

The Clinical Supervisor's Handbook

for
Marriage and Family Therapy Program
Louisville Presbyterian Theological Seminary



(Revised August 2013)

Clinical Supervisor's Handbook

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Clinical Supervisor's Handbook

Introduction and Supervision Philosophy

Supervision of clinical work at Louisville Presbyterian Theological Seminary is central to our mission. Our quest is to provide the highest quality experience in learning new skills, developing therapist identity, and integrating theoretical, religious and spiritual issues into the work of marriage and family therapy. Toward this end, supervision is a collaborative enterprise involving the intern receiving supervision, the clinical supervisor, the MFT/PCC faculty, and the Director of Clinical Training.

Supervisors are appointed dependent upon therapeutic experience, personal maturity, and specific academic and experiential training in supervision. All supervisors are qualified to provide supervision toward professional certification in Pastoral Counseling and Marriage and Family Therapy. Supervisors, while embracing a variety of therapeutic and supervisory models, approach supervision with awareness of the client and intern in a systemic context.

General Position Description

Contract and Renewal



Clinical supervisors in the Marriage and Family Therapy Program at Louisville Presbyterian Theological Seminary are offered an annually renewable one-year contract to provide supervision services. This contract is made by the MFT Program Director, in collaboration with the Director of Clinical Training, and approved by the Dean of the Seminary. Supervisors are accountable for their work to the Director of Clinical Training, the MFT Program Director, the Dean of the Seminary, and to seminary personnel policies and procedures.

The annual contract will define services to be provided, rate of pay for service, expectations for service, and length of service.

Supervisors will be paid at a rate annually established by Louisville Presbyterian Theological Seminary.

Dates of service are fiscal year June 1 through May 31.

Renewal of contracts with supervisors will be contingent upon evaluation of supervisor's participation in the MFT Program and the Program's need for supervisors. Supervisors will be presented a contract for annual service no later than April 30 of each year.

Qualifications

Supervisors appointed by Louisville Seminary and must meet the following criteria:

- Hold as a minimum Clinical Fellow status with the American Association of Marriage and Family Therapy (AAMFT).
- Be approved as a Supervisor by AAMFT, or be a Supervisor Candidate (SC) under ongoing supervision. Supervisor Candidates must submit their supervision plan with a timetable for completion to the Director of Clinical Training.
- Hold as a minimum Member status in the American Association of Pastoral Counselors. Those theologically trained are encouraged to obtain Fellow or Diplomate status.
- Five (5) years of clinical practice of Marriage and Family Therapy as a licensed or certified therapist.
- Be able to articulate a.) a personally integrated systemic model of marriage and family therapy that they use in clinical practice, and b.) a guiding systemic supervisory philosophy and how this relates to training marriage and family interns in a seminary context.
- Demonstrate the ability to integrate spiritual and theological dynamics with clinical practice.
- Be committed to providing marriage and family therapy supervision at the intersection of theory, clinical practice, faith, and theology.
- Maintain and verify personal liability insurance for personal clinical practice.
- Demonstrate personal maturity and willingness to explore their own personal issues, biases and frames of reference that influence supervision.
- Be multi-culturally aware and integrate this into supervision practice.

Responsibilities Outline

Supervisors will be responsible for clinical supervision of assigned students and will participate in designated administrative activities central to the MFT Program as outlined below. (See main sections “Clinical Supervision,” “Administration,” and “Ethical and Professional Standards” for details.)

Clinical Supervision

- ✓ Provide adequate consistent weekly supervision for students to meet the minimum expectation of 1 hour of supervision per 5 hours of clinical experience throughout the calendar year. Supervisors will be assigned dyads by the Director of Clinical Training.
- ✓ Be responsible for responding to clinically-related student crises.
- ✓ Be available to supervise one-two dyads per year if an Approved Supervisor and one dyad a year if a Supervisor Candidate.
- ✓ Provide opportunities for students to work with and observe the supervisor's clinical work. In this context, "clinical work" includes participating in co-therapy with the supervisor, observing the supervisor working with clients, and/or role-playing.
- ✓ Supervisors may be offered additional group supervision ("Live") opportunities, in mutual agreement with the Director of Clinical Training.

Administrative

- ✓ Attend Clinical Staff meetings, as scheduled.
- ✓ Participate in MFT admissions screening interviews.
- ✓ Complete all forms required by the MFT Program.
- ✓ Review and approve student documentation of clinical and supervision hours as reported on monthly Practicum Logs.
- ✓ Keep complete records of all supervision offered in accordance with AAMFT and other professional standards.
- ✓ Seek opportunities for personal growth in supervision skills.
- ✓ Obtain coverage for individual supervisees during times of vacation or absences other than times of seminary closure and obtain face-to-face supervision for individual supervisees if absence exceeds 10 days. Supervisor providing coverage will be responsible for responding to clinically-related student crises. For assistance with supervision availability please contact the Director of Clinical Training.

