University of Hawai‘i

Department of Psychology

Clinical Studies Program

Practicum Handbook

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2016-2017 Academic Year Update

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INTRODUCTORY STATEMENT

Dear Practicum Students and Supervisors:

The purposes of this Handbook are to describe the philosophy of training offered by the Clinical Studies Program (CSP) and to provide guidelines for the implementation of this philosophy in the practicum setting. Because some of the CSP practicum training occurs at community sites, we hope that this Handbook will help integrate the didactic and applied portions of training for students, campus supervisors, and site supervisors.

The forms found in this Handbook are designed to provide students ideas on how to document and justify psychological services in a typical Clinic. We realize that this Handbook is not a substitute for expertise or information on clinical matters that can be acquired through extensive reading, supervised experience, and the opportunity to exercise clinical judgment. We appreciate that each practicum setting has its own established protocol that students will be required to follow at the site. As such, please use this Handbook as a reference

We hope your involvement in training will be rewarding and that this Handbook enhances the affiliation between the CSP and practicum sites.

Sincerely,

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PRACTICUM TRAINING PHILOSOPHY

Scientist-Practitioner Approach

The CSP training approach is based on our value that the most humane psychological assessments, interventions, and consultations are those that are evidence-based. This value is reflected in the Program's cognitive behavioral and biopsychosocial theoretical orientation. The scientist-practitioner approach includes accountability for the effectiveness of services, evidence-based clinical decisions, and ongoing assessment of outcome. Basic and applied psychological science guide the rationale for clinical services. Scientific methodology and statistics inform clinical decisions.

Students in the CSP devote their first year of training to basic psychology, scientific methods, statistics, professional ethics and issues, psychopathology, and diagnostic assessment. The assessment course includes analogue practicum experiences involving "professional" clients (i.e., undergraduate student volunteers). Students engage in required clinical practicum training during the second and third years of the program. Concurrent with practica, students complete clinical courses in psychotherapy, adult and childhood disorders and treatments, and ongoing assessment. With this background, it is hoped that practicum students will enter training sites prepared to synthesize classroom and clinical experience. This is facilitated by the provision of both on-campus and onsite supervision and oversight. In addition to required clinical courses and practicum training, advanced students usually take elective clinical courses (e.g., neuropsychology), continue to take courses in basic psychology and statistics, and pursue their own research (including a Masters thesis and Doctoral dissertation). The emphasis upon science and research reflects the philosophy that the knowledge-base in clinical psychology will develop only if those trained in the discipline are accountable for services provided and contribute information to the discipline. Graduates of the CSP are trained to provide direct clinical services, program planning and evaluation, and organizational consultation as well as to conduct research and teach at the university level.

Practicum Training

The following are general guidelines to supplement the specific details concerning training at each individual practicum site.

Because the CSP affiliates with a number of community agencies, it is important to outline expectations of the agency, the student, and the onsite supervisor. The practicum commitment is for 15 - 20 hours per week, typically for two academic semesters. Students entering their first practicum will have a developing background knowledge in clinical psychology, but may have little direct clinical experience.

Agency. Within the constraints of the population the agency serves, students should have an opportunity to provide psychological services to a range of clients (e.g., adults, children, families, and groups) with a variety of presenting problems. As much as possible, the agency's service opportunities should include evidence-based

assessment, consultation, psychotherapy, program planning, and program evaluation. Approximately 10 hours of client contact per week should be available to the students. Case conferences and supervision should be available at the agency on a regular basis.

Students. Practicum students will maintain the highest of professional ethics and standards and execute all clinical services according to the values of the scientist-practitioner and the guidelines in this Handbook. Students will prepare for provision of empirically-based services by reading relevant literature, attending case conferences and seminars, and actively participating in supervision. Students should be able to explain the purpose and evaluate the effectiveness of all assessment and intervention approaches selected. Students will come to case conferences and supervision prepared as explicated by their supervisors in their particular practicum site. Such preparation could include a summary of the session or consultation, scored and interpreted tests, background reading, consideration of the next steps or new directions, and the generation and support or refutation of clinical hypotheses via treatment formulation and assessment. Students should also select and provide a rationale for empirically-supported assessment and treatment approaches. It is also recommended, if consistent with the operations of the particular site, that students provide a therapeutic contract with clients outlining expectations and responsibilities by all parties as well as a description of the known effectiveness of the proposed intervention.

Supervision. In most cases, an onsite doctoral level psychologist provides clinical supervision. Simultaneously, course enrollment in the courses Child Practicum or Adult Practicum will provide on-campus oversight (or at times, direct supervision) of clinical activities by a CSP faculty member or instructor. It is recognized that each site and each supervisor will have his or her own supervision style and involvement. As much as possible, however, supervision should include observation by the supervisor or other students or a review of an audio or video taping of the client contact. The supervision should focus upon general clinical and professional skills, empirically-based assessments and therapies, and assistance in addressing the student's sense of ambiguity and anxiety.

Early in the student's experience, supervision might also include a point-by-point comprehensive review of a session or consultation. However, later supervision might focus on larger more significant issues, such as evaluation of treatment effectiveness. Supervisors are encouraged to evaluate students on clinical skills in empirically-supported assessment and treatment, knowledge base in relevant literature, use of adequate evaluation of treatment effectiveness, use of maintenance strategies and provision of client follow-up.

ETHICS AND STANDARDS

This section is intended to acquaint trainees with general policies and information that will contribute both to the efficient operation of clinical sites and to the professional development of trainees. It will also help trainees to understand the responsibilities they are asked to assume during practicum.

The trainees working in clinical settings should maintain a mature, responsible role with their clients. While the onsite supervisor will be the most immediate authority on proper procedures in answering questions that arise in interaction with clients, CSP faculty members are also available for consultation.

In order to work effectively, clinical trainees clearly must become familiar with a certain fund of base-rate information, instruction and "tradition" in interacting with and treating clients. Trainees will learn much of this in supervision and more formal classwork. In addition, trainees are encouraged to read and be conversant with the following materials to prepare for client contact:

American Psychological Association. (2010). Ethical principles of psychologists and code of conduct. Retrieved from http://apa.org/ethics/code/index.aspx

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

American Psychological Association. (1973). Ethical principles in the conduct of research with human participants. Washington, DC: Author. (also see: http://www.apa.org/ethics/code2002.html)

American Psychological Association. (1985). Technical standards for educational and psychological tests. Washington, D.C.: APA. (also see: http://www.apa.org/science/standards.html#overview)

American Psychological Association. (1987). Casebook on ethical principles of psychologists. Washington, D.C.: APA.

American Psychological Association. (1987). General guidelines for providers of psychological services. American Psychologist, 42, 712-723. (also see: http://www.apa.org/pi/guide.html)

American Psychological Association. (1995). Training in and dissemination of empirically-validated psychological treatments: Report and recommendations. The Clinical Psychologist, 48, 3-24.

Barlow, D. H. (Ed.) (2007). *Clinical Handbook of Psychological Disorders: Fourth Edition: A Step-by-Step Treatment Manual.* (4th Ed.). New York: Guilford.

Beck, J. S. (1995). *Cognitive Therapy: Basics and Beyond*. New York: Guilford.

Bellack, A.S. & Hersen, M. (Eds.). (1998). Behavioral assessment: A practical handbook. MA: Allyn and Bacon.

Bennett, B. F., Bryant, B. K., VandenBos, G. R., & Greenwood, A. (I990). Professional liability and risk-management. Washington, D.C.: American Psychological Association.

Chambless, D.L., Baker, M.J., Baucom, D.H., Beutler, L.E., Calhoun, K.S., Crits-Christoph, P, et al. (1998). Update on empirically-validated therapies II. The Clinical Psychologist, 51, 3-21.

Chambless, D.L. & Ollendick, T.H. (2001). Empirically supported psychological interventions: Controversies and evidence. Annual Review of Psychology, 52, 685-716.

Dobson, D., & Dobson, K. S. (2009). *Evidence-based Practice of Cognitive-Behavioral Therapy.* New York: Guilford.

Dobson, K. S. (Ed.) (2010). *Handbook of Cognitive-Behavioral Therapies.* (3rd Ed.). New York: Guilford.

Fischer, J., & Corcoran, K. (1994). Measures for clinical practice. (Vols. 1-2). New York: The Free Press.

Goldfried, M., & Davison, G. (1994). Clinical Behavior Therapy (expanded edition). New York: Wiley.

Greene, R. L. (1999). The MMPI-2/MMPI: An Interpretative manual (2nd ed.). Boston: Allyn and Bacon.

Groth-Marnat, G. (2003). Handbook of psychological assessment (4th ed.). New York: Wiley.

Haynes, S.N., Leisen, M.V., & Blaine, D.D. (1997). Functional analytic clinical case models and clinical decision making. Psychological Assessment, 9, 334 - 348.

Hersen, M. & Turner, S.M. (Eds.) (1994). *Diagnostic interviewing.* New York: Plenum Press.

Ivey, A.E., Gluckstern, N.B., & Ivey, M.B. (1997a). *Basic attending skills.* North Amherst, MA: Microtraining Associates.

Ivey, A.E., Gluckstern, N.B., & Ivey, M.B. (1997b). *Basic influencing skills.* North Amherst, MA: Microtraining Associates.

Jacobs, D., & Brewer, M. (2004). APA practice guideline: Provides recommendations for assessing and treating patients with suicidal behaviors. *Psychiatric Annals, 34,* 373-380.

Kazdin, A. E., & Nock, M. K. (2003). Delineating mechanisms of change in child and adolescent therapy: Methodological issues and research recommendations. *Journal of Child Psychology and Psychiatry, 44,* 1116-1129.

Ledley, D. R., Marx, B. P., & Heimberg, R. G. *Making Cognitive Behavioral Therapy Work*. (2nd Ed.). New York: Guilford.

Lezak, M.D. (1995). *Neuropsychological assessment* (3rd ed.)*.* New York: Oxford Press.

Meehl, P. (1973). Why I do not attend case conferences. In P. Meehl (Ed.), *Pschodiagnostics: Selected papers* (pp. 225-302). New York: Norton.

Miller, W.R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing People for Change.* (2nd Ed.). New York: Guilford.

Milne, D., Sheikh, A., Pattison, S & Wilkinson, A. (2011). Evidence-based training for clinical supervisors: A systematic review of 11 controlled studies. *The Clinical Supervisor, 30*, 53-71.

Nathan, P.E. & Gorman, J.M. (Eds,) (2002). *A guide to treatments that work* (2nd ed.). New York: Oxford University Press.

Robinson, J.P., Shaver, P.R., & Wrightsman, L.S. (1991). *Measures of personality and social psychological attitudes.* San Diego, CA: Academic Press.

Roth, A., & Fonagy, P. (2004). *What Works for Whom? A Critical Review of Psychotherapy Research.* (2nd Ed.). New York: Guilford.

Sattler, J. M. (2006). *Assessment of children* (5th ed.). San Diego, CA: Jerome M. Sattler, Publisher.

Schutte, N.S. & Malouff, J.M. (1995). *Sourcebook of adult assessment strategies.* New York: Plenum Press.

Special section: Empirically supported psychological therapies. (1998). *Journal of Consulting and Clinical Psychology, 66,* 3-167.

Sturmey, P., & Hersen, M. (2012). *Handbook of Evidence-Based Practice In Clinical Psychology.* New Jersey: Wiley.

Van Hasselt, V.B. & Hersen, M. (Eds.) (1996). *Sourcebook of psychological treatment manuals for adult disorders.* New York: Plenum Press.

Wright, J. H., Basco, M. R., & Thase, M. E. (2006). *Learning Cognitive-Behavior Therapy: An Illustrated Guide.* Washington, DC: American Psychiatric Publishing.

Interagency Standards and Practice Guides, Department of Health and Department of Education, State of Hawaii: http://www.hawaii.gov/health/mental-health/camhd/library/pdf/purplebook.pdf

Confidentiality

1. Definitions

The following definitions and observations are taken from:

Siegel, M. (1979). Privacy, ethics, and confidentiality. Professional Psychology, 10, 249-258.

PRIVACY refers to the freedom of individuals to choose for themselves the time and the circumstances under which, and the extent to which, their beliefs, behavior, and opinions are to be shared or withheld from others.

