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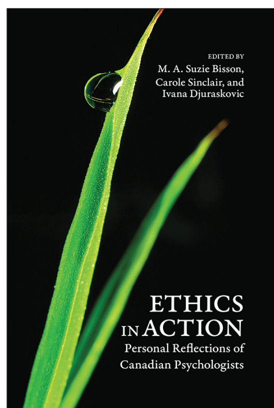

ETHICS IN ACTION: PERSONAL REFLECTIONS OF CANADIAN PSYCHOLOGISTS

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Couple and Family Therapy: Steps to Responsible Caring for Practitioners, Supervisors and Educators

Jeff Chang, E. Aiofe Freeman-Cruz

> *Recently, I met an acquaintance, Faith,[1] at a social event. After greeting each other, I asked about her partner, Rob. "We're not doing too well. He's at home, but I think we might split up." I said, "Aw, I'm sorry to hear that. Are you guys seeing anyone?" She responded with the name of an experienced clinical psychologist, whom I sometimes consulted. Expecting to hear how positively the work was going, I replied, "Oh, he's great. Is it going well?" Faith replied, "Not really. He just lets us go on, and sometimes I feel like he is more positive toward Rob than me. I'm not so sure it's going to work.*

Overview

Both authors of this chapter have had the good fortune to have had training in couple and family therapy (CFT).[2] For a long time, we assumed that most psychologists have had such training. While the vignette above is a composite, we have both heard of situations in which psychologists could have benefited from understanding families as systems. This invited us to wonder how psychologists establish competence in CFT, given that a sizable proportion of Canadian counselling and clinical psychologists practice CFT. Falender et al. (2004) define competence as knowledge, skills, values, and meta-knowledge. The College of Alberta Psychologists states that competence is acquired by "education, training and/or experience" (CAP, 2023, p. 13). These statements sharpen the questions we wish to pose in this chapter: How do Canadian psychologists gain the knowledge to conceptualize their treatment of families in a theoretically and empirically sound way? How do they learn the skills to develop a working alliance

with multiple clients and effectively deliver family-based clinical interventions? Or, to link these questions with the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association [CPA], 2017), how can psychologists best honour Principle II (Responsible Caring)?

In this chapter, we will discuss pathways to competence in CFT for Canadian psychologists. First, we describe our backgrounds and how we developed an interest in this topic. Next, we examine how much couple and family therapy psychologists actually do. Third, we unpack Principle II (Responsible Caring). Finally, we discuss how psychologists can establish competence, and our personal perspectives on competence in CFT.

About Us

Jeff: I am a counselling psychologist. In the early 1980s, I studied for a master's degree in counselling psychology and worked in children's mental health agencies, where many of my colleagues were interested in CFT, mainly in structural and strategic approaches (Haley & Richeport-Haley, 2003; Lynch & Lynch, 2000). I took a CFT course in my master's program and sought out practica where I could work with families. After moving to Calgary in the mid-1980s, I continued to work in child and youth mental health agencies while completing the requirements to become a registered psychologist in Alberta. My workplace employed two American Association for Marriage and Family Therapy (AAMFT) approved supervisors and provided me with 200 hours of supervision for my family work. In addition, I took additional courses to qualify as a clinical member (as they were then called) of the AAMFT, and later trained as an approved supervisor. I was fortunate to be part of the vibrant CFT community in Calgary in the 1980s and 1990s. In a varied career in child and youth mental health, employee assistance programs, private practice (largely in the area of high-conflict divorce), and academia, family systems thinking has permeated my clinical work, teaching, and publications. In 2011, I started to work part-time as a clinical supervisor at the Calgary Family Therapy Centre. As a full-time counselling professor at Athabasca University, and part-time clinical supervisor, my mission is to support the development of new practitioners. This background, along with the composite anecdote provided above, led me to wonder how psychologists who do CFT acquire their competence to do so.

Aiofe: I am a registered psychologist trained in counselling psychology, and completed my bachelor, master's, and doctoral degrees at the University of Calgary. Through my graduate studies, I developed an interest in working with families with a parent with an acquired brain injury. My master's thesis examined the retrospective accounts of the experiences of adolescents who lived with a parent

with an acquired brain injury, which led me to see how these families were underserved in counselling (Freeman, 2012). I further explored family systems theories as part of my doctoral research, which I later applied in my doctoral practicum at the Calgary Family Therapy Centre (CFTC), where Jeff supervised my work. I consider myself fortunate also to have taken a course during my training from Dr. Karl Tomm about his approach to family therapy (Tomm et al., 2014). During my predoctoral internship at the University of Manitoba Student Counselling Centre, I learned couple therapy under Dr. Lori Mac who was trained in the Gottman Method of CFT (Gottman & Gottman, 2015). I have continued to apply systemic therapies in my work with individuals, couples, groups, and families. I assumed that most counselling psychologists were competent to work with couples and families, but later learned that many have not had any CFT training or supervised practice at all. I am grateful for the support I have received to learn CFT but have often wondered how other early-career psychologists develop their CFT competence.

