville, KY 40292
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Fax:
Email: emma.sterrett@louisville.edu
Website: http://louisville.edu/kent/programs/family-therapy
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2015
Renewal Date: May 01, 2016
**Louisiana**
Louisiana at Monroe, University of (MA)
Dr. Jana Sutton
Program Director
Marriage and Family Therapy Program
368 Strauss Hall
Monroe, LA 71209-0280
Phone: (318) 342-1208
Fax: (318) 342-1213
Email: sutton@ulm.edu
Website: www.ulm.edu/mft
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2018
Renewal Date: May 01, 2019

**Louisiana**
Louisiana at Monroe, University of (PhD)
Dr. Jana Sutton
Program Director
Marriage and Family Therapy Program
368 Strauss Hall
Monroe, LA 71209-0280
Phone: (318) 342-1208
Fax: (318) 342-1213
Email: sutton@ulm.edu
Website: www.ulm.edu/mft
Program Accredited: Doctoral
Program Type: Campus-Based
Self-Study Due Date: April 01, 2018
Renewal Date: May 01, 2019

**Maryland**
University of Maryland (MS)
Dr. Norm Epstein
Professor of Family Studies
Department of Family Studies
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College Park, MD 20742
Phone: (301) 405-4013
Fax: (301) 314-9161
Email: nbe@umd.edu
Website: http://www.gradschool.umd.edu/catalog/programs/fmst.htm
Facebook:
Program Accredited with Stipulations*: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2018
Renewal Date: November 01, 2019

Program Accredited with Stipulations - The Commission will award initial accreditation or renewal of accreditation to programs evidencing substantial compliance with accreditation standards. Initial accreditation shall be granted for a period not to exceed five (5) years. Renewal of accreditation shall be granted for a period not to exceed six (6) years (Shorter periods of accreditation may be awarded at the discretion of the Commission). A program with deficiencies may be awarded accreditation with stipulations provided they can be corrected within a specified period of time. COAMFTE will specify "stipulations" that must be addressed in an interim report, due at a time determined by COAMFTE, or by an interim site visit to be conducted at a time determined by COAMFTE. (COAMFTE Accreditation Manual: Policies and Procedures)

Massachusetts
Massachusetts Boston, University of MS
Dr. Gonzalo Bacigalupe
Program Director
Family Therapy Program
100 Morrissey Boulevard
Boston, MA 02125-3393
Phone: (617) 287-7631
Fax: (617) 287-7664
Email: gonzalo.bacigalupe@umb.edu
Website: http://www.familytherapy.umb.edu/
Facebook: https://www.facebook.com/group.php?gid=16381104676
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2015
Renewal Date: May 01, 2016

Michigan
Michigan State University (PhD)
Dr. Adrian Blow
Program Director, MFT
Department of Human Development and Family Studies
East Lansing, MI 48824-1030
Phone: (517) 432-7092
Fax: (517) 432-2953
Email: blowa@msu.edu
Website: http://hdfs.msu.edu/graduate/couple-and-family-therapy
Facebook:
Program Accredited with Stipulations*: Doctoral
Program Type: Campus-Based
Self-Study Due Date: October 01, 2018
Renewal Date: November 01, 2019

Program Accredited with Stipulations - The Commission will award initial accreditation or renewal of accreditation to programs evidencing substantial compliance with accreditation standards. Initial accreditation shall be granted for a period not to exceed five (5) years. Renewal of accreditation shall
be granted for a period not to exceed six (6) years (Shorter periods of accreditation may be awarded at the discretion of the Commission). A program with deficiencies may be awarded accreditation with stipulations provided they can be corrected within a specified period of time. COAMFTE will specify "stipulations" that must be addressed in an interim report, due at a time determined by COAMFTE, or by an interim site visit to be conducted at a time determined by COAMFTE. (COAMFTE Accreditation Manual: Policies and Procedures)

**Minnesota**
Argosy University- Twin Cities (MA)
Dr. Jo Nelson
Program Director
1515 Central Parkway
Eagan, MN 55121
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Fax: (651) 994-0144
Email: janelson@argosy.edu
Website: http://www.argosy.edu/Colleges/ProgramDetail.aspx?id=865
Facebook: Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2015
Renewal Date: May 01, 2016

**Minnesota**
St. Mary's University of Minnesota-(PDI)
Dr. Samantha Zaid
Director, MFT Programs
School of Grad. & Professional Programs
2500 Park Ave. South
Minneapolis, MN 55404
Phone: (612) 728-5140
Fax: (612) 728-5121
Email: szaid@smumn.edu
Website: http://www.smumn.edu/graduate-home
Facebook:
Program Accredited with Stipulations*: Post-Degree
Program Type: Campus-Based
Self-Study Due Date: April 01, 2017
Renewal Date: May 01, 2018

Program Accredited with Stipulations - The Commission will award initial accreditation or renewal of accreditation to programs evidencing substantial compliance with accreditation standards. Initial accreditation shall be granted for a period not to exceed five (5) years. Renewal of accreditation shall be granted for a period not to exceed six (6) years (Shorter periods of accreditation may be awarded at the discretion of the Commission). A program with deficiencies may be awarded accreditation with stipulations provided they can be corrected within a specified period of time. COAMFTE will specify "stipulations" that must be addressed in an interim report, due at a time determined by COAMFTE, or by an interim site visit to be conducted at a time determined by COAMFTE. (COAMFTE Accreditation Manual: Policies and Procedures)
Minnesota
St Cloud State University (MS)
Dr. Jennifer Connor
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720 Fourth Ave. South
St. Cloud, MN 56301
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Fax: (320) 308-3216
Email: jjconnor@stcloudstate.edu
Website: http://bulletin.stcloudstate.edu/gb/programs/MarriageandFamilyTherapyprogram.asp
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2017
Renewal Date: November 01, 2018

Minnesota
Minnesota, University of (PhD)
Dr. Steven Harris
MFT Director
Family Social Science, MFT Program
290 McNeal Hall, 1985 Buford Avenue
St. Paul, MN 55108
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Fax: (612) 625-4227
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Website: http://fsos.cehd.umn.edu/graduate.html
Facebook:
Program Accredited: Doctoral
Program Type: Campus-Based
Self-Study Due Date: April 01, 2014
Renewal Date: May 01, 2015

Minnesota
St. Mary's University of Minnesota-(MA)
Dr. Samantha Zaid
Director, MFT Programs
School of Grad. & Professional Programs
2500 Park Ave. South
Minneapolis, MN 55404
Phone: (612) 728-5140
Fax: (612) 728-5121
Email: szaid@smumn.edu
Website: http://www.smumn.edu/graduate-home
Facebook:
Program Accredited with Stipulations*: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2017
Renewal Date: May 01, 2018
Program Accredited with Stipulations - The Commission will award initial accreditation or renewal of accreditation to programs evidencing substantial compliance with accreditation standards. Initial accreditation shall be granted for a period not to exceed five (5) years. Renewal of accreditation shall be granted for a period not to exceed six (6) years (Shorter periods of accreditation may be awarded at the discretion of the Commission). A program with deficiencies may be awarded accreditation with stipulations provided they can be corrected within a specified period of time. COAMFTE will specify "stipulations" that must be addressed in an interim report, due at a time determined by COAMFTE, or by an interim site visit to be conducted at a time determined by COAMFTE. (COAMFTE Accreditation Manual: Policies and Procedures)

**Minnesota**
St Cloud State University (PDC)
Dr. Jennifer Connor
Program Director
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Email: jjconnor@stcloudstate.edu
Website: http://bulletin.stcloudstate.edu/gb/programs/MarriageandFamilyTherapyprogram.asp
Facebook:
Program Accredited: Post-Degree
Program Type: Campus-Based
Self-Study Due Date: October 01, 2017
Renewal Date: November 01, 2018

**Minnesota**
Capella University (MS)
Dr. Carol Messmore
Program Director
Marriage and Family Therapy Program
Capella University
Minneapolis, MN 55402
Phone: 888-227-3552
Fax: 888-227-8492
Email: carol.messmore@capella.edu
Website: http://www.capella.edu
Facebook:
Program Accredited: Masters
Program Type: Online/Distance-Based
Self-Study Due Date: April 01, 2017
Renewal Date: May 01, 2018

**Mississippi**
Southern Mississippi, University of (MS)
Dr. Heath Grames
Assistant Professor
MFT Program
Mississippi
Reformed Theological Seminary (MA)
Dr. James Hurley
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Jackson, MS 39209-3099
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Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: May 01, 2014
Renewal Date: May 01, 2015

Missouri
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Fax: (417) 823-3442
Email: kbrown@forest.edu
Website: http://www.forest.edu/ac-mft.aspx
Facebook: https://www.facebook.com/MFTatForest
Program Accredited: Post-Degree
Program Type: Campus-Based
Self-Study Due Date: October 01, 2018
Renewal Date: November 01, 2019

Missouri
The Forest Institute (MA)
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Website: http://www.forest.edu/ac-mamft.aspx
Facebook: https://www.facebook.com/MFTatForest
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2018
Renewal Date: November 01, 2019

Missouri
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Program Director
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Fax: (314) 977-2614
Email: csmitt12@slu.edu
Website: http://www.slu.edu/cft.xml
Facebook: http://www.facebook.com/slumedft
Program Accredited: Doctoral
Program Type: Campus-Based
Self-Study Due Date: May 01, 2014
Renewal Date: May 01, 2015

Nebraska
Nebraska Lincoln, University of (MS)
Dr. Cody Hollist
Assistant Professor
PO Box 830801
Lincoln, NE 68583-0801
Phone: (402) 472-5801
Fax: (402) 472-2283
Email: chollist2@unl.edu
Website: http://cehs.unl.edu/cyaf/grad/mftMasters.shtml
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2016
Renewal Date: May 01, 2017

Nevada
University of Nevada, Las Vegas (MS)
Dr. Katherine Hertlein
Program Director
4505 Maryland Pkwy
New Hampshire
Antioch University New England (PhD)
Dr. Kevin Lyness
Program Director
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Fax: (603) 357-0718
Email: klyness@antioch.edu
Website: http://www.antiochne.edu/ap/mftphd/
Facebook: http://www.facebook.com/groups/92799951321/
Program Accredited: Doctoral
Program Type: Campus-Based
Self-Study Due Date: April 01, 2015
Renewal Date: May 01, 2016

New Hampshire
New Hampshire, University of (MS)
Dr. Barbara Frankel
Associate Professor of Family Studies
Dept of Family Studies -- Pettee Hall
55 College Road, Room 202
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Phone: (603) 862-2134
Fax: (603) 862-3271
Email: family.studies@unh.edu
Website: http://www.chhs.unh.edu/fs/index
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2018
Renewal Date: November 01, 2019

New Hampshire
Antioch University New England (MA)
Dr. Lucille Byno
Director - MFT Program
Applied Psychology
40 Avon Street
Keene, NH 03431
Phone: 603-358-6860
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Email: lbyno@antioch.edu
Website: http://www.antiochne.edu/ap/mft/
Facebook: http://www.facebook.com/groups/92799951321/
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2016
Renewal Date: May 01, 2017

New Jersey
Seton Hall University (MS)
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Program Director
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South Orange, NJ 07079
Phone: 973 275-2856
Fax:
Email: Ben.Beitin@shu.edu
Website: http://www.shu.edu/academics/education/ms-family-therapy/index.cfm
Facebook:
Program Accredited with Stipulations*: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2019
Renewal Date: May 01, 2020

Program Accredited with Stipulations - The Commission will award initial accreditation or renewal of accreditation to programs evidencing substantial compliance with accreditation standards. Initial accreditation shall be granted for a period not to exceed five (5) years. Renewal of accreditation shall be granted for a period not to exceed six (6) years (Shorter periods of accreditation may be awarded at the discretion of the Commission). A program with deficiencies may be awarded accreditation with stipulations provided they can be corrected within a specified period of time. COAMFTE will specify "stipulations" that must be addressed in an interim report, due at a time determined by COAMFTE, or by an interim site visit to be conducted at a time determined by COAMFTE. (COAMFTE Accreditation Manual: Policies and Procedures)

New Jersey
Seton Hall University (EdS)
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Program Director
College of Education and Human Services
400 South Orange Ave.
South Orange, NJ 07079
Phone: 973 275-2856
Fax:
Email: Ben.Beitin@shu.edu
Website: http://www.shu.edu/academics/education/eds-family-therapy/index.cfm
Facebook:
Program Accredited with Stipulations*: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2019
Renewal Date: May 01, 2020

Program Accredited with Stipulations - The Commission will award initial accreditation or renewal of accreditation to programs evidencing substantial compliance with accreditation standards. Initial accreditation shall be granted for a period not to exceed five (5) years. Renewal of accreditation shall be granted for a period not to exceed six (6) years (Shorter periods of accreditation may be awarded at the discretion of the Commission). A program with deficiencies may be awarded accreditation with stipulations provided they can be corrected within a specified period of time. COAMFTE will specify "stipulations" that must be addressed in an interim report, due at a time determined by COAMFTE, or by an interim site visit to be conducted at a time determined by COAMFTE. (COAMFTE Accreditation Manual: Policies and Procedures)

New York
Syracuse University-(MA)
Mr. Thom deLara
Director - MFT Program
David B. Falk College of Sport and Human Dynamics
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Phone: (315) 443-9830
Fax: (315) 443-4062
Email: tdelara@syr.edu
Website: http://humanecology.syr.edu/MarriageFamilyTherapy/Default.aspx
Facebook:
Program Accredited with Stipulations*: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2019
Renewal Date: November 01, 2020

Program Accredited with Stipulations - The Commission will award initial accreditation or renewal of accreditation to programs evidencing substantial compliance with accreditation standards. Initial accreditation shall be granted for a period not to exceed five (5) years. Renewal of accreditation shall be granted for a period not to exceed six (6) years (Shorter periods of accreditation may be awarded at the discretion of the Commission). A program with deficiencies may be awarded accreditation with stipulations provided they can be corrected within a specified period of time. COAMFTE will specify "stipulations" that must be addressed in an interim report, due at a time determined by COAMFTE, or by an interim site visit to be conducted at a time determined by COAMFTE. (COAMFTE Accreditation Manual: Policies and Procedures)

New York
Rochester, University of (MS)
Dr. Jenny Speice
Associate Professor
Dept of Psychiatry, Family Therapy Prog.
300 Crittenden Blvd.
Rochester, NY 14642
Phone: (585) 275-4716
Fax: (585) 276-2065
Email: jenny_speice@urmc.rochester.edu
Website: www.urmc.rochester.edu/psychiatry/institute-for-the-family/family-therapy/master
Facebook: http://goo.gl/o7or3
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2016
Renewal Date: May 01, 2017

New York
Rochester, University of (PDI)
Ms. Carol Podgorski
Associate Professor
Intensive Family Therapy Program
Dept. of Psychiatry; 300 Crittenden Blvd.
Rochester, NY 14642
Phone: (585) 275-8307
Fax: (585) 760-6611
Email: carol_podgorski@urmc.rochester.edu
Website: www.urmc.rochester.edu/psychiatry/institute-for-the-family/family-therapy/post-degree
Facebook: http://goo.gl/o7or3
Program Accredited: Post-Degree
Program Type: Campus-Based
Self-Study Due Date: April 01, 2016
Renewal Date: May 01, 2017

New York
Iona College (MA)
Dr. Robert Burns
Program Director
Egan Hall
715 North Ave.
New Rochelle, NY 10801-1890
Phone: (914) 633-2514
Fax: (914) 637-7710
Email: rburns@iona.edu
Website: http://www.iona.edu/academic/artsscience/departments/counsel/
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: May 01, 2014
Renewal Date: May 01, 2015
New York
Syracuse University-(Ph.D.)
Mr. Thom deLara
Program Director
David B. Falk College of
Sport and Human Dynamics
Syracuse, NY 13244
Phone: (315) 443-9830
Fax: (315) 443-4062
Email: tdelara@syr.edu
Website: http://humanecology.syr.edu/MarriageFamilyTherapy/Default.aspx
Facebook:
Program Accredited: Doctoral
Program Type: Campus-Based
Self-Study Due Date: May 01, 2014
Renewal Date: November 01, 2015

North Carolina
Pfeiffer University (MA)
Dr. Susan Wilkie
Program Director
Marriage and Family Therapy Program
4701 Park Road
Charlotte, NC 28209-3217
Phone: (704) 945-7359
Fax: (704) 521-8617
Email: susan.wilkie@pfeiffer.edu
Website: http://www.pfeiffer.edu/marriage
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: November 01, 2014
Renewal Date: November 01, 2015

North Carolina
East Carolina University (MS)
Dr. Damon Rappleyea
Program Director
M.F.T. Program
Dept of Child Devel and Family Relations
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Phone: (252) 737-2042
Fax: (252) 328-5418
Email: rappleyead@ecu.edu
Website: http://www.ecu.edu/che/cdfr/msmft.html
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2018
Renewal Date: May 01, 2019
**North Carolina**
Pfeiffer University, Raleigh-Durham Campus  
Dr. Jeffrey Krepps  
Site Director  
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Phone: (919)238-2428  
Fax: (919) 941-2920  
Email: jeffrey.krepps@pfeiffer.edu  
Website: http://www.pfeiffer.edu/marriage  
Facebook:  
Program Accredited: Masters  
Program Type: Campus-Based  
Self-Study Due Date: April 01, 2016  
Renewal Date: May 01, 2017

**North Carolina**
Appalachian State University (MA)  
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Phone: (828) 262-6049  
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Program Accredited: Masters  
Program Type: Campus-Based  
Self-Study Due Date: October 01, 2016  
Renewal Date: November 01, 2017

**North Carolina**
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Dept of Child Devel and Family Relations  
Greenville, NC 27858-4353  
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Fax: (252) 328-5418  
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Website: http://www.ecu.edu/che/cdfr/phdmft.html  
Facebook:  
Program Accredited: Doctoral  
Program Type: Campus-Based  
Self-Study Due Date: April 01, 2018
Renewal Date: May 01, 2019

**North Dakota**
North Dakota State University (MS)
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MFT Program- CDFS Department
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Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2015
Renewal Date: May 01, 2016

**Ohio**
Ohio State University (PhD)
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Fax: (614) 292-4365
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Facebook:
Program on Probation**: Doctoral
Program Type: Campus-Based
Self-Study Due Date: October 01, 2018
Renewal Date: November 01, 2019

Program on Probation - A program with deficiencies may be awarded accreditation with stipulations provided they can be corrected within a specified period of time. COAMFTE will specify "stipulations" that must be addressed in an interim report, due at a time determined by COAMFTE, or by an interim site visit to be conducted at a time determined by COAMFTE. Programs that fail to clear stipulations in their first year of carrying stipulations will be placed on probation for a period of time not to exceed one year. Programs that fail to clear all stipulations within the two year period may have their accreditation revoked. (COAMFTE Accreditation Manual: Policies and Procedures)

**Ohio**
Akron, University of (PhD)
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Facebook:
Program Accredited: Doctoral
Program Type: Campus-Based
Self-Study Due Date: October 01, 2015
Renewal Date: November 01, 2016

Ohio
Akron, University of (MS)
Dr. Karin Jordan
Program Director
Dept of Counseling and Spec. Ed.
302 Buchtel Common
Akron, OH 44325-5007
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Fax: (330) 972-5292
Email: kj25@uakron.edu
Website: http://www.uakron.edu/education/academic-programs/counseling/masters/mft-masters/index.dot
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2015
Renewal Date: November 01, 2016

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Oklahoma State University (MS)
Dr. Glade Topham
Director - MFT Specialization
MFT Program, Dept of HDFS
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Website: http://ches.okstate.edu/mft/
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2015
Renewal Date: May 01, 2016

Oregon
Lewis and Clark College (MCFT)
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Website: http://graduate.lclark.edu/dept/cpsy/mft.html
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: November 01, 2013
Renewal Date: May 01, 2015

Oregon
Oregon, University of (M.Ed.)
Dr. Jeff Todahl
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5251 University of Oregon
Eugene, OR 974035251
Phone: (541) 346-0909
Fax: (541) 346-6778
Email: cft@uoregon.edu
Website: https://education.uoregon.edu/program/couples-and-family-therapy
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: November 01, 2014
Renewal Date: November 01, 2015

Pennsylvania
LaSalle University (MA)
Dr. Donna Tonrey
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Clinical-Counseling, MFT Concentration
1900 West Olney Avenue
Philadelphia, PA 19141
Phone: (215) 997-0188
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Website: http://www.lasalle.edu/admiss/grad/psych/mft.php
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2017
Renewal Date: November 01, 2018
Drexel University (PDI)
Dr. Stephanie Brooks
Program Director
1505 Race Street, Bellet Building,
4th Floor, Suite 403, Mail Stop 905
Philadelphia, PA 19102-1192
Phone: (215) 762-6781
Fax: (215) 762-1153
Email: sb55@drexel.edu
Website: http://www.drexel.edu/familyTherapy/
Facebook: facebook.com/cft.drexel
Program Accredited: Post-Degree
Program Type: Campus-Based
Self-Study Due Date: April 01, 2017
Renewal Date: May 01, 2018

Pennsylvania
Thomas Jefferson University (MMFT)
Dr. Kenneth Covelman
901 Walnut Street
Philadelphia, PA 19107
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Fax:
Email: Kenneth.Covelman@Jefferson.edu
Website: http://www.jefferson.edu/university/health_professions/departments/couple-family-therapy.html
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2018
Renewal Date: May 01, 2019

Pennsylvania
Council for Relationships (PDI)
Dr. Bea Hollander - Goldfein
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4025 Chestnut Street, 1st Floor
Philadelphia, PA 19104
Phone: (215) 382-6680 x3110
Fax:
Email: bhg6@verizon.net
Website: www.councilforrelationships.org
Facebook:
Program on Probation**: Post-Degree
Program Type: Campus-Based
Self-Study Due Date: October 01, 2018
Renewal Date: November 01, 2019