CONFIDENTIALITY involves professional ethics rather than any legalism and indicates an explicit promise or contract to reveal nothing about an individual except under conditions agreed to by the source or subject.

PRIVILEGE (or privileged communication) is a legal term involving the right not to reveal confidential information in a legal procedure. Privilege is granted by statute, protects the client from having his/her communications revealed in a judicial setting without explicit permission and is vested in the client by legislative authority.

A breach of privilege is a breach of confidentiality, but a breach of confidentiality may be outside the scope of privilege (e.g., if it occurs outside of any legal proceedings).

Breaches of privacy and confidentiality often occur in a seemingly innocuous manner. For example, a psychologist should never discuss a client in the presence of another client, family, friends, or anyone. Whether on the telephone or in person, a psychologist should simply not make clients an item of casual gossip or chitchat. 'I have a client who - - - ' is all too often the kind of casual party-talk that is potentially destructive. The only exception to any of the above is the professional staff or case conference, or the supervision hour in which case the colleagues involved are bound by the same ethical practices. Discussion of client problems with fellow clinical graduate students for purposes of consultation is definitely to be encouraged, but only when undertaken under conditions of

utmost confidence (i.e., no use of client names; discussion occurs in the Clinic or other comparable private settings).

Along related lines, psychologists should answer no questions on the telephone except when the caller is clearly identifiable and well known to the psychologist, and the informed consent of the client has been obtained. In general, such matters should be done in writing and on proper authorization.

2. Effect on Clinical Procedure

The importance of confidentiality cannot be overstated. The assurance that the information the client reveals in interviews is kept in strictest confidence can make the difference between successful therapy and failure. For example, the client must be informed if, for training purposes, recording devices are employed or a colleague-assistant is observing behind a one-way mirror. We suggest that if they are to be employed in a particular case, trainees inform their clients of these procedures at the outset of consultation, rather than intrusively reminding them on a session-by-session basis. To assist you in providing this information to clients, two steps can be taken. First, the intake interviewer could describe the dual training-service functions of the Clinic to a prospective client during the latter's first phone contact or intake interview. This description could include the Clinic's use of observation and recording devices for professional training only (if applicable). Secondly, the intake interviewer could present the client with appropriate consent forms.

During the screening intake the interviewer should inform the client of several possible exceptions to a policy of strict confidence. One would be if the client's record were subpoenaed by a court of law. Another would be when a client's revelations or threats of wrongdoing clash with legal obligations to report (e.g., child abuse or suicide). Also see details of the Tarasoff precedent (e.g., 'Tarasoff and the Duty to Warn", in Professional Psychology, 1977, 8, 125-128; "Tarasoff.-Five Years Later', in Professional Psychology, 1982, 13, 511 - 516) and consult appropriate items on reading list above. Finally, you may ask a client to waive confidentiality by obtaining their consent in writing in order to share information about them with another professional, or to seek information from said professional.

These policies also pertain to children and students. The clinician is responsible for discussing the seeking or releasing of information before it happens, and to share only such material as will benefit the client. In the case of a school-age child, especially if the school has shared its records or has had a part in the referral, the parent should be advised that any material that will be helpful to the child in the school situation will be shared with the school. However, it is important that the release form authorizing this be signed by the parent.

Cultural and Diversity Competence

The CSP program expects students to demonstrate willingness and effort to develop cultural and diversity-related competency, and the ability to work effectively with individuals from diverse groups. This is one of the most important ethical standards for trainees to follow. During the course of training, students are expected to exhibit the ability to work effectively, benevolently, and without discrimination, with those from traditionally marginalized groups.

Students should familiarize themselves with APA's document, "Preparing professional psychologists to serve a diverse public: A core requirement in doctoral education and training", available at http://www.apa.org/pi/lgbt/resources/policy/diversity-preparation.aspx. In this document, students are described as training to become psychologists who can competently serve all members of the public by developing acceptable knowledge, skills, and awareness to work effectively with diverse individuals. At times, potential conflicts may arise between trainees' personal views, beliefs, and religious values and those of clients. Such conflicts may at times even impede the provision of competent professional services. It is essential that such potential conflicts be explored, understood, and addressed during training so that trainees are prepared to interact beneficially with all of their clients, especially those from traditionally marginalized or discriminated groups.

Supervisors are to help trainees to develop the competency and skills, as well as the cognitive flexibility required to serve a side diversity of populations, including those from all ethnic/racial backgrounds, sexual orientations, religious traditions, ages, and disability statuses. The CSP program is responsible for ensuring that trainees exhibit the ability to work effectively and beneficially with clients whose group membership, demographic characteristics, or worldviews may be different from their own. Trainees should not expect to be exempt from having any category of potential clients assigned to them for the duration of their training. Students can consult with supervisors on issues related to work with diverse groups, and they are also welcome to consult with CSP faculty members on this topic.

The following section is provided as a guide only. It is understood that each practicum will have its own set of policies, procedures, forms, and record-keeping mechanism. Students should consult with their supervisors for site-specific instructions.

CASE ASSIGNMENTS

A. Client Referral

Every attempt is made to maintain diversity in the client population of the CSP practicum sites. Therefore, over the two years of required practicum, clients should comprise a full range of diagnostic categories and ages, including adults, children, families, couples, etc. The decision to assign clients to trainees for assessment, consultation, etc., or refer them should be mindful of the desirability of the case for training purposes. However, the trainee must also consider his/her ability to provide the necessary services warranted for each potential client. Some trainees mistakenly believe that, once assigned a client, they must proceed to offer that client a full range of Clinic services. However, initial assessment meetings may lead the trainee and supervisor to conclude that the client cannot benefit from consultation with the trainee or in the Clinic. The decision to refer, to continue treatment, or to terminate further client contact is always the responsibility of the trainee and supervisor.

Sometimes individuals contact a Clinic without the knowledge of a therapist with whom they are currently consulting. Professional relationships and the welfare of the client may be jeopardized unless these individuals are advised to discuss such changes with their current therapist. If prospective clients assert their desire to switch therapists, claim that their other therapist assented, or simply decline to discuss their dissatisfaction with their current therapist, that is their right. In some of these situations, it may be useful to seek the client's authorized consent in order to contact the other therapist. In such cases, the trainee should work closely with the supervisor to consider the cost-benefits, to observe professional protocol and ethical guidelines, and to consider any potential effects on the newly-developing therapeutic relationship.

B. Initial Contact Interview (Intake/Screening)

At the time of the intake, the client can (depending on the site) complete New Client Information and History and Personal Data Forms (see Appendix A) or a comparable form provided by the site. Clinics usually conduct an initial, brief intake interview for screening and information purposes. How the potential client is approached at this first contact, how the Clinic is presented, and how clients interpret responses to their questions are important factors in their acceptance or rejection of further contact.

The intake interview is a two-way information exchange. The interviewer tries to learn both the client's problems and whether or not the Clinic could be of service. At the same time, the Clinic's function is explained so that the client can begin to determine whether or not the types of services offered appear suitable. In addition, the client will be presented with information regarding fees and release forms (as appropriate). Also obtained are client signatures on initial consent forms (see Appendix B as an example) and the client's schedule of hours available for appointments. Finally, an Intake Form (see Appendix C) can be completed and assignments are made to a Clinic staff or trainee. Suggestions for intake interviewing are in Appendix D.

C. Contacting the Client

When you receive your Clinic assignment, consult with your Clinic supervisor. Each client must have a trainee and a supervisor responsible for them at all times. Supervisors typically request some consultation about a case--based on Intake information--prior to the first assessment or therapy appointment. Therefore, consult your supervisor before meeting your new client.

In most cases, appointments may be arranged by telephone. When calling, the trainee should identify himself or herself by name even if the requester is not the client. Vague responses like "a friend,' or 'never mind, I'll call later' only create an uncomfortable cloak-and-dagger situation at the other end of the line. However, care must be exercised to protect the confidentiality of the client. Thus, the trainee should not reveal his/her Clinic affiliation to anyone but the client. This also applies to leaving messages. It is best to call a second time rather than leave the Clinic number. In writing to a client, it is important that the Clinic address is not given on the outside envelope; please use a blank stamped envelope. However, do use official Clinic letterhead if available.

In the event that a client informs the assigned therapist that (s)he has decided not to pursue treatment (whether this is a new referral or a transfer case), the therapist should write a note explaining the reasons for closing the case, sign and date it, and place it in the client's file.

D. Appointments

After an appointment has been made, it must be recorded in the Clinic's schedule book (varies widely by clinic). This may involve informing the secretary of the date and time of the appointment and scheduling a room. Be sure to make your appointments and room reservations in advance. The trainee is also responsible for notifying the Clinic secretary of changes or cancellations of appointments. This will facilitate making new appointments and assure the client of the clinician's interest. By the same token, notice received at the Clinic of changes or cancellations should be forwarded to the trainee as quickly as possible by the secretary. Therefore, be certain the Clinic has a record of your current home and office addresses and phone numbers, and notify the Clinic

immediately of any changes-both permanent (e.g., moving to another residence or placement) and temporary (e.g., vacation). Speak to your supervisor for specifics related to your site.

In the event that a personal emergency arises and the trainee will be late or unable to see the client, an attempt should be made to reach the client. If one is unable to do so, contact the Clinic secretary so that the client can be notified.

E. The First Meeting

There are certain issues which trainees should plan to address during their first meeting with a new client, even though the intake interviewer may already have broached these topics. These issues include: confidentiality, observation and/or taping or sessions, payment, and treatment planning (including length of treatment and/or current session allocation).

In addition, it is usually helpful to discuss the client's expectations regarding psychotherapy. Attention to these matters should serve not only to orient the client to the psychotherapy process, but to begin forming the therapeutic alliance as well. Supplying a copy of the Client's Guide to Psychotherapy (see Appendix E) is worthy of consideration.

F. Assessment

Trainees should plan with their supervisor to determine which assessment strategies (e.g., testing, observations, questionnaires, self-monitoring, etc.) are most appropriate in any given case. Trainees should seek to accomplish baseline, process, outcome, and follow up measures of the progress of therapy for each client. Each target behavior (e.g., depression, assertiveness) should be measured using multiple methods (e.g., self-monitoring and questionnaires) and multiple sources (e.g., self, spouse, clinical rating). When the client has come to the Clinic for assessment only, then trainees should be prepared to provide clarification of the referral question and a rationale for each measurement device and procedure selected.

When testing is being conducted with children and young adolescents, the age of the child and the nature of the presenting problem may influence the evaluation procedures. The testing situation should be informal and geared to the particular child. This approach does not de-emphasize the significance of more formal testing. Tests can be an efficient way of getting to know the child's individual abilities and attitude toward success and failure.

Trainees should not be restricted to the Clinic area during either assessment or treatment. Beyond traditional test instruments and batteries, trainees may desire to undertake various kinds of analog or field observations, ranging from settings such as local shopping centers to public school or college classrooms, to using other trainees to create special situations (i.e., public speaking seminar,

opposite-sex encounters, etc.). Like the choice of more traditional test instruments, decisions regarding "in vivo" or "ecological" assessments should be made in conjunction with the case supervisor. At all times, care must be taken to avoid jeopardizing client confidentiality while still delivering maximally beneficial assessment and treatment services.

Suggestions for preparation of an Assessment Report are provided in Appendix F. Additional suggestions for ongoing assessment of treatment process and outcome are addressed in the Treatment section.

G. Consultation

1. General Comments

If assessment data compiled indicate that the client is in need of physical, psychiatric, or neurological examination, arrangements are made after prior consultation with the case supervisor. Prior to speaking with any consultant--be prepared; consult pertinent literature and case material. Please remember when consulting with outside professionals to respect client confidentiality unless you have written permission by client to use their name.

When it is necessary to consult other professionals who have had contact with the client, you and the client should complete an Authorization for Release of Confidential Information form. Clients need only provide their name and signature. The therapist should, in the presence of the client, complete those parts of the form requiring names, titles, and addresses, because often clients provide incomplete, inaccurate, or illegible information. Before sending out Clinic correspondences (e.g., release of information request forms, client reports) trainees must first review it with the Clinic supervisor. Correspondence must be on Clinic letterhead, and a copy should be retained in the client's file.