Psychology Practitioners and Family Intervention

It appears that psychologists do a considerable amount of CFT. Hunsley et al. (2013) found 26.6% of Canadian psychology practitioners offer couple or family therapy, and 20.8% of Canadian practitioners report family systems as one of their theoretical approaches. Much earlier, Hunsley and Lefrebvre (1990) surveyed members of the Canadian Register of Health Service Providers in Psychology. Sixty-two of the 88 respondents (70.4%) reported regularly conducting family or couple therapy. Norcross and Karpiak (2012), surveying 588 American Psychological Association (APA) Division 12 (Society for Clinical Psychology) members, found that about half provide couple therapy, while about one-third practice family therapy. Between 30% and 40% of Employee Assistance Program referrals are for couple and family concerns (Azzone et al., 2009), which we think provides a fair representation of the proportion of clients receiving family intervention in community practice. In fact, it might be an underestimate because clients requesting counselling may have needed or benefited from family intervention but did not know to request it.

We believe that even when clients and referral sources do not directly request family intervention, conceptualizing the situation by using family systems theory is helpful. Mastikhina et al. (2013), surveying 1,136 Alberta psychologists, found that 16% of their clientele are children and 16% adolescents. Jeff argues that those who work with children and adolescents should be competent to work with their families (Chang, 2013). Aiofe learned this lesson while working with a blended family that identified their teen as "the problem." As she started to support the teen to have his voice heard in the family, she found that his family

thought that the teen sharing his feelings more was just "whining" and/or "pushing back." Their reaction invited more angry outbursts, and then withdrawal, from the young man. This led the parents to question the benefit of family therapy. They saw their teen as more opinionated and "not any better" in terms of the presenting problem of angry outbursts. Focusing primarily on supporting the teen, Aiofe realized that she inadvertently had neglected to engage the parents. As she started to engage the parents and approach the work more systemically, the parents became aware of their contributions to change by responding (mostly) supportively to the teen's newfound voice. They also came to recognize the teen's contributions to the family, creating a context for the teen to "feel like I matter." The therapist-client system recovered from a disruption to the therapeutic relationship that could have contributed to a poor outcome.

We also have found that, in working with individual clients, even adult clients' problems are rarely isolated from personal or family relationships. We take the position that even when "family therapy" is not specifically requested by clients or relational problems are not the focus of therapy, psychologists need to be prepared to treat couple or family concerns in some capacity (directly or indirectly) so they can intervene appropriately. How well prepared are psychologists to do this?

Formal Recognition of Competence in Couple and Family Therapy

We believe that CFT is a distinct professional domain, with a robust body of theory, research, skills, and intervention models, distinct from individual psychotherapy. In contrast to Canada, regulatory and certifying bodies in the United States (US) have long established frameworks for evaluating and recognizing CFT competence, which we describe here. The scarcity of such frameworks in Canada places the onus on individual practitioners to find ways of striving to establish and maintain the levels of competence needed.

American Association for Marriage and Family Therapy (AAMFT)

Most US states' requirements for Licensed Marriage and Family Therapists (MFTs) follow the AAMFT's standards, which incorporate rigorous coursework and supervision requirements. Required are three courses in family studies, three courses in family therapy, three courses on human development, and ethics and research courses. Finally, 1000 hours of direct client contact and 200 hours of supervision are required. In Canada, where MFTs do not have a distinct licence, one can earn the AAMFT designation of "Clinical Fellow" by undertaking equivalent coursework and supervised practice (AAMFT, 2012). More recently,

the Canadian Association for Marriage and Family Therapy has begun to award the credential "Registered Marriage and Family Therapist" with similar requirements for education and supervised practice.

In Canada, as of June 2017, there were 693 Clinical Fellows of the AAMFT (AAMFT, 2017). Of the 663 who listed a professional certification/licensure or a degree, only 46 (7%) are licensed as psychologists, while 125 (19%) list social work credentials, and 120 (18%) list theological or pastoral training. The majority (58%) identify as counsellors or psychotherapists (e.g., Registered Clinical Counsellors [British Columbia] or Registered Psychotherapists [Ontario]).[3]

American Board of Professional Psychology (ABPP)

Board certification as an ABPP "Specialist," recognizes "advanced levels of practice including doctoral and post-doctoral preparation" (ABPP, 2015, p. 1). This applies to 15 specializations, including Couple and Family Psychology (CFP). For the Specialist designation in CFP, ABPP requires an APA- or CPA-accredited doctoral degree and internship (or equivalent), graduate course work and/or extensive continuing education in CFP, one year of postdoctoral training in CFP, and an oral exam based on a video work sample. As of September 2022, of the 68 ABPP board certified psychologists in Canada, one was certified in the CFP specialization.

We are not suggesting that only psychologists who possess one of these three designations are competent to provide CFT. However, these designations signify specific competency-based advanced training to the profession and the public. From an ethical perspective, we believe that the legal principle "everything which is not forbidden is allowed" (Slynn et al., 2000, p. 256) is not enough; it falls short of our ethical obligation to ensure that we are competent to the point of benefiting and not harming clients (Ethical Standard II.11).