Program on Probation - A program with deficiencies may be awarded accreditation with stipulations
provided they can be corrected within a specified period of time. COAMFTE will specify "stipulations" that must be addressed in an interim report, due at a time determined by COAMFTE, or by an interim site visit to be conducted at a time determined by COAMFTE. Programs that fail to clear stipulations in their first year of carrying stipulations will be placed on probation for a period of time not to exceed one year. Programs that fail to clear all stipulations within the two year period may have their accreditation revoked. (COAMFTE Accreditation Manual: Policies and Procedures)

Pennsylvania
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Program Accredited with Stipulations*: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2019
Renewal Date: May 01, 2020

Program Accredited with Stipulations - The Commission will award initial accreditation or renewal of accreditation to programs evidencing substantial compliance with accreditation standards. Initial accreditation shall be granted for a period not to exceed five (5) years. Renewal of accreditation shall be granted for a period not to exceed six (6) years (Shorter periods of accreditation may be awarded at the discretion of the Commission). A program with deficiencies may be awarded accreditation with stipulations provided they can be corrected within a specified period of time. COAMFTE will specify "stipulations" that must be addressed in an interim report, due at a time determined by COAMFTE, or by an interim site visit to be conducted at a time determined by COAMFTE. (COAMFTE Accreditation Manual: Policies and Procedures)

Pennsylvania
Philadelphia Child & Family Ctr (PDI)
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Philadelphia, PA 19118-8092
Phone: (215) 242-0949
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Website: http://www.philafamily.com
Facebook:
Program Accredited: Post-Degree
Program Type: Campus-Based
Self-Study Due Date: April 01, 2015
Renewal Date: May 01, 2016

**Pennsylvania**
Drexel University (MFT)
Dr. Eric Johnson
Program Director
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MS 905
Philadelphia, PA 19102-1192
Phone: (215) 762-1426
Fax: (215) 762-1153
Email: ejohnson@drexel.edu
Website: http://www.drexel.edu/familyTherapy/
Facebook: facebook.com/cft.drexel
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2017
Renewal Date: May 01, 2018

**Pennsylvania**
Evangelical Theological Seminary (MA)
Dr. Joy Corby
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121 South College St.
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Email: jcorby@evangelical.edu
Website: http://evangelical.edu/master-of-arts-marriage-family-therapy/
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2017
Renewal Date: May 01, 2018

**Rhode Island**
Rhode Island, University of (MS)
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MFT Program-Transition Center
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Phone: (401) 874-5962
Fax: (401) 874-4020
Email: jadams@mail.uri.edu
Website: http://www.uri.edu/hss/mft
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2018
Renewal Date: November 01, 2019

South Carolina
Converse College-(MMFT)
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Fax: (864) 596-9221
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Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2017
Renewal Date: May 01, 2018

South Carolina
WestGate Training & Consult. Network (PDI)
Dr. Cathy Sparks
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Phone: (864) 583-1010
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Email: cathy.sparks@spart5.net
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Program Accredited: Post-Degree
Program Type: Campus-Based
Self-Study Due Date: May 01, 2014
Renewal Date: November 01, 2015

Texas
St. Mary's University (Ph.D.)
Dr. Carolyn Tubbs
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Family Life Center
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San Antonio, TX 78228-8539
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Website: http://www.stmarytx.edu/grad/counseling/?go=flc
Facebook:
Program Accredited: Doctoral
Program Type: Campus-Based
Self-Study Due Date: October 01, 2015
Renewal Date: November 01, 2016

Texas
University of Houston Clear Lake (MA)
Dr. Leslye Mize
Program Director, Family Therapy Program
Behavioral Sciences Program
2700 Bay Area Boulevard
Houston, TX 77058-1098
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Fax: (281) 283-3397
Email: mize@uhcl.edu
Website: http://prtl.uhcl.edu/portal/page/portal/HSH/HOME/PROGRAMS/FT
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2015
Renewal Date: May 01, 2016

Texas
Texas Tech University (PhD)
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Director, MFT Program
Dept. of Applied and Professional Studies
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Fax: (806) 742-5033
Email: douglas.smith@ttu.edu
Website: http://www.hs.ttu.edu/mft/
Facebook:
Program Accredited: Doctoral
Program Type: Campus-Based
Self-Study Due Date: April 01, 2016
Renewal Date: May 01, 2017

Texas
Our Lady of the Lake University - San Antonio (MS)
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Director -- MFT Program
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San Antonio, TX 78207
Phone: (210) 431-3914
Fax: (210) 431-4055
Email: mpolanco@lake.ollusa.edu
Website: http://www.ollusa.edu/s/1190/ollu.aspx?pgid=3260
Facebook:
Program Accredited with Stipulations*: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2018
Renewal Date: November 01, 2019

Program Accredited with Stipulations - The Commission will award initial accreditation or renewal of accreditation to programs evidencing substantial compliance with accreditation standards. Initial accreditation shall be granted for a period not to exceed five (5) years. Renewal of accreditation shall be granted for a period not to exceed six (6) years (Shorter periods of accreditation may be awarded at the discretion of the Commission). A program with deficiencies may be awarded accreditation with stipulations provided they can be corrected within a specified period of time. COAMFTE will specify "stipulations" that must be addressed in an interim report, due at a time determined by COAMFTE, or by an interim site visit to be conducted at a time determined by COAMFTE. (COAMFTE Accreditation Manual: Policies and Procedures)

Texas
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Email: lbohanon@lake.ollusa.edu
Website: http://www.ollusa.edu/s/1190/ollu.aspx?sid=1190&gid=1&pgid=1804
Facebook:
Program Accredited with Stipulations*: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2018
Renewal Date: November 01, 2019

Program Accredited with Stipulations - The Commission will award initial accreditation or renewal of accreditation to programs evidencing substantial compliance with accreditation standards. Initial accreditation shall be granted for a period not to exceed five (5) years. Renewal of accreditation shall be granted for a period not to exceed six (6) years (Shorter periods of accreditation may be awarded at the discretion of the Commission). A program with deficiencies may be awarded accreditation with stipulations provided they can be corrected within a specified period of time. COAMFTE will specify "stipulations" that must be addressed in an interim report, due at a time determined by COAMFTE, or by an interim site visit to be conducted at a time determined by COAMFTE. (COAMFTE Accreditation Manual: Policies and Procedures)

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Fax: (210) 438-6409
Email: ctubbs@stmarytx.edu
Website: www.stmarytx.edu/grad/counseling
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2015
Renewal Date: May 01, 2016

**Texas**
Abilene Christian University (MMFT)
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Director - Marriage and Family Institute
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Email: Jaime.Goff@acu.edu
Website: http://www.acu.edu/mft
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2016
Renewal Date: November 01, 2017

**Utah**
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Program Director
274 TLRB--BYU
School of Family Life
Provo, UT 84602
Phone: (801) 422-2349
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Website: http://mft.byu.edu/
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2015
Renewal Date: May 01, 2016

**Utah**
Brigham Young University (PhD)
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274 TLRB--BYU
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Fax: (801) 422-0163
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Facebook:
Program Accredited: Doctoral
Program Type: Campus-Based
Self-Study Due Date: April 01, 2015
Renewal Date: May 01, 2016

Utah
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Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2019
Renewal Date: May 01, 2020

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Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2017
Renewal Date: November 01, 2018
Virginia
Virginia Tech University- Blacksburg (PhD)
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Phone: (540) 231-3301
Fax: (540) 231-7209
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Program Accredited: Doctoral
Program Type: Campus-Based
Self-Study Due Date: October 01, 2015
Renewal Date: November 01, 2016

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Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2018
Renewal Date: November 01, 2019

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Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: May 01, 2014
Renewal Date: May 01, 2015

**Washington**
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Chair, Child, Couple, & Family Ther Pro
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Fax: (206) 441-3307
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Website: http://www.antiochsea.edu
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2015
Renewal Date: November 01, 2016

**Washington**
Pacific Lutheran University-(MA)
Dr. David Ward
Program Director
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Tacoma, WA 98447
Phone: (253) 535-8284
Fax: (253) 536-5139
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Website: http://www.plu.edu/marriage-family-therapy/home.php
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: April 01, 2017
Renewal Date: May 01, 2018

**Wisconsin**
Wisconsin Stout, University of (MS)
Dr. Dale Hawley
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Website: http://www.uwstout.edu/programs/msmft/
Facebook:
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: November 01, 2014
Program on Probation - A program with deficiencies may be awarded accreditation with stipulations provided they can be corrected within a specified period of time. COAMFTE will specify "stipulations" that must be addressed in an interim report, due at a time determined by COAMFTE, or by an interim site visit to be conducted at a time determined by COAMFTE. Programs that fail to clear stipulations in their first year of carrying stipulations will be placed on probation for a period of time not to exceed one year. Programs that fail to clear all stipulations within the two year period may have their accreditation revoked. (COAMFTE Accreditation Manual: Policies and Procedures)
their accreditation revoked. (COAMFTE Accreditation Manual: Policies and Procedures)

**Wisconsin**
Family Therapy Training Institute (PDI)
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Program Director
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Milwaukee, WI 53208-0440
Phone: (414)345-4465
Fax: 
Email: kevin.o'brien@aurora.org
Website: http://www.aurorahealthcare.org/services/familiysocial/ftti.asp
Facebook: 
Program Accredited: Post-Degree
Program Type: Campus-Based
Self-Study Due Date: April 01, 2017
Renewal Date: May 01, 2018

**Ontario**
University of Guelph (MS)
Dr. Olga Sutherland
Program Director
Dept of Family Relations & App Nutrition
Couple and Family Therapy Center
Guelph, ON NIG 2W1
Phone: (519) 824-4120 x56256
Fax: (519) 823-7819
Email: osutherl@uoguelph.ca
Website: http://www.uoguelph.ca/family/
Facebook: 
Program Accredited: Masters
Program Type: Campus-Based
Self-Study Due Date: October 01, 2016
Renewal Date: November 01, 2017

**Quebec**
Argyle Institute of Human Relations (PDI)
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Montreal, PQ H3Z 2Y5
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Fax: (514) 931-5629
Email: jkeefler@argyleinstitute.org
Website: http://www.argyleinstitute.org
Facebook: 
Program Accredited: Post-Degree
Program Type: Campus-Based
Quebec
Jewish General Hospital-(PDI)
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Program Director
Couple and Family Therapy Training Prog
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Website: http://www.jgh.ca/cftp/
Facebook:
Program Accredited: Post-Degree
Program Type: Campus-Based
Self-Study Due Date: October 01, 2017
Renewal Date: November 01, 2018

American Association for Marriage and Family Therapy
112 South Alfred Street Alexandria, VA 22314-3061
Phone: (703) 838-9808 | Fax: (703) 838-9805
Appendix N
Research Funding Crisis White Paper
The Case for Funding Research on Marriage, Cohabitation, and Interpersonal Processes

The quality and stability of committed, intimate relationships have profound impacts on overall physical health, mental health, economic security, and child health and wellbeing. Unfortunately, recent statistics suggest that fewer people in the United States are married today than ever before, 42% of children are born to unmarried parents, and roughly half of marriages in the U.S. end in divorce. Moreover, relationship distress is the leading reason for seeking mental health counseling. Despite these demonstrated needs, no federal entity currently has the responsibility and authority for funding science to advance either a deeper understanding of intimate relationships or the development of new and/or improved interventions to strengthen their quality and longevity. While such research has historically been funded by the National Institutes of Health (NIH), institutes of NIH have changed their priorities, effectively excluding opportunities for new research on relationships and related programs and interventions. Additionally, the Administration for Children and Families and the National Science Foundation do not support research on the development or testing of relationship interventions.

Thus, we propose that Congress and the President encourage institutes to prioritize the science of intimate relationships, marriage, and interpersonal processes and related interventions to improve relationship outcomes.

The High Cost of Relationship Dysfunction and Dissolution

The mission of the NIH is to “seek fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce the burdens of illness and disability.” Relationship dysfunction is a public health issue that is directly related to this mission. Specifically, relationship dysfunction and dissolution are robustly associated with:

- Mortality
- Depression, suicide, and other mood disorders
- Alcoholism and substance abuse
- Domestic violence
- Obesity, elevated blood pressure, and diminished immune system functioning

Parental relationship conflict, instability, and dissolution are also associated with negative outcomes for children:

- Child abuse and maltreatment
- Growing up in poverty
- Poorer academic achievement
- Poorer physical and mental health

The consequences of intimate relationship distress are enormous. Taking into account only the effects of family breakdown on poverty rates, the United States is estimated to spend $112 billion dollars per year on the costs of family breakdown. A mere one percent reduction in rates of family fragmentation would save taxpayers $1.12 billion annually in expenditures related to poverty.
Funding for research in this area has eroded within the NIH over the past 15 years. Around 2000, the National Institute of Mental Health (NIMH) reoriented its priorities and explicitly discontinued support for research focused on improving couples’ outcomes. In more recent years, the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) has also reoriented its priorities and has explicitly abandoned the intention to fund research designed to inform effective interventions for couples unless the outcomes are focused on immediate outcomes for children. As a result, there is no federal funding for research targeted on understanding and improving intimate relationship dysfunction – even though it has been demonstrated to be a critically important risk factor for many of the physical and mental health problems targeted by the broader mission of the NIH. Additionally, marital distress has an enormous impact on global life satisfaction\textsuperscript{14} – larger than most of the physical and mental health problems targeted by NIH.

To put the funding picture into perspective, according to the NIH’s RePORTER search tool, the federal government will have spent $150,572,217 in FY 2012-2013 on projects with “depression” in the title and only $2,981,495 on projects with “marriage” in the title. Strikingly, 6.7% of the population is depressed during a 12-month period\textsuperscript{15} while 31% of those who are currently married report clinical levels of marital distress\textsuperscript{16}. Thus, on a per capita basis, NIH allocates $0.03 for each maritally-distressed person but $7.15 for each depressed person. If currently divorced or unmarried individuals were included in these calculations, the per-capita funding would be even more disparate.

**Relevance to Health Disparities Concerns**

The evidence is clear that the issues described above impact racial/ethnic minority populations and those with low-income levels most dramatically.

- The unmarried birth rate varies greatly by race/ethnicity as well as by income and education level. For example, 72% of African-American children are born to unmarried parents versus 36% of White children\textsuperscript{17}.
- Among pregnant minority couples with low-income levels, only 44% will be together by the child’s 1\textsuperscript{st} birthday\textsuperscript{18}.
- Most models of intervention or education for couples are based on middle-class, mostly White samples. New research commissioned by the Administration for Children and Families suggests that these interventions may not work as well for disadvantaged populations\textsuperscript{19,20}, but no funding is available to develop or test new models.
- Although many believe that the divorce rate is falling, new evidence suggests that the divorce rate has actually been increasing in recent decades\textsuperscript{21}. Further, researchers have known for some time that divorce is much more common among the least educated and among those who are racial/ethnic minorities\textsuperscript{22}.

**Conclusion**

Intimate relationship health is at the center of all of our lives. When our relationships are healthy, we are more likely to be well and resilient and so are our children. When our relationships are unhealthy, other aspects of our lives tend to suffer. Relationship science has made great strides in the last 40 years; however, there is still considerable work needed to sustain and improve the health of the nation’s marriages and intimate relationships. It is our hope that Congress and the President will give due consideration to our proposal to encourage institutes to prioritize the science of
intimate relationships, marriage, and interpersonal processes and interventions to improve relationship and marriage outcomes.

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**References**

Appendix O
Educational Pathways to Couple and Family Psychology Specialization
Examination of Competency Board Certified in Couple and Family Psychology

By American Board of Couple and Family Psychology, an ABPP Board (Nurse, 2005)

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Independent Clinical counseling Practices as a licensed Psychologist

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Postdoctoral education and training to enhance competency in the specialty, especially if the doctoral program did not provide a thorough family psychology emphasis. This may occur in an institute or in other venues (continuing education, supervision) that develop specialty competencies.

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Development of Core Competencies Specifically applied to Family Psychology:

- Application of Scientific Knowledge to practice.
- Psychological Assessment
- Psychological Interventions
- Consultation-Interprofessional Collaboration
- Supervision
- Professional Development
- Ethical Issues
- Individual & Cultural Diversity (N.J.Kaslow,Celano & Stanton, 2005)

Foundation: All family psychologists must have a broad and general education in professional psychology. (APA Guidelines & Principles of Accreditation)
AZUSA PACIFIC UNIVERSITY SAMPLE CURRICULUM

Doctor of Psychology in Clinical Psychology: Family Psychology
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APU’s Doctor of Psychology (Psy.D.) in Clinical Psychology with an emphasis in Family Psychology is a professional doctorate identified as a practitioner-scholar program. The curriculum provides the courses and training necessary to meet the educational requirements in the state of California for licensure as a psychologist.

Mission Statement
The Doctor of Psychology program educates, prepares, and trains students to become practitioner-scholars in psychology with professional competencies in relationship, research, assessment, intervention, diversity, integration of faith and practice, and family psychology.

Program Goals
The Doctor of Psychology program at Azusa Pacific University:

- Seeks to educate and train students to be practitioner-scholars so they are equipped to provide quality psychological services to their communities based upon the findings of research and the science of psychology.
- Approaches the knowledge of psychology from a Christian perspective and trains students to exemplify the servanthood of Christ in their practice of psychology.
- Provides an integrative sequence of courses so students may understand the interrelationship between ethics, moral and spiritual identity formation, theology, and psychology.
- Emphasizes family psychology, the distinctive focus on the interaction between individual, interpersonal, and environmental aspects of human behavior.
- Recognizes the diversity of human experience and enables students to respond to the variety of human needs.
- Encourages individual growth and development as part of the educational experience so students develop congruence and authenticity as they balance the demands of professional and personal life.

The Discipline of Family Psychology
Based on systems theory, the discipline of family psychology recognizes the dynamic interaction between persons and environments without detracting from an awareness of individual, intrapsychic issues.

A doctoral program in clinical psychology with an emphasis in family psychology incorporates numerous elements from several disciplines within psychology (e.g., clinical psychology, developmental psychology, personality theory, environmental psychology, neuropsychology, psychobiology, and social psychology). All the disciplines are related by the theoretical understanding of the dynamic, reciprocal relationship between these factors as they impact human behavior.

This theoretical foundation undergirds the program courses at APU. In courses that have traditionally had an individual focus, systemic aspects relevant to the content area are incorporated. By the end of the program, students will think systemically and apply systemic analysis to clinical situations. In an era when it is increasingly difficult for people to navigate their way through the complex world in which they live, a Doctor of Psychology in Clinical Psychology with an emphasis in Family Psychology...
Psychology will best prepare students to provide psychological services.

**The Seven Core Competencies of the Psy.D. Program**

The curriculum for the Psy.D. program is competency based. Such a curriculum recognizes that it is essential to identify core competency areas in psychology as the primary organizing principle for a professional degree. Successful degree completion requires the achievement of the competencies necessary to function well in the field of psychology. The curriculum reflects concern for the development of seven core competencies in psychology: research and evaluation, relationship, assessment, intervention, diversity, consultation and education, and management and supervision. The seven professional competency areas are defined briefly:

1. **Research and evaluation** comprise a systematic mode of inquiry involving problem identification and the acquisition, organization, and interpretation of information pertaining to psychological phenomena. Psychologists have learned to think critically and engage in rigorous, careful, and disciplined scientific inquiry. Education and training in the epistemological foundations of research, the design and use of qualitative and quantitative methods, the analysis of data, the application of research conclusions, and sensitivity to philosophical and ethical concerns is needed for psychologists to develop in this area.

2. **Relationship** is the capacity to develop and maintain a constructive working alliance with clients. This competency is informed by psychological knowledge of self and others. In the development of the relationship competency, special attention should be given to the diversity of persons encountered in clinical practice. Curriculum design includes education and training in attitudes essential for the development of the relationship competency, such as intellectual curiosity and flexibility, open-mindedness, belief in the capacity to change, appreciation of individual and cultural diversity, personal integrity and honesty, and a value of self-awareness. Experiential learning with self-reflection, direct observation, and feedback by peers and experts is essential in the development of this competency.

3. **Assessment** is an ongoing, interactive, and inclusive process that serves to describe, conceptualize, and predict relevant aspects of a client. Assessment is a fundamental process that is interwoven with all other aspects of professional practice. As currently defined, assessment involves a comprehensive approach addressing a wide range of client functions. Assessment takes into account sociocultural context and focuses not only on limitations and dysfunctions but also on competencies, strengths, and effectiveness. Assessment increasingly addresses the relationship between the individual and his or her systemic context. The assessment curriculum is not limited to courses but involves a pattern of experiences covering general principles as well as specific techniques. Supervised skill training is an essential component of the assessment curriculum.

4. **Intervention** involves activities that promote, restore, sustain, or enhance positive functioning and a sense of well-being in clients through preventive, developmental, or remedial services. The intervention competency is based on the knowledge of theories of individual and systemic change, theories of intervention, methods of evaluation, quality assurance, professional ethical principles, and standards of practice. Effective training for intervention includes knowledge of a broad diversity of clients and teaching materials, practicum client populations, teachers, and supervisors. Service systems reflect diversity. The issues of power and authority are particularly relevant to this competency.

5. **Diversity** refers to an affirmation of the richness of human differences, ideas, and beliefs. An inclusive definition of diversity includes but is not limited to age, color, disability and health, ethnicity, gender, language, national origin, race, religion/spirituality, sexual orientation, and socioeconomic status, as well as the intersection of these multiple identities and multiple statuses. Exploration of power differentials, power dynamics, and privilege is at the core of understanding diversity issues and their impact on social structures and institutionalized forms of discrimination. Training of psychologists includes opportunities to develop understanding, respect, and value for cultural and individual differences. A strong commitment to the development of knowledge, skills, and attitudes that support high regard for human diversity is integrated throughout the professional
psychology training program and its organizational culture.

