Chapter 10. Comprehensive Examination

Purpose and Dates

After finishing the Research Apprenticeship and prior to the dissertation, doctoral students are required to pass a written comprehensive examination to demonstrate their knowledge of the principles of clinical psychology. The comprehensive examination is a crucial aspect of the program’s emphasis on the goal of teaching critical thinking in psychology. The exam is graded for evidence that the student can think like a scientist-practitioner, integrating knowledge from both domains. Studying for and taking the exam allows the student the opportunity to specialize in an area of psychology, and many students choose to do their comps in the area in which they plan to do their dissertation. A passing grade on comps indicates that the faculty believe that the student is ready to undertake the dissertation.

Comprehensive exams are offered once each Fall and Spring semester. The date will be announced by the department chair or Director of Clinical Training. Most clinical students take comps during the first semester of their third year in the program, which allows them to stay on track to finish the program in 5 years.

Topics

Students choose one topic about which they wish to become knowledgeable from the list of important topics in psychology provided by the faculty. This topic is the focus of their study for comprehensives. For each topic, core issues are provided to help students organize their preparation (see below). The topics that students choose from are:

1. Children, Families, and Cultures (CFC)
2. Anxiety and Anxiety-Related Disorders
3. Mood Disorders
4. Personality Theory and Personality Disorders
5. Psychotherapy Outcome and Process

Note on DSM-5

Because DSM-5 was recently published, a clarification is in order with regard to the DSM-5 material the student is responsible for in four comps areas: CFC, Anxiety and Anxiety-Related...
Disorders, Mood Disorders, and Personality Theory and Personality Disorders. Note that there is no further clarification needed for the comps areas of Psychotherapy.

For the CFC comps area, as when DSM-IV was the diagnostic manual, the exam will include the relevant CFC material in DSM-5 in all the categories in which it appears.

For a student taking Anxiety and Anxiety-Related disorders, the exam will include the DSM-5 groupings of Anxiety Disorders, Obsessive-compulsive and Related Disorders, and Trauma and Stressor-Related Disorders, for adults.

For a student taking Mood Disorders, the exam will include the DSM-5 groupings of Bipolar and Related Disorders, and Depressive Disorders, for adults.

For a student taking Personality Theory and Personality Disorders, the exam will include the DSM-5 Personality Disorders (which are largely unchanged from DSM-IV) as well as the Alternative DSM-5 Model for Personality Disorders.

The faculty realize that most of the literature is on DSM-IV or earlier, so questions may ask you to know about the literature according to the DSM-IV diagnoses and organization. However, you should be knowledgeable about DSM-5 as well in your comps area. For example, we have often had questions about changes across successive editions of the DSM, and in this vein you could be asked what changes were made from DSM-IV to DSM-5 and why (i.e., what conclusions the empirical literature suggested about shortcomings in DSM-IV for a specific diagnosis or grouping of diagnoses, and thus why DSM-5 has been changed the way it has).

There are some general changes in DSM-5 that you should be able to speak to. Examples are how developmental considerations influenced the organization of DSM-5 (especially for CFC comps); the fact that there are no longer five axes and thus how issues such as contextual factors (former Axis IV) are now addressed; and the new concept of severity ratings. Additionally, there are changes that are disorder-specific and will be relevant in that context.

**Format**

There are two 3-hour examination sessions and one page-limited take-home paper. Questions may separately address or integrate behavior disorders, assessment, therapy, theory, research issues, and history and systems (note that every exam will include at least one question on history and systems issues relevant to the topic).

The task for the take-home paper is to write a maximum of 20 typewritten double-spaced pages, not counting cover page, abstract, or references, on a question provided 4 weeks before the
examination sessions. Handwritten papers will not be read, and additional pages beyond 20 will not be read. The paper must be turned in to the departmental administrative assistant by 9 a.m. on the day of the examination sessions.

If a student has a question about the take-home, direct it to DCT, who will forward it as necessary. Some questions may not be provided with answers, if the faculty decide that the student should use their best judgment with regard to the question.

One of the reasons for the take-home question is to provide the student with an opportunity to produce a product that reflects his or her depth of study. Thus the faculty expects all work submitted to be exclusively that of the student, including editing. Students are expected to work completely independently on the take-home exam. They cannot discuss the exam with anyone, including current and past students, and especially other students taking the exam. Note also that if faculty respond to a question raised by one student, faculty will send the response to all students working on that exam question (except in the unlikely event that the question is clearly irrelevant to anyone else). Students may not ask for nor receive comments from faculty or other students on any written material they prepare in answering the take-home question.

In preparing the take-home section, students should follow the most current APA publication manual.

Within each 3-hour examination session, students may be asked one or more questions. In recent years students have generally been asked two questions per session. Citations (but not full references) are expected on the answers written on the day of the examination.

**Procedure**

**Eligibility.** For a student to be eligible to take comps in a given semester, the student's Research Apprenticeship must be completed at least 6 weeks before the examination date set by the university. Research Apprenticeship is considered completed when (1) the student has successfully completed three semesters of Research Apprenticeship; (2) the written product from the Research Apprenticeship has been approved, signed by the student's research advisor, and filed with the departmental assistant to the chair; and (3) the student has turned in the Eligibility to Register for the Comprehensive Examination form (obtainable from the departmental assistant to the chair), signed by the advisor. Although the minimum time between completion of research apprenticeship and comps is 6 weeks, it is advisable to allow a longer period to prepare for comps.