Furthermore, competence is not binary; there are degrees of competence. For example, Patterson (2009) suggests a "level" system for self-assessing competence. "Level A" practitioners are specialists "equivalent to specialty designation as either an ABPP-or AAMFT-approved supervisor or are certified as a family or couple therapist by state licensing boards" (p. 195). Level B clinicians "regularly see couples or families conjointly, and in addition to graduate coursework in the field obtain at least 12 hours of continuing education courses [annually] and obtain consultation specifically focused in this area . . ." (p. 195). Level C practitioners "occasionally see couples or families conjointly for relatively common problems and short duration, obtain some continuing education . . . [obtain] focused consultation as needed, and have had some graduate-level training in the field" (p. 195).

In the following sections, we describe and operationalize *Responsible Caring* for psychologists practicing CFT and invite readers to reflect on their current level of competence and how to maximize it.

Principle II (Responsible Caring)

Minimally, we must "do no harm" (CPA, 2017, II. Values Statement, para 1). Although all clients are vulnerable, in families some clients are more vulnerable than others. As psychologists we "have a responsibility to responsibly care for all individuals and groups. . . . [with the] greatest responsibility be to individuals and groups in the most vulnerable position" (CPA, 2017, Principle II, Values Statement, para 6). In CFT, seniors and children, who are less articulate and powerful, are typically the more vulnerable. Accordingly, psychologists providing CFT have an added obligation to ensure that the more powerful members of the family do not dominate therapy. One way of doing this is for psychologists to ensure that the more vulnerable member(s) understand the nature and purpose of therapy and are willing to participate, and not to simply be agents of the more articulate family members.

For example, when Jeff receives a referral for child or adolescent therapy in his private practice, it usually starts with a phone call from a parent. At the first appointment (his standard practice is to see the young person and their parents jointly), after some preliminary joining (Lynch & Lynch, 2000), Jeff says to the young person, "OK, I think you know that you are here because your folks are worried about you. Your mom called me to make this appointment and told me a bit about your parents' worries about you. So, I am going to ask her to summarize our phone call. While she is doing that, please listen very carefully to see if there is anything you disagree with. There may also be some things your mom says that you agree with, so once she's done, I am going to ask you to tell me what you think, OK?" At that point, the young person usually answers with "OK" or a nod.

Jeff continues, "One more thing—parents always hate it when I say this—I just need you to know that I am not here to get you to do everything your parents want. Then you would just be a zombie or a robot . . . ." At this point, depending on the age of the child and the emotional climate in the room, Jeff may inject his best robot/zombie impersonation, and say in a droning voice, with his arms outstretched, "'I have no brain. I will do what my parents say.' You don't want to be like that, do you?" And finally, Jeff might say something like, "And one more thing. Everyone here has their own ideas, and I will listen to everybody's ideas. How does that sound?"

Jeff has found that providing an age-appropriate (and hopefully humorous) overview of the CFT process for young people does a number of things. It models transparency by having the parent recap their conversation; it invites the young

person to listen carefully to how their parent frames the problems; and it makes clear that the young person might very well disagree. This conveys that Jeff is not accepting only the parents' perspective and permits him to ask about the relational aspects of the problem, which affirms that he is not merely the parents' agent or enforcer, and that he values everyone's ideas. In this way, Jeff hopes to make space for the voice of a more vulnerable family member.

The *Code* further urges psychologists to "take care to discern and balance the potential harms and benefits to the individuals and groups involved, taking into account the degree and moral legitimacy of conflicting interests" (CPA, 2017, Principle II, Values Statement, para 4). Family members often have different interests, with different goals and different ideas about how to reach them. For example, one member of a couple might seek to end the relationship against the wishes of the other. This may be based on different values about the nature of marriage. Although pragmatically the issue is one of developing a shared goal for therapy, the need to consider the "moral legitimacy" of family members' interests is much more difficult. This requires psychologists to reflect on their own values and to ensure that their personal moral positions do not compromise their clinical judgement.

Jeff has seen many couples in which an unfaithful but regretful spouse wishes to preserve the relationship with an angry, hurt, and unforgiving partner. It is difficult to balance the "moral legitimacy" of forgiveness, remorse, the nature (or even sanctity) of marriage, and the partners' mutual contribution to marital troubles before an infidelity. The discovery of infidelity, which many if not most couples consider immoral, is often the catalyst for therapy. Usually, there is a complex interplay of factors that brings the couple to this point.

At the CFTC, Aiofe saw many adolescents with their parents. She could empathize with adolescents who desired more autonomy. Her feelings about these families varied. At times, it seemed obvious to her that parents' behaviour, which she saw as "rigid" or "authoritarian," was overkill for a teen who only wanted to taste a typical amount of freedom. Other times she was alarmed that parents were abdicating their moral duty and legal authority to care for the young person by acting passively in the face of serious, even criminal misbehaviour. Sometimes she found herself aligning more with adolescents, given her belief that parents should know better and take the lead in initiating change. She felt sorry for some parents who seemed to be "saints" in the face of abuse by the teen. And, often, parents simply wanted her to "fix" their child. In all these, Aiofe found that conceptualizing the situation systemically helped her to refrain from aligning unhelpfully with part of the family or helped her to manage her frustration with some family members.