2. Psychiatrist

You and your supervisor may wish to meet with the consulting psychiatrist to discuss issues related to your client's medical illness, differential diagnosis, or case management. By far, the most common psychiatric consultation issue is to determine whether psychotropic medication is warranted, and, if so, which type.

We offer some guidelines below that hope to maximize the training opportunity inherent in the psychiatric consultation process. Specifically, this opportunity comprises: (a) learning how to communicate client information succinctly and in a manner consistent with what is typically expected in more medically-oriented settings; (b) developing a working

knowledge of medications, their side effects, and considerations for or against prescribing.

When a trainee and supervisor determine that a psychiatric consultation is warranted, the trainee should contact the office of the physician for an appointment. The case supervisor may choose to attend also.

At the outset of the consultation, the psychiatric consultant will be seeking to establish a diagnosis. Therefore, he or she desires to obtain from you a clear sense of symptomatology and history.

The desirable format for presenting necessary information would be:

(a) identifying characteristics - e.g., age, sex, marital status, employment, previous episodes of the problem, previous hospitalizations.

(b) chief complaint- what the client and/or significant others say is wrong.

(c) history of present illness - precipitant, onset, duration, etc.

(d) pertinent mental status information (e.g. orientation, coherence, affect)

Family history of mental illness might also be of interest (but is never diagnostic).

Therefore, a typical way of beginning the consultation would be to explain:

“This client is a 41-year-old married male (it's his first marriage, of 19 years, and he has two children) who is a professor of psychology. He currently complains of fatigue and panic attack, which he has never experienced before. He was hospitalized for three weeks 14 years ago, for alcoholism, but reports no other hospitalizations for psychiatric problems. He experienced his first panic attack one month ago, which he reports happened while sitting at his computer, despairing at completing the text of a manuscript he'd been working at for 6 months. He reports that his parents, now deceased, both drank heavily . . . “.

It is important for the trainee to recognize from the guidelines and case example sketched above, that it would not be appropriate to launch into a case-conference presentation with the consulting psychiatrist, nor to immediately develop the detailed format required for an Assessment Report. Much of that information may become quite useful to the consulting psychiatrist (e.g., behavior during interview, results of psychological tests, functional analyses, etc.), but at the outset, he or she

will typically seek and will be trying to process information in the format above.

After you and the consultant have discussed the case, if medication is recommended, a second training opportunity is present. Speak openly with the psychiatrist--in an atmosphere not of challenge, but of edification--about considerations in his or her decision. Ask about how that medication compares with others, and about problems you might monitor, as well as what you might expect will be the impact on your psychotherapeutic interventions. Take the responsibility for doing your own follow-up reading.

H. Case Disposition

After the entire assessment is completed (e.g., intake interview report, information from other agencies, reports from consultants, assessment report), the trainee and supervisor should review the material to ensure that the case is suitable for the Clinic and/or the trainee. Initial screening and assessment can be faulty. Therefore, the initiation or continuation of treatment is always a matter of consideration by the trainee and supervisor. If referral elsewhere or to another therapist seems appropriate, procedures for doing so should be developed with the supervisor. If therapy at the Clinic is deemed appropriate, the trainee and supervisor should arrange treatment planning.

The following section is provided as a guide only. It is understood that each practicum will have its own set of policies, procedures, forms, and record-keeping mechanism. Students should consult with their supervisors for site-specific instructions.

TREATMENT

The following section assumes that the assessment work-up has indicated that treatment in the Clinic by the trainee is the most appropriate recommendation.

At this time, in order to reflect the changing nature of client demographics, data on the efficacy of treatments, insurance benefits, and models of clinical training, initial authorization for treatment will typically be limited. If treatment is expected to exceed the authorized number of sessions, the trainee must request additional sessions by the time 3/4ths of the sessions have been completed. The request is generated by completing an Outpatient Treatment Report (see Appendix G). Authorization to extend treatment is not automatic. If your request is incomplete or provides insufficient information about progress, treatment integrity, prognosis, etc. it may be denied or curtailed. In order that all clients are fully informed of the Clinic policies, trainees should discuss them at the outset of their work with each new client. Treatment planning on a case-by-case basis will determine the frequency and rate of therapy sessions. It should not be policy to restrict therapy to a once weekly, 50-minute session; instead the frequency or rate of therapy sessions is determined by the trainee, the supervisor, and the client.

Therapy cases are typically assigned under close supervision of the onsite supervisor, with weekly meetings to monitor progress. The student also must be enrolled in the CSP practicum seminar and present at least one case per semester to the practicum class.

It is both the on campus and onsite supervisors' responsibility to monitor the trainee's activity and to assure appropriate control over the conduct of the assessment and therapeutic procedures. However, the onsite case supervisor has the fundamental responsibility for maintaining proper care of the client.

A common problem arising in treatment is the failure to develop a therapeutic contract with the client. (A useful discussion of the contract can be found in Wiener, I. B. (1975), Principles of Psychotherapy. New York: Wiley). It is recommended that all therapy arrangements should be preceded by a verbal and understood "therapy contract' regarding the expectations, commitments, and responsibilities agreed on by all parties.

Necessary Considerations of Psychotherapy

1. Knowledge Base: Critical evaluation of psychopathology, treatment, learning and other relevant literature.

2. General Assessment: Strategy to get a 'general idea' of what the problem is (e.g., structured and semi-structured interviews, self-report diaries.) May include interviews with other pertinent members in client's life (e.g., family, teachers).

3. Specific Assessment and Treatment Plan: Sensitive, reliable, valid, and reasonably objective measures of some theoretically relevant aspects of the problem and maintenance factors, as indicated by the General Assessment, are identified. A treatment plan in the form of a functional analysis is sometimes developed (see Appendix H). Measures to assess behavioral and situational targets of treatment are collected ongoing through treatment and follow-up.

Baseline issues must be considered. A client's condition will vary naturally over time, and it's reasonable to assume that many people seek treatment when their condition is approaching its worst stage. Consequently, a client's condition may improve from this worst stage relatively quickly, an improvement that could easily be misinterpreted as a treatment effect. To accurately gauge treatment effects, you must have a good understanding of the natural variability of the client's condition. When, and for how long was it at its worst, best, and so on. Treatment effects must be judged relative to your determination of the natural variability of the disorder.

4. Consider (based on 1-3):

    a. Given unlimited resources, control, and time, can anything be done?

    b. How close to anything can you come and still be reasonably confident of success? (Attempts at treatment may be unreasonable for a number of reasons, often having to do with a lack of environmental control.)

5. Treatment:

    a. (based on 1) - What has worked for this particular problem in the past?

       or. . .

    b. (based on 1) - What modification of an empirically-validated technique has a reasonable chance of success with this particular problem?

       or . . .

    c. (based on 2) - What novel use of an empirically-validated technique for some other problem has a reasonable chance of success with this problem?

       or . . .

    d. "Experimental" treatment with special recognition of the importance of 3 and 7.

6. Treatment Integrity: Is treatment being carried out as planned?

7. Initial Treatment Evaluation (based on 3): After some reasonable length of time- Stay the course? Slight change? Start over?

8. Social validation: Are there more global indicators of improvement? (e.g., relationships, school/job performance, outlook.)

9. Maintenance: What specific skills or strategies will allow client to maintain gains? Are 'booster' sessions a consideration?

10. Follow-up: Are treatment gains maintained for some reasonable length of time (e.g., six months) after termination of treatment?

The following section is provided as a guide only. It is understood that each practicum will have its own set of policies, procedures, forms, and record-keeping mechanism. Students should consult with their supervisors for site-specific instructions.

CLIENT FORMS AND RECORDS

A. General

When a person is referred to a Clinic, an appointment is set for an intake, and the individual becomes a "client". A record folder is made for each client. Trainees should always use the title "Clinical Psychology Trainee" in signing forms, correspondence or in describing their Clinic role.

Some Clinics maintain a dual system of record keeping which involves two case records on clients. Identifying Records contain application material, identifying material obtained at intake (such as name, address, phone, and family names), signed release forms, intake evaluation, and schedule forms. If a client is referred elsewhere, or applies but is not seen for an interview, application and referral information is filed. A Clinical Record is made for all clients that are seen for an appointment. The assessment reports, diagnostic summaries, all therapy notes and summaries, treatment plans and evaluations, and clinical information from outside agencies are filed in this folder. In some Clinics, these materials may be in the same record as the identifying information.

B. Specific Forms

The forms and materials included in the typical Identifying Record are listed below:

(1) Intake/Screening Form

(2) Fee information

(3) Consent Form for Tape Recording and Observation of Sessions by Authorized Clinic Personnel and CSP supervisor

(4) Clinic Authorization Form

(5) Outside Permission Form

The forms and materials included in the typical Clinical Record are listed below:

(1) Appointment sheet - every client's folder usually has an inserted cover sheet to permit your logging every appointment, whether or not someone showed up, who they are (i.e., spouse, child, etc.), etc.

(2) Assessment report
(3) Initial test materials

(4) Consulting records

(5) Each session's therapy notes, treatment plan, and treatment process and outcome measures

After each therapy session, the assigned therapist should write a short note on the file. These notes should clearly indicate coverage of any client homework assignments, session themes, problems discussed, and any interventions undertaken as well as their effectiveness. They should indicate assignments and plans for the next session. If the appointment is canceled, note that, too. Individual style, preference, and skill dictate whether or not the therapist takes notes during the session itself, and how extensively. Obviously, intake and assessment interviews cover a great deal of information that may have to be recorded in the session. In later sessions, if the trainee prefers to take notes during the session, it would be important to minimize loss of eye contact and to learn to take notes in a generally unobtrusive fashion. Notes should be supplemented with objective indices of behavior change, such as self-monitoring forms or brief questionnaires selected from the functional analysis.

(6) Monthly Progress Summaries

Trainees might also be expected to write a brief progress summary on each client. This report should be done at the end of every month and signed by the supervisor. The monthly summary is not a rehash each session, although one may elect to highlight or summarize them. Rather, a more general paragraph or two should describe the therapist's notions as to what went on in terms of elements of active treatment, process, direction, particular difficulties, emerging themes, plans, consultations, etc. Please note that this is an overall summary of the month rather than a simple rewording of therapy session notes. Progress should be documented with objective assessment data. The most current functional analysis should be included and evaluated. Missed and/or canceled sessions should be noted, as should phone calls, letters, and other relevant communications and additions to the client's file.

(7) Closing Summary

When a case is closed, a termination or closing summary (see Appendix I for an example) must be approved by the supervisor before submitting it to the folder. The Closing Summary should include number of sessions, presenting problems, treatment procedures for each problem, a clinical rating of outcome, objective indexes of functioning (e.g., questionnaires), and reason for termination. If a follow-up is planned, include a signed

consent form from the client giving permission for evaluation of long-term outcome. Again, students should consult with supervisors for Clinic policy. If follow-up is planned, the therapist should remind the client of the Clinic's post-therapy follow-up procedures. Therefore, it is important to note the address at which the client can be reached at that time. Clients should also routinely be reassessed at the time of termination using measures that will elucidate change expected from the functional analysis and offer descriptive information at a normative and idiographic level. In many cases, this may take the form of simply re-administering some or all of the assessment measures given at baseline. Of course, results of this assessment should be shared with the client, as they were at the outset. In many cases, these measures will have already been taken, as part of ongoing monitoring of target behaviors, thereby providing the information that leads to the decision to conclude therapy! Ideally, trainees' assessment procedures should be designed or undertaken so as to focus on particular target behaviors. The point here is that whether initial assessment involved behavioral or field observations or projective tests, the trainee is responsible for making a serious effort to document statements about progress in as rigorous a fashion as possible.

At some sites, when the Clinic secretary has checked the clinical folder for content, it is marked "closed' and filed in the closed file cabinet. The secretary then moves the identifying record to a separate drawer for "closed' identifying records.

(8) Test materials for ongoing, post-treatment, and follow-up periods

(9) Clinic Record Checklist - record materials when you add them to the file (e.g., assessment reports, therapy notes, closing summary). Also record the name of your supervisor and dates. It is important that the checklist is updated at all times.

(10) Outpatient Treatment Reports

If you expect to exceed the number of authorized sessions with a client, you typically must request additional sessions. An Outpatient Treatment Report must be submitted to your onsite supervisor several sessions before your number of approved sessions have been used. Include evidence of treatment outcome and, if indicated, a revised functional analysis.