**Registration for comps.** Students must register for comps in the semester they take them. Students registering for any course work during the semester they take the Comprehensive
Examination are assessed no additional fee for the exam (register for PSY 998A, Doctoral Comps with classes). However, graduate students who have finished their course work and residency requirement (3 years of full-time enrollment) and who want only to take the Comprehensive Examination in a particular semester can register for the comprehensive examination only (one credit hour of tuition, zero course credit) during the semester that they take the examination (register for PSY 998B, Doctoral Comps without classes).

In addition to registering for the class in Cardinal Station, the student must inform the department of his or her intention to take comps by registering with the department assistant to the chair, no later than 6 weeks before the exam date set by the university. The student must also inform the department assistant to the chair of his or her chosen topic no later than 6 weeks before the exam. The assistant to the chair informs the Director of Clinical Training which topics have been chosen. As part of the procedures to ensure, insofar as possible, that the exam is graded without knowledge of the student's identity, clinical faculty are not told which students have chosen which topics. Students may, of course, inform any faculty of their topic if they so choose, but should take care to safeguard the confidentiality of other students.

**Registration for the M.A. Degree.** Doctoral students in Psychology are eligible to receive an M.A. degree when they have passed comps. As a part of registration for comps with the departmental assistant to the chair, there are graduation and admission to doctoral candidacy forms to fill out. **Note that this MA degree is in General Psychology, not Clinical Psychology; the Department does not award a master’s degree in clinical psychology.** Students who have received their MA degree should make sure to represent the degree accurately on their vita.

**Take-home question.** The assistant to the chair distributes the take-home questions to students exactly 4 weeks before the examination date set by the university. The paper must be handed in by 9 a.m. on the day of the examination sessions. (See **Format** for more details.) Students should not put their names on their papers but rather on a separate sheet that can be removed by the assistant to the chair before the paper is read.

A student is considered to be taking the exam officially once he or she has received the take-home question. Therefore a student who receives the question but does not turn in a paper or write the examination sessions in that semester fails the exam.

**Examination sessions.** On the first day designated for comps by the Department, the student takes a written exam on his or her topic in two sessions (usually 9am-12pm and 2-5pm, but check these hours to be sure in the semester in which you're taking comps). The questions asked in these sessions are not provided in advance.
Question Writing and Grading

Examination questions are written and graded by several faculty per topic. The faculty in charge of writing questions for a topic may vary from semester to semester. All students selecting a particular topic in a semester are given the same take-home and examination session questions.

Each answer, including the take-home, is graded by two faculty members, although not necessarily the same two faculty members for a student's entire exam. Exam booklets are identified only by a number, so that readers are not informed of the identity of the student. Grades are assigned independently (i.e., faculty do not discuss students' answers with each other until the exams have been graded by all readers).

Answers are graded within the range of 0.0 (F) to 4.3 (A+). The department has adopted the following guidelines for grading questions:

4.0 (A): Within the examination context, the answer addresses all parts of the question well; it is correct, pertinent, complete and well organized.

3.0 (B): The answer on the whole is acceptable with no major deficiencies in correctness, pertinence, completeness, and/or organization.

2.0 (C): The response is below an acceptable level. While some parts of the answer may be correct and pertinent, the overall quality of the answer is less than acceptable due to a lack of correctness, pertinence, completeness, and/or organization.

1.0 (D): The response is far below minimal standards of acceptability. While the correct response may be alluded to or tangentially referred to, the majority of the answer is either incorrect, irrelevant, and/or highly disorganized.

0.0 (F): The entire answer is either incorrect, irrelevant, and/or highly disorganized, or no answer is given at all.

If the two readers of a question have assigned grades that differ by more than 1 grade point (for example, one reader gives a 2.3 while the other gives a 3.4), the administrative assistant, in consultation with the Director of Clinical Training, selects another faculty member to be a third reader (without revealing the previous readers' grades). Although third readers are occasionally required, the inter-rater reliability of readers is generally very high.

When all questions have been read, the assistant to the chair averages grades from all readers. The take-home paper, morning examination session, and afternoon examination session are each
weighted equally (i.e., if two questions are asked in each examination session, then the take-home question counts twice as much as any question asked on the day of comps). All readers' grades and the overall average grade are reported to the department faculty.

The Department of Psychology faculty make the decision on the passing and failing of comprehensive exams approximately three weeks after the in-class test date. The Departmental requirements for a passing exam are (a) an average grade of 2.8 or higher and (b) a grade of 2.8 or higher on at least half of the questions asked. A student whose scores do not meet both of the requirements fails the exam. Additionally, clinical students are required to pass both the “in-class” portion (questions asked on the day of comps) and the “take-home” portion of the exam, each with an average score of 2.8 or higher. Students who complete the requirements for passing the exam and whose overall average is 3.7 or higher pass the exam with honors.

A student who fails the exam, according to university regulations, is allowed to take comprehensives a second time. For non-clinical students the entire exam must be retaken. For clinical students, if either the “in-class” or “take-home” portion of the exam has been passed successfully, the student does not need to retake that portion of the exam. In cases in which the student retakes only the “in-class” or “take-home” portion of the exam the student must retake that portion in its entirety and receive a passing grade on that reexamined portion (2.8 or higher) in order to pass the complete comprehensive exam. The same conditions for passing with honors as used for the first exam apply to the combined original and retaken portion of the exam.