This is not merely a theoretical exercise. In both kinds of situations above, our personal values influence our view of the moral legitimacy of family

members' positions, which in turn affects the therapeutic relationship with the family. Individual therapy often includes exploration of the single client's values and reflection on their moral positions. On the other hand, in CFT, contrasting or conflicting values can, and often do, emerge. When clients feel very strongly about their positions, perhaps because of underlying issues or deep feelings of hurt, a pattern of mutual disqualification and defensiveness can emerge, which may include an angry backlash. Psychologists providing CFT must have the skills to deal with patterns of conflict that arise within tense or even volatile therapy sessions. In our view, responsible caring in CFT requires psychologists to have the skills to interrupt volatile patterns of conflict. At minimum we must do no harm; ideally, we should have the skills to use these expressions of conflict therapeutically. We believe that psychologists doing CFT must examine their personal values and moral positions about family life, and refrain from imposing them on clients, while exercising the skills to manage difficult interactions in sessions.

Competencies in Couple and Family Therapy

Is specialized training in CFT necessary? Given our view that CFT is a distinct professional domain, we think so. The Values Statement of Principle II (Responsible Caring) states, that psychologists "engage only in those activities in which they have competence or for which they are receiving supervision" (CPA, 2017, para 5). Ethical Standard II.6 is more specific, urging psychologists to "Offer or carry out (without supervision) only those activities for which they have established their competence"—an affirmative responsibility to *establish* competence.

In a classic article on CFT competence, Tomm and Wright (1979) distinguished *conceptual*, *perceptual*, and *executive* skills in CFT. These skills or competencies are mirrored in the *Code*. For example, to conduct the necessary risk/benefit analysis, psychologists would "Assess the individuals and groups . . . adequately enough to ensure that they will be able to discern what will benefit and not harm them" (CPA, 2017, Ethical Standard II.13), and "be sufficiently sensitive to and knowledgeable about individual and group characteristics, culture, and vulnerabilities to discern what will benefit and not harm [them]" (Ethical Standard II.14). For CFT, this means that psychologists must have adequate theoretical knowledge about family development and family therapy to notice and make sense of clinical dynamics—what Tomm and Wright call *perceptual* and *conceptual* skills. In addition, Ethical Standard II.9 requires psychologists to "keep themselves up to date with a broad range of relevant knowledge, research methods, techniques, and technologies . . . through the reading of relevant literature, peer consultation, and continuing education activities." This reflects the need to possess the skills to work with multiple participants and intervene effectively—*executive* skills.

Within the discipline of psychology, Rodolfa et al. (2005) articulated a "Cube Model" of competency, which distinguished *foundational* competencies (those required of all psychologists) from *functional* competencies (the "knowledge, skills, and values necessary to perform the work of a psychologist" [p. 351] in a particular area of practice). Foundational competencies include reflective practice, research, interpersonal relationships, ethical and legal fluency, cultural competence, and understanding of service delivery systems. Functional competencies are defined as: "(a) assessment–diagnosis–case conceptualization, (b) intervention, (c) consultation, (d) research– evaluation, (e) supervision–teaching, and (f) management–administration" (p. 351). By and large there is agreement that newly registered psychologists will exercise the first four competencies almost universally. Elsewhere (Chang, 2020), Jeff argues that few opportunities exist for psychologists, even graduates from many CPA-accredited programs, to gain competence in clinical supervision (Chang, 2020). Moreover, in our experience, management-administration is practiced only by a minority of new psychologists. As such, we focus below on the first four functional competencies of Rodolfa et al. (2005), operationalizing them for psychologists who wish to develop and maintain competence in CFT.

Assessment–Diagnosis–Case Conceptualization

The first functional competency distinguished by Rodolfa et al., (2005) is *assessment–diagnosis–case conceptualization*. In CFT, the capacity to conceptualize family functioning, provide a coherent diagnosis, and plan treatment rests upon fluency in theory and research on family development and functioning, family-based assessment frameworks, and models of family therapy.

THEORY AND RESEARCH ON FAMILY DEVELOPMENT AND FUNCTIONING

Psychologists practicing CFT should have conceptual understanding of both typical and clinical families. We believe this includes: family systems theory (Smith-Acuña, 2010), the family life cycle (McGoldrick et al., 2015), diverse family structures based on ethnicity (McGoldrick et al., 2016), blended families (Bray & Kelly, 1999), divorcing and post-divorce families (Carter, 2011), immigrant families (Zagelbaum & Carlson, 2010), refugee families (Djuraskovic & Chang, 2012; van der Veer, 1999), families with an LGBTQ2S+ member (Goldberg & Allan, 2012), and families influenced by chronic or life-threatening illness (Leahy & Wright, 1987; Wright & Leahy, 1987). In addition, CFTs need the skills to explore existing theory and research about other family structures or concerns, and the capability to integrate newly acquired knowledge into their practice.

APPROACHES TO FAMILY ASSESSMENT

There are many approaches to family assessment; the scope of this chapter permits only a brief review. Two prominent approaches are worthy of mention here. The Circumplex Model views cohesion and flexibility as key elements in family functioning (Olson, 2000, 2008). Conversely, the *Beavers Systems Model of Family Functioning* (Beavers & Hampson, 2000) focuses on family competence and family style. Family style is assessed along a continuum of centripetal (inwardly focused) and centrifugal (outwardly focused) elements. Proponents of each approach developed a suite of standardized tests that use ratings from parents, children, and trained professional raters who describe behaviours of family members correlated with these theoretical constructs. With these brief descriptors in mind, the reader might correctly imagine that families at the extremes would exhibit problems. For example, problems might occur when families either lack or have an excess of either cohesion or flexibility, or when they are extremely inwardly or outwardly focused.