(11) Group Therapy and Multiple Records

When a group is seen on a regular basis, separate cases must be opened for each member of the group and a record also kept of the group as a whole. On the appointment sheet in the case folder for each client involved in the group, it should be stated: 'Member of a group-see group

folder.' At termination, each individual case should be closed and appropriate closing summaries written relating to the individual client. The group folder should also be appropriately closed and final summary on the group written.

(12) Follow-up

If consent was obtained by the Clinic, a follow-up questionnaire can be mailed to clients six-months after termination. The questionnaire could include information ranging from continuing adjustment to thoughts about the characteristics of the therapist they consulted in the Clinic (see Appendix J). The Clinic secretary should notify trainees when their client returns their questionnaire. You are to encouraged to read your client's returned questionnaire as feedback relevant to the support or refutation of your clinical hypotheses.

(13) Outgoing Reports and Correspondence

When a properly signed release of information form is received by the Clinic from another professional who requests information about a client being seen (or formerly seen), the trainee should consult with the case supervisor. Information typically released includes the signed assessment report and if present, the signed closing summary. All release of information is recorded, signed, and dated in the client's file. The secretary may take these materials and photocopy them on Clinic letterhead, attach a brief Clinic cover letter and stamp the materials, "CONFIDENTIAL-FOR PROFESSIONAL USE ONLY." All reports and correspondence are first to be reviewed by the supervisor before being sent to the requesting source. With proper authorization, telephone contacts may substitute for or complement written summaries. The latter are preferred, but practical issues and logistics sometimes necessitate telephone calls or responses. Clinics do not routinely send out session notes or raw test materials.

(14) Transfer of Clients to a Different Therapist

Therapy cases in hospitals, general service agencies, or private practice sometimes must be transferred to another professional. When the therapist anticipates leaving the Clinic, he/she notifies the client 3-8 weeks in advance so that considerations regarding clinical and procedural matters may be adequately addressed. If we assume the therapist has decided to refer the client to another therapist in order to continue treatment, the trainee should consult with the onsite supervisor.

The departing therapist may offer to make a referral by providing several names from which the client could choose, or the therapist may simply acknowledge the clients' desire to pursue it themselves.

If the client agrees to accept a referral, it is not uncommon for the therapist to telephone the new therapist that he/she is recommending in order to facilitate this transition, although this is not always necessary. The personal telephone call is not a magic wand, nor is it intended to be one. In other words, if the new therapist has a waiting list, no vacancies, or is about to depart for vacation, it would be inappropriate to pressure them to open a slot that doesn't exist or to refuse to acknowledge a gracious, but clear declination by them. If the prospective therapist can take on the case after a few weeks to a month, this information would be conveyed to the client who can then make informed plans about dealing with the hiatus.

Finally a report entitled, Transfer Summary should be prepared by every departing therapist. This should convey in writing what the departing therapist will probably have elaborated verbally to the prospective therapist. This would include:

(a) What was worked on and accomplished in therapy.

(b) A description of the client's current level of functioning and degree of disability.

(c) Recommendations about ongoing and future interventions.

(d) Observations about what the new therapist should expect in the course of therapy.

Case transfer also involves many issues of therapist and client, such as separation anxiety, and feelings of "failure”. All of these and related issues should certainly be the province of supervision of cases.

For those who further wish to consider the clinical and procedural aspects of client reassignment, the following articles may be useful:

Muller, R. (1986). The trainee and the transfer case: Why is this case different from all other cases? American Journal of Psychotherapy, 40, 265-276.

Wapner, J. H., Klein, J. G., Friedlander, M. L., & Andrasik, F. J. (1986). Transferring psychotherapy clients: State of the art. Professional Psychology: Research and Practice, 17, 492-496.

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SUPERVISION

A. Mechanics

Trainees may expect up to two hours of supervision weekly from an onsite doctoral level clinical psychologist or the equivalent. One of those two hours may involve a supervisor's observation, listening to a tape of the treatment session, or sitting in on the session. One hour may also involve group supervision. Trainees are also required to enroll in the CSP practicum course which typically involves group-style supervision meetings.

B. General Comments

For most students, supervision in psychotherapy represents a different kind of learning experience than those in which they have typically been involved (i.e., classes or small seminars). Yet for all the differences, many of the goals and processes of the ideal educational experience are captured and intensified in the supervision engagement. Some of the points are perhaps best illustrated by commenting on several of the more common errors and misconceptions about supervision.

"Therapy supervisors will be most helpful if they remove the ambiguity of clinical work for the novice."

In fact, despite every effort to understand, predict, control, or otherwise conceptualize a client's problems, clinical work is marked by a great deal of ambiguity at various points. Certainly the role of supervisor may include providing some training in structured assessment and therapies, and assistance in diminishing ambiguity and anxiety. Nonetheless, trainees must learn that besides knowledge and a desire to help, they must also develop a realistic tolerance for ambiguity and frustration. These latter two terms are not synonymous with therapist failure.

"A supervisor will teach in the fashion of classroom instructor by lecturing on the client's problem, while trainees passively listen and take notes."

Adopting the stance of a passive recipient will enhance neither a traditional seminar nor therapy supervision. A high degree of structure is often useful, even desirable in the early stages of therapy supervision. As trainees progress, they are expected to take greater responsibility for critically reviewing and planning their clinical and supervision sessions. Trainees should always come to supervision prepared to discuss their assessment/treatment sessions. This

should include the trainee's very recent review of the session (perhaps editing the audiotape), having scored and interpreted tests, done appropriate background reading, and considered next steps or new directions. Trainees are ill-prepared to benefit from supervision or to grow professionally if their general approach to supervisory meetings can be characterized by the approaches, "Tell me what happened," or "Please, tell me what to do next."

To overcome early concerns centering on evaluation apprehension, the trainee is urged to understand that activity based on fear of getting the wrong answer is a strategy doomed to failure. On the contrary, learning to generate and support or refute clinical hypotheses via treatment formulation and intervention is a goal that demands much more active involvement.

"I must review, point-by-point, every moment of a therapy session with my supervisor. That way they can catch me in errors that may seriously harm my client."

The conceptual or data base that suggests danger for any client being treated by a supervised trainee instead of a licensed professional is nonexistent. Therefore, the way you and your supervisor choose to review client sessions will vary. Early in training, point-by-point, comprehensive review may be quite useful. Over time, its value will diminish, as it becomes apparent that larger, more significant issues might usefully comprise the supervisory session. Indeed, some supervisors adopt a model whereby they are available for consultation but how this consultation is used and the form it takes may be left completely to the trainee. The point is, the models of good supervisor practice will vary, and trainees must be alert to these alternatives and how their input can affect variations that will be best suited to their current level of training.

C. How to Prepare for Supervision Meetings

The following questions are adapted from "Fundamentals of Clinical Supervision" by Bernard and Goodyear (1992) who offer them as an outline for preparing ones progress notes. Even so, they also provide excellent considerations for reviewing and organizing ideas in preparation for clinical supervision.

1. What were your goals for this session?

2. Did anything happen during the session that caused you to reconsider your goals? How did you resolve this?

3. What was the major theme of the session and the important content?

4. Describe the interpersonal dynamics between you and the client during the session.

5. How successful was the session?

6. What did you learn (if anything) about the helping process from the session?

7. What data support your answers to #5 and #6?

8. What are your plans and goals for the next session?

9. What specific questions do you have for your supervisor regarding this and/or future sessions.

10. Is there any literature you have consulted or plan to consult that may further inform your work on this case?

At another point in their text, Bernard and Goodyear provide useful guidelines and "ground rules" for group supervision. They suggest that these "ground rules' be offered for the group's consensus as a way to think about and focus the feedback that group members provide one another.

1. Note what the therapist did.

    a. What were things you liked about the therapist's approach? (No one likes to hear criticism right off the bat.)

    b. What seemed to be the client's reaction to the therapist's behavior?

    c. What would you have added to the session?

    d. What things did the therapist do that you might have done in a different way?

    e. Were there any things in the session done by the therapist that you think were unhelpful? If so, what do you believe could have been done instead?

2. Note what the client did.

    a. What do you think of this client and the client's concerns?

    b. What themes were evident?

    c. Were there any inconsistencies that confused you?

    d. Did the client's input seem to make things clearer?

3. Note what the session accomplished.

a. Given what you know about this client, did the session accomplish any process goals or outcome goals derived from the functional analysis?

b. What would you say was the major accomplishment of this session? What data supports this?

c. What would you say was the major flaw of this session?

4. If this were your client, what would be reasonable and productive goals for the next session? How would you accomplish these goals?

Please discuss these questions and “ground rules” with your supervisor and supervision group. For some they may serve as the basis for a shared “set of expectations" as to what will constitute the materials to be reviewed in supervision. At the very least, these materials will orient each trainee toward active and constructive preparation for supervision.

D. Evaluation and Feedback

1. By supervisor

The numerous bases for evaluation of a trainee's clinical performance will often vary among individual supervisors. In an effort to provide some degree of standardization, we hope this Handbook will provide a clarification of the CSP’s expectations of trainees. Supervisors complete a Evaluation of Practicum Student Form toward the end of each academic semester (see Appendix K)

The trainee and supervisor should become familiar with the Form’s questions and categories in order to base judgments on continuous, ongoing observations rather than last-minute recollections. Thus, periodic updates and feedback sessions between trainee and supervisor would allow the evaluation outline to be used in a constructive and/or remedial fashion. However, the entire form should be turned in to the CSP’s Associate Director. The signature of the trainee at the end of the report indicates that it has been discussed by supervisor and trainee.

2. By trainee

Each semester, the trainee will complete a Practicum Site Evaluation Form (see Appendix L). Concerns should also be brought to the attention of the CSP Clinical Director and Associate Director. These reports play a significant role in the 'quality control' of practicum training; thus they can be of great importance. These completed evaluations are not viewed by your supervisors. Although each trainee should discuss the evaluation of

the supervisor with him or her directly, only the CSP faculty retain the Forms.

E. Conflict

Disagreements between trainees and supervisors do arise. Sometimes they focus on how to approach a client's problems. Less often they center on the supervisor's failure to keep appointments (accessibility problems), unwillingness to wean the trainee from co-therapy with the supervisor, or some such matter. Trainees ignore such problems at their own risk and concomitant risk to their clients. To remedy conflicts or disagreements, trainees must assume a professional role and candidly discuss such problems with their supervisors. If such direct recourse has been taken and failed, it would be appropriate to seek mediation, assistance, or advice from the CSP Director or Associate Director.

The following section is provided as a guide only. It is understood that each practicum will have its own set of policies, procedures, forms, and record-keeping mechanism. Students should consult with their supervisors for site-specific instructions.

CASE CONFERENCES

Most Clinics hold regular case conferences which trainees are expected to attend. In addition, case conferences are also typically held on a regular basis during the CSP practicum courses (supervision). It is hoped that each trainee can present two cases per semester. These presentations are expected to provide documentation that the guidelines presented in this Handbook have been followed. It is the responsibility of the presenters to have arranged necessary details for their own material (e.g., overhead projector, photocopies, handouts, blackboard outlines, advance notice of suggested reading).

For case presentations, the following general sequence is recommended (with modifications as warranted for specific presentations):

Abstract (summary)
Source of referral and presenting problem
Demographic and personal information (age, sex, ethnicity, marital status, occupation, etc.)
Historical information of pertinence (i.e., social, sexual development)
Assessment information
Case formulation, functional analysis, and treatment plans
Outcome, problems, follow-up, miscellaneous issues

It is useful to consider a case presentation from the point of view of both clinical and didactic issues. That is, the presenter should try to offer an informative clinical case to the audience as well as try to seek their clinical consultation. At the same time, it is often most educational to try to focus on some aspect(s) of the case that proved edifying to the therapist(s).

Holding questions and interruptions to a minimum at first allows the presenter to clarify the major issues in an organized fashion, while introducing their own stylistic variations. Questions, debates, and audience participation are to be encouraged during the latter parts of the presentation. (All students are highly encouraged to read the classic paper by Paul Meehl entitled 'Why I do not attend case conferences" in his book Psychodiagnosis: Selected Papers, Norton, 1977).

