

8-6-2013

Perceptions and Practices in MFT Educational Reform

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Abstract

Perceptions and Practices in MFT Educational Reform

Louisa Kimball Baker, PhD

University of Connecticut, 2013

National calls began more than sixty years ago to address the gap between the therapeutic services clients need and the quality of care they receive. In the last decade, the Marriage and Family Therapy (MFT) profession has begun to address those calls by instituting a shift from an input- to an outcome-based educational paradigm in its Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) accredited training programs. This dissertation study asked program directors and clinical faculty ($n = 111$) from those programs to: (a) describe the larger context for the educational reform; (b) discuss their program's efforts to address the required changes; (c) critique their efforts to date; and (d) indicate interest in collaborative efforts within and across professions. An exploratory mixed methods design was used to gather participant feedback. Quantitative data were analyzed using a descriptive statistics design; qualitative data were coded using an iterative content analysis procedure to triangulate quantitative findings. Results suggest the majority of educators do not have a strong understanding of the historical reform context. Many feel unprepared and unsupported to make programmatic changes. Efforts to identify, operationalize, implement, evaluate, and revise competencies have been done with little to no collaboration across programs or with other disciplines, a finding consistent with previous research (e.g., Hoge, Tondora, & Marrelli, 2005). Despite educators' stated desire for access to resources, however, only one participant demonstrated active interest in a collaborative, interdisciplinary post-dissertation website.

Perceptions and Practices in MFT Educational Reform

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B.A., Johns Hopkins University, 2003

M.A., University of Connecticut, 2008

A Dissertation

Submitted in Partial Fulfillment of the

Requirements for the Degree of Doctor of Philosophy

at the

University of Connecticut

2013

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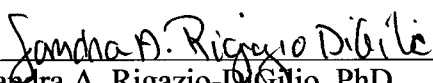
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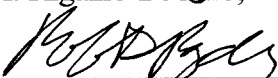
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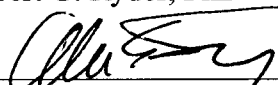
Perceptions and Practices in MFT Educational Reform

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Acknowledgements

Just as it takes a village to raise a child, that same village is needed to complete a dissertation. This work could not have been done without the patience, expertise, and guidance of my major advisor, Sandra Rigazio-DiGilio. I cannot say enough about her to describe my admiration for her, both professionally and personally. I am grateful for all she has done for me, shown me, and taught me during our time together. I also would like to acknowledge the impact of Robert Ryder and Doris LaPlante, as their ideas, feedback, and support shaped this project and my studies over my time at the University of Connecticut. Allen Ivey's expertise, experience, and kindness have been likewise been fundamental for my growth and progress and I'm grateful for his willingness to engage with my efforts later in the process. I could not have conceived of a better advising team to help me understand and explore my interests. I am grateful to Kenna Thurston for her skills, her valuable feedback, and her interest in seeing this project through to its completion. I am also appreciative of Clark Guo for his unfailing optimism and thorough, thoughtful consultation.

I also need to acknowledge the impact of some special people outside of the university who have provided emotional and intellectual counsel over the years. First, my husband and partner in crime: Michael Baker. Many spirited discussions to strategize about various aspects of the project have deepened my respect for his wisdom and intelligence. I thank my children, Liam and Baby-As-Yet-Unnamed Baker, for making me laugh and helping me remember why I work. I am grateful to my parents and sister, Miriam, Peter, and Alexandra Kimball, for their continued interest in my work and support of all of my crazy ideas. Finally, I want to acknowledge the importance of my friendship with Rina Farber-Mazor. Without her perspective, feedback, and reframes, I would have stopped long ago. Thank you all.

Dedication

This is dedicated to my family.

Thank you for your love, support, and inspiration to keep moving forward.

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Chapter 1: Introduction

For well over half a century, the US and Canada have experienced shifting demographics, increasing psychological distress and disorder, and growing disparities in the access to quality and relevant mental health services. Such circumstances have prompted calls to decrease the widening gap between the mental health services clients need and deserve and the quality of care they actually receive. Despite these calls, the mental health care system, particularly in the US, remains ill-equipped to meet the needs of individuals and families facing the most chronic and severe mental health conditions and the needs of underrepresented and underserved populations (Hoge et al., 2007; Jackson, 1999; New Freedom Commission on Mental Health, 2003; Takeuchi, 2002; Takeuchi & Uehara, 1996; US Center for Mental Health Services, 2000; US D.H.H.S., 2001).

Included among a host of clinical, cultural, contextual, socio-economic, political, and institutional factors contributing to this state of affairs is the lack of attention being given to the international call for social service professions to effectively transform scientist/practitioner preparation programs from input-based to outcome-based training (Chenail, 2009; Nelson & Smock, 2005). This call is intended to ensure that mental health professionals develop the competencies necessary to establish clinically and culturally relevant mental health care delivery systems for all citizens (Hoge, Tondora, & Marrelli, 2005; Jackson, 1999; Takeuchi, 2002).

Even though these calls have been accompanied by an infusion of strategies, resources, and procedures to guide social service professions' informed efforts to address the need for educational reforms, it is still the case that these professions have been slow to address this call and have not given sufficient attention to the core recommendations necessary to do so (Hoge et al., 2007). Two core recommendations are specific to this study: (a) engaging in interdisciplinary

collaboration; and, (b) becoming informed by principles, definitions, and models of competence that have evolved through years of research and application within many disciplines (e.g., Annapolis Coalition, 2006a; 2006b; New Freedom Commission, 2003).

The failure to heed these two particular recommendations serves – in part – to explain our current state of affairs. For example, regarding the call for interdisciplinary collaboration, a careful review of efforts across professions reveals that competency development has been highly variable and primarily independent. As a result, efforts to move toward outcome-based training resemble a “patchwork quilt of initiatives that have been conducted independently [and that are] somewhat variable in content, reflecting the unique history, purpose, and processes employed in these diverse efforts” (Hoge, Paris, et al., 2005, p. 595).

The consequences of the historical divide that continues to encourage pioneering work within one mental health profession to go unnoticed by others and to discourage opportunities to collaborate and build on such work has significant implications, as highlighted by recent evaluations of advancements within each discipline (e.g., Hoge, Paris, et al., 2005). These evaluations indicate: (a) significant similarities in competencies identified across disciplines, with little reference to the interdisciplinary knowledge base that could be used to advance this work more expeditiously; and, (b) minimal evidence of progress in developing competencies that can be operationalized, achieved, and demonstrated with reliability, validity, and utility.

Concomitantly, the failure to draw on well-established models of competency development has resulted in professional competency sets that are generally considered too comprehensive and idealistic to be achievable by the typical student, practitioner, or educator (Hoge, Paris, et al., 2005; Storm, Todd, Sprenkle, & Morgan, 2001). As a result, these competencies have yet to be sufficiently incorporated into scientist/practitioner preparation

programs (Commission on Accreditation for Marriage and Family Therapy Education, 2008) or credentialing venues (Shaw, 2008). This makes it less likely that work on competencies will actually address the gap between the mental health needs of individuals and families living within today's intercultural society and the professional competencies of our nation's mental health care delivery system (Hoge, Paris, et al., 2005).

While it is commonly acknowledged that interdisciplinary collaboration would facilitate efforts within the United States' five core mental health professions to identify, define, and assess common or core competencies with some degree of reliability, and validity, efforts to collaborate have not been implemented on a wide scale (e.g., Hoge, Paris, et al., 2005). Additionally, while it is commonly recognized that social service disciplines do not have the scope of knowledge or existing competency models necessary to take on this task, systematic efforts to draw from such knowledge bases and models in ways that inform each profession's development of core competencies have yet to be advanced in ways that have made it possible to directly infuse viable competences into the goals and objectives of scientist/practitioner preparation programs (e.g., Hoge, Paris, et al., 2005). This is clearly evident in trans-disciplinary comparative evaluations that indicate the ways in which these two circumstances have contributed to the lag in knowledge advancements regarding the multilayered competencies that mental health care delivery systems must possess to improve the accessibility and quality of health care to all of America's citizens (Abreu, Chung, & Atkinson, 2000; Carter, 2005; Hoge, Tondora, & Marrelli, 2005; Pedersen, 2008; Ponterotto, Utsey, & Pedersen, 2006; Pope-Davis, Coleman, Liu, & Toporek, 2003; Sue, 2005; 2006; Sue, Ivey, & Pedersen, 1996). This lag significantly hinders the call for outcome-based preparation programs deemed necessary to

produce a contemporary mental health workforce capable of providing services for all persons experiencing psychological distress and disorder.

Given the critical nature of mental health disparities in the US and Canada, it is important to identify factors that dissuade interdisciplinary collaboration and knowledge sharing. Additionally, it is important to explore the ways in which providing information about the potential benefits of interdisciplinary work and about established and effective competency models might influence efforts to develop competencies and outcome-based preparation programs. Finally, it is important to explore the ways in which offering venues for knowledge sharing and collaboration might influence efforts to adhere to recommendations to engage in such work.

This study addresses the need for further research to better understand the factors contributing to the lack of progress being made to transition mental health scientist/practitioner preparation programs from input-driven to outcome-based training and the lack of attention being given to recommendations for interdisciplinary collaboration and knowledge sharing to expedite this process, as illustrated in one of the five core mental health professions: Marriage and Family Therapy (MFT). Additionally, the study examines the implications of the tendency to neglect these two core recommendations. Finally, the study explores the ways in which leaders in this profession respond to possible venues for interdisciplinary collaboration and knowledge sharing. Specifically, this study addresses four primary research objectives:

1. To examine the degree to which MFT leaders have a comprehensive understanding of: (a) the international call for transformations in the preparation of future generations of MFT professionals; (b) the relationship between this call and the broader call for transformations in the international mental health care delivery

- system; and (c) the recommendations they have been expected to consider as responsible providers of health care services.
2. To examine the efforts being made within the MFT profession to address these calls as well as the obstacles that have hindered progress, with particular emphasis on the degree to which this discipline is engaging in interdisciplinary collaboration and is considering established models of competence (e.g., within the field of multicultural counseling and therapy (MCT); Abreu, Chung, & Atkinson, 2000; Carter, 2005; Pedersen, 2008; Ponterotto, Utsey, & Pedersen, 2006; Pope-Davis, Coleman, Liu, & Toporek, 2003; Sue, 2001; 2005; 2006; Sue, Ivey, & Pedersen, 1996).
 3. To examine the ways in which MFT leaders critique their efforts to address this call and evaluate their progress in the context of the two core recommendations and recent national evaluations of the progress that has been made across the five core mental health professions to date.
 4. To obtain an initial understanding of the degree to which asking questions about the possibilities, limits, and barriers to interdisciplinary collaboration and knowledge sharing, while also making information and collaborative opportunities available to study participants: (a) *initiates requests* for further resources and collaborative forums among MFT leaders; and, (b) generates *active interest in* and *commitment to* both contributing to and engaging in interdisciplinary knowledge sharing and collaboration.

Participants in the study included MFT program directors and clinical faculty members from graduate and post-graduate training programs accredited by the national accrediting body for MFT education and training (The Commission on Accreditation for Marriage and Family

Therapy Education - COAMFTE) who agreed to participate in an online electronic survey. The survey included four main sections.

The first section addresses the respondents' understanding and critique of the reasons for the international call upon social service professions to develop competency-based models of practice and outcome-based preparation programs as well as their knowledge about advancements being made in other mental health professions.

The second section addresses the respondents' description and evaluation of: (a) their programmatic efforts to transition to COAMFTE outcome-based educational standards; (b) the progress they have made thus far in identifying, operationalizing, implementing, evaluating, and revising competencies that centrally inform their programs of study; and, (c) any interdisciplinary collaboration or knowledge sharing they have incorporated into their work.

The third section provides information about the national recommendations related to interdisciplinary collaboration and knowledge sharing, the national evaluations of the degree to which these recommendations have informed the transition to outcome-based training across the five mental health professions, and the results of these efforts. Respondents were then asked to evaluate their efforts in the context of this information.

The final section provides information about resources and venues for interdisciplinary collaboration and knowledge sharing and respondents were asked about the degree to which they would consider using resources and/or participating in interdisciplinary forums. A mechanism was included to assess the degree to which participants were actively interested in contributing to and engaging in venues for interdisciplinary knowledge sharing and collaboration.

Data analysis included both quantitative and qualitative methods in this exploratory study. Descriptive data were compiled and frequencies were calculated to provide responses to

the four research questions. Qualitative data analysis included the identification of categories in items where respondents were asked to think critically about their efforts to: (a) identify core competencies relevant to their training programs; (b) transition to outcome-based training; and (c) consider future venues that might be beneficial in their ongoing work. These data not only add context to the quantitative findings, but also will inform the post-dissertation development of a proposed website designed to provide electronic resources and collaborative forums.

The information respondents obtain from simply participating in this study provides important reference points for MFT faculty in COAMFTE-accredited programs to critically examine: (a) the degree to which efforts toward educational reform have successfully moved the MFT profession to develop the outcome-based competency standards necessary for today's practitioners to provide equal access to quality services for all persons; (b) the ways in which reluctance toward interdisciplinary scholarship and knowledge sharing across five core mental health professions has hindered efforts to establish a contemporary mental health care delivery system capable of providing equal access to quality mental health services to the most vulnerable, underrepresented, and underserved individuals and families; and (c) the range of opportunities that can be made available to obtain resources from within and beyond the MFT profession that can inform continued efforts to develop core competencies and outcome-based preparatory programs.

On a broader level, both the resources provided to participants as part of the study and the findings obtained from this study will be useful to the American Association for Marriage and Family Therapy (AAMFT), the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), and COAMFTE accredited graduate and post graduate programs charged with developing outcome-based scientist/practitioner preparation programs. Further, it is

hoped that the information obtained from this study will help to sensitize professional organizations, accrediting bodies, and faculty – across the five core mental health disciplines – to the factors that continue to hinder each profession's progress toward developing core competencies that can be achieved and demonstrated with reliability and validity and that can then be successfully incorporated into preparation programs and credentialing venues. Finally, the electronic resources and forums that are anticipated to be developed, based on the findings, will provide venues to facilitate interdisciplinary collaboration and knowledge sharing that may help to expedite the development of competencies and outcome-based preparatory programs that can begin to produce researchers and practitioners capable of addressing the growing disparities in access to quality and relevant mental health services that continue to exist.

Chapter 2: Literature Review

The literature review will present the contextual backdrop for this study. Specifically, the international calls and associated recommendations for educational and mental health care reforms will be articulated. Efforts across the five core mental health disciplines to: (a) develop clinically, culturally, and contextually competent scientist/practitioners; (b) define, achieve, and demonstrate core competencies; and, (c) infuse these competencies into preparation programs will be summarized. Salient obstacles that have consistently hindered these efforts will be reviewed, giving particular emphasis to the lack of interdisciplinary collaboration and the dearth of efforts to consider established methods and models for developing mental health competencies. The final section will summarize the ways in which the literature reviewed informed the purpose of the study and the development of the online survey.

Contextual Backdrop: Defining Competence in Behavioral Health

Competencies in behavioral health practice have been defined as “a collection of the basic or minimum skills that each practitioner should possess in order to provide safe and effective care” (Graves, 2005, p. 15). Competent professional practice is marked by “habits of mind, critical thinking, and analysis, professional judgment in assessing situations and ascertaining appropriate responses, and evaluating and modifying decisions via reflective practice” (Epstein & Hundert, 2002, p. 227). Professional competencies are dynamic, complex, measurable, and comparable across practitioners and should be continually evaluated and revised (Kaslow et al., 2007; Marrelli, Tondora, & Hoge, 2005). Most clinical tasks require the “simultaneous or sequenced demonstration of multiple competencies” (Hoge, Tondora, & Marrelli, 2005, p. 517). The definition and assessment of competent clinical practice will be

discussed as it pertains to training student therapists and in context of the wider systemic calls to accountability and service to a diverse clientele.

International Calls for Educational and Mental Health Care Reforms

In response to the Surgeon General's *Report on Mental Health, Culture, Race, and Ethnicity* (US D.H.H.S., 2001), and reports from the President's New Freedom Commission on Mental Health (2003) and the Annapolis Coalition on Behavioral Health Workforce Education (2006a; 2006b), the literature has been replete with international calls for mental health care reform. Specifically, the five core mental health professions recognized by the Federal Health Resources Services Administration (i.e., clinical social work, marriage and family therapy, psychiatry, psychiatric nursing, and psychology) have been called upon to improve the accessibility, effectiveness, and relevance of services to individuals and families facing the most chronic and severe mental health conditions and to underrepresented and underserved populations. This section will identify prominent factors prompting these calls and document efforts across these five professions to respond by developing core competencies and outcome-based scientist/practitioner preparation programs. Particular attention will be given to:

1. The historical forces that prompted similar calls by leaders in the field of MCT over 60 years ago;
2. The contemporary factors and forces currently driving the trend toward developing competency-based models and outcome-based training; and
3. The implications of the mental health professions' slow response to address these calls.

Historical calls to address mental health care disparities. The call to develop a competent mental health care delivery system is generally considered "relatively recent" (Hoge,

Paris, et al., 2005, p. 627) even though similar calls to address mental health care disparities originated well before the Surgeon General's Report (US D.H.H.S., 2001). In fact, significant mental health disparities were identified as far back as 1950 as part of the Civil Rights movement, and calls to address these disparities have been constantly and increasingly voiced over the past 60 years, mainly by leaders in the MCT field (Sue, Ivey, & Pedersen, 1996).

The Civil Rights movement affected the face of psychotherapy and research. During national conversations about and demonstrations supporting racial equity in the United States, psychologists committed to social justice created a number of associations designed to further the scholarship of and about specific racial/ethnic groups in the late 1960s and early 1970s (Arredondo & Perez, 2003). The leadership of these groups responded to systematic racism in scientific inquiry that was promoted by deficit-based racial assumptions.

In 1981, Allen Ivey, president of American Psychological Association's (APA) Division 17, the Society of Counseling Psychology, commissioned a committee tasked with developing multicultural competencies in clinical psychotherapy. It took another twenty years for that committee's work to be endorsed as the *Multicultural Counseling Competencies* (Arredondo et al., 1996; Sue, Arredondo & McDavis, 1992) and the *Multicultural Guidelines on Education and Training, Research, Practice and Organizational Development for Psychologists* (Arredondo & Perez, 2003). Sue (2001) explains that, while APA's endorsement was considered a transformative event,

Calls for incorporating cultural competence in psychology have been hindered for a number of reasons: belief in the universality of psychological laws and theories, the invisibility of monocultural policies and practices, differences over defining cultural

competence, and the lack of a conceptual framework for organizing its multifaceted dimensions. (p. 790)

Two decades later, work has continued on defining and operationalizing culturally competent mental health practice. For example, Sue (2001) proposed an organizational model that accounts for the multidimensionality of culturally competent psychotherapy. The model is intended to provide direction for training, practice, and research and account for practice that perpetuates mental health disparities. It accounts for race- and culture-specific attributes (e.g., African American, Asian American, Latino American, Native American, European American), levels of analysis (i.e., societal, organizational, professional, and individual), and components of cultural competence (i.e., knowledge, awareness, and skills). The model references the complexity of working with clients in a culturally appropriate manner and seeks to provide a framework to address the disparity of services provided to racial and ethnic minority populations.

Recent calls to address mental health care disparities. Improving the competency of the mental health care delivery system is an increasingly forefront issue. “Policymakers laud it, educational programs are required to produce it, and consumers increasingly demand it” (Hoge, Tondora, & Marrelli, 2005, p. 512). In fact, for more than a decade, concerns about provider competency and its impact on the accessibility and quality of health care in America have been detailed in reports by national commissions and coalitions which have concluded with specific recommendations for educational and service delivery reforms (e.g., Annapolis Coalition, 2006a; 2006b; New Freedom Commission, 2003). The Institute of Medicine (IOM; 2006) stated that the “mediocrity of health care providers’ education is a substantive factor undermining the quality of care and has been associated with unequal access to health care services” (Brooks, 2010, p. 1).

Evidence drawn from such reports substantiate claims that America's mental health care delivery systems and preparation programs have not kept pace with dramatic changes in the country's demographic landscape and mental health needs (e.g., US D.H.H.S., 2006), and therefore have not successfully addressed the call to develop a contemporary mental health care delivery system in the United States. Two core strategies consistently proposed to address these calls, and specific to this study, have been proposed:

1. The five core mental health disciplines must make the development of viable workforce competencies a priority for in-depth study and development (i.e., Annapolis Coalition, 2006a; 2006b).
2. The five core mental health disciplines must then incorporate these core competencies into scientist/practitioner preparation programs (i.e., New Freedom Commission, 2003).

Furthermore, two core recommendations from these, and other national reports, outline the need for competent practice in behavioral health care:

1. Mental health professions must work collaboratively to ensure that current and future generations develop competencies in delivering clinically, culturally, developmentally, and linguistically effective and relevant services (Hoge, Morris, et al., 2005).
2. Mental health professions must identify and assess reliable and valid competencies in behavioral health by drawing from established methods and models of competency development (Hoge, Morris, et al., 2005).

Hoge, Morris, et al. (2005) provided strong rationale for tailoring therapeutic services to the needs of a diverse clientele, citing statistics from sources including the Institute of Medicine

(2001) and the US Department of Health and Human Services (2001). The Institute of Medicine notes that despite rapid changes in client needs, the “health care delivery system... frequently falls short in its ability to translate knowledge into practice” (2001, p. 3). The influence of numerous factors, including context, culture, developmental stage, and linguistic resources must be accounted for in the conceptualization and treatment of client distress (e.g., Hoge, Morris, et al., 2005; Huang, Macbeth, Dodge, & Jacobstein, 2004; Kaslow, Celano, & Stanton, 2005; Limb & Hodge, 2011; Sue, 2001). Furthermore, as professionals collaborate serve the needs of their clients in the best possible way, attention must be paid to the definition and assessment of competencies at multiple levels of context: individual, team, organizational, and systemic (Hoge, Morris, et al., 2005).

A substantive body of knowledge and highly developed models of competency development exist in fields outside and related to behavioral health (e.g., business, education, organizational psychology) that must be consulted in the creation of a set of competencies for mental health practice. Hoge, Morris, et al. (2005) suggested that “rigorous and systematic efforts to make progress” in developing competency models should be a top priority (p. 654). Strategies for systematic progress include establishing data collection methods that are reliable and representative, and gathering data from varied sources including focus groups, interviews, and observation.

Working Toward Educational and Mental Health Care Reform

This section will provide a historical perspective on the dynamics within the mental health care enterprise that have heightened attention to defining, achieving, and demonstrating core competencies. The section will also highlight the forces that have prompted the movement

from input-based to outcome-based training, supervision, and continuing education. Specific attention will be given to:

1. Efforts to develop clinically, culturally, and contextually competent scientist/practitioners (Epstein & Hundert, 2002; Graves, 2005; Hoge, Paris, et al., 2005).
2. Efforts to define, achieve, and demonstrate a set of core competencies, to infuse these into preparation programs, and to develop a competent workforce (Marrelli, Tondora, & Hoge, 2005).
3. The historical and contemporary obstacles that have consistently hindered efforts to produce a contemporary mental health care delivery system, with particular emphasis on the lack of interdisciplinary collaboration and the dearth of efforts to consider cultural and contextual models of competence that have evolved over the past 50 years in the field of MCT (e.g., Carter, 2005; Pedersen, 2008; Ponterotto, Utsey, & Pedersen, 2006; Pope-Davis, Coleman, Liu, & Toporek, 2003; Sue, 2005; 2006; Sue, Ivey, & Pedersen, 1996).

This section will serve as a foundation for the contextualization of the MFT profession's move to outcome-based competencies and the degree to which this move has addressed cultural and contextual competence. Additionally, the information presented will inform the development of the online survey.

Efforts to Create Competent Scientist/Practitioners

In psychology, the *scientist-practitioner model* has influenced curriculum content, evaluation, and pedagogy (Kaslow, 2004). In the specialty field of professional psychology, Goldfried and Wolfe (1996) identified three distinct generations of inquiry related to the

competence of its practitioners. The first, beginning in the 1950s, and ending in the late 1960s, researchers asked questions about the effectiveness of psychotherapy as it related to client change. Bell (2005) noted that studies during this time focused on how different therapies produced change in generalized clinical presenting problems.

The second generation of competency inquiry began in the 1960s and lasted for a decade. During this time, researchers carefully selected clients and therapeutic procedures, controlling variables in university settings with graduate students simulating the therapeutic relationship (Goldfried & Wolfe, 1996). Researchers in the second generation investigated the specific procedures that produced change in specific clinical problems. The third generation of competence inquiry in the field of professional psychology began in the 1980s and extends to the present. Researchers are using increasingly sophisticated design and controls, examining the influence of manualized treatments on clients with specific diagnoses.

The field of professional psychology has conducted many studies investigating the effectiveness of clinical intervention on client distress (see Bell, 2005). The field has not, however, evaluated the practice itself or the effectiveness of the practitioners conducting it. Furthermore, as Bell (2005) noted, there is “currently no systematic way of determining if clinical psychology training programs are producing adequately trained practitioners who are competent in their practice” (pp. 2-3).

Professional psychologists have been involved in public discussion about competent therapeutic practice since the Boulder Conference on Graduate Education in Clinical Psychology in 1949 (Raimy, 1950). Topics of discussion at that conference included training issues, ethics, professional relations, and professional regulation through certification and licensure (Baker & Benjamin, 2000). The “scientist-practitioner” model, the belief that psychologists should be

proficient as both researchers *and* clinical practitioners, was adopted at that time and continues to influence the field to the present day, although the limitations of the Boulder model have led to discussion of the need for new models for graduate education (Snyder & Elliot, 2005; Wedding, 2005).

The 1973 American Psychological Association Vail Conference housed the proposal for changes to the discipline's training curriculum. Attendees called for a revision to the accreditation process for graduate programs, asking for "a focus on the competency of graduates rather than content of knowledge" of their training experiences (Bell, 2005, p. 31). For more than a decade, researchers have supported this position, saying, "specialty area skills and expertise alone do not necessarily imply proficiency" (Kurpius, 1997; Leonard, 1997; Robinson Kurpius, Fuqua, Gibson, Kurpius, & Froehl, 1995; as cited in Hellkamp, Zins, Ferguson, & Hodge, 1998, p. 228).

The National Counsel of Schools of Professional Psychology (NCSPP) was founded in 1976 to improve and enhance professional psychology training. Two years after its creation, NCSPP members resolved that professional psychology curricula would be formally evaluated using outcome research, rather than assuming that any one curriculum would produce competent practitioners (Weis, 1992). The next two important conferences, held in 1981 and 1986, continued to focus efforts on improving graduate education and on discussing how to measure effective practice in professional psychology. The work done at those conferences became the foundation for NCSPP's educational model that describes the knowledge, attitudes, and skills required for competent practice as a professional psychologist. The model includes six broad competencies: relationship, assessment, intervention, research / evaluation, consultation / education, and management / supervision.

The first competency area, relationship, includes three domains: comprehensive knowledge of theory and research as it pertains to the therapeutic relationship; self-awareness; and knowledge about others, with attention to cultural and contextual factors (Polite & Bourg, 1992). Gold and DePiano (1992) report that knowledge of assessment, the second competency area, includes: formulating questions, selecting methods, collecting and processing information, generating theory-based hypotheses, and disseminating findings orally and through written communication.

The intervention competency involves a practitioner's ability to work with clients at all levels: individual, systemic, and programmatic. Specific areas of knowledge include biofeedback, diagnostic testing, electroencephalography, pharmacology, and others (Bent & Cox, 1991). The fourth competency, research and evaluation, was defined as both the consumption and production of scientific findings (Trierweiler & Stricker, 1992). The consultation and education competency refers to the sharing of knowledge with clients, a collaborative activity in which the psychologist "facilitates the identification and resolution of specific problems" (Bell, 2005, p. 36; Illback, Maher, & Kopplin, 1992).

The final competency requires the psychologist to demonstrate knowledge in the ethical standards and professional guidelines, public policy, and service issues when managing and supervising health professionals. The competency area includes engagement with professional mentorship to enhance professional competence over time (Bent, Schindler, & Dobbins, 1992).

In 2004, professional psychologists joined at *The Competency Conference: Future Directions in Education and Credentialing in Professional Psychology* (Kaslow et al., 2004). At that forum, issues around education, credentialing, and public image were the focus, creating a sense of momentum, community, and engagement in the future of the psychology profession.

Several models for competency have been published following the conclusion of that summit, including the *Stairway Model* (Collins et al., 2007) to prepare students for clinical readiness; a four level matrix model (Snyder & Elliot, 2005) that is intended to replace the Boulder Model; and the *Cube Model* (Rodolfa et al., 2005) that defines foundational knowledge, attitudes, and skills across the professional lifespan.

In response to the “workforce crisis” in mental health care identified in the historical national calls (e.g., New Freedom Commission, 2003), major efforts to identify and measure competent practices have become increasingly common among other behavioral health organizations besides professional psychology as well. Such efforts echo the work of medical and nursing professionals, who aim to motivate and educate new practitioners, assess their skills, and discriminate between trainees headed for advanced practice and those unqualified to do so (Epstein & Hundert, 2002). The Accreditation Council for Graduate Medical Education defined six broad areas of competence; the field continues to work toward a well-defined set of expectations that can be measured and assessed in training clinicians (e.g., Epstein & Hundert, 2002; Kessler & Burton, 2011; Lawrence et al., 2011). The nursing profession has a history of competency-based education dating back more than twenty-five years (e.g., Ironside, 2004). Medicine, nursing, and psychology share common factors in their competency establishment processes. Namely, each profession’s effort responded to the changing healthcare environment, to disparities in quality care for underserved populations, and to limited funding for prevention and treatment initiatives (Brooks, 2010). While discussion of the history of the medical and nursing education professions is beyond the scope of this paper, their efforts have demonstrated cohesive exploration of educational innovation and are an important foundation for current behavioral health initiatives.

Defining, implementing, and developing competence. The Institute of Medicine (IOM; 2003) has called for a systematic, vigorous effort to develop a workforce that includes a well-defined set of core competencies. The IOM (2003) takes the position that,

Defining a core set of competencies across educational oversight processes could ... reduce costs as a result of better communication and coordination, with processes being streamlined and redundancies reduced. Integrating core competencies into oversight processes would likely provide the impetus for faculty development, curricular reform, and leadership activities. (p. 5)

Furthermore, the education reform movements of the 1980s and 1990s called for greater accountability in the demonstration of quality education (Guskey, 1994), with outcome-based education being one of several methods for designing curricula and pedagogy that facilitate student learning of specifically defined outcomes. Hoge, Paris, et al., (2005) outline the efforts of different disciplines in behavioral health field to develop the competencies to be implemented in training programs. They highlight the efforts of addiction counselors, interdisciplinary health professionals, marriage and family therapists, professional psychologists, psychiatric mental health nurse practitioners, psychiatric rehabilitation practitioners, psychiatrists, social workers, and professions specializing in children's mental health, and serious and persistent mental illness. Efforts made by each of the professions and specialties have been largely conducted independently (Hoge, Paris, et al., 2005), despite recommendations toward interdisciplinary coordination and knowledge sharing (e.g., IOM, 2003).

In a related article, Marrelli, Tondora, and Hoge (2005) presented a "step-by-step" process for behavioral health professions to develop competency models. The first step in creating a competency model is to define the objectives clearly and specifically, laying out the

need for the competencies, the units of analysis, the timeframe, and the implications of the application of the competencies on the workforce. After the objectives are clarified, data collection methods must be carefully selected and a communication and education plan should be created.

Through analysis of the collected data, the authors suggested the compilation of the competencies core to the job or profession. Similar competencies should be grouped together with the objective not being to create an exhaustive list of competencies, but a list of practical, achievable goals for training and job performance; “in most cases, to remain manageable, the number of competencies should be 20 or fewer” (p. 555). Then, the preliminary list should be reviewed by subject matter experts and revised based on their feedback. Next, the revised competencies should be illustrated by behavioral examples, with each example demonstrating three or more levels of proficiency.

The implementation of the operationalized competency model should be done strategically, according to Marrelli, Tondora, and Hoge (2005). The model can be used for personnel selection, training and development, performance management, succession planning, rewards and recognition, and compensation. The final step after the implementation is to evaluate and update the competency model. Feedback and data should be used to revise the model on a regular basis and new competency studies should be implemented when the job or organization changes significantly.

Obstacles to competent practice. The IOM (2003) highlights some of the challenges of competencies integration, including the incorporation of those competencies into the oversight system beyond training (e.g., through licensure requirements or continuing education). Some of those barriers include “time constraints, oversight restrictions, resistance from the professions,

and absence of political will, the overall health care financing system is a large impediment to integrating the core competencies into practice settings” (p. 10).

Peterson (2011) identified nine challenges to designing and implementing an outcome-based educational program. First, learning the concepts of outcome-based education requires a shift in thinking about how successful education is assessed. The second challenge to competent practice is defining the program’s educational outcomes. The third challenge relates to the second in the definition of the outcomes; programs must determine which sources of information they will apply in the creation of their program-specific educational goals. Once the programs have outlined their educational goals, Peterson (2011) suggests that the development and implementation of systematic assessment of those goals is the fourth challenge to the implementation to an outcome-based training program.

The fifth goal is for programs to design benchmarks whose successful completion indicates competent practice along each of the educational objectives. These tasks must be clear, concrete, and measureable (Gehart, 2011b). Those benchmarks need to be reviewed regularly, with feedback being integrated into continued program development. Peterson identified the process of designing or selecting measurement tools to be the next challenge to outcome-based education.

The final two challenges identified by Peterson (2011) focused on resources. The first is the challenge of involving all faculty members in the process of outcome-based education. Each faculty member needs to understand how his or her efforts are moving students and the program towards competent clinical practice. The final challenge is to garner the financial, emotional, and energy resources required to implement and assess competence in training. Peterson notes the

special burden that this last challenge has on programs not housed in universities (i.e., freestanding programs, post-degree programs).

The Current State of Affairs

Competency models and competency-based training approaches are increasingly being implemented in mental health care to guide curriculum content intended to ensure accountability and outcomes in scientist/practitioner preparation, credentialing, and continuing education (e.g., Kaslow, 2004; Kaslow, Celano, & Scranton, 2005; Kaslow et al., 2007; Marrelli, Tondora, & Hoge, 2005; Motamedi & Sumrall, 2000; Peterson, 2004; Rubin et al., 2007). The relatively recent focus in the mental health field on accountability has contributed to the ongoing and increasing unpreparedness to meet the demands of a changing consumer population. This section will identify the generally accepted practice of developing a defined set of competencies that can be taught and evaluated, and will present information about the early stage of development most mental health professions are working within.

Competency has been generally addressed across social service professions as relating to: (a) *knowledge* (i.e., awareness of or understanding about facts, rules, principles, guidelines, concepts, theories, or processes needed to provide competent service); (b) *skills* (i.e., the ability to perform specific tasks and functions needed to provide competent service); and, (c) *awareness or personal and professional dispositions* (i.e., values, attitudes, traits, and the behaviors that are manifestations of these human characteristics and that contribute to providing competent service) (e.g., Athey & Orth, 1999; Epstein & Hundert, 2002; Graves, 2005; Lucia & Lepsinger, 1999; Spencer, McClelland, & Spencer, 1994). Three additional categories of critical competencies for family therapists include: (a) *perceptual* (i.e., how therapists assess client needs based on based on client report and observation); (b) *conceptual* (i.e., how perceptions of client-based data

inform treatment planning); and (c) *executive* (i.e., how treatment plans are directly translated to practice by way of intervention skills and strategies) (Cleghorn & Levin, 1973).

Professions tend to engage in similar patterns as they develop the competencies specific to their practitioners. Those stages include: (a) defining and operationalizing competencies; (b) identifying training and supervisory approaches to facilitate the development of such competencies; (c) identifying methods and measures to evaluate the effectiveness of these approaches; and, (d) developing methods and measures to assess the ongoing process of competency development and the degree to which such competencies are achieved and can be demonstrated (Epstein & Hundert, 2002; Gehart, 2011b; Graves, 2005).

In the mental health field, like other professional groups, most of the attention has focused on identifying a consensual set of knowledge, skills, and attitudes and has resulted in emerging competency sets that have been identified by a small group of each specific profession's experts. The results of their efforts are generally considered too comprehensive and idealistic to be achievable by the typical student, practitioner, or educator (Hoge, Morris, et al., 2005; Hoge, Tondora, & Marrelli, 2005; Storm, Todd, Sprenkle, & Morgan, 2001). Overall, less attention is focused on operationalizing these competency sets, implementing training methods for achieving these competencies, and developing methods and measures to ensure when and how competencies are achieved and can be demonstrated by both current and future generations of scientist/practitioners (Carlson, 2008; Miller, 2005; Platt, Miller, Todahl, & Lesser-Bruun, 2004; Pedersen, 2000; 2003; Sue, 2003).

Furthermore, the identified competencies across the mental health professions have yet to be sufficiently incorporated into preparation programs or credentialing venues, making it less likely that work on competencies will actually address the gap between the mental health needs

of today's intercultural society (Hoge, Morris, et al., 2005). The attention given to: (a) defining and operationalizing cultural and contextual competencies; (b) designing, implementing, and evaluating training sequences; and, (c) developing methods and measures to ensure that the competencies can be demonstrated generally lags behind advancements made in the clinical competencies traditionally considered relevant for effective practice (Arredondo & Arciniega, 2001; Arredondo et al., 1996; Rigazio-DiGilio, 2004; Sue, Arredondo, & McDavis, 1992). The next section will provide an overview of the state of competency development and outcome-based preparation programs in one of the five core mental health disciplines, Marriage and Family Therapy.

Identifying and Defining Competence for Marriage and Family Therapy (MFT)

The American Association for Marriage and Family Therapy (AAMFT) is the organizational and accrediting body for MFT practitioners in the United States and Canada. According to the AAMFT website, an estimated 50,000 practitioners are licensed to provide therapeutic services as marriage and family therapists. Fifty states and the District of Columbia regulate marriage and family therapists; two provinces in Canada have passed regulations for MFT practitioners.

An emphasis on outcome-based, learning- or student-centered instruction has, in the last decade, required behavioral health training programs such as MFT to (a) identify clear learning goals, objectives, and outcomes, (b) measure student learning performance using direct rather than indirect methods, (c) consistently communicate student outcome performance and, (d) improve programs based on the evaluative student feedback (Chenail, 2009). Outcome-based education shifts the focus “from what is *taught* to one of what is *learned*” (italics in original; Nelson & Smock, 2005).

The commitment to assessing performance as a set of demonstrable skills in clinical settings represents educational reform. The standard input-based curriculum required students to complete a set of courses and five hundred hours of supervised client contact in order to be deemed competent practitioners. Educators employing an outcome-based pedagogy, in contrast, must have clearly identified and defined ideas of competent practice, must implement and evaluate those ideas, and must revise the curriculum and activities accordingly (Marrelli, Tondora, & Hoge, 2005). Students in outcome-based educational programs must be able to demonstrate their knowledge, skills, and attitudes in order to be considered competent in their field of practice.

The challenge for any profession engaging in outcome-based educational standards is defining what competent practice in the field entails. In a similar procedure to the medical field, the MFT profession looked to the leadership of a group of experts to define competent practice in couple and family therapy (AAMFT, 2004; Nelson, 2005; Nelson et al., 2007; Northey, 2005). To that end, the COAMFTE formed a Standards Review Committee to design the profession's first outcome-based standards in 2004 (Peterson, 2011). The goal of that group was to "define the domains of knowledge and requisite skills in each domain that comprise the practice of marriage and family therapy" (Northey, 2004, p. 4). Further, the group purported to "not only define the knowledge and skill levels, but also how such knowledge and skill would be obtained" (Northey, 2005, p. 11). The work done by that group was adopted by AAMFT as the core competencies of marriage and family therapy.

Implementing standards of practice in the MFT field addressed four issues: (a) a massive increase in practicing therapists across two countries (Miller, 2010); (b) reimbursement for services by managed care companies; (c) professional legitimacy among other mental health

providers (e.g., social work, psychology, psychiatric nursing; Miller, Todahl, & Platt, 2010) and (d) quality and equitable care for clients (e.g., Miville et al., 2009; Sue, Arredondo, & McDavis, 1992). Miller and his colleagues assert that “without sufficient and clearly identified core competencies, marriage and family therapists (MFTs) will be less likely to be deemed ‘qualified’ to provide services” (Miller, 2005; Platt, Miller, Todahl, & Lesser-Bruun, 2004, as cited in Miller, Todahl, & Platt, 2010, pp. 3-4). Some MFT educators have noted that the list of measurable skills required of family practitioners is reassuring to beginning student therapists (e.g., Figley & Nelson, 1989). After mastering such skills, trainees can continue to gain confidence as they increase experience in the field.

Determining critical skills for couple and family therapy practitioners. The call for competencies in mental health professions follows the work of civil rights advocates. Calls for competence in practice that began six decades ago have largely been ignored by the behavioral health disciplines, despite the efforts of many leaders in the field of multicultural counseling (e.g., Abreu, Chung, & Atkinson, 2000; Carter, 2005; Pedersen, 2008; Ponterotto, Utsey, & Pedersen, 2006; Pope-Davis, Coleman, Liu, & Toporek, 2003; Sue, 2005; 2006; Sue, Ivey, & Pedersen, 1996).

Two decades after the competency movement began, researchers began working to define the critical elements of therapeutic practice with families; that work was done with little, if any, reference to the interdisciplinary work of multicultural leaders. Cleghorn and Levin (1973) named three categorical areas of critical skills for family therapists: perceptual, conceptual, and executive. Perceptual skills were identified as those that help the training clinician view the case based on client report and observation, conceptual skills put those observations into a picture of the family’s context that allows for intervention, and the executive skills are those that make that

intervention possible. Cleghorn and Levin outlined a model for identifying and evaluating family therapist skills via specific and measurable training objectives, recommending different skill requirements according to the student's developmental level, with experienced and advanced family therapists being expected to demonstrate more complex skills than beginning practitioners.

Constantine (1976) identified critical skills for family therapists that required specific training techniques. Other researchers identified skills that are taught in training programs and are believed to be important for family therapists but have not been empirically validated as related to positive outcomes in treatment (e.g., Liddle & Halpin, 1978; Liddle & Saba, 1982). Tomm and Wright (1979) identified the major functions, competencies, and skills of family therapists. The four major therapist functions were identified as engagement, problem identification, change facilitation, and termination. Within those four categories, general therapeutic competencies describe the skills or abilities to achieve them. Tomm and Wright's model uses the perceptual, conceptual, and executive skill set framework (Cleghorn & Levin, 1973), pairing perceptual/conceptual skills with a corresponding executive skill.

The Basic Family Therapy Skills Project created an empirically derived set of basic skills for family therapists (Figley & Nelson, 1989). The group contacted more than two thousand experienced supervisors and family therapy practitioners to determine which general skills were the most basic or essential for training family therapists. After reducing the list to eliminate redundancy, the authors reported 292 generic therapist characteristics or self-attributes (e.g., sensitivity, intelligence, acceptance, warmth) and created a list of the top 100 that are necessary for family therapy (Figley & Nelson, 1989). Over the course of the next four years, the authors categorized the other participant responses by schools of family therapy and differentiated

model-specific characteristics (Figley & Nelson, 1990; Nelson & Figley, 1990; Nelson, Heilbrun, & Figley, 1993).

These models significantly informed the development of the MFT core competencies. Over the next two decades following the development of the therapy model-specific approach to competency, researchers engaged in projects to determine the skills, knowledge, and attitudes required for competent family therapy practice. Several Delphi studies were published (e.g., Blow & Sprenkle, 2001; Hovestadt, Fenell, & Canfield, 2002; White & Russell, 1995) focusing on competent practice in supervision and with specific populations of clients. These studies became foundational for the development of the current list of competencies for family practitioners and were based on models that ignored the efforts of many experts in the field. Brooks (2010) points out that couple and family therapy training programs share similar challenges and mandates to develop curricula with other healthcare professions, and “can benefit from what other health care professions have discovered about effective ways to institutionalize outcome-based education” (p. 70). Such challenges and mandates include the demonstration of clinical proficiency and professionalism.

Commissioning competent marriage and family therapy training. The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) is charged with setting standards for MFT training and holding programs accountable for meeting those benchmarks (Keller, Huber, & Hardy, 1988). COAMFTE embraced the philosophical shift from input- to outcome-based education in Version 11.0 of the Standards for Accreditation. Beginning in 2008, programs seeking first time or renewed accreditation needed to demonstrate a commitment to the competency movement during reviews of their training curricula. Programs seeking accreditation status need to: (1) engage in ongoing self-study and development, (2)

continually evaluate themselves in relation to their institution's and program's mission, and (3) demonstrate how they meet "established standards as measured by their own stated goals, educational objectives, and established outcomes" (COAMFTE, 2008, p. 4).