Jeff has used these instruments in assessments related to child protection issues, alongside measures of individual personality and psychopathology. Although many clients in child protection matters experience significant individual problems, Jeff has found it helpful to present test data about family patterns. Parents often feel less blamed and may be more likely to engage in services when the emphasis is not exclusively on their individual problems.

Among non-standardized approaches to family assessment, we are most familiar with the *IPscope* ("IP" standing for *interpersonal patterns*), developed by Karl Tomm (1991) and his colleagues at the CFTC (Tomm et al., 2014). Interpersonal patterns are coupled behaviours that bring about either problematic or helpful outcomes. Here we describe just three kinds of IPs to give the reader a flavour of the work that is possible from this perspective.

Families usually present for therapy with problems at the foreground of their thinking, so we first identify what Tomm calls *pathologizing interpersonal patterns* (PIPs). In Aoife's example of her work with adolescents and their families, parents' criticizing coupled with a young person's feelings of being misunderstood might exacerbate problems. Similarly, a young person acting aggressively coupled with parents withdrawing passively could be a problem-maintaining pattern. In response, we might have families reflect on what Tomm calls *healing interpersonal patterns* (HIPs), which are possible antidotes to a PIP. For example, parents expressing empathy might be coupled with a young person's feeling of being understood. HIPs fit under the umbrella of what Tomm calls *wellness interpersonal patterns* (WIPs), which are recurrent and healthy.

The IPscope was Aiofe's introduction to family assessment and intervention. As a budding therapist just beginning to feel competent in treating individuals, Aiofe had no clue how to begin to think about families. Practically speaking,

her supervision often entailed identifying PIPs and potential HIPs as a basis for intervention. Also, the case note format at CFTC requires identification of PIPs, HIPs, and other IPs, and the recording of their strength as experienced both by the clients and by the therapist. This "forces" trainees to think in terms of what goes on between people to complement psychology's default perspective of what goes on within people. In our view, this is a valuable avenue toward conceptual CFT competence.

MODELS OF FAMILY THERAPY

It is also necessary for psychologists working with families to have a theoretically coherent approach to therapy. Many theoretical models of CFT are adaptations of individually based theories (e.g., Crisp & Knox, 2009; Dattilio, 2010; Gerson, 2009; Scarf, 1987; Zinker, 1998). A psychologist's fluency with individual psychotherapy theories can be extrapolated to CFT.

On the other hand, many theoretical approaches to CFT are based on models of social organization or interpersonal interaction not rooted in individual psychology (e.g., Campbell et al., 1992; Haley & Richeport-Haley, 2003; Lynch & Lynch, 2000; Titelman, 2015). Such approaches focus more on what goes on between people, how interactions shape perceptions, and what we typically refer to as "personality."

In his master's program, Jeff had been trained in pragmatic, present-focused models like behavioural (Thompson & Williams, 1985), cognitive-behavioural (Meichenbaum, 1977), and instructional approaches (Martin & Hiebert, 1985). His first post-master's jobs, working mainly with "acting out" adolescents and their families, required the development of family-based case conceptualizations. He found that CFT approaches like strategic (Haley & Richeport-Haley, 2003) and structural (Lynch & Lynch, 2000) therapy, which are similarly pragmatic and present-focused, gave him concrete guidance—something he craved as a novice counselling psychologist.

Intervention: The Working Alliance in CFT

The second *functional* competency described by Rodolfa et al. (2005) is *intervention*. We just described several theoretical approaches to CFT; within each of these approaches, there is a myriad of intervention techniques. Here, we focus on the development and maintenance of the working alliance in CFT, which is essential irrespective of theoretical orientation.

The most robust research on the working alliance in CFT produced the *System for Observing Family Therapy Alliances* (SOFTA; Friedlander et al., 2006). SOFTA conceptualizes the working alliance in family therapy as having four dimensions: (a) safety within the therapeutic system, (b) shared sense of purpose within the family, (c) engagement in the therapeutic process, and (d) emotional

connection with the therapist. Friedlander et al. developed a coding system in which therapists and/or observers rate empirically derived behavioural correlates to evaluate the strength of the therapeutic alliance with the family as a whole. We assume that readers who are trained in individual counselling skills are familiar with (c) and (d), which are important in individual therapy. Accordingly, here we describe the first two dimensions, which are unique to CFT (Friedlander et al., 2006).

Safety within the therapeutic system refers to the extent to which clients feel comfortable participating fully in therapy (Friedlander et al., 2006). In CFT, it is particularly important that family members feel safe enough with both other family members and the therapist to participate in therapy without being attacked, judged, or rejected by them (Higham et al., 2012). This is more complex than in individual therapy where the client only needs to feel safe with the therapist. Clients who report feeling safe in CFT are more likely to take risks and be open to new learning. Otherwise, clients may refuse to disclose or participate, and are more likely to be defensive (Higham et al. 2012).

The extent to which family members see themselves working collaboratively to improve family relationships and achieve common therapeutic goals is called *shared sense of purpose* by Friedlander et al. (2006). Most of the time, CFT begins with family members having different views of the problem, possible solutions, and indicators of progress. Developing mutually agreeable goals that do not simply align with what one family member wants, is essential (Escudero et al., 2008).