The clinical faculty provides written feedback on the exam to a clinical student who fails on the first exam, with the aim of providing information to help the student prepare for taking the exam again. The faculty also will work with a student who has failed comps; for example, a student may approach a faculty member with expertise in the area in which he or she is doing comps with a request to do a readings course that will concentrate on preparation for comps.

Additional Topics

Although the comprehensive topics provide extensive coverage of important areas in clinical psychology, students may suggest additional topics for faculty consideration. To submit a topic, a student must provide the title, core issues, possible take-home questions, and possible examination session questions. An acceptable new topic will have to be similar in breadth to the topics already established. If accepted, the topic can be used for the examination by the student who submits it or any student in the semester after it is submitted.
Temporary or Permanent Cancellation of a Comps Area

The faculty must ensure that sufficient question writers and readers are available for every area offered for comps. Occasionally it may not be possible to offer comps in a given area in a semester because, for example, of faculty sabbaticals. Additionally, when a faculty member leaves, the program may need to cancel a comps area for the foreseeable future. When a comps area is temporarily or permanently canceled, the faculty will give advance notice.

Comps Study and Writing Tips

Below are listed some tips based on students’ and the clinical faculty’s combined wisdom as to how students can best study for and write passing comps answers. Naturally, we cannot promise that following these strategies will lead to a passing grade, but previous students have told us that these tips are very useful, or at least help to relieve some anxiety.

Deciding when to take comps. Most students take comps in their third year, and taking them in the Fall of the third year allows the student to stay on track for finishing in 5 years. Some students do not finish Research Apprenticeship until close to the date for registration for comps and may need to think about whether they have allowed themselves enough time to study. It is recommended that students consult with their advisors about whether they are ready to take comps. Although the advisor cannot offer assurance of passing, he or she may be able to offer perspective on whether the student is on track for taking comps or should take another semester to study.

Study tips. Consult with students who have taken comps recently in your chosen area. Some students report that they found journal articles more useful than chapters or books. We expect citations (and references in the take-home) to original empirical articles as well as review articles, so keep this in mind in your studying.

The Department has a notebook with previous comps questions. These are useful for you to see the types of questions asked. It is also useful to take some of the earlier exams under simulated exam conditions. This can help you assess how well prepared you are in both exam content and test-taking skills. Additionally, making up and then answering in writing your own exam questions can help you prepare. If you tend to get anxious during exams, it may be particularly important to practice writing answers under simulated exam conditions.

Take-home question tips. This is a paper that should read like the student has a solid grasp of the material and that you have the “big picture” about the topic of the question. The paper should appear well organized. To that end, it helps to have an introductory paragraph that tells the reader what will be covered. Headings and subheadings also give an impression of
organization and aid the reader. Be sure to have as many citations (and references) as the topic requires, and unless the question specifically asks for an historical view, many of these citations should be quite recent.

Remember that this question contributes to your final comps grade the same as two questions on the day of comps, so if you write a good take-home, you’ve really given yourself a good start on passing comps. We’re aware that you had 4 weeks to work on it, so polished writing is useful (but don’t overdo the amount of time you put into it and wind up studying insufficiently for the in-class portion).

It is recommended that you complete the take-home at least a week before the exam if possible. This will allow you time to review your articles and notes for the “in-class” portion of the exam. You may, if you choose, hand in the take-home prior to its due date, although you may not make additional revisions once you hand it in.

“In-class” questions tips. An important tip is to answer the question asked. Pay very close attention to the question asked, answering all parts. If you don’t know much about the topic, it doesn’t help to tell us a lot about some other topic instead just to show us you do know something. If you really don’t know much about the question asked, tell us what you do know, and closely related information (but keep in mind it needs to be closely related), and then tell us how you would go about learning more (i.e., a research strategy for this particular topic).

If you’re not sure about what a question is asking, it’s crucial to let us know that. If you guess but don’t tell us your uncertainty, and if you guess wrong, we’ll think you don’t know the answer and are trying to cover that fact (which leads to a low grade). We try to write clear questions, and before distributing them several faculty read each question to try to ensure its clarity, but sometimes we may write an unclear question. Tell us why the question seems unclear to you, what the different possibilities are for what it means, how you are choosing to interpret it (and thus what you will be answering) and why. Then proceed to answer the question you have told us you think we’ve asked. Even if you’ve guessed wrong about what we meant, we’ll know your reasoning and can judge whether we agree with how you got there. Often, we’ll realize from what you tell us that we were unclear, and give you the benefit of the doubt even if you’ve answered a different question from what we thought we were asking. But this can only happen if you give us your reasoning.

Organization of in-class answers is very important. It’s well worth the time to sketch out an outline. (Keep in mind, however, that the outline is not part of the answer.) Readers will have the impression that you are organized and on top of the material if you use headings in your answer. Don’t worry, however, about transitions between sections or parts of an answer. That’s an element of polished writing (which should be evident in your take-home) that’s not important
enough to worry about on the in-class questions.