Accreditation standards set expectations for what competent programs and, by extension, competent graduates of that program, should be doing. Broadly, the accreditation standards include the following areas: eligibility, administrative and organizational structure, professional and staff resources, student entrance requirements, curriculum, clinical supervision, clinical facilities, and program evaluations (Stevens-Smith & Hinkle, 1993). The educational standards allow clients to receive the same standard of care when seeking treatment with any "competent" MFT practitioner.

Defining competence in MFT education: Accreditation standards. Accreditation standards represent an attempt to define effective practices for therapists in training (Bickman, 1999) by outlining expectations for the achievement of the educational programs' goals. Shaw (2008), in his review of licensure and certification standards across mental health professions, asserts that, "while licensure is based on standard minimum knowledge and practice requirements in each of the mental health fields, accreditation sets minimum standards for quality with which an educational program or institution educates students" (p. 20).

The standards for COAMFTE accredited programs were first proposed in 1971. Those standards represented an attempt to regulate educational requirements across MFT training programs. The review process outlined in the standards document was published as the first *Manual on Accreditation* in 1975 (COAMFTE, 2008). The standards outlined in the manual serve four purposes: (a) to provide oversight to ensure quality education in MFT; (b) to stimulate the improvement of professional MFT education; (c) to act as a guide for prospective students in

the selection of educational programs; and (d) *to establish and maintain standards which will ensure that institutions and agencies meeting them provide students with appropriate learning resources to acquire the requisite skills, knowledge, and ethical sensitivity to be professionally competent* (emphasis added, COAMFTE, 2008). The final objective highlights the way in which the profession has sought to set standards for competent practice in educational programs.

The COAMFTE, under AAMFT mandate, established the standards adopted by programs seeking to be accredited. The commission initiates a full review of the standards every four years, examining annual reports and public feedback to draft necessary revisions. The standards are proposed by the Commission, and then approved by AAMFT legal staff. The drafted proposed standards are distributed to MFT educators, clinicians, and other vested stakeholders. The standards are then published and a public hearing at the next AAMFT annual conference is held to provide opportunity for additional comment. The Standards Review Committee reviews the feedback from those various sources and develops recommendations for the Commission, who then develops the final standards (COAMFTE, 2008).

The most recent Accreditation Standards, published in 2005 and known as Version 11.0, reflect the MFT field's shift from input- to outcome-based educational expectations. Programs seeking accreditation or reaccreditation status are "required to demonstrate that graduates of their program achieve the sufficient level of knowledge and skills to be a competent therapist" (COAMFTE, 2008, pp. 11-12). Programs can demonstrate student competence using standards drawn from several sources, including the MFT Educational Guidelines, the AAMFT Core Competencies, the AAMFT Code of Ethics, the AMFTRB Examination Domains, Task Statements, and Knowledge Statements, and respective state licensing regulations (COAMFTE, 2008). The current accreditation standards allow programs to either develop their own ways of

measuring MFT knowledge or use the former standard (input-based) curriculum expectations.

The next section will describe how the AAMFT Core Competencies were created as tools for programs seeking accreditation status to use in their assessment of competent practice in training therapists.

The determination of competent clinical practice. In January 2003, the AAMFT assembled a task force charged with creating and codifying competencies for MFT practitioners. The task force included 50 members, a five-member steering committee, and an AAMFT staff member (Nelson et al., 2007). The MFT core competencies were based on the clinical expertise of the task members, empirical research, evidence-based family therapy, and the contextual relationship between MFT and the broader healthcare system. The steering committee reviewed competency models from different disciplines (e.g., nursing, medicine, and substance abuse) as well as related research as they prepared to determine the elements of competent clinical practice (Hoge, Paris, et al., 2005).

While engaging with this research, each steering committee member was asked to develop competencies specific to couple and family counseling (Hoge, Paris, et al., 2005). The first draft included 273 potential competency skills; those skills were clarified, categorized, and reduced by the committee. That smaller group was then mapped onto the accreditation domains of knowledge to ensure that they represented the field's expectations and current practices.

The second draft of clarified skills determined by the committee was sent to the competency task force. Members of that group provided feedback that resulted in the addition of ten competencies. The new list was distributed to the mental health disciplines, consumer and advocacy groups, appropriate federal agencies, and AAMFT members. Feedback from those constituents was integrated in order to produce the final draft (AAMFT, 2004). That draft was

first shared publicly at an educators' summit in July 2004 to discuss implementation and assessment strategies. The summit brought together accreditors, educators, and regulators to discuss how to adopt and assess the agreed upon competencies (Hoge, Paris, et al., 2005).

Peterson (2011) describes the history of outcome-based education in MFT training as relating to how the field was developed. The recognition of COAMFTE by the US Department of Education (US D.O.E.) in 1978 established MFT was a distinct profession. In 2004, COAMFTE was informed that it would need to move from input-driven to outcome-based standards in order to maintain recognition from the US D.O.E.. COAMFTE announced reform to the accreditation standards from input- to output-based pedagogy in 2005 (Gehart, 2011a). Such standards require programs and students to demonstrate therapeutic competence, rather than assuming that the completion of certain courses and clinical experience requirements are indicators of clinical competence. Beginning with Version 11.0, programs must show that their student therapists practice knowledge, awareness, and skills competently (COAMFTE, 2008).

Outcome-based educational standards are less prescriptive in nature than traditional standards, allowing programs to determine which competencies to identify, operationalize, implement, and evaluate as part of their curricula (AAMFT, 2004). The outcomes identified by the Version 11.0 standards are defined as “those measurable goals and objectives that the accrediting body, institution, program, or other entity set for competencies and achievements of students, faculty, supervisors, and the program” (AAMFT, 2004, p. 3). Gehart (2011a) noted that training programs are not required to use the nationally published core competencies to meet accreditation standards but programs must identify and clearly define a set of expectations to measure student competence.

Application of the core competencies. The MFT competencies outline the skills that a competent therapist should be able to demonstrate in order to receive such a designation and be considered eligible for independent practice. The competencies were designed to “assist the field in determining what family therapists do, how skilled they are, how those skills may assist in leading to positive outcomes for clients in therapy, and how we can better understand the work that lies ahead” (Nelson et al., 2007, p. 429). Furthermore, the model of competence intends to identify characteristics that predispose a person to success as a family therapist, defining the knowledge, skills, and personal characteristics believed to be associated with competent practice (Nelson et al., 2007).

The core competencies were designed to be relevant to MFT stakeholders, including accreditation board members, MFT trainers, and regulators at the state and national levels (Northey, 2004). The competencies “define knowledge and skill levels, the areas in which such knowledge and skills would be obtained, and characteristics that might predispose one for success as a marriage and family therapist” (Hoge, Paris, et al., 2005, p. 601). Furthermore, the competencies were based on the tasks required for clinical practice and clinical research, as well as evidence-based therapies, and trends in family therapy (Nelson et al., 2007).

The final draft of the 128 couple and family therapy core competencies are applied to license-eligible practitioners, with the skills intended to be indicative of readiness for independent (non-supervised) clinical practice. The competencies are also used as benchmarks during the two- to three-year graduate training process for Master’s level practitioners. Some educators believe that the achievement of competence as described in the core competencies takes ten years to accomplish (Nelson et al., 2007), whereas in the MFT profession, such achievement is expected in a two to four year time frame, beginning in graduate studies and

being completed at the time of licensure. Hoge, Morris, et al., (2005) recommend that “initiatives to identify and assess competencies in behavioral health must strive to achieve reliability and validity through the use of established methods of competency development” (p. 654), warning against “casual approaches to these complex tasks” (p. 654) and an “armchair competency development”, in which the list of competencies is based on expert opinion rather than empirical validation (Hoge, Tondora, & Marrelli, 2005).

The MFT competencies are broken into two domains: primary and subsidiary (AAMFT, 2004; Hoge, Paris, et al., 2005). The six primary domains identify practice-related expectations. The first, *admission to treatment*, is related to the interactions between the therapist and client prior to the creation of the therapeutic contract. The second, *clinical assessment and diagnosis*, focuses on the skills required to identify clinical issues based on client report of the presenting problems. Competence in *treatment planning and case management* identifies the activities that direct the course of treatment as well as any out-of-session therapeutic work. The activities used to create change are categorized as *therapeutic interventions*. MFT practitioners are also expected to display competence in the *legal issues, ethics, and standards* of the profession. Finally, therapists are expected to be involved in the systematic investigation of effective therapy through participation in and use of *research and program evaluation*.

The subsidiary level of the MFT core competencies involves the way in which each of the six primary domains is categorized. Each domain includes skills that fall into five areas: *conceptual, perceptual, executive, evaluative, and professional*. The first three areas are drawn from the earlier work of Cleghorn and Levin (1973), while the last two, evaluative and professional, and were added to clarify additional areas of skills. The evaluative skills are those

required to assess treatment protocols and clinical research critically. Professional skills are those used for the development of the therapist as an independent practitioner.

Implementation of Clinical Competencies in Training Programs

A limited number of articles have described the ways that MFT programs are integrating the core competencies into the training curriculum. Each implementation of the competencies to educational or training practice involves the application of activities or instruments for student learning. Miller (2010) proposes using the Objective Structured Clinical Examination (OSCE) as a formative exercise for training students in family counseling. Once developed to assess student skills in different mock clinical scenarios, the tool evaluates not only what the student knows (knowledge), but also how he/she would use the knowledge (skill implementation). Miller (2010) proposes that MFT programs use the tool in order for students to integrate feedback into their clinical practice and has adapted the OSCE for use in MFT programs so that the scenarios target the core competencies' executive skills (AAMFT, 2004; Nelson et al., 2007). Research suggests that this form of assessment targets a broader range of skills than traditional oral or written examinations (Newble, 2004; Watson, Stimpson, Topping, & Porock, 2002). The OSCE is an example of interdisciplinary work, being used in medical and other professional training contexts prior to its application to clinical practice.

Other examples of the integration of competencies into MFT training curricula include the use of clinical simulation to educate students about a variety of therapeutic scenarios (Hodgson, Lamson, & Feldhousen, 2007; Miller, Linville, Todahl, & Metcalfe, 2009). The authors advocate the use of simulated scenarios to work with domestic violence, homicidal and suicidal ideation, child maltreatment, and involvement with courts. Simulated scenarios create an opportunity for training therapists to practice the skills necessary to address different clinical

issues while preventing unethical or harmful treatment to actual clients. Simulations also provide opportunities to repeat portions of the interactions to refine and enhance with necessary skills.

Assessment and Evaluation of Competence

The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) requires training programs to evaluate the skills of student therapists (Nelson & Johnson, 1999) prior to entering, during, and at the conclusion of their clinical training. However, the accrediting body does not specify which clinical skills should be implemented or evaluated. Nelson and Johnson (1999) report no standardized instruments, with the exception of their own proposed device, that have been applied to assess competence at the numerous stages of clinical development.

Nelson and Johnson (1999) devised the Basic Skills Evaluation Device (BSED) to assess family therapy trainee skills and progress over time. The BSED was created using skills and instruments from the literature, skills identified by the work group, and a list of skills drawn from previous research (Figley & Nelson, 1989). The instrument is divided into five skills areas: conceptual, perceptual, executive, professional, and evaluative. Based on feedback, the authors also added an optional theory-specific skills dimension. The authors of the instrument report its content validity based on expert feedback but they are clear that the instrument has not been validated concurrently with other evaluation tools.

Interdisciplinary Collaboration

Even though national calls have urged for interdisciplinary collaboration (e.g., New Freedom Commission, 2003; Annapolis Coalition, 2006a; 2006b), the development of competencies within the core mental health disciplines has been highly variable and primarily independent. While the multiple reasons for this encapsulated approach to knowledge

advancements will be a matter for historians to decipher, its continuation significantly hinders the mental health care system's responsibility to address long-acknowledged mental health care disparities. This has resulted in:

1. A relatively recent commitment to develop competencies and the early stages of development reflected by work advanced to date.
2. Significant similarities in the core competencies identified across disciplines, with little reference to the interdisciplinary knowledge base that could be used to more expeditiously advance this work.
3. A dearth of evidence suggesting progress in developing competencies that: (a) are well defined; (b) can be achieved; and, (c) can be demonstrated with reliability and validity.
4. A lack of a core set of general clinical, cultural, and contextual competencies essential for all mental health professionals, as well as any efforts to advance this core set of competencies across disciplines collaboratively.

The lack of reference to work done outside of the mental health field has resulted in the creation of competencies that are broad, lacking specificity required to operationalize, implement, and evaluate in training practitioners.

MFT interdisciplinary competency development efforts. The field of marriage and family therapy originated as an interdisciplinary approach to treatment with practitioners of varied professional backgrounds unified by systemic thinking and practice. While the mental health field has called for interdisciplinary collaboration to address educational reform in family therapy, the leaders of the field became focused on the specific goals and skills required of the specific discipline. Their efforts to consult with other disciplines appear cursory; with little time

given to respond and insufficient attention given to responses garnered from those stakeholders (see Nelson et al., 2007 for discussion of competency development methodology). Kaslow et al. (2004) noted the importance of a commitment to within- and cross-discipline work in the development of competencies:

Collaborative efforts and sharing of best practices is encouraged, both within and among constituent groups and across settings. ... It is critical that multiple and diverse constituency groups work together to struggle with the challenging and vexing questions that remain. (p. 710)

Kaslow and associates noted the challenges in educational reform that are not addressed by AAMFT or COAMFTE. The documents published by AAMFT and COAMFTE have suggested that revision of the competencies will occur with some regularity but have paid little attention to the changing needs and faces of the populations with whom marriage and family therapists work. Kaslow et al. (2007) suggest an ongoing revision process that responds to the challenges of clinical training and practice in the United States and Canada:

Once competencies are well defined, stakeholders and assessment experts may develop consensus regarding comprehensive and effective strategies for competency assessment across the professional life span and devise solutions to key challenges. Strategies from other professions for forging consensus may be useful in guiding our efforts. (p. 448)

At this time, the leadership of the field of marriage and family therapy has disregarded efforts being made in other fields to identify, operationalize, implement, evaluate, and revise practitioner competencies. MFT's reliance on outdated information and lack of moving beyond the borders of the field into other mental health professions or professions with expertise in developing competency models has led to a set of competencies that, among other things, do not

fully define the broad scope of practice as described by interdisciplinary leaders (e.g., Arredondo & Arciniega, 2001; Arredondo et al., 1996; Rigazio-DiGilio, 2004; Sue, Arredondo, & McDavis, 1992).

Conclusion

The final section summarizes and analyzes the literature reviewed in this chapter. This conclusion contextualizes: (a) the work being done in one illustrative mental health profession to address the national call to establish core competencies and output-driven training standards intended to produce a contemporary mental health care delivery system; (b) the ways in which and the degree to which this profession's work has been informed by national recommendations for disciplines to collaborate with one another and to draw from established methods and models of competency development, with efforts drawn from the field of multicultural counseling and therapy highlighted for illustrative purposes; and (c) the ways in which the literature reviewed informed the purpose of the study and the development of the electronic survey.

Literature Critique

This critique focuses on four areas of concern: the speed with which the competencies were developed, the operationalization of the current competencies, the commitment in the current list of competencies to culture and context, and finally the interdisciplinary collaboration demonstrated by AAMFT with respect to the development of the competencies.

Development speed. In the marriage and family therapy field, the 128 core competencies for training and practice were commissioned by AAMFT and created by a group of experts in a period of less than two years. Other fields that have engaged in the work of identifying and defining competence spend decades engaging in discussions and collaborative work to determine the core principles and skills required of their practitioners (e.g., Arredondo & Perez, 2003;

Aubry, Flynn, Gerber, & Dostaler, 2005; Kaslow, 2004) the MFT competencies were created and distributed in less than five years. Miller, Todahl, and Platt (2010) noted that professional organizations tend to engage in competency development using a similar set of tasks: (a) define competency, (b) align those definitions with the organization's values, (c) identify and list competencies, (d) explore implementation and evaluation protocols, and (e) struggle with the complexity and implications of the task.

Implementing and evaluating non-operationalized competencies. The speed of the process by which the MFT competencies were developed may also be in part to blame for the criticism that they have vaguely defined outcome variables that are difficult to operationalize and evaluate (Nelson & Smock, 2005). Despite the lack of specificity, however, training programs are increasingly including core competencies into their curricula. Those programs are challenged with how best to implement those competencies and how to measure when students in clinical practice have achieved them. At this time, no guidance has come from AAMFT about how best to approach the implementation or evaluative tasks required to demonstrate that training programs are producing competent practitioners.

Even if AAMFT were to provide guidance about how programs should operationalize, implement, and evaluate the competencies, however, that list would need to be revised with regularity in order to remain relevant to the changing needs of clients and practitioners in the mental health field. It is generally acknowledged that competency lists have a lifespan of three to five years; after that time, the lists become outdated and require revision (ASPH Education Committee, 2006). Since the MFT core competencies were published in 2006, no further revisions have been made to that document.

Culture and context. Another criticism of the current competency list is its lack of clarity around issues of culture and context in clinical practice. It was found that stakeholder feedback regarding the list of competencies “focused on the need for clarity of meaning and the important role of cultural competence” (Nelson et al., 2007, p. 426). The task force responsible for the creation of the list interpreted the need to clarify the call for cultural competence by revising the preamble to the document, broadening definitions of client and family systems, as well as saying: “The core competencies encompass behaviors, skills, attitudes, and policies that promote awareness, acceptance, and respect for differences, enhance services that meet the needs of diverse populations, and promote resiliency and recovery” (Nelson et al., 2007, p. 426). No further clarity is provided about the contextual factors and cultural competencies that must be demonstrated in order to prepare a workforce that provides care that is “client-centered, timely, efficient, and equitable” (Nelson et al., 2007, p. 418).

The few competencies in the document that more directly address culture and context are vague and difficult to operationalize and therefore implement into the training curriculum. As stated by Rigazio-DiGilio (2004),

The competencies that directly or indirectly address culture and context lack the level of specificity necessary to explicitly identify and assess competencies MFTs need to possess to provide effective and relevant service to diverse populations. As important, cultural and contextual competencies are insufficiently accounted for as foreground factors that should define and inform revisions and extensions in our profession’s theories, therapies, and practices, and that should be considered at the point of theory development, research design, and professional identity development. (p. 1)

The efforts to identify and operationalize culturally and contextually appropriate competencies for marriage and family therapists have been largely inconsistent, despite a stated goal of “improv[ing] the quality of services delivered by marriage and family therapists... in the context of the broader behavioral health system” (AAMFT, 2004, p. 1).

Interdisciplinary collaboration. It is generally acknowledged that the mental health care delivery system has much to learn from work on competencies that has been advancing in other disciplines for several decades (Brooks, 2010; Hoge, Morris, et al., 2005). However, the responsibility to define competencies representative of a field’s scope of practice has typically been delegated to “experts” within each mental health profession. As a result, competencies defined by mental health professions have been minimally informed by principles, definitions, and models that have evolved through years of research and application within many fields, and specifically, within the fields of education, medicine, and MCT. “Many of the reforms efforts ... ‘have been implemented without a deep understanding of what learning really means and the specific circumstances and strategies that are likely to promote it’” (Ewell, 1997, p. 3 as cited in Driscoll & Wood, 2007). Ewell (1997) highlighted the importance of using emerging research to guide efforts in educational reform. This is particularly relevant to today’s mental health care crisis and to this project, given that these extensive bodies of knowledge continue to be underutilized by several of the core mental health disciplines and minimally inform efforts to identify, operationalize, advance, and assess the clinical, cultural, and contextual competencies necessary to provide accessible, quality, effective, and relevant services.

Literature-informed survey construction. The literature highlighted throughout this review provides context for how one field, marriage and family therapy, has approached the development of competencies. The field’s approach is not novel, following a similar set of steps

to that of the medical and behavioral health fields. Where it differs, however, is in its lack of commitment to ongoing collaboration, despite the field's tradition of interdisciplinary teamwork.

This dissertation project sought to determine the progress of the accredited couple and family therapy training programs in the US and Canada in the implementation of the educational reforms, with special attention paid to the efforts being made to step outside the confines of the profession to share knowledge and resources. The survey sought to gather feedback from program leadership and educators about their experiences with the reform. The survey was designed in consultation with interdisciplinary scholars using literature from numerous professions, both in the behavioral field and more broadly. Throughout the survey, participants were provided access to resources in their own work. At the end, each participant was offered the opportunity to continue to engage in cross-disciplinary knowledge sharing and collaboration in the hopes of moving away from disciplinary silos to competent clinical practice.

Chapter 3: Research Methods

Purpose for Study

This study extends work already done in the area of outcome-based education in marriage and family therapy graduate and post-graduate studies (e.g., Brooks, 2010; Gehart, 2011b; Graves, 2005; Heetderks, 2008; Hodgson, Lamson, & Feldhousen, 2007; Miller, 2010; Miller, Linville, Todahl, & Metcalfe, 2009; Miller, Todahl, & Platt, 2010; Nelson & Graves, 2011; Perosa & Perosa, 2010; Peterson, 2011) and complements these and other efforts in the wider mental health field and other disciplines (e.g., Bell, 2005; Falender et al., 2004; Hellkamp, Zins, Ferguson, & Hodge, 1998; Hoge, Paris, et al., 2005; Kaslow, Celano, & Stanton, 2005). The study specifically builds on the work of Brooks (2010), who found that MFT faculty members were only minimally aware of the ways in which core competencies were intended to facilitate the move to outcome-based preparatory training.

This study addresses the need to understand the degree to which MFT faculty members are aware of the relationship between the profession's move to competency-based best practice standards and outcome-based preparatory education and the call for major reform in mental health care delivery systems. Additionally, the study investigates the factors contributing to the lack of progress being made in the MFT profession to transition mental health scientist/practitioner preparation programs from input-driven to outcome-based training. The project explored the lack of attention being given to recommendations to collaborate with other mental health disciplines and to draw from established models of cultural competence to expedite this process. Finally, the study explored the ways in which leaders in this profession respond to possible venues for interdisciplinary collaboration with core mental health disciplines and for learning more about established and relevant models of cultural competence.

Research Questions

The study explored four primary research questions:

RQ1. To what degree do MFT leaders have a comprehensive understanding of: (a) the call for educational reforms in the preparation of future generations of MFT professionals; (b) the relationship between this call and the broader call for transformations in mental health care delivery systems; and, (c) the recommendations they have been called upon to consider as one way to meet their responsibility to develop effective outcome-based scientist/practitioner preparation programs as an initial step in transforming the mental health workforce?

RQ2. What efforts are being made within the MFT profession to address the call for reliable and valid competency models and outcome-based preparation programs and what obstacles are defined as hindering progress, with specific emphasis on investigating the degree to which MFT program directors and clinical faculty members are engaging in interdisciplinary collaboration with other mental health disciplines and are considering established models of competence (e.g., MCT)?

RQ3. How do MFT program directors and clinical faculty critique their efforts to address the call for reliable and valid competency models and outcome-based preparation programs independently and evaluate their progress to date, first within their own context, and later, within the context of broader information about: (a) recommendations for interdisciplinary collaboration and knowledge sharing in advancing successful educational reforms; and, (b) evaluations of the progress made thus far across the five core mental health professions?

RQ4. To what degree does asking questions about the possibilities, limits, and barriers to interdisciplinary collaboration and knowledge sharing, while also making information and collaborative opportunities available to study participants: (a) *initiate requests* for further

resources and collaborative forums among MFT leaders; and, (b) generate *active interest in* and *commitment to* both contributing to and engaging in interdisciplinary knowledge sharing and collaboration?

Research Methods and Procedures

Participant Sample

Despite the prevalence of electronic surveys in the United States, limited research has been done to examine its effectiveness as an information-gathering tool (Sue & Ritter, 2007). To that end, the determination of response rates varies across sources:

There is a wide range of response rates that are considered acceptable. In general, a response rate [for e-mail surveys] of 50% is adequate, a 60% response rate is good, and a 70% response rate is considered very good (Kittleson, 1997). Overall, the literature indicates that the response rates for e-mail surveys range between 24% and 76%. (Sue & Ritter, 2007, pp. 7-8)

In a meta-analysis of the efficacy of recruitment using e-mail surveys, Sheehan (2001) found an average response rate of roughly 37% across 31 social science studies, a figure below the indicated adequate survey response rate suggested by Kittleson (2007). Recent research specifically surveying MFT faculty found a response rate consistent with that average (e.g., Grams, Carlson, & McGeorge, 2007). This study looked to obtain a response rate percentage consistent with those found in studies of the marriage and family therapy field, as these percentages fall within the range indicated by Sue and Ritter (2007).

Participants in this study included MFT program directors and clinical faculty members from COAMFTE-accredited graduate and post-graduate training programs that consented to participate in the online survey. There are 92 COAMFTE accredited graduate and post-graduate

training programs in the United States and Canada (AAMFT, 2013). Among the 92 programs, 21 include more than one type of terminal degree (e.g., MA and PhD). Ninety-six people serve as program directors, with some directors responsible for the administration of more than one terminal degree within their training program. The previous COAMFTE accreditation standards, Version 10.3, required accredited programs to include between two and five core clinical faculty involved in the training of MFT students (AAMFT, 2004). A review of published program websites revealed that not all programs comply with these former standards: programs list core faculty sizes as small as one and as large as thirty educators.

Using the estimation that 37% of the clinical faculty and program directors would respond to the invitation to participate (Sheehan, 2001) and accounting for recruitment timing and other factors, the total subject pool was estimated to include between 60 and 100 people. The final number of respondents in the online survey was 111 program directors and clinical faculty members. Of that group, 46 completed the survey, for a participation rate of 41.4%. That rate was slightly higher than those provided in previous research of online surveys with this population.

Measures

Demographic questionnaire. The demographic questionnaire found at the end of the survey (Appendix A) included variables adapted from questionnaires used by researchers collecting survey data from COAMFTE Accredited Programs (e.g., Brooks, 2010; Graves, 2005). For example, program demographics included questions about geographic location, degree(s) offered, years accredited, and year of accreditation renewal. Personal and professional characteristics of the participants also were obtained, including age, gender, ethnicity, highest

degree earned, professional license(s), and position in current program (e.g., assistant / associate / full professor, clinic director, program director).

Online survey. The online survey (Appendix A) included four main sections, with both quantitative and qualitative items comprised of multiple-choice, yes/no, five-point Likert-scale, and open-ended questions. The survey had an anticipated completion time of 15 - 20 minutes, depending on the depth of information the participants were willing to provide. The survey concluded with an invitation for participants to email the research assistant if they were interested in contributing to and/or engaging in online venues for interdisciplinary knowledge sharing and collaboration.

In accordance with protocols for internet-based research provided by the university ethics review board, the online survey was formatted in a way that allowed participants to skip questions if they wished by providing the response “*I choose not to answer*” in quantitative questions or “*no*” in open-ended qualitative questions. Additionally, participants were able to withdraw from the study at any point.

Section one. The first section of the survey addressed the respondents’ understanding and critique of: (a) the call for a transition to outcome-based educational standards in all mental health preparation programs, including the rationale for this call, the recommendations for establishing core competencies and outcome-based training standards, and the recommended methods for developing core competencies that reflect best practice; (b) the process by which the professional association for MFT developed core competencies for MFT practice (AAMFT, 2004); and (c) the process by which the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) developed outcome-based standards for MFT accredited programs (COAMFTE, 2005).

Section two. The second section of the survey asked participants to describe and evaluate: (a) their programmatic efforts to transition to COAMFTE outcome-based educational standards; (b) the progress they have made thus far in identifying, operationalizing, implementing, evaluating, and revising competencies that centrally inform their programs of study; and, (c) any interdisciplinary collaboration or knowledge sharing they have incorporated into their work.

Section three. Section Three began with a brief explanation of the broader recommendations related to interdisciplinary collaboration and knowledge sharing, the evaluations of the degree to which these recommendations have informed the transition to outcome-based training across the five mental health professions, and the results of these efforts. Links to references also were provided for those interested in further reviewing public documents pertaining to each of these three issues. These descriptions were followed by questions that asked respondents to reconsider evaluative items responded to in Section Two in the context of the broader information introduced at the beginning of this section.

Section four. Section Four began with a brief description of the range of public resources available to assist mental health professions in the move towards competency-based standards and outcome-based education. Links to illustrative resources were part of this description. The description was followed by items asking respondents to comment on the usefulness of such resources as well as the degree to which they would consider participating in and contributing to an interactive website dedicated to sharing and advancing knowledge regarding competency-based standards and outcome-based education. Specifically, respondents were asked to indicate the degree to which they would consider contributing to and engaging in within-discipline and interdisciplinary knowledge sharing, forums, and work groups.

Final page. The survey ended with a final page offering information about a post-dissertation website to be developed by the researcher for the purpose of interdisciplinary knowledge sharing and collaboration. Participants who completed and submitted the online demographic questionnaire and survey were invited to email the research assistant if they wished to participate in or contribute to this website.

Procedures

Survey Construction

Cook, Heath, and Thompson (2000) mention several factors affecting survey response rates: information salience to participants, survey length, and follow-up. Each of these variables was addressed in the construction of the measure and in the data collection process. To construct the survey used in this study, the research team drew from: (a) initial results of a content analysis examining cross disciplinary efforts to address competencies and educational reforms in mental health professions including marriage and family therapy, social work, counseling, and psychology (Baker, Thurston, & Rigazio-DiGilio, in work); (b) publicly available reports and research identified throughout this study; (c) established models of cultural competency; and, (d) surveys previously developed to elicit feedback from program directors and other educators about the state of their graduate psychotherapy training programs (e.g., Bell, 2005; Brooks, 2010; Graves, 2005; Heetderks, 2008; Nelson & Graves, 2011). Specifically, this broad knowledge base informed:

1. Survey items that correspond with the four research objectives addressed within each major section of the survey.
2. Descriptive and evaluative resources made available throughout the survey.
3. Evaluative Likert scales in Sections Two and Three of the survey.

Once the draft was in its final form, the researcher solicited feedback from four experts in competency-based standards and outcome-based training, to determine the face and content validity of the proposed online survey (Anastasi, 1988). The total design concept (Nelson & Allred, 2005) describes how poor questionnaire design and sampling error can be avoided to ensure the instrument is relevant and valid. Reviewers were provided information about the study objectives, the general purpose of the survey, and the specific purpose of each section of the survey, including the final page. They were asked to complete the survey and to provide specific recommendations for ways in which the survey could be improved, giving special attention to the following questions:

1. Do the survey and final page contain items that specifically address the research objectives?
2. Do the items in each section of the survey and the final page accurately reflect the intended purpose of the section?
3. What recommendations do you have for:
 - a. Eliminating potential redundancies?
 - b. Reducing potential ambiguities?
 - c. Addressing critical information not already covered?
4. Are the survey sections and final page formatted well (i.e., easy to read, clear instructions, easy to access links)?
5. Do the survey sections and final page read clearly?
6. Does the identified time it will take to complete the survey (15 to 20 minutes) accurately represent the time it took you to do so?
7. Did the survey format or length dissuade you from responding to the invitation on the final page?

The researcher additionally asked for the experts' recommendations and suggestions regarding the following broader topic:

1. Given the number of online surveys MFT faculty are asked to complete, what do you recommend should be highlighted about the study or the resources that will be made available to study participants to best generate faculty interest in the study and in completing the online survey and final page?

Reviewer feedback was incorporated into the online survey. The experts were then asked to re-review the survey to ensure that their feedback was accurately addressed. The reviewed and modified survey was submitted to the Institutional Review Board for approval before participants were recruited for the study.

Recruitment Procedures

The Directory of MFT Training Programs (2013) was used to identify names and contact information for MFT program directors of all COAMFTE-accredited Masters, doctoral, and post-degree training programs in the United States and Canada ($n = 92$). Directors were asked to identify the MFT clinical faculty employed by their institutions that participate in programmatic efforts to address the current COAMFTE requirements for outcome-based training (COAMFTE, 2008). They were also asked to forward the survey to their clinical faculty in the final communication to increase potential faculty participation. Appendix B includes the Participant Recruitment Protocols that were used to recruit participants through all phases of data collection.

Phase one. The research assistant made an initial telephone or voicemail contact with MFT program directors with information about the study and requested both their participation in the online survey as well as the contact information for all MFT clinical faculty participating in programmatic efforts to address the current COAMFTE requirements for outcome-based

training (COAMFTE, 2008). The research assistant removed program directors from the population pool if they indicated that they were not interested in participating in the study. This information was stored separately from all data collected online (i.e., demographic questionnaires and surveys) to ensure the confidentiality of all participants.

Immediately after each contact, the research assistant sent an invitation email to directors that expressed interest in participating in the survey and/or in providing the names of the MFT clinical faculty. This and all subsequent emails to MFT program directors and MFT clinical faculty members explained the study in more detail, as well as the rights of study participants and the limits to confidentiality (UConn IRB, 2009). The directors were invited to participate in the study and were provided with the research assistant's email address to identify the MFT clinical faculty. The email additionally included a link to the online introduction and participant consent page, demographic questionnaire, and survey, which provided SSL encryption to ensure the security of the data transmission (UConn IRB, 2009). Invitation emails were stored separately from all data collected online (i.e., demographic questionnaires and surveys) to ensure the confidentiality of all participants.

In addition, throughout this and all other phases of data collection, program directors that sent emails identifying MFT clinical faculty received an appreciation email from the research assistant, thanking them for the list and welcoming them to complete the survey if they had not done so already. The email included the same link to the online introduction and participant consent page, demographic questionnaire, and survey. Appreciation emails were stored separately from all data collected online (i.e., demographic questionnaires and surveys) to ensure the confidentiality of all participants.

Phase two. MFT clinical faculty identified by program directors were sent an invitation email, indicating how they were identified and providing information about the study along with a request to participate in the online survey. The email included the same link to the online introduction and participant consent page, demographic questionnaire, and survey.

Phase three. The third phase of data collection involved: (a) sending reminder emails to program directors who did not respond to the invitation email requesting the list of MFT clinical faculty within a two-week period, including a brief description of the study, a request to participate, the link to the online introduction and participant consent page, demographic questionnaire, and survey, and a request for the names and contact information of the MFT clinical faculty; and, (b) sending reminder emails to identified MFT clinical faculty, thanking them for participating, and reminding them to consider participating if they had not yet had the time to do so. The link to the online introduction and participant consent page, demographic questionnaire were included in the email.

To increase the likelihood that clinical faculty would have access to the survey to participate, the research team altered the original recruitment protocol, securing IRB approval for the revisions. The revised protocol asked program directors to forward the survey on to their clinical faculty members rather than asking them to send the contact information for those persons to the research assistant. The revised protocol also included the ability for the research team to find clinical faculty contact information on each program's published website. The two-pronged approach allowed for greater dissemination of the survey to the clinical faculty, either directly from the program director or from the research team.

Final phase. In the final phase of recruitment, directors who had not yet responded were sent a final reminder email about the study, along with a request to participate, an identified date

on which the survey would close, the same link to the online introduction and participant consent page, demographic questionnaire, and survey, and a request to forward the survey directly to the MFT clinical faculty. Additionally, for programs whose program director did not send the survey directly or send names of clinical faculty to the research assistant, the survey was sent to clinical faculty identified by the research team from the published program websites, as per the revised IRB-approved protocol. All identified MFT clinical faculty also received a final reminder, thanking them for participating, reminding them to consider participating if they had not yet had the time to do so, identifying the date that the study would close, and the same link to the online survey.

Data Collection

Potential participants interested in completing the online demographic questionnaire and survey were instructed to link to a website (a Professional SurveyMonkey Account that provides SSL encryption to ensure that any data intercepted during transmission cannot be decoded and that individual responses cannot be traced back to an individual respondent). The online survey (Appendix A) began with a participant consent page that explained the study in more detail, as well as the rights of study participants and the limits to confidentiality (UCONN IRB, 2009).

After reading the consent page, potential participants were instructed to click “yes” to indicate that they had read the information contained on the page and agreed to participate in this study or “no” to indicate that they did not agree to participate in the study. Those who clicked “no” were directed to the last page of the survey where they were asked to voluntarily explain their reasons for declining as a way to assist the researcher in designing future studies for this program of research. No explanations were received. Those who clicked “yes” were directed to the full online survey.

Participation Incentive

To provide incentive, emails for each data collection phase informed potential participants that the online survey contained information about and links to resources that could be useful to them in their efforts to address current reform requirements (COAMFTE, 2008). In addition, participants who completed and submitted the online survey were invited to participate in and contribute to a website that will be developed post-dissertation for sharing information and resources (Cook, Heath, & Thompson, 2000; Goritz, 2005).

Data Analysis Procedures

Quantitative data. The research questions posed in this cross-sectional exploratory project led to a global analysis of the data. Based on the broad nature of the research questions posed in this study, data were analyzed using a descriptive statistics design (e.g., Brooks, 2010). Descriptive research, including the use of survey design, is used to gather information about the characteristics of a population (Babbie, 2004; Brooks, 2010; Creswell, 2003). Surveys are used to collect standardized information from a sample of a population or, in this case, the entire population of MFT educators in COAMFTE-accredited training programs (Babbie, 2004; Brooks, 2010; Nelson & Allred, 2005). Survey research has been used in the field of marriage and family therapy to explore a number of issues including clinical training, supervision, and accreditation standards (e.g., Lee, Nichols, Nichols, & Odom, 2004; Nelson & Prior, 2003; Russell & Peterson, 2003).

For this particular analysis, participant feedback was reviewed in its totality and was not broken down into subgroups. In addition, the breakdown of response percentages for each survey item was ranked and considered both within the context of the question and combined with other survey items to provide feedback in response to exploratory research questions. Future research

using this dataset will include analysis by demographic variable groupings (e.g., gender, education, position, program location, etc.).

Qualitative data. A conventional content analysis procedure was used to determine categories for the open-ended questions found throughout the survey (Hennink, Hutter, & Bailey, 2010; Hsieh & Shannon, 2005). Inductive analytic procedures were used to discover patterns in the data (Onwuegbuzie & Leech, 2006). The research team created a classification system to break up the data into typologies, using iterative coding techniques (Miles & Huberman, 1994; Patton, 1980). The research team avoided using preconceived categories, allowing them to be derived directly from the data (Kondracki & Wellman, 2002). Team members acknowledged that researcher bias is an inevitable component of any qualitative analysis. Therefore, close attention was paid to the worldviews held by each person on the research team in order to minimize the unintended effects of biased data interpretation.

Research team's worldviews. Ponterotto (2005) described the role of the researcher's values in qualitative data analysis as axiology. That axiology influences the researcher's understanding and interpretation of the data. The transparency of the researchers' worldviews and biases is thus a critical component of qualitative analysis. Prior to the coding process and at several junctures throughout the qualitative data analysis, team members actively discussed the ways in which worldviews, expectations, biases, and positions of power might be influencing the analysis. These exchanges included, but were not limited to discussions about: (1) the evolution of their teaching, supervision, mentoring, and research philosophies, which developed over different times and in different contexts; (2) their perceptions of prior input-driven educational standards and current outcome-based educational standards that have or are now informing the ways in which scientist/practitioner preparation programs socialize and train new generations;

(3) the direct and indirect activities and / or experiences they have been and are currently involved in regarding the advancement, critique, and evaluation of current AAMFT competencies and COAMFTE standards; (4) their knowledge about and perceptions of past and current standards as these have evolved over time; (5) their expectations regarding the ways in which current competencies and standards are being addressed; and (6) their beliefs about the ways in which current national calls, competencies, and standards will be incorporated and will influence the preparation of competent and relevant mental health scientist/practitioners.

To provide a context for the collaborative qualitative analysis process that unfolded, some of the core components of each member's worldviews, expectations, and biases as discussed in the ongoing dialogues are summarized. The primary researcher is a doctoral candidate in a COAMFTE accredited training program that offers both Master's- and doctoral-level degrees. Her teaching, supervision, mentoring, and research philosophies are influenced by an emphasis on collaborative knowledge sharing both within and across disciplines. She has worked closely with interdisciplinary scholars, supervisors, and educators while forming her professional foundation as a scientist/practitioner. Her training program began the move to outcome-based education with a demonstrated commitment to the operationalization of the competencies to include culture and contextual factors. Her training included a strong commitment to issues of social justice and access to relevant and appropriate therapeutic services for all persons in need. The implementation of her program's selected competencies became formalized after the primary researcher had completed the didactic portion of the program. The primary researcher's interest in outcome-based education led to an involvement in the program's competency development during her doctoral internship.

The primary researcher's beliefs about input-driven standards are informed by her experience as having been assessed by them in both her Master's and doctoral academic programs. While completing her Master's degree program requirements, she turned to faculty and supervisory advisors to provide additional guidance about what constituted competent clinical practice and research. Based on those discussions, she engaged in advanced studies by enrolling in the doctoral program. She spent the next several years working on various research and clinical projects to examine how the behavioral health field as a whole is addressing the need for clinical competence. Her perceptions of the current outcome-based standards are influenced by the research she has done in the area of educational reform across disciplines, by discussions with faculty, students, and clients about standards of care, and by personal experience in a program attempting to respond to the myriad calls for educational reform.

Based on her studies of interdisciplinary outcome-based educational standards as they relate to the production of clinically and culturally competent practitioners, the first research team member perceives this current call to educational reform as a reiteration of calls that have been made over a long history in the US. Based on her studies of existing literature across disciplines, she perceives mental health professions as particularly slow to respond, demonstrating an unwillingness to engage in within- or cross-disciplinary collaborative efforts. She is not convinced that this current reform movement will lead to substantial, relevant, or long lasting changes in the mental health workforce.

After earning a Master's degree in rehabilitation counseling, the second research team member attended a COAMFTE-accredited post-degree program, which trained professionals from various mental health disciplines in the specialty of marriage and family therapy. MFT training at that time was theoretically specific and reflected a competitive culture where each

MFT approach was vying for disciples and funding, and each training program was competing for students and credibility. To survive, each program staked out its theoretical territory at the expense of broader formulations. Finding the way out of this state of affairs was difficult because practitioners (either clinically or academically oriented) were discouraged from noticing commonalities across models and disciplines and ran the risk of being perceived as disloyal to their programs.

The second research team member's move toward integration did not emerge from the profession's knowledge base or from mentors but rather from her practice as an inpatient and outpatient clinician in an urban hospital. In this setting, she found her services to be of little value to many who came to her for help; what she knew from her training was not sufficient. At the same time, her life experiences in the wider community began to reveal the limits of the counseling and MFT therapy models, which were not just less relevant to underrepresented and underserved populations, but actually exclusionary and biased.

In her doctoral work in psychology, she learned from and collaborated with multidisciplinary scientist/practitioners brought together under the professional discipline of multicultural counseling and therapy (MCT). She became active in teaching, publishing, and presenting geared toward varying disciplines grounded in the MCT philosophy. Since joining a COAMFTE-accredited Master's and doctoral program as a faculty member, her scholarship has focused on advancing integrative and alternative models of family therapy that are not simply extensions of traditional theories and approaches, but provide multiple means to relate client need to particular therapeutic techniques across all disciplines. Her work at the university, her interest in developing an integrative disposition in her students, and her professional activities

and conversations at the national and international levels about scientist/practitioner preparation programming led to her knowledge about outcome-based program design.

Given her years of experience, she perceives this current call as reflecting one in a series of calls, over more than half a century, urging all mental health professions to address (in theory, practice, and research) underrepresented and underserved populations and communities. Based on her multidisciplinary affiliations, she perceives mental health professions as slow to respond to these calls and as resistant to collaborating across disciplines and to fully appreciating the boundaries of their own competence and the expertise each discipline offers. She is apprehensive that this current movement will lead to differences of any real significance, but rather represent a continuation of the status quo.

Both team members acknowledged the aspects of their worldviews that were complementary and the ways in which this could influence the qualitative data analysis such that we could reach consensus quickly. As well, both members recognized that, while it is impossible to separate one's worldview from the research endeavor, overtly attending to worldviews throughout the research process was one way to ensure that this did not occur. Thus, the team designed ways to keep this in the forefront through frequent discussions and check-ins to make sure we did not move too quickly into consensus and that the analysis provided a depth and breadth to the research questions being explored.

After initial discussions about our worldviews and biases, the first step in the analysis procedure was to identify categories based on participant data. The research team (consisting of the primary researcher and her major advisor) collaboratively generated categories to address issues of credibility (Lincoln & Guba, 1985). In this analytic procedure, several efforts were

made to manage credibility: peer debriefing, prolonged engagement, persistent observation, member checks, and triangulation (Hsieh & Shannon; Lincoln & Guba, 1985; Manning, 1997).

In the conventional content analysis procedure described by Hsieh and Shannon (2005), data were read and re-read to derive codes by highlighting words or phrases that captured key concepts. The research team made notes about first impressions and initial analysis, with labels emerging for codes that reflected more than one key idea. Codes were then sorted into categories based on their relationships. The first category indicated that the participant had a deep understanding of the issues presented in the question prompt; the second category represented responses that indicated some or limited understanding of the issues; the final category was for responses that indicated no understanding.