6. Consultation is a planned, collaborative interaction that is an explicit intervention process based on principles and procedures found within psychology and related disciplines in which the professional psychologist does not have direct control of the actual change process.

Education is the directed facilitation by the professional psychologist for the growth of knowledge, skills, and attitudes in the learner. Students are required to complete experiential tasks in consultation and education as part of their coursework or internship.

7. Management consists of those activities that direct, organize, or control the services of psychologists and others as offered or rendered to the public.

Supervision is a form of management blended with teaching in the context of relationship directed toward the enhancement of competence in the supervisee. This competency is informed by the knowledge of professional ethics and standards, theories of individual and systemic functioning and change, dysfunctional behavior and psychopathology, cultural bases of behavior, theoretical models of supervision, and awareness of diversity. Self-management processes and structures are provided for students. Demonstrated competence in supervision includes the development of receptivity to supervision and the acquisition of skills in providing supervision.


Acceptance of Admission and Registration

Upon notification of admission, applicants must confirm intent to attend in writing to the department by April 15. A $500 deposit is also required by April 15. Please note that 100 percent of the deposit is applied toward tuition. Admission is for the next academic year only and may not be deferred.

Curriculum

The Psy.D. curriculum has been designed to meet the requirements of the APA for professional education in psychology. Courses stress the importance of critical thinking in the discipline of psychology, and the curriculum provides a breadth of knowledge regarding scientific psychology. Cultural and individual diversity perspectives are woven into courses across the curriculum. Since this is a professional degree, clinical education and application of scientific knowledge to clinical domains are stressed throughout the curriculum, as well as in the clinical practicum experience.

The program embodies an emphasis in family psychology. All of the courses incorporate a systemic perspective on psychology, which includes an awareness of the dynamic interaction between individuals, interpersonal relationships, and the environment. In addition to the interdisciplinary courses that integrate ethics, theology, and psychology, issues relevant to Christian faith are addressed in the curriculum where appropriate.

PPSY 700A Theories of Personality and Psychotherapy 3
PPSY 700B Moral Identity Formation and Psychotherapy 3
PPSY 700C Psychopathology 3
PPSY 700D Introduction to Clinical Practice: Basic Skills 3
PPSY 700E Advanced Developmental Psychology 3
PPSY 700F Psychotherapy and Cultural Diversity 3
PPSY 700G Christian Spiritual Formation and Psychotherapy 3
PPSY 700H Assessment I 3
PPSY 700I Family Therapy 3
PPSY 700J Clinical Practicum 3
PPSY 700K Interdisciplinary Integration and Psychotherapy 3
PPSY 701 Clinical Practicum I: Professional Practice and an Introduction to Case Conceptualization 2
PPSY 702 Clinical Practicum II: Legal and Ethical Competence 2
PPSY 711 Psychology and Systems Theory 3
PPSY 712 Theories of Change and Evidence-based Treatment 3
PPSY 713 Assessment II: Personality 4
PPSY 714 Assessment III: Intelligence and Academics 4
PPSY 715 Adult Psychology 3
PPSY 716 Family Psychology 3
PPSY 717 Child Psychology 2 or PPSY 735 Adolescent Psychology
PPSY 718 History and Systems of Psychology 3
PPSY 719 Social Psychology 2
PPSY 721 Addictive Behaviors 2
PPSY 722 Research Design I 3
PPSY 723 Research Design II 3
PPSY 724 Couples Theory and Therapy 3
PPSY 726 Biblical Ethics and Psychotherapy 3
PPSY 727 Clinical Practicum III: Diversity Competency 2
PPSY 728 Clinical Practicum IV: Domestic Violence and Case Conceptualization 2
PPSY 729 Treatment Planning 1
PPSY 730 Cognition 2
PPSY 731 Dissertation Development 1
PPSY 734 Gerontology 2
PPSY 736 Social Ethics and Psychotherapy 3
PPSY 737 Clinical Practicum V: Interdisciplinary Integration 2
PPSY 738 Clinical Practicum VI: The Future Psychologist - Management, Private Practice, and Advocacy 2
PPSY 739 Psychobiology 3
PPSY 740 Consultation in Clinical Psychology 2
PPSY 744 Supervision in Clinical Psychology 2
PPSY 745 Dissertation I 1
PPSY 746 Dissertation II 1
PPSY 747 Dissertation III 1
PPSY 748 Dissertation IV 1
PPSY 750 Predoctoral Internship (Full-time, Predoctoral Internship: 2 semesters/1 unit each) 1
PPSY 753 Moral and Spiritual Identity Formation in the Family 3
PPSY 754 Assessment IV: Projectives 4
PPSY 755 Dissertation V 1
PPSY 756 Dissertation VI 1
PPSY 757 Psychopharmacology 2
PPSY 758A Techniques of Change: Cognitive-behavioral Interventions 2
PPSY 759A Techniques of Change: Solution-focused Brief Therapy 2
PPSY 760 Techniques of Change: Psychodynamic Interventions 2
Take four two-unit courses 8
PPSY 798
Special Topics
Total Units 133

267
See below for more information regarding the five-year academic plan versus the six-year academic plan.

Electives
Students are required to take four elective courses in residency. Students may take miscellaneous electives in psychotherapy, integration, or assessment; other courses related to clinical psychology; or they may complete one of the elective concentrations described below.

Psychodynamic Systems of Psychotherapy Concentration
The psychodynamic systems of psychotherapy elective concentration provides an opportunity for students to learn a comprehensive model of personality, psychopathology, and psychotherapy that reflects the systemic epistemology of the doctoral program. This course sequence provides a historical overview of major psychodynamic systems of theory and therapy (from origins to the present). Each course focuses on key theorists, theoretical constructs, conceptualization and treatment planning, supporting research, and clinical demonstration and application. Students seeking a Certificate of Proficiency in Psychodynamic Systems of Psychotherapy must complete the three-course sequence of electives and a yearlong clinical practicum placement where students are permitted to provide psychodynamic psychotherapy to clients:

PPSY 763 Psychodynamic Systems of Psychotherapy I 2
PPSY 764 Psychodynamic Systems of Psychotherapy II 2
PPSY 765 Psychodynamic Systems of Psychotherapy III 2

For more-detailed information, contact Theresa Clement Tisdale, Ph.D., at tctisdale@apu.edu.

Family Forensic Psychology Concentration
The family forensic psychology elective concentration provides an opportunity for students to pursue more-focused training in the specialty area of forensic psychology. This concentration strives to prepare graduate students for competitive forensic psychology internships and postdoctoral training experiences. While completion of the certificate program does not guarantee placement in supervised training sites, it enhances the student’s educational foundation in preparation for advanced training in forensic psychology. Students seeking the Certificate of Proficiency in Family Forensic Psychology must complete the four-course sequence of electives:

PPSY 770 Introduction to Forensic Psychology 2
PPSY 771 Forensic Assessment 2
PPSY 772 Family Forensic Psychology I 2
PPSY 773 Family Forensic Psychology II 2

For more-detailed information, contact Marjorie Graham-Howard, Ph.D., chair of the Department of Graduate Psychology, at mlhoward@apu.edu.

Five- and Six-Year Academic Plans

Five-Year Program
Participation in the full-time plan requires attending classes during the day or evening at least two days per week, plus occasional Saturday courses (usually four Saturdays in a year). An additional 12–15 hours per week minimum for practicum is required throughout the program.

Six-Year Program
Participation in the reduced-load-per-semester, six-year plan requires attending classes during the day or evening at least two days per week plus occasional Saturday courses (usually four Saturdays in a year). An additional 12–15 hours per week minimum for practicum is required in the first three years of the program or more depending upon student progress.

Students take electives during the program and choose either child psychology or adolescent psychology. (Electives may be taken in semesters other than where indicated. Students are encouraged to consider how best to balance each semester.)

**Clinical Training**

Clinical training is central to the practitioner-scholar (Psy.D.) model for educating clinical psychologists. Azusa Pacific’s program is committed to assisting students in developing the essential knowledge base, attitudes, and therapeutic skills necessary to function as a clinical psychologist. Quality clinical training provides practitioners with experiences that ensure depth and breadth of clinical interventions, diversity of clients, the opportunity to develop therapeutic competencies that integrate their theoretical coursework with direct client experience, and the development of the seven core competencies in professional psychology.

Clinical training at the doctoral level involves three years of practicum and a full-time, yearlong internship (a limited number of two-year, half-time internships are available in some settings). Students entering the program with existing clinical training or licensure must still complete the program’s clinical training sequence.

In their clinical placements, students gain experience in a variety of clinical settings including inpatient/residential, child, outpatient, brief/managed care, and settings utilizing psychological assessment. Supervision is provided by the field placement sites as well as psychologists on the APU faculty.

Concurrent with their supervised practicum, students participate in an on-campus course that provides a forum for the review of the clinical practicum experience.

For those students who are licensed or registered in mental health professions other than psychology, the Department of Graduate Psychology requires that all practicum training in the Psy.D. program be entirely separate from any practice under such existing license or registration. For purposes of predoctoral training in psychology, all students are to be identified exclusively as psychology trainees, psychology students, or psychology interns. Practicum students are not allowed to make known in any manner any other status they may hold in other mental health professions. Practicum hours from training in psychology may not under any circumstances be “double counted” toward training required for other mental health professions. If a student conducts a clinical practice or performs mental health services under an existing nonpsychology mental health license while he or she is a student in the Psy.D. program, then the Department of Graduate Psychology officially recommends that these students consider the impact of their education and training in psychology on such practice and that they seek supervision for any services that may be deemed to be part of the profession of psychology. During the clinical practicum component of the program, the student completes a minimum of 1,500 hours of clinical training, including supervision, direct client contact, and an assessment practicum completed over the course of the program. These hours of clinical training occur in addition to any master’s-level training hours.

**Prerequisites for Clinical Training at the Doctoral Level**

Students entering the program with an accredited master’s degree in psychology or a closely related field are likely to have earned hours of supervised clinical placement, including hours of direct client contact, supervision, and other supervised activities. Such training provides a foundation for clinical training at the doctoral level but is not a substitute for the Psy.D. training sequence.
Clinical Training Coursework

Practicum
The clinical training sequence begins in the first year of the program and continues through the third year, in preparation for the predoctoral internship. Each semester, the student participates in a clinical practicum (CP) course that emphasizes the development of a particular clinical competency. Students are required to demonstrate their accomplishment of the competency by passing comprehensive exams, successfully completing the coursework and clinical training sequence, and completing a dissertation. Competencies by CP course are:
CP I: Professional Practice and an Introduction to Case Conceptualization
CP II: Legal and Ethical Competence
CP III: Diversity Competency
CP IV: Domestic Violence and Case Conceptualization
CP V: Interdisciplinary Integration
CP VI: The Future Psychologist – Management, Private Practice, and Advocacy
The Clinical Practicum I–VI sequence is coordinated with the science, theory, and clinical coursework in the program. The opportunity to apply the course material is considered essential to the development of the core competencies in psychology.
In the second year, students take courses that provide a theoretical foundation in psychology and the theoretical orientation of the program (Systems Theory, History and Systems, Research Design), as well as clinical courses in assessment (Assessment I and II) and specific clinical issues (Treatment Planning). These courses coordinate with CP I–II, the introductory practicum courses that develop basic competency in professional ethics and legal issues, and include rehearsal, role play, and interviewing opportunities for students. The first practicum is at the university’s Community Counseling Center. External practicum site placements coordinate with CP III–VI.
During the third year of the program, students take clinical courses in Techniques of Change and specific clinical populations (Adolescent Psychology, Family Psychology, Addictive Behaviors, Couples Theory and Therapy), as well as two interdisciplinary courses (Biblical Ethics and Family Ethics). These courses provide material relevant to the experiences in external practicum sites during CP III–VI.
In the fourth year of the program, students take additional science and interdisciplinary courses (Social Psychology, Cognition, and Social Ethics), population-specific clinical courses (Adult Psychology and Gerontology), emerging clinical competency courses (Consultation and Supervision), and a course in Psychopharmacology that is intended to prepare students for internship.

Internship
The program requires a predoctoral internship in a one-year, full-time or two-year, half-time (1,800 hours minimum) setting. Students are encouraged to complete the clinical dissertation prior to the internship, which allows the student to focus on the internship as the capstone of the clinical training sequence.
The director of clinical training (DCT) meets with prospective interns each June to discuss the internship application process. A special vita and application workshop is held. During the summer before they apply to internship, students are encouraged to study the APPIC Directory for options that fit their training needs. Additional information about Uniform Notification Day, APPIC requirements and forms, interviewing skills, reference and cover letters, and other issues specific to internship application is provided in monthly seminars.
All students are strongly encouraged to apply for APA-accredited or APPIC-recognized internship
sites. The department understands that some students may be unable to relocate due to family and occupational responsibilities and therefore may also choose to apply to CAPIC sites as well. All internship sites must meet APPIC standards. Upon receiving approval from the DCT, students may begin the application process of obtaining a predoctoral internship.

**Quality Assurance in Clinical Placements**
The director of clinical training (DCT) and the Clinical Training Committee have an ongoing responsibility to ensure that the program’s clinical training standards meet all state licensing and APA requirements. All clinical training is intended to be consistent with the requirements stated in the Laws and Regulations Governing the Practice of Psychology in the State of California. Modifications in state law shall be reflected in program changes to ensure training consistent with the current practice of psychology. Additionally, the clinical training required by the Psy.D. at APU is consistent with APA ethical and professional standards and training guidelines.

**Director of Clinical Training**
The DCT organizes, plans, and coordinates all aspects of clinical training for the program. The DCT is a licensed psychologist in the state of California with a background demonstrating mastery in the core areas of clinical training and the diverse training setting required by the program (inpatient/residential, child, brief/managed care, and psychological assessment). All clinical placements must be approved by the DCT and must meet the requirements for quality of training experience, depth and quantity of supervision, and level of appropriateness for doctoral-level training. The DCT coordinates and oversees all clinical placements, develops appropriate training experiences for students in the on-campus counseling centers, and establishes contractual relationships with off-campus sites.

**Clinical Training Committee**
The Clinical Training Committee (CTC) is a subset of APU faculty comprising licensed psychologists and MFTs, and has direct oversight of or provides direct supervision to students in the program. The CTC is chaired by the DCT and meets regularly to review and establish policies related to clinical training, grant approval to students to begin the clinical practicum sequence, and sit on students’ Clinical Competency Examination panels.

**Evaluation Procedures**
The clinical training goals and objectives are integrated into the clinical practicum sequence and coordinated with the clinical courses in the program. Outcomes in the clinical sequence are measured throughout the program and include regular presentations of audio- or videotaped work of students, classroom demonstrations and role plays, assessment reports presented in class, mini-competency exams, supervisor evaluations, integration paper, Clinical Competency Exam, intern acceptance and level, and licensure acquisition.

**Formative Evaluation**
Formative evaluation consists of feedback given to students by their field placement supervisor, on-campus clinical supervisor, and supervision groups. Although primarily verbal and situational, this evaluative form is of great importance due to its immediacy to clinical interventions and the issues arising during the students’ clinical placements.

**Summative Evaluation**
Summative evaluation occurs at the end of each semester of clinical placement. Students are evaluated by their field site supervisor as well as by all faculty members. The site supervisor evaluation is
discussed with students prior to its being sent to the DCT and becoming part of the students’ clinical files. Students receiving inadequate evaluations are placed on probation, counseled by their faculty advisor, and, should their clinical performance fail to meet expected standards, dismissed from the program. The CTC may require students to complete remediation assignments to meet competency standards. As noted above, students are evaluated at the end of each semester for the achievement of competency in key clinical areas. These mini-competency exams prepare the student for the Clinical Competency Exam, a cumulative evaluation of readiness for the predoctoral internship.

Students also evaluate their site experience and site supervisor at the end of each semester. These evaluations are submitted to the DCT and are used to ensure the quality of placement sites and on-campus supervision groups.

Clinical Competency Examination
As a final evaluation measure, each student must pass a Clinical Competency Exam. To prepare for the exam, students must complete required coursework, seminars, and clinical training. Upon completion of the above, students may apply to take the Clinical Competency Exam.

A student submits an example of his or her clinical work (case presentation, assessment, treatment plan, and a videotape or audiotape of student-client interaction including a verbatim transcript and process comments), along with his or her clinical portfolio (including supervisor evaluation, verification of practicum hours, list of assessments performed, curriculum vita, and conference presentations or published works), to a two-member faculty committee (including at least one member of the CTC). The student presents a client case in which he or she has performed the initial assessment, case history, and mental status exam; an analysis of the client’s psychological testing, if available; and a case summary, including legal and ethical issues in the case, treatment planning based upon empirically supported interventions, case management, diversity issues, and the transference and counter-transference involved in the case. The presentation must include a 50-minute video or audiotape of student interaction with the client. In addition, the student must respond to a case vignette, including the same elements noted above. Students must include a family psychology perspective in their interaction with the cases and demonstrate an ability to discuss the interdisciplinary (psychology, ethics, theology, and philosophy) dimensions of the case. The purpose of this exam is to ensure that the student has developed the requisite skills to successfully enter an internship. Successful completion of the exam is required before January 31 of the year for which the internship is sought.

Research and Clinical Dissertation
Overview of Research Competency Objectives
The program recognizes that a comprehensive practitioner-scholar clinical psychology training program involves training clinicians to be critical consumers of psychological research and proficient with relevant clinical research and analysis methodologies, grounded in delivering services that are evidence-based and empirically defensible. The program is designed to give students the essential research skills that every competent clinical psychologist needs to operate in a diverse marketplace. Emphasizing the acquisition of a solid foundation in clinically relevant research principles and skills, the APU Psy.D. research pedagogy is based on an integration of an academic model of classroom instruction and a mentoring model of individual and group research supervision. The research curriculum provides a foundational education in research methodologies and analytical procedures that enables the student to engage in more-advanced, individually focused research experiences consistent with the practitioner-scholar model. The faculty values the development of research skills as a significant component of clinical training and, therefore, has developed a research program that includes:
1. Academic courses.
2. Individual research mentoring by faculty.
3. Voluntary research groups facilitated by faculty-mentors.
4. Faculty research programs and institutional research support.
5. Possible collaboration with extramural research facilities.
6. Integration of solid scientific support for clinical theory, intervention, and assessment courses.

A discussion of these components of APU’s broader research program is articulated hereafter.

The research and evaluation competencies necessary for the practice of clinical psychology are gained through a sequence of research courses and supervision that ultimately culminates in the creation and defense of a clinical dissertation. Students are required to take three research courses during their first year of the program that provide the foundations for critical evaluation of qualitative and quantitative research, research problem formulation, the scientific method, literature review, research design, hypothesis formulation and testing, presentation and discussion of research results, and research ethics. The Psy.D. student formulates a research problem, reviews relevant literature, designs the appropriate research methodology, and submits a proposal for the clinical dissertation.

The research and dissertation sequence is designed to produce practitioner-scholars who have the requisite knowledge to function effectively in a variety of clinical settings. Upon completion of the program, the student will be able to demonstrate competency in the following areas of research and practice:
1. Employ critical thinking skills pertaining to psychological phenomena.
2. Evaluate existing clinical research and practice.
3. Formulate clinical problems.
4. Design research methodology.
5. Assess relevancy of qualitative and quantitative data.
6. Analyze and present research findings.
7. Discuss relevant implications of findings.
8. Demonstrate skill in written communication.

Research Courses and Dissertation Development
Research coursework offered at the beginning of the program provides the necessary research knowledge base to enter into a more-intensive research process with a supervising faculty member. In addition to academic instruction, students will begin to formulate their research questions and benefit from the expertise of faculty members and more-senior students also working with the dissertation chair.

Research Design I: Research Design I begins the development of a clinical dissertation. In this course, students gain expertise engaging in sound scientific methodology. During the semester, students:
1. Are exposed to basic concepts in a philosophy of science for psychology.
2. Receive a broad survey of qualitative and quantitative research designs.
3. Learn to critically evaluate the merits and shortcomings of research to identify problem areas or gaps.
4. Understand how research problems are formulated.
5. Organize and synthesize literature relevant to the student’s dissertation topic.
6. Formulate the initial stages of the clinical dissertation.

During this semester, students should select a dissertation chair and begin to consolidate their research interests.

Research Design II: This course is offered in the spring semester and is intended to build upon the
foundation established in Research Design I. In this course, students develop and hone their scholarly writing skills, receive more-detailed instruction on qualitative and quantitative methodologies, and gain an understanding of program evaluation, needs assessment, survey research, and clinical outcome research. During this course, students will have met with their dissertation chair, consolidated their research topic, and planned the prospective research methodology, data collection, and analysis. By the end of this course, students apply the information obtained in both research design courses (I, II) and, under the supervision of their dissertation chair, participate in dissertation research groups to produce an initial literature review.

Dissertation Development: The intent of this course is to familiarize the student with research ethics and to provide specialized education in the type of dissertation the student has chosen to undertake (e.g., program consultation, advanced statistics for quantitative dissertations, advanced training in the use of a computerized qualitative analysis program for qualitative dissertations, etc.). Students receive focused instruction on the type of clinical dissertation they have chosen. During this semester, students develop their methodology section and a prospectus for successful completion of their dissertation.

Research Mentoring
Upon completion of the research sequence, students enter into research mentoring with their dissertation chair. Each subsequent semester, students enroll in dissertation units and consensually set specific research milestone requirements to achieve the objectives of completing the clinical dissertation and functioning independently as a practitioner-scholar. From the time the student chooses a dissertation chair in the first semester of the program to the completion of the clinical dissertation, the student is involved in individual supervision and/or voluntary research groups facilitated by the dissertation chair. Both settings are designed to solidify the principles and skills learned in the academic research and dissertation sequence. The dissertation proposal defense must be completed by June 30 prior to application for the predoctoral internship. Students must register for continuation units beginning in the internship year until the dissertation is complete.