As noted above, citations are expected on in-class questions (but not references). Any statement that would warrant one or more citations in a paper should have at least one or two citations in an “in-class” answer. On the other hand, don’t limit your content just so you can write down a huge number of names and dates. It’s important to cite not just review articles, but also some empirical studies, so plan your studying with this in mind. In reading citations, readers are aware that you didn’t have the sources in front of you. Give as much of a citation as possible; you’ll get more credit for the full citation, but absolute perfection is not demanded. On the “in-class” questions, it’s fine to use “et al.” for three or more authors even the first time you cite a reference (which is different from correct APA style). Give precise dates if possible; if you don’t remember the exact date, say something like “2005 or 2006.” It’s best, of course, to get the authors right, but if you’re not sure, tell us what you think they are.

It’s critical to plan your time well. An exceptional answer to one part of a question does not make up for no answer to another part of the question. If you have a multi-part question, put your emphasis in terms of time and writing on the percentage each part is worth. (If percentages are not given, assume there’s an equal emphasis on all parts.) Readers take into account that we are only giving you 1.5 hours per question. We don’t expect the same kind of answer you would be able to produce if you had more time, but we do expect you to use your time well.

Core Issues

On the following pages are the core issues for each of the topics. All inquiries about what issues are covered by a topic and other such questions should be prepared in writing and emailed to the Director of Clinical Training, and a decision will be made by the clinical faculty. Core issues in any topic area are provided as an organizational guide only. Students should understand that the list of core issues is not intended as an exhaustive catalogue of all questions that might be asked on each topic.
Comprehensive Examination Topics in Children, Families, and Cultures

The Comprehensive Exam in Children, Families, and Cultures (CFC) is aligned with the mission of the CFC concentration. As such, it assesses students’ understanding about child and family function and dysfunction within our multicultural society. It examines CFC students’ understanding of developmental and sociocultural issues impacting children and families and their ability to describe how to translate this knowledge into useful clinical applications and research approaches. From this perspective, children and families are seen as a part of a network of reciprocal influences; thus various units of this network (e.g., the individual child, the marital couple, parent-child dyads, the community, and culture) must be examined both separately and in relation to the other family components. In an effort to address the complexity of this area, a general list of topics is provided below. This is not an exhaustive list, and the topics are not necessarily mutually exclusive; i.e., you may be asked how factors in one topic area are related to factors in another. Within each topic area, you will be expected to know both historical and cultural factors, as well as how the topic is influenced by developmental changes.

A. Developmental Psychopathology

Questions will focus on those disorders commonly applied to children. Students will be expected to know diagnostic areas only as they pertain to child and adolescent behavior disorders. For example, questions in an area such as substance abuse would address only that literature which pertains to the role of substance abuse in child and adolescent disorders, not the broader scope of substance abuse as applied to adults. The selection of content areas for questions in psychopathology will correspond to the DSM-5 and dimensional constructs of psychopathology (e.g., internalizing problems, externalizing problems).

B. Conceptual Models of Developmental Psychopathology (biological, psychodynamic, attachment, sociocultural, and learning theories)

1. Etiological theories and supporting evidence regarding various childhood psychopathologies listed in (A), including the historical development of these theories as well as current perspectives.

2. Processes and factors that shape child development (both normal and abnormal), including protective and vulnerability factors in the lives of children. Factors to consider would include parent-child relationships: mutual influences between marital and family processes and psychopathology (both parental and child),
sibling relationships, relationships outside the family (e.g., peers, other adults in the community), and broader sociocultural issues such as poverty, single/teenage parenthood, and minority status.

3. Developmental continuities: Do disordered children grow up to be disordered adults? Are certain childhood conditions or symptoms more closely related to adult conditions or symptoms? How does pathology change with development?

4. Relationship between constitutional and environmental factors: What is the relationship between infant temperament and child-rearing styles, and how do each influence development? What is the interface between behavioral, genetic, and environmental models of child adjustment?

C. Assessment

1. Special assessment problems associated with children, e.g., reliability/validity of teacher ratings vs. clinical observation vs. parent ratings; problems with validity of children's self-reports; developmental considerations that must be incorporated into child assessment techniques; the role of multicultural issues in assessment.

2. Strengths and weaknesses of DSM-5 as a diagnostic tool for children (for example, the relative value of dimensional and categorical approaches).

How have organizational changes from DSM-IV to DSM-5 that are based on developmental considerations had an impact on diagnoses relevant to children and adolescents?

3. Familiarity with a variety of paradigms for assessing child behavior disorders, e.g., behavioral techniques (including self-monitoring, behavioral observation), assessment of attachment, techniques of assessing dyads within a family and whole families, child behavior checklists, play interviews, and assessment of cognitive or learning problems in terms of their contribution to behavior disorders. How these assessment approaches could be used in making clinical interpretations, in clinical decision-making, in ruling in/out emotional and behavioral problems, and in differential diagnosis.

D. Psychotherapy with Children

1. Modalities: Familiarity with theoretical approaches for the core modalities used for treating children and adolescents (individual therapy includes psychodynamic,
behavioral, cognitive-behavioral; parent guidance, family therapy, etc.). Familiarity with evidence-based practice. Empirical evidence for the therapeutic appropriateness, effectiveness, and efficacy of various modalities for child disorders.

2. **Challenges and Unique Considerations** associated with each modality for application with children, e.g., identifying the client, the involuntary client, family therapy vs. individual therapy, multicultural issues in child psychotherapy, taking into account developmental changes when evaluating outcomes.

3. **Prevention/Early Intervention:** Understanding the basic approaches to prevention of psychopathology. Familiarity with the major prevention programs in the literature (e.g., prevention for conduct problems, teenage pregnancy, Head Start).