After a preliminary effort to code data independently, the research team discovered discrepancies in the placement of data in the selected categories. In coding the first 38 statements of the first question, we found discrepancies on 14 items, resulting in an agreement rate of 63%. The first coding effort of the first 32 statements from the second qualitative question resulted in an inter-coder agreement rate of 75%. We discussed the nature of the discrepancies and determined that an additional layer of specificity needed to be added in order to capture the level of participant comprehension of the issues. It became clear that the second category, previously indicating some or limited understanding of the issues, needed further specification. That category was broken into two: (1) responses indicating a moderate degree of understanding, and (2) responses indicating a low degree of understanding. The research team added a category to code for participant responses that indicated a desire not to respond to the question.

As Patton (1980) noted, “once these labels have been identified from an analysis... the next step is to identify the attributes or characteristics that distinguish one thing from another” (p.

307). The research team created preliminary definitions of each of the four categories and began to delineate the difference between a clear, moderate, and low understanding of the issues as they pertained to each question. As the research team coded the remaining data, we further refined these definitions consensually and gained clarity on the code that indicated no understanding as well.

The research team re-coded the first fifty items of the first two qualitative questions and discussed the results. There was a 90% agreement rate for the first question, with five discrepant items of the total 50. There was a 92% agreement rate for the second question, with four discrepant items of the total 50. Each discrepancy was discussed and consensually re-coded. The research team noted that all discrepancies in the first fifty statements were adjacent by one degree (i.e., one person indicate a low degree of understanding while the other selected a moderate degree of understanding). Discussion about each of the items revealed that the coders had emphasized different parts of the data statements in making coding determinations. We clarified the definitions further, consensually refining statements to ensure shared understanding. The coding matrix definitions were finalized as follows:

Research question: In 2005, COAMFTE made the decision to transition from input-driven to outcome-based education. Briefly explain your understanding of the reasons for this philosophical shift.

1. High degree of understanding: Response indicates a sense for the wider trend in education across disciplines, and that all professions must engage in this type of reform. The response will also include reference to accountability to consumers and students.

2. Moderate degree of understanding: Response suggests that educational standards need to be better or more accountable / measureable with a sense that the mental health field or MFT education needs to be better (i.e., professional silo).
3. Low degree of understanding: Response focuses solely on accountability to managed care. References are possible to a connection between evidence-based education and the evidence-based treatment movement (with a focus on measurable outcomes). A possible reference to the needs of individual training programs changing (i.e., program silo).
4. No understanding: AAMFT / COAMFTE is perceived to be forcing change in the programs. The participant may refer to not knowing why the changes need to be made.

Research question: Over the last decade, several national calls have been made for mental health preparation programs to shift from input-driven to outcome-based training (e.g., New Freedom Commission, 2003). Briefly explain your understanding of these calls.

1. High degree of understanding: Response demonstrates a sense of wider context for the changes, particularly a connection between current efforts and history of calls (e.g., discounting the belief that this reform movement is new).
2. Moderate degree of understanding: The response indicates no understanding of the wider context but demonstrates the idea that pedagogical shifts have and are occurring, likely coupled with the connection between education and clinical treatment.
3. Low degree of understanding: The response focuses on treatment or educational outcomes and general accountability.

4. No understanding: The response indicates lack of knowledge about calls for educational reform from a national level.

A corresponding sample of quotes were collected that best captured each of the defined categories. As stated by Frake (1962), “the purpose of this analysis is to discern and report ‘how people construe their world of experience from the way they talk about it’” (p. 74, as cited in Patton, 1980, p. 307). The words and categories used by participants represent the indigenous typologies that “are clues ... that the phenomena to which the labels refer are important to the people... and to fully understand the [response] it is necessary to understand those terms and their implications for the program[s]” (Patton, 1980, p. 308).

Other qualitative data. In keeping with the inductive content analysis procedure (Hsieh & Shannon, 2005), data from other qualitative questions were coded to identify preliminary categories and subcategories. After review of the codes, the research team met in consensus sessions to determine the final categories and subcategories for each question. The research team developed a coding matrix that was used to classify the data. The final coding matrix included definitions that clarified each category and subcategory along with representative quotes to illustrate each.

Eighteen of the quantitative questions included opportunities for participants to provide feedback of a qualitative nature, either by asking them directly for comments or for clarification of one of the categories they selected. Responses from those sections were used to triangulate and inform the quantitative results. Those analyses are included with the corresponding quantitative data analysis for clarity.

In addition, in the last section of the survey, there were opportunities for participants to identify the resources and expertise that they have or that they need in order to further their

efforts to advance and evaluate required educational reforms. Participants were asked to assess their professional level of expertise in the areas of competency identification, operationalization, implementation, evaluation, and revision. Participants who rated themselves as having some or strong expertise were asked what they would contribute to an ongoing collaborative knowledge and resource-sharing forum. Those who assessed their level of expertise as minimal or none were asked what they felt would be important for their learning (e.g., documents, webinars, forums, etc.). The qualitative data taken from the follow up questions were listed and frequencies were included.

Instrument bias. To clarify that the intention of this project was to explore educators' views on the outcome-based educational reform in the field of Marriage and Family Therapy and not to suggest that the researcher was taking a position in support of or in opposition to that educational reform, a question was asked early in the survey to provide a venue for participant feedback about the shift. The intent of the question was to give participants an opportunity to share their thoughts about the reform movement as it relates to competent clinical practice. The question was open-ended and the feedback from that question was used to inform the findings of both the quantitative and qualitative data included throughout the remainder of the survey.

Chapter 4: Data Analysis

The objective of the study was to determine how competencies are being used in MFT training programs and how programs are collaborating in order to facilitate the shift from input-driven to outcome-based education. The quantitative data were obtained from the online survey. The survey questions asked the participants to describe the process by which they are addressing the outcome-based educational paradigm shift. The participants included 111 MFT program directors and clinical faculty members from COAMFTE-accredited graduate and post-graduate training programs in the United States and Canada.

This mixed methods exploratory project used an online survey with open and closed questions to triangulate findings. In the examination of the quantitative data, a distribution analysis was conducted to determine the dispersion of the survey responses. Specifically, percentages of the responses for each item of the survey were compared based on the frequency or the number of responses of each survey questions (n). The n varied for each of the survey questions with a maximum number of respondents for a quantitative question of 65 participants. Qualitative data were used to explore a number of issues around the educational reform requirements. The qualitative questions were analyzed using an inductive analytic procedure, with participant data coded by the research team. The maximum number of respondents for a quantitative question was 88 participants.

Demographic Information

Participants were asked to provide demographic details about themselves and about their respective programs. The demographic questionnaire was placed at the end of the survey: by including questions about personal information at the end of the survey, respondents were believed to have developed confidence in the study's objective (Iarossi, 2006). Forty-six people

provided information about themselves and their programs. The demographic questionnaire was generally designed to include questions first about the programs and next about the participants themselves to encourage maximum response.

Program information. Several questions focused on program demographics. Forty-six people provided information about their programs. The breakdown of program locations by region is included in Table 1. The most frequently represented locations were the West, with 28.3% of the responses, the Midwest, represented by 26.1% of the responses, and the Northeast, with 23.9%.

Table 1

Program Location by Geographic Region (Q39, n = 46)

	Response Percent	Response Count
Northeast (CT, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT)	23.9%	11
Southeast (AL, AR, FL, GA, KY, LA, MS, NC, SC, TN, VA, WV)	8.7%	4
Midwest (IL, IN, IA, KS, MI, MN, MO, ND, NE, OH, SD, WI)	26.1%	12
Southwest (AZ, NM, OK, TX)	10.9%	5
West (AK, CA, CO, HI, ID, MT, NV, OR, UT, WA, WY)	28.3%	13
Canada (AB, MB, ON, PQ)	4.3%	2
Prefer not to answer	8.7%	4

The majority of the programs (80.4%) described include a Master's degree; 39.1% of the programs described include a doctoral degree. An additional 19.6% of the programs with faculty members that participated in the study include post-degree or certification in MFT. The most frequently described Master's level programs had been in operation for 26 to 30 years (21.6%), doctoral programs for six to 10 years (20.0%), and post-degree programs were evenly dispersed along the spectrum, ranging from three to more than 40 years. The most frequently described Master's level program had been COAMFTE accredited for six to 10 years, doctoral program for 11 to 15 years, and the post-degree programs were again dispersed along a spectrum ranging

from less than three years to more than 40 years. The Master's level programs have been complying with the COAMFTE Version 11 standards for one to two years (17.6%) and three to four years (17.6%). Doctoral level programs and post-degree programs were likewise split with one to two years (13.3%) and three to four years (13.3%) and less than one year (25%) and four to five years (25%) respectively. Participants whose programs included doctoral studies were most likely to prefer not to answer questions about the demographics of their programs.

Program directors and faculty identified the date of their next scheduled accreditation site visit, beginning in 2013 (the year the survey was administered) and ending in 2019 to reflect the current 6-year reaccreditation cycles. This question was included in the survey to determine the urgency with which programs are considering their response to the required educational reform. Each site visit requires programs to catalog and describe their educational practices around student competency, so it was presumed that programs with recent or impending site visits will be considering their pedagogical strategies more frequently than those with more time until their next visit. The most frequently selected date was 2017, representing 19.6% of the programs described in the study. The next most frequently selected dates were 2013 (13% of the programs), 2014 (10.9% of the programs), and 2015 (8.7% of the programs). Thirteen percent of the participants did not know when their next accreditation site visit was scheduled.

To learn about the type of collaboration occurring between the MFT programs described in the survey data and the other mental health preparation programs potentially housed in the institutions represented by the participants, the survey asked respondents to describe the types of educational and supervisory exchanges that occur across programs. The five most frequently selected exchanges were: students from other mental health preparation programs taking MFT courses (54.3%), MFT students taking courses in other mental health preparation programs

(45.7%), MFT faculty and students engaging in collaborative initiatives with other mental health preparation programs (43.5%), faculty and students from other mental health preparation programs engage in collaborative initiatives in the MFT program (41.3%), and faculty from other mental health preparation programs teach / supervise in the MFT program (37.0%). Minimal exchange occurs across 28.3% of the identified mental health preparation programs and 17.4% of the participants reported that no other mental health preparation programs are housed in the institution. One person provided qualitative feedback that his or her program collaborates well with continuing education workshops and seminars.

The most frequently chosen educator positions that were identified as being actively involved and responsible for outcome-based training was one full professor (41.2%), two associate professors (38.7%), two assistant professors (41.2%), and five adjunct instructors or supervisors (28.0%). Table 2 shows the distribution of educator profiles across programs. Several participants provided clarification on their responses. One indicated that all members of their faculty are adjunct, with no full-time educators; another reported that the program has twenty adjunct professors; one said that the program director is a full time, non-tenure track position, and the final response was that the participant's program has one faculty-in-residence, a non-tenured position.

Table 2

Ranks of Educators Actively Involved in Instituting and Evaluating COAMFTE Accreditation Standards (Q43, n = 41)

Educator Rank	Percentage of Responses						Prefer Not to Answer
	0	1	2	3	4	5	
Full Professor	0.0%	41.2%	32.4%	8.8%	5.9%	2.9%	8.8%
Associate Professor	3.2%	29.0%	38.7%	9.7%	0.0%	6.5%	12.9%
Assistant Professor	3.4%	34.5%	41.4%	3.4%	3.4%	0.0%	13.8%
Adjunct Professor	15.8%	21.1%	5.3%	0.0%	10.5%	21.1%	26.3%
Adjunct Instructor / Supervisor	0.0%	12.0%	20.0%	12%	8%	28%	20%

Note. The adjunct professor category is a designation commonly found in post-degree or certificate programs.

Participants could skip categories that did not apply to their programs, which accounts for the variability in response numbers across categories.

Participant information. Participants in the study included 18 people who identified as program directors; the remaining 28 people who self-identified their professional roles in their programs included their positions as clinic directors, instructors, supervisors, and advisors.

Twelve people identified as holding the rank of full professor, nine as associate professor, and six as assistant professor. Three people identified as adjunct faculty. The overwhelming majority of participants identified as holding degrees in MFT: 20 of 34 respondents hold Master's degrees (58.8%), 26 of 43 respondents hold a doctoral degree (60.5%), four out of five respondents hold a post-degree in MFT (80%), and three quarters hold a specialty certificate in MFT (75%). Other reported degrees or certifications were psychology, counseling, sociology, religion, human development and family studies, and nursing. Of the 46 people who responded, 87% hold a license or certification in MFT, 13.0% in counseling, 19.6% in psychology, and 6.5% in social

work. Other certifications noted by participants included: AAMFT Approved Supervisor and registered nurse.

The final three questions of the survey asked participants personal data: age, gender, and cultural identity. Forty-six people responded to the question about age and the three most frequently chosen age ranges were 61-70 years old (28.3%), 30-40 years old (23.9%), and 41-50 years old (23.9%). The respondents were evenly distributed with 23 each identifying as male and female. The cultural identity question allowed for textual analysis. Of 46 people who responded, 73% described themselves as “white,” “Caucasian,” or “European-American.” Two percent described themselves as Asian, and 6% described themselves as biracial. Twenty-six percent of the group described themselves in reference to their country of origin (e.g., American, Canadian, and Irish). Four percent described themselves with respect to their religions (i.e., Jewish) and 2% referenced their sexuality (i.e., member of the LGBTQ community).

Research Question One

The data analysis and subsequent discussion of that analysis is organized by research question in order to ensure clarity. Data from each of the questions inform the other, however, and the overlap will be discussed where appropriate. The first research question of the study asked participants to comment qualitatively:

To what degree do MFT leaders have a comprehensive understanding of: (a) the call for educational reforms in the preparation of future generations of MFT professionals; (b) the relationship between this call and the broader call for transformations in mental health care delivery systems; and, (c) the recommendations they have been called upon to consider as one way to meet their responsibility to develop effective outcome-based

scientist/practitioner programs as an initial step in transforming the mental health workforce?

Two survey items, soliciting feedback from participants about their knowledge, specifically addressed the research question. The first survey item asked participants about educational reform efforts as they relate to graduate marriage and family therapy training. The question asked participants to “briefly explain [their] understanding of the reasons for [the] philosophical shift” from input-driven to outcome-based education in 2005. Qualitative data were organized into five categories corresponding with their level of understanding about the shift. Participant responses were codified as representing a high, moderate, low, or no degree of understanding. An additional category was included for people who chose to not provide data, as indicated by responding “*no*” or “---.”

Representative participant statements can be found in Table 3. Of the 88 people who responded, 15 indicated a high level of understanding about the reasons for the philosophical shift, representing 17% of the population. Twenty-four people indicated a moderate degree of understanding, or 27% of the educators. The largest number of responses indicated a low degree of understanding: 27 responses, or 31% of the educators. There were 18 responses that indicated no understanding of the reasons for the COAMFTE philosophical shift (20% of the educators) and four responses indicating a desire not to provide information (5%).

Table 3

*Representative Participant Data Indicating Degree of Comprehension about COAMFTE**Educational Reform Efforts (Q2, n = 88)*

Representative Participant Data	
High Degree	<p>To increase the rigor of the accreditation, and concurrently, to keep pace with the shift in a) mental health disciplines; and b) federal, state, and private research funding institutions, which, generally, only support empirically supported treatments that are outcome oriented.</p> <p>This shift corresponds to an increased emphasis in higher education to focus on competence rather than content. Students are taught how to act in competent manners, then they are given the chance to demonstrate this competence. It is thought that this provides students greater autonomy over their education as well as the ability to become competent without having to jump through hoops like having certain amounts of client contact hours.</p> <p>Outcome-based systems are the accepted standard for supporting quality improvement across business, industry, healthcare, and education. K-12 education moved this way much earlier under the NCATE standards. I understood that COAMFTE was late in moving to OBE, and was under some pressure by their own [<i>sic</i>] accrediting body, CHEA, to make this shift. It is my understanding that external oversight bodies such as accrediting, health commissions, and licensing boards urged educators to develop reliable and sophisticated methods for systematically assessing students' educational development, evaluating program objectives and curricula, as well as predicting performance. Efforts to improve the quality of health care services has resulted in the emergence of "best practice" and "evidence informed practice" models which has challenged health care professionals to develop clear mechanisms to certify clinical competency and to ensure skilled and competent practitioners. Nursing, medicine, and other fields first transitioned to outcome based education and now we have begun the transition. In 2005 the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) developed new outcome based accreditation standards to be implemented by July 31, 2007 in all accredited programs because of increasing attention on evaluating the quality of education and clinical training in health care professional programs.</p>
Moderate Degree	<p>In order to move forward as a field, we need to be able to demonstrate our effectiveness in educating and training students. Therefore, outcomes must be shown at every level (student, supervisor/instructor, program, field).</p> <p>To keep pace with other social service professions</p> <p>This shift reflects a desire to evaluate the efficacy of inputs on achievement of educational objectives. In so doing, educational inputs can be modified as required to assist student learning.</p> <p>To follow along with trends regarding public mental health and recovery oriented care. Also due to evidence based practices that are very much</p>

	emphasized in the field
Low Degree	<p>This was a shift from a prescriptive approach with COAMFTE defining what each program should offer/do/evaluate, and instead move it to a program defined outcome that is to be articulated and then evaluated.</p> <p>Outcomes help determine learning. Educators and funders are hoping to make learning for efficient and accountable.</p> <p>I think its [<i>sic</i>] easier to demonstrate effectiveness as a field if we can demonstrate effective training. The best way to demonstrate effective training is through outcome-based measures.</p> <p>My understanding of the reasons for this shift center around a broader paradigm shift affecting other fields and clinical services beyond MFT or even mental health therapy. The last 10 years in the US have been marked by economic slowing. As a result there have been increased budgetary strains on insurance companies, government funding agencies and other forces which monitor the flow of money and other resources toward human services. It is my perception that this strain on finances has led to an increase in accountability requirements for the "products" of human service and human service training programs. In other words, the measurable, external outcomes of human service provisions have taken on paramount importance as they are easier for those outside the human service fields to justify resource expenditure.</p>
No Degree	<p>Alignment with State licensure standards and other standards.</p> <p>To evaluate whether learning is translated into practice</p> <p>I am not sure of the reasons for this philosophical shift. However it sounds as if outcome based will only limit input with regards to what is considered only outcome based and not making a more "comprehensive" blending of the two.</p> <p>Who knows</p>

As indicated in an earlier chapter, the raters delineated categories with clear differentiating characteristics. Participants whose responses indicated a high degree of understanding were designated by those with an understanding of the wider trend towards evaluating competence rather than input across education and across fields of study. In addition, those responses indicated a commitment and accountability to consumers (clients) and students. Some representative statements that highlight this degree of comprehension include:

First, I believe the shift is in response to a change in the Department of Education as it measures student growth and learning processes. Second, I think the change is a result in a cultural shift towards measurable outcomes in tracking achievement in a variety of settings, including managed care and insurance for example. Third, I hope the shift is in

response to the ideas of evidenced based practice which [*sic*] encourages therapists to utilize research to inform ethical and competent clinical practice with clients.

Another response indicating a high level of comprehension stated,

I believe the decision arose out of a larger shift in education toward outcome-based education. Additionally, it was done to make training programs more accountable in terms of defining what they will deliver to students, how they will deliver it, and measuring, in some way, what the students actually receive (the outcomes).

In contrast to those persons with a high level of understanding, some 20% of the responses indicated no understanding of the reasons why COAMFTE instituted a shift in educational requirements for training programs. Participants in that category responded simply with a “no idea” or “I don’t know,” although some provided data, like “Primarily, there was a philosophical shift from theory to application” and “I imagine it was to allow greater flexibility for the variety of programs, but I don’t know the actual reason.”

The more difficult statements to code were those in the middle of the comprehension definitions: those that indicated a moderate degree and those that indicated a low degree. The majority of the discrepancies between raters occurred in the categorizations of data in these two distinctions (68% of the 19 statement discrepancies). The most primary distinction between a moderate and low degree of understanding was the difference between the belief that either the mental health or MFT educational standards, need to be better, indicating a view of insularity around behavioral health. Those responses indicating low degree of understanding were those that focused more narrowly, talking about individual programs needing to change their strategies. Those statements tended to focus on accountability to managed care companies as a primary

driving force for the change as well. Statements representing a moderate degree of comprehension included those like,

Although input is important in the process of education, COAMFTE and other organizations interested in maintaining the quality of education and the quality of professionals entering the mental health field needed a measure of whether the input was yielding the desired results, and whether the implementation process (of education) was reaching the aims/standards that were set.

This first example demonstrates the focus on MFT and behavioral health as needing to change their educational standards, without indication of understanding that all fields are being asked to reform their practices in a similar way. Another person said,

There is a shift professionally across our field to measure our results as opposed to what we provide, to determine if there is match that the inputs result in what the goals of our programs purport to achieve. In essence, COAMFTE is placing itself in a position to be accountable, as well as to increase quality of programming, and to hold programs accountable for their results.

This person focused singularly on the MFT field, noting the requirements set by the regulatory board to change educational standards for this particular subset of training practitioners.

Statements indicating a lower degree of comprehension include, “So that programs and the COAMFTE can have measurable outputs to account for program success” and “To move to a system of measuring the competence of students graduating from MFT programs rather than just requiring hours-driven requirements.” Both of these examples highlight the focus on accountability or a shift from one set of requirements to another. Neither demonstrates an

understanding of any wider efforts or requirements to demonstrate competency in educational or professional outcomes.

The next survey question asked educators to talk about the impact of the broader calls to educational reform on their understanding of the requirements set in MFT education. Participants were given an in-text reference to the President's New Freedom Commission on Mental Health (2003) that recommended transformations in mental health care delivery systems and then were encouraged to select a link that brought them to a list of other illustrative resources. Participants were informed that they would be able to access the full resources as well at the conclusion of the survey. Using these two sets of information as a backdrop, they were encouraged to provide feedback as it related to the national context.

Participant responses ($n = 79$) were again categorized into five codes corresponding with degrees of comprehension: high degree, moderate degree, low degree, and no degree. The fifth category represented items wherein the educator indicated a desire to not answer the question, as evidenced by responding "no" or "---." Participants whose responses indicated a high degree of understanding were designated by those with an understanding of the context of this educational shift, a connection between the current efforts and a history of calls spanning several decades. Data indicating a moderate degree of understanding talked about how pedagogical shifts are occurring and often made a connection between education and work with clients, but without an understanding of the broader professional and historical context. Responses demonstrating a low degree of understanding tended to focus on outcomes and accountability, and those demonstrating no understanding often denied knowledge altogether of any historical or cross-professional links to educational reform. Representative participant statements can be found in Table 4.

Of the 79 people who responded, eight indicated a high level of understanding about the reasons for the philosophical shift, representing 10% of the faculty. Fourteen people indicated a moderate degree of understanding, or 18% of the educators, while 20 demonstrated a low level of comprehension (25%). The largest number of responses to this question indicated no understanding of the broader context for the educational reform with 29 responses or 37% of the educators. Eight responses indicated a desire not to provide information to this question (10%). Representative data for each of the categories can be found in Table 4.

Table 4

Comprehension of National Calls for Behavioral Health Delivery Transformation (Q3, n = 79)

	Participant Data
High Degree	<p>My understanding is that such professional training is easily isolated in academic institutions that are more oriented to their own internal culture than to the employment and consumer contexts graduates are preparing to serve. This creates a vulnerability to maintaining training practices that meet institutional requirements that do not generate the necessary competencies for effective service provision in the real world.</p> <p>These calls have been in response to expectations [<i>sic</i>] for effectively trained mental health practitioners. The movement of many industries to outcome-based measurement has preceeded [<i>sic</i>] our efforts to do the same. Insurance [<i>sic</i>] companies and other stakeholders expect that MFTs provide services whose outcomes can be measured.</p> <p>The field is trying to keep pace with other mental health disciplines, notably psychology, in standardizing education and treatment approaches. Many of our theories are based on anecdotal, not empirical, support. [Also] to increase the rigor of the accreditation, and concurrently, to keep pace with the shift in a) mental health disciplines; and b) federal, state, and private research funding institutions, which, generally, only support empirically supported treatments that are outcome oriented. This was described as the conservative political agenda, [<i>sic</i>] that then was embraced as progressive education, again, calling for accountability in education, that education be based on what people will do in the "real world" and what students should demonstrate upon receiving their education. The expectation of measuring outcomes to become more scientific in the approach to education parallels the matching expectation to measure the outcomes in mental health professions.</p>
Moderate Degree	<p>My understanding is that having outcome-based training is a better reflection of what students learn and provides greater insight into the quality of not only programs, but the graduates they are preparing to work in the mental health field. Outcomes are now being seen--in psychology as well as medicine--as more</p>

important than input. All of the professions are moving in this direction, with the understanding is that outcomes are more important than input.

These calls follow the belief that "what gets measured gets done." While what programs "do" (input) is important, measuring the actual results of the training offered ensure effectiveness. The measurement of outcomes are [*sic*] intended to be used in a continuous feedback loop of ongoing quality improvement.

Evidence based programs are currently where the field is going. The field is examining what are best practices and this is a realistic way to do provide us with these answers about what are best practices

Low Degree	<p>My understanding is that professional workplaces require a particular skill set that they hope mental health preparation programs can accommodate</p> <p>I think we need to demonstrate what we are doing is effective in order to get reimbursed from 3rd party payors. The importance of this begins at the graduate school level, not just at the level of independent practice.</p> <p>This shift was to hold programs accountable, but to also give them more freedom to explore what the outcomes would be for the program.</p> <p>That outcome-based training is more effective and more easily monitored and will therefore improve the rigor of our training programs.</p>
No Degree	<p>The have been trying to make a paradigm shift based on a philosophical position.</p> <p>I am not familiar with these.</p> <p>I am not aware of these calls. I do not think any of the faculty members are either. It is not part of our discussions.</p> <p>I did not know of these "calls" but I am aware of "outcome-based training" and I know that it produces higher quality, more qualified professionals than "input-driven" programs produce.</p>

Participants demonstrating a high degree of comprehension about the professional and historical context were least frequently represented in this question (of those who provided data).

These people said things like,

We, along with other mental health professions, have long been criticized by the medical profession of promising too much and delivering too little. These calls are part of that larger cultural shift affecting every aspect of the mental health profession that demand accountability. It is basically an epistemological question - how do we know what we say we know? How do we know that we are actually effectively training people for marriage and family therapy? That is what the shift [*sic*] to outcomes is all about - measuring the effect of what we do, rather than focusing on the input.

The person's response shows his or her understanding of the tension between the mental health profession and others that has historically arisen from issues relating to outcome and accountability. The feedback provides a sense of history, that the person recognizes that the MFT profession is responding to long time calls to demonstrate effectiveness in training and clinical outcomes. Another participant demonstrated a larger sense of the history of calls in behavioral health service delivery, speaking to the number of calls that have occurred in different forums:

It has not just been one decade. Myriad national calls for accountability have been made for several decades. All address the need for more accountability preparing researchers and clinicians to work with minority populations (who have been inadequately and unjustly treated by health and mental health professions for longer than any of us care to remember). Responses thus far are little different than those before it. Failure seems inevitable.

The person appears to be reflecting as someone with longstanding experience in the field, responding with concern about this newest response to calls to reform educational standards. The next smallest group of participants was those that had a moderate degree of understanding about the context of the current educational reform efforts. Statements in this category included,

The calls are to call attention to the fact that just because programs are set up to provide 'quality' education, it doesn't guarantee quality results. The shift is meant to ensure that the programs are actually producing 'quality' mental health professionals.

Another person said, "My understanding is that having outcome-based training is a better reflection of what students learn and provides greater insight into the quality of not only programs, but the graduates they are preparing to work in the mental health field." Both responses highlight that the mental health field, or MFT programs specifically, was called to

demonstrate that practitioners are being trained to work effectively with clients. Neither indicates an understanding of how the behavioral health changes are part of a much wider change across the US and Canada.

The next largest group of responses was those with a low degree of comprehension about the historical and professional context of the current educational reform movement. A participant in this group said,

I have not read any of the ‘several national calls’, but I would assume that they are calling for training to focus on the actual outcomes of mental health training so that programs are measuring student performance and achievement (the knowledge and skills they acquire), as opposed to what they are taught. The thinking would be that training would change in a way that focuses on students and what they acquire (again, knowledge and skills) in their mental health training. The what and the how of teaching would have to be adjusted toward achieving measurable outcomes.

This response indicated no knowledge of the national calls but made inferences about what they might have said. The focus of the feedback was on the need for mental health training to change, missing reference to larger recommendations for reform. Another person whose response indicated low understanding of the connection between the national calls and the educational reform in this profession said simply, “Accreditation standards are being updated and by measuring outcome the accrediting body can hold programs more accountable for meeting standards.” The person’s response indicated that he or she is responding solely to the requirements set by COAMFTE, not taking into account the broader context.

The most frequently demonstrated level of understanding about the broader context was no understanding, representing 37% of the statements. Most of these respondents said things like,

“I am not aware of the details of the movement” or “I do not know.” Some of the respondents in this category indicated a lack of knowledge but then made comments about their beliefs (e.g., “I do not know the reason for these calls - other than using data as proof when in fact there needs to be much more sophisticated understanding of data”).

When the two qualitative questions are considered together, the data show that a comparatively small percentage of people overall have a strong understanding of the broad historical context of the educational reform efforts in this country or that AAMFT / COAMFTE are not the first professional organization to undertake such a task as instituting requirements for competency-based education. Furthermore, many of the respondents appeared to believe that accountability to managed care was the driving force for instituting such change, an incomplete understanding at best. Between 20% and nearly 40% of the MFT leadership demonstrated no understanding at all of the efforts made by the profession or by other interdisciplinary professions.

Research Question Two

The second exploratory research question was designed to explore information about what accredited programs are doing to respond to the educational reform requirements, given the national calls discussed above. The question asked,

What efforts that are being made within the MFT profession to address the call for reliable and valid competency models and outcome-based preparation programs and what obstacles are defined as hindering progress, with specific emphasis on investigating the degree to which MFT program directors and clinical faculty members are engaging in interdisciplinary collaboration with other mental health disciplines and are considering established models of competence (e.g., MCT)?

Sixteen quantitative items were considered to gain an understanding of those efforts. The descriptive summary of the data was conducted by categorically summarizing the percentage distribution of each survey response.

International organization level (AAMFT / COAMFTE). Prior to asking questions about what specific programs were doing across the US and Canada, the survey asks participants to identify steps taken at the level of the professional organization (AAMFT) and educational regulatory levels (COAMFTE). Table 5 shows the percentage breakdowns of the responses to identify the steps MFT program directors and clinical faculty members believed to have been used to establish the 2004 MFT core competencies and the 2005 COAMFTE accreditation standards.

The top five steps believed to have been taken by AAMFT to establish the 2004 MFT core competencies were: (1) drawing from a task analysis of clinical practice, clinical research, evidence-based family therapies, and emerging trends in family therapy to determine the knowledge and skills MFTs should possess (42%); (2) drawing from established and validated competency-based models and methods of model development and evaluation (37%); (3) regularly collaborating with MFT professionals with established expertise in competency-based models / outcome-based educational models (35%); (4) providing open and extended venues for obtaining and using feedback from the broader MFT profession to revise proposed competencies / standards (35%); and, (5) regularly collaborating with other mental health professions with established expertise in competency-based models / outcome-based educational models (28%).

The top five steps believed to have been taken by COAMFTE to establish the accreditation standards were: (1) regularly collaborating with MFT professionals with established expertise in competency-based models / outcome-based educational models (35%);

(2) regularly collaborating with other mental health professions with established expertise in competency-based models / outcome-based educational models (32%); (3) regularly collaborating with national entities recommending these reforms (32%); (4) drawing from established and validated outcome-based educational models and methods of model development and evaluation (32%); and, (5) providing open and extended venues for obtaining and using feedback from the broader MFT profession to revise proposed competencies / standards (31%).

As indicated in the table, none of the eleven steps, recommended in the interdisciplinary competency literature, was selected by more than 42% of the respondents.

Table 5

*Steps Taken by AAMFT and COAMFTE to Establish Core Competencies and Accreditation**Standards (Q5, n = 65)*

Choice	AAMFT	COAMFTE
Regularly collaborating with MFT professionals with established expertise in competency-based models / outcome-based educational models	35%	35%
Regularly collaborating with other mental health professions with established expertise in competency-based models / outcome-based educational models	28%	32%
Regularly collaborating with disciplines outside the mental health enterprise with established expertise in competency-based models / outcome-based educational models	23%	23%
Regularly collaborating with national entities recommending these reforms	26%	32%
Drawing from a task analysis of clinical practice, clinical research, evidence-based family therapies, and emerging trends in family therapy to determine the knowledge and skills MFTs should possess	42%	26%
Drawing from established and validated competency-based models and methods of model development and evaluation	37%	28%
Drawing from established and validated outcome-based educational models and methods of model development and evaluation	22%	32%
Providing open and extended venues for obtaining and using feedback from the broader MFT profession to revise proposed competencies / standards	35%	31%
Providing open and extended venues for obtaining and using feedback from other mental health professions to revise proposed competencies / standards	15%	17%
Providing open and extended venues for obtaining and using feedback from disciplines outside the mental health enterprise to revise proposed competencies / standards	9%	18%
Providing open and extended venues for obtaining and using feedback from relevant national entities to revise proposed competencies / standards	12%	25%
Other	11%	12%
None of the above	11%	9%
Prefer not to answer this item	26%	20%

Eighteen participants elected to provide qualitative data in response to this question, selecting “other” and making comments. Of those 18 people, 12 indicated that they were not sure or did not know the steps taken by AAMFT or COAMFTE to establish the core competencies

and accreditation standards. A few respondents felt that they were not clear on all of the details of how either organization engaged in its respective processes, with one person saying, “I only marked the boxes for items that I have first hand [*sic*] knowledge of. The other items may have occurred but I cannot confirm one way or the other.” Another said, “I really don't know the answer of any of the above questions. I guess I hope they learned from others, but I'm not sure.”

Some people who provided feedback provided additional steps or ideas that they felt were missing from the list. One person indicated that he or she felt that AAMFT / COAMFTE provided “comment periods and solicit[ed] response from accredited program faculty regarding Standards 11.0 development.” Another person was unsure about the steps, but said, “From what I surmise and have learned along the way much of the above was done.” Another, again unsure of the details, said “I believe that there was a task force appointed to develop the core competencies and drafts were shared with clinical membership, but I don't know what the range of the task force was.”

Other participants commented on the process, as they understood it to have happened. Some of the responses indicate disbelief that some or any of the steps listed were used by AAMFT/ COAMFTE. One person responded, “Were any of these ideas really implemented. [*sic*] As afar [*sic*] as I know, very little was done after the long list was published, a book was made available (expensive), and programs were left on their own to figure it out.” Another said,

I think AAMFT and COAMFTE would say they did all of these. But they did [not] take enough time, they did not offer enough ways to get feedback, and they do not have a good record of collaborating with other professions or thinking they are not experts. The idea that we could work with others or learn from others is not one of our strong points.

Other respondents supported that position, saying, “Both [AAMFT and COAMFTE] perceive that this process was collaborative but was not so. They were very selective on whom they consulted with”. Another person commented on the nature of the “collaborative” efforts, saying: “Not to an extent that I felt included as an educator and supervisor in the profession - which appears to be a significant failing.”

The next question asked program directors and clinical faculty to identify the products they believed to have been incorporated in the development of the core competencies and accreditation standards. These products have all been identified in the interdisciplinary competency literature.

The top six products developed by AAMFT in incorporating the core competencies were: (1) an identified core set of competencies / standards recognized as common across all mental health professions (29%); (2) professional opportunities to train MFT professionals, educators, and supervisors to incorporate competencies / standards into MFT preparation programs and continuing education venues (29%); (3) a core set of reliable and valid competencies / standards that can be implemented across MFT preparation programs and continuing education venues (23%); (4) a core set of clearly defined competencies / standards that can be implemented across MFT preparation programs and continuing education venues (23%); (5) a core set of reliable and valid competencies / standards that have been incorporated into professional membership / accreditation requirements (20%); and, (6) a core set of reliable and valid competencies / standards that have been or are being incorporated into licensure requirements (20%).

The top five products identified as having been developed by COAMFTE in the incorporation of the accreditation standards were: (1) a core set of clearly defined competencies / standards that can be implemented across MFT preparation programs and continuing education

venues (31%); (2) a core set of clearly defined competencies / standards that include measurable benchmarks to determine the effectiveness of MFT preparation programs and continuing education venues (29%); (3) a core set of reliable and valid competencies / standards that can be implemented across MFT preparation programs and continuing education venues (28%); (4) clearly defined recommendations and reliable and valid resources that MFT professionals, supervisors, and educators can draw from to incorporate competencies / standards into MFT preparation programs and continuing education venues (28%); and, (5) professional opportunities to train MFT professionals, educators, and supervisors to incorporate competencies / standards into MFT preparation programs and continuing education venues (28%). Table 6 summarizes the percentage breakdowns of the responses to identify the products. None of the products were identified by more than 31% of the respondents, an indication that either respondents are not aware of the presence of these products, or they do not believe them to have been used. Forty-seven educators skipped both this question and the question before it about the steps taken by AAMFT and COAMFTE in the competency identification and implementation process, making an interpretation of the overall data more difficult.

Table 6

Products Developed by AAMFT and COAMFTE (Q6, n = 65)

Choice	AAMFT	COAMFTE
An identified core set of competencies / standards recognized as common across all mental health professions	29%	20%
A core set of reliable and valid competencies / standards that can be implemented across MFT preparation programs and continuing education venues	23%	28%
A core set of clearly defined competencies / standards that can be implemented across MFT preparation programs and continuing education venues	23%	31%
A core set of clearly defined competencies / standards that include measurable benchmarks to determine the effectiveness of MFT preparation programs and continuing education venues	9%	29%
Clearly defined recommendations and reliable and valid resources that MFT professionals, supervisors, and educators can draw from to incorporate competencies / standards into MFT preparation programs and continuing education venues	12%	28%
Professional opportunities to train MFT professionals, educators, and supervisors to incorporate competencies / standards into MFT preparation programs and continuing education venues	29%	28%
A core set of reliable and valid competencies / standards that have been incorporated into professional membership / accreditation requirements	20%	20%
A core set of reliable and valid competencies / standards that have been or are being incorporated into licensure requirements	20%	11%
Systematic methods / plans / measures to evaluate competencies/standards and to make revisions based on these evaluations and other advancements in the field	9%	18%
Other: (Specify below.)	9%	9%
None of the above	11%	12%
Prefer not to answer this item	20%	17%

Fourteen people provided specification after choosing the “other” category. Eight of those people (57%) said they did not know what products have been or are being developed, one person said that the question should be asked of his or her program director, and one person knew only that the competencies exist, were created by AAMFT, and are “adopted (but not required) by COAMFTE”. Six people were critical of AAMFT and COAMFTE. One person said, “The clarification of ‘reliable and valid’ content is really the crux of the matter. The Core

Competencies and other accreditation standards are in place, but have not, to my knowledge, been researched for reliability, validity, trainability, etc.” Another person echoed that concern, saying,

I am not aware of projects that match competencies with outcomes in the MFT field. (This does not mean that they don't exist). In my observation, attempts to create measurable/observable outcomes and measurable/observable competencies still seem to be needed before a translation into educational outcomes can take place. The ‘new’ workplace focus is on "integrative practice" yet the profession remains divided by a wide range of disciplines and competition for funding. Currently ‘techniques du jour’ that receive evidence base are funded in spite of other research linking competent practitioner quality to positive outcomes.

Another participant felt that the efforts that have been made thus far have left the field in a state where there are “still vagaries and a lack of truly reliable or valid competencies.” Another person supported that position, saying, “We did not take the time or follow the steps required to create these products. Unfortunately we are on very shaky ground.” Another said,

It does seem that there was a push to institute new competencies, and then there was the resultant realization that no one knew what this meant, and then a backtracking (or backfill) to a small degree in helping people understand what this shift to outcomes was all about.

Finally, one person clarified his or her selection of one of the products, saying, “I want to be very clear that checking PROFESSIONAL OPPORTUNITIES TO TRAIN MFT PROFESSIONALS ... does not imply that I believe the training has been adequate. It has been myopic, ignorant, and autocratic.”

Overall, the qualitative responses inform the quantitative data, with the majority of people believing that none of the products suggested in the competency literature have been or are being developed by AAMFT and / or COAMFTE. The qualitative data make clear that faculty either: (a) do not know what AAMFT and COAMFTE have done or are doing with competency development, a comment echoed in other survey responses with regard to a lack of transparency from the organizations to the programs and practitioners; or (b) are aware that the process that has been implemented lacks empirical (and programmatic) support.

Programmatic level. To demonstrate what accredited programs are doing across the US and Canada to address the shift to outcome-based training standards, the survey asked educators to identify the professional activities that MFT faculty members use in their planning for and implementation of outcome-based education. The results indicated that nine professional activities were performed by at least half of the 63 MFT faculty respondents. The nine professional activities included: working independently (52.4%), regularly collaborating in MFT faculty subgroups (55.6%), regularly collaborating as a full MFT faculty group (85.7%), regularly collaborating with MFT practicum / internship supervisors (71.4%), regularly collaborating with MFT students (66.7%), regularly receiving feedback from MFT practicum / internship supervisors (73%), regularly receiving feedback from MFT students (88.9%), utilizing or drawing from resources provided by other COAMFTE-accredited programs (54%), and receiving formal AAMFT training (61.9%).

Two people provided additional data after having selected the “other” category. One person said that faculty worked independently on course requirements, but final decisions about course content were made with team input. In addition, the faculty at that institution used information learned at statewide trainings to augment their efforts. The other person shared the

belief that following the accreditation standards is “not a hard task that requires or deserves the type of collaborative energies listed above,” commenting that the standards as they exist are “elementary” in nature. The person continued to say that he or she has “been part of this [and other professional] organizations long enough to know that the standards designed by COAMFTE will not move our profession any closer to taking responsibility for populations we choose not to understand or serve.”

Competency domains addressed in programs. Table 7 summarizes the percentage breakdowns of the efforts to identify, operationalize, implement, evaluate, and revise activities and pedagogical strategies for each of AAMFT’s different primary domains: admission to treatment, clinical assessment and diagnosis, treatment planning and case management, therapeutic interventions, legal issues, ethics, and standards, and research and program evaluation. Fifty-seven respondents completed the assessment of the required AAMFT primary domains.

Table 7

Stages of Competency Development across Primary Domains (Q8 – Q15; n = 57)

	Nothing Formally Yet	Preliminary Stages	To Some Degree	To a Significant Degree	Prefer Not to Answer
Domain One: Admission to Treatment					
A. Identify	4%	0%	25%	68%	4%
B. Operationalize	4%	4%	35%	54%	4%
C. Implement	5%	4%	39%	49%	4%
D. Evaluate	5%	12%	39%	40%	4%
E. Revise	19%	19%	30%	28%	4%
Domain Two: Clinical Assessment					
A. Identify	4%	2%	16%	75%	4%
B. Operationalize	5%	2%	21%	68%	4%
C. Implement	5%	4%	25%	63%	4%
D. Evaluate	7%	11%	23%	56%	4%
E. Revise	21%	19%	25%	32%	4%
Domain Three: Treatment Planning and Case Management					
A. Identify	4%	2%	25%	67%	4%
B. Operationalize	4%	4%	28%	61%	4%
C. Implement	4%	5%	28%	60%	4%
D. Evaluate	4%	11%	32%	51%	4%
E. Revise	18%	19%	28%	32%	4%
Domain Four: Therapeutic Interventions					
A. Identify	0%	0%	23%	74%	4%
B. Operationalize	0%	4%	28%	65%	4%
C. Implement	2%	4%	32%	60%	4%
D. Evaluate	4%	7%	32%	54%	4%
E. Revise	16%	19%	30%	32%	4%
Domain Five: Legal Issues, Ethics, and Standards					
A. Identify	2%	4%	16%	77%	2%
B. Operationalize	5%	0%	25%	68%	2%
C. Implement	5%	2%	23%	68%	2%
D. Evaluate	5%	5%	30%	58%	2%
E. Revise	18%	23%	21%	37%	2%
Domain Six: Research and Program Evaluation					
A. Identify	4%	5%	33%	54%	4%
B. Operationalize	5%	11%	30%	51%	4%
C. Implement	7%	12%	26%	51%	4%
D. Evaluate	5%	18%	26%	47%	4%
E. Revise	18%	28%	21%	30%	4%

Domain one: Admission to treatment. The majority of the 57 respondents have identified (68%) and operationalized (54%) the first AAMFT domain to their estimation of a *significant degree* (NOTE: participants were not asked to define each of the categories; the indication of significance is purely subjective on the part of the participant). Less than half of the 57 respondents have implemented, evaluated, and revised the domain to either to a *significant degree* (implement = 49%, evaluate = 40%, revise = 28%) or to *some degree* (implement = 39%, evaluate = 39%, revise = 30%). Most of the 57 respondents have identified, operationalized, implemented, evaluated, and revised the first AAMFT domain to *some degree* or more. Fewer respondents report that they have revised their programs based on evaluations and feedback as compared with the earlier four steps, but the combined degree percentages indicate that over half of the respondents have engaged in a revision process (58% to *some* or a *significant degree*).