In our work at CFTC, we found that clarifying PIPs can be very useful in inviting a shared sense of purpose. Seeing family difficulties as part of a pattern can reduce mutual blame and facilitate participation in therapy. Influenced by narrative therapy (e.g., Madigan, 2019), we have sometimes framed the purpose of therapy as a joint family project with a specific name (e.g., "Helping Wesley Restore His Reputation," "The Mutual Respect Project," or "Supporting Kendra to Overcome Fears").

Aiofe worked with Jasmine (12 years old) and her parents. Her parents only told Jasmine about her first appointment on the same day, as she was picked up from school. Naturally, Jasmine was enraged at having family therapy "forced" on her in a less than transparent way. During the first few sessions, Aiofe tried to negotiate several joint projects to develop a shared sense of purpose, but Jasmine was having none of it. Eventually, as Aiofe worked to develop safety in the therapeutic system, not judging or blaming Jasmine, and balancing her empathy and support for her with that of her parents, Jasmine began to trust Aiofe as *the family's* therapist. In the fourth session, Jasmine began to warm to the project of developing a better relationship with her parents. Jasmine objected strongly to our first attempt at naming this project "Developing More Co-operation at Home." She thought it placed the onus on her alone to change. Our revised title

"Developing More Co-operation Between Everyone at Home" was acceptable to both Jasmine and her parents. How we labelled the project was important. This illustrates the fluidity of working alliances as therapy progresses.

Supervising practicum students, predoctoral interns, and registered provisional psychologists, Jeff has observed new CFTs inadvertently emphasizing emotional connection with one member of the family over others. For example, he once observed a session in which a mother castigated her teenaged son, and then expressed a great deal of distress over his criminal behaviour. The supervisee did not moderate the mother's blamefulness of the young man, and then expressed a great deal of empathy for the mother: "It must feel terrible as a mother to see your son violate the values you've tried to instill in your son." The young man seethed as he thought the supervisee was taking his mother's side. In focusing on engagement and emotional connection with the mother, the supervisee inadvertently offended the young man.

Consultation

The third functional competency delineated by Rodolfa et al. (2005) is consultation. Family systems ideas provide useful guidance for psychologists when organizations delivering services became "stuck." Relational issues between the participants—whether these are family members, professionals within systems (e.g., frontline workers and management, physicians, and other professionals)' or different systems themselves (e.g., parents and school personnel, child protection authorities and treatment providers)—can reduce the efficacy of systems.

Family systems ideas have been used to provide consultation to a variety of organizations (Matheny & Zimmerman, 2001), including career development services (Hall, 2003); primary health care (Mayer et al., 1996; McDaniel et al., 2014; Rolland, 2015); family businesses (Lee & Danes, 2012; Pieper et al., 2013); family law/dispute resolution (Chang, 2016; Roberts, 1992); medical education (Botelho et al, 1990); oncology units (Baumann, 2006; Tolley, 1994); organizational consulting (Lee & Danes, 2012); pediatric psychology (Kazak et al., 2002; Piazza-Waggoner et al., 2013); persons with intellectual disabilities (Fennessy et al., 2015; Rhodes, 2003); preschools (Knoche & Witte, 2017; McDowell, 1999,); psychogeriatrics (Purves & Phinney, 2013); social service agencies (Imber-Black, 1988; Woodruff & Engle, 1985); sports teams (Zimmerman, 1994); and veterans with PTSD (Ohye et al., 2015).

For instance, Jeff has found CFT concepts useful when consulting with workplace teams. In one of his first forays into organizational consulting in the 1990s, the CEO of a small oilfield service company asked him to meet with a staff team that he thought was functioning poorly due to interpersonal conflicts. Structural family therapy (Lynch & Lunch, 2000) concepts like hierarchy, executive subsystem functioning, alliances, and coalitions helped him to conceptualize

the situation, intervene, and make recommendations to leadership about how to manage some aspects of the situation. He also uses the IPscope (Tomm et al. 2014) when consulting with organizations. Recently, he consulted with the staff of a social agency. Several PIPs that interfered with team functioning were identified, possible HIPs were brainstormed, and WIPs (albeit weak and largely forgotten) were unearthed and appreciated.

Research-Evaluation: Empirical Support for Family Therapy

Research-evaluation is the fourth foundational competency identified by Rodolfa et al. (2005) that is common for early-career psychologists. Given that, after graduation and licensure, psychologists are much more likely to be consumers of research than researchers, we focus here on how psychologists can stay current with the empirical evidence related to CFT.

There are a number of sources that psychologists can consult regarding the current state of CFT research. Major CFT journals and organizations publish periodic updates on the state of the evidence for CFT (e.g., Carr, 2019a, 2019b; Pinsof & Wynne, 1995; Sexton & Alexander, 2002; Sprenkle, 2002, 2012; Stratton, 2016). Many major family therapy texts (e.g., Nichols & Davis, 2017; Sexton & Lebow, 2016) contain sections on empirically supported models of CFT and review the research base of CFT. APA Division 43 (Society for Couple and Family Psychology) publishes the journal *Couple and Family Psychology: Research and Practice*. Finally, Sexton et al. (2011), seeking to encourage greater adoption of evidence-based CFT, provide criteria by which CFT research should be evaluated.