The presentation of cases that are still in the formative stages as well as more advanced ones is encouraged. Unfortunately, many trainees may fear that their treatment is not far enough along for case presentation. However, case conference is clearly well suited for such times when consultation, feedback, or spirited debate may be most useful for the trainee's and supervisor's ongoing case formulation and planning.

The following forms are provided as a guide only. It is understood that each practicum will have its own set of policies, procedures, forms, and record-keeping mechanism. Students should consult with their supervisors for instructions.

Appendix A

NEW CLIENT INFORMATION FORM (example)

Today's Date:

Referred by:

Name:

Date of Birth:

Parents or Guardians Names (for minor):

Complete Mailing Address:

Home Phone:

Work Phone:

Employer/Address:

Person Responsible for bills/address:

Insurance Carrier/Address:

Insurance Numbers:

Family Physician/Address:

Date of Last Physical Exam:

Current Medications/Dosages:

Person to Notify in Case of Emergency/Address/Phone:

PERSONAL HEALTH HISTORY
(Circle the appropriate categories)

1. Chronic ailment of any kind
2. Alcoholism
3. Anemia
4. Arthritis/Rheumatism
5. Asthma or Allergies
6. Birth Defects/Retardation
7. Cancer
8. Diabetes
9. "Accident Prone"
10. Ear, Nose, Throat Disorder
11. Epilepsy
12. Eye Disorders (Specify)
13. Gastrointestinal disorders (Specify)
14. Glaucoma
15. Heart Disease
16. High Blood Pressure
17. History of Broken Bones
18. Kidney or Bladder
19. Mental Disorders (Specify)
20. Sexual dysfunction
21. Skin disorder
22. Spinal
23. Stroke
24. Suicide
25. T.B.
26. Thyroid
27. Venereal
28. Surgery
29. Other (Specify)

Appendix B

CONSENT FORMS (example)

CONSENT FORM FOR TAPE RECORDING AND/OR VIDEO RECORDING
AND
OBSERVATION OF SESSIONS BY AUTHORIZED CLINIC PERSONNEL

Because of the training function of the Clinic, we request that each client being treated or tested by the Clinic trainees be willing to have the sessions tape/video recorded and/or observed by authorized Clinic personnel. The purpose of this request is to facilitate adequate supervision of each case by the Clinic's staff as well as by the responsible faculty at the University of Hawaii's Clinical Studies Program. Confidentiality of the material will be maintained in accordance with the ethical guidelines set down by the American Psychological Association. If you are willing to grant such permission, please sign below.

Client signature

Witness
Date

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, the undersigned, request ______________________________

to disclose the following information:

Need for the disclosure:

Name or title of the person or organization to which the disclosure is to be made:

I understand that the information to be released from my record is confidential and protected from disclosure without my written authorization. I also understand that I have the right to cancel my permission to release information, at any time before it is released. I understand that my consent to release information will expire 90 days from this date if not acted upon prior to that time.

Signature of Client:
Print Name of Client:
Date:
Client's Date of Birth:

Signature of Parent/Guardian:
Print Name of Parent/Guardian:
Date:

WITNESSED BY ME THIS ____DAY OF _____________, 20___.

Name: Position:

Appendix C

INTAKE OR SCREENING FORM (example)

Case No.	Date of Intake:
Name:	Intake by:
Address:	Referral Source:
	Education:
Phone H:	Occupation:
Phone W:	Marital Status:
Age:	Ethnicity:
Sex:	

Client Problem Description:

Relevant History:

Therapy and Hospitalization History:

Medical History and Current Medication (note any allergies):

Drug/Alcohol/Tobacco/Caffeine Use:

Mental Status (attitude toward examiner, appearance, motor, speech, apparent thought organization, mood, orientation, understanding of own condition, ability to relate to examiner):

Suicidal/Homicidal Ideation/Plans:

Diagnostic Impression (DSM 5):

Additional Comments:

Problems with being wait-listed:

Therapy or Assessment Assignment (Therapist/Supervisor):

Appendix D

INTAKE OR SCREENING INTERVIEW OUTLINE (example)

(approx. 60 min.)

Stated Goals

To get general information for case assignment purposes and to communicate information on how the Clinic operates to the client.

Referral Sources

Find out who referred them to the Clinic and why they were recommended.

At Outset

This is for initial screening purposes, and that a more complete intake assessment will follow at their first few appointments. At that time, they may be asked to review some of the material they present now with their therapist.

Interview

Attempt to obtain fairly concrete information by asking concrete questions. Address the problem first: "What would you like our consultation to be about?"; "What is it you'd like us to help you with?"; "What brings you to contact the Clinic at this time?"

Dealing with the Problem

1. Who's involved?
2. How long has it been going on?
3. Previous consultation with psychiatrist, psychologist, social worker?
4. Is the client on any psychotropic medication?
5. If previous consultation--from whom, whether it helped, what happened, is it OK to consult with previous counselor? (get signed release)
6. If they sound or appear depressed (loss of appetite, crying, loss of sleep) --ask about suicide.
7. General additions and qualifications.

Tips for Clarifying the Problem

1. Ask for examples-"I have a pretty good picture but it would be made clearer if you can give me a recent incidence of this."
2. "Many people choose not to come to a psychologist for this sort of problem-is there anything else involved?"
3. Scope of problem(s)--e.g., family, work, education ,personal, leisure time, sexual.

Conveying Clinic Information

1. Run by (e.g., DOH, Castle, Tripler, UH).
2. Has two functions: a) provide service to the community; b) train doctoral level clinical psychologists.
3. Staff includes students training for doctorate--easiest to think of them as you would an intern in a hospital. As such they work with clients and meet regularly with onsite supervisors and CSP faculty for consultation and supervision. Supervisor might: a) sit in or conduct session; b) listen to an audiotape or watch a videotape of session; c) observe through 1-way window. Audio and video tapes and observation windows are a common practice. All strictly legal and ethical. Obtain client's signed permission and the confidence of these proceedings are strictly protected by law. No one would be involved who was not involved in treatment or consultation of case.
4. Find out if they have questions up to this point.

If there is expressed or implied reluctance regarding taping

1. Assure client there is no basis for concern.
2. Bound by professional ethics and the law.
3. Never had a problem about client protection or violation of confidence.
4. Emphasize importance to client--i.e., it is of some benefit to client to facilitate or enhance consultation with other clinicians involved in their treatment.

Fees

1. Fee is $XXX /hour, and reimbursable by some insurance plans.
2. Ask if their insurance covers consultation with a licensed psychologist. If they are uncertain tell them to find out from benefit's representative and call you back before the first session and bring insurance forms with them, including waiver to allow insurance company to pay Clinic directly.
3. Fees set by during phone intake--payment begins at first session.

If reluctance is expressed regarding student therapists

1. Explain that many of the Clinic staff have a great deal of experience
2. Clinic has a high degree of success with a variety of problems.
3. Client is not a guinea pig.
4. Tell the client to come and see-no commitment they cannot control.

Closing

Explain that the person who'll be consulting with the client will call to arrange a meeting time of mutual convenience. Provide alternatives if there is a waiting list and if it’s too long. Ask client to let the Clinic know if he or she is seen elsewhere. Get schedule of hours, name, address, and phone number.

Appendix E

A CLIENT'S GUIDE TO PSYCHOTHERAPY*

The decision to begin psychotherapy is one which may have important consequences for the rest of your life. Research has shown that when individuals enter this type of treatment with a good understanding of what they are about to undertake, they are likely to achieve more favorable results. This pamphlet contains information about the unique process of psychotherapy. It will provide you with a written record of the practices and responsibilities of the client and the therapist. Read it and then ask your therapist any remaining questions you may have. No pamphlet can hope to provide accurate information about all types of psychotherapy or all therapists. Use this pamphlet as the focus for a discussion with your therapist about his or her specific practices.

In the information which follows, the term therapist refers to either a psychologist, social worker, counselor, or psychology trainee. The trainees are graduate students working toward the Ph.D. in clinical psychology. The profession of psychiatry has not been included since its practice is complicated by the use of physical treatments such as the prescription of drugs. However, much of the information included in this pamphlet is applicable to psychotherapy as practiced by a psychiatrist.

DESCRIPTION OF PSYCHOTHERAPY

In psychotherapy, you and a trained mental health professional work out strategies for handling problems of daily living. Problems that can be effectively dealt with include but are not limited to:

--anxiety and fears
--depression
--habit control
(e.g., smoking, overeating)
--interpersonal difficulties
--low self-esteem
--guilt
--alcoholism

In addition, therapy can lead to personal growth through clarification of your thoughts and feelings about yourself, others, and events in your life. If you are uncertain as to whether your current concerns would best be dealt with by this form of treatment, discuss this with your therapist during your first session.

The majority of the time you spend in therapy will consist of talking about the issues you have presented to your therapist. However, along with " talking therapy, " other methods may be employed, such as relaxation and assertiveness training, hypnosis, and role playing.

Furthermore, treatment can involve an individual, family, couple, or group, depending upon the nature of the problem. The specific form of your therapy will also depend upon the theoretical orientation and background of your therapist. Some therapists focus discussion on your childhood and the past while others will emphasize the present. For some, the essential goal is insight into the cause of problems, while others work for

direct behavior changes using very specific techniques. You may wish to ask your therapist about his or her orientation at the start of therapy so that you will know what to expect during your treatment.

The length of treatment varies depending upon the therapist, the client and the nature of the presenting problem. Problems that are severe, that affect many areas of your life or have persisted for a long period of time will generally require a more lengthy treatment. It is not uncommon for therapy to last up to a year or even longer. However, many problems improve or begin to improve within 10-12 weeks. After several sessions, the therapist may be able to give you some idea of the estimated length of treatment. Generally, sessions are scheduled for once a week and last 45-50 minutes, giving the therapist the remainder of the hour to make notes which will aid in planning further treatment and assessing progress.

THERAPIST RESPONSIBILITIES

The therapist will usually devote the first few sessions to assessing the types and extent of problems or concerns you have. This process requires him or her to ask detailed questions about your history, life situation, and present distress. You may be asked to complete questionnaires and self-monitor some behaviors and life events. After the therapist has identified the specific problem areas, the two of you will agree upon a therapy plan including goals, methods to accomplish these goals, ways to measure progress, and approximate length of time to achieve these goals. Periodically, there should be a joint assessment of progress which may include reformulation of the goals.

If you require some medical treatment such as medication, the therapist will refer you to a physician, usually a psychiatrist. Therapy ordinarily will continue at the same time that you are receiving the additional medical treatment. If, at any time, your therapist believes that he or she can no longer be of help to you, another appropriate professional will be suggested.

CLIENT RESPONSIBILITIES

As a client in psychotherapy you will also have certain responsibilities. It is important for you to attend all of your scheduled appointments on time. Unlike many other appointments you may have, psychotherapy will start promptly at the designated time. If you are late, you will not have the benefit of a full session.

Equally important are the responsibilities you have to be as active, open, and honest as possible with your therapist. Your most important responsibility, however, is to work toward the goals you and the therapist have agreed upon. Seeing a therapist for one hour per week will be of little benefit without additional effort outside the therapy office. This work can include thinking about the material covered in your sessions, making yourself aware of your behavior, or working on specific assignments made by your therapist. Examples of the latter might be keeping a log, reading a special book or practicing a new skill.

FEES

Another client responsibility is the prompt payment of fees. Many therapists will discontinue treatment if fees are chronically unpaid. Fees for psychotherapy vary depending upon locality, treatment setting, and type of helping professional. If you are unable to afford the fees of a private practitioner, many mental health clinics have a sliding scale so that fees can be adjusted somewhat according to family income or ability to pay. Many therapists will expect you to pay for a missed session unless you cancel at least 24 hours in advance, except, of course, if your absence is due to an accident or illness.

Part or all of your fee may be paid by health insurance. However, even if you have insurance coverage, you are still responsible for the treatment fee. Some therapists are willing to collect the fee directly from the insurance company, while others will want you to pay the fee directly to them and then be reimbursed by your insurance company. To determine if you are eligible for insurance benefits, read your contract or call the insurance company, since recent changes may have been made which are not included in your contract. In general, you will want to check on three key elements: Does your insurance cover mental health services, does it apply to outpatient care, and will your company reimburse for the helping professional you have consulted (e.g. psychologist, social worker, or other).