Ethical & Professional

- ✓ Be engaged in direct client contact.
- ✓ Comply with all applicable ethical standards and legal requirements, including those relating to conflict of interest and dual relationships with students, faculty and staff.
- ✓ Meet all AAMFT and AAPC ethical and professional standards.
- ✓ Abide by all governance policies and procedures of Louisville Seminary.

CLINICAL SUPERVISION

An Overview

Supervision in the Marriage and Family Therapy Program consists of face-to-face consultation in which an AAMFT Approved Supervisor/Supervisor Candidate and a supervisee, or supervisees, agree to engage in systemic reflection upon the concrete processes of and challenges in the practice of marriage and family therapy for the purpose of enhancing personal and professional growth. All faculty and clinical staff in the MFT program are experienced pastoral counselors and/or AAMFT Approved Supervisors or Supervisor Candidates who have strong commitments to the importance of intensive supervision for the developing therapist. Supervision takes place in two formats, individual and group. Both forms of supervision are required in each practicum experience.

Individual supervision is defined as a weekly 1 hour/1.5 hours meeting in which a clinical supervisor meets face-to-face with one student or one dyad (two students) to reflect upon each student's marriage and family therapy client cases. The clinical supervisor is to be informed of all client contact and clinical concerns whether occurring at the on-campus site (LSCTC) or at the student's off-campus site.

Group supervision is defined as face-to-face meetings between a supervisor and up to ten students for group reflection upon each student's presentation of cases which occurs in rotation.

Supervision is not psycho-education. Each supervisory conversation takes shape through reflection upon case report and/or raw data (direct observation, DVD presentation, or audio tape) from the presenting supervisee's practice. Although there is a therapeutic or personal-growth dimension to all good supervision, the boundaries of the supervisory conversation are clearly around the concrete processes of the supervisee's professional practice and relationships. The working alliances in supervision may require reflection; particularly as problems surrounding isomorphism and parallel process between treatment and training express themselves in the supervisory relationship. Reflection upon the intra-psychic and inter-personal systems involved is required. The boundary to these conversations is established around the task of making necessary systemic changes to provide effective marriage and family therapy for clients and not in search of personal or systemic change for the supervisee.

Supervision is not personal therapy, however, portions of the supervisory conversation may address any relevant matter involving the supervisee's current training and the working alliances sustaining it. These conversations focus on the task of marriage and family therapy and seek to return to that practice with increased knowledge and skill. Students in their respective practicum sites may receive various didactic enrichment and training experiences including seminars, lectures, and administrative activities. These are a legitimate and necessary

part of a practicum experience but are not considered in the required total hours of clinical supervision.

Program Requirements

Supervision is required at the ratio of 1 hour of supervision (individual or group) for every 5 hours of direct client counseling a student provides. A minimum of 125 hours of supervision is required for graduation from the MAMFT Program. At least 50% of all supervision will focus on raw data from the student's clinical work made available to the supervisor by means of direct observation, DVDs, or audiotapes.

Individual Supervision

During the Practicum series, students will typically have two supervisory appointments which are made by the Director of Clinical Training. The first clinical supervisor will oversee a student's progress through Practicum I and II. At the end of Practicum II, a new supervisor will be appointed to guide the student through the remaining two Practicum levels. Students will normally receive supervision for a minimum of one hour per week.

Group Supervision

In addition to individual supervision, all students enrolled in practicum are required to participate in the MAMFT Program's Live Supervision groups, Interdisciplinary Case Conferences (ICC), and selected training events comprising the balance of hours spent in the teaching/learning process. The variety of orientations among our faculty and clinical staff permits students to be exposed to a diversity of theoretical frameworks.

Supervision Structure and Procedure

Individual Supervision



Intern Assignments and Supervisory Agreements

Supervisors will be assigned dyads by the Director of Clinical Training, in conversation with the Clinical Staff. Every intern accepted for supervision will complete a *Supervision Practices Agreement* (see Appendix) that will be filed in the student's central MFT portfolio. This agreement outlines the limits and conditions of the supervisory services offered and provides informed consent regarding methods to be used and ethical guidelines to be followed while in supervision.

Practicum Description

Every student must complete four course levels of Practicum in the MAMFT program. The prerequisite/co-requisite for beginning the clinical experience is the course *Family Therapy: Theory and Practice*. **Practicum I establishes the foundation for all further supervised clinical practice.** Through structured exercises and closely supervised counseling, students will learn basic skills necessary to continue through the practicum cycle. Practicums II-IV are designed to assist the student in skill development and professional formation.

The goal of reaching a competent level of knowledge and experience in marriage and family therapy drives both coursework and practicum experience. Moving through the Practicum cycle demands demonstrating specific core competences gained through academic and clinical work, as well as completing the minimum specified hours of supervised counseling (see Appendix, Practicum syllabi and form samples).