Clinical Dissertation
Definition of the Dissertation
To obtain a doctorate in clinical psychology, it is necessary to complete a clinical dissertation. The clinical dissertation is a written document relevant to professional issues and practice in clinical psychology. It involves:
1. Identification of a clinical problem or gap in the field.
2. A plan to solve the problem or contribute to the existing knowledge base.
3. Critical review and synthesis of the available research.
4. Contribution of the student’s research.
5. Analysis of the findings and articulation of the relevance to the science of clinical psychology.

The nature and scope of the Psy.D. clinical dissertation is distinct from the type of dissertation required in a Ph.D.; it is intended to demonstrate satisfaction of the research and evaluation competency in professional psychology. The Psy.D. research curriculum and clinical dissertation teach students to follow “a systematic mode of inquiry involving problem identification and the acquisition, organization, and interpretation of information pertaining to psychological phenomena” (NCSPP, 1992). Completion of the research and dissertation courses demonstrates the competency “to engage in rigorous, careful, and disciplined scientific inquiry.” The clinical dissertation may fall within one of six broad categories:
Clinical Application: This is a product or program relevant to the application of professional
psychology. The dissertation involves a review of relevant literature, development of a product or program (including support documentation), and implementation or evaluation of at least a portion of the application or product.

Critical Literature Analysis: Students may seek to synthesize and critique a body of research that is relevant to the practice of clinical psychology. This dissertation involves a comprehensive review, critique, and synthesis of the research literature in an area of clinical psychology, noting implications for further research and clinical application.

Program Consultation: Students may provide psychological consultation to an existing program, institution, or organization. The consultation dissertation includes a review of relevant literature, a needs assessment (collection of data), analysis of results, and recommendations to the client.

Qualitative Research: Using qualitative research methodology, students conduct a literature review and collect and analyze qualitative data (e.g., interviews) to contribute to an area of clinical psychology that does not easily or conveniently lend itself to empirical data analysis. The findings from qualitative data analyses often illuminate new avenues of empirical research.

Quantitative Research: This dissertation involves a literature review, hypothesis formation and testing, research design, statistical analysis, and the description and discussion of the research findings. The research project may analyze original data (involving data collection and subject recruitment), perform a secondary data analysis (involving access to an existing data set), or conduct a meta-analytic research synthesis.

Theoretical Development: Dissertation students comprehensively review existing literature in a specific area of professional psychology and seek to significantly modify, reformulate, or advance a new conceptual or theoretical area or model relevant to the practice of psychology.

Dissertation Committee
The Dissertation Committee consists of no fewer than three members. Additional external readers with expertise in the area of study are encouraged as agreed upon by the committee chair. It is expected that students make initial contact with the person they would like to chair their committee during the semester in which they take Research Design I. Selection and approval of the entire committee is a requirement for completion of the Research Design II course.

All Dissertation Committee members must hold an earned doctorate from an accredited institution. The chair must be a core faculty member in the Department of Graduate Psychology. The remaining members may be full-time faculty members from the Department of Graduate Psychology or another department at APU, an adjunct faculty in the department, or a person from outside the APU community. If the student chooses a person from outside the APU community, it is necessary to secure the approval of the committee chair. Students should choose committee members in conjunction with the chair whose research interests and content expertise are closely related to the area of their dissertation.

Dissertation Proposal Review
During Research Design II and Dissertation Development, students conduct their initial literature review, develop their methodology section, and begin work on their proposal. Students continue to develop their dissertation proposal with consultation from the dissertation chair, committee members, and the director of research during Dissertation I–VI (one course each semester). The proposal must be approved by the chair and committee members at a proposal defense as a final requirement to gain approval to submit applications for placement in predoctoral internship. Failure to complete the dissertation proposal defense by the deadline results in a minimum one-year delay in applying for an internship. It is the student’s responsibility to schedule the proposal defense with the dissertation chair and committee. The proposal deadline is the last working day in June of the student’s second Psy.D. year. The draft proposal must be provided to the committee at least two weeks prior to
the meeting. Students review the proposal with the committee, indicate how the dissertation study will enhance development of the core competencies in psychology, present an understanding of the relevant literature, provide a rationale for the proposed dissertation, describe the scope of work and choice of methods, and answer questions regarding the proposal. Formal approval of the dissertation proposal by the entire committee is necessary to proceed with the dissertation study.

Dissertation Process and Oral Defense
After the approval of the dissertation proposal, students proceed with the development of their dissertation. The Dissertation Committee chair and members are available to students to guide the work. Institutional Review Board approval must be secured before any research activity with participants commences. The Dissertation I–VI courses and interaction with the committee facilitates completion of the dissertation, since students must fulfill certain milestone requirements to proceed in the program.

All students are responsible for the timely completion of their dissertation. Students should note that there is an additional dissertation fee for each semester beyond the final semester of coursework in which the dissertation is not complete. This fee allows students to access university resources, including faculty advisement. The maximum length of time for completion of the dissertation is eight years from the date of matriculation.

The written dissertation must follow current APA style and university guidelines in the dissertation manual. Once the dissertation is complete and meets the requirements of the Dissertation Committee chair and members, students must then successfully defend the dissertation in front of the entire committee. At the oral dissertation defense, students formally present the dissertation to the committee, demonstrating that the dissertation is their work and that they are able to explain and defend it. If the defense is deemed acceptable by the committee, then the committee signifies its approval using appropriate forms. The committee must have unanimous agreement to approve the dissertation defense. It is likely that changes and additions will be required to complete the dissertation following an acceptable defense. If their dissertation defense is rejected, students must demonstrate substantive improvement in their ability to defend their dissertation, consistent with the response of the committee, prior to a second oral defense.

Following approval of the defense, students make necessary corrections in their written dissertation as requested by the committee within 30 days of the defense. These corrections must be approved by the dissertation chair and any other member(s) of the committee who wish to review them. The final corrected copy is then submitted to a technical reader, who reviews the dissertation to determine compliance with APA style and university guidelines. These corrections are returned to students and must be completed within a month.

Students are allotted 10 hours per dissertation for editing. Should the dissertation require more time than the allotted 10 hours, the student will be billed at the hourly rate charged by the dissertation editor until the dissertation is approved for binding. Following approval of these corrections, students submit one copy of the corrected dissertation to the library representative to ensure technical compliance. Final submission includes copies duplicated according to specifications of the Department of Graduate Psychology for binding and distribution to University Microfilms Incorporated for inclusion in Dissertation Abstracts. A final approval signifying completion of all the required filings must be filed with the department to satisfy the degree dissertation requirement. Failure to complete all of the above within six months of the oral defense may result in a requirement that the student repeat the oral defense.

Students are required to consult the APU Doctoral Programs Handbook for Style and Format Requirements for the year of their dissertation defense to determine specific deadlines for May graduation.

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Degree Posting
The doctoral degree is posted after the student has met all degree requirements, including documentation of completion of the predoctoral internship. Degree posting dates conform to those published in the Graduate Catalog.

Psy.D. Doctoral Assistantships

Funds are allocated to provide six Teaching-Research Assistantships (TRAs) each academic year. Students may apply each year for the first four years of their Psy.D. program. TRAs receive 50 percent tuition remission plus an annual stipend of $6,250. TRAs must provide 15 hours of service per week in the Department of Graduate Psychology during September through June of the academic year. The director of the Psy.D. program determines the roles and responsibilities of the TRAs. The Department of Graduate Psychology reserves the option to, in certain circumstances, divide the TRA positions into eight-hour-per-week positions (each student receiving one-half of the benefits) in order to assist more students.

Students must reapply for the positions each year. Students who are awarded a TRA position during any year are welcome to reapply for each of the first three years of their doctoral program. Decisions are made yearly, based upon the needs of the faculty and the program. Preference is given to applicants who evidence strong academic credentials (high GPA and GRE scores, in particular) and financial need. Cultural knowledge and language skills that facilitate the provision of psychological services in an underserved community and commitment to provide psychological services in an underserved community following graduation are also taken into consideration. Applications for the assistantships and criteria for evaluation of applications are available in the Department of Graduate Psychology.

Adherence to Five- or Six-Year Track
Students are admitted to the Psy.D. program based on their stated intent to adhere to one of the two course sequence tracks created for the program. The five-year track requires greater weekly time commitment and more units per semester.

Once admitted, students must adhere to the selected track unless special permission is granted by the director of the Psy.D. program. The Psy.D. faculty believe that participation in a cohort of peers throughout the program is an important factor in academic and professional development. Certain courses or mandatory seminars may be scheduled on Saturdays. Saturday attendance may be necessary to fulfill degree requirements.

Progress Review and Annual Evaluation
An annual student progress evaluation is conducted in July, following the summer term. All aspects of student progress in the program are reviewed and a letter is sent to students informing them of the results of the review, noting strengths or completion of particular requirements and areas for improvement or remediation needed in order to remain current in the program.

The program evaluates multiple domains of student training beyond that of academic success. Other areas of evaluation that are expected competencies of professional psychologists include evaluation of intrapersonal, interpersonal, and professional development and functioning as articulated in the Comprehensive Evaluation of Student-Trainee Competence in Professional Psychology Programs, produced by the Student Competence Task Force of the Council of Chairs of Training Councils (CCTC). In addition to policies outlined in the catalog, other sources of program policy include the Clinical Training Manual and the Dissertation Manual.

Academic Probation and Disqualification
Students must maintain a minimum cumulative GPA of 3.0 throughout the period of their enrollment. Students will be placed on academic probation if a cumulative 3.0 grade-point average is not
maintained, or when they obtain a grade below a B- in their coursework. Students may be disqualified from further graduate work if a cumulative 3.0 GPA is not maintained or if they obtain a total of two grades below a B- in their coursework.

Identification of Students with the Profession of Psychology
To facilitate the identification of students with the profession of psychology, all students are required to join the American Psychological Association as student members upon acceptance into the program. APA membership provides many benefits, including subscriptions to the Monitor on Psychology and American Psychologist.

Personal Psychotherapy Required
All Psy.D. students must complete 30 hours of psychotherapy with a licensed psychologist of their choice. Additional individual psychotherapy may be recommended or required by the program as part of the degree requirements if deemed necessary by Department of Graduate Psychology faculty.

Academic Advising
Each student selects a Dissertation Committee chair during his or her first semester in the program. That faculty member also serves the student as his or her academic advisor. In addition, the program director and the clinical training director may provide information regarding program planning and special concerns.

Duties and Responsibilities of the Clinical Training Faculty, Staff, Agencies, and Students

Director of Clinical Training (DCT): The DCT organizes, plans, and coordinates all aspects of clinical training for the APU PsyD program and reports directly to the Director of the PsyD program. The DCT is a licensed clinical psychologist in the state of California with a demonstrated mastery in clinical training reflective of the diverse training settings required by the program (inpatient/residential, child, brief/managed care, and psychological assessment). The Director of Clinical Training for practicum is Sheryn Scott, PhD and for internship portion of the program is Marjorie Graham-Howard, PhD

Responsibilities include:
1. Serving as primary liaison with practicum placement agencies to inform agencies of APU Department of Graduate Psychology’s policies and procedures, respond to agency and student needs as they arise, and provide consultation to agencies in strengthening their programs.
2. Screening sites; regular phone contact with agency personnel, and site visits as needed and possible.
3. Reviewing all student evaluations pertaining to clinical performance, goals, and objectives.
4. Approving appropriate practicum sites for student placement.
5. Conducting annual appointments with students to discuss current/future practicum and internship plans, assist with internship application process, and review professional development issues.
6. Coordinating with the Clinical Administrative Assistant and Associate DCT to effectively manage the Clinical Training program.
7. Annually updating Clinical Training Manual
8. Coordinating and preparing materials for practicum, internship, and post-doctoral applications.
Note: Any concerns regarding policies or progress should be referred to the DCT.

Clinical Administrative Assistant: The Clinical Administrative Assistant assists the DCT and the Associate DCT in the administration of the doctoral program including answering student questions regarding practicum and internship. Other responsibilities include:

1. Developing and managing practicum and internship site contract relationships and reviewing site agreements.
2. Developing and maintaining PsyD clinical databases and records including student files, evaluations, eligibility requirements, etc.
3. Coordinating CCEs.
4. Serving on Clinical Training Committee.
5. Reviewing dissertations for APA style, accuracy, and readability.
6. Sending out evaluation requests for all students placed in the field and overseeing their return and appropriate dispensation.

Clinical Training Committee (CTC): The CTC, comprised of licensed PsyD and MA faculty, has direct oversight of or provides direct supervision to the PsyD students. The Clinical Administrative Assistant and a student representative selected by the Graduate Psychology Student Union sit on the committee as well. The CTC reports to the Department of Graduate Psychology faculty and serves to design and facilitate the best possible training for aspiring clinical psychologists. The CTC is chaired by the DCT and meets bi-monthly before departmental faculty meetings. Additional tasks include:

1. Establishing clinical training policies.
2. Approving students to begin and/or continue the clinical placement sequence.
3. Handling students’ special requests/exceptions to policy.
4. Providing special student hearings regarding placement, remediation, etc.
5. Sitting on Clinical Competency Exam panels.

Affiliated Sites: Affiliated Sites are those sites having a formal contract with the Department of Graduate Psychology to provide training at the practicum level. Affiliated Sites:

1. Sign an annual Practicum Training Agreement.
2. Provide a training program with clearly defined goals and recognize students as trainees only (not experienced or paid staff).
3. Provide to the Department of Graduate Psychology for each site supervisor his or her license and number, state and date of licensure, and current license expiration date.
4. Provide a written evaluation each semester of student progress that is completed by the site supervisors, reviewed with the student, and signed by the student. Site supervisors return the evaluations by mail to the APU Department of Graduate Psychology. Students may not deliver the evaluations themselves. Students are not given credit for the practicum until the evaluation form is received by the Department.
5. Must immediately notify the DCT of any problem regarding a student’s performance including, but not limited to policies and procedures, health standards, safety, cooperation, and/or ethical behavior. Any resulting investigation and/or proposed resolution may involve the Department of Graduate Psychology.
6. Are expected to promptly notify the DCT of any changes in supervision and/or other components of the training contract.
7. Are encouraged to utilize audio and/or videotaping in the supervisory/training process at the site as students must present videotapes of their work in Clinical Practicum classes.
Additionally, supervisors are strongly encouraged to regularly use live supervision, video and/or audiotapes when providing supervision to students.

8. Provide a regularly updated description of their training program, as strong preference is given to sites that offer staff in-services, workshops, and/or seminars in addition to regular supervision.


10. Provide a minimum of two (2) hours of group or one (1) hour of individual supervision per week. Groups shall be a maximum of four (4) students, and individual supervision shall be offered as first preference in sites providing such.

11. Provide supervision by a licensed psychologist who have expertise in the site’s specialties. Additional supervision can be supplied by other license personnel or on occasion, post-doctoral students.

12. Require from students only those services that fall within the guidelines of the educational preparation and qualifications of the APU program, APA ethical guidelines, and laws.

13. Provide only formal client contact (individual or group therapy, assessment, psychoeducational group, etc.) versus informal client contact (hiking, games, etc.)

14. Provide appropriate counseling rooms, office space, climate control, and furniture. Additionally, the sites must provide adequate safety conditions, particularly at night (outside lighting, alarm systems, locks, and telephone access). All materials and protocols must be provided whenever play therapy and/or assessment training is offered.

15. Provide, as practicable as possible, a wide range of professional experiences to the students (e.g., diverse populations, various modalities, and psychoeducational work).

16. Strictly adhere to all legal and professional guidelines for clinical practice when providing clinical training to the students. Only those sites manifesting the highest regard for ethical and professional considerations shall be considered for field placement sites. The Department of Graduate Psychology consistently monitors field placement sites for legal and ethical concerns and will remove students from any setting in which there is demonstrated disregard for these standards.

17. Permit, upon reasonable request, an inspection by APU and/or agencies charged with accreditation of the curriculum. Such an inspection shall include the site facilities, services available for clinical experiences, student records, and other items pertaining to clinical training. Notwithstanding the foregoing, it is understood that the training site shall comply with all federal, state, and local laws, ordinances and regulations regarding patient confidentiality.

18. Generally provide a one-year training placement beginning in September to include 600 hours of experience approximately half being direct service hours (excluding school settings).

Students: Students are considered those individuals currently enrolled in the doctoral or master’s program at APU whether they are currently attending classes or not. Situations occasionally arise in which a student must take a leave of absence from the program for a semester, and there are no scheduled classes in July and August. However, students are bound at all times to follow the guidelines of this manual. Other responsibilities of students include:

1. Knowing and following the contents of this manual as well as the guidelines set forth in the Graduate Student Handbook. The status of a student’s records and his/her successful and timely progress through the program may be adversely affected if these guidelines are not followed.

2. Being familiar with APA’s Ethical Principles of Psychologists and Code of Conduct and conducting themselves accordingly.
3. Reporting conditions to Dr. Scott that differ from those for which the agency, student, and school contracted or that interfere with proper training. Such conditions might include, but are not limited to:
   a. Supervision that does not meet the terms of the contract
   b. Exploitation in any form including sexual harassment, workload, and/or inappropriate requests
   c. Failure of the agency to supply sufficient training opportunities (inservices, case conferences, client load, and/or supervision)
   d. Financial or administrative difficulties or changes in personnel at the agency that adversely affect professional standards and/or the clinical or administrative functioning of the agency
   e. Discrimination based on race, color, national origin, age, gender, sexual preference, religion, or physical handicap
   f. Violations of laws and the APA ethical principles
4. Completing an annual Clinical Skills Goals statement
5. Submitting at each semester’s end an evaluation of both the supervisor and the practicum site to their Clinical Practicum instructor. **Final grades are withheld until this step is completed.**
6. Providing an annually updated curriculum vita to Dr. Scott during the fall advisement process.
7. Completing the psychotherapy requirement as stated in the program description: “All PsyD students must complete 30 hours of psychotherapy with a licensed psychologist of their choice. Additional individual psychotherapy may be recommended or required by the program as part of the degree requirements if deemed necessary by the faculty of the Department of Graduate Psychology.”
8. Accurately recording earned clinical training hours on a summary sheet indicating type of service provided or training received. These summary sheets must be submitted at each semester’s end to the class instructor and become part of students’ clinical files. **Final grades are withheld until this step is completed.** Students are encouraged to keep summary sheet copies for their own records.
9. Fulfilling the requirements of their practicum placement. Practicum sites may, at times, require more than the weekly 12-15 hours specified by APU; and students are expected to honor the additional requirement providing it was an agreement made at the time the position was accepted.
10. **Acting professionally** (field placements are to be regarded as regular employment regardless of students’ volunteer status). This includes being prompt for meetings and clinical sessions, dressing appropriately, and addressing any difficulties on-site with either the training director or supervisor. Dr Scott or Dr. Graham-Howard should be asked to intervene only if difficulties cannot be resolved at the site.
11. Fully understanding the conditions in which a student’s clinical placement experience may be terminated prematurely:
   a. An inability to resolve a poor match between training site and student. In this instance Dr. Scott must be contacted to work with the student, the assigned supervisor, and the training site to determine the best outcome for all involved. The student must petition the Clinical Training Committee if a change in practicum is desired.
   b. The site has been found to be involved in illegal, unprofessional and/or unethical behavior, or has not been providing the promised training to the student. In such cases, Dr. Scott must be contacted to assess the situation and
to determine whether or not the situation can be remedied and/or if the student should be reassigned to an alternative site.

c. The student has been found to be involved in illegal, unprofessional, and/or unethical behavior by the practicum site, or is otherwise seen as not meeting minimum standards for performance. In this case, Dr. Scott must be contacted to assess the situation and to determine the appropriate action(s)
Appendix Q cont.

Appendix B
ADHERENCE TO VALUES AND STANDARDS
OF
PRACTICUM/INTERNSHIP SITE

I hereby agree to abide by the policies and procedures of the practicum/internship site in which I have been placed. I will abide by the site’s values and position even if they differ from my own. If I have reason to believe that my actions or behaviors violate the site’s policies and/or the American Psychological Association Code of Ethics, I will immediately inform my site supervisor and the Director of Clinical Training at Azusa Pacific University.

___________________________________________________________________

Student’s name ____________________________________________

Please print

___________________________________________________________________

Student’s signature __________________________________________

Date

___________________________________________________________________

Director of Clinical Training

Date
Appendix Q cont.

Appendix C

See attached APA Insurance PDF form or visit the website to download an application at:

www.apait.org
Appendix Q cont.

Appendix D
Sample Curriculum Vita
FULL NAME, M.A.
(larger font)

Address
City, State    Zip
Phone
E-mail

EDUCATION

xxxx-present  Department of Graduate Psychology
Azusa Pacific University
Student in Clinical Psychology, PsyD program
(if applicable) Advanced to candidacy on __________

xxxx-xxxx   Department of Graduate Psychology
Azusa Pacific University
M.A. – Psychology

xxxx-xxxx   All American College
Anytown, U.S.A.
B.A. – Psychology (summa/magna/cum laude, if applicable)

• List any other degrees you have. Put them in date order.

SUPERVISED CLINICAL EXPERIENCE

09/00 to 00/01   Preinternship (xx hours)
All American Agency, Anytown, U.S.A.
Delivered coffee to supervisors on time everyday, etc.

xxxx to xxxx   Clerkship (xx hours)
Place
Tested the supervisor’s dog for perceptual skills, etc.
Supervisor(s): Not So Wise One, Ph.D.

xxxx to xxxx   Practicum II (xx hours)
Place
Looked over supervisor’s shoulders while he read the comics
Supervisor(s): Hope to Never See Again, Ph.D.

xxxx to xxxx   Practicum I (xx hours)
Place
Supervisor looked over my shoulder while I read the comics
Supervisor(s): If I See Again, I’ll Die, Ph.D.

• If, in between or alongside any of these, you had other clinical activities, then include them by date. If it was a paid job, then highlight that fact in the description of duties.
• In each case, make the description of duties as succinct as can be, while at the same time conveying the breadth and depth of your experience.