E. **Sociocultural Processes**

1. Unique features: Biopsychosocial effects of microaggression; bias and prejudice; acculturation and ethnic identity development; multicultural frameworks in treatment; multilingual development and translation issues in assessment and intervention; mental health barriers and disparities.

2. Specific minority populations (e.g. African-Americans, LGBT populations).

F. **Research Strategies**

1. What are the major research strategies that are employed for understanding, treating, and preventing child and adolescent disorders?

2. What challenges and unique considerations must be considered in research targeting children, adolescents, and families (e.g., maturational effects in longitudinal work; potential biases in various reporting sources such as parents, teachers, peers; difficulties in self-report and self-monitoring in young children, dependency issues in data analysis)? What is the state of the art regarding approaches to sampling, research design, and analysis?

3. What resolutions have been proposed and/or used to address the problems encompassed in # 2 above?
G. Ethical Issues

1. Engaging in ethical treatment related to research with children and families, e.g., problems posed by primary prevention efforts; conflicts that arise between the child's right for confidentiality and the parents' right to access their child's assessment and treatment data.
Anxiety and Anxiety-Related Disorders

*This topic area covers disorders classified as “Anxiety Disorders,” “Obsessive-Compulsive and Related Disorders,” and “Trauma and Stressor-Related Disorders” in DSM-5. Throughout this section, the phrase “anxiety and anxiety-related disorders” refers to disorders in all three of these DSM-5 classifications.

*Given that much of the research conducted on anxiety-related disorders was based on DSM-IV rather than DSM-5, you may also cite research on DSM-IV “Anxiety Disorders” when relevant.

A. Theories and Constructs

1. Identify and evaluate the major theories of emotion and discuss how anxiety is addressed by these different theories.

2. What is the role of perception, memory, situational parameters, autonomic and central nervous system processes, neurobiology, heredity, socialization, and learning in the etiology, experience, and control of anxiety?

3. How can anxiety be conceptualized as a cognitive construct?

4. What are the potential advantages of anxiety from an evolutionary perspective? What are the potential disadvantages?

5. Compare and contrast the constructs of anxiety, fear, worry, and panic.

6. Compare and contrast the major theories of each of the anxiety and anxiety-related disorders. Evaluate the empirical evidence bearing on each theory.

7. What is the current status of the state and trait constructs in anxiety?

8. What does cross-cultural research suggest about the experience of anxiety? Do the etiology, prevalence, and experience of anxiety differ for individuals in different parts of the world? For different genders, age groups, or racial/ethnic groups here in the United States?

9. How does the construct of anxiety fit into recent conceptualizations of negative affectivity?

B. Assessment
1. How are anxiety and its related constructs (e.g., panic, fear, behavioral avoidance, cognitive processes, body sensations, and fear of fear) assessed? What are the major traditions in the assessment of these constructs? How do these assessment strategies relate to theories of anxiety? How are these assessment strategies used to establish differential diagnosis, both within the anxiety-related disorders and between anxiety and other disorders?

2. Discuss the reliability and validity of varying assessment strategies for measuring anxiety and its related constructs. How do measures differ in randomized clinical trials and clinical settings?

3. What are the relationships among different ways of (devices for) assessing anxiety and related constructs? What implications do these relationships have for theories of anxiety?

4. What are potential research strategies to further develop the assessment of anxiety and anxiety-related disorders?

C. Research Design

1. What methodological problems are present in the study of human emotion in general and anxiety in particular?

2. What research paradigms have emerged in the study of anxiety and anxiety-related disorders and their treatment? Discuss the strengths and weaknesses of these paradigms.

3. Design a study to address an unresolved issue in the a) theory, b) assessment, c) psychopathology, and d) treatment of anxiety and anxiety-related disorders.

D. Psychopathology

1. How does DSM-5 classify anxiety and anxiety-related disorders? Describe the changes that were made from DSM-IV. For each major change, describe the rationale and any empirical research that led to the changes.

2. Describe the rationale for creating separate categories for “Obsessive-Compulsive and Related Disorders” and “Trauma and Stressor-Related Disorders.” What are the similarities and differences between these disorders and those now classified as “Anxiety Disorders?”

3. Critically evaluate the current DSM-5 system with regard to anxiety-related disorders. What
are the issues involved in differential diagnosis of anxiety and anxiety-related disorders? What are the findings on comorbidity with other disorders? Critically review alternative nosological approaches.

4. Trace the historical antecedents to the current diagnostic system for classifying anxiety, focusing on the general approach to classification as well as on each specific disorder. For example, when did social phobia become a diagnosable disorder? Prior to that time, how would an individual with these symptoms have been diagnosed? What are the effects of the creation of a new diagnosis (e.g., more research, possible pathologizing of public speaking anxiety)?

5. What are the advantages and disadvantages of a dimensional classification system of anxiety and anxiety-related disorders?

6. How has the diagnostic classification (and conceptualization) of panic and agoraphobia changed over time?

7. In the absence of intervention, what is the prognosis for each of the anxiety and anxiety-related disorders?

8. What role does anxiety play in all psychopathology? What is the relationship between anxiety and depression in particular? Between anxiety and anger, stress, and mania?

9. Are the socially anxious, the phobic, the panicked person all experiencing the "same kind" of anxiety? Can they all be treated alike? What does this say about theories of anxiety?