CONFIDENTIALITY

The codes of ethics for psychotherapists and the state laws regulating most kinds of therapists consider the personal information you discuss to be confidential. This means that the helping professional may not reveal any information about you to another person without your explicit permission. Records of your treatment will be kept in a locked file. There are some very special circumstances which are exceptions to this rule. In a very small number of situations, therapists are legally required to disregard confidentiality. For example, if you reveal information that indicates a clear danger or injury to yourself or others (e.g., potential suicide or homicide), the therapist will need to contact appropriate authorities or family members. Also, all helping professionals are required by law to report any knowledge of the abuse or neglect of a child or an incompetent or disabled person.

The therapist may discuss your case with a supervisor or with other professionals clearly concerned with the case. If your fees are paid by a third party, such as an insurance company, certain details of your treatment (e.g., dates of treatment and diagnosis) must be revealed to obtain reimbursement. Many insurance companies now allow you to file claims directly with them so this information will not be seen by your employer.

Finally, with your permission, some therapists may make audiotapes or videotapes of your treatment sessions for their own review or for supervision of their work. However, they will not disclose the contents of their tapes to others without your written consent.

EFFECTS AND RISKS OF TREATMENT

Psychotherapy is a time-consuming and expensive endeavor so you will want to know about its effectiveness. The success of your therapy depends on a large variety of factors including the nature of your problems, the effort you put into the process, and the type and length of treatment, and the therapist's skill. Nevertheless, on the average, two-thirds of all clients show improvement during therapy.

At times this process will involve the stirring up of painful or uncomfortable thoughts and feelings. It may also lead indirectly to the loss of important relationships, such as when a client who is experiencing marital difficulties decides to seek a divorce. Nevertheless, the overall gains you achieve through therapy should generally outweigh these potential risks.

HANDLING DISSATISFACTION WITH TREATMENT

It is not unusual to feel angry and upset at times about what happens in therapy. Questions or concerns about the treatment you receive should first be raised with your therapist. Exploring your thoughts and feelings, even when they are negative, is an important part of the therapy process. If after discussing the issues with your therapist you are still not satisfied, you have several options. You may seek a second opinion concerning your treatment. Another approach would be to switch to a new therapist. Competent therapists recognize and accept that they will be able to serve the needs of some clients better than others.

If you believe your therapist's behavior is either unusual or does not adhere to professional standards, you again have several alternatives. If your therapist is employed by a mental health agency, you may bring the matter to the attention of the program director. Another option you may choose is to contact the appropriate state or national professional association or the state licensing or certification board.

ALTERNATIVE SOURCES OF HELP

You should be aware that other helping systems exist that may be used in conjunction with or in place of therapy. Before engaging in one of these activities, you should discuss the decision with your therapist to assure that it will be a useful option for you at this time. You may want to consider:

--Individual self help such as educational books, recreational activities, or changes in your living or job situation.

--Peer support groups such as Parents Without Partners, Alcoholics Anonymous, or Weight Watchers.
--Crisis intervention services including crisis hotlines, rape crisis centers, and shelters for battered women.

--Assistance from other kinds of agencies such as legal, vocational, or pastoral counseling.

OTHER SPECIFIC QUESTIONS YOU MAY WANT TO ASK YOUR THERAPIST

1. What are the therapist's qualifications to help you (e.g., training, credentials, experience)?

2. What is the therapist's treatment orientation or philosophy?

3. What are the therapist's values in areas that may have special pertinence to you (e.g., homosexuality, divorce, religion, nontraditional life styles)?

4. Are you permitted to phone the therapist between sessions or at night?

5. What arrangements does the therapist have for emergencies or for when he or she is out of town?

*This guide was adapted from one prepared and copyrighted (1982) by Patricia Lacks, Ph.D., Jennifer Stolz, M.A., and Jeffrey L. Levine, M.A.

Appendix F

ASSESSMENT REPORT OUTLINE (example)

I. IDENTIFYING INFORMATION

A. Subject's name, age, date and place of birth, sex, ethnicity, marital status, occupation

B. Reason for referral

C. Diagnostic methods used and dates administered

D. Examiner and agency providing assessment

II. PRESENTING PROBLEMS

A. Nature of Problems

Although this category covers the presenting complaint as described by the clients themselves, it may include more than their own construction of the problem. If the intake interviewer believes that the presenting problem may best be construed in other terms, the interviewer's reconstruction of the client's original conception of the difficulty should also be included in this section. For example, the client may present a problem of being nervous in certain social settings, but further questioning may reveal that the anxiety is accompanied by deficit assertiveness.

B. Historical Setting Events

This material is useful primarily with those clients for whom an evaluation of the current situation proves to be somewhat difficult (e.g., the client states the problems in vague and abstract terms). Thus, the report should include any early developmental data that may be a context for current problems and give clues to the dimensions of the problems, such as the exact nature of the deviant behavior (e.g., deficiency versus inhibition) and the situations where it is most likely to occur.

C. Current Situational Determinants

The antecedent situational variables-whether they serve to elicit respondents, cognitions, or act as discriminative stimuli for operants-should be described in this category. (N.B. - In the case of a child problem, present information on the family separately or as a subcategory. Describe people present in the house and significant others who affect the

child. Describe general family atmosphere and note marital status, if relevant).

D. Relevant Organismic Variables (physiological and behavioral)

In addition to physiological states of the client and any potential effects of medication currently being taken, the clinician should note the client's emotional-motivational characteristics, sensory-motor skills, and covert labeling activity--either as a primary determinant of the problem (e.g., 'I must be perfect in this situation") or as a secondary attribution of the difficulty (e.g., "My rapid heartbeat must mean that I am having a heart attack').

E. Dimensions of Problem

Any information relevant to the duration, pervasiveness, frequency, and magnitude of the problem should be included in this category.

F. Consequences of problems

In addition to information about what may be reinforcing the client's problem behaviors, positive and negative consequences of the person's current or future functioning should be included here as well (e.g., job status, interpersonal functioning, mood, life satisfaction, productiveness, etc.).

III. BACKGROUND INFORMATION

This section is designed to provide the early and current learning context for the individual. Note information that indicates behavioral and situational assets and deficits that may be relevant to the acquisition and maintenance of current problems.

A. Family, social, and legal history

B. Educational and work history

C. Past problems, diagnoses, situations (precipitants), treatments, response to treatment (medical , psychological)

D. Current behavioral and situational assets and deficits

Assets such as a social network, satisfying job, physical characteristics, aptitudes, abilities, and interests can provide leads to possible social reinforcements for use in altering the client's environment which has the potential for eliciting and/or reinforcing adaptive behaviors (e.g., a cooperative spouse).

IV. BEHAVIORAL OBSERVATIONS (MENTAL STATUS EXAM)

Included here are the therapist's observations of what may be a sample of the clients' behavior in the therapeutic relationship, and perhaps even outside the therapy interaction as well. Any aspects of the client's physical appearance that might categorize them as being typical or different from their reference group is noted as well, since it might provide leads for the impact they may have on others. In this section should also be included any pertinent information regarding the client's mental status (e.g., behavior, affect, perception, thought). Mental status is derived primarily from observation, but also from certain specific questions, and is often useful for providing relatively standardized descriptive and diagnostic information. Even if your mental status evaluation reveals absolutely nothing noteworthy, your written observations should clearly indicate that you have considered this part of the assessment process.

A. Attitude toward examiner (e.g., angry, guarded, suspicious, uncooperative, belligerent, apologetic, indifferent, depressed; cooperative, friendly, etc.)

B. Appearance (e.g., unkempt, dirty, bizarre, inappropriate attire, poorly nourished; well-groomed, etc.)

C. Motor behavior (e.g., tense, restless, hyperactive, agitated, tremors, tics, muscle spasms, odd mannerisms, relaxed, calm)

D. Speech (e.g., mute, underproductive, lack of spontaneity, delayed, soft, loud, slurred, over-productive, unclear; unremarkable, etc.)

E. Apparent thought organization and content (e.g., loose associations, tangential, flight of ideas, incoherent, perseverative, word salad, echolalic, neologistic, delusional --persecutory, being controlled, grandiose--, hallucinations--auditory, visual, olfactory, tactile--, obsessions; clear, coherent, intact)

F. Mood (e.g., depressed, anxious, apathetic, apprehensive, elated, flat, inappropriate; appropriate to content, euthymic, etc.)

G. Orientation to person, place, time

H. Memory

I. Suicidal and homicidal ideation

J. Understanding of own condition

K. Ability to relate to examiner (withdrawn, passive, regressed, aggressive, personable, assertive)

V. INTELLECTUAL AND NEUROPSYCHOLOGICAL EVALUATION

A. Comment on judged validity of results and indicate any factors that may have affected test performance (e.g., lack of motivation, low stress tolerance, hostility toward examiner) and how scores may be expected to change with a lessening of these factors

B. Present IQ and all subtest scores with mean and std. deviation for population for comparison

C. Discuss subtest score scatter and intra-subtest variation

D. Point out intellectual strengths and weaknesses

E. Comment on any signs of organicity or a learning disability

F. Indicate client's ability to use own intellectual resources in social, school, and vocational environments

VI. PERSONALITY FUNCTIONING

The content of this section, more than any other, will reflect your own theoretical biases in the manner that you interpret the interview and test data. Tests should be used to obtain data that support or disconfirm hypotheses derived from the referral question, presenting problem, intake evaluation, interview, and an understanding of the extant literature. For each test administered, indicate the purpose, rules of score interpretation, results, validity of results, and interpretation. Note how tests' results converge and diverge with one another and with information from the interview and behavioral observations.

This section would include reliable and valid instruments designed to assess the following:

A. Definition of problem behaviors- verbal, motoric, and physiological indices of language-cognitive, emotional-motivational, and sensory-motor repertoires

B. Severity of such problem(s) (frequency; magnitude; generality)

C. Determinants of the problem(s)

1. conditions which intensify and alleviate condition

2. the client's perceived origins of condition

3. dysfunctional cognitive, affective, and motoric characteristics

4. specific antecedents and consequences

D. Past attempts to change (nature and results)

E. Assets for change (behavioral and environmental)

VII. SUMMARY

A. Integrate relevant findings from presenting problems, interview, behavioral observations, and intellectual and personality assessment.

B. Emphasize most important conclusions relevant to referral question

C. Indicate behavioral and situational assets and deficits

D. List targets for modification (may be presenting problems and/or those identified by the examiner; not all identified problems are targets for modification; includes behavioral and situational maintenance variables)

E. For each targeted problem, identify:

1. Relevant historical setting events

2. Current situational determinants

3. Organismic variables (physiological and behavioral)

4. Dimensions of problem (duration, pervasiveness, frequency, and magnitude)

5. Consequences of problem

VIII. DSM-5 DIAGNOSES

IX. RECOMMENDATIONS FOR TREATMENT AND ASSESSMENT

A. Indicate motivation for treatment

B. Estimate prognosis

C. Suggest type of intervention for each target for modification

D. Identify assessment devices for evaluation of treatment process and and outcome.

E. Indicate if further assessment is needed to identify or rule out problems or address referral question.

X. PRIORITY AND MOTIVATION FOR TREATMENT

This is a-particularly useful category in a Clinic setting, especially where therapeutic time may be at a premium. A "low', 'medium', or "high" priority can be given on the basis of a consideration of the consequences of not seeing this particular client in treatment.

Some general classification of the client’s motivation-such as high, medium, or low-should be indicated, together with the data on which the inference has been made (e.g., verbal commitments to change, past attempts at behavior change).

Appendix G

OUTPATIENT TREATMENT REPORT (example)

Client's Number/Name:
Date of Initial Session:
Therapist's Name:
Supervisor's Name:
Date of This Report:
Total Number of Sessions to Date:
Number of Sessions Approved at Last Review:
Number of Approved Sessions Remaining:

DSM 5 Diagnosis:

On Admission: Current:

Targets for Modification:

Progress Since Last Review: (include objective data):

Changes in Treatment Plan or Treatment Focus:

Reason(s) for Continued Treatment:

Criteria for Discharge:

Anticipated Discharge Date:

Number of Sessions Requested:

Therapist's Signature	Date
Supervisor's Signature	Date

Approval:

Number of Sessions	Date

Approved by

Signature

Appendix H

TREATMENT PLAN: FUNCTIONAL ANALYSIS (example)

Development of an initial treatment plan follows from an integration of information from the literature, a general intake evaluation, and the assessment report. In time, ongoing assessment data will also inform the necessity of modifying or maintaining treatment plans. Integration of this information into a treatment plan involves the following steps.