Ten people provided feedback in the form of qualitative comments after the quantitative choice selection. Two of those people talked about the challenges of engaging in the reform process, both focused on a lack of resources, either in personnel or more generally. Other feedback focused on program-specific discussion. Two people talked about how they have engaged in the process of educational reform to the extent that it is required of them, with one saying that his or her program does “just enough to remain accredited without compromising the research and training we are engaged in...” while another said, “we have done this but to a large degree it is an exerciser [*sic*] without wisdom and deep meaning”.

Four responses focused on the practicality of integrating competencies into the program curriculum. One person talked about how the program organized the competencies in “ways more specific to our program’s educational outcomes for evaluation and review purposes,” while another reported that his or her program has developed its own competencies and domains. One

person reported that the competencies have been implemented and evaluated to a more significant degree in practicum experiences than in courses. Another talked about the program's overall commitment to using regularly gathered assessment data to inform program revision. The final response focused on the applicability of the current competencies to doctoral programs, "these competencies largely have to do with clinical training that occurs in master's [*sic*] level programs. We try to focus on Research at the PhD level and so we do not see these as germane to our mission."

Domain two: Clinical assessment and diagnosis. The table shows that more than half of the 57 respondents have identified (75%), operationalized (68%), implemented (63%), and evaluated (56%) the second AAMFT's primary domain to a *significant degree*. The percentage of programs that have revised their curriculum is more spread, although the majority of programs (57%) have revised to *some* or a *significant degree*. Seven people commented on this question, with the same qualitative categories highlighted as were discussed with regard to the competency process for Domain One. Those categories included resource constraints, engagement in the process, organizational efforts, and the applicability of the competencies to the educational focus of doctoral programs.

Domain three: Treatment planning and case management. The data showed that more than half of the 57 respondents have identified (67%), operationalized (61%), implemented (60%), and evaluated (51%) the third AAMFT's primary domain to a *significant degree*. The majority of responses indicate that programs have revised curriculum to *some* or a *significant degree* (57%). More programs, however, identified that they had not yet done anything formal in revising their programs in this domain than in previous domains. Six people commented on this question, with the same qualitative categories highlighted as were discussed with regard to the

competency process for the previous domains. Those categories included resource constraints, engagement in the process, organizational efforts, and the applicability of the competencies to the educational focus of doctoral programs.

Domain four: Therapeutic interventions. More than half of the 57 respondents have identified (74%), operationalized (65%), implemented (60%), and evaluated (54%) the fourth AAMFT's primary domain to a *significant degree*. A higher percentage of participants reported that they have, to *some* or a *significant degree* revised their curriculum based on evaluations and feedback. Six people commented on this question, with the same qualitative categories highlighted as were discussed with regard to the competency process for the previous domains. Those categories included resource constraints, engagement in the process, organizational efforts, and the applicability of the competencies to the educational focus of doctoral programs. The person focused on doctoral education reported that therapeutic intervention competencies are discussed as they "pertain to the practice of clinical research and how to evaluate the process and effectiveness of clinical practice."

Domain five: Legal issues, ethics, and standards. More than half of the 57 respondents have identified (77%), operationalized (68%), implemented (68%), and evaluated (58%) the fifth domain to a *significant degree*. Fifty-eight percent of the respondents reported that their programs have revised curriculum to *some* or a *significant degree*. Six people commented on this question, with the same qualitative categories highlighted as were discussed with regard to the competency process for the previous domains. Those categories included resource constraints, engagement in the process, organizational efforts, and the applicability of the competencies to the educational focus of doctoral programs.

Domain six: Research and program evaluation. More than half of the 57 respondents have identified (54%), operationalized (51%), and implemented (51%) the domain to a significant degree. Nearly half of the 57 respondents (47%) have conducted assessments to evaluate students' developing competencies and the program's effectiveness. Just over half of the participants indicated that they have revised the curriculum in response to those evaluations to some or a significant degree (51%).

Six people commented on this question, with the same qualitative categories highlighted as were discussed with regard to the competency process for the previous domains with a few additional ideas. Those categories included resource constraints, engagement in the process, organizational efforts, and the applicability of the competencies to the educational focus of doctoral programs. One person reported that his or her program has “distinguished doctoral and masters [*sic*] level competencies for all of the domains,” saying further, “COAMFTE and AAMFT offer little guidance on this”. One program has recently hired a fulltime faculty person to focus on research and program evaluation, while another program reported just beginning an evaluative process of the program.

Additional domains or competency sets. To address the possibility that some programs have created additional programmatic domains or competency sets, the instrument asked participants to provide information about those domains / competency sets and about where the programs are in identifying, operationalizing, implementing, evaluating, and revising the competency elements of those additional domains.

Table 8 summarizes the percentage breakdown of those optionally identified domains or competency sets. Sixty-five percent of the respondents indicated that they have not created two additional domains or competency sets; 35% reported they had not created any additional

domains. Of those that have additional domains or competency sets, less than half had identified, operationalized, implemented, evaluated, and revised the competencies to any degree.

Table 8

Stages of Competency Development across Optional Domains (Q14 - Q15, n = 57)

Choice	Nothing Formally Yet	Preliminary Stages	To Some Degree	To a Significant Degree	Prefer Not to Answer	Not Applicable
Additional Domain / Competency Set One						
A. Identify	2%	0%	7%	35%	21%	35%
B. Operationalize	2%	2%	12%	28%	21%	35%
C. Implement	2%	5%	9%	28%	21%	35%
D. Evaluate	2%	5%	12%	26%	19%	35%
E. Revise	11%	9%	12%	18%	16%	35%
Additional Domain / Competency Set Two						
A. Identify	2%	0%	4%	11%	21%	63%
B. Operationalize	2%	0%	5%	9%	21%	63%
C. Implement	2%	2%	4%	9%	21%	63%
D. Evaluate	2%	2%	7%	5%	21%	63%
E. Revise	2%	5%	5%	4%	21%	63%

Twenty people provided qualitative description of the primary domain or competency set identified by their programs. Six of the domains (30%) were described as focusing on cultural competence or diversity; two of those also specified a commitment to social justice as part of this additional domain. Three of the domains focused on self of the therapist and two others described professional or interpersonal competency (e.g. “emotion awareness and regulation; response to emotion in others; constructive response to difference; capacity to form therapeutic alliance; effective use of power and influence”). Two people identified metaframeworks as a focus of their programs. Another highlighted core skills that cut across theories in systemic-relational therapy. One person indicated that knowledge of human development and family systems were a focus of competence in his or her program. Another focuses on teaching as a

competency area. Finally, one participant identified theological and spiritual analysis of clinical work as a focus of the program.

Five people described a second additional primary domain or competency set identified by their programs. One person reported that person of the therapist is an additional domain. Another reported that familiarity with therapy models is a conceptual and perceptual focus of the program. Three of the responses provided no additional descriptions, with one person saying, “None,” another, “?”, and the third talking about how the program has “done this but to a large degree it is an exerciser [*sic*] without wisdom and deep meaning” (a response included in each of the comments sections of this series of questions).

Overall, most participants reported identifying, operationalizing, implementing, and evaluating each of the six AAMFT domains to a significant degree. Fewer participants identified additional competency sets or domains, but those that did indicated the belief that they had generally followed a similar pattern of progress in those sets as well.

Learning activities. Table 9 summarizes the percentage breakdown of the responses of 50 participants on the learning activities specifically implemented to provide students opportunities to develop the six primary domains. More than half of the 50 respondents have included course work (admission to treatment = 58%, clinical assessment and diagnosis = 70%, treatment planning and case management = 64%, therapeutic interventions = 74%, legal issues, ethics, and standards = 74%), clinical work (admission to treatment = 58%, clinical assessment and diagnosis = 64%, treatment planning and case management = 66%, therapeutic interventions = 68%, legal issues, ethics = 64%), and clinical supervision (admission to treatment = 68%, clinical assessment and diagnosis = 74%, treatment planning and case management = 76%, therapeutic interventions = 76%, legal issues, ethics = 74%), in each of the five indicated

domains. For the research and program evaluation domain, course work (64%) was the only learning activity identified by more than half of the respondents. For five of the six identified domains and the two additional optional domains or competency sets, clinical supervision was the primary vehicle for addressing competency education, followed by course work and clinical work. Supervision training, advising, and research initiatives were used less frequently as opportunities for didactic and practical learning.

Table 9

Program Components to Develop Core Competencies (Q17, n = 50)

Domain	Course Work	Clinical Work	Clinical Supervision	Supervision Training	
1. Admission to Treatment	58%	58%	68%	36%	
2. Clinical Assessment / Diagnosis	70%	64%	74%	36%	
3. Treatment Planning /Case Management	64%	66%	76%	38%	
4. Therapeutic Interventions	74%	68%	76%	40%	
5. Legal Issues, Ethics, and Standards	74%	64%	74%	40%	
6. Research and Program Evaluation	64%	32%	34%	20%	
7. Competency Set 1	30%	28%	32%	22%	
8. Competency Set 2	6%	6%	8%	4%	
Domain	Advising/ Mentoring	Research Initiatives	Other	N/A	Prefer not to Answer
1. Admission to Treatment	30%	8%	6%	10%	8%
2. Clinical Assessment / Diagnosis	28%	6%	6%	8%	8%
3. Treatment Planning /Case Management	32%	16%	6%	8%	8%
4. Therapeutic Interventions	30%	22%	8%	8%	8%
5. Legal Issues, Ethics, and Standards	38%	6%	6%	10%	6%
6. Research and Program Evaluation	30%	40%	6%	14%	10%
7. Competency Set 1	24%	12%	4%	40%	20%
8. Competency Set 2	2%	2%	2%	66%	24%

Seven people responded to the request to describe additional or “other” components of their programs as they pertain to the six primary domains and potentially to the two additional domains. Of the seven respondents, only one person provided additional data, saying that his or her program implements workshops and extended training toward play therapy certification as part of Domain Four: Therapeutic Interventions.

Other responses in this qualitative prompt included description of learning activities or training foci implemented to provide students more opportunities to develop the identified competencies, including self of the therapist, social justice, and diversity. Other participants commented more generally on their program’s reform process, saying, “We added perfunctory materials to meet COAMFTE standards.” One person reported that the new standards had not changed the program’s focus on or commitment to preparing students to work nationally and internationally. A colleague agreed that the competencies had not changed the program; the competencies were fit to the program rather than the other way around.

Assessment efforts. Participants were asked to identify the types of assessment methods they use to evaluate the students’ developing competencies and the program’s effectiveness. Ten assessment methods were identified as being used in over half of the programs. Those methods included grades (77.1%), faculty evaluations (93.8%), supervision evaluations (93.8%), practicum/internship evaluations (85.4%), student self-reports (79.2%), student program appraisals (68.8%), papers (89.6%), presentations (81.3%), demonstrations (75%), and program portfolios (56.3%). The top five assessment strategies include faculty evaluations, supervision evaluations, papers, practicum/internship evaluations, and student self-reports. Program portfolios were used the least frequently, but were identified by over 56% of the participants as assessment strategies to evaluate student competency and program efficacy. One respondent

identified that his or her program had not incorporated any assessment methods to evaluate student and programmatic competency and four people reported that they used other evaluative methods.

Four people responded to the request to specify “other” assessment methods they use to evaluate student competencies and program effectiveness. One person highlighted grading rubrics and theses. Another program uses the *Student Life Stress and Satisfaction Survey*, the *Global Assessment of Student Functioning Survey*, and the *Cohort Peer Review of Interpersonal Competency Survey*. Two other respondents commented that the assessment methods identified in the question had been part of their respective programs prior to the shift to outcome-based education.

Table 10 summarizes the extent to which evaluative methods were integrated into programs and the participants’ view of the development of those evaluative methods. Participants were asked to indicate where they believe their programs to be in identifying, using, evaluating, and revising assessment methods across six learning areas: courses, clinical work, clinical supervision, supervision training, advising / mentoring, and research. The table shows that participants are overwhelmingly using evaluative methods in each of the identified areas (courses = 47.9%, clinical work = 45.8%, clinical supervision = 52.1%, supervision training = 37.5%, advising and mentoring = 35.4% and research initiatives = 33.3%).

Table 10

Extent to Which Evaluative Methods were Incorporated into Program (Q20, n = 48)

Choice	No Methods	Identifying Methods	Using Methods	Evaluating Methods	Revising Methods	N/A	Prefer Not to Answer
Courses	4%	2%	48%	8%	33%	0%	4%
Clinical Work	4%	0%	46%	23%	21%	0%	6%
Clinical Supervision	0%	2%	52%	17%	21%	0%	8%
Supervision Training	4%	8%	38%	8%	17%	17%	8%
Advising and Mentoring	19%	6%	35%	2%	23%	8%	6%
Research Initiatives	17%	4%	33%	6%	19%	15%	6%
Other	2%	2%	4%	2%	2%	69%	19%

Two people identified other program components, with one response indicating that the participant did not understand the question and the other person saying that all of the listed components are integral to his/her program and were not incorporated to comply with the new standards requirements.

When asked to describe the extent to which the findings from the identified assessment methods inform program revisions, participants responded most frequently that the findings significantly inform revisions (38%). Twenty-three percent of the 48 respondents said that they were able to use some findings of the assessment methods to inform revisions, while 25% said that they were exploring how the findings of the assessment methods might inform program revisions.

Five people provided supporting comments, with one person saying that his or her program is currently working on establishing reliable benchmarks, a task that he/she identifies as “complicated and very detailed.” Two other responses indicate that the programs are just

beginning evaluative processes. One person clarified earlier data, saying, “Our multi-method approach provides convincing evidence of our success rate, which is high... Our method is not outcome based, but process based.” The person goes on to say that the program’s approach to evaluation indicates student success in the areas of research design, implementation, and evaluation, as well as treatment and evaluation of services for underserved populations. The person indicated that the program takes the evaluative data and uses them “to inform all curricular and pedagogical program decisions.”

Evaluation of student competency. At least half of the 48 respondents believe that more than 90% of the students meet or exceed the competency benchmarks in five of the six core domains (not including research and program evaluation). Specifically, 56% of the respondents stated that above 90% of the students meet or exceed benchmarks in admission to treatment, 54% said that above 90% students meet or exceed benchmarks in clinical assessment and diagnosis, 50% said that above 90% students meet or exceed benchmarks for treatment planning and case management, 52% said that above 90% students meet or exceed benchmarks for therapeutic interventions, 60% said that above 90% students meet or exceed benchmarks for legal issues, ethics, and standards, and 46% said that above 90% students meet or exceed competency benchmarks for research and program evaluation. Across the six domains, an average of 4% of participants felt that there was insufficient data to evaluate students’ ability to meet or exceed the benchmarks, with a range of 2.1% to 8.3%.

Research Question Three

For research question three, the guiding question asked,

How do MFT program directors and clinical faculty critique their efforts to address the call for reliable and valid competency models and outcome-based preparation programs

independently and evaluate their progress to date, first within their own context, and later, within the context of broader information about: (a) recommendations for interdisciplinary collaboration and knowledge sharing in advancing successful educational reforms; and, (b) evaluations of the progress made thus far across the five core mental health professions.

After they had received information about the national calls for educational reform, educators were asked to describe the factors they had considered when they identified the core competencies for their program. The qualitative data can be found in Appendix C. Nine categories were derived from the data and can be found in Table 11, along with subcategories that further explained the consideration factors.

Table 11

Factors Considered when Identifying Programmatic Core Competencies (Q16, n=53)

CATEGORY	SUBCATEGORIES
Pre-existing curriculum	Fit to what was already taught Included clinical work and supervision Competencies only part of assessing student ability assessment Easily assessable
Organizational culture, focus, structure, mission	Program Larger institution Core values History and present context of program AAMFT / COAMFTE requirements (including history)
Desired Knowledge, Skills, and Awareness (KSA)	Student developmental needs considered
Feedback	Students Alumni Supervisors Internships
Personal expertise	Faculty assessment of student needs Faculty assessment of competence in therapy Faculty preferences
All competencies considered	Requirements of AAMFT / COAMFTE Additional competencies included
Licensing	Licensing examination Local licensing requirements
Unknown	Competencies identified without or before participant
Other	Ethical standards Client care

Respondents frequently reported ($n = 8$) that they considered the curriculum that existed already in their program when they determined which competencies were going to be formally assessed. For example, one respondent said, “To be honest, we fit the competencies to the program as we had already developed it.” Another person indicated that his or her program considered how they would assess the competencies prior to selecting the ones for the program. One faculty member described the process of selecting the competencies for the program, saying:

As a faculty group, a discussion occurred where the 128 core competencies were evaluated and a determination made as to which competencies fit into which courses.

Then the group looked at what assignments would be completed to verify competency and then what would the grading rubric look like to determine competency and to what level of competency was obtained.

One person said that his or her program not only considered the didactic coursework but the material and competence that can be assessed through supervision and client care. Another common category across respondents ($n = 10$) was a consideration of locally contextual factors including the mission of the program, the department in which the program is housed, and the institution itself. One person said, “We look at the AAMFT core competencies and the needs of our communities of interest. One of our primary communities of interest are [*sic*] state license boards. We also look at other programs to see how they are measuring their effectiveness.” Another recalled considering the “history and current context of our program, as well as the needs of the community for which our training program serves.” Others focused on their program’s particular strengths or values, “We consider the AAMFT and COAMFTE core competencies, our context in [our state], our external stake holders, the faith-based institution mission and core values, the College which houses the MFT program as well as [the state professional organization] and the [state regulatory board] requirements” or we “consider our program’s (relatively) unique features.”

Another group of participants ($n = 6$) focused on discussion about the knowledge, skills, and awareness that their program identified wanting their students to leave their program possessing. One person specified, “We want our doctoral students to be well prepared to teach, supervise, do research, and otherwise advance the field of MFT.” Another person, who knew about the identification process but was likely not personally involved, said that the faculty considered “what competencies they learned as students, what they needed during practice, and

what they felt students needed to learn to become competent therapists.” Other participants ($n = 11$) reported that their programs had considered all of the core competencies, with one person saying that his or her program “wanted our students to be able to demonstrate all of them at their developmental level.”

Faculty expertise was another common category ($n = 10$). Participants spoke of faculty competency selection processes as involving personal assessment about the components of competent work in the field. For example, educators considered the “qualifications required for competent MFT Faculty and researchers” or “what we thought were the most important [competencies]”. Faculty also expressed personal preference for some competencies over others: “it seemed to me that the existing expertise / views of existing influential academic faculty were a primary influence in the core competency project,” or “each faculty member reviewed what they [*sic*] enjoyed about the programs they went to individually and identified the core competencies that were important to them [*sic*].”

A small number of programs used feedback from other stakeholders beyond the faculty in their identification of the core competencies ($n = 4$). The most frequently mentioned stakeholders included supervisors, internships, alumni, and students. One person said that his or her program considered “feedback from students in the field, from other practitioners, supervisors, internship sites, etc.” and another reported that his or her program considered “student and alumni feedback regarding their perceived needs.” Other sources of data included licensure requirements, with programs looking to state regulations and the national AMFTRB examination for guidance. Only one person referred to the consideration of client care in his or her identification process.

Following a quantitative question about the places in the teaching program where each of the domains is addressed, participants were asked to provide data about the teaching tools or

learning activities that they have used that they find to be particularly effective in helping students increase their clinical competence (Appendix D). Seven broad categories arose from the responses: group work, assessment strategies, experiential activities, supervision, coursework, mentoring relationships, and clinical work. A number of subcategories were associated with each of the identified categories. The categories and subcategories can be found below.

Table 12

Teaching Tools to Effectively Increase Clinical Competence (Q18, n=50)

CATEGORIES	SUBCATEGORIES	FURTHER SUBCATEGORIES
Activities	Group work	Learning groups
		Presentations at conferences
		Conference participation and / or presentations
		Presentations to other stakeholders
	Assessment	Student self-reflection
		Assessment tools (e.g., rubrics)
		Supervisor / faculty feedback
	Experiential activities	Skills practice
		Role play
		Cultural immersion
Learning Venues	Supervision	Case conceptualization of clinical work
		Video / live documentation of mock or real clients
		Ethics
		Feedback / critique
	Coursework	Linking concepts to theories
		Capstone project
		Portfolio
		Workshops with specific clinical topics
	Mentoring	Faculty to student
		Student to student
	Clinical work	Internship
		Practicum

Two broad categories encompass the faculty feedback about teaching tools used in their programs. The first is description of the activities themselves. Group work ($n = 3$) was described as discussions in classes, group supervisory scenarios, and conjoint efforts on creating presentations for conferences or other audiences. Assessment was commonly noted ($n = 9$) as a

tool related to the implementation of learning activities in the curriculum. Several respondents talked about rubrics that they had developed for a number of different clinical scenarios, including case conceptualization, case documentation, and treatment planning. One respondent said, “We have a specified grading rubric that students are well aware of ... to assess the outcomes of our programs across all the domains.” Other respondents talked about the importance of student self-assessment, with the student taking stock of the areas in which he or she has strengths as well as areas for continued growth.

The third category describing teaching tools was best described to be experiential activities. Participants talked about role-play as means of practicing required clinical skill and as a vehicle for feedback about that skill demonstration. One person reported that his or her program has “adopted a client simulation exercise where students role play the entire therapeutic process from admission to treatment to evaluation.” Another described, “Repeated, structured interactive skill practice” in two areas of the program: supervision and class work. That person also reported the use of a learning activity based on the Objective Structured-Clinical Exercises (OSCE) that simulates therapeutic encounters. Two respondents described the use of cultural immersion projects that allow students to engage with people and communities to increase their cultural awareness. Other areas of practice and learning addressed using experiential activities include the research process, ethical and legal awareness, and service learning.

The second broad category describing the data was termed “learning venues.” Each of the subcategories in this section described the places in the curriculum where activities or interactions occurred that provided opportunity for students to learn and demonstrate competency. The first venue was supervision. Supervision was described as a means of providing feedback to students, with one person saying the, “use of live, and especially video

tape review supervision, when combined with the core competencies of MFT practice, has been [sic] the most effective learning opportunity [sic]”. Another person reported,

Our program has three years of group supervision (56 hours per year) in which the core competencies (especially the integrated [sic] of theory and practice) are integrated into clinical hour [sic]. Both supervisors and students believe that group supervision is the core of our program.

Through supervision, students talk about ethical issues and application, conceptualize case treatment, and receive feedback on the data they provide (i.e., live, audio, or student report). The second venue for learning comes in the classroom, with four people explicitly describing activities that occur in the context of course content. One person reported that research courses provide students the opportunity to apply their knowledge and skills. Another noted, “Within courses, application to student’s own personal processes (reflexivity, self-research) along with case application and extended experiences in practice and self-evaluation also improve outcomes.” Another person talked about how his or her program extends the coursework through presentation of a series of workshops on applied clinical topics that allow for “focused study in key areas affective clinical practice such as Domestic Violence, Substance abuse [sic], Sexual Addiction, Trauma, Relationship Education, Affairs, Therapy and the Brain, Etc.” The workshops “offer focused training in key topic areas that are covered in courses but not extensively.”

The third venue for learning was described in the formalized mentorship relationships. Participants described faculty and student relationships as being important opportunities for growth, with one person noting, “faculty interaction, in a one-to-one teaching model, that creates a connection with students and allow for a mentoring relationship to develop” as particularly

effective in helping students increase their clinical competence. Other faculty identified a mentoring relationship that occurs between students as being an effective teaching tool. One person talked specifically about formalized supervision between advanced and beginning students, while another described a “process with third-year students assisting first year students with basic clinical skills.”

The final area identified by faculty that provides students opportunities to improve their clinical competence is through clinical work. Supervision of that clinical work was described above as an important formative and summative assessment tool to improve work with clients. Also mentioned was the formal internship year as providing “a great deal of learning opportunities, which covers most, if not all, of the core competencies.”

Of the 50 participants responding to inquiry about teaching tools, eight refused to provide feedback (16%) and three indicated that the question was not applicable to their program’s efforts to address educational reform (6%). One person reported that his or her program does not “drink the purple cool aid,” while another said that none of the learning activities that his or her program uses “would be of benefit to programs committed to current COAMFTE standards.” Still another said, “We have a well-established training record based on understanding the learning needs of our students – none were chosen to address competencies as these have been identified by AAMFT or COAMFTE. Our definition of competencies is not in line with our professional organization.”

Quantitative data. A descriptive summary of the data from several questions intended to understand the faculty critique was conducted by categorically summarizing the percentage distribution of each survey response. The four professional activities that were highlighted reflect national calls and interdisciplinary literatures on outcome-based educational standards in

behavioral health. These include: (a) collaborating with experts in competency modeling and assessment across a broad range of disciplines; (b) collaborating with experts in competency modeling and assessment relevant to culturally, linguistically, and developmentally diverse populations; (c) drawing from rigorous and systematic methods of competency development and assessment available in other fields; and (d) working separately on identifying competencies and linking these directly to the program.

Participants identified most frequently that they *seldom* collaborate with interdisciplinary competency experts (53%). They also reported most frequently that they *never* collaborate (32%) with experts to create models and assessments that are linguistically, culturally, and developmentally appropriate for students and clients. They *seldom* have drawn from methods of competency development and assessment from other fields (38%), preferring to work separately on identifying competencies and linking them to their respective programs (almost always = 38%). When considered together, the results suggest that MFT programs work individually, without consultation from multidisciplinary experts or consulting the efforts made in other fields.

Nine people commented on the extent to which their programs have engaged in the listed professional activities. Two people did not understand the question; one person said “no,” he or she was not willing to provide additional information, and one person noted a typographical error in the survey. Of those remaining persons who provided feedback, one person said that he or she was not able to provide meaningful answers to the question. Another said that there has not been much activity in his/her program to date and another focused on the barriers to progress (i.e., lack of resources and models for competence in his/her area). Two other people specified that their program’s collaborative efforts predate the reform requirements and are not related to that reform. One of those people said, “We do not see this shift as a valid one.”

Participants were asked to indicate which, if any, of six reforms and products had been integrated into their training curricula. The products and reforms were identified from national calls and interdisciplinary literatures. The largest percentage of respondents indicated that the statement that their programs' competencies include prevention, early intervention, and recovery- and resilience-oriented approaches was *somewhat representative* (43%). Most also believed that cultural and linguistic competencies are included in their competency models (51% of the respondents). The majority of responses indicate that they believe their efforts have significantly moved beyond identifying core competencies (53%), and the majority of respondents indicated that they disagreed with the statement that they are only beginning to address the development, implementation, and assessment of those competencies (45%). To further support that data, the majority of the responses indicate that educators believe they have developed or incorporated reliable and valid measures of competence to assess student progress (45%). The vast majority of educators (70%) further believe that their identified competencies are not too comprehensive or idealistic to be achieved by the typical student.

Seven people commented on this question. Three people did not understand the content of the questions and one person said that he/she did not want to provide feedback. Of the people who provided feedback, one person said that at his/her program's early stage of progress, "it's difficult to answer." The two other respondents talked about how their programs have not done what they have done in response to AAMFT / COAMFTE requirements. Each program reports competency in a number of areas, including prevention, early intervention, rehabilitation, recovery, resilience, and cultural and linguistically appropriate approaches to treatment. One of the people said, "We do not address these issues using the outcome-based framework currently

purported to reflect best practices, as we do not support that assumption (nor does any validly derived research data / findings.”

Research Question Four

Given the backdrop of information about national calls, steps, and products, participants were asked about their willingness to engage in collaborative efforts to further their progress in educational reform. For research question four, the guiding question asked:

To what degree does asking questions about the possibilities, limits, and barriers to interdisciplinary collaboration and knowledge sharing, while also making information and collaborative opportunities available to study participants: (a) *initiate requests* for further resources and collaborative forums among MFT leaders; and, (b) generate *active interest in* and *commitment to* both contributing to and engaging in interdisciplinary knowledge sharing and collaboration?

A descriptive summary of the data was conducted by categorically summarizing the percentage distribution of each survey response.

Taking action: Faculty expertise as a resource. Given that most programs work separately on their efforts to shift to outcome-based educational reform standards, educators were asked to describe their level of expertise in each of the areas of the reform process, from identifying competencies to revising the program. Participants were asked to evaluate first their own level of expertise then were asked what they needed if they felt they had little or no expertise and were asked what they would share if they had some or strong expertise. The numbers of respondents were compared across questions to see how many people would request assistance and how many would offer assistance, based on their expertise.

Perceived personal expertise. Forty-eight percent of the 48 respondents felt they have minimal expertise in identifying and operationalizing the competencies, while 35% have some expertise. Thirty percent of the 48 respondents believed that they possess minimal expertise in designing and implementing learning activities for students to develop necessary MFT competencies, 37% have some expertise / activities, and 26% have strong expertise / activities.

Nearly half of the 48 respondents (43%) felt they have minimal expertise / activities to reliably evaluate students' developing competencies and the program's effectiveness in teaching those competencies, 30% have some expertise / activities, while only 15% have strong expertise / activities in designing and incorporating assessment methods or tools. A smaller percentage felt that they have expertise in using findings from various methods of assessment / evaluation to inform program revisions or modifications. Forty-one percent of the 48 respondents identified themselves as having minimal expertise / activities, while 35% have some expertise / activities, and 7% that have strong expertise / activities in using findings from various methods to inform program revisions.

Table 13

Frequency Table of Expertise in Competency Process (Q26, Q29, Q32, Q35, n = 46)

	Level of Expertise			
	Strong	Some	Minimal	None
Identifying / operationalizing	9%	35%	48%	2%
Designing and implementing	26%	37%	30%	0%
Assessing	15%	30%	43%	4%
Revising	11%	35%	41%	7%

Note. Data were combined from four questions. Each question included data from 46 participants.

Following each of the personal assessments was two follow up open-ended questions. Persons identifying themselves as having some or strong expertise in the given development stage were asked what resources (e.g., documents, webinars, forums, etc.) they could contribute

to the proposed website. Persons identifying themselves as having minimal or no expertise were asked what resources they would like to see made available on the proposed website.

Each of the four quantitative question prompts asking for expertise assessment were answered by 46 participants; the number of people that provided feedback dropped dramatically: the first set of follow up questions (regarding identification and operationalization of competencies) included 32 responses, the second set (regarding implementation of competencies) included 31 responses, the third set (evaluation of competencies) included 30 responses, and the final set of questions received 28 responses. A summary of the qualitative responses can be found in Appendix E.

Table 14

Number of Participants Offering and Identifying Resource Needs According to Stage in Competency Process (Q27, Q28, Q30, Q31, Q33, Q34, Q36, Q37)

	Offered Resources	Identified Resources
Identifying and Operationalizing	10	15
Designing and Implementing Competencies	11	12
Assessing Competency	11	16
Revising Program	8	11

Note. This table combines data from eight survey items with varying numbers of participants.

Identifying and operationalizing. Twenty educators identified themselves as having some or strong expertise in identifying and operationalizing competencies; 10 provided ideas about resources that could be helpful to others (4 other participants responded that they did not know or did not have anything to share). Therefore, 50% of the educators with some level of expertise were willing to provide resources to peers. Twenty-three educators reported minimal or no expertise in that area; 15 of them identified resources that would be helpful to them (3 others indicated they were not sure what they needed). Sixty-five percent of the people who reported

little or no expertise were able to identify resources that they need to continue their work more effectively.

Participants with at least some degree of expertise in identifying and operationalizing competencies were willing to contribute rubrics; curriculum development ideas; examples of stage development, webinars, and conceptual frameworks; and participate in in vivo discussions with faculty leadership about available resources. Those with a lesser degree or no expertise in this area of the process (as with all subsequent areas) asked for concrete examples, standardized resources, and information from other experts. One person asked specifically for a centralized resource collection venue and clear information about the timing and availability of trainings. One respondent was looking for ideas and information specific to doctoral level programs (not simply a repeat of the competencies for Master's level, licensure-based programs).

Designing and implementing. Twenty-nine educators reported having some or strong expertise in designing and implementing learning activities in their programs; 11 provided ideas about resources that could be helpful to others (6 others responded that they did not have resources to share). Thus, 38% of the educators with some level of expertise were willing to provide resources to peers. Fourteen faculty educators reported minimal or no expertise in this area and 12 of them (86%) had ideas about what they need in terms of resources (two other people responded, saying they did not know what they needed).

Participants with some degree or higher of expertise in designing and implementing learning activities offered resources including: workshops, webinars, presentations, professional development plans that allow students to customize their educational tracks, sample syllabi, assignments, learning activities, and student products, and consultation with other leaders about available resources. Those persons with little to no expertise asked for manuals, webinars,

examples, and forums. One person said, “I am new to this type of programming and feel most anything could be useful.” Another person asked for information about interdisciplinary work that has been done in outcome-based educational efforts. One participant asked for an online forum for an exchange of questions as well as a document-sharing system to allow for the exchange of forms (e.g., examples of charts, syllabi, etc.).

Evaluating competence. Twenty-one educators indicated some or greater expertise in assessing competence: 11 of those educators (52%) offered resource ideas; three others responded that they did not have resources to share. Twenty-two educators indicated minimal expertise and 13 (59% of the group) indicated resources that would be helpful to them, with three others not being sure what they needed.

Participants with at least some degree of expertise in designing and incorporating assessment methods to reliably evaluate student competence and program effectiveness were willing to contribute examples of online evaluative systems, expertise in helping struggling students, syllabi, rubrics, aggregated reports, automation tools, action plans, and in vivo discussions with other leaders about available resources. Those participants who identified that they needed further resources indicated interest in workshops linking measurement, observation, and learning experiences, manuals, webinars, trainings, documents, rubrics, venues to gather and plug in data, examples of appropriate data collection techniques, and valid and reliable assessment instruments with high inter-rater reliability. One person asked for resources from competency experts in other fields of study.

Revising programs based on evaluative feedback. Twenty-one educators indicated some or strong expertise in using various methods of assessment or evaluation to inform program revisions; eight of those educators (38%) had ideas about resources to share, and an additional

five educators indicated not being sure. Twenty-two educators reported little to no expertise in revising their programs; 11 of those educators (50%) provided ideas about what they needed, with four other educators not knowing.

In the final category, participants that identified themselves as having some degree or higher of expertise in using evaluative outcomes to inform program revisions offered a number of resources. Some of those proposed resources included: an assessment cycle, sample forms to incorporate feedback into curriculum revision, guidance about how to use data to inform change, action plans, and in vivo conversations with other leaders. Those persons who reported little to no expertise asked for forums, “any documents or webinars that can be shared with supervisors and faculty,” and examples.

Other participant responses. Other feedback focused on COAMFTE’s influence in their training program’s efforts, saying, “I don’t know if our forms would be of benefit to anyone since I don’t know what other programs are doing. COAMFTE will not advise and will not share.” Another person talked about the isolated nature of current programmatic efforts, saying, “I’d love to see how other programs are operationalizing and evaluating standards and benchmarks.” In the area of program revision based on evaluative feedback, one person said, “My question is always changing or revising toward what? Since COAMFTE hasn’t developed a set of standards specific to PhD programs it is difficult to figure out where we ‘should’ be headed.” Another person used the feedback opportunity to criticize the lack of guidance provided by COAMFTE with regard to the re-accreditation process, specifically the self-study reports, saying, “It would be useful of [*sic*] COAMFTE outlined in greater detail, with specific examples, of what they look for in their self-study reports.” These data, when considered in the context of the other quantitative and qualitative data suggest that participants feel unsure about how to

address the educational reform requirements and are looking for more guidance and support, both from other programs and from COAMFTE / AAMFT.

Taking action: Evaluating interdisciplinary resources. To assess what educators, those self-identified as experts and non-experts, would do with resources made available to them, they were asked to review three resource summaries and rate their utility. The resources included: (a) *Consultation and Interprofessional Collaboration: Modeling for the Future* (Arredondo, Shealy, Neale, & Winfrey, 2004), (b) *A Synergistic Model to Enhance Multicultural Competence in Supervision* (Ober, Granello, & Henfield, 2009), and (c) *Implementing the COPA Model in Nursing Education: Promoting Competence, Quality Care, and Patient Safety* (Lenburg, Abdur-Rahman, Spencer, Boyer, & Klein, 2011). The first resource (Resource A) was identified most frequently as very useful (30%), followed by the second (Resource B = 15%) and the third (Resource C = 13%). Sixty-three percent of the respondents felt that the article on consultation and collaboration would be at least somewhat useful to them, 61% felt that the synergistic model would be somewhat or very useful, and 48% thought that the nursing model would be useful to them. A similar percentage of respondents across the three resources indicated that they were unable to determine the utility of the articles.

Taking action: Website participation. After asking participants about the resources they felt they could contribute or that they would need if offered, based on their level of expertise in outcome-based education, the final survey question asked them to rate the benefits to contributing to or participating in such a shared venue. Among the respondents who responded the question, 63% of the respondents saw a benefit in participating in a website of this nature, designed for educational leaders from COAMFTE-accredited programs, although only 41.3% would see benefit in contributing to a website for that same group of educators. Just over 41% of

the respondents saw benefit in participating in a website designed for educational leaders across mental health disciplines, while 21.7% saw benefit to contributing to such a website.

Six participants responded that they would see benefit in another option, which they were asked to specify textually. Two people said that they were not sure about the benefit of a collaborative website, with one person specifying that he or she has too many other responsibilities to “add this task to my already too long list of things to complete.” Two responses can be grouped together as evidence of a broader understanding of the competency movement. The first person reported that he or she would “readily contribute to and participate in a website that was designed to address alternate methods of training and that was committed to methods that valued the need for overall changes aimed at equalizing services provided.” The other participant said,

IF [*emphasis in the original*] the website was dedicated to providing an online venue for those of us seriously discussing the relevance of the directions our professional organization and accrediting body are taking (and imposing on programs with experts beyond those invested in and committed to these directions) then I am in. However given the graying of our profession and the growing number of young professionals who lack the historical understanding to actually grasp this as a never ending cycle of failures, I doubt many will request such a venue. This reality is unfortunate because (unless this is an AAMFT-sanctioned venture) you might be able to provide online space that could generate more visionary possibilities than any AAMFT national conference or sponsored publication has thus far.

The participant’s critique summarized the quantitative responses from the majority of the participants indicating they would be interested in participating in a website for COAMFTE-

accredited programs only, and few of them would contribute resources or expertise to them. The person went on to suggest that if the website were to invite members of other professional organizations (e.g., AFTA, IFTA, Division 43, etc.); additional requests for participation would likely support the creation of such an interdisciplinary venue. This person demonstrates both an understanding of the historical context of the current competency reform movement and of the wider forces that both support and constrain that movement.

Taking action: Beyond the survey. At the end of the survey, participants were encouraged to contact the research assistant to provide information to be included on the post-dissertation collaborative website. The website was advertised to be tailored to the needs of the participants that respond to it, including resources that would be particularly helpful to that group. Participants were asked to: (a) send the research assistant the names and types of materials they are willing to contribute and / or topics they would like to discuss through webinars or forums; and / or (b) indicate the types of online resources that would benefit the participants and their programs. Not only was this data intended to inform the construction of the website, they also provided insight into the educators' willingness to request further resources and collaborative forums and potentially commit to contribute to engaging in interdisciplinary knowledge sharing and collaboration. One month after the close of the testing window, only one person corresponded with the research assistant to inquire about the website. That person did not provide information about the types of resources he or she wanted to contribute, nor did he or she indicate what would be helpful to him or her in future work.

Additional Contextual Data

One additional question was asked of participants to help understand their thoughts about the educational reform in MFT graduate training. As previously discussed, the question was

included to provide participants an opportunity to share their thoughts about the connection between the reform requirements and the development of a “competent and relevant mental health workforce.” The question was intended to give participants an opportunity to voice their support of or concerns about the reform efforts.

Using the same inductive data analysis technique as other open-ended questions, the research team categorized participant statements into categories and subcategories as indicated below in Table 16. Each of the five categories includes subcategories with corresponding statement frequencies. Seventy-six responses were coded into one of five designations based on their beliefs about the link between the shift to OBE and the development of a competent and relevant workforce. The codes included: yes, no, both, depends, and unsure. The respondents were equally split between the positive and negative responses, with 22 each providing reasons to support their views. An additional 11 respondents felt that there were arguments both for a contribution to a changed workforce and against, while nine respondents presented conditions for the workforce change to occur. Finally, 12 responses indicated that the educators were not sure whether there is a link between OBE and ultimate changes in the quality of the workforce.

The explanations that the educators provided became the data for the categories and subcategories, each of which is compiled in the table below. The five categories include discussion of the legitimacy of the shift, the feasibility of the shift, the perceived benefits of the shift, the perceived disadvantages of the shift, and the perceived uncertainty of the benefits or disadvantages. Selective representative data are included to provide illustration of the subcategories.

Table 15

Qualitative Analysis Categories, Subcategories, and Frequencies (Q4, n = 76)

Question: Do you think that the profession's shift to outcome-based education will contribute to developing a competent and relevant mental health workforce? Please explain.	Answers Provided: Frequency *				
	Yes	No	Both	Depends	Unsure
	22	22	11	9	12
Categories and Subcategories Explanations Provided by Respondents	Explanations Provided: Frequency **				
	Yes	No	Both	Depends	Unsure
Category 1: Legitimacy of Shift					
Represents legitimate shift to advance quality training and outcomes	5				
Does not represent legitimate shift to advance quality training and outcomes		10			1
Uncertain if it represents legitimate shift to advance quality training and outcomes		1	1	2	1
Programs already train effective/relevant MFTs		3	1		1
Category 2: Feasibility of Shift					
Insufficient resources to implement /evaluate/ demonstrate shift		1	2		1
Insufficient leadership competency / guidance to implement /evaluate/demonstrate shift		2	1	1	2
Category 3: Perceived Benefits of Shift					
Clearer identification of goals to be achieved and evaluated	8	2	6	1	1
Increased program accountability to train competent and relevant MFTs	6		2		1
Greater accountability on clinicians to obtain necessary competencies for MFT practice	2		1		
Category 4: Perceived Disadvantages of Shift					
Decreased attention to theory advancement		2	1		1
Decreased attention to model development / implementation / evaluation		2	1		1
Increased legitimacy of untested theories and approaches presumed credible		3	1		1
Decreased attention to personal development of therapist		2	2		
Decreased attention to the "art" of therapy		4	4	1	1
Danger of returning to era where mental health		3	1		1

Categories and Subcategories Explanations Provided by Respondents	Explanations Provided: Frequency **				
	Yes	No	Both	Depends	Unsure
/ social science attempted to emulate hard science					
Added level of program accountability diverts attention from quantity and quality of training		2	4		1
Decreased standardization across programs impacts identity of profession / credibility of program / quality of programs / link to existing licensure laws		5	4	1	3
Category 5: Perceived Uncertainty of Benefits or Disadvantages					
Unclear if training students toward better outcomes ensures they will be better clinicians.	2	1	1	1	3
Some merits of input-measures have been lost		2	1		1
Might increase range and practicality of learning	1	1		1	1
Need a balance between “art” and “science”			2	1	1
Should not compromise creativity and exploration of new models and ideas.		2	1	2	1
Requires continued commitment to mature as a profession and as training programs in this area	1		1	2	1

* Represents answers provided by 76 participants choosing to respond to survey question 4.

** Represents various explanations provided by 76 participants choosing to answer survey question 4.

Category one: Reform legitimacy. The first category included four subcategories. Five responses indicated that the efforts represent a legitimate shift to advance quality training and outcomes and believe that the change from input- to outcome-based education (OBE) will result in a change in the workforce. One person said, “I believe that a more competent and relevant workforce is the intended outcome of this shift in the profession and I believe it will be the eventual outcome as we refine our training programs and program evaluation procedures.” Eleven responses fell into a subcategory that the efforts do not represent a legitimate shift to advance quality training and outcomes. Of that group of 11 educators, 10 concluded that the shift would not contribute to a competent and relevant workforce, while one person was unsure. Five

people's responses indicated that they were uncertain if the efforts represent a legitimate shift.

One person concluded that it would not contribute to a changed workforce, saying, "I think that in theory it makes sense, but I'm not convinced that it will make a positive difference in practice." Another person said the shift would both contribute and not contribute, saying,

I believe that it may help although programs under the old standards have been producing high quality mental health professionals for many years. There is an added level of program accountability under the new standards that may produce more competent graduates but it comes at a high cost to programs and students...I am not convinced that overall this change will produce a much greater quality of MFT graduates.

Two people indicated that the reform would help, "If it is assessed appropriately and it doesn't become all about numbers and rubrics. Teaching and training, especially in therapeutic practice, is an art and this needs to be recognized and valued." One person was unsure, saying, "Not sure, most of what seems [like] learning outcomes are the same actions with different words. Let's face it, we don't [*sic*] have more resources to carry on the real evaluation needed and the thinking that should accompany this evaluation. In the end, I think 95% is just superficial or fake with little understanding of the real issues."

Five responses were coded into a subcategory representing people who believed that programs already train effective and relevant MFT practitioners. Of those five responses, three indicated that the shift will not contribute to the development of a competent workforce, with one person explaining, "I think most MFT programs were producing competent graduates. Good programs will use the new standards to improve their teaching and assessment. However, poorer quality programs may use the new standards to reduce the rigor of their programs." Another person thought it both would and would not contribute, and the fifth educator was unsure.