10. What is the evidence regarding the contribution of and interaction of biological and psychological factors in anxiety and anxiety-related disorders?

11. What influence do parenting and parental anxiety have on the development of anxiety and anxiety-related disorders?

12. What is the current status of theories of the etiology of the various anxiety and anxiety-related disorders? How can we identify individuals at risk for the various disorders?

13. What is the role of panic in the various anxiety and anxiety-related disorders?

14. What is the relationship between childhood anxiety and adult anxiety and anxiety-related disorders?
15. What role does anxiety sensitivity play in the origins of panic and phobias?

16. What is the role of false alarms and learned anxiety in the anxiety and anxiety-related disorders?

17. What is the relationship between anxiety and anxiety-related disorders and personality disorders?

E. Interventions

1. What are currently the major treatment approaches to anxiety and anxiety-related disorders? What relationship do these approaches have to theories of anxiety?

2. Trace the history of treatment approaches for anxiety and specific anxiety-related disorders.

3. What factors would guide your decision in choosing a particular treatment approach for a patient with each of the anxiety disorders?

4. In the treatment of anxiety and anxiety-related disorders, how does each therapy explain the process of change, how therapists of other orientations achieve change, and spontaneous remission?

5. Critically review the empirical status of psychotherapy process and outcome research in anxiety and anxiety-related disorders.

6. On what basis have certain therapies been classified as "empirically supported" or "empirically validated"? What are the currently identified empirically supported treatments for each of the anxiety and anxiety-related disorders? Review the major studies that have lead to these conclusions.

7. What are the clinical decisions you must make from the time a client who is anxious contacts you to the time of termination?

8. How does the efficacy of any therapeutic method bear upon the theory of etiology and vice versa?

9. What is the status of combined, integrative, and eclectic treatments (both biological and psychological) for anxiety and anxiety-related disorders? What are the pros and cons of integrative treatments?
10. To what extent are particular therapeutic interventions effective across all anxiety and anxiety-related disorders, and do they show differential effectiveness across disorders? Are any of these interventions also effective in other DSM-5 disorders?

11. To what extent are particular therapeutic interventions effective for all clients with a similar anxiety or anxiety-related disorder? How do client variables (e.g., racial or ethnic background, gender) affect the outcome of these interventions? Why do some treatments that are successful for many individuals with a particular disorder fail to be effective for others? What direction should a therapist take when an established treatment fails?

12. Given what we know about the etiology and risk factors for anxiety and anxiety-related disorders, what prevention programs are suggested and what do we know about their effectiveness?

F. Integrative Considerations and Future Directions

1. What is the effect of assessment methods on treatment?

2. What is the effect of treatment methods on assessment of outcome?

3. What is the effect of assessment of therapeutic outcome on theories of anxiety and anxiety-related disorders?

4. We have typically focused our efforts at understanding negative affects while we have ignored positive affects. Speculate on how this may affect our understanding of anxiety.

5. Typically clinical psychologists turn to "basic research" in psychology for constructs and research direction. What clinical research on anxiety and/or anxiety-related disorders can be used to advance more basic research and how would it be applied?

6. What are the most important future directions for theory, assessment, psychopathology, and intervention in anxiety and anxiety-related disorders?

7. What are the most important future directions for evaluating DSM-5 and improving future diagnostic systems?
Mood Disorders

This comprehensive exam area pertains to all the conditions classified as “Bipolar and Related Disorders” and "Depressive Disorders" in DSM-5. The term “mood disorders” refers to disorders in both classifications.

A. Theories and Constructs

1. What are the theories of the etiology of mood disorders? Critically evaluate the literature concerning etiology of mood disorders.

2. Compare and contrast each of the major theories of mood disorders.

   (a) What are the major constructs of each theory of mood disorders?

   (b) What is the validity of these constructs?

   (c) How are each of the constructs operationalized and assessed?

   (d) What is the adequacy of the operationalization of each construct?

3. Evaluate the strengths and weaknesses of each theory of mood disorders.

4. What is the empirical status of each major theory of mood disorders?

5. How does each theory explain the process of change in the treatment of mood disorders?

6. How does each theory explain therapeutic change in its own system, spontaneous remission, and change via other therapeutic approaches?

B. Assessment

1. What are the ways mood disorders are assessed?

2. What are the reliability and validity of these assessment methods?

3. What are potential research strategies to further develop the assessment of mood and mood disorders?
C. Research Design

1. What are potential research strategies to address unresolved issues in etiology, assessment, process, and outcome?

D. Psychopathology

1. How does DSM-5 classify mood disorders? Describe the changes that were made from DSM-IV. For each major change, describe the rationale and any empirical research that led to the changes.

2. Describe DSM-5 changes regarding the relation between bereavement and mood disorders. Describe the rationale for the changes as well as any controversy around the changes.

3. Describe the rationale for creating separate categories for “Bipolar and Related Disorders” and "Depressive Disorders.” What are the similarities and differences between these disorders?

4. Critically evaluate the current DSM-5 system with regard to mood disorders. What are the issues involved in differential diagnosis of mood disorders? What are the findings on comorbidity with other disorders? Critically review alternative nosological approaches.

5. What is the current information on the incidence and prevalence of mood disorders? Are there cultural differences in the prevalence?