CFT Training in Canadian Psychology

CFT is not emphasized in Canadian psychology education. In preparation for this chapter, Jeff reviewed the course offerings listed on university, departmental, and program websites for the Anglophone CPA-accredited clinical (n=22) and counselling psychology (n=5) programs.[4] Based on web-based information, 13 programs have at least one CFT course listed in their program's course offerings. Eight programs have one course, four programs have two courses, and one program has more than two courses. Only one program, McGill University's counselling psychology program, requires a course in CFT. Fourteen programs do not list any dedicated CFT course.

Among programs without a dedicated CFT course, 10 describe some consideration of family systems ideas and techniques in a child/adolescent therapy course. Three programs describe covering family factors in the context of human development or psychopathology coursework. Seven programs list CFT or family systems approaches as a part or possible part of one or more clinical interventions or clinical practice courses. While it is possible that students in programs without

a dedicated CFT course are exposed to some family systems or CFT content, this likely depends on the inclination of faculty and on whether students advocate for such exposure. In contrast, Patterson (2009) indicates that most APA-accredited clinical and counselling psychology programs have at least one CFT course and several programs have a specialized track of four or more courses.

What is not clear from reviewing public web pages and university calendars is whether programs actually deliver the courses listed. For example, one clinical psychology program's webpage lists the frequency of course offerings, but the CFT course in the university calendar is not listed. In another case, a counselling psychology program lists a CFT course in the university calendar, but this course is not listed in the potential electives in the PhD program or in the underlying master's program. We understand that universities often apply budgetary pressure to academic programs to discourage them from offering low enrolment courses, and that such pressure is even more acute for labour-intensive professional practice programs. This means that students must be assertive and persistent in seeking opportunities to develop CFT knowledge—often outside of psychology.

Our experience mirrors the need to go outside psychology for training in CFT. When Jeff was seeking courses in the 1990s to fulfill requirements for AAMFT Clinical Membership, he could not find appropriate graduate psychology courses and ended up taking them in social work and nursing. The situation had not changed in the early- to mid-2000s, when he was doing his PhD. Aiofe was required to take a family therapy course as a condition of a practicum at CFTC. It was cross-listed in social work and medical science, but not as a psychology course, so she could not use it as an elective in her doctoral program. Although the course was excellent, and she had no regrets about taking it, this did not seem equitable given that no CFT course was available within her counselling psychology program.

In summary, CFT courses are not readily available in Canadian clinical and counselling psychology programs. Students can find practica or internship rotations in CFT if they are persistent and assertive. Given the proportion of psychologists who do CFT, and the paucity of coursework and clinical supervision, it is an open question as to how most psychologists establish competence.

Moving Forward to Ensure Competence

Training and Supervision Opportunities

Many psychologists who work with couples and families will continue to do so. Given the significant demand, we believe it is neither desirable nor realistic to limit the work that psychologists do with couples and families. In this chapter, we seek to open a conversation about psychologists' competence in CFT and how it

can be enhanced. Although acquiring and maintaining competence is the ethical responsibility of individual practitioners, psychology educators, practice leaders, and professional associations can ease the way for individuals. In addressing the apparent competence gap, we recommend going beyond the existing focus in Canadian surveys on the proportion of psychologists practicing CFT, and “drill down” to how psychologists developed and maintain their CFT competence. The availability of CFT training in predoctoral internship sites also should be examined.

Students interested in developing CFT competence face challenges. As noted above, CFT courses are rare in CPA-accredited programs, and courses from disciplines other than psychology may not be accepted toward licensure or as program electives. Although large organizations might hold internal seminars on CFT, smaller clinical sites may not have the resources to do so. Practicum students and interns might be able to select a site like a family service agency that provides CFT and is staffed by experienced couple and family therapists. It appears that only a small number of psychology internship consortia across the country offer rotations in CFT.

Psychologists who have completed licensure have more flexibility to chart their own course of future professional development. There are many private training programs that provide intensive training and a certification option if the learner engages in clinical supervision. For example, certification programs in Emotionally Focused Therapy (Greenberg & Johnson, 2010) and the Gottman Method (Gottman & Gottman, 2015) are currently available for those with the capacity and interest to embark on the extensive training required. AAMFT’s accreditation arm, the Commission on Accreditation of Marriage and Family Therapy Education (COAMFTE), accredits post-degree programs geared toward helping practitioners already licensed in another behavioural health discipline specialize in CFT. However, there are no longer any in Canada. Since May 2018, the Faculty of Social Work at the University of Calgary has offered a graduate-level continuing education certificate program in couple and family therapy, with coursework delivered online and supervised clinical practice. Although these programs contribute to the competence required of psychologists practicing CFT, individual psychologists must take the initiative to develop and enhance their competence by seeking them out.