1. Identify situational, physiological (organic), language-cognitive, emotional-motivational, and sensory-motor variables involved in not only target problems but also causal or maintenance factors.

2. Synthesize these variables as a clinical hypothesis in the form of a functional analysis that indicates the type and direction of relation between variables (see illustration and examples attached).

3. Rank order the targets of intervention considered of high importance and modifiability on the functional analysis.

4. Indicate and justify planned treatment for each targeted variable.

5. Select reliable, valid, and feasible assessment instruments for each targeted variable and determine frequency of measurement. Measures to assess behavioral and situational targets of treatment are collected ongoing through treatment and follow-up.

6. Record treatment process and outcome indexes in therapy session notes and monthly summaries. Plot scores over time. Discuss scores and progress with client.

7. Evaluate the adequacy of plan with supervisor. Revise plan as needed and set objective termination goals. Determine if “booster sessions” are indicated.

8. Use functional analysis and treatment outcome assessment data to guide completion of the Closing Summary at termination.

9. With proper authorization by the Clinic and client, conduct a follow-up assessment to determine whether treatment gains are maintained.

Appendix I

CLOSING SUMMARY (example)

Client Number/Name: Number of Therapy Sessions:
(including intake)

Therapist: Supervisor:

Dates of First and Last Sessions:

Dates of First and Last Treatment Plan:

Today's Date:

Presenting Problem(s) from Intake and assessment.

Major Problem(s) dealt with in therapy (include above if deal with, plus any other problem(s) which emerged during assessment, therapy, and revision of treatment plan)

Treatment procedure(s) employed for each of the above problem areas

Treatment Outcome

a. List outcomes separately for each target problem and causal variable, commenting on efficacy of particular treatment techniques and adequacy of functional analysis. Include assessment scores and graphs.

b. Provide a clinical rating for each target problem :

1. much worse
2. moderately worse
3. slightly worse
4. no change
5. slightly improved
6. moderately improved
7. much improved
8. not applicable

Reason for termination

Other Comments

Address at which client may be reached in six months

Appendix J

FOLLOW-UP/CLIENT SATISFACTION FORMS (example)

Dear

An important aspect of providing health services is the knowledge of how things eventually turned out. You can probably appreciate how information about the outcome of your therapy can help us to constantly strengthen and improve our treatment, training, and research.

Therefore, we routinely send out this brief questionnaire to each client about six months following completion of treatment. We would like to know how you have been feeling and what you have been doing, especially with regard to your reasons for seeking treatment at the Clinic. Your willingness to candidly complete the attached form may also be helpful to future clients. It may take 10-15 minutes to fill out.

When people are asked to give follow-up information, they often answer in a socially acceptable way, and try to please their ex-therapist by leaving him/her with a good impression. Many people are so reluctant to report developments that they fear might disappoint their therapist (e.g., relapses, new problems, or other unhappy occurrences), that they distort the truth. We cannot overemphasize that negative reports are just as important to us as positive ones.

If you have any questions about these materials, please contact the Clinic. We look forward to receiving your appraisal of your treatment and your current situation.

Sincerely,

Director

Follow-up/Client Satisfaction Survey (example)

For each question, please circle the response which best indicates your answer.

1. How many times were you seen for psychotherapy?

5 or less	6 to 15	6 to 25	more than 25
(1)	(2)	(3)	(4)

2. Did your therapist have a good understanding of your problems?

Very Poor	Poor	Fair	Good	Very Good
(1)	(2)	(3)	(4)	(5)

3. Have your problems changed for the better or worse as a result of therapy?

Much Worse	Worse	No Change	Better	Much Better
(1)	(2)	(3)	(4)	(5)

4. How well are you coping with your problems now, compared to when you began therapy?

Much Worse	Worse	No Change	Better	Much Better
(1)	(2)	(3)	(4)	(5)

5. Over all, how would your rate your therapist?

Very Poor	Poor	Fair	Good	Very Good
(1)	(2)	(3)	(4)	(5)

6. Overall all, how would you rate the services you received?

Very Poor	Poor	Fair	Good	Very Good
(1)	(2)	(3)	(4)	(5)

7. If you had other personal or family problem would you return here again for services?

Definitely Not	Probably Not	Maybe	Probably	Definitely

(1) (2) (3) (4) (5)

8. If you had any concerns about therapy or dissatisfactions with your therapist, did you feel he or she was open to discussing them with you?

Very Open	Open	Don't Know	Closed	Very Closed
(1)	(2)	(3)	(4)	(5)

Please answer the following questions:

1. If there have been significant improvements or setbacks, what do you attribute them to?

2. Have you developed any new symptoms or problems? If 'yes" please elaborate.

3. Please indicate things in therapy that did not work for you and/or any concerns that you have that were not resolved in therapy.

4. Have you or anyone in your family required psychotherapy or developed emotional problems or received medical attention in the last six months?

5. Please add any information that you think might be of assistance in this follow-up.

Please check all of the following that apply:

____I am in therapy with someone else.

____My needs were/are met for the time being.

____My needs were not met.

____I would want to see the same therapist again if the need arose.

____I would seek a different therapist if the need arose.

Name:

Date:

Appendix K

EVALUATION OF PRACTICUM STUDENT FORM

Name of Student ________________________ Name of Supervisor __________________________

Agency ________________________________ Evaluation Period: F Sp Su 20____

Supervisors: Please complete this form for each practicum student you supervise. The form and supervisory feedback should be reviewed and discussed by the supervisor and student at the end of each semester. The supervisor's evaluation will be reviewed by the Associate Director and Director of Clinical Studies.

CHECK APPROPRIATE BOX:
[ ] Student's Own Evaluation
[ ] Supervisor's Evaluation of Student

Supervisor's Context for Evaluation (CHECK ALL THAT APPLY)

____ Supervision ____ Audiotape ____ Group Therapy Supervisor
____ Co-therapy ____ Observation ____ Other _____________________
____ Videotape ____ Seminar

There are four sections to this evaluation form: I. Professional and Ethical Conduct, II. Clinical Competence and Performance, III. Use of Supervision, and IV. Open-ended Comments for Student's Strengths and Recommendations for Professional Growth.

CIRCLE THE MOST APPROPRIATE RATING, using as your reference group pre-doctoral graduate students in training.

1 = UNSATISFACTORY - behavior that is either consistently problematic or of serious nature. If circled, elaborate under "Comments/Recommendations" at end of section, noting behavioral changes needed to warrant future satisfactory performance.

2 = MARGINAL - behavior that is problematic but not consistently demonstrated or behavior needing improvement but not of serious nature. If circled, elaborate under "Comments/Recommendations" at end of section, noting behavioral changes needed to warrant satisfactory performance.

3 = SATISFACTORY - refers to behavior considered average or expected for practicum students at this level of training

4 = GOOD - refers to behavior that is better than average to very good

5 = EXCELLENT - refers to behavior that is outstanding

NA = Refers to "Not Ascertained"

I. PROFESSIONAL AND ETHICAL CONDUCT

		Unsatisfact.	Marginal	Satisfact.	Good	Excellent	
1.	Shows sensitivity to ethical issues and knowledge of APA ethical guidelines.	1	2	3	4	5	NA
2.	Demonstrates professional demeanor, behavior, and attire.	1	2	3	4	5	NA
3.	Shows appropriate role differentiation. Does not engage in activities with client that are inappropriate to therapist-client relationship.	1	2	3	4	5	NA
4.	Completes commitments in prompt and professional manner.	1	2	3	4	5	NA
5.	Shows no impairment in professional functioning as a result of emotional interference or personal problems (or if impaired, seeks professional help).	1	2	3	4	5	NA

COMMENTS/RECOMMENDATIONS:

II. CLINICAL COMPETENCE AND PERFORMANCE

	A. ASSESSMENT	Unsatisfact.	Marginal	Satisfact.	Good	Excellent	
1.	Able to identify and classify (DSM-5) nature of disorder or problem using DSM guidelines.	1	2	3	4	5	NA
2.	Appropriately assesses danger of client's behavior to self or others.	1	2	3	4	5	NA
3.	Knows when and how to consult with others and refer.	1	2	3	4	5	NA
4.	Able to apply cognitive and/or behavioral assessment methods.	1	2	3	4	5	NA
5.	Demonstrates knowledge and skill in administering and interpreting psychometric tests and/or other assessment measures used at this training site.	1	2	3	4	5	NA
6.	Engages in ongoing assessment of problems and treatment effectiveness throughout therapy.	1	2	3	4	5	NA

	B. INTERPERSONAL THERAPY SKILLS	Unsatisfact.	Marginal	Satisfact.	Good	Excellent	
1.	In regard to agency, has smooth working relationship with other treatment team members and is aware of agency dynamics.	1	2	3	4	5	NA
2.	In regard to clients, conveys empathy and acceptance.	1	2	3	4	5	NA
3.	Uses questions, reflection, and summarizing statements effectively when working with clients.	1	2	3	4	5	NA

C.	GENERAL THERAPEUTIC SKILLS & CONCEPTUAL INTEGRATION	Unsatisfact.	Marginal	Satisfact.	Good	Excellent	
1.	Shows evidence of an organized conceptual understanding of client's problem and uses this conceptualization to guide assessment and/or treatment.	1	2	3	4	5	NA
2.	Shows knowledge of empirical literature and theories relevant to problem/behavior disorders and uses this to guide assessment and/or treatment.	1	2	3	4	5	NA
3.	Able to respond sensitively and effectively to client resistance or negative affect.	1	2	3	4	5	NA
4.	Able to summarize and analyze therapy process or important aspects of a therapy session.	1	2	3	4	5	NA
5.	Keeps regular, clear progress notes containing relevant data regarding problem, issues, changes, treatment, and goals.	1	2	3	4	5	NA
6.	Acknowledges limitations.	1	2	3	4	5	NA
7.	Acknowledges professional strengths.	1	2	3	4	5	NA

D.	SPECIFIC THERAPEUTIC SKILLS	Unsatisfact.	Marginal	Satisfact.	Good	Excellent	
1.	Demonstrates skill in cognitive interventions.	1	2	3	4	5	NA
2.	Demonstrates skill in behavioral interventions.	1	2	3	4	5	NA
3.	Demonstrates skill in crisis intervention and suicide management.	1	2	3	4	5	NA

		Unsatisfact.	Marginal	Satisfact.	Good	Excellent	

4.	Demonstrates skill in other therapeutic techniques/modalities used at this practicum training site (please list and rate)						
	______________________________	1	2	3	4	5	NA
	______________________________	1	2	3	4	5	NA
	______________________________	1	2	3	4	5	NA

E.	ABILITY TO WORK WITH DIVERSE POPULATIONS	Unsatisfact.	Marginal	Satisfact.	Good	Excellent	
1.	Able to work effectively with persons of both genders; is aware of own sex role attitudes and impact on others.	1	2	3	4	5	NA
2.	Able to work effectively with persons of different racial, ethnic, and cultural backgrounds.	1	2	3	4	5	NA
3.	Demonstrates respect for clients of differing sexual orientation, political or religious values.	1	2	3	4	5	NA
4.	Able to work effectively with persons of different age groups.	1	2	3	4	5	NA

COMMENTS/RECOMMENDATIONS:

III. USE OF SUPERVISION OR BEHAVIOR IN PRACTICUM

		Unsatisfact.	Marginal	Satisfact.	Good	Excellent	
1.	Consistent and punctual in attendance.	1	2	3	4	5	NA
2.	Comes prepared with appropriate materials.	1	2	3	4	5	NA
3.	Open and responsive to feedback and suggestions from supervisor.	1	2	3	4	5	NA
4.	Actively participates, raises questions or issues to expand knowledge and skills of self (or others).	1	2	3	4	5	NA
5.	Accepts responsibility for learning and enlarging body of knowledge and experiences.	1	2	3	4	5	NA
6.	Consults supervisor when unsure.	1	2	3	4	5	NA
7.	Overall quality of work produced.	1	2	3	4	5	NA

COMMENTS/RECOMMENDATIONS:

IV. ADDITIONAL COMMENTS:

A. STUDENT'S STRENGTHS

B. RECOMMENDATIONS FOR STUDENT'S PROFESSIONAL GROWTH

____ ____________________

Signature of Practicum Student Date

____ ____________________

Signature of Practicum Supervisor Date

Appendix L

PRACTICUM SITE EVALUATION

The purpose of this form is to monitor practicum experiences of students and to aid the Clinical Studies Program in future practicum placement decisions. This form will be reviewed only by the Director and Practicum Coordinator of the Clinical Studies Program, and no copy of this will be given to your site supervisor.