Category two: Reform feasibility. Several people's responses were coded as describing the feasibility of the shift as evidence of their belief that the shift would or would not contribute to changes in the workforce. Four responses discussed insufficient resources to implement, evaluate, or demonstrate the shift. One person cited the insufficient resources as being a reason why the shift will not contribute to practical change. Two people felt that the shift both will and will not contribute to a change, citing resource challenges: "While there are some merits to [educational reform], I think a lot more needs to happen. ... I don't think there is a shared measure of effective outcomes, and ... broader goals may not be achieved." One person was unsure due, at least in part, to the resource insufficiency whether a change would result in the workforce.

The second subcategory of responses categorized as discussion of the feasibility of the shift was the insufficiency of leadership to guide programs to implement, evaluate, and demonstrate the shift. Six educators' responses are highlighted in this category, with two people citing lack of leadership as explanation for why the shift would not contribute to change in the workforce. One person broadened the scope of the concern to not only include this generation of students becoming competent practitioners, but also becoming future educators themselves, saying,

Educational outcomes are important in order to assess whether or not programs and students are meeting the goals they set out to meet. However, without examining how these outcomes are achieved, it is difficult to ensure that students are learning principles, or that future educators will understand what to do and why.

Another person said it both will and will not affect change in workforce development, saying,

It has ... potential, although many of the licensure laws are written for an in-put based [sic] model. ... The issue is around how to define competence at a masters [sic] level... It seems to depend on the agency they work for or whether they want to be in private practice or go on for further education. “

One person reported that the connection between educational reform and workforce transformation depends on “some boundaries / benchmarks from the larger organization [that] are still needed.” One educator said, “Honestly I’m not sure. ... In education I still believe there is a lag in terms of identifying the most meaningful outcomes to measure and how to do this in a field that focuses on developing ... nuanced interpersonal skills.”

Category three: Perceived benefits of the reform. The next category discussed in the data is the perceived benefits of such a shift. Eighteen people’s responses fell into a category that highlighted clearer goal identification for students to achieve and educators to evaluate. Eight cited the clearer goal identification as reason why the shift will contribute to a change in the workforce, with one person saying, “It places the emphasis on outcomes that benefit consumers.” Two people indicated that the shift would not contribute, with one saying, “I don’t really think that it has changed much on how we train our student ... just how we track them. “ Six educators cited the clearer goals as being part of the reason the shift would both contribute and not contribute to change, making statements like, “While I think the input-measures had merit that might’ve been lost... outcome-based education is practical, pragmatic, and holds us accountable for the graduates we are sending into the field. I ... believe this is directly related to competence and relevance.” Another person said that it depends on this and other factors, “I do think that a focus on outcome-based education will help with competencies, more than an input-based approach--if faculty and supervisors can indeed make the paradigm shift necessary to truly

embrace outcomes.” One person was unsure, saying, “I hope it starts to hold programs accountable for competently training its student[s]”.

The second subcategory falling under the category of perceived benefits of the shift was increased program accountability to train competent and relevant MFT practitioners. Six people cited this explanation as evidence of the way that OBE will ultimately contribute to a relevant and competent workforce, saying things like, “It forces educational programs to think through outcomes and how best to meet expectations. This, I think, can't help but improve intentional education.” Two people cited it as both contributing and not contributing, with one saying, “The way that COAMFTE has gone about developing its standards has shifted the focus away from field-defined standards to program-defined standards to a large degree, thus increasing variability to what might be called ‘MFT training’”. One person was unsure about the link, based on issues of accountability.

The final subcategory highlighted greater accountability on clinicians to obtain competencies necessary for MFT practice: two people indicated belief that OBE would contribute to a competent workforce, with one noting, “There is a growing body of research demonstrating the educational effectiveness of an outcome-based approach to mental health.” Another person indicated that the shift would both contribute and not contribute to changes in healthcare delivery. That educator said,

The benefits of outcome-based education is [*sic*] that it creates an expectation, and helps others achieve [*sic*] a level of skill and understanding to be credible mental health professionals. However, mental health differs from the physical/medical model of health in that there are psychological processes occurring [*sic*], and a great deal of [other] factors ... that are difficult to measure.

The person went on to caution the profession about the danger of being caught up in outcomes at the expense of human processes.

Category four: Perceived disadvantages of reform. The fourth category derived from this data analysis illustrated explanations of the disadvantages of the shift. Eight subcategories were used to describe the explanations in this category. The first was a concern about the decreased attention to the advancement of MFT theory. Two people cited this as reason why the shift would not contribute to change, one person indicated that this was part of the reason the shift would and would not contribute to change, and one person was unsure but cautioned that an “either or approach is ill informed” with outcome-based educational standards needing to be balanced with inputs.

The second concern was a decreased attention to model development, implementation, and evaluation because of the shift to OBE. Two people cited the model development as reason why the shift will not result in change; one person cited it as part of the reason the shift would and would not contribute to change, and one person was unsure, using the same explanation as was coded for the previous subcategory.

Five people discussed an increased legitimacy of untested theories and approaches, both of which were presumed to be credible: three cited this as reason why the educational shift would not result in change in the workforce, saying that the effort is “just another attempt to try and quantify something that we have no proof is occurring successfully.” One described the presumed legitimacy of such theories and approaches as part of the reason the shift would and would not contribute to change, and one person was unsure about the link between the educational reform and changes in the workforce. One person’s response argued that the educational reform would both contribute and not affect the workforce development,

I think the focus on evidence based work, application, and hands on learning will result in more skilled practitioners within a limited scope but it will also mean that the ability to explore the infinitely varied permutations of the human mind in a peer-reviewed academic setting will probably be curtailed even further, leaving more room for untested and potentially hazardous theories and procedures to emerge on the fringes of the mainstream. Creativity and exploration are at risk with the new direction.

This person's response represented a number of the subcategories, explaining decreased attention to theory advancement in life, training, and therapy, decreased attention to model development, implementation, and evaluation in training and therapy, and increased legitimacy of untested theories and approaches that gain credibility in training and therapy.

Four people cited a decreased attention to the personal development of therapists as evidence of their positions: two said that the educational changes will not result in changes in the workforce, saying that the focus on outcome-based training has taken resources otherwise given to students for their educational, professional, and personal development. Two people said that they both would and would not contribute to meaningful change, saying,

Outcome-based education will certainly make sure that the content that needs to be learned and the skills to be demonstrated are clearer, and the goals of the educational model are reached. However, I still am not sure that the personal development of each professional is truly affected by knowledge in the academic sense. In today's educational system, values that are not considered as important in the licensing process are the importance of personal formation and maturation, the deep sense of mentorship with development of a coherent personal philosophy of life, and the integration of who we are

into what we do. Thus, we form knowledgeable and skillful people who may or may not be decent individuals.

In a related critique, ten people expressed concern about a decreased attention to the “art” of therapy due to the increase focus on the measurability of outcomes, the science of evaluation, and the need to demonstrate skills, knowledge, and awareness consistently. Four people cited the decreased attention to therapy as an art as reason why they do not see a link between the OBE shift and workforce change, “It may lead to standardization of practice, but not to the development of the art of therapy and deeper wisdom,” four cited it as part of the reason the shift would and would not contribute to change; one person indicated that he or she thought it depends on this and other factors; and one person was unsure of the link between this educational reform and the presumptive workforce change.

In a similar critique of the educational shift in MFT training, some people indicated concern about the danger of returning to an era where behavioral health attempted to emulate hard science. Seven people explained their position about the link between the educational reform and workforce development in the context of this concern, with three people indicating that they do not see the reform resulting in workforce development, one person saying the educational changes would and would not contribute to changes in the workforce, and one person not being sure. In a representative statement, one person said,

I believe that outcome-based education is limited to measuring aspects of a student's education process that are easy to measure, when I believe that there are a number of intangible benefits that students gain during their educational process. I fear that as outcome based education becomes more prevalent, the intangible gains, because they

often can not [*sic*] be quantified, will lessen and the educational process will become more rigid.

As is clear throughout the analysis of the project data, assessment is a substantial concern for educators, as they are asked to demonstrate that the outcomes they have selected for their programs are being integrated into the curricula and that the students are learning them and applying them to clinical practice.

Seven educators' responses were coded into a subcategory that described how the added level of program accountability diverts attention from the quantity and quality of the training. In a typical response for this category, one person said,

As a faculty member who has helped develop and implement an outcome based system at our master's [*sic*] program, the hustle and bustle of keeping up with 'paperwork' of accreditation takes away from the 'relationship building' and working with students and colleagues.

This person's focus on the practicality of changing documentation practices represents a critique of the reform and a commentary on the commonly cited need for more resources to help educators determine best practices for their efforts to respond to the accreditation standards.

The last critique of the shift was described as the concern that decreased standardization across program affects the identity of the profession, the credibility, and quality of programs, and the link to existing licensure laws. One person said, "The outcomes required by COAMFTE aren't necessarily tied to competency. I believe there will be increased variability in the competency of the students," while another said,

I think we'll probably end up with a both/and approach. For example, we can talk about specific core competencies that every MFT needs to have but who is to say how many

clinical hours are required to facilitate their attainment? So, I think some programs will end up having objectives and competencies but will also require ‘input’ driven program requirements.... like, you'll meet certain competencies by doing 500 hours of client contact.

Five people cited this critique as reason why the educational reform will not contribute to change in the workforce, four people indicated the critique as part of the reason why the change both will and will not contribute to workforce development, one person said that link depends on this critique and other factors, and three people were unsure about the contribution of OBE to workforce changes.

Category five: Uncertainty. The fifth category that arose from the qualitative data was described as perceived uncertainty of the benefits or disadvantages of the educational reform shift and its link to the development of a competent and relevant workforce. Some of the subcategories echo those from earlier categories and some are unique to this category. The first subcategory arising from the data indicates that some educators were unclear whether training students towards better outcomes in the training programs ensure that they will be better clinicians in the context of and beyond their training experiences. Despite citing the critique, two people still indicated that they thought the reform would result in changes in the workforce. One person used the critique as support of his or her position that the educational changes would not change workforce development, one person said the reform would both influence and not influence the workforce, one person said that the workforce change depends on this and other factors, and three people were unsure. This subcategory wove its way through other categories; representative participant feedback has been presented in the context of other previously discussed analyses.

Four people commented on the loss of the merits of the input-measures used under the last version of the accreditation standards (Version 10.3; COAMFTE, 2005). Two people cited the critique as evidence that the shift to OBE will not result in changes in workforce development, calling the shift an effort to rename the educational standards that already exist; one person thought the shift would and would not contribute to change, and one person was unsure.

In a more positive critique, four people felt that the change might increase student and educator creativity in the learning process, with one person citing the explanation as evidence of the link between the educational shift and workforce development, saying if the shift is “done well... the new standards allow more range and practicality of learning.” One person, despite the positive nature of the subcategory, felt that the educational shift would not change workforce development; one person thought that influence depends on this and other factors; and one person was unsure.

Another critique described in this category was the balance between the “art” and “science” of therapeutic practice. Two people thought the educational reform would both contribute and not contribute to workforce development, citing this critique; one person thought that influence depends on this and other factors; and one person was unsure. One person said,

Much of the work that we do is "art," alongside the "science" that we teach our students from the textbooks and research literature. If our students begin to mechanize the way that do things (i.e., rigidly conforming to manualized approaches and methods), then everyone loses. If our students are still allowed to personalize the work they do to the unique needs of patients while simultaneously integrating their unique selves/personalities into the process, then everybody wins.

Six participants' responses were coded as indicating that the shift to OBE should not compromise the creativity and exploration of new models and ideas. Two people cited this concern as reason why they did not believe that the shift would result in change beyond the educational experience; two people thought that influence depends on this and other factors; and one person thought that the reform would both influence and not influence changes in workforce development. One person was unsure.

The final subcategory of data represents a critique of the profession as a whole and was described as the requirement of continued commitment to mature as a profession and as individual training programs in this area. "It is wise to direct learning toward goals. Goals are difficult to operationalize and measure. It will take a while for the educational community to acquire proficiency in this process." One person cited this explanation as evidence of the link between OBE and workforce development; one person thought the shift to OBE would both contribute and not contribute to changes in the workforce; two people thought that a change depends on this and other factors; and one person was unsure.

Chapter 5: Discussion

The purpose of this study was to contribute to the research about the one mental health field's attempts to address national calls to reform education. The interdisciplinary calls, emanating over a six-decade period, recommend changes to input-based training to ensure that practitioners have the knowledge, skills, and awareness to provide clinical care that is relevant and effective for all persons in need. Discussion of the study's findings is organized in the following way. First, contextual findings about the participants and the programs they represent will be discussed, including demographic information. The remainder of the discussion will focus on the four research questions and is arranged by those questions. As the findings related to each research question inform the others, discussion will focus on the ways the data support and contradict each other. The discussion will conclude with additional contextual data that may help to interpret the findings.

Participant Demographics

Following Iarossi (2006), the demographic questionnaire was placed at the conclusion of the online survey, allowing participants to focus on the content of the research study as their primary participation goal. Research suggests that placement of demographic data requests increases participant response to the personal information, as there tends to be a higher investment in the survey completion after participants have responded to the content of the study. Participants of this survey did not replicate that finding, with 46 people completing the demographic section as compared with 86 people who completed the first question.

Some interpretations of the participant drop off may reflect obstacles that participants may have considered in making a determination not to provide such data. For example, participants may have stopped providing feedback because they did not have the time to

complete the study, which may suggest a lack of resources. Alternatively, they may have felt they could not provide the desired data, suggesting concerns about social comparison or representing a lack of knowledge / awareness. Another potential speculation about the reason for participant drop-off with regard to demographic data may be related to privacy, with participants not wanting any demographic profile to be associated with their survey responses.

Program Demographics

Participants were asked first to answer questions about their program. The responses indicate a variety of programs represented by the faculty participating in the survey. Geographically, responses came from programs in all sectors of the United States and Canada, with the largest percentages coming from the Northeast, Midwest, and West portions of the US. Given that the programs with the largest number of faculty and largest number of MFT programs come from those three geographical regions, it may be that the results reflect this distribution (AAMFT, 2013).

The overwhelming majority of the programs represented in the survey include Master's-level programs. This is an expected outcome as the majority of training programs (66% of the 114 accredited degree programs) across the US and Canada includes a terminal Master's degree (e.g., MA, MS, MFT, MEd, MSSW, MDiv, MMFT; AAMFT, 2013). A disproportionately high percentage of participants from programs with doctoral degrees (PhD, PsyD, DMFT) were represented in this study, which may due to the emphasis on research participation and production in programs offering that degree.

Accreditation site visit dates were distributed across the six-year cycle, with a large number expecting a visit in the next two to four years. These contextual data are important as they suggest that people currently in preparation for a site visit will be most likely to be thinking

concretely about the different aspects of outcome-based educational reform and ensuring that they can document their programs' progress in changing, modifying, or highlighting effective program pedagogical strategies. The most frequently selected reaccreditation site visit date was four years from the completion of this study. This finding can be interpreted as providing a period that gives participant programs time to gather and submit required visit documentation prior to the COAMFTE notification issued eighteen months prior to accreditation expiration (COAMFTE, 2008).

Participant Demographics

The questions focused on participant demographics were found at the end of the survey. The smallest number of participants responded to this final series of questions ($n = 41$). The majority of those respondents identified as Caucasian, with just under half reporting an age between 30 and 50 years old. The sexes were evenly split for people who self-identified.

Overall, program faculty members represented in this study tended to include more associate and assistant professors than full professors. In addition, many programs identified adjunct faculty as making up a large portion of their educational team. These data are interesting given the typical engagement level of adjunct faculty in graduate programs. Adjunct instructors tend to be less involved in programmatic strategy planning due to the nature of their employment and may have less connection overall with the culture of the program and the program's educational mission and/or outcomes and objectives. Future research will attempt to gather information from the adjunct instructors to determine how the educational reform instituted in the programs where they teach is being translated into their work with students.

Most of the people involved in the study hold at least one academic degree or certification in MFT, despite the field's history of and value for interdisciplinary expertise. When

asked about the level of collaboration among programs by both students and faculty, participants said that students from other mental health preparation programs work with MFT students in classes, collaborative initiatives, and supervisory experiences. Nearly half of the participants (45.7%) reported, however, that minimal or no exchange occurs with other mental health programs. This finding is supported by previous research, which says, "training ... occurs in disciplinary silos, leaving students unprepared for multi-disciplinary practice (APA, 1998; Casto & Julia, 1994; Richards, 1996)" (Hoge, Tondora, & Marrelli, 2005, p. 511).

Research Question One

The first research question in this study explored MFT educators' understandings of the context around the current educational reform efforts in the profession. The educators were asked questions about both the call to education reform in MFT training and more broadly to the calls that have been made over the course of sixty years in a number of behavioral health and interdisciplinary fields (e.g., MCT, business, education, medicine, law).

The first survey question asked participants to discuss the reasons for the philosophical shift in MFT training from input- to outcome-based educational standards. Analysis of those data revealed that more than half of the profession's leaders have little or no idea of why the shift occurred. Less than 20% of the leadership has a high level of understanding; the rest have a moderate (and incomplete) comprehension of the factors influencing the shift. That moderate comprehension tended to suggest an insulated view of how the mental health profession needs to improve its educational standards for students and clients. Missing is the larger contextual and historical understanding that educators across professions have a responsibility to consumers and students to provide the training that results in quality training opportunities, products, and services.

The next survey question was designed to provide a broader perspective of the competency reform movement in MFT by asking participants to provide information about their knowledge of the national, cross-disciplinary calls for such reform. Even fewer people demonstrated a high or even moderate understanding of the wider context, with responses in those categories representing a *combined* 28% of the MFT leadership. The largest percentage of responses indicated little to no understanding about the national calls. Through feedback from three qualitative questions and with later quantitative questions, it was clear that the vast majority of MFT educators did not have a strong understanding for the call, the relationship between that call and the broader systems calls, or the recommendations that they accessed throughout the remainder of the survey in the form of resources, question items, and opportunities for collaboration.

This finding is consistent with previously published articles in the professionally sponsored journal (*Journal of Marital and Family Therapy*). For example, Miller, Todahl, and Platt (2010) describe the history of the competence movement as beginning with the apprenticeship system during the medieval guilds. They highlight the rise of functional analysis that identified job skills necessary for a number of professions in the 1930s. Then, moving forward thirty years, they discuss the economic climate that led the US and the UK to reform education with the goal of improving job skills that would respond to global competition in the marketplace. The seminal work of McClelland (1973) was next identified as an impetus for changing how people thought about intelligence and competence, with strong arguments made for considering new ways to measure success in the workplace. A twenty-year gap brought their timeline to the 1990s, when the MFT profession reportedly began pushing to articulate the standards and outcomes necessary for its practitioners.

Missing from Miller, Todahl, and Platt's competency movement narrative is discussion of the numerous socio-political and cultural forces that were occurring in other professions, both in the gaps of time and concurrently with the events that they mentioned. For example, missing is the work of interdisciplinary scholars committed to social justice as well as the national calls to address cultural competence in behavioral health education and practice (e.g., Abreu, Chung, & Atkinson, 2000; National Alliance on Mental Illness, 2010; National Institutes of Health, 2010). Moreover, Arredondo and Perez (2003) discuss the impact of the Civil Rights movement of the 1950s and 1960s in the US as it led to social and political change that influenced how behavioral health was conceptualized and practiced in clinical work and research. At that time, President Johnson pledged to apply scientific research to social problems in the initiation of the Great Society Agenda. That Agenda led to a collection of national and regional research centers focused on the investigation of mental health problems among underserved racial / ethnic minority groups (National Institutes of Health Almanac, 2010-2011). The next decade (late 1960s to 1970s) saw the concurrent creation of organizations dedicated to developing and promoting culturally competent ideas that influence therapeutic treatment.

President Carter's Commission on Mental Health identified similar deficiencies in the behavioral health system, recommending policy changes that would result in more effectively serving the needs of underserved populations (President's Commission on Mental Health, 1978). In 1981, Allen Ivey, division leader at the American Psychological Association (APA), created a committee dedicated to the development of multicultural competencies, which resulted in important landmark efforts to define and operationalize effective clinical treatment informed by cultural and contextual influences.

Despite that committee's recommendations over thirty years ago and the subsequent work done in the interdisciplinary field of MCT, however, several national reports highlight disparities in mental health service delivery to underserved populations (e.g., New Freedom Commission, 2003; US D.H.H.S, 1999; 2001; 2006).

Also missing in the AAMFT-supported version of the competency movement history is discussion of the work largely pioneered by professional psychologists but informed by collaborations with commissions throughout North American and Europe over the course of three decades (see Kaslow, Borden, et al., 2004 for a historical overview). In the 1980s, the National Council of Schools and Programs of Professional Psychology (NCSPP) developed a competency-based core curriculum and highlighted the knowledge, skills, and attitudes necessary for professional functioning. In Canada, the Regulatory Bodies for Professional Psychologists came to consensus in 2001 on competency-based regulations in a document known as the Mutual Recognition Agreement.

Several behavioral health conferences focusing on educational and professional competence have been held in the US over the last four decades as well (e.g., Vail Conference, Scottsdale Competencies Conference, Annapolis Conference on Behavioral Health Workforce Education and Training). The Annapolis Coalition Conference (2004) has been responsible for a plethora of research advancing the competencies in behavioral health education (e.g., Hoge, Huey, & O'Connell, 2004; Hoge et al., 2005; Hoge et al., 2009; Hoge et al., 2005; Hoge, Tondora, & Marrelli, 2005; Marrelli, Tondora, & Hoge, 2005). The recommendations that have come out of the work done by that group continue to inform best practices for competency-based mental health education and clinical work.

Findings Summary

It is clear that the information drawn upon by the profession of marriage and family therapy appears to be limited, lacking the contextual and historical richness of efforts being made both in the behavioral health field and in interdisciplinary efforts. Such an orientation to educational reform is echoed through the findings of the study, as the majority of the MFT leaders who participated in this study demonstrate a limited understanding of how this profession's efforts fit into the broader context.

Research Question Two

Given the understanding that MFT training programs appear to be working without the benefit of contextual or historical knowledge of how the educational reform movement is linked with other efforts across disciplines, it was important to get feedback about the efforts that programs seeking first-time accreditation or seeking to maintain current accreditation are engaging in in response to the COAMFTE requirement to move to an outcome-based educational paradigm.

Organizational-Level Data

The second research question explored what programs are concretely doing to address the call for educational reform. Through a series of survey items, specific emphasis was placed on collaboration and particularly on interdisciplinary consultation and resource sharing (e.g., Hoge, Morris, et al., 2005; IOM, 2006; Kaslow et al., 2004). Those items provide information about educators' views of the steps taken by AAMFT to establish the core competencies and by COAMFTE to establish the educational benchmarks required for programs to earn or maintain accreditation status. This second general research question provided concrete data to clarify and

augment responses from the first, which asked participants to talk about the shift from input- to outcome-based education more broadly.

None of the specific steps for the creation of outcome-based standards reported in interdisciplinary literature garnered support from more than 42% of the respondents. The most frequently selected step educators believed AAMFT took was the review of the profession's own literature to determine the skills and knowledge that MFT practitioners should possess. This response represents a popular view among the educators in this study that the experts that determined the requirements for the profession only looked inward to determine what constituted appropriate and relevant knowledge, skills, and awareness for its practitioners.

That view is supported by the description of the process taken to construct the list of core competencies, as described by Nelson et al. (2007). The AAMFT convened task force was put together in January 2003 and included six couple and family therapy experts: James Alexander and Susan Johnson, authors of two relational theories of therapy, "included for their work in developing and implementing family therapy models" (Northey, 2005, p. 11); Ronald Chenail, Russell Crane, and Thorana Nelson for their work in MFT training programs, research, assessment, and evaluation; and Linda Schwallie, for her experience on regulatory boards in addition to her broad clinical experience. That group of people compiled the first draft of what was to become the current list of core competencies in a six-month period. During that period, the task force reviewed seventeen resources, nearly twenty percent of which were documents produced by AAMFT-related authors or organizations (Nelson et al., 2007).

In July 2003, the original list of 126 items was sent to a 50-person task force, made up of MFT trainers, supervisors, and educators. Those experts modified the list by adding seven competencies. Their draft was disseminated to the general membership in October 2003; the

feedback from 75 respondents was the addition of seven more competencies, bringing the total to 140 core skills, attitudes, and knowledge items.

This third draft was sent for the first time to national behavioral health organizations, where “the majority of [the] stakeholders did not provide specific feedback on the CC.” The committee members highlight that one organization asked to disseminate the draft as it stood to their own constituents, and another pledged general support for the project (Nelson et al., 2007, p. 424). Only one organization was said to have provided concrete recommendations: those recommendations were to include competencies focused on recovery, risk, and protective factors, as suggested in other literatures (e.g., Hoge, Morris, et al., 2005). Based on that collective feedback, the draft was *reduced* by one competency, suggesting little to no modification in response to the “interdisciplinary collaboration.”

The final step in modifying the competencies came in July 2004; a year and a half after the commission of the task force to create them; when a group of 130 MFT educators came together at the Educators’ Summit. That group of experts considered the implications of the competencies and the corresponding move to outcome-based education. Their efforts reduced the 139 competencies to the current version that includes 128. A year and a half later, COAMFTE disseminated the Current Accreditation Standards (Version 11.0), which include the requirement that programs looking to earn or maintain accreditation identify how they are teaching and evaluating student competence. Programs are encouraged, but not required, to use the list of competencies provided by AAMFT.

The core competencies were sent to a group of graduate programs across the nation that self-identified as “early adopters” of the requirements. Those programs, known collectively as the Beta-Test Group, were charged with implementing the core competencies into their curricula.

In that process, they worked to refine the competencies, identify potential challenges to their implementation, and develop resources to help other training programs (Brooks, 2010). Three products were said to have resulted from the two-year efforts of that group of programs: a revised supervision instrument, a Rubrics Cube, and a website designed to share ideas and resources. A search of the AAMFT website, consumer-based online resources through popular search engines, and scholarly literature reveals that none of those resources are publicly (or privately) available for educators or practitioners. This is to suggest that even collaborative efforts made within the profession are unsupported by the national organization, leaving programs to “fend for themselves” in changing their curricula.

Based on the review of the entire competency creation process – a process described by AAMFT as collaborative and interdisciplinary in nature – it is clear from the published literature that the efforts were primarily collaborative only within the profession for a limited period and among those people identified as experts by the organization. When asked in this study to identify other steps that were collaborative and interdisciplinary in nature (e.g., Hoge, Morris, et al., 2005) that AAMFT or COAMFTE may have consulted, the majority of participants (themselves leaders in the organization as educators in the accredited training programs) believed that none had been used by either organization.

Participants were even less optimistic about the creation of products by AAMFT / COAMFTE recommended by the same interdisciplinary literature. No one product was believed to exist by more than 31% of the group. Participants reported most frequently that COAMFTE had created a core set of clearly defined standards that can be implemented across preparation programs and continuing education venues. Despite the existence of such a set of standards, participants were markedly less confident that the clear set of competencies could be

implemented in those same venues. The data suggest that overall, faculty do not believe that competencies have been defined in reliable, valid, or clear ways for implementation in training programs and continuing education. Their assessment is consistent with other research that says,

In behavioral health, a common outcome of attention to the issue of competency has been published 'lists' of the knowledge or skills considered essential for practice... Largely unaddressed are questions regarding what constitutes a competency and how it can be reliably assessed... The value of existing competency inventories will be enhanced in their practical application if there is a clearer foundation that provides a framework for both defining and assessing competency within the context of behavioral health practice. (Hoge, Tondora, & Marrelli, 2005, p. 512)

Programs are mandated to select, define, implement, evaluate student progress, and revise pedagogical strategies to improve student-learning outcomes based on a set of competencies that faculty have not assessed as being valid, reliable, or clear. It appears, however, that they are left to do their work with little guidance from AAMFT / COAMFTE, an idea supported by several respondents, who said things like “very little was done after the long list was published, a book was made available (expensive), and programs were left on their own to figure it out” and “I don’t know what other programs are doing. COAMFTE will not advise and will not share.”

Program-Level Data

At the program level, despite the concerns that faculty expressed about the competencies with which they have to work, educators are engaging in a number of activities to attempt to integrate the educational reform into their current practices. Their activities can be categorized in three ways: (a) working independently; (b) collaborating with other MFT faculty, students, and supervisors; and (c) engaging in training opportunities with other MFT professionals at AAMFT.

These findings are again not surprising, despite calls for consultation and multidisciplinary collaboration (e.g., Arredondo, Shealy, Neale, & Winfrey, 2004) and they support the data from earlier study findings. Hoge, Tondora, and Marrelli (2005) discuss the tendency for programs to operate in “disciplinary silos,” modeling distrust for, or unwillingness to engage in multi-disciplinary practice. The authors caution that such an approach leaves students unprepared to work effectively in collaborative settings outside of their training programs. The approach also leaves each program to “reinvent the wheel,” working to find, implement, and evaluate resources that others might have already vetted or discarded. Given that one of the typically stated barriers to progress in educational change is lack of resources and an overextension of faculty time (e.g., Brooks, 2010), it is surprising that programs have not historically attempted to join together to work more efficiently.

Identifying, defining, implementing, and evaluating competence. When looking more closely at the program-level efforts to incorporate the core competencies into training, some interesting categories emerge. The primary domains designated by AAMFT were broken into the five steps (identification, operationalization, implementation, evaluation, and revision) and participants were asked the extent to which their program had engaged in processes for the competencies associated with each domain. In the first domain: *admission to treatment*, the majority of respondents had identified and operationalized the competencies to a significant degree. Just under half of the respondents had implemented those defined competencies into their curricula.

The second domain: *clinical assessment and diagnosis*, appears to have a greater degree of competency development, with more than half of the respondents reporting that they had identified, operationalized, implemented, and evaluated the competencies to a significant degree.

The third, fourth, and fifth domains: *treatment planning and case management, therapeutic interventions, and legal issues, ethics, and standards*, were similarly advanced in progress, with more than half of the participants reporting that they had identified, operationalized, implemented, and evaluated competencies in those areas. The second through fifth domains of practice represent the bulk of the treatment exchange process, with programs focusing efforts on the therapeutic process in the room over the course of the clinical experience. With many graduates moving out of their training programs into employment in agencies with an Approved Supervisor on staff and where intake clinicians or program directors address admission to treatment, the training programs' focus on these areas makes sense.

Participants reported a lesser degree of advancement in the final primary domain: *research and program evaluation*, although more than half of the respondents reported that they had identified, operationalized, and implemented competencies to a significant degree for that domain. Evaluative efforts are lacking in this area, which can be understood in the context of the makeup of the programs across the US and Canada as being primarily focused on the education of Master's level practitioners.

In addition to the six primary domains of therapeutic practice identified by AAMFT, some programs have created domains or competency sets of their own to reflect the program mission or particular curricular emphasis. Thirty-seven participants reported one additional domain, and twenty-one participants reported two additional domains or competency sets specific to their program. Some of those identified domains or competency sets included: metaframeworks, social justice, professional maturity, interpersonal competency, self- / person-of-the-therapist, theory specific interventions (e.g., systemic-relational therapy), cultural competence, spirituality, and teaching. The participants whose programs included additional

domains indicated most frequently that they had significantly engaged in the entire competency process for those domains.

Overall, the majority of participants felt that they have successfully identified, defined, and implemented across five of the six required clinical domains. The final domain (research and program evaluation) appears to be less advanced, a finding that both makes sense and is problematic for the future of the field with respect to its relationship with other behavioral health providers. The area of research and program evaluation has been identified by AAMFT as a primary goal for MFT practitioners, yet programs appear to be having more difficulty integrating the domain into clinical practice and education.

Given that the majority of the training programs across the US and Canada are Master's level or certificate / post-degree programs (AAMFT, 2013), the focus on practical clinical skills rather than theoretical or scientific research and program evaluation skills is not surprising. A recent study of clinical and student members of AAMFT indicates that 67% of clinical members have a terminal Master's degree (33% hold a doctoral degree) and 88% of student members report that the highest degree they will seek is a Master's degree, compared with 12% of that same group pursuing a doctorate (Todd & Holden, 2012). The authors of that study conclude,

The striking difference between [the clinical and student members' degree status] raises some interesting questions about the future of marriage and family therapy in policy and research arenas. Since a master's [*sic*] degree is primarily a clinical degree, questions and concerns can be formulated about whom will be doing research about family therapy for family therapists. (p. 16)

The findings from this research study illustrate that training programs place less emphasis on research and program evaluation overall than on the clinical skills that the majority of the students will need in their future Master's-level clinical careers.

Competency implementation strategies. Since the majority of the participants identified that they have implemented competencies in all six of the primary domains, it is useful to explore the strategies for doing so. Respondents reported that coursework was the primary vehicle for teaching competencies across the six primary domains. Clinical supervision was identified as being used to implement the selected competencies for the majority of respondents across five of the six domains, not including research and program evaluation. Clinical work, supervision training, and advising / mentoring were other frequently used strategies to teach and assess competencies. Given the clinical nature of the training programs in the field, these findings are not surprising.

Research initiatives were the least frequently identified by participants as a method to discuss or explore student competency. The most frequently identified domains studied in research initiatives were therapeutic interventions and research and program evaluation. Based on these data, we may interpret that when programs focused on competency-based training are engaging in research initiatives, their efforts focus most frequently on the processes of research and program evaluation, and secondarily on clinical intervention (e.g., empirically validated treatment).

Assessment. Most of the programs are using traditional assessment methods to evaluate student competency achievement: grades, faculty and supervisor evaluation, student self-report appraisals, papers, presentations, and demonstrations. In addition, program portfolios are popular vehicles for a more comprehensive assessment of skill and knowledge. One respondent noted

that his or her program was using the same evaluative methods that it had used under the old accreditation standards. Program educators reported that they are most frequently employing their evaluative methods in clinical supervision, courses, and generally in clinical work.

Roughly half of the respondents believed that 90% of their students meet or exceed the program competency benchmarks in all six of the primary domains. About a quarter of the respondents felt that 61-90% of their students meet or exceed those benchmarks. These data clearly suggest that, despite the challenges of defining, implementing, and choosing evaluative strategies to assess student competency, most students are demonstrating that they possess the knowledge, skills, and awareness that their programs are asking them to develop.

Curriculum / program revision. Participants were asked to report how the results of their assessments have informed program or curriculum revision. Earlier data suggested that revision is done least frequently across the six domains of practice. Specific data support that conclusion, with only 38% of the programs reporting that findings from assessment methods have significantly informed revisions to their curricula. Nearly a quarter of the group felt that their programs were using some evaluative findings to inform revisions and another full quarter was still exploring how the findings might inform future revisions.

Findings Summary

When considered together, the data gathered to learn about the reform efforts suggest that programs have moved beyond the identification and operationalization stages and are implementing activities and assessing student competencies through those activities. The educators overwhelmingly believe that their students have demonstrated competence when assessed. They have not engaged in consistent revision processes, however, based on feedback that evaluative and stakeholder feedback mechanisms provide.

It is also clear that, while MFT educators are attempting to integrate the competencies into their programs, they believe that they were made primarily by a group of people who consulted with the profession's literature and only cursorily with other resources. That perceived insularity, modeled by AAMFT and COAMFTE, appears to be replicated by the programs themselves. Consistent with other professions, MFT educators have, mostly, focused their efforts towards their own programs and secondarily to the profession. Very little collaboration appears to be occurring across disciplines, despite the access that many of the programs have to students, faculty, and experts from other mental health professions who are housed in their department or institution. This finding is discussed further in the context of the next two research questions.

Research Question Three

The third focus of this study explored educators' critique of their efforts to address reform within their own context and later with information about recommendations for collaboration and evaluations of efforts made across behavioral health professions. Programs received information about the new accreditation standards in January 2006; those accreditation standards vastly changed how programs document effective training to COAMFTE. Previous standards (Version 10.3; COAMFTE, 2005) asked programs to document coursework, practicum sites, and clinical training opportunities as indications that students were being trained to be effective practitioners. If programs could prove that their students were completing the specified number of clinical hours and were earning passing grades in their courses, the students were considered competent. The new standards (Version 11.0; COAMFTE, 2005) changed the paradigm such that the burden for documentation of competence became more detailed, with programs needing to demonstrate where the competencies were being taught and how they were being evaluated.

Critique in Context of the Individual Programs

One of the open-ended questions in this study asked faculty members to describe the factors their program considered when determining which of the core competencies would be defined, implemented, and evaluated in their training curriculum. The question represented an opportunity for faculty to be critical of their efforts prior to receiving formal information about recommendations and critiques across professions. Several categories arose from that data, including a consideration of the program curriculum at the time of competency adoption; the organizational culture; the knowledge, skills, and awareness that the faculty wanted their graduates to espouse; specific local licensing requirements; and faculty expertise. All of the considerations highlighted by the participants can be categorized as a program- or profession-level analysis. No educator mentioned review of other behavioral health efforts and only three discussed collaboration with stakeholders related to the profession. In fact, the broadest contextual reference made was to the requirements set by AAMFT / COAMFTE or to the state with respect to state licensing laws.

The approach to selecting competencies adopted by the majority of the programs suggests taking “the path of least resistance,” consulting with the established programmatic benchmarks and expectations to determine how to fit the proposed competencies into the curriculum in order to make as few structural changes as possible. Such an approach to competency adoption was, in fact, championed by AAMFT:

Participants [at the Educators’ Summit] were reassured that (a) the steering committee believed that most of the competencies were already addressed in programs and would not require an entirely new design for graduate education, (b) the CC [core competencies] most likely would be incorporated into COAMFTE accreditation standards in some

fashion, but the steering committee would not be dictating how that would occur, and (c) programs themselves would help develop the tools for assessing the competencies because it was believed that programs were already doing this, but not necessarily in a systematic or formal fashion. (Nelson et al., 2007, p. 425)

This position was taken by AAMFT in response to negative feedback from the educators, who expressed concern about the way student (and by extension, programmatic) competence would be assessed by the organization. Educators reported uncertainty about how to reorganize their programs to comply with the standards that COAMFTE would begin to enforce in order to maintain accreditation status.

After discussion of the competency selection process at the programmatic level, participants were asked to share information about how they were implementing those identified competencies. Again, the intent of the question was to ask educators to be critical of their efforts to respond to the reform requirements. Participants identified three broad sets of activities they use to implement (and assess) the competencies: group work, particular assessment tools, and experiential activities. Specific learning venues were also identified: clinical work, mentoring relationships, coursework, and supervision. Supervision of clinical work has long been considered a cornerstone of MFT training, with a plethora of research (a search of EBSCOhost databases including *Academic Search Premier*, *ERIC*, *PsycINFO*, *MasterFILE Premier*, *CINAHL Plus with Full Text*, and *Social Work Abstracts* resulted in $n = 539$ articles about supervision published in JMFT and $n = 157$ articles on supervision and competence) focusing on the supervisory relationship as an opportunity to provide formative and summative feedback to training therapists (e.g., Crane, Griffin, & Hill, 1986; Inman, 2006; Sparks, Kisler, Adams, &

Blumen, 2011; Russell, DuPree, Beggs, Peterson, & Anderson, 2007; Serovich & Mosack, 2000).

Critique in the Context of Interdisciplinary Research Findings

The next two questions asked participants to be critical of their efforts after being given recommendations for mental health professions to communicate and collaborate with each other in order to share resources and knowledge. The survey data found that educators feel that they have moved beyond identifying core competencies. This represents a contrast to interdisciplinary research and national policy statements that mental health professions have not done so and have no reliable or valid measures of competency (Hoge, Morris, et al., 2005). Research has suggested that the identified competencies have furthermore typically been identified by experts and tend to be too comprehensive to be achieved by the typical student (Hoge, Paris, et al., 2005).

Participants also were informed of the similarities in competencies identified across mental health professions (Hoge, Morris, et al., 2005), despite the tendency for professions to work separately, unaware of the strategies and progress being made by others. Recent reviews have revealed that most mental health professions are “shouldering the burden of marshaling resources and technical assistance to support these solo efforts” (Hoge, Morris, et al., 2005, p. 659), despite the identified difficulties in garnering such resources (Brooks, 2010).

After being presented with national recommendations for effective work in competency development and the research about competency development across disciplines, participants were asked to identify how the efforts made by their programs compared with national, cross-disciplinary efforts. The majority of respondents reported seldom or never collaborating with either experts in competency modeling and assessment or in competency modeling and assessment relevant to culturally, linguistic, and developmentally diverse populations.

Furthermore, the vast majority of respondents had seldom or never drawn from the rigorous and systematic methods of competency development and assessment available in other fields. In fact (and not surprisingly given the other data), the majority of participants reported *often* or *almost always* working separately to identify the competencies and link them to the programs, just as AAMFT and COAMFTE did when they developed the competencies to be used by the programs.

Respondents only *somewhat* or did not, for the most part, believe that their identified competencies include prevention, early intervention, rehabilitation, and recovery- and resilience-oriented approaches but did believe that cultural and linguistic competencies are included in their competency model. Given that the concrete recommendations given to the competency development group in AAMFT by professionals from other fields include these areas of focus, this finding represents further evidence that the efforts to work collaboratively at the beginning of the process were merely superficial.

The majority of respondents responded that they had significantly moved beyond identifying the core competencies and have moved beyond the beginning stages of the development and implementation of strategies to implement and assess those competencies. For example, nearly half of the respondents felt that they have developed or incorporated reliable and valid measures of competence. This finding is interesting given that such small percentages of respondents identified earlier in the study that they had operationalized, implemented, and evaluated their competencies and even fewer said that they had used evaluative data to revise their programs across the six primary domains of practice identified by AAMFT. Perhaps when being asked to speak globally about their efforts, educators were more confident that had made progress than when they were asked specifically to break down progress into its components.

Findings Summary

Despite working independently, respondents reported feeling confident that their competencies are achievable (with 70% of the respondents believing that their competencies were achievable by the typical student in their program) and that they have, in contrast to other mental health professions (and in contrast to their previous responses), moved significantly beyond identifying competencies. This information leads us to the next research question, which centers on participant willingness to share the resources that are believed to be valid and reliable and the knowledge necessary to further programmatic progress in educational reform.

Research Question Four

The fourth research question examined the degree to which asking questions about the possibilities, limits, and barriers to interdisciplinary collaboration and knowledge sharing, while making information and collaborative opportunities available would: (a) *initiate requests* for further resources and collaborative forums; and (b) generate *active interest in* and *commitment to* both contributing to and engaging in interdisciplinary knowledge sharing and collaboration. This question follows naturally from the data suggesting that programs tend to work independently to date but feel that they have developed learning activities and assessment tools that measure student competence.

There were several sources of data used to explore this question. The first came in a quantitative question asking participants to comment on their perception of the utility of three resources. Each of the resources represented multidisciplinary efforts across behavioral health fields: clinical psychology, counseling supervision, and nursing education. Participants were asked to select a link that would bring them to a one-page outline of the articles. They were then asked to rate how useful they believed each of the resources could be to their continued

educational reform efforts. The majority of respondents believed that the articles about (a) consultation and collaboration and (b) multicultural competence in supervision would be at least somewhat useful to their work. Slightly less than half of the group reported belief that the nursing model could help their programs transition to outcome-based education.

A review of the online resource storage site, however, revealed different information. Only four people reviewed the article synopsis identified most frequently as “very useful,” with one person previewing it and three downloading it. One person previewed the synergistic model article, while four downloaded it, and two people previewed while three downloaded the COPA nursing model resource. Those data indicate that educators determined the utility of the resources without consulting the resources themselves, possibly reviewing the titles only to make their decision. This conclusion should be interpreted with caution, as there is a possibility that one person downloaded the resource and shared it with peers.

The second source of information to address the question of active interest generation and commitment to engagement and contribution to interdisciplinary work was participant use of the final resource folder. The final resource folder contained the full articles summarized for the earlier question, several concrete examples of models used in other fields that could be implemented directly in training programs, illustrative references about educational reform, and a collection of interdisciplinary resources and products. The three full articles summarized for the earlier question were each previewed fewer than two times each and were downloaded no more than four times. The national educational reform calls (e.g., Annapolis Coalition, 2006; IOM, 2000; 2001; New Freedom Commission, 2003; US D.H.H.S., 2001) were viewed or downloaded no more than four times. The resources and products folder was accessed (with

documents being either previewed or downloaded) a maximum of eight times. The folder titled “other disciplines” included three articles, none of which was viewed more than four times.

Based on the number of people that actually looked at and / or directly downloaded the resources (the one page synopses, the models, the national calls, and the resource folder contents), it is fair to conclude that the first two sources of information provide clear evidence that participants were unwilling to *actively engage* in or *commit to* interdisciplinary resource review, even when the action required little more than visiting a website and selecting an electronic link. These two questions did not ask the participants to provide any information or personal expertise, asking them only to consult and evaluate resources that had been compiled for them at no cost.