6. What is the historical perspective to the diagnostic classification of mood disorders? Critically evaluate the current classification and alternatives to it.

7. What are the changes in manifestation of mood disorders as a function of age? What are the implications of age-related issues for theory, diagnosis, and treatment of mood disorders?

E. Interventions

1. What are the major treatment approaches for mood disorders?

   (a) How are each of these different in methods of treatment (techniques), the therapist,
and client behaviors?

(b) What are the underlying rationales for the techniques employed?

(c) How do multicultural issues affect the therapist’s behavior in each treatment approach?

2. There has often been a theoretical competitiveness concerning possible causal pathways for depression and the implied treatments based on different etiological models. What empirical support can be found, for the treatment of which symptoms, based upon which theories?

3. What are the clinical decisions you must deal with, from the time an apparently mood disordered client walks into your office to time of discharge?

F. Integrative Considerations and Future Directions

1. A tragic outcome of many mood disorders is suicide. Discuss the relationship between mood disorders and suicide, including theoretical, diagnostic, and treatment implications.

2. What are the frontiers of knowledge and the potential studies to move the frontiers of knowledge in each of the major theories of mood disorders?

3. What are the most important future directions for evaluating DSM-5 and improving future diagnostic systems?
Personality Theory and Personality Disorders

A. Personality Theory

1. From a history/systems perspective, describe the evolution of theorizing in personality.

2. Discuss the debate between "person" and "environment" as it relates to personality and development. How do situational/interactional theories of personality enter the debate?

3. Provide an integrated and comprehensive definition of "personality" using a range of theoretical perspectives and constructs.

4. Discuss the Cartesian "mind/body" problem as it relates to personality theory.

5. Discuss the role personality plays in psychopathology.

6. Critically evaluate the evidence in support of genetic determinants of personality. Do the same for cultural influences on personality.

7. Discuss continuum approaches in comparison to categorical approaches to understanding personality.

B. Etiology and Assessment

1. Etiology, assessment, and treatment of the following Personality Disorders:
   a) Paranoid (301.00)
   b) Schizoid (301.20)
   c) Schizotypal (301.22)
   d) Histrionic (301.50)
   e) Narcissistic (301.81)
   f) Antisocial (301.70)
   g) Borderline (301.83)
   h) Avoidant (301.82)
   i) Dependent (301.60)
   j) Obsessive Compulsive (301.40)
   k) Other Specified Personality Disorder (301.89)
   l) Unspecified Personality Disorder (301.90)
C. Further Issues in the Assessment of Personality Disorders

1. General problems in the assessment of personality disorders (i.e., problems with classification systems).

2. Describe the “Alternative DSM-5 Model for Personality Disorders” in Section III of DSM-5. In practical terms, how would you go about making a personality disorder diagnosis using this system? Critically evaluate this system, citing relevant research.

3. Diagnosis of multiple disorders.

4. DSM-5 as a diagnostic tool for personality vs. alternative nosological approaches.

5. DSM-5 issues: historical development of the personality disorders criteria, criticisms of the current system, overlapping diagnoses for each personality disorder.

6. The validity and reliability of personality assessment (i.e., objective, projective, self-report, observer/rater).

7. Issues of minority/cultural biases in personality assessment instruments (both objective and projective personality assessment instruments).

D. Issues in the Treatment of Personality Disorders

1. Major theoretical approaches (behavior therapy, interpersonal and family therapies, psychodynamic therapy, cognitive therapy, group therapy, supportive therapy, pharmacotherapy) for treating the above disorders. Empirical evidence for therapeutic effectiveness and appropriateness of various modalities for each disorder.

2. Special problems associated with personality-disordered clients in treatment, including "typical" reactions to the therapy situation by each disorder, and common "countertransference" reactions of therapists.

3. Special problems in evaluating psychotherapy outcome in personality-disordered
clients.

E. Research Design Considerations

1. Discuss the methodological problems present in the study of personality in general and personality disorders specifically.

2. Identify any emergent research paradigms that have attempted to study personality disorders, and discuss their strengths and weaknesses.

3. Identify research directions for evaluating the proposed alternative DSM-5 model and improving future classification of personality disorders.
Psychotherapy Outcome and Process

A. Theoretical Perspectives

1. What are the basic theories of psychotherapeutic intervention?

2. What factors are postulated to account for the process of change in each psychotherapeutic approach? What research evidence exists pertaining to these factors?

3. Trace the history of each theoretical system, noting major contributions and changes that have taken place over time since each theory was first developed.

4. How would each system explain failure to change?

5. What integrative and eclectic theories of psychotherapy currently exist?

6. What change factors are common to all therapies? What evidence exists to support these conclusions?

7. What is the relationship between change in psychotherapy and change as a result of other processes, e.g., maturation?

8. How can developmental and social psychological processes for understanding behavior change (e.g., attachment, attribution theory, persuasion and interpersonal influence, expectations, labeling, interpersonal attraction, cognitive dissonance) be applied to psychotherapy?

B. Methods of Therapeutic Intervention

1. Compare and contrast contemporary psychotherapeutic interventions.

2. Trace the history of each major approach, noting changes across time in the practice of psychotherapy and specific methods utilized by practicing clinicians.

3. For each major approach, in what way are the methods and interventions used dependent on the diagnosis of the client? What methods have been developed for specific DSM diagnoses?