Supervisory Contracts

The structure of Practicum supervision involves the submission, in writing, of a clear Supervision Contract at the beginning of each practicum level outlining specific goals for personal and professional growth, related to specific practicum objectives.

Philosophy of Contracts

Contracts between each clinical supervisor and student in practicum will ordinarily have four parts:

1. Administrative and Clinical Responsibilities – Defines the overall responsibilities of each supervisee. The forms used for Practicum I-IV contracts contain standardized responsibilities. Supervisors may include additional requirements as needed for levels II-IV. Standard responsibilities include: 1. Present raw data (videotape, DVD, or audiotape) or case report during the supervisory time each week. 2. Maintain a 1:5 ratio of supervision to client contact hours. 3. Complete administrative paperwork in a timely fashion. 4. Follow all policies and procedures for Louisville Seminary Counseling Training Center.

2. Specific Measurable Goals – Goals established for Practicum may reflect one or more of the following areas:

Professional goals – These goals relate to particular competencies targeted for the supervisee to learn. Goals are best kept simple and definite to be effective. They normally are negotiated to express the expectations of the supervisor and the particular needs of the student and are related to the specific objectives of the practicum section. The manner in which their achievement can be accurately evaluated is of paramount importance. (Examples: a. Increase focus on assessment tools in the formulation of client diagnosis as applicable to treatment planning. b. Use resources and conduct empirical/research regarding best practices and effective treatment for specific client issues.)

Psychological goals – These goals relate to the personal needs of both parties involved in supervision and how these needs will be met. In concrete terms they express what each person needs from the other in order to work effectively together. Effective psychological goals follow candid discussions of anything in the way of effective teamwork in the supervisory relationship.

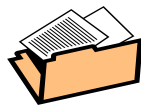
Integration goals – These goals relate to integrating clinical practice with theory, theology, and use of self in the practice of therapy. This area of concentration includes concern for pastoral/ministerial formation and how what the student is learning in diverse areas of the program are brought together intellectually, behaviorally, emotionally, and socially in clinical practice.

3. Specific Actions to Reach Goals – In this contract area, expectations are identified regarding what the student therapist will do to meet the goals established in the contract. Although general guidelines can be identified, naming specific actions will enable both supervisor and student to measure success in obtaining goals.
4. Method of Evaluation for Each Goal – This section establishes the criteria for measurement of successful completion of goals. The form for Practicum I-IV contracts contains standardized methods. Supervisors may include additional methods as needed

for practicum levels II-IV. Standard methods include: 1. Supervisor and student will meet regularly where student will present case reports, audiotape or videotape. 2. Supervisor will observe, if possible or necessary. 3. A Mid-Practicum Evaluation will be completed. 4. A final evaluation and Clinical Staff Review will be completed at the end of each Practicum level. This evaluation may include conversation between the clinical and administrative supervisors to gain a fuller picture of the student's clinical skills demonstrated at the off-campus clinical site.

A standard Practicum I contract with possible goals has been developed to guide both the student and the supervisor in the preparation of the remaining three contracts. (See *Supervision Contracts* in Appendix.)

Supervision Records



A supervision note is required for each supervision session. Recommendations regarding process and administration should be kept in the supervisees' file. Supervision notes will be kept in a formal file maintained by the Supervisor for the intern. The MFT Program will have access, when necessary, to these notes as a part of the intern's educational record. Supervisors will store supervision notes for a minimum of three (3) years after the intern has completed the MAMFT Program. Notes should include:

- Intern's name
- Date of session
- Method of supervision (live, video-taped, case review)
- Identification of case presented by intern
- Assessment of interns' presentation (i.e., assessment of case, case conceptualization, clinical reasoning, interventions with case, counter transferences, etc.)
- Supervisory interventions
- Assessment of intern's progress
- Assignments
- Plan, amendments to supervisory plan

Written evaluations and documentation of any action with the intern will be provided for the intern's central file, maintained by the MFT Administrative Assistant.

Practicum Record Logs

Interns are to provide their supervisor with a completed log showing hours of therapy given and hours of supervision received (see Practicum Log example in Appendix). It is the intern's responsibility to provide these documents. ***It is the supervisor's responsibility to be certain interns are aware of this expectation and to follow up with their interns.*** Supervisors are expected to sign-off on the clinical and supervisory hours reported by the intern, verifying that the hours earned are accurately recorded. Forms are filed with the MFT Program Office.

Observational Methods

Fundamental to supervision practice is maintaining reliability between interns' reporting of session and their actual functioning in therapy. Assuring client welfare and providing the best supervision requires using effective and appropriate observation methods. The *Supervision Contract* and client's informed consent should include provisions for audiotaping, videotaping and live supervision. Supervisors are encouraged to make as much use of direct experience and observation of interns' work as possible.