Personal Perspectives

Aiofe: As a student, I came into CFT with optimism. I had some theoretical background, but not enough to give me a solid foundation. I felt excited at the prospect of learning CFT both in theory and in practice, but I had not anticipated the steep learning curve. Working with real families, I felt unprepared. Although I was learning theory while practicing with families, I became keenly aware that

there was more happening in the room than I had originally anticipated. When stepping into the room with families, I was faced with many things to attend to: (a) multiple people with different perspectives of "the problem;" (b) pre-existing relationships and alliances within the family with their own socio-cultural history that often left me playing catch-up; and (c) an expectation that I "fix" their problem. Not only was I practicing my newly learned skills as a CFT, which felt clumsy at best, but I was struggling to incorporate my existing skills into a family context. Concurrently. I was integrating old and new theoretical ideas. I sought solace in CFT books, which I found did not help me in my practice. Speaking with my classmates and supervisor, I found I was not alone. Feeling I had taken a step backward in terms of my skills, Jeff encouraged me to be patient with the process and normalized the feeling that my skills had eroded. He further suggested I stop reading because it was confusing me. I could not incorporate the theory (conceptual skills) quickly enough to help my executive skills, muddying the process. As I continued to learn, one day, it just made sense.

Reflecting on my experience, I have some suggestions for novice CFTs. First, I found the informal and open atmosphere of supervision helped me to open up and be honest about my struggles, questions, and confusion. That said, the most helpful, yet frustrating, part of supervision was Jeff's capacity to not "fix" or resolve the challenges, but to help me manage and normalize the discomfort of the learning process. The steep learning curve I experienced after having been trained as an individual therapist required significant shifts in thinking. This process takes time, and I came to realize that both the supervisor and supervisee need to be prepared to sit in the uncomfortable space of being in-between when one is learning to apply such new skills. Despite my frustration of not having someone "fix it" for me, it was a valuable experience that helped me incorporate other new skills and revise my theoretical orientation accordingly.

Jeff: As a supervisor, I have found it exciting and satisfying to support several doctoral practicum students and predoctoral interns in counselling psychology to learn CFT. Aiofe's experience, feeling she had taken a step back in terms of her skills, is common. Thinking in terms of Tomm and Wright's (1979) conceptual, perceptual, and executive skills, students who have mainly studied individual models of therapy must learn how to think about what happens between people as much as what happens within people. In terms of perceptual skills, I work to support novice CFTs to make sense of what they are seeing. In terms of executive skills, psychology graduate students often have learned to interview using an individual-based microskills approach (e.g., Cormier et al., 2016), which teaches them to be intensively present with one person. As such, new CFTs often end up being chairpersons of sessions, insofar as they engage in serial individual interviews, speaking with one family member, then another. This can lead to family members, other than the one conversing with the therapist, to "tune out." As

their executive skills develop, they learn to interview the family as a whole, using circular questions (Fleuridas et al., 1986). This enables novice CFTs to notice interpersonal patterns and invite the family into a more systemic view, which in turn strengthens their perceptual and conceptual skills.

Conclusion

Given that counselling and clinical psychologists spend a significant amount of time intervening with families, they have an ethical responsibility to acquire adequate knowledge and skill. Students and trainees seeking to develop competence in CFT must seek opportunities carefully and advocate with their universities and training sites to provide such opportunities. Community agencies need to continue to develop their capacity to serve families and to pass their knowledge on to trainees and staff. Universities should strive to provide courses within the limits of curriculum requirements and develop affiliations with training sites that serve families and couples. As a profession, psychology needs to survey stakeholders to ascertain the needs of the field. It also needs to ensure that counselling and clinical psychologists have sufficient expertise in CFT to be able to mentor newer practitioners, while socializing them to their professional identity as psychologists. Together, these elements can contribute to ongoing competence in the field of CFT, ensuring ethical practice with couples and families.

Questions for Reflection

1. In couple and family therapy, it is your responsibility to engage each person, balance the airtime each person has, and make each person feel heard. In individual therapy, you need to empathize deeply and develop understanding with a single client. Reflect on the differences between these two experiences and how they relate to your own practice.
2. Identify one or two strongly held values that you hold regarding spousal or family relationships. How might your values influence your work when you see families or couples?
3. Do you think CFT is a distinct professional domain, requiring specific theoretical knowledge and supervised practice? Why or why not?
4. Evaluate your skills and knowledge in CFT against the AAMFT Core Competencies (AAMFT, 2004) (https://www.aamft.org/Documents/COAMFTE/Accreditation%20Resources/MFT%20Core%20Competencies%20(December%202004).pdf). Develop a plan to enhance your competence over the next year.

NOTES

1. Other than the authors, all persons mentioned in this chapter have been given pseudonyms.
2. In this chapter, we use the terms "couple and family therapist" and "couple and family therapy" (both abbreviated as "CFT"). Although the terms "marriage and family therapist" and "marriage and family therapy" (both abbreviated as "MFT") are in common use, we consider "CFT" more inclusive given that not all couples are married. We retain the use of "MFT" when referring to specific organizations or a licensure status.
3. These statistics were based on a directory search for an earlier version of this chapter. It was not possible to obtain more up-to-date statistics because the AAMFT directory was reformatted and would not allow searches by province or territory only.
4. Universities listing more than one program under the "clinical" category (e.g., "clinical" and "clinical developmental") are counted as one program. Two programs are listed in more than one area: The University of Alberta's program in School and Clinical Child Psychology is counted here as a clinical psychology program. The University of Toronto/Ontario Institute for Studies in Education's program in Clinical and Counselling Psychology is counted here as a counselling psychology program.

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