4. What are issues in combining psychotherapy approaches? What are the similarities and
differences between different approaches to integration (e.g., technical eclecticism, assimilative integration, theoretical integration, etc.)? Describe and evaluate the integrative and eclectic treatments that have been proposed. What are the challenges in studying the efficacy and effectiveness of integrative or eclectic treatments?

5. What are issues in combining psychosocial and pharmacological treatments (e.g., issues in working with a psychiatrist who is prescribing the medication; issues in the therapeutic alliance)? What are the efficacy/effectiveness findings on such combined treatments?

6. What effect has managed care had on the practice of psychotherapy? On training in psychotherapy?

7. What is the relationship between method and theory, e.g., does one necessitate the other, how does evidence pertaining to one affect the other?

8. What special problems exist associated with psychotherapy with children (e.g., who is the client, the involuntary client, parent-therapist relationship, multiple individual therapists in the family context)?

9. Compare and contrast the process of change in and effectiveness of psychotherapy vs. non-traditional forms of help giving (e.g., counseling by paraprofessionals, bibliotherapy, self-help groups).

C. Assessment in Psychotherapy

1. What are the most important criteria for evaluating the outcome of psychotherapy? Which of these criteria are applicable regardless of psychotherapy school or approach? Which are specific to the approach chosen?

2. What methods and measures have been developed for assessing psychotherapy outcome, including techniques such as meta-analysis?

3. What methods and measures have been developed for assessing psychotherapy process?

4. How is the assessment of psychotherapy outcome different in clinical practice from what is employed in randomized clinical trials? In efficacy vs. effectiveness research?

5. What problems exist in the assessment of psychotherapy outcome and process? What role do reliability and validity play?
D. Outcome of Psychotherapy

1. Critically evaluate current conclusions concerning the efficacy and effectiveness of psychotherapy.

2. On what basis have certain therapies been classified as "empirically supported" or "empirically validated"? What are the currently identified empirically supported treatments? Probably efficacious treatments? Review the major research studies that have lead to these conclusions. What are the advantages and disadvantages of this approach?

3. What psychotherapies not on the most current list will likely be classified as empirically supported in the near future? What kind of research is needed for a brand-new therapy approach to be considered empirically supported?

4. To what extent are the research findings on therapeutic efficacy generalizable to the real-world conditions of psychotherapy practice? How can research become more relevant to the practicing clinician? What research designs are useful in studying the effectiveness of therapy?

5. What are ways of studying the cost-effectiveness of psychotherapy? What are current conclusions?

6. What is the status of the literature on negative or deterioration effects in psychotherapy?

7. What therapist variables affect psychotherapy outcome?

8. What client variables affect psychotherapy outcome?

9. What is the importance and role of client and therapist expectancies?

10. What are findings on the effect of length of treatment on client outcome? Are there variables that moderate this effect?

11. What factors promote maintenance of therapy change?

12. What factors promote generalization of change?

13. What special problems might exist in evaluating psychotherapy outcome with children?
14. What factors influence who seeks psychotherapy and who stays in therapy?

15. Trace the history of psychotherapy outcome research over time.

E. Selection and Matching

1. Discuss "uniformity myths" and their effects on psychotherapeutic process and outcome.

2. Critically evaluate the appropriateness of psychotherapy for special populations (e.g., minority groups, disadvantaged, mentally retarded, etc.).

3. Critically review the empirical literature pertaining to the matching of clients to appropriate treatment.

4. What do the theory and research on stages (and levels) of change suggest about client-treatment matching?

5. What is the effect of client-therapist similarity or differences on the outcome of therapy (e.g., gender, racial/ethnic background, sexual orientation)?

6. What special problems exist associated with psychotherapy with clients from different backgrounds from the therapist (e.g., gender, racial/ethnic group, sexual orientation, SES)? What should therapists do, know, or be aware of when working with such clients? What are the findings on how to maximize effectiveness with clients who have a different background from the therapist?

7. What characteristics differentiate informal help-seekers vs. formal help-seekers vs. non-help seekers?

8. Compare psychotherapy and self-change methods (change without therapy).

F. Psychotherapy Process

1. What are current research programs and findings on psychotherapy process in major psychotherapy approaches? What is the theoretical basis of current process research paradigms, such as critical moments and markers?

2. What role do "nonspecific" factors play in producing change?

3. What is the importance and role of the therapeutic alliance? In what way is this relationship
similar and different across varying approaches to psychotherapy? How is the therapeutic alliance related to therapy outcome? What other aspects of the relationship (e.g., empathy) are related to outcome? What are theories and empirical findings on ruptures or impasses in the alliance?

4. What is the importance and role of resistance?

5. What are current theories and findings on the role of emotion in psychotherapy?

6. Trace the history of psychotherapy process research over time.

G. Research Methods in Psychotherapy

1. How have group comparison and single-subject research designs been applied to the study of psychotherapy?

2. Which treatment evaluation strategies have been adopted to study psychotherapy outcome?

3. Which research designs have been used to investigate psychotherapy process? Discuss from a historical perspective, including new applications of earlier research (e.g., 1950's, 1960's, or earlier), as well as more recent methods such as task analysis. What are the advantages and disadvantages of qualitative vs. quantitative research?

4. What control groups are needed for answering which specific questions?

5. What ethical issues exist in research on psychotherapy? How can these be dealt with?

6. What practical research strategies can be utilized by the clinician in applied settings?

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