The final source of information to explore this research question was the emails sent directly from participants to the research assistant. The email contact provided information about both requesting additional resources and collaborative opportunities and generation of active interest and commitment to interdisciplinary work. Only one participant of the 111 who consented to participate in the study (less than one percent of the group) sent emails to the research assistant and that person neither asked for nor offered resources for the website. This final data source, particularly when triangulated with the two previous resources, makes clear that MFT leaders demonstrated, on the whole, a very low degree of *active interest in* and *commitment to* interdisciplinary knowledge sharing and collaboration and were unwilling or uninterested in requesting additional resources or collaborative forums within the profession.

Perhaps one way to understand the lack of active engagement in the resource sharing and other collaborative efforts can be found in the data from the question about the connection between educational reform and the stated goal to improve access to quality mental health care.

The data from the open-ended question were clear: educators are split about the legitimacy of the educational reform as a means of creating a competent workforce. Some people (roughly 29% of the respondents) believe that the reform will result in change overall, most frequently citing clearer goal identification for students to achieve and educators to evaluate, increased programmatic accountability to produce graduates with pre-determined knowledge, skills, and awareness, greater student / practitioner accountability to learn and integrate the clinical competencies into practice, and the legitimacy of the shift as a means to advance quality training.

Other educators (just under 29%) commented on the assumption that reforming education will result in competent practitioners, most frequently questioning the legitimacy of the shift. A few responses cited resource and leadership concerns, and indicating concern about the perceived benefits of the shift. Some educators focused on the way that the reform is resulting in decreased attention to theory, model development, implementation, and evaluation. Others indicated concern about the ways that untested theories and approaches are being presumed to be credible. Still others focused on a decreased attention to the personal development of the therapists due to the focus on academic outcomes, drawing attention away from the “art” of therapy” in an attempt to emulate a scientific or medical model of treatment where measureable constructs become the benchmark for successful treatment.

Some educators highlighted issues like documentation and bureaucracy as detracting from the quality of student training. Still others were concerned about how the lack of standardization across program requirements would affect the credibility and quality of the programs and the identity of the profession. Those same educators cited concerns about how the licensure laws tend to require documentation that resembles input-based training (e.g., number of client contact hours, number of supervision hours, courses taken, etc.). Licensure laws represent

the gateway to independent practice and typically require some degree of continuing education in order to maintain connection with current research and best practices in the field. Hoge et al. (2005; 2009) recommended that competency-based training and assessment needs to be extended into the continuing education of the existing workforce. To date, no public discussion in the field of MFT has extended the competency-based paradigm to either licensure requirements or continuing education.

Sixteen percent of the responses were coded as indicating that the respondent was unsure whether the profession's shift to outcome-based education would contribute to the development of a competent and relevant workforce. This group of people most frequently talked about being unsure whether training students to demonstrate certain benchmarks would ensure that they would be better clinicians beyond their formal training. They also cited concern about the changes in standardization across programs and the implications for the programs, profession, and licensing.

Four other notable categories arose from the data, although the infrequency of their occurrence excluded them from the analysis table. The first category was termed *selective interpretation of the research*. When justifying their thoughts on qualitative questions like the last one described in this section, respondents sometimes made broad statements about research findings that suggested both bias and a limited understanding of the larger research body. One example was when a respondent indicated that the shift to outcome-based educational standards in public school secondary education has led to a general decline in student performance, a conclusion not shared across the education literature (e.g., National Center for Education Statistics, 2013). Another person indicated that outcome-based education “intentionally include[s] the workplace / employer in both determining competencies necessary for effective

professional service as well as evaluating the new professional's skills acquired during the training experience." While the inclusion of students, supervisors, and other stakeholders is recommended in the interdisciplinary competency literature (e.g., Hoge, Morris, et al., 2005), none of the MFT research or calls have suggested that employers evaluate new professionals using these standards, nor has it integrated feedback from those stakeholders in a meaningful way (as evidenced in the earlier data analysis). Nelson et al. (2007) speak to these limitations in the MFT competency identification and implementation process, saying,

This project is not without limitations, both in development and implementation. The initial list and revisions were developed by a certain group of steering committee members. Although efforts were made to ensure a diversity of thought and perspective relative to MFT practice, training, and context, the group was what it was. (p. 428)

The acceptance of the development and implementation procedures as being "what they were", without concern about what they mean for the quality and relevance of the identified competencies to consumers, represents a continuation of the behavioral health's historical lack of response to the needs of our constituents.

The second category across the qualitative data was representation of understanding of the historical context of the educational reform efforts in the United States. A small number of participants indicated an understanding that the efforts being made by the MFT profession are not "novel" or "cutting edge" as they have been portrayed, but represent an effort in a series of attempts to change the face of education to benefit consumers. For example, one person described the current reform as "a late, rushed, and inadequate response to calls for health and mental health professions to be more accountable for training in accredited programs," saying

that he or she is skeptical about the current efforts as a person who has “cycled through most of the calls.” The person points out that,

Myriad national calls for accountability have been made for several decades. All address the need for preparing researchers and clinicians to work with minority populations (who have been inadequately and unjustly treated by health and mental health professions for longer than any of us care to remember). Responses thus far are little different than those before it. Failure seems inevitable.

Another person with an understanding of the educational reform as part of an ongoing learning process described him or herself as having been involved in the professional efforts at a number of levels, as an educator, program director, and an accreditation site visitor. That person noted, “Many programs are struggling with the philosophical shift,” citing challenges in identifying measurable outcomes, measuring those that can be measured, and collecting enough data to develop reports or to revise their programs. He or she said,

Unfortunately, even if programs are achieving and substantiating achievement of their stated outcomes, we have not matured to the point that we can verify that the intended outcomes actually make a difference in client well being... We have a long way to go to reach maturity as a field when it comes to developing training programs that foster actual competencies that we know make a difference for the better with client systems as the ‘end users’ of our program outcomes.

Both of these respondents indicated an understanding of the broader professional field and the call to treat underserved populations.

In a related category, it was interesting to note that only two respondents referenced the underserved populations highlighted by persons with a sense of historical understanding as

evidence of the need to reform educational standards. The first person said that programs require greater accountability to “provide at a minimum the standard of care in a culturally sensitive context.” The other person referenced the ways in which the behavioral health field has not responded to several decades’ calls to address disparities in service delivery and treatment to minority populations.

The fourth interesting supplementary category is the single reference made to the use of resources outside the MFT field. The person describes interdisciplinary collaboration as one of the “down sides to outcome based [*sic*] education” saying, “we are participating in systems which [*sic*] value ideas that are antagonistic to the main values of the field as I was taught it” and “we are utilizing ideas, categories, education standards etc [*sic*] that are at odds with our own theories about systems, context, process and relationships.” This view directly contradicts a wide body of research that describes the benefits of working with other stakeholders, both within and across professional disciplines. For example, the IOM (2003) argues that quality behavioral healthcare in the US “will not be achieved unless the healthcare specialties collaborate in identifying and defining core competencies that are shared in five key areas: patient-centered care, work in interdisciplinary teams, evidence-based practice, quality improvement, and informatics” (Hoge, Morris, et al., 2005, p. 660). Hoge, Morris, et al. (2005) reported that “current competency initiatives in behavioral health reveals considerable similarity in the competencies identified” and that, “progress on defining, teaching, and assessing these competencies is likely to proceed at a much greater pace if there is an effort to pursue this work collectively” while recognizing the “unique competencies that define each discipline or specialty” (pp. 660-661).

The lack of collaboration between faculty and between programs may be understood in the context of the research findings: concerns about resources; the benefits and drawbacks of the assumption that the shift from input- to outcome-based education will result in a change in the mental health workforce; and about the feasibility or practicality of making a change in an established training system. As Hoge, Huey, and O'Connell (2004) pointed out, "educational systems have never been known for their responsiveness or propensity to change." The authors continue to say that the gap between training programs and the substantial changes in the needs of mental health consumers that have occurred over the last two decades was identified over 25 years ago (Feldman, 1978). The gaps continue to exist to the present, with numerous national reports over the last decade admonishing local, state, professional, and federal entities for the predominantly stalled movement toward rectifying disparities in mental health service delivery (US D.H.H.S., 2001).

Overall, the data from the final research question analysis paint a bleak picture for educational reform in this profession. Despite numerous calls, recommendations, and resources provided in a number of behavioral health, medical, business, and law professions, the leaders of COAMFTE-accredited training programs (program directors and clinical faculty) have suggested themselves to be unwilling to work substantially either with each other or with the larger systems. They have shared that they, overall, did not feel involved in, informed about, trained in, or guided about the educational shift and yet are required to implement new standards of training and practice in order to maintain accreditation status. At the same time, they did not take the time to explore the efforts made by other professions, nor have they indicated active interest in engaging in efforts to be involved, trained, guided, and / or supported in the competency requirements as they pertain to their training programs. The leaders appear to prefer to work in

the disciplinary silos described by interdisciplinary experts in competency-based education.

While none of these findings is surprising in the context of the broader reform efforts across professions, the implications for a profession that prides itself in its roots as a transdisciplinary field and its commitment to working with larger relational systems are substantial.

Current Programmatic Efforts and Comprehension in Context

The results of this study suggest a number of categories: a lack of understanding of the national calls to reform educational practice to benefit clients; independent efforts made by programs to address the mandate to change their educational paradigms that are marked by difficulty defining, implementing, and assessing student competence; a general frustration about the challenges of making the shift from input- to outcome-based education; and a lack of interdisciplinary collaboration. In order to understand these findings, we must look at the current context of the MFT field. The profession sponsors two publications, one academic (*The Journal of Marital and Family Therapy*), and one popular (*The Family Therapy Magazine*). The material presented in those resources can be illustrative of the priorities and positions of the profession itself. It is useful to try to understand how this study supports and contradicts the findings printed in those publications.

In the last decade, a number of resources have been published to inform practitioners, academicians, and consumers that MFTs are “taking a leadership role” and are “one of the first mental health organizations to meet the challenge of preparing the next generation of behavioral healthcare professionals by developing a set of clinical competencies” (Nelson et al., 2007, p. 420). That conclusion is not supported by the work previously done in other fields (e.g., medicine, business, education, psychology, nursing, etc.), work that was consulted with at the Annapolis Coalition, where AAMFT reportedly was active. The Annapolis Coalition efforts

demonstrated a strong commitment to interdisciplinary collaboration that includes use of resources created by other fields, including behavioral health.

In a concerning statement that further highlights AAMFT's lack of connection to the efforts of the broader behavioral health field, Miller (2005) said,

As I perused the competency literature across other professional disciplines, I could find no theoretical basis for describing a single rubric for defining competence. Each professional organization that adopts a competency orientation must make some fundamentally subjective decisions regarding where to draw the line for what counts as the minimum "core" standard of competency. This was the initial and most critical job of the AAMFT Competency Steering Committee. (p. 22)

Miller's assessment directly conflicts with the Annapolis Coalition's recommendation to create a *competency collaborative* to link groups and organizations that are developing behavioral health competencies. The recommendation includes the direction that "this collaborative should identify the optimal common or core competencies to be demonstrated by most providers" (Hoge, Morris, et al., 2005, p. 659). AAMFT's "key member[ship]" at the Annapolis Coalition (Nelson et al., 2007) should have provided the guidance and interdisciplinary resources that Miller reports missing.

In the 22 issues of JMFT published since the Nelson et al. (2007) article describing the process for creating the MFT core competencies (October 2007-April 2013), there have been 13 articles that discuss the state of core competencies in MFT training (Bischoff, Springer, Reisbig, Lyons, & Likcani, 2012; Caldwell, Kunker, Brown, & Saiki, 2011; Gehart, 2011b; Lee & Nichols, 2010; Miller, 2010; Miller & Lambert-Shute, 2009; Miller, Linville, Todahl, & Metcalfe, 2009; Miller, Todahl, & Platt, 2010; Nelson & Graves, 2011; Perosa & Perosa, 2010;

Sparks, Kisler, Adams, & Blumen, 2011; Sprenkle, 2010; Woolley, 2010). The articles discuss a number of issues pertaining to competence-based education, including assessment, supervision, and training strategies. In the decade since the identification of the core competencies (written in 2003 and disseminated in 2005), none of the research findings have been integrated into any proposed revisions. This is in contrast to the published statement that “regular revision” of the core competencies would occur (AAMFT, 2004).

Four of the thirteen (31%) JMFT articles were authored or co-authored by John Miller, a faculty member at one of the eight nationally selected Beta-Test Group graduate programs charged by AAMFT with attempting to implement the core competencies in educational practices and evaluate the effectiveness of the competency implementation and student results. In a departure from the traditionally within-profession focus, Miller studied the competency movement in the fields of law, medicine, and education. Miller, Todahl, and Platt (2010) describe the steps found to be “almost universal” across disciplines in the process of moving to a competency-based model:

Professional organizations typically follow a common path of (a) defining competency, (b) aligning competency definitions with the organization’s values, (c) identifying and listing the competencies, (d) investigating curricula, implementation, and evaluation protocols, and (e) struggling under the enormity and complexity of the task. (p. 64)

The procedure taken by AAMFT appears to have been no different than those in other fields with regard to the definition and alignment of those definitions with organizational values and the identification and listing of a set of core competencies believed to represent those definitions and values. The feedback from educators in accredited programs indicates that many are currently struggling with the enormity and complexity of the curricula changes and evaluation efforts.

Miller, Todahl, and Platt (2010) noted, “One also finds that these steps are consistently organized around competencies that have been defined by the discipline’s professional organization” (p. 64). This finding is consistent with earlier work (e.g., Hoge, Tondora, & Marrelli, 2005) that discusses the “armchair approach” to defining competence and the silo efforts made by programs and professions to determine what comprises competent practice. Again, in this respect, the efforts made by AAMFT are consistent with other professional standards of practice as the organization and its educational programs work to identify, define, implement, evaluate, and revise the curricula and supervisory practices that serve as the vehicle for teaching and assessing competent clinical practice. The problem identified by several respondents throughout the study was a lack of guidance from the professional organizations about (a) how to implement the educational reform, and (b) the efforts of other accredited programs. This lack of communication has further reinforced the isolative nature of the efforts being made by the programs, as they attempt to respond to the reform requirements.

Three of the 13 articles published in JMFT after the Nelson et al., (2007) competency creation process article (23%) focus on competencies in the context of doctoral education; the other 10 (77%) describe competency in outcome-based education more broadly. The competencies, as they are currently stated, are intended to represent the “knowledge and skills that define the entry-level skills necessary for independent practice (licensed at the master’s [*sic*] level) as a marriage and family therapist” (Nelson et al., 2007, p. 420). No additional or supplementary competencies have been applied to doctoral level or more advanced practitioners, despite the commitment made in the seminal document describing the core competencies that “the competencies will be reviewed and modified at regular intervals to ensure the competencies are reflective of the current and best practice of MFT” (AAMFT, 2004). The extent to which any

formal review has occurred is represented by a special section of the profession's journal to a series of articles investigating the state of doctoral education (Lee & Nichols, 2010; Sprenkle, 2010; Woolley, 2010).

In a departure from the other MFT literature discussing strategies for assessing student therapist competence, one of the thirteen articles responds to the Annapolis Coalition recommendation to integrate client feedback directly into the assessment of clinical practice and competence (Sparks, Kisler, Adams, & Blumen, 2011). The authors identify that the “continuous incorporation of client feedback [into the program curriculum] embodies collaborative, strengths-based, integrative, and diversity-centered program values” and conclude that the commitment helps students “learn a system for being accountable to clients, the profession, and service communities” (p. 452). Their efforts represent a preliminary response to the interdisciplinary calls (e.g., Hoge et al., 2009), to ethical standards of accountability to clients, and to the research / practice gap described elsewhere (e.g., Sprenkle, 2003; Storm, Todd, Sprenkle, & Morgan, 2001).

Findings Summary

This review of the recent MFT literature reveals that limited work is being done at the profession-level to respond to the calls to collaborate and to “think outside the [MFT] box.” The steps and products resulting from these preliminary efforts require additional research and practical support in order to be integrated into clinical training in a meaningful way. The efforts made at the organizational level are echoed at the program levels; people report feeling isolated, although confident, in their efforts to address the educational reform. While the educators expressed some interest in resources, only one actively sought information and / or was willing to engage in knowledge and resource sharing efforts. Collaboration, not only within the

profession but also beyond its confines, is essential in ongoing efforts in order to ensure that MFT can address the concerns and barriers identified by educators as providing competent mental health service to all persons.

Study Significance

Despite the growing disparities in access to quality and relevant mental health services, the call for mental health professions to transform scientist/practitioner preparation programs from input-driven to outcome-based training has been insufficiently addressed, specifically with respect to core recommendations to engage in interdisciplinary collaboration and knowledge sharing. This study provides several contributions and extensions to the research in this area concerning one mental health profession. The study contributes to our understanding of the factors that dissuade professions from engaging in the interdisciplinary collaboration and knowledge sharing considered necessary to expedite this transformation in ways that also ensure reliable, valid, relevant, and pragmatic competency-based models and outcome-based programs of study. It also explores the degree to which providing information about and venues for such engaging in such work influences participants' interest in and inquiries about contributing to and participating in these types of systematic advances.

An immediate contribution particularly to the MFT profession was provided through the survey itself. That is, by participating in the study, MFT educators could access important information and resources intended to inform their examination of the advancements they have made to date as well as the directions they might take in their continuing efforts to identify relevant core competencies and outcome-based programs of study. Information about national calls to action, recommendations about best practices, and supporting documentation were provided to all participants of the project. Furthermore, participants had access to several

theoretical and practical applications of outcome-based interdisciplinary educational models and strategies for use in their own work. Participants could draw from work done in a number of fields, including multicultural therapy (MCT), nursing, and psychology.

Reporting the findings of this initial exploratory study through interdisciplinary publication and presentation venues will provide broader and longer-term contributions. These findings are intended to illuminate important reference points that educators across professions can consider when examining their efforts to contribute to the development of a competent, contemporary mental health delivery system, as well as the future directions their work should take to ensure that such contributions are made expeditiously and systematically. Specifically, it is hoped that the findings will help to sensitize professional organizations, accrediting bodies, and faculty – across the five mental health disciplines – to the factors that continue to hinder each profession's progress toward developing core competencies and to the currently available resources and venues that can be accessed to overcome these obstacles.

Finally, the website that will be designed based on these findings and participant contributions is intended to provide resources and venues to facilitate interdisciplinary collaboration and knowledge sharing. Such efforts may help to expedite the development of competencies and outcome-based preparatory programs that can begin to produce researchers and practitioners capable of addressing the growing disparities in access to quality and relevant mental health services that continues to exist in the United States.

Study Limitations

The study includes limitations to its generalizability to other professions or educational programs. First, it focused on one profession and targeted training programs that are accredited by that one specific professional organization's (AAMFT) educational accrediting body

(COAMFTE). In the field of mental health practice, couple and family therapy is conducted not only by clinicians associated with AAMFT, but also by other professionals including, but not limited to: counselors associated with the American Counseling Association (ACA), by psychologists associated with the American Psychological Association (APA), by nursing professionals associated with a number of accrediting bodies (e.g., ACEN, CCNE, ANCC) and by clinical social workers associated with the National Association for Social Workers (NASW), among others. This project's focus on one discipline represents a threat to the external validity of the data, as the results of the study may not generalize to the experiences of accredited programs across the other four core mental health disciplines. Furthermore, as indicated in the review of the literature and earlier in this discussion, the mental health field historically tends to avoid interdisciplinary collaboration, so efforts made to study MFT may not be applied to practitioners from other disciplines.

A second limitation relates to the subject pool in this study. MFT program directors and clinical faculty members are regularly recruited for participation in research projects and may view participation as an additional burden to their already overextended schedule of responsibilities (Brooks, 2010). One participant, when asked about his or her understanding of the impetus for the COAMFTE educational reform, replied, "I'm going to quit this survey now. I just don't have the time to create narrative answers. Sorry." This statement is consistent with findings from previous research identifying barriers to participation in initiatives: educators report workload demands, administrative requirements, and teaching as forcing them to prioritize their time and resources to their assigned tasks (Brooks, 2010).

The survey recruitment period began towards the end of the semester and continued into early summer. The primary wave of recruitment was focused on program directors with the

expectation that they would have fewer direct teaching responsibilities and potentially would be less impacted by the conclusion of the semester. Clinical faculty members were recruited toward the beginning of the summer, with the hope that they would be able to find time to participate after between their semester-end and year-end academic and personal summer responsibilities. Each group of potential participants (program directors and clinical faculty) was invited personally and then received follow up reminders to encourage them to participate if they had not already done so. This method was selected as a means of maximizing response rate, along with information about the study and about participant confidentiality, a six-week data collection period that allowed participants to provide feedback over an extended period, and the professional incentives previously mentioned (IAR, 2011).

It is conceivable, however, that despite the efforts to maximize participation, persons who elected to participate in the study represent different characteristics than those who chose not to take part. Some research (e.g., Copas, Johnson, & Wadsworth, 1997; Turner, 1999; Waltermaurer, Ortega, & McNutt, 2003) suggests that participation or self-selection bias may affect the external validity of results. In the case of this study, people who are most engaged in the educational reform efforts in their programs were most likely to respond, believing that they have feedback to share that could be used to impact future AAMFT / COAMFTE requirements.

The revised survey recruitment strategy included gathering contact information from online program websites and, as a result, the research assistant received feedback that not all of the faculty members listed were directly responsible for MFT graduate student education, despite their online designation to the contrary. Those persons who received an invitation from that method either: (a) chose to participate in the research, (b) reviewed the invitation to participate and determined they were not an appropriate candidate, or (c) disregarded the invitation

altogether. Without the ability to link participants to their data, we have no way to confirm how many faculty chose the second and third options. As a result, the clinical faculty who participated may not adequately represent the overall pool of educators responsible for MFT training. It is believed that the recruitment methods maximized the number of core clinical faculty involved in the education and planning of program curricula.

The third study limitation is related to the bias inherent in self-report survey data. This project used an online survey sent to program directors and clinical faculty members of COAMFTE accredited graduate and post-graduate programs. Studies of response bias and social desirability suggest that participants may alter their responses in order to ensure acceptance from peers (e.g., Furnham, 1986), despite the researcher's efforts to conceal participant identity for the purposes of confidentiality. It is possible that faculty members responded in a way that indicated they were more knowledgeable or in favor of educational reform than they actually were. Without observational or other forms of data to triangulate the validity of their responses (Perosa & Perosa, 2010), the results may be skewed to represent a greater understanding of and progress towards outcome-based educational best practices. This is one of the reasons that the study survey included items requiring mixed analytic methods, to allow qualitative data to provide additional information to support the quantitative findings.

Future Research

This research study focused on three areas of interest in the educational reform efforts of one mental health profession: the steps that profession has taken thus far, the products it has used or is in the process of using, and the collaboration that it and its practitioners continue to do in their efforts to advance the reform. Future research efforts have been identified throughout the

study, particularly in the discussion chapter, with additional studies outlined below to expand upon that proposed research agenda.

Interdisciplinary collaboration and knowledge sharing have been identified as venues to expedite the development of reliable, valid, and relevant competency standards and outcome-based preparatory programs, capable of producing scientist/practitioners who can provide competent and relevant services to all those in need. Given the critical nature of mental health disparities, it is important to gain a better understanding of the factors that dissuade interdisciplinary collaboration and knowledge sharing, as well as the potential venues for reconciling these factors. Findings of this nature will provide direction for trans-disciplinary efforts to establish a contemporary mental health care delivery system capable of providing equal access to quality and relevant mental health services to the most vulnerable, understudied, underrepresented, and underserved individuals and families.

Research investigating the process of the transition or the products derived from this process will begin as explorations of specific disciplines but will then branch into interdisciplinary efforts. In addition, such efforts will begin as purely exploratory, and will then compare programs actively engaged in interdisciplinary efforts with those that are not, and then will compare programs using products developed via interdisciplinary efforts with those from disciplines with established competency-based methods and models.

Specific to the field of marriage and family therapy, findings from this study will be used to inform the post-dissertation development of a website designed to provide online resources and forums. Later studies will examine the process of interdisciplinary collaboration that emanates from this and other such venues and the effectiveness and relevance of the products

derived from such efforts. In the future, research will examine the degree to which these efforts contribute to the development of clinically and culturally competent scientist/practitioners.

Furthermore, the questions asked of program directors and clinical faculty in this study can be analyzed in many different ways, depending on the information sought. This particular project was exploratory and intentionally broad, looking at how the MFT leadership as a whole has responded to the calls for reform. Future research will, for example, compare the responses of persons with a greater degree of administrative responsibilities (program directors) with those people more directly responsible for instituting that reform (clinical faculty). Additional research will target analyses based on other demographic variables, including program location, faculty ranking (e.g., assistant professors compared with full professors), gender, and educational attainment. Other analyses will also compare the progress of Master's only versus combined (Master's and doctoral), doctoral only, and post-degree or certificate programs to see if there are any differences in how reform is addressed based on that variable.

To extend the knowledge in this area, exploratory studies like this one will be implemented across the other core mental health disciplines, with the hope of addressing similar research questions and objectives. Such studies will: (a) further expand our understanding of the nature and degree of reluctance toward interdisciplinary scholarship within the core mental health professions; (b) examine efforts within or across disciplines that have led to interdisciplinary progress as well as factors that have hindered such progress; and, (c) determine the degree to which making information and collaborative opportunities available invites consideration of or active requests for further resources and collaborative venues. Such research will help to sensitize professional organizations, accrediting bodies, and faculty to the factors that continue to hinder each profession's progress toward developing core competencies that can

be achieved and demonstrated with reliability and validity and that can then be successfully incorporated into preparation programs and credentialing venues. Similarly, such research will inform the development of other interdisciplinary venues, and could investigate the usage, benefits, and limitations of such venues.

Trans-disciplinary investigations will be initiated as well. For example, researchers across the five core mental health disciplines could collaborate in designing and investigating the utility of interdisciplinary venues where mental health organizations and / or mental health educators actively contribute to and participate in interdisciplinary knowledge sharing and collaboration as part of the process of transitioning to competency based standards and outcome-based training. Research of this nature will initially investigate the degree to which professions actively contribute to and participate in venues that offer interdisciplinary knowledge sharing, interdisciplinary forums, and interdisciplinary workgroups that specifically address the development of competency standards for research and practice and outcome-based preparatory programs for scientist/practitioners.

Later research will investigate the products derived from such efforts. For example, studies will investigate the degree to which significant interdisciplinary collaboration contributes to common outcome-based criteria factors across all professions. Additionally, studies will examine the degree to which programs whose members actively contribute to and participate in such efforts are advancing in their work to identify, define, and assess common or core competencies with some degree of reliability and validity and are developing reliable, valid, relevant, and useful programs of study / evaluative tools / pedagogical strategies, etc.

Future studies will investigate the degree to which: (a) interdisciplinary transfers of knowledge creates a trans-disciplinary knowledge base that integrates principles from across the

core mental health professions and beyond so that core competencies within each discipline can be articulated and then woven together to form a common set of outcome expectations for scientist/practitioner preparation programs; (b) new generations of mental health professionals provide clinically and culturally competent and relevant services; and, (c) new generations of mental health professionals focus efforts on establishing mental health care delivery systems (e.g., agencies, institutions, policies) capable of providing equal access to quality and relevant mental health services to our most vulnerable, understudied, underrepresented, and underserved individuals and families.

References

- Abreu, J. M., Chung, R. H., & Atkinson, D. T. (2000). Multicultural training: Past, present, and future directions. *The Counseling Psychologist*, 28, 641-656.
- American Association for Marriage and Family Therapy (AAMFT; 2004). *Marriage and family therapy core competencies*. Retrieved from [http://www.aamft.org/about/coamfte/Version%2011%20Standards/MFT%20Core%20Competencies%20\(December%202004\).doc](http://www.aamft.org/about/coamfte/Version%2011%20Standards/MFT%20Core%20Competencies%20(December%202004).doc).
- American Association for Marriage and Family Therapy (AAMFT; 2013). *Directory of MFT training programs*. Retrieved from http://www.aamft.org/cgishl/twserver.exe?run:COAPRGS_1
- American Psychological Association (APA; 1998). *Interprofessional health care services in primary care settings: Implications for the education and training of psychologists*. Washington, DC: Author.
- Anastasi, A. (1988). *Psychological testing*. New York, NY: Macmillan.
- Annapolis Coalition. (2006a). *Building a national strategic plan for behavioral health workforce development*. Retrieved from http://www.annapoliscoalition.org/national_strategic_planning.php.
- Annapolis Coalition. (2006b). *Quick reference guide to strategic goals, objectives, and actions*. Retrieved from http://www.annapoliscoalition.org/files/Strategic_Planning/QRefGuide_to_GoalsObjsActions.pdf.
- Arredondo, P., & Arciniega, G. M. (2001). Strategies and techniques for counselor training based on the multicultural counseling competencies. *Journal of Multicultural Counseling and Development*, 29, 263-273.

- Arredondo, P., & Perez, P. (2003). Expanding multicultural competence through social justice leadership. *The Counseling Psychologist*, 31(3), 282-289.
- Arredondo, P., Shealy, C., Neale, M., & Winfrey, L. L. (2004). Consultation and interprofessional collaboration: Modeling for the future. *Journal of Clinical Psychology*, 60(7), 787-800.
- Arredondo, P., Toporek, R., Brown, S. P., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development*, 24, 42-78.
- Association of Schools of Public Health Education Committee. (ASPH; 2006). *Master's degree in public health core competency development project, Version 2.3 (October 2004 – August 2006)*. Retrieved from http://www.sph.unc.edu/images/stories/faculty.../asph_competencies.pdf.
- Athey, T. R., & Orth, M.S. (1999). Emerging competency methods for the future. *Human Resource Management*, 38(3), 215–225.
- Aubry, T. D., Flynn, R. J., Gerber, G., & Dostaler, T. (2005). Identifying the core competencies of community support providers working with people with psychiatric disabilities. *Psychiatric Rehabilitation Journal*, 28(4), 346-353.
- Babbie, E. (2004). *The practice of social research* (10th ed.). Belmont, CA: Wadsworth Publishing.
- Baker, D., & Benjamin, L. (2002). The affirmation of the scientist-practitioner. *American Psychologist*, 55, 241-247.
- Baker, L. K., Thurston, K. R., & Rigazio-DiGilio, S. A. (in work). *Competencies in mental health education and practice: An interdisciplinary content analysis*. Manuscript in

progress, Department of Human Development and Family Studies, University of Connecticut, Storrs, CT.

Bell, M. T. (2005). *A model using trainee outcome for evaluating the effectiveness of professional psychology graduate programs*. (Unpublished doctoral dissertation). Spalding University, Louisville, KY.

Bent, R., & Cox, R. (1991). Intervention competency. In R. Peterson, J. McHolland, R. Bent, E. Davis-Russell, G. Edwall, K. Polite, D. Singer, & G. Stricker (Eds.), *Core curriculum in professional psychology* (pp. 96-100). Washington, DC: American Psychological Association.

Bent, R., Schindler, N., & Dobbins, J. (1992). Management and supervision competency. In R. Peterson, J. McHolland, R. Bent, E. Davis-Russell, G. Edwall, K. Polite, D. Singer, & G. Stricker (Eds.), *Core curriculum in professional psychology* (pp. 121-126). Washington, DC: American Psychological Association.

Bickman, L. (1999). Practice makes perfect and other myths about mental health services. *American Psychologist*, 54(11), 965-978.

Bischoff, R. J., Springer, P. R., Reisbig, A. M. J., Lyons, S., & Likcani, A. (2012). Training for collaboration: Collaborative practice skills for mental health professionals. *Journal of Marital and Family Therapy*, 38(s1), 199-210.

Blow, A. J., & Sprenkle, D. H. (2001). Common factors across theories of marriage and family therapy: A modified Delphi study. *Journal of Marital and Family Therapy*, 27(3), 385-401.

- Brooks, S. (2010). *Outcome based education and the quest for competency: Perspectives from couple and family therapy educators*. (Unpublished doctoral dissertation). Drexel University, Philadelphia, PA.
- Caldwell, B. E., Kunker, S. A., Brown, S. W., & Saiki, D. Y. (2010). COAMFTE accreditation and California MFT licensing exam success. *Journal of Marital and Family Therapy*, 37(4), 468-478.
- Carlson, J. (2008). *Inclusive cultural empathy: Making relationships central in counseling and psychotherapy*. Washington, DC: American Psychological Association.
- Carter, R. T. (2005). *Handbook of racial-cultural psychology and counseling, Vol. 2: Training and practice*. Hoboken, NJ: John Wiley & Sons.
- Casto, R. M., & Julia, M. C. (1994). *Interprofessional care and collaborative practice*. Pacific Grove, CA: Brooks/Cole.
- Chenail, R. J. (2009). Learning marriage and family therapy in the time of competencies. *Journal of Systemic Therapies*, 28, 72-87.
- Cleghorn, J. M., & Levin, S. (1973). Training family therapists by setting learning objectives. *American Journal of Orthopsychiatry*, 43, 439-446.
- Collins, P. Y., Patel, V., Joesti, S. S., March, D., Insel, T. R., Daar, A. S., ... Walport, M. (2011). Grand challenges in global mental health. *Nature*, 475, 27-30.
- Commission on Accreditation for Marriage and Family Therapy Education. (COAMFTE; 2005). *Accreditation standards: Graduate & post-graduate marriage and family therapy training programs, version 11.0*. Alexandria, VA: American Association for Marriage and Family Therapy.

Commission on Accreditation for Marriage and Family Therapy Education. (COAMFTE; 2008).

Accreditation manual: Policies and procedures Alexandria, VA: American Association for Marriage and Family Therapy.

Constantine, L. L. (1976). Designed experience: A multiple, goal-directed training program in family therapy. *Family Process*, 15(4), 373-387.

Cook, C., Heath, F., & Thompson, R. L. (2000). A meta-analysis of response rates in web- or internet-based surveys. *Educational and Psychological Measurement*, 60(6), 821-836.

Copas, A. J., Johnson, A. M., & Wadsworth, J. (1997). Assessing participation bias in a sexual behaviour survey: Implications for measuring HIV risk. *AIDS*, 11(6), 783-790.

Crane, D. R., Griffin, W., & Hill, R. D. (1986). Influence of therapist skills on client perceptions of marriage and family therapy outcome: Implications for supervision. *Journal of Marital and Family Therapy*, 12(1), 91-96.

Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches*. Thousand Oaks, CA: Sage Publications.

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed*, (Vol. I). Washington, DC: Georgetown University Child Development Center.

Driscoll, A., & Wood, S. (2007). *Developing outcome-based assessment for learner-centered education: A faculty introduction*. Sterling, VA: Stylus Publishing.

Epstein, R. M., & Hundert, E. M. (2002). Defining and assessing professional competence. *Journal of the American Medical Association*, 287, 226-235.

Ewell, P. (1997). Organizing for learning. *AAHE Bulletin*, 50(4), 3-6.

- Falender, C. A., Erikson Cornish, J. A., Goodyear, R., Hatcher, R., Kaslow, N. J., Leventhal, G., Shafranske, E., Sigmon, S. T., Stoltenberg, C., & Grus, C. (2004). Defining competencies in psychology supervision: A consensus statement. *Journal of Clinical Psychology, 60*(7), 771-785.
- Feldman, S. (1978). Promises or community mental health services and training: Ships that pass in the night. *Community Mental Health Journal, 14*(2), 83-91.
- Figley, C. R., & Nelson, T. S. (1989). Basic family therapy skills, I: Conceptualization and initial findings. *Journal of Marital and Family Therapy, 15*(4), 349-365.
- Figley, C. R., & Nelson, T. S. (1990). Basic family therapy skills, II: Structural family therapy. *Journal of Marital and Family Therapy, 16*(3), 225-239.
- Frake, C. (1962). The ethnographic study of cognitive systems. In T. Gladwin and W. H. Sturtevant (Eds.), *Anthropology and human behavior*. Washington, DC: Anthropology Society of Washington.
- Furnham, A. (1986). Response bias, social desirability and dissimulation. *Personality and Individual Differences, 7*(3), 385-400.
- Gehart, D. (2011a). The core competencies: A new pedagogical model for MFT education. *Family Therapy Magazine, 10*(5), 14-17.
- Gehart, D. (2011b). The core competencies and MFT education: Practical aspects of transitioning to a learning-centered, outcome-based pedagogy. *Journal of Marital and Family Therapy, 37*(3), 344-354.
- Gold, S., & DePiano, D. (1992). Assessment competency. In R. Peterson, J. McHolland, R. Bent, E. Davis-Russell, G. Edwall, K. Polite, D. Singer, & G. Stricker (Eds.), *Core curriculum*

- in professional psychology*. (pp. 89-95). Washington, DC: American Psychological Association.
- Goldfried, M., & Wolfe, B. (1996). Psychotherapy practice and research: Repairing a strained alliance. *American Psychologist*, 51, 1007-1016.
- Goritz, A. (2005). *Incentives in web-based studies. What to consider and how to decide*. Retrieved from www.websm.org.
- Grams, W. A., Carlson, T. S., & McGeorge, C. R. (2007). Integrating spirituality into family therapy training: An exploration of faculty members' beliefs. *Contemporary Family Therapy*, 29, 147-161.
- Graves, T. (2005). *Building a bridge between graduation and marriage and family therapy competency*. (Unpublished Master's thesis). Utah State University, Logan, UT.
- Guskey, T. (1994). Defining the differences between outcome-based education and mastery learning. *School Administrator*, 51, 34-41.
- Heetderks, J. (2008). *MFT educators' use and opinions regarding assessment methods for MFT core competencies*. Unpublished doctoral dissertation, Alliant International University, Irvine, CA.
- Hellkamp, D. T., Zins, J. E., Ferguson, K., & Hodge, M. (1998). Training practices in consultation: A national survey of clinical, counseling, industrial/organizational, and school psychology faculty. *Consulting Psychology Journal: Practice and Research*, 50(4), 228-236.
- Hennink, M., Hutter, I., & Bailey, A. (2010). *Qualitative research methods*. Washington, DC: SAGE Publications.

- Hodgson, J. L., Lamson, A. L., & Feldhousen, E. B. (2007). Use of simulated clients in marriage and family therapy education. *Journal of Marital and Family Therapy*, 33(1), 35-50.
- Hoge, M. A., Huey, L. Y., & O'Connell, M. J. (2004). Best practices in behavioral health workforce education and training. *Administration and Policy in Mental Health*, 32(2), 91-106.
- Hoge, M. A., Morris, J. A., Daniels, A. S., Stuart, G. W., Huey, L. Y., & Adams, N. (2007). *An action plan on behavioral health workforce development*. Cincinnati, OH: The Annapolis Coalition on the Behavioral Health Workforce.
- Hoge, M. A., Morris, J. A., Daniels, A. S., Huey, L. Y., Stuart, G. W., Adams, N., Paris, Jr., M., Goplerud, E., Horgan, C. M., Kaplan, L., Storti, S. A., & Dodge, J. M. (2005). Report on recommendations: The Annapolis Coalition conference on behavioral health work force competencies. *Administration and Policy in Mental Health*, 32(5/6), 651-663.
- Hoge, M. A., Morris, J. A., Stuart, G. W., Huey, L. Y., Bergeson, S., Flaherty, M. T., Morgan, O., Peterson, J., Daniels, A. S., Paris, M., & Madenwald, K. (2009). A national action plan for workforce development in behavioral health. *Psychiatric Services*, 60(7), 883-887.
- Hoge, M. A., Paris, Jr., M., Adger, Jr., H., Collins, F. L., Finn, C. V., Fricks, L., Gill, K. J., Haber, J., Hansen, M., Ida, D. J., Kaplan, K., Northey, Jr., W. F., O'Connell, M. J., Rosen, A. L., Taintor, Z., Tondora, J., & Young, A. S. (2005). Workforce competencies in behavioral health: An overview. *Administration and Policy in Mental Health*, 32(5/6), 593-631.

- Hoge, M. A., Tondora, J., & Marrelli, A. F. (2005). The fundamentals of workforce competency: Implications for behavioral health. *Administration and Policy in Mental Health*, 32(5/6), 509-531.
- Hovestadt, A. J., Fenell, D. L., & Canfield, B. S. (2002). Characteristics of effective providers of marital and family therapy in rural mental health settings. *Journal Of Marital & Family Therapy*, 28(2), 225-231.
- Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15(9), 1277-1288.
- Huang, L., Macbeth, G., Dodge, J., & Jacobstein, D. (2004). Transforming the workforce in children's mental health. *Administration and Policy in Mental Health*, 32(2), 167-187.
- Iarossi, G. (2006). *The power of survey design: A user's guide for managing surveys, interpreting results, and influencing respondents*. Washington, DC: The World Bank.
- Illback, R., Maher, C., & Kopplin, D. (1992). Consultation and education competency. In R. Peterson, J. McHolland, R. Bent, E. Davis-Russell, G. Edwall, K. Polite, D. Singer, & G. Stricker (Eds.), *Core curriculum in professional psychology* (pp. 115-120). Washington, DC: American Psychological Association.
- Inman, A. G. (2006). Supervisor multicultural competence and its relation to supervisory process and outcome. *Journal of Marital and Family Therapy*, 32(1), 73-85.
- Institute of Medicine. (IOM; 2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academy Press.
- Institute of Medicine. (IOM; 2003). *Health professions education: A bridge to quality*. Washington, DC: The National Academies Press.

- Institute of Medicine. (IOM; 2006). *Improving the quality of health care for mental and substance-use conditions: Quality chasm series*. Washington, DC: The National Academies Press.
- Instructional Assessment Resources. (IAR; 2011). *Conduct research: Response rates*. Retrieved from <http://www.utexas.edu/academic/ctl/assessment/iar/teaching/gather/method/survey-Response.php?task=research>.
- Ironside, P. M. (2004). "Covering content" and teaching thinking: Deconstructing the addictive curriculum. *Journal of Nursing Education*, 43, 5-12.
- Jackson, L. (1999). Ethnocultural resistance to multicultural counseling and training students and faculty. *Cultural Diversity and Ethnic Minority Psychology*, 5, 27-36.
- Kaslow, N. J. (2004). Competencies in professional psychology. *American Psychologist*, 59(8), 774-781.
- Kaslow, N. J., Borden, K. A., Collins, F. L., Jr., Forrest, L., Illfelder-Kaye, J., Nelson, D., & Rallo, J. S. (2004). Competencies conference: Future directions in education and credentialing in professional psychology. *Journal of Clinical Psychology*, 60(7), 699-712.
- Kaslow, N. J., Celano, M. P., & Stanton, M. (2005). Training in family psychology: A competencies-based approach. *Family Process*, 44, 337-353.
- Kaslow, N. J., Rubin, N. J., Bebeau, M. J., Leigh, I. W., Lichtenberg, J. W., Nelson, P. D., Portnoy, S. M., & Smith, I. L. (2007). Principles and recommendations for the assessment of competence. *Professional Psychology: Research and Practice*, 38(5), 441-451.

- Keller, J. F., Huber, J. R., & Hardy, K. V. (1988). Accreditation: What constitutes appropriate marriage and family therapy education? *Journal of Marital and Family Therapy*, 14(3), 297-305.
- Kessler, C., & Burton, J. H. (2011). Moving beyond confidence and competence: Educational outcomes research in emergency medicine. *Academic Emergency Medicine*, 18 Supplement, 25-26.
- Kittleston, M. (1997). Determining effective follow-up of e-mail surveys. *American Journal of Health Behavior*, 21(3), 193-196.
- Kondracki, N. L., & Wellman, N. S. (2002). Content analysis: Review of methods and applications in nutrition education. *Journal of Nutrition Education and Behavior*, 34, 224-230.
- Kurpius, D. J. (1997). *Report on committee on standards for practice and training*. Unpublished manuscript.
- Lawrence, K., Allen, T., Brailovsky, C., Crichton, T., Bethune, C., Donoff, M., Laughlin, T., Wetmore, S., Carpienier, M. M., & Visser, S. (2011). Defining competency-based evaluation objectives in family medicine: Key-feature approach. *Canadian Family Physician*, 57(10), 373-380.
- Lee, R. E., III & Nichols, N. C. (2010). The doctoral education of professional marriage and family therapists. *Journal of Marital and Family Therapy*, 36(3), 259-269.
- Lee, R. E., III, Nichols, D. P., Nichols, W. C., & Odom, T. (2004). Trends in family therapy supervision: The past 25 years and into the future. *Journal of Marital and Family Therapy*, 30(1), 61-69.

Lenburg, C. B., Abdur-Rahman, V. Z., Spencer, T. S., Boyer, S. A., & Klein, C. J. (2011).

Implementing the COPA model in nursing education and practice settings: Promoting competence, quality care, and patient safety. *Nursing Education Perspectives*, 32(5), 290-296.

Leonard, S. (1997). *Principles for the recognition of proficiencies in psychology*. Unpublished manuscript.

Liddle, H. A., & Halpin, R. J. (1978). Family therapy training and supervision literature: A comparative review. *Journal of Marriage and Family Counseling*, 4(4), 77-98.

Liddle, H. A., & Saba, G. W. (1982). Teaching family therapy at the introductory level: A conceptual model emphasizing a pattern which connects training and therapy. *Journal of Marital and Family Therapy*, 8(1), 63-72.