Name ________________________ Practicum Site ______________________________

1. Total client contact hours in individual/couples/family therapy ________

2. Total contact hours in group therapy (including psychoeducational) ________

3. Total client contact hours in assessment ________

4. Total hours of on-site supervision (include group supervision, but not hours noted below for case conferences) ________

5. Total research hours ________

6. Total hours in on-site seminars/workshops ________

7. Total hours in case conference/staffings ________

8. Percent of time devoted to specific populations (can be overlapping %):

   a. single adult outpatient ________
   b. group ________
   c. family ________
   d. marital ________
   e. adult inpatient ________
   f. child/adolescent inpatient ________
   g. community consultation ________
   h. individual child outpatient ________
   i. severely mentally ill ________
   j. ethnic/racial minorities ________

9. Mean number of sessions per client ________

10. Total number of different individuals/ families/couples/groups seen in therapy ________

11. Theoretical orientation of supervision

____

Please use the following scale in answering the following questions.

1	2	3	4	5
not at all		moderately		thoroughly

12. To what degree were the science and practice of clinical psychology integrated at this practicum site?

    1 2 3 4 5

13. To what degree were assessment and treatment integrated at this practicum site?

    1 2 3 4 5

14. To what extent was this training experience consistent with an emphasis on sensitivity to gender, ethnic, and other individual differences?

    1 2 3 4 5

15. If any difficult ethical issues concerning either clients or staff arose during the course of your practicum, to what extent do you feel that they were satisfactorily resolved? (If you did have a problem in this area, please describe on an additional sheet).

    1 2 3 4 5 NA

16. If any problems or conflicts arose during the course of your on-site supervision, to what extent do you feel that they were satisfactorily resolved? (If you did have a problem in this area, please describe on an additional sheet).

    1 2 3 4 5 NA

17. What do you wish you had known before beginning your training on this practicum site that might have made your experience more beneficial? (Please answer on an additional sheet).

18. Overall rating of the training experience at this practicum site:

1	2	3	4	5
poor		adequate		excellent

19. Did you get what you hoped you would from this training experience? What, if anything, was lacking? What, if anything, exceeded your expectations? (Please answer on an additional sheet).

Appendix M

Dealing with suicide in clinical training settings: Students

Suicide in clinical settings is an all too common occurrence. Approximately 1 in 5 psychotherapists loses a patient to suicide during their career. The aftermath of these experiences for clinician-survivors, including stigma, legal issues, and fear of negative judgment can further aggravate the pain and trauma of the loss.

It sometimes occurs that students in practicum training experience the loss of a patient through suicide. This section is meant to offer assistance to such students. First, the frequency of these occurrences is often unknown. However, suicide is a leading cause of premature death for many emotionally distressed people, and over 90% of all completed American suicides are by persons with mental disorders. About half of those who die by suicide will have seen a mental health provider at one time point in their lives. It is normal for providers and those otherwise connected to suicide victims to experience psychological trauma and grief.

The following suggestions might assist you now and in the future if someone you provide care for should die by suicide. First, value and practice the training and knowledge base you receive in risk assessment and harm prevention, routinely inquiring about suicide with all of your cases. If someone in your care dies by suicide, you will be comforted by having received and utilized relevant training and in assessing and managing risk. If you feel you need extra help in honing your risk assessment and management skills, seek out additional training and knowledge with the help of your supervisors, professors, or both.

If you discover that one of your cases is at risk of self-harm, seek out supervision and involve other professionals. Knowing that other professionals were participating in the treatment or assessment plan will also provide comfort if a negative outcome should occur. In addition, if you have lost one or more clients to suicide, the following webpage provides materials pertaining to clinician-survivors that might be helpful, including resources, connections to others, information, support, and help.
http://mypage.iu.edu/~jmcintos/basicinfo.htm

Dealing with suicide in clinical training settings: Supervisors and training sites

The following guidelines are intended to help supervisors of practicum students and training sites manage in the aftermath of students' clients who die by suicide. These recommendations are based on those suggested by the Clinician Survivor Task Force of the American Association of Suicidology.

Supervisors

Allow plenty of time to meet with the supervisee. Let them talk about their emotions and thoughts, without judging the adequacy of their care or trying to determine responsibility.

If appropriate, remind trainee they are not alone, and if relevant, self-disclose experiences. Review the client's file and details of the case, including session recordings if available. Discuss supervisee's next steps, including other clinical activities and self-care, and clarify whether student can or should talk to others or seek counseling or other support; in addition, discuss what record keeping is needed and document the supervision session and recommendations. Consider whether the student should contact, meet, or suggest a referral for, client's significant others, taking care to maintain client confidentiality and to prevent them from attributing negligence on the trainee's part. Discuss with the student the possibility of attending the client funeral. Monitor the supervisee's emotional state, future client work, and interactions with professionals.

Training Programs/Sites

Faculty and staff should consistently demonstrate empathy, unconditional support, and respect. After the supervisor and trainee meet, the supervisor should meet with superiors to discuss the incident, inform legal counsel, and malpractice insurance carrier. If necessary, include the student in such meetings. Encourage and allow the student, her or his peers, and faculty/staff to learn from the situation. Prevent other students, faculty, or staff to penalize, blame, or pressure the student to "get over" possible grief; permit the student to grieve. Do not undermine the impact of the incident on the student, peers, supervisor, faculty/staff; instead, determine how the event can be used to help the program and student.

Appendix N

Description of specific practicum training sites

Practicum sites include a variety of settings addressing the psychological needs of adult, child, and family client populations. The on-campus ("in-house") training sites are described in detail below. There are also numerous external, off-campus training sites in which students complete practicum experiences. These sites are summarized more concisely below. Please note that the available practicum sites may grow and shift over time.

1.) On-campus practicum sites

Center for Cognitive Behavioral Therapy—Childhood Disorders. This on-campus placement is under the routine supervision of Drs. Mueller and Nakamura (Dr. Floyd filled in while Dr. Nakamura was on leave in AY 2014-2015). Students in this practicum setting receive training in the assessment and treatment of childhood anxiety, depression, ADHD and disruptive behavior disorders. Some students also are placed in the public school system and receive training in school consultation, including universal prevention, early intervention and school based mental health services. Student are also provided an opportunity to enroll in a separate practicum focused on psycho-educational assessment, which has been taught either by core faculty (e.g. Dr. Mueller) or CSP affiliate licensed psychologists.

Under service contracts from the Child and Adolescent Mental Health Division of the Department of Health of the state of Hawai'i and from another contract with the State of Hawai'i Department of Education, families are seen in the clinic for a series of assessment and treatment sessions. Students participate in all phases of the assessment-treatment process: they interview families and children, administer standardized tests, implement empirically supported assessments and treatments, and consult with teachers and other care-providers. All assessment and treatment activities are supervised by Drs. Mueller and Nakamura (or Floyd) through weekly clinical supervision meetings.

The setting exemplifies a scientist-practitioner approach to clinical training. Drs. Mueller and Nakamura are active clinical researchers and consult with the Hawai'i Department of Education and the Child and Adolescent Mental Health Division of the Hawai'i Department of Health. Many students conduct Masters theses and dissertations in association with the clinic. The clinic uses empirically supported assessment and treatment strategies, treatment outcome is measured using standardized instruments, and students follow recent research developments through ongoing clinical-research didactics.

Center for Cognitive Behavioral Therapy—Eating Disorders. This on-campus placement is under the supervision of Dr. Vitousek. Students in this practicum setting receive training in the assessment and treatment of eating disorders including anorexia nervosa, bulimia nervosa, and binge eating disorder in adults and adolescents. In addition, some students provide assessment and therapy services for adolescents in their school setting. Clients are seen in the Center for a series of assessment and treatment sessions. Students participate in all phases of the assessment-treatment process: They interview clients and administer standardized, empirically supported

assessment and treatment packages. All assessment and treatment activities are supervised by Dr. Vitousek through weekly clinical supervision meetings.

This setting also exemplifies a scientist-practitioner approach to clinical training. Dr. Vitousek often publishes, consults, and provides keynote talks and training workshops in the field. A number of students conduct Masters theses and dissertations in association with the clinic, the clinic uses empirically supported assessment and treatment strategies, and students follow recent research developments through ongoing clinical-research seminars.

Center for Cognitive Behavioral Therapy- OnTrack Hawaii. This on-campus placement is under the supervision of Dr. David Cicero. The OnTrack Hawaii clinic is a new and innovative early intervention service for youth and young adults who have recently began to experience symptoms of psychosis. Our clinic follows the model of the Recovery After Initial Schizophrenia Episode (RAISE) program, which is an initiative funded by the National Institute of Mental Health. The RAISE program and is designed to provide comprehensive therapeutic intervention as soon as possible after the onset of symptoms of psychosis. OnTrack Hawai'i provides psychiatric services including individual therapy, family therapy, medication evaluations, and employment and education services, to individuals aged 15-24 who have experienced symptoms of psychosis within the past two years.

The clinic is a collaboration between the Department of Psychology, the Hawaii Adult Mental Health Division, the Hawaii Child and Adolescent Mental Health Division, and the John A Burns School of Medicine Department of Psychiatry. Funding is provided by the Substance Abuse and Mental Health Services Administration.

Training experiences available to students in this practicum include assessment of early psychosis and schizophrenia spectrum disorders, individual therapy, supported education and employment, family therapy, and group therapy such as social skills training. Students will gain experience working with multidisciplinary teams that are common in schizophrenia treatment.

University of Hawai'i Center for Student Development. The University Center for Student Development, located on the University of Hawai'i campus, offers a full spectrum of outpatient psychological, academic, and career assessment and counseling services to university students. Students also often select additional training in group psychotherapy. Students receive weekly individual and group supervision from counseling center staff. The Center for Student Development has a strong training orientation (e.g., case conferences, training seminars), with an APA-approved internship training program.

2.) Off-campus practicum sites

External practicum sites help to ensure broad training, including training in evidence-based practice, to diverse clients. Practicum placements are discussed with and approved by the student's faculty advisor and the associate director to ensure that they are appropriate to the student's training needs, progress in the program, and long-term career goals. As shown in Table 2, numerous practicum settings are available and offer a variety of training opportunities. They include both inpatient and outpatient medical and psychiatric settings, community agencies, and specialized private outpatient clinics. Some sites provide clinical training within the context of ongoing

clinical research programs. Supervision is provided by licensed mental health professionals, typically licensed psychologists.

These sites can be summarized as belonging to a number of categories that represent the types of mental health services provided in the external community. Populations are typically diverse and representative of the multicultural environment in the state of Hawai'i. Some sites tend to serve populations that are rural and underserved, in areas of the state that are often characterized by poverty and a wide array of problems and life stressors. Specifically, the sites I Ola Lahui Rural Hawai'i Behavioral Health, based at Waimanalo Health Center, and Waianae Coast Comprehensive Health Center, serve the rural, underserved communities on the eastern and western coasts of Oahu, respectively. Both of these practicum sites now also have APA-approved internship training programs.

Another setting in which students conduct practicum activities includes the Tripler Army Medical Center (TAMC). At TAMC, students have conducted practicum placements in various tracks focusing on different areas of psychology including behavioral medicine, child and family psychology, and oncology. Students have also conducted practicum experiences in other sites working with different types of populations such as the Hawai'i State Hospital, assessing and treating forensic inpatients with severe and persistent mental illness, the Federal Detention Center, assessing and treating inmates, and Ho'omau Ke Ola, assessing and treating clients with substance-related disorders. Many sites include experiences in a variety of psychological services, including assessment and treatment, although some settings may focus more on assessment or more on intervention. For example, some settings where students have conducted primarily assessment work have included the Pacific Neuropsychology Institute, Waikiki Health and Wellness Clinic, and Pacific Forensic Associates.