• If you had other clinical experience before coming to APU, then list it under a separate heading titled, ADDITIONAL CLINICAL EXPERIENCE.

OTHER WORK EXPERIENCE
• List any other jobs that, while not clinical, may convey skills that are transferable or that enhance the person you are (e.g., classroom teacher, pastor/youth minister, computer programmer, etc.).

RESEARCH EXPERIENCE
• List any research assistantships or research practica you may have had and include dates, names of projects, supervisors, etc.

Master’s Thesis: Title, description advisor. Note whether it was presented or submitted for publication. (PsyDs will not have this line.)

Doctoral Dissertation: By the time you are applying, you must have had the proposal approved. List the title, description, name of chair, status at time of application (e.g., “data collection in process,” or “data collected,” or, even better, “defended on ________,” but if not, “anticipated date of completion ______” – hopefully before beginning internship).

PROFESSIONAL AFFILIATIONS
• List all of your student memberships in psychological associations.

HONORS
• List all of your honors from college to the present.

SELECTED PROFESSIONAL SEMINARS
• If you have attended many of these and they are relevant to the internship experience, then list them. If not, then skip this section;

COMPUTER LITERACY
• List all of the applications, platforms, languages, and statistics programs you know.

SEPARATE PAGE: LOG OF TESTS YOU KNOW (MOST IMPORTANT)
Label any way you like (“testing log,” “test competency,” etc.) List the tests by category: e.g., intellectual functioning, neuropsychological, objective personality, projectives, achievement, vocational, etc., and list the NUMBER of each test you have done. If you have been keeping a log of your work from day one of Practicum (as advised during orientation), it should be very easy to produce this part.
PsyD Student Psychotherapy Verification

Use a separate form for each psychotherapist verifying hours of group or individual psychotherapy received that may be credited toward the 30 hour requirement of the PsyD program. **Psychotherapy must be performed by a California licensed clinical psychologist, and psychotherapy performed by the student’s supervisor shall not be credited. No erasures or corrections may be made. If any error has been made, complete a new form. Ensure the form is complete and correct.** Students are to submit the completed form to the Graduate Psychology Clinical Training Office prior to submitting his or her Intent to Graduate.

**Student: Complete Section I**

**Psychotherapist: Complete Section II**

### I. Student: (please type or print clearly in ink.)

<table>
<thead>
<tr>
<th>Name</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Int.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number &amp; Street</td>
<td>City</td>
<td>State</td>
<td>Zip code</td>
<td></td>
</tr>
<tr>
<td>Cell</td>
<td>Home telephone</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### II. Psychotherapist: (please type or print clearly in ink.)

Dates the student received Group or Individual Psychotherapy in accordance with Azusa Pacific University Department of Graduate Psychology PsyD program requirements.

<table>
<thead>
<tr>
<th>From</th>
<th>to</th>
<th># Therapy hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>mo / day / year</td>
<td>mo / day / year</td>
<td></td>
</tr>
</tbody>
</table>

Were you licensed by the California Board of Psychology during the entire period of this therapy?

☐ Yes    ☐ No    (please check)

Office address

<table>
<thead>
<tr>
<th>Number &amp; Street</th>
<th>City</th>
<th>State</th>
<th>Zip code</th>
</tr>
</thead>
</table>

Daytime phone number
Type of license ______________________  License number ______________________

State of license ______________________  Date originally licensed ______________

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

____________________            ________________
date               print name                            signature and title
Appendix Q cont.

Appendix F
Reprinted from the APU Graduate Catalog.

Academic Integrity

The maintenance of academic integrity for a quality education is the responsibility of each student at Azusa Pacific University. Cheating or plagiarism, in connection with an academic program, is an offense for which a student may be expelled, suspended, or disciplined. Academic dishonesty is a serious offense which diminishes the quality of scholarship and defrauds those who depend upon the integrity of the educational system.

Academic dishonesty includes:

1. **Cheating** – Intentionally using, or attempting to use, unauthorized materials, information, or study aids in any academic exercise.
   - Students completing any examination should assume that external assistance (e.g., books, notes, calculators, conversations with others) is prohibited unless specifically authorized by the instructor.
   - Students may not allow others to conduct research or prepare any work for them without advance authorization from the instructor.
   - Substantial portions of the same academic work may not be submitted for credit in more than one course without authorization.

2. **Fabrication** – Intentional falsification or invention of any information or citation in an academic exercise.

3. **Facilitating Academic Dishonesty** – Intentionally or knowingly helping or attempting to help another commit an act of academic dishonesty.

4. **Plagiarism** – Intentionally or knowingly representing the words, ideas, or work of another as one’s own in any academic exercise.

See also: “Grievance Procedure” and “Due Process.”

Graduate Student Grievance Procedures and Due Process

In the area of academics, protocol requires that student concerns or grievances about course content and relevancy, grading, teaching style, and the like, be taken up first with the professor of the given class. Failure to resolve the matter at that point may require a meeting with the appropriate department chair, or finally, the dean of the school or college. In the event that informal procedures fail to resolve the problem, the student will indicate in writing the nature of the grievance, the evidence upon which it is based, and the redress sought.

I. Definitions

A. A grievance is a statement by a student that he/she was wronged by Azusa Pacific University. The grievance may be caused by a failure of Azusa Pacific University to follow its established policies and practices.

B. A student is anyone who has officially enrolled in a graduate program at Azusa Pacific University at the time the perceived wrong occurred.

C. A complaint is the formal statement of a grievance that the student files with an appropriate administrative officer.

D. An appropriate administrative officer is the dean of the relevant college or school, the chair of the relevant department, the registrar, the director of graduate admissions, or the director of student financial services.

II. Time Limits

Anyone who cannot perform some procedural step within the time limits stated in this document must make prior
written request of the appropriate administrative officer for an extension before the time limit has been exceeded. Failure on the part of a complainant to observe any time limit or receive an extension shall be taken to mean that the student has abandoned his/her complaint, and no further action on the matter shall be allowed. Failure on the part of someone named and accused in a complaint to object to the complaint after the complaint has been referred to the appropriate administrative officer or to observe a time limit or receive an extension, shall be interpreted as an indication of that person’s agreement with all statements in the complaint, provided he/she has been given a written copy of the complaint or grievance on a timely basis.

III. Legal Counsel
The presence of legal counsel is not permitted, but the student may request and receive permission to have an APU student or faculty member present at the meetings for support.

IV. Settlements Prior to a Hearing
A. If the grievance can be resolved by the mutual consent of both parties before it comes to a hearing, and the resolution requires some formal administrative action under the established policies of the university, college, or school, then the parties shall forward to the appropriate administrative officer a statement of the grievance and its proposed resolution. This statement must be approved by both parties. The appropriate administrative officer may then either approve the resolution and take the required action or order that the remainder of the grievance procedure be carried out.
B. If the proposed resolution does not require administrative action, then the resolution shall be considered the final step in the procedure, and no subsequent complaints or defenses on the matter shall be heard.

STEP 1
WHO ACTS:
Student
Meet with the person(s) immediately involved in the dispute (other party) and try to resolve the problem.
Other Party
Discuss the problem with the student.
Time Limit
The meeting between the student and the other party must take place within 10 working days after it is requested.

STEP 2
WHO ACTS:
Student
If Step 1 has not resolved the problem, refer the issue to the appropriate administrative officer. Submit a written statement of the grievance and the requested resolution.
Administrative Officer
Consult with the parties involved. Try to resolve the issue.
Time Limit
The student must consult with the administrative officer within 10 working days after meeting with the other party, or if no meeting has been held, within 5 days after the end of the time limit in Step 1.

STEP 3
WHO ACTS:
Student
If Steps 1 and 2 have not resolved the problem, the student must request (in writing) a meeting to be arranged by the dean of the college or school with the other party, and the dean of the college or school.
Other Party
Meet with the student and the dean of the college or school.
**Dean of the College or School**
A. Meet with the student and the other party. If the problem cannot be resolved at this meeting, direct the parties involved to write a statement of the grievance and their action with respect to that grievance. Each party shall receive a copy of the opposing party’s statement. The original statements shall be forwarded to the chair of the Committee on Graduate Student Grievances (CGSG).

B. Notify the chair or supervisor of the department or office of the other party, and, if appropriate, the administrator responsible for the issue under debate, that a formal grievance hearing will be held. Only the names of the parties involved shall be made known; all other details must be held in strict confidence.

**Time Limit**
The meeting between the dean of the college or school, the student, and the other party must take place within ten working days after the student requests it. If the matter remains unresolved, the results of the meeting must be submitted to the chair of the CGSG within three days of the meeting.

**STEP 4**
WHO ACTS:

**CGSG**
Conduct a hearing on the grievance in accordance with approved procedures and submit recommendations to the dean of the college or school and to the principals.

**Time Limit**
A schedule for the hearing must be set within 10 working days after the committee receives the statements of grievance from the principals along with the results of the meeting between the two parties and the dean of the college or school.

**STEP 5**
WHO ACTS:

**Dean of the College or School**
Review the documents to make sure that all steps in this procedure have been followed; then consider the recommendations of CGSG, make a decision, and send a written notification of the decision to all parties.

**Time Limit**
The decision of the dean of the college or school must be made within 10 working days following receipt of the documents.

**Appeals**
Either of the parties involved in the grievance may appeal the administrative officer’s decision to the associate provost of Azusa Pacific University. This appeal must be made within five days after the administrative officer has announced a decision. The associate provost’s decision shall be final.

**Failure to File Grievance**
Any student who has a complaint or grievance against the university must follow this procedure or will waive any claim against the university. Nursing students with grievances related to clinical problems should review the procedures outlined in the School of Nursing Handbook.

**Standards of Conduct** In accordance with the ideals of Christian education, it is the goal of Azusa Pacific University that the campus environment promote sound academic and personal growth experiences. The administration believes it is important for each student to develop a living/learning style that is consistent with the Christian beliefs of Azusa Pacific University and reflected in both on- and off-campus behavior. Graduate students are expected to use personal discretion involving activities that may be spiritually or morally destructive. It is the intention of the university to resolve violations of established policies and standards of
conduct in a way that will maintain respect for the individual. The university may terminate, for reasonable cause, the registration of any student who violates university policies and regulations. A full printed copy of the procedures is available at the Office of Student Life, (626) 815-3883. (See also “Academic Integrity” and “Fraudulent Records Policy.”)
Appendix Q cont.

Appendix G
Clinical Practicum I, II, III, IV, V, VI Requirements
Clinical Practicum I: Professional Practice and Case Conceptualization

1. Attend 2 hours of class each week during which therapeutic skills are reviewed, professional ethics taught, and the applications of various theoretical models discussed.
2. Work at a local school, as designated by CCC, treating referred children 4 hours per week.
3. Attend a weekly group supervision and work with volunteer undergraduates in a simulated psychotherapy process. Continue work at assigned school placement and work with community clients at CFDC.
4. Know the APA Ethical Principles of Psychologists and Code of Conduct. Successfully complete the mini-competency exam in Laws & Ethics in Professional Practice. Those receiving an inadequate result the first time must retake the exam at the end of the summer session. **Students must successfully pass the exam to proceed with their practicum sequence.**
5. Maintain regular attendance and participation in class.
6. Maintain regular attendance and participation at all required CCC functions.
7. Videotape clinical work.
8. Complete Clinical Skills Goals for the year.
9. Submit verification of APA membership and verification of malpractice insurance.
10. Demonstrate Core Interpersonal Qualities including warmth, genuineness, respect, empathy, concreteness, confrontation, self-disclosure, immediacy, and potency at a basic level of three (3).
11. Accrue approximately 100 hours of experience including didactic training, supervision, clinical sessions, and administrative time.

Clinical Practicum II: Legal & Ethical Competency

1. Attend 2 hours of didactic training per week.
2. Attend a weekly group supervision and work with volunteer undergraduates in a simulated psychotherapy process. Continue work at assigned school placement and work with community clients at CCC.
3. Successfully complete the mini-competency exam in Laws & Ethics in Professional Practice. Those receiving an inadequate result the first time must retake the exam at the end of the summer session. **Students must successfully pass the exam to proceed with their practicum sequence.**
4. Maintain regular attendance and participation in class.
5. Maintain regular attendance and participation at all required CCC functions.
6. Videotape clinical work.
7. Demonstrate an ability to create a treatment plan and contract, handle crisis situations, and effectively complete an initial assessment of a client.
8. Write a one page evaluation of achieved and not achieved goals by the end of the semester.
9. Obtain approximately 100 hours of experience including didactic training, supervision, clinical sessions, and administrative time.
Clinical Practicum III: Diversity Competency

1. Attend 2 hours of class each week. Part of class time is spent in a small group of eight or fewer students during which supervisor and placement issues are discussed and case presentations made. The remaining 1 hour consists of a didactic presentation on diversity or other relevant clinical material determined by the professor.
2. Participate in a practicum placement 12-15 hours per week. At least 8 of these hours will be in direct client contact including formal psychological assessment and/or clinical treatment.
3. Videotape clinical sessions. Exceptions must be discussed with class instructor.
4. Maintain regular attendance and participate in class.
5. Successfully complete a mini-competency exam on diversity. Students receiving inadequate results must retake the exam in January. **Students must successfully pass the exam to proceed with the practicum sequence and apply for a third-year placement.**
6. Provide verification of APA membership and malpractice insurance coverage.
7. Submit appropriate evaluation papers at the end of the semester. Inadequate performance at practicum site will cause class grade to be lowered.
8. Complete the Clinical Skills Goals statement.
9. Obtain 300 hours of training, supervision, and clinical work.

Clinical Practicum IV: Diagnostic Competency

1. Attend 2 hours of class each week. The primary focus of the course is to facilitate discussion of applied diagnosis, case presentations, and practicum site issues. The course also includes a didactic presentation on diagnosis, diversity, treatment planning, etc.
2. Same as CP II, #2-4.
3. Successfully complete a mini-competency exam on diagnosis and assessment. **Students must successfully pass the exam to proceed to the following practicum experience.**
4. Submit appropriate evaluation papers at the end of the semester. Inadequate performance at practicum site will cause class grade to be lowered.
5. Obtain 300 hours of training, supervision, and clinical work.

Clinical Practicum V: Domestic Violence & Clinical Competency

1. Attend 2 hours of class each week. During the first half of the semester, students will receive information about domestic violence, including identification, assessment, and treatment of those involved. The second half of the semester is dedicated to integrating the skills necessary to pass the CCEs.
2. Same as CP III, #2-4.
3. Provide verification of APA membership and current malpractice insurance coverage.
4. Submit appropriate evaluation papers at the end of the semester. Inadequate performance at practicum site will cause class grade to be lowered.
5. Complete the Clinical Skills Goals statement.
6. Obtain 300 hours of training, supervision, and clinical work.
Clinical Practicum VI: Interdisciplinary Competency

1. Attend and participate in all sessions of the weekly 2-hour class.
2. Participate in a practicum placement 12-15 hours per week. At least 8 of these hours will be in direct client contact including formal psychological assessment and/or clinical treatment.
3. Videotape clinical sessions. Exceptions must be discussed with class instructor.
4. Successfully complete a competency exam on interdisciplinary integration. This includes an in-class case presentation and a case write-up. **Students must successfully pass the exam to proceed to internship.**
5. Submit appropriate evaluation papers of site and supervisor at the end of the semester. Inadequate performance at practicum site will cause class grade to be lowered.
6. Write a one page evaluation of achieved and not achieved goals by the end of the semester.
7. Complete a reflection paper or journal on the impact and import of spiritual and religious diversity to clinical practice.
8. Obtain 300 hours of training, supervision, and clinical work.
Appendix Q cont.

Appendix H
PRACTICUM
TRAINING AGREEMENT

This document is to certify that a training agreement exists between

______________________________________________________

name of site

and the Department of Graduate Psychology, Azusa Pacific University, for the purpose of providing its PsyD students with a practicum placement in clinical psychology.

The training provided by the facility shall consist of either (a) 9 months, 15 hours per week, or (b) 12 months, twelve hours per week of supervised professional experience in the field of clinical psychology appropriate for advanced doctoral students. The training facility shall provide the school with performance evaluations on each student at the end of each semester (December and April) and August (for 12-month placements).

The training facility shall retain full responsibility for the care of clients and shall maintain administrative and professional supervision of students for all aspects of the work that they perform. Supervision shall be provided weekly throughout the training term by licensed professionals and shall consist of (check one) ______ 1 hour of individual per week or ______ 2 hours of group per week. Each student maintains his/her own malpractice insurance, a copy of which is available upon request.

This agreement shall remain in effect throughout the academic or fiscal year of ___________ or until one or both of the parties request cancellation.

Practicum

Beginning date: ____________ Ending date: ____________ Student: _________________

Signed: ____________________________ Signed: ____________________________

Sheryn Scott, PhD Director of Training or Supervisor
Director of Clinical Training

Date ____________________________ License ____________________________ Lic. #

______________________________ ______________________________
Signature of PsyD practicum student Date
Practicum Schedule and Goals

The purpose of this section is to provide an outline to guide initial discussions between practicum students and on-site supervisors. It is important that both students and clinical facility personnel have a clear understanding of their respective expectations and responsibilities. Students and supervisors should discuss matters such as work schedules, supervision times, vacation periods, training goals, and all other parameters relevant to the successful completion of the practicum. A frank discussion of these issues at the onset of the practicum will enhance the training experience and prevent misunderstandings.

1. The nature of the practicum experience. How will the student’s time be distributed?

2. Specific training goals for the student:
   a.
   b.
   c.
   d.

3. Student’s work schedule (specify days and hours)  
   academic holidays, etc.  
   Student vacations,  
   _____ Monday _______ to _______  
   ________________________________________  
   _____ Tuesday _______ to _______  
   ________________________________________  
   _____ Wednesday _______ to _______  
   ________________________________________  
   _____ Thursday _______ to _______  
   ________________________________________  
   _____ Friday _______ to _______  
   ________________________________________  
   _____ Saturday _______ to _______  

4. Supervision schedule:  

5. Stipend and/or expense
reimbursement (if any):

7. Liability insurance coverage: 8. Miscellaneous/other:

________________________________________

Signatures of Agreement:
Student: _____________________________   Supervisor: ____________________________
Appendix Q cont.

Appendix I
PSY.D. CLINICAL AFFILIATION AGREEMENT

This agreement is entered into by and between _______________________________________________ (hereinafter referred to as “training site” and Azusa Pacific University. Azusa Pacific University agrees to send to the above-named training site only those students enrolled in the Clinical Psychology degree program and for the purpose of receiving clinical instruction and experience.

The parties hereto covenant and agree to the following:

1. STATUS OF AZUSA PACIFIC UNIVERSITY AND THE TRAINING SITE

   It is expressly understood and agreed that this agreement is neither intended nor shall be construed to create the relationship of agent, servant, employee, partnership, joint venture or association between Azusa Pacific University, the training site, and students. Rather, this agreement is by and between independent contractors, namely Azusa Pacific University and the training site.

2. STATUS OF STUDENTS

   It is expressly agreed and understood by Azusa Pacific University, the training site, and students that the students participating in clinical training experiences are in attendance for educational purposes as explained in paragraph 2.1.4 herein; and such students and any other employees or agents of the training site in any way involved in the clinical training site are not considered employees of Azusa Pacific University for any purpose whatsoever, including, but not limited to compensation for services, workers’ compensation, unemployment, employee benefit programs.

   2.1 General Information

   2.1.1 The course of instruction (clinical training program) shall cover a period of time mutually agreed upon between Azusa Pacific University and the training site.

   2.1.2 Azusa Pacific University and the training site shall not discriminate against any students participating in the program on the basis of race, color, sex, creed, religion, age, and physical handicap or disability.

   2.1.3 Students are fulfilling specific requirements for clinical experiences as part of a degree requirement; and therefore Azusa Pacific University’s students shall not be considered
employees of either Azusa Pacific University or the training site for purposes of workers’ compensation, unemployment, employee benefit programs, or any other purpose.

2.2 Responsibilities of Azusa Pacific University

2.2.1 Azusa Pacific University ensures that each student is covered by liability (malpractice) insurance with limits not less than $1,000,000 per occurrence by way of Certificate(s) of Coverage. Azusa Pacific University agrees to maintain proof from its students of professional liability coverage with limits not less than one million ($1,000,000) per occurrence and three million ($3,000,000) annual aggregate per student for all activities under this agreement.

2.2.2 Azusa Pacific University shall permit students to apply for clinical placements only upon satisfactory completion of the prerequisite didactic portion of the curriculum.

2.2.3 Azusa Pacific University shall enforce rules and regulations governing students that are mutually agreed upon between Azusa Pacific University and the training site, including compliance with all policies as applicable, including, but not limited to confidentiality and a drug free workplace. Students shall maintain confidential all patient records in accordance with all federal, state, and local laws and regulations.

2.3 Responsibilities of the Training Site

2.3.1 The training site agrees to abide by the field training guidelines established by the Department of Graduate Psychology, Azusa Pacific University.

2.3.2 The training site shall designate individual(s) to be responsible for the educational and experiential supervision of the implementation of the student’s clinical experience.

2.3.3 The training site shall require a student to render only those services within the student’s educational preparation and qualification and related to the objectives of Azusa Pacific University.

2.3.4 The training site shall notify Azusa Pacific University should any student fail to abide by the training site rules and regulations, policy(ies) and procedure(s) and/or who does not meet employee standards for safety, health, cooperation, or ethical behavior. Any pending investigation and/or proposed resolution of the matter shall occur in consultation with Azusa Pacific University.

2.3.5 The training site shall provide Azusa Pacific University with evaluations of each student’s performance on forms provided by Azusa Pacific University.