Limb, G. E., & Hodge, D. R. (2011). Utilizing spiritual ecograms with Native American families and children to promote cultural competence in families. *Journal of Marital and Family Therapy*, 37(1), 81-94.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

Lucia, A., & Lepsinger, R. (1999). *The art and science of competency models: Pinpointing critical success factors in organizations*. San Francisco, CA: Jossey-Bass/Pfeiffer.

Manning, K. (1997). Authenticity in constructivist inquiry: Methodological considerations without prescription. *Qualitative Inquiry*, 3, 93-115.

Marrelli, A. F., Tondora, J., & Hoge, M. A. (2005). Strategies for developing competency models. *Administration and Policy in Mental Health*, 32(5/6), 533-561.

McClelland, D. C. (1973). Testing for competence rather than for "intelligence." *American Psychologist*, 28(1), 1-14.

- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis* (2nd ed.). Thousand Oaks, CA: SAGE Publications.
- Miller, J. K. (2005). The question of competence. *Family Therapy Magazine*, 4(4), 28-31.
- Miller, J. K. (2010). Competency-based training: Objective Structured Clinical Exercises (OSCE) in marriage and family therapy. *Journal of Marital and Family Therapy*, 36(3), 320-332.
- Miller, J. K., & Lambert-Shute, J. (2009). Career aspirations and perceived level of preparedness among Marriage and Family Therapy doctoral students. *Journal of Marital and Family Therapy*, 35(4), 466-480.
- Miller, J. K., Linville, D., Todahl, J., & Metcalfe, J. (2009). Using mock trials to teach students forensic core competencies in marriage and family therapy. *Journal of Marital and Family Therapy*, 35(4), 456-465.
- Miller, J. K., Todahl, J. L., & Platt, J. J. (2010). The core competency movement in marriage and family therapy: Key considerations from other disciplines. *Journal of Marital and Family Therapy*, 36(1), 59-70.
- Miville, M. L., Duan, C., Nutt, R. L., Waehler, C. A., Suzuki, L., Pistole, M., & ... Corpus, M. (2009). Integrating practice guidelines into professional training: Implications for diversity competence. *The Counseling Psychologist*, 37(4), 519-563.
- Motamedi, V., & Sumrall, W. J. (2000). Mastery learning and contemporary issues in education. *Action in Teacher Education*, 22(1), 32-42.
- National Alliance on Mental Illness. (2010). *NAMI public policy platform*. Retrieved from http://www.nami.org/Content/NavigationMenu/Find_Support/MulticulturalSupport/Public_Policy_Platform/MAC_Public_Policy_Platform.htm.

National Center for Education Statistics. (2013). *Surveys and programs*. Retrieved from <http://nces.ed.gov/surveys/SurveyGroups.asp?group=1>

National Institutes of Health. (2010). *National Institutes of Health Almanac: Bethesda, MD*. Retrieved from http://www.nih.gov/about/almanac/archive/2010-2011/Almanac_2010-2011.pdf.

Nelson, T. & Figley, C. R. (1990). Basic family therapy skills, III: Brief and strategic schools of family therapy. *Journal of Family Psychology*, 4(1), 49-62.

Nelson, T. S., & Allred, D. D. (2005). Survey research in marriage and family therapy. In D. H. Sprenkle & F. P. Piercy (Eds.), *Research methods in family therapy* (pp. 211-237). New York, NY: Guilford Press.

Nelson, T. S. (2005, July/August). Core competencies & MFT education. *Family Therapy Magazine*, 20-23.

Nelson, T. S., Chenail, R. J., Alexander, J. F., Crane, D. R., Johnson, S. M., & Schwallie, L. (2007). The development of core competencies for the practice of marriage and family therapy. *Journal of Marital & Family Therapy*, 33(4), 417-438.

Nelson, T. S., & Graves, T. (2011). Core competencies in advanced training: What supervisors say about graduate training. *Journal of Marital & Family Therapy*, 37(4), 429-451.

Nelson, T. S., Heilbrun, G., & Figley, C. R. (1993). Basic family therapy skills, IV: Transgenerational theories of family therapy. *Journal of Marital & Family Therapy*, 19(3), 253-266.

Nelson, T. S., & Johnson, L. N. (1999). The basic skills evaluation device. *Journal of Marital and Family Therapy*, 25(1), 15-30.

- Nelson, T. S., & Prior, D. (2003). Theory of change projects in MFT programs. *Contemporary Family Therapy*, 25, 133-151.
- Nelson, T. S., & Smock, S. A. (2005). Challenges of an outcome-based perspective for marriage and family therapy education. *Family Process*, 44, 355-362.
- Newble, D. (2004). Techniques for measuring clinical competence: Objective structured clinical examinations. *Medical Education*, 38, 199-203.
- Northey, Jr., W. F. (2004). *Marriage and family therapy core competencies task force: Final report to the board of directors*. Retrieved from [http://www.aamft.org/resources/Educators%20Summit/CC%20Taskforce%20Final%20Report\(5-15-04\).doc](http://www.aamft.org/resources/Educators%20Summit/CC%20Taskforce%20Final%20Report(5-15-04).doc).
- Northey, Jr., W. F. (2005, July/August). Are you competent to practice marriage and family therapy? *Family Therapy Magazine*, 10-13.
- Ober, A. M., Granello, D. H., & Henfield, M. S. (2009). A synergistic model to enhance multicultural competence in supervision. *Counselor Education & Supervision*, 48, 204-221.
- Onwuegbuzie, A. J., & Leech, N. L. (2006). Linking research questions to mixed methods procedures. *The Qualitative Report*, 11(3), 474-498.
- Patton, M. Q. (1980). *Qualitative evaluation methods*. Beverly Hills, CA: SAGE Publications.
- Pedersen, P. B. (2000). *A handbook for developing multicultural awareness* (3rd ed.). Alexandria, VA: American Counseling Association.
- Pedersen, P. B. (2003). Increasing the cultural awareness, knowledge, and skills of culture-centered counselors. In J. McFadden (Ed.), *Culture and counseling: New approaches*. (pp. 31-46). Needham Heights, MA: Allyn & Bacon.

- Pedersen, P. B. (2008). Ethics, competence, and professional issues in cross-cultural counseling. In J. E. Trimble (Ed.), *Counseling across cultures* (6th ed.) (pp. 5-20). Thousand Oaks, CA: Sage Publications.
- Perosa, L. M., & Perosa, S. L. (2010). Assessing competencies in couples and family therapy/counseling: A call to the profession. *Journal of Marital and Family Therapy*, 36(2), 126-143.
- Peterson, C. M. (2011). Challenges and opportunities in outcome-based standards. *Family Therapy Magazine*, 10(5), 20-22.
- Peterson, R. L. (2004). Evaluation and the cultures of professional psychology education programs. *Professional Psychology: Research and Practice*, 35(4), 420-426.
- Platt, J., Miller, J. K., Todahl, J. & Lesser-Bruun. (2004). *Competency across disciplines: Applications for MFT*. Paper presented at the 2004 American Association for Marriage and Family Therapy National Conference, Atlanta, GA.
- Polite, K., & Bourg, E. (1992). Relationship competency. In R. Peterson, J. McHolland, R. Bent, E. Davis-Russell, G. Edwall, K. Polite, D. Singer, & G. Stricker (Eds.), *Core curriculum in professional psychology* (pp. 83-88). Washington, DC: American Psychological Association.
- Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology*, 52, 126–136.
- Ponterotto, J. G., Utsey, S. O., & Pedersen, P. B. (2006). *Preventing prejudice: A guide for counselors, educators, and parents* (2nd ed.). Thousand Oaks, CA: Sage Publications.

- Pope-Davis, D. B., Coleman, H. L., Liu, W. M., Toporek, R. L. (2003). *Handbook of multicultural competencies in counseling and psychology*. Thousand Oaks, CA: Sage Publications.
- President's Commission on Mental Health. (1978). *Report to the President*. Washington, DC: Author.
- President's New Freedom Commission on Mental Health. (New Freedom Commission; 2003). *Final Report - Achieving the promise: Transforming Mental Health Care in America*. Rockville, MD: US Department of Health and Human Services (US D.H.H.S.) Pub. No. SMA-03-3832.
- Raimy, V. (1950). *Training in clinical psychology*. Hoboken, New Jersey: Prentice Hall.
- Richards, R. R. (Ed.) (1996). *Building partnerships: Educating health professionals for the communities they serve*. New York, NY: Jossey-Bass.
- Rigazio-DiGilio, S. A. (2004). *Including explicit cultural and contextual competencies*. Report prepared by Sandra A. Rigazio-DiGilio to the AAMFT Core Competencies Steering Committee.
- Robinson Kurpius, S. E., Fuqua, D. E., Gibson, G., Kurpius, D. J., & Froehle, T. C. (1995). An occupational analysis of consulting psychology: Results of a national survey. *Consulting Psychology Journal: Practice and Research*, 47, 75-88.
- Rodolfa, E., Eisman, E., Rehm, L., Bent, R., Nelson, P., & Ritchie, P. (2005). A cube model for competency development: Implications for psychology educators and regulators. *Professional Psychology: Research & Practice*, 36(4), 347-354.

- Rubin, N. J., Bebeau, M., Leigh, I. W., Lichtenberg, J. W., Nelson, P. D., Portnoy, S., Smith, I. L., & Kaslow, N. J. (2007). The competency movement within psychology: An historical perspective. *Professional Psychology: Research and Practice*, 38(5), 452-462.
- Russell, C. S., DuPree, W. J., Beggs, M. A., Peterson, C. M., & Anderson, M. P. (2007). Responding to remediation and gatekeeping challenges in supervision. *Journal of Marital and Family Therapy*, 33(2), 227-244.
- Russell, C. S., & Peterson, C. M. (2003). Student impairment and remediation in accredited marriage and family therapy programs. *Journal of Marital and Family Therapy*, 29, 329-337.
- Serovich, J. M., & Mosack, K. E. (2000). Training issues for supervisors of marriage and family therapists working with persons living with HIV. *Journal of Marital and Family Therapy*, 26(1), 103-111.
- Shaw, A. L. (2008). *Comparison of family therapy training requirements for licensure or certification in six mental health disciplines*. (Unpublished doctoral dissertation). Brigham Young University, UT.
- Sheehan, K. B. (2001). Chapter survey response rates: A review. *Journal of Computer-Mediated Communication*, 6(2), 6.
- Snyder, C. R., & Elliot, T.R. (2005). Twenty-first century graduate education in clinical psychology: A four level matrix model. *Journal of Clinical Psychology*, 61, 1033-1054.
- Sparks, J. A., Kisler, T. S., Adams, J. A., & Blumen, D. G. (2011). Teaching accountability: Using client feedback to train effective family therapists. *Journal of Marital and Family Therapy*, 37(4), 452-467.

- Spencer, Jr., L. M., McClelland, D. C., & Spencer, S. M. (1994). *Competency assessment methods: History and state of the art*. Boston, MA: Hay/McBer Research Press.
- Sprenkle, D. H. (2003). Effectiveness research in marriage and family therapy: Introduction. *Journal of Marital and Family Therapy*, 29(1), 85-96.
- Sprenkle, D. H. (2010). The present and future of MFT education in research-focused universities. *Journal of Marital and Family Therapy*, 36(3), 270-281.
- Stevens-Smith, P., & Hinkle, J. S. (1993). A comparison of professional accreditation standards in marriage and family counseling and therapy. *Counselor Education & Supervision*, 33(2), 116-127.
- Storm, C., Todd, T., Sprenkle, D., & Morgan, M. (2001). Gaps between MFT supervision assumptions and common practice: Suggested best practices. *Journal of Marital and Family Therapy*, 27(2), 227-240.
- Sturkie, K., & Bergen, L. (2001). *Professional regulation in marital and family therapy*. Boston, MA: Allyn & Bacon.
- Sue, D. W. (2001). Multidimensional facets of cultural competence. *The Counseling Psychologist*, 29(6), 790-821.
- Sue, D. W. (2003). *Overcoming our racism: The journey to liberation*. San Francisco, CA: Jossey-Bass.
- Sue, D. W. (2005). *Strategies for building multicultural competence in mental health and educational settings*. Hoboken, NJ: John Wiley & Sons.
- Sue, D. W. (2006). *Addressing racism: Facilitating cultural competence in mental health and educational settings*. Hoboken, NJ: John Wiley & Sons.

- Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development*, 70, 477-487.
- Sue, D. W., Ivey, A. E., & Pedersen, P. B. (1996). *A theory of multicultural counseling and therapy*. Pacific Grove, CA: Brooks/Cole.
- Sue, V. M., & Ritter, L. A. (2007). *Conducting online surveys*. Los Angeles, CA: Sage Publications.
- Takeuchi, D. (2002). Race, place, and diversity. *Family Therapy Magazine*, 10-13.
- Takeuchi, D. T., & Uehara, E. S. (1996). Ethnic minority mental health services: Current research and future conceptual directions. In B. L. Levin & J. Petrila (Eds.), *Mental health services: A public health perspective* (pp. 63–80). New York, NY: Oxford University Press.
- Todd, T., & Holden, E. (2012, September/October). AAMFT's all member survey: A summary. *Family Therapy Magazine*, 10-60.
- Tomm, K. M., & Wright, L. M. (1979). Training in family therapy: Perceptual, conceptual and executive skills. *Family Process*, 18(3), 227-250.
- Trierweiler, S., & Stricker, G. (1992). Research and evaluation competency. In R. Peterson, J. McHolland, R. Bent, E. Davis-Russell, G. Edwall, K. Polite, D. Singer, & G. Stricker (Eds.), *Core curriculum in professional psychology*. (pp. 103-111). Washington, DC: American Psychological Association.
- Turner, H. A. (1999). Participation bias in AIDS related telephone surveys: Results from the National AIDS Behavioral Survey (NABS) non-response study. *Journal of Sex Research*, 36(1), 52-58.

- University of Connecticut Institutional Review Board. (UCONN IRB; 2009). *Guidance for computer and internet-based research involving human participants*. Retrieved from http://www.irb.uconn.edu/internet_research.html.
- US Center for Mental Health Services. (2000). *Cultural competence standards in managed care mental health services: Four underserved/underrepresented racial/ethnic groups*. Rockville, MD: Author.
- US Department of Health and Human Services. (US D.H.H.S.; 1999). *Mental health: A report of the Surgeon General*. Rockville, MD: US Public Health Service.
- US Department of Health and Human Services. (US D.H.H.S.; 2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the Surgeon General*. Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- US Department of Health and Human Services. (US D.H.H.S.; 2006). *The rationale for diversity in the health professions: A review of the evidence*. Rockville, MD: US Department of Health and Human Services, Health Resources and Services Administration.
- Waltermauer, E. M., Ortega, C. A., & McNutt, L. (2003). Estimating the prevalence of intimate partner violence: Assessing the impact of abuse status on participation bias. *Journal of Interpersonal Violence, 18*(9), 959-974.
- Watson, R., Stimpson, A., Topping, A., & Porock, D. (2002). Clinical competence assessment in nursing: A systematic review of the literature. *Journal of Advanced Nursing, 39*(5), 421–431.
- Wedding, D. (2005). New visions and revisions: Why isn't graduate education in psychology more relevant to professional practice? *Journal of Clinical Psychology, 61*, 1127-1130.

- Weis, B. (1992). Toward a competency-based core curriculum in professional psychology: A critical history. In R. Peterson, J. McHolland, R. Bent, E. Davis-Russell, G. Edwall, K. Polite, D. Singer, & G. Stricker (Eds.), *Core curriculum in professional psychology*. (pp. 13-21). Washington, DC: American Psychological Association.
- White, M. B., & Russell, C. S. (1995). The essential elements of supervisory systems: A modified Delphi study. *Journal Of Marital & Family Therapy*, 21(1), 33-53.
- Woolley, S. R. (2010). Purposes, diversities, and futures in MFT doctoral education. *Journal of Marital and Family Therapy*, 36(3), 282-290.

Appendix A: Online Survey

PERCEPTIONS AND

1. Study Information and Participant Consent

Principal Investigator: Sandra Rigazio-DiGilio, Ph.D.
Doctoral Student: Louisa K. Baker, LMFT

You are invited to participate in this study about the perceptions and practices of MFT Program Directors and Clinical Faculty involved in instituting educational reforms required by COAMFTE.

I am a doctoral candidate at the University of Connecticut and have been investigating the transition from input-driven to outcome-based training that has been taking form within mental health professions over the last decade. As part of these investigations, I am interested in broadening the field's knowledge about the ways in which MFT educational leaders responsible for instituting and evaluating these reforms:

1. Understand the rationale for the transition.
2. Define competency standards and outcome-based criteria.
3. Examine the impact of reforms on their training of MFT scientist/practitioners.
4. Evaluate the impact of reforms on the development of MFT professionals capable of addressing today's mental health needs.

Participant responses also will inform the development of a website with resources and networking venues that may be of benefit to educational leaders charged with instituting and evaluating the effectiveness and relevance of required reforms.

Your participation in this study involves completing an online survey which will take approximately 20 to 25 minutes, depending on the details you provide and the resources (available throughout the survey) you decide to review or download. If you consent to participate, but later change your mind, you may exit the survey at any time. You also have the option to skip questions you do not wish to address.

Your participation is voluntary and anonymous. No remuneration is offered and no identifying information is required. While no guarantees can be made regarding the interception of data sent via the Internet by any third parties, the survey website provides SSL encryption to ensure that any data intercepted cannot be decoded or traced back to individual respondents.

Completing the survey involves no risk to you. However, your participation will:

1. Broaden our profession's understanding of the ways educational reforms are shaping the training of MFT scientist/practitioners.
2. Inform the development of a website that educational leaders may find useful as they continue to address and evaluate these reforms.

If you have questions about this project, please contact me at Louisa.Baker@uconn.edu or my major advisor at Sandra.Rigazio-DiGilio@uconn.edu. If questions arise about your rights as a research participant please contact UConn's Institutional Review Board at 860-486-8802.

An official IRB-stamped version of this file is available by [right clicking here and choosing "open in new window"](#). After your review, simply close the window to return to the survey.

Please complete the following question to begin the survey.

Thank you.

PERCEPTIONS AND
<p>1. I have read the above information and I agree to participate in this study.</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p>
<p>2. Current Perceptions of Required Educational Reforms</p>
<p>Thank you for agreeing to participate in this study.</p> <p>SECTION ONE focuses on your perceptions of changes in educational requirements for COAMFTE-accredited MFT graduate and post degree programs.</p> <hr/> <p>Please do not use your browser's back button to review your responses as this will result in your responses not being saved.</p> <hr/> <p>1. In 2005, COAMFTE made the decision to transition from input-driven to outcome-based education. Briefly explain your understanding of the reasons for this philosophical shift.</p> <div><div></div></div> <hr/> <p>If survey does not advance to next page complete any instructions [NOTED ABOVE IN RED] before moving forward.</p> <hr/>
<p>3. Current Perceptions of Required Educational Reforms</p>
<hr/> <p>Please do not use your browser's back button to review your responses as this will result in your responses not being saved.</p> <hr/>

PERCEPTIONS AND

1. Over the last decade, several national calls have been made for mental health preparation programs to shift from input-driven to outcome-based training (e.g., New Freedom Commission, 2003). Briefly explain your understanding of these calls.

NOTE: A list of illustrative references can be downloaded [by right clicking here and choosing "open in new window"](#).

Simply close the window to return to the survey.

Additionally, once you submit the survey, you will be provided a link to a variety of **Resource Folders**, one of which includes the full documents for each reference identified in this list.

If survey does not advance to next page
complete any instructions **[NOTED ABOVE IN RED]** before moving forward.

4. Current Perceptions of Required Educational Reforms

Please do not use your browser's back button to review your responses
as this will result in your responses not being saved.

1. Do you think that the profession's shift to outcome-based education will contribute to developing a competent and relevant mental health workforce? Please explain.

5. Current Perceptions of Required Educational Reforms

Please do not use your browser's back button to review your responses
as this will result in your responses not being saved.

PERCEPTIONS AND

1. Please identify which of the following STEPS were among those taken:

A. By AAMFT to establish the 2004 MFT Core Competencies, and/or

B. By COAMFTE to establish the 2005 Accreditation Standards.

(Check all that apply.)

	AAMFT	COAMFTE
Regularly collaborating with MFT professionals with established expertise in competency-based models / outcome-based educational models	<input type="checkbox"/>	<input type="checkbox"/>
Regularly collaborating with other mental health professions with established expertise in competency-based models / outcome-based educational models	<input type="checkbox"/>	<input type="checkbox"/>
Regularly collaborating with disciplines outside the mental health enterprise with established expertise in competency-based models / outcome-based educational models	<input type="checkbox"/>	<input type="checkbox"/>
Regularly collaborating with national entities recommending these reforms	<input type="checkbox"/>	<input type="checkbox"/>
Drawing from a task analysis of clinical practice, clinical research, evidence-based family therapies, and emerging trends in family therapy to determine the knowledge and skills MFTs should possess	<input type="checkbox"/>	<input type="checkbox"/>
Drawing from established and validated competency-based models and methods of model development and evaluation	<input type="checkbox"/>	<input type="checkbox"/>
Drawing from established and validated outcome-based educational models and methods of model development and evaluation	<input type="checkbox"/>	<input type="checkbox"/>
Providing open and extended venues for obtaining and using feedback from the broader MFT profession to revise proposed competencies / standards	<input type="checkbox"/>	<input type="checkbox"/>
Providing open and extended venues for obtaining and using feedback from other mental health professions to revise proposed competencies / standards	<input type="checkbox"/>	<input type="checkbox"/>
Providing open and extended venues for obtaining and using feedback from disciplines outside the mental health enterprise to revise proposed competencies / standards	<input type="checkbox"/>	<input type="checkbox"/>
Providing open and extended venues for obtaining and using feedback from relevant national entities to revise proposed competencies / standards	<input type="checkbox"/>	<input type="checkbox"/>
Other: (Specify below.)	<input type="checkbox"/>	<input type="checkbox"/>
None of the above	<input type="checkbox"/>	<input type="checkbox"/>
Prefer not to answer this item	<input type="checkbox"/>	<input type="checkbox"/>

If you checked "other", please identify steps(s) below.

PERCEPTIONS AND

2. Please identify which of the following PRODUCTS have been or are being developed by:

A. AAMFT to incorporate the 2004 MFT Core Competencies into the MFT profession, and/or

B. COAMFTE to incorporate outcome-based standards into MFT preparation programs.

(Check all that apply.)

	AAMFT	COAMFTE
An identified core set of competencies / standards recognized as common across all mental health professions	<input type="checkbox"/>	<input type="checkbox"/>
A core set of reliable and valid competencies / standards that can be implemented across MFT preparation programs and continuing education venues	<input type="checkbox"/>	<input type="checkbox"/>
A core set of clearly defined competencies / standards that can be implemented across MFT preparation programs and continuing education venues	<input type="checkbox"/>	<input type="checkbox"/>
A core set of clearly defined competencies / standards that include measurable benchmarks to determine the effectiveness of MFT preparation programs and continuing education venues	<input type="checkbox"/>	<input type="checkbox"/>
Clearly defined recommendations and reliable and valid resources that MFT professionals, supervisors, and educators can draw from to incorporate competencies / standards into MFT preparation programs and continuing education venues	<input type="checkbox"/>	<input type="checkbox"/>
Professional opportunities to train MFT professionals, educators, and supervisors to incorporate competencies / standards into MFT preparation programs and continuing education venues	<input type="checkbox"/>	<input type="checkbox"/>
A core set of reliable and valid competencies / standards that have been incorporated into professional membership / accreditation requirements	<input type="checkbox"/>	<input type="checkbox"/>
A core set of reliable and valid competencies / standards that have been or are being incorporated into licensure requirements	<input type="checkbox"/>	<input type="checkbox"/>
Systematic methods / plans / measures to evaluate competencies/standards and to make revisions based on these evaluations and other advancements in the field	<input type="checkbox"/>	<input type="checkbox"/>
Other: (Specify below.)	<input type="checkbox"/>	<input type="checkbox"/>
None of the above	<input type="checkbox"/>	<input type="checkbox"/>
Prefer not to answer this item	<input type="checkbox"/>	<input type="checkbox"/>

If you checked "other", please identify product(s) below.

If survey does not advance to next page
complete any instructions [NOTED ABOVE IN RED] before moving forward.

6. Required Educational Reforms: Current Practices

PERCEPTIONS AND

SECTION TWO focuses on efforts being made by MFT Educational Leaders to institute and evaluate the reforms required by COAMFTE.

Please do not use your browser's back button to review your responses as this will result in your responses not being saved.

1. Which of the following professional activities do the MFT Faculty engage in to address your program's transition to outcome-based training? (Check all that apply.)

MFT Faculty . . .

- ☐ Work independently
- ☐ Regularly collaborate in MFT faculty subgroups
- ☐ Regularly collaborate as a full MFT faculty group
- ☐ Regularly collaborate with non-MFT faculty
- ☐ Regularly collaborate with MFT practicum / internship supervisors
- ☐ Regularly collaborate with MFT students
- ☐ Regularly collaborate with COAMFTE
- ☐ Regularly collaborate with other COAMFTE-accredited programs
- ☐ Regularly receive feedback from MFT practicum / internship supervisors
- ☐ Regularly receive feedback from MFT students
- ☐ Utilize / draw from resources provided by other COAMFTE-accredited programs
- ☐ Utilize / draw from resources provided by other mental health training programs / professions
- ☐ Collaborate with external consultants with expertise in competency-based models / outcome-based education
- ☐ Collaborate with external consultants with expertise in specific competencies or competency sets that are not strongly represented in the program
- ☐ Draw from established / validated competency-based models and methods of model development and evaluation
- ☐ Draw from established / validated outcome-based educational models and methods of model development and evaluation
- ☐ Received formal AAMFT training
- ☐ Received formal training from other discipline(s)
- ☐ None of the above
- ☐ Prefer not to answer this item
- ☐ Other (please specify)

PERCEPTIONS AND

If survey does not advance to next page
complete any instructions **[NOTED ABOVE IN RED]** before moving forward.

7. Required Educational Reforms: Current Practices

Please do not use your browser's back button to review your responses
as this will result in your responses not being saved.

NOTE: The items on this page are based on information from
AAMFT's MFT Core Competencies and COAMFTE's Accreditation Standards.
Relevant information is listed here for your convenience.
The list also can be downloaded
[by right clicking here and choosing "open in new window"](#).
Simply close the window to return to the survey.

AAMFT CORE COMPETENCIES

AAMFT categorizes 128 competencies (i.e., knowledge and requisite skills) within **Six Primary Domains** considered to comprise the scope of MFT practice. These are:

- A. **Admission to Treatment:** Clinical interactions prior to the establishment of a treatment contract.
- B. **Clinical Assessment and Diagnosis:** Activities focused on the identification of issues to be addressed in therapy.
- C. **Treatment Planning and Case Management:** Activities focused on directing the course of therapy and extra-therapeutic activities.
- D. **Therapeutic Interventions:** All activities designed to address the identified clinical issues.
- E. **Legal Issues, Ethics, and Standards:** All aspects of therapy that involve statutes, regulations, principles, and values of the profession.
- F. **Research and Program Evaluation:** Aspects of therapy that involve systematic analysis.

When determining the competencies essential to address in MFT preparation programs, some COAMFTE-accredited institutions have identified other **Primary Domains** considered to fall within the scope of MFT practice. As well, some programs have incorporated other **Competency Sets** (i.e., additional requisite knowledge and skills) within one or more of AAMFT's Six Primary Domains.

COAMFTE ACCREDITATION STANDARDS

COAMFTE identifies accreditation standards that reflect common practices across various methods for establishing and advancing outcome-based educational programs. These include:

PERCEPTIONS AND

A. **Identification**: Determining the competencies a program will address to prepare graduates for licensure and to assure graduates are trained to become proficient MFTs in entry and/or doctoral level positions.

B. **Operationalization**: Translating these competencies into measurable goals and objectives that can be reliably demonstrated and evaluated throughout the course of training.

C. **Implementation**: Incorporating curriculum and didactic / clinical teaching practices that support the achievement of identified competencies.

D. **Evaluation**: Integrating ongoing assessment methods to: (a) reliably demonstrate / evaluate the degree to which students are developing identified competencies throughout their training; and, (b) reliably evaluate the program's effectiveness.

E. **Revision**: Modifying and improving identified competencies, curriculum and didactic / clinical teaching practices, and assessment methods in ways that are informed by program outcome data and from advancements in the profession.

PART ONE

CURRENT STAGE IN TRANSITION PROCESS

QUESTIONS 1 THROUGH 8 ask the same question about the MFT Core Competencies that are identified under each of **AAMFT's Six Primary Domains** and about any additional **Primary Domains** or **Competency Sets** developed by your program. For each of these domains and competency sets, please identify the extent to which your program has:

A. **Identified** the competencies you address;

B. **Operationalized** these competencies;

C. **Implemented** curriculum and didactic/clinical teaching practices specific to these competencies;

D. Integrated assessment methods to reliably **evaluate** students' developing competencies and the program's effectiveness; and,

E. Made **revisions** informed by data collected through your program's methods of evaluation.

PERCEPTIONS AND

1. AAMFT DOMAIN ONE: ADMISSION TO TREATMENT

	Nothing Formally Yet	Preliminary Stages	To Some Degree	To a Significant Degree	Prefer Not to Answer
A. Identify	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Operationalize	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Implement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Evaluate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Revise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments?

2. AAMFT DOMAIN TWO: CLINICAL ASSESSMENT AND DIAGNOSIS

	Nothing Formally Yet	Preliminary Stages	To Some Degree	To a Significant Degree	Prefer Not to Answer
A. Identify	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Operationalize	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Implement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Evaluate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Revise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments?

3. AAMFT DOMAIN THREE: TREATMENT PLANNING AND CASE MANAGEMENT

	Nothing Formally Yet	Preliminary Stages	To Some Degree	To a Significant Degree	Prefer Not to Answer
A. Identify	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Operationalize	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Implement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Evaluate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Revise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments?

PERCEPTIONS AND**4. AAMFT DOMAIN FOUR: THERAPEUTIC INTERVENTIONS**

	Nothing Formally Yet	Preliminary Stages	To Some Degree	To a Significant Degree	Prefer Not to Answer
A. Identify	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Operationalize	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Implement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Evaluate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Revise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments?

5. AAMFT DOMAIN FIVE: LEGAL ISSUES, ETHICS, AND STANDARDS

	Nothing Formally Yet	Preliminary Stages	To Some Degree	To a Significant Degree	Prefer Not to Answer
A. Identify	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Operationalize	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Implement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Evaluate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Revise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments?

6. AAMFT DOMAIN SIX: RESEARCH AND PROGRAM EVALUATION

	Nothing Formally Yet	Preliminary Stages	To Some Degree	To a Significant Degree	Prefer Not to Answer
A. Identify	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Operationalize	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Implement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Evaluate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Revise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments?

PERCEPTIONS AND

7. OTHER PRIMARY DOMAIN OR COMPETENCY SET ONE: A **Primary Domain** your program identifies as falling within the scope of MFT practice or a **Competency Set** your program identifies that includes additional requisite knowledge and skills that you have incorporated within / across AAMFT's six Primary Domains.

(Please specify the **Primary Domain** or **Competency Set** in the box below.)

	Nothing Formally Yet	Preliminary Stages	To Some Degree	To a Significant Degree	Prefer Not to Answer	Not Applicable
A. Identify	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Operationalize	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Implement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Evaluate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Revise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please describe the **Primary Domain** or **Competency Set** identified by your program.

8. OTHER PRIMARY DOMAIN OR COMPETENCY SET TWO: A **Primary Domain** your program identifies as falling within the scope of MFT practice or a **Competency Set** your program identifies that includes additional requisite knowledge and skills that you have incorporated within / across AAMFT's six Primary Domains.

(Please specify the **Primary Domain** or **Competency Set** in the box below.)

	Nothing Formally Yet	Preliminary Stages	To Some Degree	To a Significant Degree	Prefer Not to Answer	Not Applicable
A. Identify	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Operationalize	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Implement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Evaluate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Revise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please describe the **Primary Domain** or **Competency Set** identified by your program.

8. Required Educational Reforms: Current Practices

PERCEPTIONS AND
<p>Please do not use your browser's back button to review your responses as this will result in your responses not being saved.</p>
<p>PART TWO IDENTIFY CORE COMPETENCIES</p>
<p>1. Briefly describe the factors MFT faculty members considered when identifying the core competencies for your program.</p>
<div></div>
<p>9. Required Educational Reforms: Current Practices</p>
<p>Please do not use your browser's back button to review your responses as this will result in your responses not being saved.</p>
<p>PART THREE IMPLEMENT</p>

PERCEPTIONS AND

1. Identify which components of your program include additional learning activities specifically **implemented to provide students more opportunities to develop your identified core competencies.**

(For each domain, check all components that apply.)

	Course Work	Clinical Work	Clinical Supervision	Supervision Training	Advising/ Mentoring	Research Initiatives	Other Specify below	N/A	Prefer not to Answer
DOMAIN 1 Admission to Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DOMAIN 2 Clinical Assessment / Diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DOMAIN 3 Treatment Planning / Case Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DOMAIN 4 Therapeutic Interventions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DOMAIN 5 Legal Issues, Ethics, and Standards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DOMAIN 6 Research and Program Evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PROGRAM DOMAIN 7 Domain/Competency Set 1 [If previously identified.]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PROGRAM DOMAIN 8 Domain/Competency Set 2 [If previously identified.]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you checked "other" please identify domain number and associated component(s) (e.g., D2 = Workshops).

2. Identify one or more learning activities specifically **implemented by your program that you have found to provide particularly effective / relevant opportunities for students to develop your identified competencies.**

10. Required Educational Reforms: Current Practices

PERCEPTIONS AND

Please do not use your browser's back button to review your responses
as this will result in your responses not being saved.

PART FOUR
EVALUATE AND REVISE

1. What types of assessment methods have you incorporated into your program to reliably evaluate the students' developing competencies and the program's effectiveness? (Check all that apply.)

☐ We have not incorporated any assessment methods into the program

☐ Grades

☐ Faculty evaluations

☐ Supervisor evaluations

☐ Practicum / Internship evaluations

☐ Student self-reports

☐ Student program appraisals

☐ Papers

☐ Presentations

☐ Demonstrations (e.g., role plays, raw data)

☐ Program portfolios

☐ Prefer not to answer

☐ Other (please specify)

PERCEPTIONS AND

Please do not use your browser's back button to review your responses
as this will result in your responses not being saved.

PART FOUR
EVALUATE AND REVISE

1. What types of assessment methods have you incorporated into your program to reliably evaluate the students' developing competencies and the program's effectiveness? (Check all that apply.)

☐ We have not incorporated any assessment methods into the program

☐ Grades

☐ Faculty evaluations

☐ Supervisor evaluations

☐ Practicum / Internship evaluations

☐ Student self-reports

☐ Student program appraisals

☐ Papers

☐ Presentations

☐ Demonstrations (e.g., role plays, raw data)

☐ Program portfolios

☐ Prefer not to answer

☐ Other (please specify)

PERCEPTIONS AND				
4. To what extent do findings from the assessment methods you have incorporated to date inform program revisions / modifications?				
Insufficient data to inform revisions	Exploring how findings might inform revisions	Using some findings to inform revisions	Findings significantly inform revisions	Prefer not to answer
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Comments? <div> <input type="text"/> </div>				
<p>If survey does not advance to next page complete any instructions [NOTED ABOVE IN RED] before moving forward.</p>				
11. Required Educational Reforms: Resources and Products				
<p>SECTION THREE focuses on the steps taken and the products identified or developed by you and your program in your continued work to incorporate and evaluate outcome-based training practices.</p>				
<p>Please do not use your browser's back button to review your responses as this will result in your responses not being saved.</p>				
<p>NOTE: Items on this page are informed by literature, across mental health professions, addressing calls for educational reform and examining responses to these calls. Relevant information is outlined here for your convenience.</p> <p>You can download this outline and associated references <u>by right clicking here and choosing "open in new window"</u>. Simply close the window to return to the survey.</p> <p>Once you submit the survey, you will be provided a link to a variety of Resource Folders, one of which includes the full documents of all references listed in this document.</p>				

PERCEPTIONS AND

Concerns about the quality and accessibility of mental health care have led to calls for systematic efforts to develop training programs that incorporate competencies essential to conduct research and provide effective and relevant services. While mental health professions (MHPs) have begun to address these calls, the move to competency-based training is in an early phase of development.

A: Recommendations have included calls for MHPs:

1. To strive for reliability and validity by drawing from systematic methods of competency development and assessment available in a broad range of fields
2. To communicate – as a formal collective – with professional associations, state departments of health, accrediting organizations, and other relevant bodies to promote competency model adoption in training, certification, and licensing processes
3. To communicate – as a formal collective – with federal, state, and other associations regarding funding collaborative programs of research to evaluate the link between competent professional performance and mental health care outcomes

B: Regarding competency models and training approaches, the most recent reviews reveal that:

1. MHPs have not significantly moved beyond identifying core competencies
2. Striking similarities exist in the content of competencies identified across MHPs
3. No reliable and valid measures of competence have yet been established
4. The emerging competency sets, which have typically been identified by experts, tend to be too comprehensive and idealistic to be achieved by the typical student
5. Identified competencies are not being systematically incorporated across training programs, licensing agencies, and certification boards

C: Recommendations intended to accelerate these efforts have included calls for MHPs to collaborate with:

1. Experts in competency modeling and assessment across a broad range of disciplines (e.g., medicine, business, education) and relevant to culturally, linguistically, and developmentally diverse populations
2. Other MHPs to identify common competencies and assessments, consider cooperative endeavors, assemble key resources, and make those resources accessible to educational leaders
3. Consumers with mental health needs, specifically those from underrepresented and underserved communities

D: Regarding current efforts, the most recent reviews indicate that:

1. Most MHPs are working separately and are often unaware of the strategies and progress being made by other MHPs
2. Most MHPs are shouldering the burden of marshaling resources and technical assistance to support these solo efforts
3. Many MHPs are identifying small pools of leaders within their discipline who are considered experts in outcome-based education to establish core competencies and training standards
4. Consumers and families have not yet had a major role in most of the work that has been done

Using this information as a backdrop, please respond to the next few items.

PERCEPTIONS AND

1. On a 4-point scale, to what extent has your program engaged in the following professional activities?

	Never	Seldom	Often	Almost Always	Prefer not to Answer
Collaborated with experts in competency modeling and assessment across a broad range of disciplines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Collaborated with experts in competency modeling and assessment relevant to culturally, linguistically, and developmentally diverse populations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drawn from rigorous and systematic methods of competency development and assessment available in other fields	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Worked separately on identifying competencies and linking these directly to your program	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments?

2. On a 3-point scale, which of the following reforms and products best represent those currently informing your program's transition to outcome-based educational standards?

	Not Representative	Somewhat Representative	Mostly Representative	Prefer not to Answer
Our competencies include prevention, early intervention, rehabilitation, and recovery- and resilience-oriented approaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cultural and linguistic competencies are included in our competency model.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
We have not significantly moved beyond identifying core competencies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
We are only beginning to address the development and implementation of strategies to build and assess these identified competencies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
We have not developed or incorporated reliable and valid measures of competence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Our identified competencies are too comprehensive and idealistic to be realistically achievable by the typical student	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments?

If survey does not advance to next page
complete any instructions [NOTED ABOVE IN RED] before moving forward.

12. Required Educational Reforms: Resources and Products

The call for outcome-based education has been addressed largely independently across mental health

PERCEPTIONS AND

professions. The result has been a patchwork of initiatives that are inconsistent, unsustainable, and difficult to attain for both students and educators.
(Hoge, Paris, et al, 2005)

SECTION FOUR first asks you to rate a few illustrative articles that have been used to inform advancements in outcome-based education. We then ask you about resources you have and resources you may need.

Please do not use your browser's back button to review your responses as this will result in your responses not being saved.

1. What is your opinion about the degree to which resources - such as the three you can link to below - may be useful to you and your program as you continue to address and evaluate required educational reforms?

NOTE: To respond to this item you can link to a 1-page outline of each resource by right-clicking on the name of the resource and choosing "open in new window". Simply close the window to return to the survey.

Once you submit the survey, you will be provided a link to a variety of **Resource Folders**, one of which includes the full documents represented by these three outlines.

	Unable to Determine	Not Useful	Somewhat Useful	Very Useful	Prefer not to Answer
Consultation and Interprofessional Collaboration: Modeling for the Future	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A Synergistic Model to Enhance Multicultural Competence in Supervision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Implementing the COPA Model in Nursing Education: Promoting Competence, Quality Care, and Patient Safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

IDENTIFY AND OPERATIONALIZE COMPETENCIES

PERCEPTIONS AND

2. How would you describe your level of expertise in **identifying and operationalizing competencies for MFT outcome-based training programs?**

	No Expertise	Minimal Expertise	Some Expertise	Strong Expertise	Prefer not to Answer
I have:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. If you answered **some or **strong**, what resources (e.g., documents, webinars, forums, etc.) could you contribute to the proposed website?**

4. If you answered **minimal or **none**, what resources (e.g., documents, webinars, forums, etc.) would be useful to you if available on the proposed website?**

DESIGN AND IMPLEMENT LEARNING ACTIVITIES

5. How would you describe your level of expertise in **designing and implementing learning activities that provide opportunities for students to develop necessary MFT competencies?**

	No Expertise/Activities	Minimal Expertise/Activities	Some Expertise/Activities	Strong Expertise/Activities	Prefer not to Answer
I have:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. If you answered **some or **strong**, what resources (e.g., documents, webinars, forums, etc.) could you contribute to the proposed website?**

7. If you answered **minimal or **none**, what resources (e.g., documents, webinars, forums, etc.) would be useful to you if available on the proposed website?**

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DESIGN AND INCORPORATE RELIABLE ASSESMENT METHODS

8. How would you describe your level of expertise in designing and incorporating assessment methods that provide opportunities for you to **reliably evaluate a student's developing competencies and a program's effectiveness?**

	No	Minimal	Some	Strong	Prefer not
	Expertise/Resources	Expertise/Resources	Expertise/Resources	Expertise/Resources	to Answer
I have:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9. If you answered **some or **strong**, what resources (e.g., documents, webinars, forums, etc.) could you contribute to the proposed website?**

10. If you answered **minimal or **none**, what resources (e.g., documents, webinars, forums, etc.) would be useful to you if available on the proposed website?**

INFORMED PROGRAM REVISIONS AND MODIFICATIONS

11. How would you describe your level of expertise in using findings from various methods of assessment / evaluation to **inform program revisions or modifications?**

	No	Minimal	Some	Strong	Prefer not
	Expertise/Methods	Expertise/Methods	Expertise/Methods	Expertise/Methods	to Answer
I have:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

12. If you answered **some or **strong**, what resources (e.g., documents, webinars, forums, etc.) could you contribute to the proposed website?**

PERCEPTIONS AND

13. If you answered **minimal or **none**, what resources (e.g., documents, webinars, forums, etc.) would be useful to you if available on the proposed website?**

THE WEBSITE

14. Would you see a benefit in contributing to and / or participating in a website designed for use by educational leaders instituting and evaluating the effectiveness and relevance of outcome-based training?

I would see a benefit in (Check all that apply):

- ☐ Contributing to a website of this nature, designed for educational leaders across mental health disciplines
- ☐ Contributing to a website of this nature, designed for educational leaders from COAMFTE-accredited programs
- ☐ Participating in a website of this nature, designed for educational leaders across mental health disciplines
- ☐ Participating in a website of this nature, designed for educational leaders from COAMFTE-accredited programs
- ☐ Neither contributing to and / or participating in a website of this nature
- ☐ Prefer not to answer
- ☐ Other (please specify)

If survey does not advance to next page
complete any instructions **[NOTED ABOVE IN RED]** before moving forward.

13. Demographic Information

SECTION FIVE

BEFORE RESPONDING TO THE **FINAL ITEM** PLEASE PROVIDE SOME BRIEF DEMOGRAPHIC INFORMATION.