2.3.6 The training site shall, upon reasonable request, permit the inspection of the training site’s facilities, the services available for the clinical experiences, student records, and such other items pertaining to clinical training by Azusa Pacific University and/or by agencies charged with the responsibilities for accreditation of the curriculum. Notwithstanding the foregoing, it is understood that the training site shall comply with federal, state, and local laws, ordinances, and regulations regarding patient confidentiality.
2.3.7 The training site shall designate and identify to Azusa Pacific University the name and professional credentials of the person to be responsible for clinical training.

2.3.8 The training site agrees to notify Azusa Pacific University in writing of any change or proposed change of the supervisor of clinical training.

2.4 Responsibilities of the Student

Each student shall be notified by Azusa Pacific University that he or she is responsible for:

2.4.1 Following the administrative policies, standards, and practices of the training site in effect when the student is at the training site.

2.4.2 Conforming to the standards, policies, and practices established by Azusa Pacific University while at the training site, including those stated in the University Catalog and Student Handbook.

2.4.3 Maintaining confidentiality of any and all information concerning patients.

2.4.4 Providing the necessary and appropriate attire and supplies required of, but not provided by the training site.

2.4.5 Securing transportation to fulfill the requirements of the clinical training program.
3. TERMS OF AGREEMENT

This agreement shall remain in effect for the period of time from _________________ to _________________ or until one or both of the parties request cancellation. Change of a field placement during the year is unusual and will only be granted in exceptional cases. Examples of exceptional circumstances include the deterioration of the training program, a supervisor’s committing unethical acts, and/or the student not receiving sufficient clinical experience. A student who wishes to change a placement must notify the Director of Clinical Training (DCT). The DCT will consult with the student’s supervisor and appropriate agency administrators before a decision is made. The student may not make any unilateral decisions regarding termination at a field placement.

A request for a change in placement initiated by the agency will be investigated by the Director of Clinical Training (DCT). It is the agency’s right to terminate a trainee for serious ethical/performance deficits. However, the agency will immediately contact the DCT to provide information, will document the difficulties in writing, and will consult on any pending dismissal from training.

It is understood and agreed that the parties herein may revise, amend, or modify this agreement by a signed, written statement by both of the parties hereto.

4. HOLD HARMLESS CLAUSE

The parties herein shall indemnify and hold each other harmless from any and all claims, losses, damages, or injuries to persons or property and all costs, expenses, and reasonable attorneys’ fees incurred in connection therewith caused by the negligent acts or omissions of the indemnifying party, its agents, employees, or students arising out of this agreement.

5. ENTIRE AGREEMENT

The training site and Azusa Pacific University agree that neither party has made any representation, warranty or covenant not fully set forth herein and that this agreement supersedes all previous communication between the parties hereto.

6. GOVERNING LAW

This agreement shall be governed by and construed in accordance with the laws of the State of California.

This agreement has been executed by:

_______________________________________   ________________________________
APU Director of Clinical Training  (please print)        Training Site Director or
Supervisor (please print)      (Degree)
Appendix Q cont.

Appendix J
Student Petition for Extension of Practicum Placement

The clinical training requirements are intended to encourage and provide comprehensive exposure to the practice of professional psychology. Students are required to complete three practicum rotations each of which provides supervised training with a specific population and/or experience. These populations are child/adolescent and adult in a clinical and assessment setting. Ordinarily these requirements are fulfilled in three different practicum sites. Occasionally, students may seek to remain at a practicum site for more than one rotation and/or year. In such cases, students must submit this petition to extend the practicum placement. The approval by the practicum site must be obtained prior to submission of the petition. The quality and breadth of the practicum experience, as well as the opportunity for new training experiences, will be important considerations in the review of this petition.

Student name: ___________________________ Date of request: ______________________

Practicum site:
_________________________________________________________________________

Supervisor/Director: _______________________ Supervisor’s phone #: ________________

Semester(s)/year of requested extension: _________ Clinical rotation to fulfill: ___________

List the practicum placement that you have competed; indicate the requirement that you have fulfilled (A=adult, CA=child/adolescent, PT=psychological testing)

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Site name</th>
<th>Date completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In this section, summarize your training experiences in the practicum that you are now completing and describe the training opportunities that will be provided should your placement be extended. Include a description of client population, assessment and treatment approaches, and didactic and supervisory experiences.

**Client population**

Present practicum:

Extended practicum:

Student Petition for Extension of Practicum Placement, cont’d.

Assessment & Treatment Approaches
Present practicum:

Extended practicum:

**Didactic Training & Supervision**

**Present practicum:**

**Extended practicum:**

List any additional new training opportunities that would be made available in the extended practicum placement:

**Practicum Site Approval**

I approve of this student’s request to complete a second clinical rotation at this practicum site. I have reviewed this petition and concur that an extended rotation would provide new clinical training opportunities as described in this petition.

__________________________________  _________________________
Supervisor’s signature     Date

**Decision**

_____ approved     _____ denied     ________________________ date notified

______________________________________
Director of Clinical Training
Appendix Q cont.

Appendix K
PsyD PRACTICUM SITE REQUEST FORM

This completed form is due in the Clinical Training Office no later than February 2, 2010.

Name ___________________________________________ Date_________________

Please print

Current placement ___________________ Specialty ____________________________
(formal assessment or clinical treatment)

List sites in order of preference:

1. ____________________________________________________________

2. ____________________________________________________________

3. ____________________________________________________________

4. ____________________________________________________________

5. ____________________________________________________________

6. ____________________________________________________________

List any specific needs you may have:
Appendix Q cont.

Appendix L
Azusa Pacific University  
Department of Graduate Psychology  
Clinical Training

Petition to Change Interview Assignment

Students **must** apply to each practicum training site to which they are assigned. Circumstances occasionally arise, however, in which a student wishes to be excepted from this requirement. Completion and submission of this form shall result in a meeting with the Director of Clinical Training, Dr. Scott, and subsequent review by the Clinical Training Committee. Allow 4-6 weeks for notification of their decision.

Student name: ________________________________ Date: ____________________

I was assigned to apply to the following training site and wish to be excepted from this assignment:

Site name: ____________________________________________________________

The reason for my petition is (be specific):

______________________________________________________________________

I understand and acknowledge that there will be a delay of up to 6 weeks before I am notified of the result of this petition and am approved to apply to an alternate site. I also understand and acknowledge that this delay may jeopardize my chance of securing a practicum at another site.

_________________________________________ Date

Signature of student

For office use only

☐ Petition received on _________________ ☐ Clinical Training Committee reviewed
<table>
<thead>
<tr>
<th>Choice</th>
<th>Status</th>
<th>Date: ______________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student notified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DCT meeting scheduled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rejected</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix Q cont.

Appendix M
Practicum Interview Outcome

Submit this completed form to Ms. Henry immediately upon acceptance of a practicum training offer.

Student: ________________________________________

Please print

I applied to the following training sites:

<table>
<thead>
<tr>
<th>Agency name</th>
<th>Date Interviewed</th>
<th>Position offered?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. __________________</td>
<td>________________</td>
<td>__________________</td>
</tr>
<tr>
<td>2. __________________</td>
<td>________________</td>
<td>__________________</td>
</tr>
<tr>
<td>3. __________________</td>
<td>________________</td>
<td>__________________</td>
</tr>
<tr>
<td>4. __________________</td>
<td>________________</td>
<td>__________________</td>
</tr>
<tr>
<td>5. __________________</td>
<td>________________</td>
<td>__________________</td>
</tr>
</tbody>
</table>

I have accepted a training position at the following site:

____________________________________________________

I will begin the practicum on: __________________________

My supervisor is: ________________________________    License #: ___________________

I understand and acknowledge that I must honor my commitment to the above-named practicum site and that I may not decline the position I have accepted in order to pursue another opportunity.

__________________________________________________

Signature of student                                        Date
Practicum Site Petition

All doctoral practicum sites must be approved by Dr. Scott in consultation with the Clinical Training Committee. Students who wish to obtain a practicum independently must complete and submit this form which will initiate the evaluation and approval process. The student should understand that approval is not automatic even though a site meets standard criteria. A student may apply to such an agency for a practicum position only after the site has been officially approved. Any exception to this procedure must be approved in writing by Dr. Scott.

Student name:       Date of request:

Practicum site:

Address:        Agency phone #:

City:     Zip:

Coordinator of Training:      License:

   Staffing, Supervision, & Weekly Commitment

   a. Number of full-time professional staff
   b. Number of part-time professional staff
      c. Number of full-time staff who are
         c1. Licensed psychologists
         c2. Board certified psychiatrists
         c3. Licensed clinical social workers
         c4. Licensed marriage & family therapists
   d. Can the agency provide a minimum of one hour of individual supervision per week by a licensed psychologist?
   e. Can the agency provide a minimum of two hours of group supervision per week by a licensed psychologist?
   f. Total number of hours per week that you would be on site
   g. Will you be financially compensated?

Name of supervisor: ________________________________  License: __________________

Description of the agency (type, services provided, population served)
Clinical Training (didactic, clinical)

Direct Services
Check the clinical activities in which you will be engaged:

a. Clinical intake interviews
b. Psychological assessment
c. Individual psychotherapy
d. Group psychotherapy
e. Other

Explain:

Indirect Services

Supervision and Didactic Training Opportunities

Mandatory Meetings:

Student Signature _________________________________________

Review of Practicum Petition

Initial Review

a. _____ Meets requirements as described in petition. Arrange for telephone interview.
b. _____ Does not meet basic criteria.

Formal Review/Comments:
Recommendation to Clinical Training Committee:

c. _____ Approved
d. ______  Denied

d. ______

Disposition

e. ______  Approved

f. ______  Denied

For Office Use Only

Date recorded __________________________         Date notified ________________
Appendix Q cont.

Appendix O
PsyD PRACTICUM TRACKING FORM

<table>
<thead>
<tr>
<th>Direct Services</th>
<th>total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Therapy hours</strong></td>
<td></td>
</tr>
<tr>
<td>Adults</td>
<td></td>
</tr>
<tr>
<td>Adolescents</td>
<td></td>
</tr>
<tr>
<td>School-age</td>
<td></td>
</tr>
<tr>
<td>Pre-school</td>
<td></td>
</tr>
<tr>
<td>Infants/toddlers</td>
<td></td>
</tr>
<tr>
<td><strong>Group Therapy hours</strong></td>
<td></td>
</tr>
<tr>
<td>Adults</td>
<td></td>
</tr>
<tr>
<td>Adolescents</td>
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<td>Pre-school</td>
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<td>Infants/toddlers</td>
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<td><strong>Family Therapy hours</strong></td>
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<td><strong>Couples Therapy hours</strong></td>
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<td><strong>Other Direct Services</strong></td>
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<tr>
<td>Teaching</td>
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<tr>
<td>Other</td>
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<tr>
<td><strong>Indirect Services</strong></td>
<td></td>
</tr>
<tr>
<td>Therapy: chart review, consultation w/ professnls</td>
<td></td>
</tr>
<tr>
<td>Assmt: chart revw, scor’g, interpret’g, rept. writ’g.</td>
<td></td>
</tr>
<tr>
<td><strong>Supervision</strong></td>
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<tr>
<td>One-on-one individual supervision</td>
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<tr>
<td>Group supervision</td>
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<tr>
<td>Peer supervision/case conference</td>
<td></td>
</tr>
<tr>
<td>In-service training/seminars/classes</td>
<td></td>
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<tr>
<td><strong>Total hours</strong></td>
<td></td>
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</tbody>
</table>
Appendix Q cont.

Appendix P
Azusa Pacific University
Department of Graduate Psychology
Clinical Training

Clinical Skills Goals

Name ____________________________  CP I II III IV V VI  Date ____________

Considering your status in the APU PsyD program, your self-expectations, and your overall educational/career goals, complete the three statements below. Be thoughtful in your answers. Submit the completed form to the Clinical Administrative Assistant, Alice Henry, who will review and record it and forward it to your program advisor for his or her consideration.

1. My goals for this year are:

2. I will achieve these goals by:

3. Behavior indicators of having achieved my goals are:
Appendix Q cont.

Appendix Q
PRACTICUM PERFORMANCE EVALUATION

Student’s Name ______________________________             Date _____________________
Practicum Site   _______________________________           Phone ____________________
Address            ________________________________            Fax    ____________________
City             _______________________________          email   ___________________

Instructions:

This form is to be completed bi-annually (semester end) by both supervisor and training student. After reviewing the evaluation with the trainee, the supervisor should submit the results directly to the Program Administrator at the above address.

Please place an ‘X’ along the continuum indicating your rating of the trainee’s performance in each area. Indicate with an ‘NA’ any item not applicable to your setting or impossible to evaluate due to lack of opportunity to observe.

<table>
<thead>
<tr>
<th>Relationships</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Agency: functions within agency structure, policies, and procedures</td>
<td></td>
<td></td>
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<tr>
<td>2. Clients: understands and is able to respond to the special needs of clientele</td>
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<tr>
<td>3. Diversity: is able to work with and respond to the needs of various cultural or ethnic groups</td>
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<tr>
<td>4. Staff: Maintains a working relationship with professionals and non-professionals</td>
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</tbody>
</table>

0 – unsatisfactory
1 – weak, needs improvement
2 – satisfactory
3 – very satisfactory
4 – highly satisfactory
5. Supervision: plans for and makes use of supervision

<table>
<thead>
<tr>
<th>Personal Qualities</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Initiative: is a self-starter and functions autonomously and competently</td>
<td></td>
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<tr>
<td>7. Responsibility: takes responsibility for own learning and completion of tasks</td>
<td></td>
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<tr>
<td>8. Self-discipline: personally plans ways and uses self to benefit clients</td>
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<td></td>
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<tr>
<td>9. Writing skills: clearly and thoughtfully records observations</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Supervision</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Makes good use of supervision</td>
<td></td>
<td></td>
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<tr>
<td>11. Accurately evaluates self</td>
<td></td>
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<tr>
<td>12. Accepts feedback and incorporates suggestions</td>
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<tr>
<td>13. Raises appropriate questions</td>
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<tr>
<td>14. Maintains thorough case notes</td>
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<table>
<thead>
<tr>
<th>Legal &amp; Ethical Issues</th>
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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td>15. Demonstrates awareness of issues</td>
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<td>16. Thoroughly evaluates the issue(s)</td>
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<td>17. Takes difficult action when necessary</td>
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<td></td>
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<tr>
<td>18. Uses consultations appropriately</td>
<td></td>
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<tr>
<td>19. Maintains appropriate documentation</td>
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<td></td>
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<td>20. Demonstrates diagnostic competency</td>
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<td>21. Is able to develop a working hypothesis</td>
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<td>22. Engages client’s strengths</td>
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<td>23. Assesses client’s resources</td>
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<tr>
<td>24. Conceptualizes the psychotherapy process</td>
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<tr>
<td>25. Recognizes countertransference</td>
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<tr>
<td><strong>Treatment cont’d.</strong></td>
<td>0</td>
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<tr>
<td>26. Resolves countertransference</td>
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<tr>
<td>27. Uses self-disclosure appropriately</td>
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<tr>
<td>28. Terminates appropriately</td>
<td></td>
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<tr>
<td>29. Refers appropriately</td>
<td></td>
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<tr>
<td><strong>Diversity</strong></td>
<td>0</td>
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<tr>
<td>30. Theoretically conceptualizes appropriate interventions for diverse populations</td>
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<tr>
<td>31. Is sensitive to cultural nuances in the treatment relationship</td>
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<tr>
<td>32. Is open to learning about issues relating to diversity applicable to population being served</td>
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<tr>
<td>33. Develops appropriate treatment plan considering cultural and ethnic differences of clients served</td>
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<tr>
<td>34. Directly addresses diversity issues in clinical sessions</td>
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</tbody>
</table>

Please rate the trainee in the following areas and provide examples and explanations for any ‘0’ or ‘1’ given.

0 – frequently observed/experienced
1 – sometimes observed/experienced
2 – occasionally observed/experienced
3 – rarely observed/experienced
4 – never observed/experienced

1. Problematic behaviors: behaviors, attitudes, or characteristics may require remediation but are not perceived as excessive or unexpected for professionals at this level of training._____

2. Impairment: an interference in professional functioning reflected in one or more of the following ways: inability or unwillingness to acquire and integrate professional skills to reach an accepted level of competency and/or inability to control personal stress, psychological dysfunction, or emotional reactions._____

3. Incompetence: lack of ability including professional and/or interpersonal skills and/or academic deficiency._____

4. Ethical misconduct: failure to adhere to and follow the APA Ethical Principles of Psychologists and Code of Conduct._____ 

Briefly describe this trainee’s strength(s):
Briefly describe this trainee’s weakness(es):

What goals should this trainee prioritize?

____________________________________________________

Supervisor’s name (please print)
Supervisor’s signature
Appendix Q cont.

Appendix R1
EVALUATION OF PROGRAM RESOURCES

This form is intended to provide useful feedback about your program site and the overall quality of your experience there. Your responses are confidential unless you choose to review them with your site’s program administrator. Please be frank and provide clarifying comments at the end of this form.

_____________________________________      ___________________________________
Student’s name (please print)                               Site name

___________________________________        _____________________________________
Student’s status/position (i.e., “Practicum I, Clinical Trainee”)              Site location

PROGRAM EVALUATION

Using the scale below, rate each program element as facilitating or inhibiting the fulfillment of your role at the site:

1   –   Very inhibiting
2   –   Somewhat inhibiting
3   –   Neutral
4   –   Somewhat facilitating
5   –   Very facilitating
n/a – Not applicable to my site

1. Staff meetings .................................................................
2. In-service training ............................................................
3. Case conferences/presentations ...........................................
4. Clinical supervision ...........................................................
5. Supervision/direction of program administrator ...........................
6. Physical environment ..........................................................
7. Support materials .............................................................
8. Testing materials (availability, variety, quality) ....................... 
9. Therapeutic materials (quality of toys, dolls, games, manuals, etc.)
10. Clerical support staff ........................................................... 
11. Billing support staff ............................................................
12. Availability of therapy rooms ..............................................
13. Method(s) of room reservations .......................................... 
14. Availability of electronic equipment (video, etc.) .................... 
15. Collegiality of work environment ....................................... 
16. On-call/emergency procedures and materials .......................
17. Training/orientation of new clinicians ------------------------------------------- _______
18. Supportive/encouraging learning environment for diverse students --------- _______
19. Education/training provided around issues of diversity regarding:
   treatment planning --------------------------------------------------------- _______
   treatment relationship ----------------------------------------------------- _______
   interventions ---------------------------------------------------------------- _______
20. Supervisors and/or training director sensitive to diversity issues and respectful of
    persons from diverse populations ----------------------------------------- _______
21. Adequate opportunities both formal and informal for discussion of diversity issues
    ------------------------------------------ ______
22. Supervisors from diverse populations ------------------------------------------ ______

OVERALL EVALUATION OF PROGRAM RESOURCES

Using the scale below, rate each item according to your experience at the site:

1 – Very unsatisfactory, strongly disagree
2 – Unsatisfactory, disagree
3 – Adequate, good, or undecided
4 – Very good, agree
5 – Outstanding, strongly agree

1. Overall rating of program ---------------------------------------------------------- ______
2. Overall program administration ------------------------------------------------------ ______
3. I would recommend this site to other students ---------------------------------------- ______
4. This program should continue to serve as a training site for students ------- ______

ADDITIONAL COMMENTS/SUGGESTIONS

Please print or type any comments or suggestions you have regarding this site.

COMPARISON OF PRACTICUM EXPERIENCE

1. Without considering your current practicum, explain in concrete terms your image of an
   ideal practicum.

2. Without considering your current practicum, explain in concrete terms the worst practicum
   you could imagine.
3. Circle the number below, ‘1’ being the worst and ‘9’ being the ideal, which most accurately reflects your current practicum experience:

1  2  3  4  5  6  7  8  9
Appendix Q cont.

Appendix R2
EVALUATION OF SUPERVISION

This form is intended to provide useful feedback regarding your supervisor’s performance and the overall quality of your supervision. Your responses shall remain confidential unless you choose to review them with your supervisor. Your responses, both verbal and quantitative, are forwarded anonymously in summary form to the program administrator (when more than one student has the same supervisor). Please be frank and provide clarifying comments at the end of this form.

Student’s name (please print)   Site name

Student’s status/position (i.e., “Practicum I, Clinical Trainee”)  

Supervisor’s name  

Date  

Using the scale below, please rate each item according to your supervision experience at this site:

1   –  Very false, never
2   –  Mostly false, seldom
3   –  Undecided, varied
4   –  Mostly true, often
5   –  Very true, always

1. Supervisor’s feedback was direct and straightforward ------------------------- _______
2. Unthinking conformity was encouraged ----------------------------------------- _______
3. Supervision provided useful conceptual framework for understanding clients  --------- _______
4. Distractions and interruptions were rare --------------------------------------- -- _______
5. Mistakes were welcomed as learning experiences ------------------------------ _______
6. Divergent viewpoints were well tolerated --------------------------------------- _______
7. Time was set aside exclusively for supervision --------------------------------- _______
8. Supervisor was direct and non-avoidant ----------------------------------------- _______
9. Exploration of new ideas and therapeutic techniques was encouraged ------- _______
10. Supervisor seemed preoccupied with personal matters ------------------------ _______
11. Practical skills were taught -------------------------------------------------------- _______
12. Supervision meetings were rarely cancelled
13. Praise and encouragement were frequently provided
14. My weaknesses and shortcomings were addressed but not overemphasized
15. Supervisor was open to feedback
16. Subtle devaluation on the basis of gender or ethnicity was present
17. Supervisor was accessible outside of regular schedule
18. Traditional gender stereotype were emphasized
19. Supervisor treated me like a colleague
20. Appropriate emphasis was given to evaluation
21. Adequate and reasonable amounts of readings were suggested
22. Supervisor violated my personal privacy
23. Exploration of personal growth issues was encouraged
24. Supervisor respected value differences between us
25. Supervisor provided a supportive/encouraging learning environment for diverse students
26. Supervisor initiated discussion of diversity issues
27. Supervisor was from a diverse population or offered referrals to diverse supervisors when appropriate
28. Supervisor was well-trained in issues of diversity
29. Supervisor was sensitive and respectful of students from diverse populations

Using the space below, print or type any additional comments and/or suggestions regarding your supervision experience.
Appendix Q cont.

Appendix S
Personal Characteristics Evaluation PCE

a. Course instructors may complete a PCE for each student that they feel that needs one at the end of each semester. Using a 5-point Likert scale, the PCE measures nine (9) personal characteristics essential to the full functioning and development of ethical and competent therapists. A rating of three (3) or higher on each criterion is considered a minimum standard of behavior.

b. Evaluation results are available to students.

c. A three-step mentoring and dismissal policy is available should a problem be identified.

i. The student receives a copy of the PCE and the professor’s comments. A copy is also distributed to the full faculty and is discussed at the subsequent student review meeting. The professor and student then meet to discuss the evaluation and any recommended remediation.

ii. Any student receiving more than one insufficient PCE during a semester must meet with his/her faculty advisor to discuss remediation and/or possible dismissal from the program.

iii. Any student receiving three (3) or more insufficient evaluations in one semester must meet with his/her advisor and two (2) additional faculty members to discuss his/her continuation in the program. Should the committee determine the student’s personal and professional behavior to be inappropriate to the counseling field and detrimental to clients, the student will be dismissed from the program.

iv. All insufficient evaluations and subsequent action become part of the student’s clinical file.
Appendix Q cont.

Appendix T
Intent to Complete Dissertation Proposal Defense and Apply for Internship

Completion of this form serves as notification to the APU Department of Graduate Psychology of the date on which you intend to defend your dissertation proposal. Your proposal defense must be completed in the Fall of the year in which you intend to apply for an internship. Failure to submit this form may result in a one-year delay in the internship application.

Student’s name (please print)   Date of proposal defense
☐ 4-year plan   ☐ 5-year plan   ☐ 6-year plan   ☐ scheduled
☐ passed

Dissertation title

Dissertation chair   Committee member

Committee member

I hereby acknowledge the requirement of APU’s Department of Graduate Psychology that I must successfully defend my dissertation proposal in order to proceed with the application process for a PsyD internship for the succeeding academic year. I recognize that any failure on my part to satisfactorily complete the PsyD curriculum and training requirements may delay my eligibility to begin an internship.

Student’s signature

Date
For office use only

☐ Curriculum review          ☐ Clinical training review
☐ Student advisory letter
☐ Dissertation chair verification          ☐ Dissertation committee notified
☐ Database updated
Appendix Q cont.

Appendix U
List of Internships

The internship provides a capstone experience in which knowledge, skills, and attitudes developed through doctoral education and practicum training are applied in a clinical setting of increased professional responsibility. The internship is a time when the theoretical and the practical come together and your professional identity as a psychologist takes shape. As such, the selection process is an important undertaking; APU strongly encourages you to pursue APA-accredited internships. Using this form, make a complete list of the internships to which you wish to apply. Use additional pages as needed. Bring the completed list to your consultation with Dr. Graham-Howard, who will advise and assist you with the application process.

<table>
<thead>
<tr>
<th>Student</th>
<th>Date</th>
</tr>
</thead>
</table>

Site ___________________________________________ Affiliation status: _____________________
Location ___________________________________________

Site ___________________________________________ Affiliation status: _____________________
Location ___________________________________________

Site ___________________________________________ Affiliation status: _____________________
Location ___________________________________________

Site ___________________________________________ Affiliation status: _____________________
Location ___________________________________________

Site ___________________________________________ Affiliation status: _____________________
Location ___________________________________________

Site ___________________________________________ Affiliation status: _____________________
Location ___________________________________________

Site ___________________________________________ Affiliation status: _____________________
Location ___________________________________________

Site ___________________________________________ Affiliation status: _____________________
Location ___________________________________________

Site ___________________________________________ Affiliation status: _____________________
Location ___________________________________________
Appendix Q cont.

Appendix V
Letters of Recommendation

- Allow at least a month for those you are asking to write recommendations for you to complete their letters.
  - Specify the deadline date by which the letters must be postmarked.

- Provide to each recommender pre-addressed labels and first-class postage to affix to their stationery. APU recommendation letters will be addressed directly on the envelope.

- Provide to each recommender a copy of your vita along with the qualities you want highlighted for each position for which you are applying.

- Provide recommenders with a brief description of the programs you are asking them to write on your behalf. This may allow them to include personal notes such as “remember when we went to school together…” or to emphasize a particular aspect about you that fits their program.

- Because the DCT must send a recommendation letter to each program for which you are applying, you must provide to him/her all of the above information.

- Suggested recommenders are your dissertation chair and/or advisor, one supervisor, and the DCT. Some sites will consider only three (3) letters. Know the requirements of the programs to which you are applying and select your recommenders carefully.

Kindly remind your recommenders one week before the deadline to send your recommendation letter. If they have already sent it, thank them for supporting you. Note: If you “released” your recommenders to send their letters without your reading them, you will not be notified when the letters are sent. However, if you request a copy of each recommendation letter, you will likely know when each letter is sent. There are obvious pros and cons to such requests.
Outline for Recommendation Letters

1. Identify your position and state reason for writing.

2. Basis of your knowledge of this student
   a. Capacity
   b. How long
   c. How well

3. Student’s ability
   a. Academic
   b. Speaking
   c. Writing
   d. Mastery of general psychology
   e. Mastery of clinical psychology

4. Professional skills and potential
   a. Psychological assessment
   b. Therapy skills
   c. Consultation skills
   d. Other
   e. Estimated ability and productivity
   f. Professional potential (relative to other students with whom you have worked)

5. Student’s research
   a. To date
   b. Estimate ability and productivity

6. Personal qualities
   a. Empathy, warmth, and genuineness
   b. Interpersonal relations
   c. Emotional stability
   d. Integrity and moral character
   e. Reliability and responsibility
   f. Creativity
   g. Grooming and appearance
   h. Ethical sensitivity
   i. Professional demeanor

7. Remaining training needs of student (next step, etc.)
8. Special strengths of this student
9. How well you believe this student will perform at an internship

9. Other comments
Appendix Q cont.

Appendix W
# PsyD INTERNSHIP TRACKING FORM

## Direct Services

<table>
<thead>
<tr>
<th>Individual Therapy hours</th>
<th>total</th>
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<tbody>
<tr>
<td>Adults</td>
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<tr>
<td>Adolescents</td>
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<td>School-age</td>
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<td>Pre-school</td>
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<td>Infants/toddlers</td>
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<tr>
<td><strong>Group Therapy hours</strong></td>
<td></td>
</tr>
<tr>
<td>Adults</td>
<td></td>
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<tr>
<td>Adolescents</td>
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<td>Pre-school</td>
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<td>Infants/toddlers</td>
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<tr>
<td><strong>Family Therapy hours</strong></td>
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<td>Couples Therapy hours</td>
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<tr>
<td><strong>Other Direct Services</strong></td>
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<tr>
<td>Consultation</td>
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<td>Presentation/Programming</td>
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<td>Psychodiagnostic testing</td>
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<tr>
<td>Interview/observation-based assmts.</td>
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<tr>
<td>Supervision of other students</td>
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<tr>
<td>Teaching</td>
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<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

## Indirect Services

| Therapy: chart review, consultation w/ professionals | |
| Assmt: chart revw, scor’g, interpret’g, rept. writ’g. | |
| **Supervision** | |
| One-on-one individual supervision | |
| Group supervision | |
| Peer supervision/case conference | |
| In-service training/seminars/classes | |

## Total hours
Appendix Q cont.

Appendix X
VERIFICATION OF INTERNSHIP COMPLETION

________________________________________________ has completed ___________ hours of training at ________________________________________________________

This internship began _____________________________ and was completed on _____________________________ as fulfillment of the requirements of Azusa Pacific University’s PsyD program.

__________________________           ___________________________________
Name of intern

Total number

__________________________           ___________________________________
Name of internship site

__________________________           ___________________________________
Name of supervisor (please print)

Supervisor’s signature

__________________________           ___________________________________
Month        Day        Year
Site

__________________________           ___________________________________
Month        Day        Year
Street

__________________________           ___________________________________
City        State        Zip
Appendix Q cont.

Appendix Y
Clinical Competency Examination

Audiotape Release

I, __________________________________________, do hereby give my permission to the print name.

Azusa Pacific University Department of Graduate Psychology to audiotape my full Clinical Competency Examination such that I, or members of the examination team may review the proceedings. The tape shall be made available to my mentor/advisor should he/she so desire. The audiotape shall remain the property of the Director of Clinical Training until I graduate from the doctoral program, at which time the audiotape shall be destroyed.

________________________________________  __________________________
Signature of student            date
Appendix Q cont.

Appendix Z
This rating form should be used to evaluate the components of clinical competence demonstrated in the written materials as well as the oral exam performance. Each of the first four (4) Roman numerals corresponds to one (1) of the four (4) products:

I. Case Presentation: Therapy tape and transcript
II. Psychological Testing Reports: Child and adult
   III. Vignette examination

The global rating at the end of this form will be used to determine the outcome of the Clinical Competency Examination: “Pass with Distinction,” “Pass,” “Pass with Remediation,” or “Fail.”

Explanation of Rating Scale

1 A rating of “1” represents a serious deficiency. While a single “1” might be sufficient for an outcome of “Fail,” in some instances a “Pass with Remediation” might be appropriate.

2 A rating of “2” represents that improvement is needed in this area. Two (2) or more “2” ratings may result in an outcome of “Fail” or a “Pass with Remediation.”

3 A rating of “3” represents a level of performance which signifies the student’s readiness to apply for a predoctoral internship. It is expected that most students will receive ratings of “3.” A “3” means the student does not need “remediation.” However, suggestions for further professional development may be offered.

4 A rating of “4” represents that the student performed at an outstanding level in that particular area and exceeded the level expected for doctoral students at this level of training.
I. CASE PRESENTATION: THERAPY TAPE AND TRANSCRIPT

A. Relationship skills

[Demonstrates empathic understanding; establishes rapport and shared goals]
Comments:

B. Case conceptualization

[Demonstrates knowledge of theory relating to case; clear treatment goals consistent with conceptualization of case]
Comments:

C. Therapy interventions

[Appropriate to client, clear relationship between theoretical formulation and interventions]
Comments:

D. Process commentary

[Ability to analyze, critique, demonstrate understanding of self as therapist and of therapeutic relationship]
Comments:

E. Inclusion of basic content

[Reason for referral, behavioral observations of client, medical/social psychological history, consultation, referral, treatment plan, diagnosis, findings from formal assessment measures, recommendations, current disposition of the case]
Comments:

OVERALL RATING:
II. PSYCHOLOGICAL TESTING REPORT – CHILD

A. Psychological assessment  1  2  3  4

[Appropriate selection of test instruments for this case; able to provide adequate rationale for
tests included; consultation/collaboration with teachers, parents, etc. for children]

Comments:

B. Test administration and scoring  1  2  3  4

[Uses correct standardization procedures; accurate scoring]

Comments:

C. Test interpretation  1  2  3  4

[Test data support interpretations made by the candidate; can describe the system used and/or
the empirical or theoretical basis for interpretations; appropriate consideration of age and
cultural factors]

Comments:

D. Report writing  1  2  3  4

[Well organized, coherent; integrates results from different instruments; clear presentation of
material; professional attitude communicated; well-integrated summary; data-based
recommendations; five-axis diagnosis]

Comments:

E. Test construction theory  1  2  3  4

[Understands the impact of reliability, validity, and standardization procedures relative to
population tested]

Comments:

OVERALL RATING:  1  2  3  4
II. Cont’d. PSYCHOLOGICAL TESTING REPORT – ADULT

A. Psychological assessment  1  2  3  4

[Appropriate selection of test instruments for this case; able to provide adequate rationale for tests included; consultation/collaboration with teachers, parents, etc. for children]

Comments:

B. Test administration and scoring  1  2  3  4

[Uses correct standardization procedures; accurate scoring]

Comments:

C. Test interpretation  1  2  3  4

[Test data support interpretations made by the candidate; can describe the system used and/or the empirical or theoretical basis for interpretations; appropriate consideration of age and cultural factors]

Comments:

D. Report writing  1  2  3  4

[Well organized, coherent; integrates results from different instruments; clear presentation of material; professional attitude communicated; well-integrated summary; data-based recommendations; five-axis diagnosis]

Comments:

E. Test construction theory  1  2  3  4

[Understands the impact of reliability, validity, and standardization procedures relative to population tested]

Comments:

OVERALL RATING:  1  2  3  4
III. ORAL VIGNETTE  (check for competence)

1. Crisis Evaluation and Intervention:
   a. Noted initial concerns about suicide, assault, abuse
   b. Tied in test date re: concern for suicide, assault, abuse
   c. Gave specifics of how to evaluate and respond
   d. Addressed legal/ethical issues re: crisis (e.g., Tarasoff)

2. Diagnosis:
   a. Connected diagnosis to information provided in vignette
   b. Ruled out possible medical explanation
   c. Considered substance abuse/child abuse
   d. Five-axis diagnosis

3. Assessment and Evaluation:
   a. Made cautionary statements re: cultural background
   b. Discussed psychological test validity, cutoffs for clinical significance
   c. Focused on most global interpretations first
   d. Tied data in with diagnostic considerations
   e. Tied data in with treatment considerations

4. Treatment Planning and Implementation:
   a. Addressed immediate/imminent crisis
   b. Considered client’s needs and goals
   c. Considered community resources
   d. Addressed confidentiality issues
   e. Addressed short-term & long-term goals/treatment

5. Professional Ethics:
   a. Addressed confidentiality in crisis situations
   b. Addressed obtaining informed consent to treatment
   c. Discussed obtaining releases to contact third parties

6. Legal Mandates and Related Issues:
   a. Tied in law relevant to crisis situation
   b. Addressed reporting mandates

7. Limitations and Judgment:
   a. Discussed when to seek consultation/ supervision
   b. Addressed if case would be appropriate for psychotherapy
   c. Addressed whether case could be handled as outpatient
   d. Discussed if client feels a good match with therapist

8. Human Diversity:
a. Addressed issues re: race, religion, sexual orientation, etc.  

b. Considered acculturation problem, if appropriate  
c. Considered cultural background/expectations for therapy  
d. Suggested community resources specific to needs  

OVERALL RATING: 1 2 3 4  

GLOBAL RATING  

Each examiner is to rate the candidate independently at the end of the exam. The examiners should then compare and discuss their ratings and jointly decide on a final rating for the candidate.

Individual Examiner Rating:

_____ Pass with Distinction  
_____ Pass  
_____ Pass with Remediation  
_____ Fail  

Final (Joint) Rating:  

_____ Split vote (one “Fail” -- needs review)  
_____ Pass with Distinction  
_____ Pass  
_____ Pass with Remediation  
_____ Fail  

Formal Feedback to Student  

A separate “Clinical Competency Exam Feedback” form (summary sheet) is provided on which to write any additional feedback, including both strengths and weaknesses that will be incorporated into the formal letter which is sent to the student to notify him/her of the exam result.  

These rating forms go into a permanent file and may be reviewed by the student in the future.  

Remediation Assignments  

The three (3) examiners must describe specific activities and products, using the “Remediation Plan for Clinical Competency Examination” form provided. The student must successfully complete all remediation assignments by a date specified by the Clinical Competency Exam Committee for the “Pass with Remediation” decision to change to a “Pass.” One (1) examiner
must be designated to discuss and evaluate remediation assignments. If there are several
different remediation assignments, examiners may divide the responsibilities.

USEFUL LINKS

California Psychology Internship Licensure Requirement: www.psychboard.ca.gov/
www.psychboard.ca.gov/licensee/instructions.pdf

National Register Criteria for Psychologists: www.nationalregister.org
Student/Trainees>Education and Training Standards

Professional Psychotherapy Never Includes Sex:
www.psychboard.ca.gov/formspubs/proftherapy.pdf
Appendix R
Northwestern University: The Family Institute
Applying for a Fellowship
Postdoctoral Clinical Scholar Fellowship Application
Postdoctoral Clinical Research Fellowship Application
Postdoctoral Clinical Scholar Fellowship Application

Below are the application materials necessary for the Postdoctoral Clinical Scholar Fellowship. Please follow the instructions below.

Applicants should:
1. Complete the Postdoctoral Clinical Scholar Fellowship Application.
2. Submit a cover letter which should describe why you are applying for this fellowship and how you feel this fellowship fits in with your career plans.
3. Submit a curriculum vita which should include information about your clinical training experiences, including employment and education history, as well as any publications, presentations and memberships in professional organizations.
4. Submit transcripts of all graduate work. Transcripts should be official, sealed copies, enclosed in a sealed envelope from the school's registrar.
5. Submit three sealed letters of recommendation that should come from individuals who have or have had direct knowledge of your clinical performance and be able to evaluate it. Sealed letters from the recommender can be sent from the applicant, directly from the recommender, or can be e-mailed from the recommender. For the Postdoctoral Clinical Scholar Fellowship, at least one letter must be from someone who has supervised your clinical work. See Guidelines for Postdoctoral Clinical Scholar Fellowship Letters of Recommendation.

Application documents can be submitted together in one package or can be sent as separate items as they are available. All documents must be postmarked by January 30, 2015.

Send application documents for the Postdoctoral Clinical Scholar Fellowship to:

Anthony Chambers, PhD, ABPP  
Director, Postdoctoral Fellowship Program  
The Family Institute at Northwestern University  
618 Library Place  
Evanston, Illinois 60201  

Questions about the Postdoctoral Clinical Scholar Fellowship should be directed to Dr. Anthony Chambers, ABPP, at a-chambers@northwestern.edu.

Applications for the Postdoctoral Clinical Scholar Fellowship will be accepted beginning October 1, 2014 and **completed applications are due by January 30, 2015**. An application is considered to be complete when all required application documents have been received by The
Family Institute at Northwestern University. Applications received after this date may not be considered for the current year. After the application has been reviewed, qualified candidates will be invited to interview. Interviews will be held in February. All applicants will be notified by letter of the faculty's decision as quickly as possible.

The Family Institute at Northwestern University actively seeks applicants from underrepresented racial and ethnic groups so that our body of students, fellows, faculty and staff will more closely reflect the diversity of American society. Furthermore, The Family Institute is committed to broad inclusiveness and affording equal opportunity to all without regard to age, gender, race, ethnicity, national origin, religion, socioeconomic background, sexual orientation or physical ability.

---

**Postdoctoral Clinical Research Fellowship Application**

Please follow the instructions below.

1. Submit a cover letter which should describe why you are applying for this fellowship and how you feel this fellowship fits in with your career plans.

2. Submit a curriculum vita which should include information about your research and clinical training experiences, including employment and education history, as well as any publications, presentations and memberships in professional organizations.

3. Submit transcripts of all graduate work. Transcripts should be official, sealed copies, enclosed in a sealed envelope from the school's registrar.

4. Submit three sealed letters of recommendation. Persons writing letters of recommendation must have or have had direct knowledge of your clinical and/or research performance and be able to evaluate it. At least one letter of recommendation must be from someone who has supervised your research work and one letter of recommendation must be from someone who has supervised your clinical work. Each letter of recommendation should be submitted in a sealed envelope with their signature across the seal.

Application documents can be submitted together in one package or can be sent as separate items as they are available.

To ensure that your application receives full consideration, all application materials must be received by January 30, 2015. After the application has been reviewed, qualified candidates will be contacted for a phone interview, and finalists will be invited to give a colloquium and interview with pertinent faculty members.

Send application documents for the Postdoctoral Clinical Research Fellowship to:

Anthony Chambers, PhD, ABPP  
Director, Postdoctoral Fellowship Program  
618 Library Place  
Evanston, Illinois 60201  
847-733-4300, ext. 312  
Questions about the Postdoctoral Clinical Research Fellowship should be directed to Dr. Anthony Chambers, ABPP, at a-chambers@northwestern.edu.
The Family Institute at Northwestern University actively seeks applicants from underrepresented racial and ethnic groups so that our body of students, fellows, faculty and staff will more closely reflect the diversity of American society. Furthermore, The Family Institute is committed to broad inclusiveness and affording equal opportunity to all without regard to age, gender, race, ethnicity, national origin, religion, socioeconomic background, sexual orientation or physical ability.

**Evaluation Forms: Family Institute**  
**Northwestern University**

| T H E *F a m i l y I N S T I T U T E*  
| Director’s Evaluation of Postdoctoral Fellow |
| --- | --- |
| Director: | Date: |
| Fellow: | Fellowship Year: |

1. Has the Fellow attended required program meetings, clinical services meetings, STIC training sessions, couples seminars, core courses, grand rounds, and other meetings geared toward the fellow’s specialty?

- [ ] Below Expectations  
- [ ] At times Below Expectations  
- [ ] Meets expectations  
- [ ] Exceeds Expectations

Comment:

2. What was the quality of the Grand Rounds Presentation?

- [ ] Below Expectations  
- [ ] At times Below Expectations  
- [ ] Meets expectations  
- [ ] Exceeds Expectations

Comment:

3. Did the Fellow develop and actualize a professional development plan?

- [ ] Below Expectations  
- [ ] At times Below Expectations  
- [ ] Meets expectations  
- [ ] Exceeds Expectations
| Comment:                                                                                     |
|                                                                                           |

| Fellow Signature: | Date: |
| Date:             |

| Director’s Signature: | Date: |
| Date:                |

### THE Family INSTITUTE

**Fellow Evaluation of Group Supervisor Form**

| Supervisor: | Date: |
| Fellow:     | Fellowship Year: |

1. How satisfied were you with your supervision overall?

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<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
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<tr>
<td>Very Satisfied</td>
<td>Satisfied</td>
<td>Neutral</td>
<td>Dissatisfied</td>
<td>Very Dissatisfied</td>
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2. How satisfied were you with your experience with this supervisor?