NOTE

After completing this information and the final item, and then submitting your survey, you will be directed to a **Main Resource Folder** where you can download information and materials that may be useful to you and your program as you continue to: (a) address the educational reforms required of

PERCEPTIONS AND			
COAMFTE-accredited programs; and, (b) examine the degree to which these reforms inform effective and relevant training for future generations of MFT scientist/practitioners.			
Please do not use your browser's back button to review your responses as this will result in your responses not being saved.			
1. Where is your program located? <input type="checkbox"/> Northeast (CT, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT) <input type="checkbox"/> Southeast (AL, AR, FL, GA, KY, LA, MS, NC, SC, TN, VA, WV) <input type="checkbox"/> Midwest (IL, IN, IA, KS, MI, MN, MO, ND, NE, OH, SD, WI) <input type="checkbox"/> Southwest (AZ, NM, OK, TX) <input type="checkbox"/> West (AK, CA, CO, HI, ID, MT, NV, OR, UT, WY) <input type="checkbox"/> Canada (AB, MB, ON, PQ) <input type="checkbox"/> Prefer not to answer			
2. What degree(s) are offered? (Check all that apply.) <input type="checkbox"/> Doctoral <input type="checkbox"/> Master's <input type="checkbox"/> Post Degree or Certificate <input type="checkbox"/> Prefer not to answer			
3. How many years have the program(s) been . . .			
	Operating	COAMFTE Accredited	Complying with Version 11.0 Accreditation Standards
Master's	<input type="text"/>	<input type="text"/>	<input type="text"/>
Doctoral	<input type="text"/>	<input type="text"/>	<input type="text"/>
Post Degree	<input type="text"/>	<input type="text"/>	<input type="text"/>
4. When is the next COAMFTE accreditation site visit? <div> <input type="checkbox"/> 2013 <input type="checkbox"/> 2016 <input type="checkbox"/> 2019 </div> <div> <input type="checkbox"/> 2014 <input type="checkbox"/> 2017 <input type="checkbox"/> Unsure </div> <div> <input type="checkbox"/> 2015 <input type="checkbox"/> 2018 <input type="checkbox"/> Prefer not to answer </div>			

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5. What ranks are held by the MFT educators actively involved / responsible for instituting and evaluating COAMFTE Accreditation Standards? Please indicate **only one designation for each Faculty Member.**

	Full Professor	Associate Professor	Assistant Professor	Adjunct Professor	Adjunct Instructor / Supervisor
Number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (please specify)	<input type="text"/>				

6. If other mental health preparation programs are housed within your university or institution, indicate which items below most represent the types of exchanges that occur across programs. (Check all that apply.)

- ☐ No other mental health preparation programs are housed within the university or institution
- ☐ Minimal exchange occurs across mental health preparation programs
- ☐ MFT faculty teach/supervise in other mental health preparation programs
- ☐ Faculty from other mental health preparation programs teach/supervise in the MFT program
- ☐ MFT students take courses in other mental health preparation programs
- ☐ Students from other mental health preparation programs take MFT courses
- ☐ MFT faculty and students engage in collaborative initiatives with other mental health preparation programs
- ☐ Faculty and students from other mental health preparation programs engage in collaborative initiatives with the MFT program
- ☐ Prefer not to answer
- ☐ Other (please specify)
-

7. What is your position in the MFT Program? (Check all that apply.)

- | | | |
|---|--|---|
| <input type="checkbox"/> MFT Program Director | <input type="checkbox"/> Advisor | <input type="checkbox"/> Adjunct Professor |
| <input type="checkbox"/> MFT Clinic Director | <input type="checkbox"/> Full Professor | <input type="checkbox"/> Adjunct Instructor |
| <input type="checkbox"/> Instructor | <input type="checkbox"/> Associate Professor | <input type="checkbox"/> Adjunct Supervisor |
| <input type="checkbox"/> Supervisor | <input type="checkbox"/> Assistant Professor | <input type="checkbox"/> Prefer not to answer |

PERCEPTIONS AND					
8. What degrees do you hold? (Check all that apply.)					
	MFT	Counseling	Psychology	Social Work	Other Specify below [Identify by # 1 - 4]
1. Master's Degree	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Doctoral Degree	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Post-Degree	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Specialty Certificate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you identified "Other", please specify degree(s) or certificate(s), and discipline(s) below.

9. What licenses and certifications do you hold? (Check all that apply.)

☐ MFT
☐ Counseling
☐ Psychology
☐ Other (please specify license[s] or certification[s] below.)

☐ Social Work
☐ Prefer not to answer

10. What is your age?

☐ Less than 30 years old
☐ 30 – 40 years old
☐ 41 – 50 years old
☐ 51 – 60 years old

☐ 61 – 70 years old
☐ More than 71 years old
☐ Prefer not to answer

11. How do you define your gender?

12. How do you define your cultural identity?

If survey does not advance to next page
complete any instructions [NOTED ABOVE IN RED] before moving forward.

14. Contributions and Suggestions

PERCEPTIONS AND**SECTION SIX**

E-mail Correspondence

Please do not use your browser's back button to review your responses
as this will result in your responses not being saved.

PLEASE CONSIDER CONTRIBUTING RESOURCES (with copyright and recognition) TO THE PROPOSED WEBSITE.

If you are willing, please send Kenna the names / types of materials you would like to contribute and / or the topics you could discuss through webinars or forums.

1. For the purpose of the study, Kenna will develop a list of the number and types of resources participants are willing to contribute to the website (with identifying data removed).

2. Once the study is completed, Louisa will contact you to discuss your contributions (with copyright and recognition).

THE WEBSITE WILL BE TAILORED TO YOUR NEEDS.

Therefore, please send Kenna a brief list of the types of online resources that would benefit you and your program. For the purpose of this study, Kenna will develop a list of the number and types of resources and venues identified by participants (with identifying data removed).

PLEASE EMAIL YOUR LIST OF CONTRIBUTIONS AND / OR RECOMMENDATIONS TO:
Kenna.Thurston@uconn.edu

NOTE: After completing the final item and submitting the survey, you will be directed to a **Main Resource Folder** where you can download information and materials that may be useful to you and your program as you continue to:

- A. Address the educational reforms required of COAMFTE-accredited programs, and
- B. Examine the degree to which these reforms inform effective and relevant training for future generations of MFT scientist/practitioners.

**CLICK THE BUTTON BELOW
TO SUBMIT YOUR COMPLETED SURVEY.**

Appendix B: Participant Recruitment Protocol

RECRUITMENT - PHASE ONE

MFT PROGRAM DIRECTORS: INITIAL CONTACT

PHONE CONTACT

Hello [Program Director],

My name is Kenna Thurston, and I am the research assistant for a study taking place at the University of Connecticut. This dissertation project is being conducted by Louisa Baker, who, along with her major advisor, Sandra Rigazio-DiGilio, has been investigating various aspects of the transition from input-driven standards to outcome-based evaluation as these educational reforms continue to take form in our and other professions. This particular study is intended to broaden what we know about the ways in which MFT Program Directors and Clinical Faculty Members understand our profession's philosophical shift from input-driven standards to outcome-based evaluation, the ways in which they are working toward developing and advancing out-come based training programs, and the types of resources and initiatives they might find useful in their continued work.

As the Program Director of [program(s)], we would like to invite you to participate in the study by completing an online survey and by providing us the names and email addresses of the MFT Clinical Faculty actively engaged in these educational reforms so that we can invite them to complete the survey as well.

With your permission, I will send you an invitation email (with the subject head - Perceptions and Practices in MFT Educational Reform) that provides a brief description of the study, a link to the survey, and my email address, as I will be responsible for sending invitations to those faculty identified by Program Directors in the US and Canada.

Will it be OK for me to send you this email today?

Thank you very much for your time.

1. Program Directors who agree to consider participation will be sent the invitation emails immediately following the phone contact.
2. Program Directors who do not agree will be removed from the anticipated list of participants.

VOICE MESSAGE

Hello [Program Director],

My name is Kenna Thurston, and I am the research assistant for a study taking place at the University of Connecticut. This dissertation project is being conducted by Louisa Baker, who, along with her major advisor, Sandra Rigazio-DiGilio, has been investigating various aspects of the transition from input-driven standards to outcome-based evaluation as these educational reforms continue to take form in our and other professions. This particular study is intended to broaden what we know about the ways in which MFT Program Directors and Clinical Faculty Members understand our profession's philosophical shift from input-driven standards to outcome-based evaluation, the ways in which they are working toward developing and

advancing out-come based training programs, and the types of resources and initiatives they might find useful in their continued work.

As the Program Director of [program(s)], we would like to invite you to participate in the study. What I will do is send you an invitation email once I end this message. The subject head will be labeled Perceptions and Practices in MFT Educational Reform. The email provides a brief description of the study, along with a link to an online survey which we hope you will complete. My email address also is included, as we are asking all MFT Program Directors in the US and Canada to send us the names and email addresses of the MFT Clinical Faculty who are actively engaged in these educational reforms so that we can invite them to complete the survey as well.

We hope you will take the time to read about the study, to complete the online survey, and to send the names and email addresses of the MFT faculty members in your program(s) so that we can invite them to participate as well.

Thank you very much for your time.

1. All Program Directors contacted through voice message will receive the invitation email by the end of the working day.

MFT PROGRAM DIRECTORS: INVITATION EMAIL

Hello [Program Director],

This email is a follow-up to our discussion *OR* to the voice mail I sent you about the study being conducted at the University of Connecticut. Below is the invitation email I mentioned I would send

Respectfully,

Kenna Thurston

Kenna Thurston, MA, Research Assistant

Phone: (781) 710-1714

Email: kenna.thurston@uconn.edu



University of Connecticut

Department of Human Development and Family Studies

Marriage and Family Therapy Program

Hello [Program Director],

As Kenna Thurston mentioned, my name is Louisa Baker and I am conducting a dissertation study that is intended to expand what we know about the ways in which MFT Program Directors and Clinical Faculty Members understand our profession's philosophical shift from input-driven standards to outcome-based evaluation, the ways in which they are working toward developing and advancing out-come based training programs, and the types of resources and initiatives MFT educators might find useful in their continued work.

MFT Program Directors and Faculty Members have been addressing these educational reforms for several years now, and we believe it is important to gain a better understanding of how this transition is understood and being approached *directly from you*, and to learn more about the resources that could help to shape this process. Therefore, we hope to obtain feedback from as

many MFT educators and supervisors as possible – throughout the US and Canada –through an online survey method.

I want to thank you for your willingness to consider participating in this study. If you decide to do so, I would like to invite you, as the Program Director of [program(s)] to:

1. Complete an online survey that should take between 15 and 20 minutes of your time (depending on the details you decide to provide). You can connect to the survey by **clicking here** or by cutting and pasting the following link into your web browser [xx]. I would like to note that the survey itself includes information about and links to resources that may be of benefit to the work you and your colleagues are already engaged in as you continue to institute the educational reforms required by COAMFTE. Additionally, one objective of this study is to develop a website with resources identified by those who complete the survey, so your input would certainly add to the value and relevance of that website.
2. Send Kenna Thurston¹ the names and email addresses of the MFT Clinical Faculty members currently working with you at [program(s)] so that she can invite them to participate as well. Her email address is kenna.thurston@uconn.edu.

Of course, you may choose to participate by completing one or both of these requests. No matter what level of involvement you select, we hope you will participate so that your responses can help to inform the findings and the wealth of resources that will shape the website.

Respectfully,

Louisa K. Baker

Louisa K. Baker, MA

Doctoral Candidate

University of Connecticut, MFT Program

Email: Louisa.Baker@uconn.edu



Sandra A. Rigazio-DiGilio, Ph.D.
Professor

University of Connecticut, MFT Program

Email: Sandra.Rigazio-DiGilio@uconn.edu

¹ To ensure the confidentiality of participants, Kenna Thurston will be solely responsible for all correspondence with participants and will store all identifying data in an encrypted password protected database that is kept separate from the online data collected. Additionally, the online survey is on a website that provides SSL encryption.

This study has been reviewed and approved by the University of Connecticut Institutional Review Board (Protocol # H12-014).

Should you have any questions about the study, please feel free to contact Kenna, Sandra, or me at the email addresses above.

If you have questions about your rights as a research participant, please contact UConn's Institutional Review Board at 860-486-8802.

To remove yourself from the invitation list for this survey, please **click here** or cut and paste the following link into your web browser [xx].

1. Program Directors who send names and addresses will receive an appreciation email with 24 hours.
2. Program Directors who do not send names and addresses within two weeks will be sent a reminder email.
3. Program Directors who remove themselves from the invitation list will receive no further correspondence.

MFT PROGRAM DIRECTORS: APPRECIATION EMAIL



University of Connecticut
Department of Human Development and Family Studies

Marriage and Family Therapy Program

Hello [Program Director],

Thank you for sending me¹ the names and email addresses of the MFT Clinical Faculty members currently working with you at [program(s)] to incorporate the educational reforms now required by COAMFTE. Adding to the potential pool of respondents will best ensure that the findings represent input from a wide number of MFT educators and supervisors involved in shaping the training and supervision of future generations of MFT scientist/practitioners.

We additionally hope you found time to complete the online survey, and, if so, we thank you for participating. However, if semester responsibilities prevented you from doing so, we hope you will consider completing the survey as your schedule becomes more manageable. Again, you can link to the survey by **clicking here** or by cutting and pasting the following link into your web browser [xx]. It should take between 15 and 20 minutes of your time (depending on the details you decide to provide) and includes information about and links to resources that may be of benefit to your program as you continue to institute the educational reforms required by COAMFTE. Additionally, a primary study objective is to develop a website with resources specifically identified as potentially useful by those who complete the survey, so your input would certainly add to the value and relevance of the resources contained on that website.

Respectfully,

Kenna Thurston
Kenna Thurston, MA, Research Assistant

Phone: (781) 710-1714
Email: kenna.thurston@uconn.edu

¹ To ensure the confidentiality of participants, Kenna Thurston is responsible for all correspondence and will store all identifying data in an encrypted password protected database that is kept separate from the online data collected. Additionally, the online survey is on a website that provides SSL encryption.

This study has been reviewed and approved by the University of Connecticut Institutional Review Board (Protocol # H12-014).

Should you have any questions about the study, please feel free to contact Kenna, me, or Sandra at the email addresses provided above.

If you have any questions concerning your rights as a research participant, you can contact the University of Connecticut Institutional Review Board (IRB) at 860-486-8802.

To remove yourself from the invitation list for this survey, please **click here** or cut and paste the following link into your web browser [xx].

RECRUITMENT - PHASE TWO**MFT CLINICAL FACULTY: INVITATION EMAIL**

University of Connecticut
Department of Human Development and Family Studies

Marriage and Family Therapy Program

Hello [Faculty Member],

My name is Kenna Thurston, and I am the research assistant for a study taking place at the University of Connecticut. This dissertation study is being conducted by Louisa Baker, who, along with her major advisor, Sandra Rigazio-DiGilio, has been investigating various aspects of the transition from input-driven standards to outcome-based evaluation as it continues to unfold in our and other professions. This particular study is intended to expand what we know about the ways in which MFT Program Directors and Clinical Faculty understand our profession's philosophical shift from input-driven standards to outcome-based evaluation, the ways in which they are working toward developing and advancing outcome-based training programs, and the types of resources and initiatives MFT educators might find useful in their continued work.

MFT Program Directors and Faculty Members have been addressing the educational reforms required by COAMFTE for several years now, and we believe it is important to both understand how these standards are understood and being approached *directly from you*, and to learn about resources that have been useful or that would be useful to you and others *directly from you* as well. Therefore, we hope to obtain feedback from as many MFT educators and supervisors as possible – throughout the US and Canada –through an online survey method.

On behalf of Louisa Baker and Sandra Rigazio-DiGilio¹, I want to thank you in advance for your willingness to consider participating in this study. If you decide to do so, I would like to invite you to complete an online survey that should take between 15 and 20 minutes of your time (depending on the details you decide to provide). You can complete the survey by **clicking here** or by cutting and pasting the following link into your web browser [xx]. I would like to note that the survey itself includes information about and links to resources that may be of benefit to you as you continue to institute the educational reforms required by COAMFTE. Additionally, one objective for this study is to develop a website with resources identified by those who complete the survey, so your input would certainly add to the value and relevance of that website.

We hope you will join this investigation about perceptions of, approaches to, and resources for making a transition to outcome-based training in ways that are useful and relevant to our future generations of MFT scientist/practitioners.

Respectfully,

Kenna Thurston
Kenna Thurston, MA, Research Assistant

Phone: (781) 710-1714
Email: kenna.thurston@uconn.edu

¹ To ensure the confidentiality of participants, Kenna Thurston is responsible for all correspondence and will store all identifying data in an encrypted password protected database that is kept separate from the online data collected. Additionally, the online survey is on a website that provides SSL encryption

This study has been reviewed and approved by the University of Connecticut Institutional Review Board (Protocol # H12-014).

Should you have any questions about the study, please feel free to contact Kenna, me, or Sandra at the email addresses provided above.

If you have any questions concerning your rights as a research participant, you can contact the University of Connecticut Institutional Review Board (IRB) at 860-486-8802.

To remove yourself from the invitation list for this survey, please [click here](#) or cut and paste the following link into your web browser [xx].

RECRUITMENT - PHASE THREE

MFT PROGRAM DIRECTORS: REMINDER EMAIL



University of Connecticut
Department of Human Development and Family Studies

Marriage and Family Therapy Program

Hello [Program Director],

About two weeks ago, we spoke on the phone [OR] I left you a phone message and sent you an email about a dissertation study taking place at the University of Connecticut. This study is informed by and intended to contribute to what we know about the ways in which MFT Program Directors and Clinical Faculty Members understand our profession's philosophical shift from input-driven standards to outcome-based evaluation, the ways in which they are working toward developing and advancing outcome-based training programs, and the types of resources and initiatives MFT educators might find useful in their continued work. The study is being conducted by Louisa Baker, who, along with her major advisor, Sandra Rigazio-DiGilio, has been investigating various aspects of this transition as it continues to take form in our and other professions.

I imagine that your semester responsibilities may have prevented you from responding. Therefore, I wanted to send a reminder email in the hopes that responsibilities have become more manageable and that you may now have an opportunity to get back to me. The essential points made in the initial email are summarized below for your convenience.

MFT Program Directors and Faculty Members have been addressing the educational reforms required by COAMFTE for several years now, and we believe it is important to gain a better understanding of how these required reforms are understood and being approached *directly from you*, and to learn more about the resources that could help shape this process. Therefore, we hope to obtain feedback from as many MFT educators and supervisors as possible – throughout the US and Canada –through an online survey method.

As the Program Director of [program(s)], we hope you will now have the time to consider participating in this study, and we again invite you to:

1. Complete an online survey that should take between 15 and 20 minutes of your time (depending on the details you decide to provide). You can complete the survey by **clicking**

here or by cutting and pasting the following link into your web browser [xx]. I would like to note that the survey itself includes information about and links to resources that may be of benefit to your program as you continue to institute the educational reforms required by COAMFTE. Additionally, one objective for this study is to develop a website with resources identified by those who complete the survey, so your input would certainly add to the value and relevance of that website.

2. Send me ¹ the names and email addresses of the MFT faculty members currently working with you at [program(s)] so that I can send them invitations to participate as well. I will only email MFT faculty identified by Program Directors, so we do hope you will agree to provide a venue for me to contact them. My email address is *kenna.thurston@uconn.edu*.

On behalf of Louisa Baker and Sandra Rigazio-DiGilio, I again want to thank you for any assistance you may decide to provide. Your participation will be of great value, so we hope you will join this important investigation about perceptions of, approaches to, and resources for making a transition to outcome-based training in ways that are useful and relevant to our future generations of MFT scientist/practitioners.

Respectfully,

Kenna Thurston
Kenna Thurston, MA, Research Assistant

Phone: (781) 710-1714
Email: *kenna.thurston@uconn.edu*

¹ To ensure the confidentiality of participants, Kenna Thurston is responsible for all correspondence and will store all identifying data in an encrypted password protected database that is kept separate from the online data collected. Additionally, the online survey is on a website that provides SSL encryption.

This study has been reviewed and approved by the University of Connecticut Institutional Review Board (Protocol # H12-014).

Should you have any questions about the study, please feel free to contact Kenna, me, or Sandra at the email addresses provided above.

If you have any questions concerning your rights as a research participant, you can contact the University of Connecticut Institutional Review Board (IRB) at 860-486-8802.

To remove yourself from the invitation list for this survey, please *click here* or cut and paste the following link into your web browser [xx].

1. Program Directors who send names and addresses will receive an appreciation email with 24 hours.
2. Program Directors who do not send names and addresses within two weeks will be sent a final reminder email.
3. Program Directors who remove themselves from the invitation list will receive no further correspondence.

MFT CLINICAL FACULTY: REMINDER EMAIL

University of Connecticut
Department of Human Development and Family Studies

Marriage and Family Therapy Program

Hello [Faculty Member],

Two weeks ago, you received an email from me about a dissertation study taking place at the University of Connecticut. The study is informed by and intended to contribute to what we know about the ways in which MFT Program Directors and Clinical Faculty Members understand our profession's philosophical shift from input-driven standards to outcome-based evaluation, the ways in which they are working toward developing and advancing outcome-based training programs, and the types of resources and initiatives MFT educators might find useful in their continued work. The dissertation study is being conducted by Louisa Baker, who, along with her major advisor, Sandra Rigazio-DiGilio, has been investigating various aspects of this transition as it continues to take form in our and other professions.

We hope you had an opportunity to complete the survey, and, if so, we want to thank you for your participation as this helps to ensure that the findings will represent input from a wide number of MFT educators and supervisors working on the graduate and post-degree transitions required by COAMFTE.

However, it may be that end of semester responsibilities prevented you from participating. If so, we hope you will consider completing the survey once your schedule becomes more manageable. You can complete the survey by **clicking here** or by cutting and pasting the following link into your web browser [xx]. I would like to note that the survey will take between 15 and 20 minutes of your time, and that it includes information about and links to resources that may be of benefit to you as you continue to institute the educational reforms required by COAMFTE. Additionally, one objective for this study is to develop a website with resources identified by those who complete the survey, so your input would certainly add to the value and relevance of that website.

We hope you have a moment to join this important investigation. Your participation will be of great value in contributing to the field's understanding of the work being done and the resources that are or that can be made available to assist our profession in making a transition to outcome-based training in ways that will be useful and relevant to our future generations of MFT scientist/practitioners.

Respectfully,

Kenna Thurston
Kenna Thurston, MA, Research Assistant

Phone: (781) 710-1714
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Should you have any questions about the study, please feel free to contact Kenna, me, or Sandra at the email addresses provided above.

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RECRUITMENT - PHASE FOUR

MFT PROGRAM DIRECTORS: FINAL REMINDER EMAIL



University of Connecticut
Department of Human Development and Family Studies

Marriage and Family Therapy Program

Hello [Program Director],

Over the last month, you received two emails from me about a dissertation study taking place at the University of Connecticut. This study is informed by and intended to contribute to what we know about the ways in which MFT Program Directors and Clinical Faculty Members understand our profession's philosophical shift from input-driven standards to outcome-based evaluation, the ways in which they are working toward developing and advancing outcome-based training programs, and the types of resources and initiatives MFT educators would find useful in their continued work. The study is being conducted by Louisa Baker, who, along with her major advisor, Sandra Rigazio-DiGilio, has been investigating various aspects of this transition as it continues to take form in our and other professions.

As is always the case, I am certain that directorship responsibilities must take priority, but I wanted to write one final email to see if you now had the time to respond, and to let you know that the survey will be closing on **[date]**.

If you are able, we would appreciate your completing the online survey that should take between 15 and 20 minutes of your time (depending on the details you decide to provide). You can complete the survey by **clicking here** or by cutting and pasting the following link into your web browser [xx]. I would like to note that the survey includes information about and links to resources that may be of benefit to your program as you continue to institute the educational reforms required by COAMFTE. Additionally, one objective for this study is to develop a website with resources identified by those who complete the survey, so your input would certainly add to the value and relevance of that website.

Finally, if time allows, we would appreciate your forwarding the instrument directly to the MFT faculty members currently working with you so they have the opportunity to participate as well.

We hope you will have a moment to join this important investigation. Your participation will be of great value in contributing to the field's understanding of the work being done and the resources that are or that can be made available to assist our profession in making a transition to outcome-based training in ways that will be useful and relevant to our future generations of MFT scientist/practitioners.

Respectfully,

Kenna Thurston

Phone: (781) 710-1714

Kenna Thurston, MA, Research Assistant

Email: kenna.thurston@uconn.edu

¹ To ensure the confidentiality of participants, Kenna Thurston is responsible for all correspondence and will store all identifying data in an encrypted password protected database that is kept separate from the online data collected. Additionally, the online survey is on a website that provides SSL encryption.

This study has been reviewed and approved by the University of Connecticut Institutional Review Board (Protocol # H12-014).

Should you have any questions about the study, please feel free to contact Kenna, me, or Sandra at the email addresses provided above.

If you have any questions concerning your rights as a research participant, you can contact the University of Connecticut Institutional Review Board (IRB) at 860-486-8802.

To remove yourself from the invitation list for this survey, please [click here](#) or cut and paste the following link into your web browser [xx].

1. Program Directors who send names and addresses will receive an appreciation email with 24 hours.
2. Program Directors who do not send names and addresses or who remove themselves from the invitation list will receive no further correspondence.

MFT CLINICAL FACULTY: FINAL REMINDER EMAIL



University of Connecticut
Department of Human Development and Family Studies

Marriage and Family Therapy Program

Hello [Clinical Faculty Member],

Over the last month, you received two emails from me about a dissertation study taking place at the University of Connecticut. The study being conducted is informed by and intended to contribute to what we know about the ways in which MFT Program Directors and Clinical Faculty Members understand our profession's philosophical shift from input-driven standards to outcome-based evaluation, the ways in which they are working toward developing and advancing outcome-based training programs, and the types of resources and initiatives MFT educators might find useful in their continued work. The study is being conducted by Louisa Baker, who, along with her major advisor, Sandra Rigazio-DiGilio, has been investigating various aspects of this transition as it continues to take form in our and other professions.

We hope you had an opportunity to complete the survey, and, if so, we want to thank you for your participation as this helps to ensure that the findings will represent input from a wide number of MFT educators and supervisors working on the graduate and post-degree transitions required by COAMFTE.

However, if teaching and supervision responsibilities have prevented you from doing so, I hope you will consider completing the survey once your schedule becomes more manageable and before the survey is closed for analysis on [date]. You can complete the survey by **clicking here** or by cutting and pasting the following link into your web browser [xx]. I would like to note that the survey will take between 15 and 20 minutes of your time, and that it includes information

about and links to resources that may be of benefit to you as you continue to institute the educational reforms required by COAMFTE. Additionally, one objective for this study is to develop a website with resources identified by those who complete the survey, so your input would certainly add to the value and relevance of that website.

We hope you will have a moment to join this important investigation. Your participation will be of great value in contributing to the field's understanding of the work being done and the resources that are or that can be made available to assist out profession in making a transition to outcome-based training in ways that will be useful and relevant to our future generations of MFT scientist/practitioners.

Respectfully,

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Appendix C: Participant Needs and Contributions to Future Collaborative Website

	CONTRIBUTIONS (<i>n</i> = 14)	NEEDED (<i>n</i> = 18)	OTHER
IDENTIFY & OPERATIONALIZE	Rubrics, evaluation forms, conceptual framework, extensive student assessment system, systematic program review assessment tools, documents, presentations, webinars, forums, resources including Gehart's (2007) MFT Competency Assessment System, sample assignments addressing specific competencies, faculty colleagues have been the best resource, curriculum development ideas, examples of programmatic stages of competency development, discussions with other program directors about online examples, student self-evaluations	Webinars, AAMFT trainings, manuals, forums suited for group / faculty participation, concrete examples of benchmark assignments, portfolios, ideas for systems to track and monitor outcomes, "pre-defined packages" that could be implemented, examples of rubrics, examples of valid evaluation measures, ideas about how to best involve relevant communities / stakeholders, models for translating heuristic models of competency based learning and teaching to MFT education (e.g., translating Bloom's taxonomy into sequential learning; how other programs / professions are specifically implementing competency-based education), examples of how competencies were developed and information about how they change regionally (if at all), I don't know what I don't know,	Unsure, possible conflict of interest due to involvement in professional training office, I have nothing to contribute at this time "I don't know if our new forms would be of benefit to anyone since I don't know what other programs are doing. COAMFTE will not advise and will not share" "I'd love to see how other programs are operationalizing and evaluating standards and benchmarks" "None for me personally; I rely on my MFT faculty to be up-to-speed on their expertise" "I think it would be useful of COMAFTE outlined in greater detail, with specific examples, of what they look for in their self-study reports. They admitted to programs having a low success rate when applying for initial and re-accreditation and if a program of study had as low of a success rate my guess is COAMFTE would

		examples of good forms for evaluation and data analysis, information from experts in other disciplines (not just mental health) in competency development and outcome-based training, notification when resources are posted and available, a centralized resource collection, something specific for PhD programs (not a repeat of Master's level, licensure-based programs)	pull the programs accreditation" "We have the linguistic reframing competencies we need" (when asked what is needed)
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	CONTRIBUTIONS (<i>n</i> = 17)	NEEDED (<i>n</i> = 14)	OTHER
DESIGNING AND IMPLEMENTING LEARNING ACTIVITIES	Workshops using experiential learning techniques to develop clinical competencies, webinars, presentations, curriculum maps and resources focusing on student development, professional development plans that allow students to identify their own competence and areas for improvement, evaluations, documents, forums, sample syllabi, assignments, and learning activities, examples of student products from training activities, discussions	Manuals, webinars, AAMFT trainings, documents, forums, "I am new to this type of programming and feel most anything could be useful", examples of learning activities that are logistically easy to do, examples, including videos, of assignments or exercises, list-serv or online forum for exchange of questions, a document-sharing system to exchange forms (e.g., examples of charts, syllabi, etc.), unknown, information from experts in other disciplines (not just mental health) in	"This part doesn't seem that difficult for us" (no offer of resources to contribute, despite identified expertise in this area) "None for me personally; I rely on my MFT faculty to be up-to-speed on their expertise" "We have the linguistic reframing competencies we need" (when asked what is needed)

	with other program directors about online examples, psychosocial assessment recording, website material	competency development and outcome-based training	
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	CONTRIBUTIONS (<i>n</i> = 14)	NEEDED (<i>n</i> = 16)	OTHER
DESIGNING AND INCORPORATING ASSESSMENT METHODS TO RELIABLY EVALUATE STUDENT COMPETENCE AND PROGRAM EFFECTIVENESS	Documents, online evaluative system, expertise in helping struggling students, unsure, assessment tools for clinical supervision, nothing to contribute at this time, example syllabi, a short clinical competence evaluation with demonstrated high inter-rater reliability, examples of rubrics, other measures, aggregated reports, automation tools, action plans from assessment efforts, discussions with other program directors about online examples	Workshops linking measures, observations, and learning experiences, manuals, webinars, AAMFT trainings, documents, rubrics, sample ideas, modules or websites that could be used to gather and plug in data, examples of data to collect and how to do so, valid assessments with high inter-rater reliability, a valid and reliable instrument to measure outcomes, information from experts in other disciplines (not just mental health) in competency development and outcome-based training, documented examples	<p>“We have developed a generic model for recording the initial assessment of a couple or family”</p> <p>“We have been commended by both COAMFTE and WASC for our programs competence in assessing educational effectiveness” (no offer of resources despite stated expertise)</p> <p>“None for me personally; I rely on my MFT faculty to be up-to-speed on their expertise”</p> <p>“We have the linguistic reframing competencies we need” (when asked what is needed)</p>

	CONTRIBUTIONS (<i>n</i> = 13)	NEEDED (<i>n</i> = 15)	OTHER
USING FINDINGS TO INFORM PROGRAM REVISIONS OR MODIFICATIONS	Cycle of assessment, description of the process and sample forms to incorporate feedback into curriculum revision, guidance in how to use both statistical and qualitative data to	Webinars, documents, forums, systematic revision document, “any good procedure if informative”, unknown, information from experts in other disciplines (not just mental health) in	<p>“None for me personally; I rely on my MFT faculty to be up-to-speed on their expertise”</p> <p>“We have the linguistic reframing competencies we need”</p> <p>“Since I'm not sure of</p>

	inform change, unsure, nothing to contribute, expertise of colleagues, action plans derived from assessment efforts, discussions with other program directors about online examples, assessment scales	competency development and outcome-based training, “any documents or webinars that can be shared with supervisors and faculty”, examples	the goal or what we need to do better given how we have limited our outcomes (i.e. research and publishing and we are doing these). My question is always changing or revising toward what? Since COAMFTE hasn't developed a set of standards specific to Ph.D. programs it is difficult to figure out where we "should" be headed.”
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Appendix D: Factors Considered in the Identification of Programmatic Core Competencies

Briefly describe the factors the MFT faculty considered when identifying the core competencies for your program. (Q16, n=53)	
PARTICIPANT FEEDBACK	THEMES
Consideration of our program's (relatively) unique features (Metaframeworks/IFS and Action Methods)	Program focus Pre-existing curriculum
I am not sure	Unknown
We use the core competencies set out by AAMFT and have designed our methods according to the Gehard book.	All competencies considered
This was done before I came on board	Unknown
The culture and structure of our program; the mission and vision of the program, graduate school, and university; perspectives of the faculty and supervisors.	Culture, structure of program Mission, vision of program and wider systems Faculty & supervisor expertise
What we wanted to see in our doctoral students when they finished the program.	Goal KSAs for graduates Faculty expertise
AAMFT Core Competencies	All competencies considered
I don't know, I wasn't a faculty member at the time when these were identified.	Unknown
They would consider impacts on curriculum, outcomes, standards in the field	Impact of selection on curriculum, outcomes, field standards
We consider the AAMFT and COAMFTE core competencies, our context in California, our external stakeholders, the faith-based institution mission and core values, the College which houses the MFT program as well as CAMFT and the BBS requirements.	All competencies Contextual factors: state, stakeholders, institutional mission, core values
It seemed to me that the existing expertise/views of existing influential academic faculty were a primary influence in the core competency project. I also had the impression that core competency development was linked to the need to better present our profession's skill set to external groups such as congress and third-party payors. That said, the primary domains appear to be organized similarly to those of the national examination.	Faculty expertise National examination structure
COAMFTE core competencies	All competencies considered
Educational outcomes, current curriculum, alumni feedback, graduate student feedback, faculty feedback, relevant changes in the field,	Current curriculum Alumni, student, faculty feedback

	Changes in the field Faculty expertise
Competencies we already cover	Pre-existing curriculum
Wanted our students to be able to demonstrate all of them at their developmental level	All competencies considered
As a faculty group, a discussion occurred where the 128 core competencies were evaluated and a determination made as to which competencies fit into which courses. Then the group looked at what assignments would be completed to verify competency and then what would the grading rubric look like to determine competency and to what level of competency was obtained.	Pre-existing curriculum
Use of existing COAMFTE and AAMFT Standards and competencies, Cultural skills and competencies related to gender, sexuality, SES, ability, religion/spirituality, the mission statement of our program, the mission of our departmental program, and feedback from students in the field, from other practitioners, supervisors, internship sites etc.	All competencies considered Additional competencies added Mission of program, department Feedback from stakeholders: students, practitioners, supervisors, internships
We identified all the theories and other competencies we identified were taught as part of our program. We also identified competencies covered as part of supervision and clinical work at the program.	Pre-existing curriculum Supervision and clinical work
Factors? I'm not sure what you mean.	Didn't understand question
Personal experience	Faculty expertise
I don't understand the question	Didn't understand question
We understood that the Core Competencies were established as competencies at the time a person is ready to license which means that some of them are more relevant to the time between receiving the graduate degree and gaining clinical experience hours under supervision as they work toward licensure. We evaluate the major domains of the core competencies using the specific competencies under those domains to give richness to the feedback, but we do not evaluate every core competency.	Developmental considerations
Historic mission of the program. Belief that competency based education inadequately prepares students for clinical work with the diversity of client. More importantly, the belief that outcome based models and common factors approach, as well as the therapeutic relationship insufficiently address vital contextual variables, such as race, culture, gender, religion, class, sexuality, that create power inequities, in therapy and outside of it.	Mission of the program Competencies only part of what the program considers

We also believe the existing outcomes measures fail to consider the personhood of the therapist. Students must examine and explore their own issues in our program, via a constructed class, as a way to preemptively prevent them from negatively impacting their work.	
COAMFTE dictates	All competencies considered
Factors that would help the student be able to practice at an entry level therapist upon graduation. The factors were to ensure the safety and quality of treatment of clients.	Developmental considerations Safe, quality client care
State Licensing Board Requirements.	State licensing requirements
Basic tenets of what it means to be a competent therapy	Faculty expertise
As I am a new faculty member, I was not present for these initial discussions. I am aware that the AAMFT Core Competencies were considered but that other factors were other identified.	Unknown
Faculty met to consider the history and current context of our program, as well as the needs of the community for which our training program serves.	Program history and contextual factors Community needs
Previous competency standards (i.e., pre-2005 input-based accreditation requirements), review of AAMFT Core Competencies, Metaframeworks perspective	Previous COAMFTE standards All core competencies considered Program focus
We look at the AAMFT core competencies and the needs of our communities of interest. One of our primary communities of interest are state license boards. We also look at other programs to see how they are measuring their effectiveness. All of this forms our core of competencies.	All competencies considered Needs of stakeholders Licensing requirements Comparison with other programs
We have considered all the core competencies throughout the program.	All competencies considered
The AAMFT Core Competencies, State Regulatory Codes, AAMFT Code of Ethics, AMFTRB Domains	All competencies considered State requirements COAMFTE / AAMFT requirements Ethics
We reviewed the AAMFT Core Competencies, the AMFTRB Exam Content Areas, Licensing requirements across all 50 states and DC, current program offerings, the AAMFT Code of Ethics, the COAMFTE accreditation standards, and student and alumni feedback regarding their perceived needs.	All competencies considered Licensing exam and requirements Pre-existing curriculum Ethics COAMFTE requirements Student & alumni

	feedback
What students will need for successful entry into professional practice, standards of practice in the field, ethical standards, AMFTRB test domains, state license requirements.	KSAs for student graduates Practice standards Ethics Licensing exam and requirements
Maintaining accreditation	COAMFTE requirements
We considered our University mission, our core commitment to social justice and diversity, the needs of the field and how our graduates can best contribute, as well as licensure requirements in our state and others; we want our doctoral students to be well prepared to teach, supervise, do research, and otherwise advance the field of MFT.	Institutional mission Program values Relevant stakeholders Licensing requirements KSAs for students
Each faculty member reviewed what they enjoyed about the programs they went to individually and identified the core competencies that were important to them.	Faculty expertise Individual preferences
Program as it has advanced over its existence.	Pre-existing curriculum
Your meaning is unclear to me.	Didn't understand question
Conceptual and Perceptual Skills: Knowledge Base, Familiarity with Therapy Models, Awareness of Diversity Issues, Recognition of Relationship Patterns, Executive Skills: Joining, Basic Therapeutic Skills, Assessment, Hypothesizing, Treatment Planning, Intervention Strategies, Integration of Models Professional Skills: Session Management, Supervision Responsibilities, Ethical Issues, Paperwork, Professional Behaviors Evaluation Skills: Therapy, Evaluation of Self, Personal Qualities <u>12 Knowledge Areas covered by the Required Coursework</u> Systemic Models Common factors and Integration of Models Therapeutic Alliance Basic Therapeutic Skills Systemic Therapeutic Interventions Human Development Human Sexuality Diversity Factors Ethics and Professional MFT Practice Self of Therapist Special Topics Research	Pre-existing curriculum
What we thought were most important and most easily assessed	Faculty expertise Easily assessed
To be honest, we fit the competencies to the program as we had	Pre-existing curriculum

already developed it.	
Faculty members were satisfied with the core competencies as defined by the AAMFT and used them in annual program reviews	All competencies considered
Accreditation Standards, research elements	COAMFTE requirements KSA for research
What competencies they learned as students, what they needed during practice, and what they felt students needed to learn to become competent therapists	KSA for graduates Faculty expertise
no	{Cannot count}
Philosophy of the program and core beliefs of faculty	Program philosophy Faculty expertise
We utilized three domains of competency..Theoretical, clinical and interpersonal	Didn't answer question
Alignment with curriculum.	Pre-existing curriculum
The primary mission of the program - qualifications required for competent MFT Faculty and researchers.	Program mission
We are a Ph.D. only program. Our focus is on developing researchers in the field so we have focused on that aspect as our core competencies: designing studies, analyzing data, publishing results etc. We focus on developing a theory of change for the clinical aspect of our program.	Goal KSAs for graduates
We look at what we already teach	Pre-existing curriculum

Appendix E: Learning Activities and Evaluative Tools

PARTICIPANT FEEDBACK	THEMES
Voluntary Peer learning groups centered around assessment	Group work Assessment
Case note rubrics	Case documentation Assessment
Providing panel discussions/presentations outside of the classroom (for students, alums, and supervisors).	Presentation Experiential
Participation in professional conferences	Conference participation
Clinical skills courses	Coursework
We have adopted a client simulation exercise where students role play the entire therapeutic process from admission to treatment to evaluation.	Role play Experiential
1. Repeated, structured interactive skill practice within class sessions and supervision 2. Trainee SelfCare framework for intentionally creating improved emotion regulation across 8 domains 3. Clinical Experience Exposure events, based on the OSCE, simulating therapist-client encounters	Repeated Interactive Class work Supervision Framework Experiential
We rely on past experience	Other
Clinical exposure experience	Clinical work
A one year Clinical Internship provides a great deal of learning opportunities, which covers most, if not all, of the core competencies.	Clinical work
Experiential immersion, such as cultural immersion projects within a class, service learning is also being considered for implementation. Practicum and internship with multiple layers of supervision are also effective. Within courses, application to student's own personal processes (reflexivity, self-research) along with case application and extended experiences in practice and self-evaluation also improve outcomes.	Experiential Cultural immersion Clinical work Supervision Coursework Student self-reflection
Utilizing the competencies and domains as feedback tool in supervision	Supervision
Role-plays	Role play
Attending and presenting at conferences	Conference participation Experiential
Capstone project	Capstone project
Case presentation with paper and rubrics Clinical assessment and case conceptualization scoring rubrics Case note and Treatment Plan rubrics	Case presentation Assessment tools
Cultural immersion travel	Experiential Cultural immersion
The internship year and reseach courses have given the student the opportunity to use their knowledge and skills they learned.	Coursework Clinical work /

	internship
Treatment Plans must be included in all student-therapist cases by the third session. The supervisor must approve it in writing.	Case documentation
Use of live, and especially video tape review supervision, when combined with the core competencies of MFT practice, has been the most effective learning opportunity.	Supervision Video
Students being required to identify core Metaframeworks concepts in each of the therapy models taught.	Other
Our final clinical case presentation not only gives us an opportunity to assess the outcomes of our programs across all the domains, it also gives the student an opportunity to develop their identified competencies to a higher level. We have a specified grading rubric that students are well aware of. Feedback from students has consistently said that students find the final clinical case presentation demanding yet beneficial in their learning.	Capstone Assessment Feedback
a. Students are being trained in evidence-based practices. b. Students are reading more about evidence-based practices. c. Students are providing outcomes for clinical practice	Other
Assignments that require actual interaction with mock clients - videotaped and critiqued. Use of state specific information in understanding ethical considerations and how they apply. Application of learned concepts to videos, individuals and families (including the students own family). Faculty interaction, in a one-to-one teaching model, that creates a connection with students and allows for a mentoring relationship to develop.	Experiential Video Critique Faculty mentoring Self-reflection
Video recorded skill demonstration and evaluation (e.g. recording a brief interview and then conducting a self assessment of specific skills followed by faculty review and assessment of the same). Model Specific Case Presentations in practicum groups (e.g. students present overviews of selected models to address specific criteria, accompanied by presentation of a specific active clinical case with video clips demonstrating identified skills from the presented model).	Experiential Video Self-assessment Supervision
Interdisciplinary conferences on assessment and treatment; Mentoring process with third-year students assisting first year students with basic clinical skills;	Interdisciplinary conferences Mentoring
None designed that would be of benefit to programs committed to current COAMFTE standards.	Other
We do action research of students' clinical learning process. This creates a level of focus on what is needed for competence that we did not see before and we think it is very effective in helping to improve competencies in all levels--theory development, practice, and research.	Assessment
We do a lot of assessments. One of the ways we assess is through pre and post tests in diversity and ethics courses. Additionally, we ask students to conduct a clinical or a research capstone which demonstrate a synthesis of	Assessment Capstone project

these skills.	
We have a well-established training record based on understanding the learning needs of our students - none were chosen to address competencies as these have been identified by AAMFT or COAMFTE. Our definition of competencies is not in line with our professional organization.	Other
Students demonstrate the ability to answer legal questions by State Legislative and Examining Board documentation.	Assessment Applied / experiential
We offer 13 intensive workshops that frame the courses that offer focused training in key topic areas that are covered in courses but not extensively. This allows for focused study in key areas affecting clinical practice such as Domestic Violence, Substance abuse, Sexual Addition, Trauma, Relationship Education, Affairs, Therapy and the Brain, Etc.	Workshops
Portfolios	Portfolio
Our program has three years of group supervision (56 hours per year) in which the core competencies (especially the integrated of theory and practice) are integrated into clinical hour. Both supervisors and students believe that group supervision is the core of our program	Supervision
Role plays, videos	Role play Video
Case conceptualizations	Case conceptualization
Students are required to prepare a teaching portfolio as part of their doctoral qualifying exams. Supervision practicum has been redesigned and doctoral students are allowed to count supervision hours provided to master's degree students as part of their clinical hours.	Teaching portfolio Assessment tools Supervision Student mentoring
The best learning activity for research is submitting a publication and getting reviewer feedback.	Experiential Feedback
We don't drink the purple cool aid	Other

8 participants refused to provide feedback

3 indicated that the question was not applicable to their program