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<tr>
<td>Very Satisfied</td>
<td>Satisfied</td>
<td>Neutral</td>
<td>Dissatisfied</td>
<td>Very Dissatisfied</td>
</tr>
</tbody>
</table>

3. My supervisor provided clear feedback on my work.

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<th>2</th>
<th>1</th>
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<tbody>
<tr>
<td>Always</td>
<td>Usually</td>
<td>Occasionally</td>
<td>Rarely</td>
<td>Never</td>
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</table>

4. My supervisor used empirical data to support an empirical approach to cases.

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<tr>
<td>Always</td>
<td>Usually</td>
<td>Occasionally</td>
<td>Rarely</td>
<td>Never</td>
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</table>

5. My supervisor utilized STIC data in supervision.
6. My supervisor required the viewing of videotapes, the listening of audiotapes in supervision, or use of “Live Supervision.”

7. My supervisor created an atmosphere that promoted safe and healthy expression of ideas and feelings.

8. My supervisor met with me consistently on a weekly basis and was on time for supervision.

9. My supervisor collaborated with me to help me achieve my learning goals.

10. How satisfied were you with your supervisor when you reached out to them by phone/email with questions or concerns?

11. My supervisor made sure that I was on top of required clinic and supervision paperwork.

12. My supervisor ensured the fair usage of time in supervision.
13. How satisfied were you with your supervisor’s ability to manage and process the group dynamics within the supervision group?

<table>
<thead>
<tr>
<th>Very Satisfied</th>
<th>Satisfied</th>
<th>Neutral</th>
<th>Dissatisfied</th>
<th>Very Dissatisfied</th>
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</table>

Please provide any additional comments about your supervision experience that was not covered by the questions:

Fellow Signature

<table>
<thead>
<tr>
<th>Supervisor:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Fellow:</td>
<td>Fellowship Year:</td>
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</table>

1. Has the Fellow been open to the supervision process and been willing to accept feedback on therapy process and to explore difficulties in supervision in a non-defensive manner?

- [ ] Below Expectations
- [ ] At times Below Expectations
- [ ] Meets expectations
- [ ] Exceeds Expectations

Comment:
<table>
<thead>
<tr>
<th>2.</th>
<th>Does the Fellow exhibit competency in systems theory including the use of Integrated Problem Center Metaframeworks (IPCM)?</th>
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<td>☐ Below Expectations</td>
<td>☐ At times Below Expectations</td>
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<td>Comment:</td>
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<th>3.</th>
<th>Has the Fellow made a concerted effort to bring in raw data to supervision (i.e., STIC data, audio, video, live interviews)?</th>
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<td>☐ Below Expectations</td>
<td>☐ At times Below Expectations</td>
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<td>Comment:</td>
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<th>4.</th>
<th>Does the Fellow provide constructive feedback and support to peers?</th>
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<td>☐ Below Expectations</td>
<td>☐ At times Below Expectations</td>
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<td>Comment:</td>
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<th>5.</th>
<th>Does the Fellow demonstrate appropriate clinical skills and judgment?</th>
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<td>☐ Below Expectations</td>
<td>☐ At times Below Expectations</td>
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<td>Comment:</td>
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6. Does the Fellow complete all clinical record keeping in a timely manner?

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<th>Option</th>
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<td>Below Expectations</td>
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<td>Meets expectations</td>
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<td>Exceeds Expectations</td>
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Comment:

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<th>Fellow Signature:</th>
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<th>Supervisor’s Signature:</th>
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Additional Comments:

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**THE Family Institute**

**Research Fellow Evaluation of Research Supervisor Form**

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<th>Fellow:</th>
<th>Fellowship Year:</th>
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1. How satisfied were you with your overall research experience with this supervisor?

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<th>Always</th>
<th>Usually</th>
<th>Occasionally</th>
<th>Rarely</th>
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2. Did you find your supervisor to be supportive and nurturing of your career?

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3. My supervisor was knowledgeable in research methods and statistics

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4. Did your supervisor help you achieve your publishing goals?
   5   4   3   2   1
   Always  Usually  Occasionally  Rarely  Never

5. Was your supervisor fair and transparent with co-authorship on publications?
   5   4   3   2   1
   Always  Usually  Occasionally  Rarely  Never

6. My supervisor created an atmosphere that promoted safe and healthy expression of ideas and feelings
   5   4   3   2   1
   Always  Usually  Occasionally  Rarely  Never

7. My supervisor collaborated with me in helping me achieve my career goals.
   5   4   3   2   1
   Always  Usually  Occasionally  Rarely  Never

8. How comfortable were you reaching out to your supervisor by phone/email with questions and concerns?
   5   4   3   2   1
   Always  Usually  Occasionally  Rarely  Never

9. Did your supervisor appropriately balance guidance with freedom to become an independent researcher?
   5   4   3   2   1
   Always  Usually  Occasionally  Rarely  Never

10. How satisfied were you that you increased your research knowledge and ability as a researcher under this supervisor?
    5   4   3   2   1
    Always  Usually  Occasionally  Rarely  Never

11. My supervisor created a fair, non-competitive, and supportive research lab environment.
    5   4   3   2   1
    Always  Usually  Occasionally  Rarely  Never

12. My supervisor appreciated the research knowledge and experience I bring to this post-doctoral fellowship.
    5   4   3   2   1
    Always  Usually  Occasionally  Rarely  Never

Please provide any additional comments about your supervision experience that was not covered by the questions:
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4. **How is the fellow’s writing and scholarly productivity?**

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**Comment:**

5. **How is the fellow’s project management ability?**

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**Comment:**

**Fellow Signature:**  
**Date:**

**Supervisor’s Signature:**  
**Date:**

**Additional Comments:**
Appendix S
Division 43 Demographic Data
Table 1
Demographic Characteristics of Division 43 Members by Membership Status, 2014

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Source: 2014 APA Directory. Compiled by Center for Workforce Studies
# Educational Characteristics of Division 43 Members by Membership Status, 2014

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Source: 2014 APA Directory. Compiled by Center for Workforce Studies
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Table 4
Employment Characteristics of Division 43 Members by Membership Status, 2014

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Source: 2014 APA Directory and Employment Update. Compiled by Center for Workforce Studies
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Appendix T
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<th>Diversity Areas and specific specialties (e.g. race, SES, LGBT, gender, religion, etc.)</th>
<th>Theoretical Orientation(s)</th>
<th>Research and/or Practice?</th>
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<td>Graduate students</td>
<td>incl. specific faculty initials and their c/f diversity specialties</td>
<td>incl. specific faculty initials and their c/f diversity specialties</td>
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<tr>
<td>Phone: (848) 445-3922 Email: <a href="mailto:skelly@scarletmail.rutgers.edu">skelly@scarletmail.rutgers.edu</a></td>
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<td>Azusa Pacific University</td>
<td>Clinical Psy.D</td>
<td>Graduate Students</td>
<td>Emphasis in religion- Christianity, Diversity core Cheung: research in family psychology and multicultural psychotherapy, expertise in family therapy and psychology, &amp; interest in immigrant mental health;</td>
<td>Systems theory</td>
<td>Both</td>
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<td>Biola University</td>
<td>Clinical Psy.D and Ph.D</td>
<td>Graduate Students</td>
<td>Diversity as part of program goals and objectives, religion- Christianity. ABM: research family and child/adolescent issues, how cultural and racial factors influence identity development and mental health</td>
<td>Christian integrative</td>
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<td>University</td>
<td>Clinical Ph.D.</td>
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<td>Ph.D.</td>
<td>Cognitive Behavioral Therapy, Psychodynamic Therapy, Family Systems, Differentiation Family and Couples Therapy</td>
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<td>Alliant University of Los Angeles</td>
<td>Clinical Ph.D. Marital and Family Therapy</td>
<td>Clinical Ph.D. All. Regan: sex, intimacy and relationship problems; differentiation-based couple therapy; differentiation and sexual satisfaction assessment; couple therapy effectiveness</td>
<td>Multicultural community – clinical psychology emphasis, gives special attention to the cultural and sociopolitical context of individuals, families, and communities.</td>
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<td>MFT Psy.D.: Couples and Family therapy emphasis</td>
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<td>Clinical Psy.D.: Family/Child and Couple therapy</td>
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<td>Dooman: Couples and family therapy from a differentiation perspective; couples and couples</td>
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<td>Hye-Sun: Therapy with minority couples and families, and couple relationships including trans- and intracultural/racial couple</td>
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<td>families dealing with critical/chronic illness or physical disability</td>
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<td>relationships, dating, and marriage</td>
<td>Clinical Psy.D.: Multicultural-Community clinical psychology emphasis</td>
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<td>5. Alliant University of San Diego</td>
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<tr>
<td>Alba Nino</td>
<td>Dorian: Couple and family therapy, family stress and resilience, couple and family diversity, family caregivers of the mentally ill; intimacy</td>
<td>Nino: immigrant families and immigrant therapists, Diversity and social justice in Couple and Family Therapy</td>
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<tr>
<td>Phone: (858) 653-4708</td>
<td>International emphasis (Also have courses that incorporate family and couples in them)</td>
<td>Clinical Psy.D.- Multicultural and</td>
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<tr>
<td>Marina Dorian</td>
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<tr>
<td>Phone: (858) 653-4630</td>
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<tr>
<td>Email: <a href="mailto:mdorian@alliant.edu">mdorian@alliant.edu</a></td>
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<td>6. Alliant University of San Francisco</td>
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<td>Multicultural emphasis; Multicultural study, LGBT Psychology</td>
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<td>Cognitive Behavioral Therapy, Psychodynamic Therapy, Family Systems</td>
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<td>Casey: Adolescent development within diverse family and school contexts; multicultural and bicultural identity; measurement of identity; women's issues</td>
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<td>Multicultural emphasis, specialties in Latin American Family therapy</td>
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<td></td>
<td>Hsieh: Cultural competency, minority issues</td>
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<td></td>
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<td>Asian-American families and couples in therapy</td>
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<tr>
<td>UCLA</td>
<td>Clinical Ph.D.</td>
<td>Diversity emphasis, ASL: mental healthcare for Asian American families, culture and child psychopathology, parent-child relations in immigrant families</td>
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<td>Families</td>
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<td>Child psychopathology and treatment, cognitive-behavior therapy, clinical assessment, adult psychopathology and treatment, family processes, assessment and intervention</td>
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</table>

Shannon Casey
Phone: (415) 957-2113
Email: slcasey@alliant.edu

Alexander Hsieh
Phone: (916) 561-3213
Email: ahsieh@alliant.edu

Anna S. Lau
Phone: (310) 206-5294, 206-5363

http://www.alliant.edu/cuppp/programs-degrees/clinical-
psychology/clinical_phd_san-francisco/strength_areas.php

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<td>Email: <a href="mailto:slau@psych.ucla.edu">slau@psych.ucla.edu</a></td>
<td>9. Palo Alto University</td>
<td>Clinical Ph.D</td>
<td>Graduate Students</td>
<td>All</td>
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<td><a href="http://www.paloalton.edu/graduate-programs/phd-programs/phd-clinical-psychology">http://www.paloalton.edu/graduate-programs/phd-programs/phd-clinical-psychology</a></td>
<td>Diversity and community mental health concentration; LGBTQ psychology concentration; plus faculty specialty in couples</td>
<td>Cognitive Behavioral Therapy, Psychodynamic Therapy</td>
<td>Both</td>
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<tr>
<td>Kimberly Balsam</td>
<td>KB: LGBT psychology, women and gender, same-sex and heterosexual couples</td>
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<tr>
<td>Phone: (650) 417-2021</td>
<td>Email: <a href="mailto:kbalsam@paloalton.edu">kbalsam@paloalton.edu</a></td>
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<td>10. Pepperdine University</td>
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<td>All: a lot of faculty specialization in</td>
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<td><a href="https://gsep.pepperdine.edu/about/people/faculty/?faculty=shelly_harrell">https://gsep.pepperdine.edu/about/people/faculty/?faculty=shelly_harrell</a></td>
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<tr>
<td>Shelley Prillerman Harrell</td>
<td>couples and family</td>
<td>multicultural and community psychology, racism and mental health, couples and relationship issues, multicultural competence, and African American mental health. Research focuses on the development of strengths-based community and clinical interventions with diverse populations.</td>
<td></td>
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</tr>
<tr>
<td>Phone: No phone number but try Cheryl Saunders, Program Administrator (866) 568-5461 or (310) 568-5607 Email: <a href="mailto:shelley.harrell@pepperdine.edu">shelley.harrell@pepperdine.edu</a></td>
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<td>11. UC Santa Barbara</td>
<td>Counseling Ph.D, Clinical Ph.D</td>
<td>Graduate Students</td>
<td>Family and Children; A lot of courses</td>
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<td>Diversity emphasized in coursework such</td>
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<td>Psychopathology, systems theory</td>
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<td>Counseling-Clinical Ph.D.</td>
<td>dealing with family and children intervention</td>
<td>as counseling LGBT clients and racial/ethnic minority counseling intervention</td>
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<tr>
<td>Collie Conoley</td>
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<td><strong>Conoley</strong>: Family dynamics of diverse populations; Psychosocial interventions for families; School-family partnerships and parent education; Cross-cultural counseling; Cultural influences on development; Effects of racism and classism on teaching and learning; Multicultural counseling process and outcome</td>
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<td>12. University of</td>
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<td>Research</td>
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<td>Massachusetts Amherst</td>
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<td>Child, Adolescent, and Family clinical psychology</td>
<td>work in Diverse population, Research specialties in race, ethnicity, social, and LGBT</td>
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<td>Jenkins: sociocultural factors, such as race, ethnicity, gender, and social class, shape the mental health and family relationships of parents and their children</td>
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<td>13. William James College</td>
<td>Clinical Psy.D</td>
<td>Graduate Student</td>
<td>Families; Specific specialties in Children and Families of Adversity and Resilience</td>
<td>Diversity emphasized; Specialty in Latino Mental Health, Louis: ethnically-diverse children, adolescents, and families with histories of trauma, chronic diseases, and behavioral and emotional challenges</td>
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<td>Gemina St Louis</td>
<td>Phone: Email: <a href="mailto:gemina_stlouis@williamjames.edu">gemina_stlouis@williamjames.edu</a></td>
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<td>14. Binghamton University, State University of New York</td>
<td>Clinical Psychology Ph.D</td>
<td>Graduate students</td>
<td>All</td>
<td>Diversity emphasized; Johnson: research interest in changes in</td>
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<td><a href="https://www.binghamton.edu/psychology/people/mjohnson.html">https://www.binghamton.edu/psychology/people/mjohnson.html</a></td>
<td>Matthew D. Johnson</td>
<td>Phone: 607-777-6315 Email: <a href="mailto:mjohnson@binghamton.edu">mjohnson@binghamton.edu</a></td>
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<tr>
<td>15. Stony Brook University, State University of New York</td>
<td>Clinical Psychology Ph.D</td>
<td>Graduate Students</td>
<td>All</td>
<td>Diversity emphasized JD: specialization with LGBT issues, and relationships.</td>
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<th>Clinical Psychology Ph.D.</th>
<th>Graduate Students</th>
<th>Emphasis on Diversity in Courses</th>
<th>Psychodynamic and Systems Theories</th>
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<td>16. Chestnut Hill College</td>
<td>Clinical Psychology Ph.D.</td>
<td>All: couple/marriage and family therapy</td>
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<td>Psychodynamic and systems theories</td>
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<td>Browning: Treating Diverse Families</td>
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<td>Garcia-Leeds: family dynamics and diversity</td>
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<td>Scott Browning</td>
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<td>Claudia Garcia-Leeds</td>
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<td>Email: <a href="mailto:GarciaLeedsC@chc.edu">GarciaLeedsC@chc.edu</a></td>
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<td>17. University of South Carolina</td>
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<td>Children, Adolescents and Families</td>
<td>Emphasis on Social and Cultural Aspects of Health, diversity, concentrations in African American and Latino communities Faculty specialization</td>
<td>Psychosocial intervention</td>
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<td>Shauna M. Cooper</td>
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<td>Cooper: AA families Lorenzo-Blanco: Latino youth and families</td>
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</tr>
<tr>
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Email: smcooper@sc.edu
http://psych.sc.edu/claurenzo-blanco

Elma Lorenzo-Blanco
lorenzob@gmail.com
http://www.psych.sc.edu/faculty/Suzanne_Swan

Suzanne Swan
Phone: (803) 777-2538
Email: dsuzanne.swan@gmail.com
http://www.psych.sc.edu/faculty/Dawn_Wilson

Dawn K. Wilson
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<td>James Brooks</td>
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<td>Phone: (615) 963-5141</td>
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<td>Email: <a href="mailto:Jbrooke42@tnstate.edu">Jbrooke42@tnstate.edu</a></td>
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<tr>
<td>19. Texas Woman's University</td>
<td>Counseling Psychology Ph.D</td>
<td>Graduate Students</td>
<td>All</td>
<td>Emphasis on multicultural psychology, plus faculty specialization in family and gender issues</td>
<td>Individual, Systemic, Integrative theories,</td>
<td>Both</td>
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<td><a href="http://www.twu.edu/psychology-philosophy/counseling-psych-philmission.asp">http://www.twu.edu/psychology-philosophy/counseling-psych-philmission.asp</a></td>
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<td>Sally D Stabb</td>
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<td>Phone: (940) 898-2301</td>
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<td>Email: <a href="mailto:SStabb@email.twu.edu">SStabb@email.twu.edu</a></td>
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<tr>
<td>22. American School of Professional Psychology</td>
<td>Clinical Psychology Psy.D</td>
<td>Graduate Students</td>
<td>All; Faculty specialization; Couple and Family Therapy</td>
<td>Diversity emphasized, faculty specialization in refugee and immigrant mental health and LGBT issues</td>
<td>Psychotherapy integration</td>
<td>Practice</td>
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<td><a href="http://clinicalargosy.edu/locations/washington-dc/clinical-psychology-doctor-of-psychology">http://clinicalargosy.edu/locations/washington-dc/clinical-psychology-doctor-of-psychology</a></td>
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<td>20. Washington State University</td>
<td>Clinical Psychology Ph.D</td>
<td>Graduate students</td>
<td>All; Child and Adolescent Psychology; Strand: parent-child coordination; development and communication within families; research interest in social skills development and school readiness of children from culturally and linguistically diverse backgrounds.</td>
<td>Diversity emphasized, plus faculty specialization in diversity issues and LGBT</td>
<td>Psychotherapy</td>
<td>Both</td>
</tr>
</tbody>
</table>

Paul Strand
Phone: (509) 372-7177
Email: pstrand@tricity.wsu.edu

21. University of Washington
http://faculty.washington.edu/scheryan/cv.htm
Sapana Cheryan
Phone: (206) 543-5688
Email: scheryan@uw.edu

Clinical Psychology (Ph.D)
Graduate students
All; Clinical child track with some focus on family
Diversity emphasized, plus faculty specialization in gender, and stereotypes
Cheryan: gender, and issues with stereotypes
Cognitive-behavioral | Both |

22. Seattle Pacific University
https://spu.edu/depts/spfc/clini

Clinical Psychology (Ph.D)
Graduate Students
All
Diversity emphasized, plus faculty specialization in family psychology and human sexuality
Biopsychosocial | Both |
<table>
<thead>
<tr>
<th>Institution</th>
<th>Program/ specialization</th>
<th>Level</th>
<th>Emphasis</th>
<th>Other Focuses</th>
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<tr>
<td>23. University of Wisconsin, Madison</td>
<td>Counseling Psychology (Ph.D)</td>
<td>Graduate School</td>
<td>All</td>
<td>Diversity emphasized, plus faculty specialization in LGBT and their emotions. Quintana: ethical issues in families and children</td>
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<tr>
<td>Steve Quintana</td>
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<td>24. University of Wisconsin, Milwaukee</td>
<td>Clinical Psychology (Ph.D)</td>
<td>Graduate Students</td>
<td>All</td>
<td>Diversity and multicultural psychology emphasized, plus faculty specialization in LGBT issues Martell: LGBT issues</td>
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<td>Cognitive-behavioral behavior analytic</td>
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<tr>
<td>Christopher R. Martell</td>
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<tr>
<td>25. Wisconsin School of Professional Psychology</td>
<td>Clinical psychology (Ph.D)</td>
<td>Graduate students</td>
<td>All</td>
<td>Diversity emphasized, plus faculty specialty</td>
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<td>Assessment and psychotherapy of secondary importance</td>
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<td>Both</td>
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<td>Program</td>
<td>Students</td>
<td>Diversity and Multicultural Issues Emphasized</td>
<td>Specialties</td>
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<tr>
<td>26. Marquette University</td>
<td>Counseling Psychology</td>
<td>Graduate students</td>
<td>Diversity and multicultural issues emphasized, plus faculty specialty in multicultural issues and LGBT issues</td>
<td>AWD: multicultural issues and LGBT issues</td>
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<td>(Ph.D.)</td>
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<td>27. Marshall University</td>
<td>Clinical Psychology</td>
<td>Graduate Students</td>
<td>Emphasis on diversity; Faculty specialty in Racial Identity, Multicultural Competency, and Black Families</td>
<td>Integrative behavioral, cognitive behavioral, and psychodynamic</td>
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<tr>
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<td>(Psy. D)</td>
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</tbody>
</table>

Daniela Jaramillo
(414) 464-9777
No email, but try
DirectorOfClinicalTraining@wvpp.edu

Alan W. Burkard, Ph.D.
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http://www.marshall.edu/psych/programs/psyd-program/

http://www.marshall.edu/psych/facultystaff/

http://www.marquette.edu/psych/graduate_overview.shtml

http://www.marquette.edu/education/faculty_staff/alan_burkard.shtml

http://wvpp.edu/wvpp/goals-objectives

http://wvpp.edu/wvpp/faculty-listing/daniela-jaramillo