Louisville Seminary Counseling Training Center (LSCTC)

The Louisville Seminary Counseling Training Center (LSCTC) is the on-campus site for MFT students' therapeutic work. This work is governed by the policies and procedures presented in the Louisville Seminary Counseling Training Center Operating Manual. Supervisors oversee their students' client records by giving attention to appropriate documentation, including initial session case write-up, treatment, and termination forms, as well as session progress notes. (See LSCTC Manual for policies and procedures.)

Practicum Evaluations and Assessments

A thorough evaluation of the progress of each student is made through each clinical experience in the Marriage and Family Therapy Program at Louisville Presbyterian Theological Seminary. This includes evaluations from supervisors in clinical assignments and in all courses within the formal curriculum. These evaluations will accumulate in the student's central file for review at the time of final evaluation as graduation approaches.

Clinical Competence

The focus of practicum evaluation is the student's clinical competence and integration of the MFT academic body of knowledge. Evaluations are designed to give consistent feed-back of progress toward specific objectives at each stage of the student's experience. A clear picture of strengths and weaknesses is the aim of such conversations between supervisor and student. Evaluation is a mutual process. Appraisal of the supervisor's work in the supervisory experience by the student is a vital part of each evaluative conference.

Evaluative Standards

Clinical competence will take into account the student's personal, professional, and academic growth toward specific standards in the practice of marriage and family therapy. Standards around which evaluations are conducted throughout the entire program involve an increased sense of professional competence in a number of fundamental qualities:

1. the ability to understand, articulate and act upon a workable conceptual framework for doing marriage and family therapy.
2. a sound knowledge of literature, research, and theory involving a number of models in marriage and family therapy.
3. demonstrated ability to engage in case management, planning, and treatment from beginning to end.
4. the capacity to present one's experience both conceptually and with an understanding of raw data in supervision and to use supervision constructively to enhance professional competence.
5. the ability to operate clinically and theoretically within a multi-cultural and broader-systems framework.
6. the ability to articulate and work within a theologically informed pastoral framework that takes seriously ministry, personal belief systems and religious commitment.
7. the capacity to maintain an adequate and responsible record-keeping system.
8. adherence to the AAMFT and AAPC Codes of Ethics.

Evaluative Procedure

Mid-Practicum Review

At the mid-point of each supervisory period or Practicum course, a written Mid-Practicum Evaluation will be prepared by the student's clinical supervisor, reviewed with the student, signed, and then submitted to the Administrative Assistant for storage in the student's central MFT file. The review shall appraise the student's specific experience over the first half of the Practicum level, specifically regarding demonstration of competencies, what has been accomplished, and what needs to be done between the present and the final evaluation for the Practicum level in clear terms for all parties to understand. It is also an appropriate time to modify the working contract for supervision and self-care.

Final Practicum Evaluation

The final Practicum evaluation consists of two parts: an assessment process incorporating three-four assessment tools, and a Formal Clinical Staff Review.

1. When a student has demonstrated the competencies required for their level of Practicum, as determined by the clinical supervisor, the required assessments will be completed.
 - a. The student will complete a self-assessment of their progress toward achievement of competencies, providing supportive comments as desired. The student will review their self-assessment with their clinical supervisor then submit the form to the Administrative Assistant to be included in the Formal Clinical Staff Review.
 - b. Based on an assessment of the student's progress toward achievement of appropriate level competencies as demonstrated by self-reports and presentations of raw data, the clinical supervisor will complete Section 1 of the Final Practicum Evaluation.
 - c. The Practicum site Administrative Supervisor will assess the student's demonstration of competencies at their clinical site and submit the assessment to the Administrative Assistant. The assessment will be included in the Formal Clinical Staff Review.
 - d. For Practicum levels II and III, a formal case write-up will be prepared by the student in consultation with their clinical supervisor. A copy of the case will be included in the Formal Clinical Staff Review and a copy will be submitted to the Administrative Assistant for inclusion in the student's central file.
2. When the assessments have been completed, a Formal Clinical Staff Review of the student's progress will be held by the full clinical staff and MFT faculty. This body, which meets bi-weekly during the fall and spring semesters, will follow the student's progress across each Practicum level.

- a. The clinical supervisor will present their completed portion of the Practicum Final Evaluation form and, for Practicum II and III, the student's formal case write-up. Based on this information, the clinical supervisor will provide a verbal report regarding the student's achievements and areas of growth.
- b. The student's "Live" supervisor will present an assessment of the student's progress in group supervision.
- c. MFT/PCC faculty members, the Director of Clinical Training, and the Administrative Assistant may provide additional input regarding observations, didactic progress, or performance in clinical settings, including the Administrative Supervisor's assessment. These comments will be added to the Final Evaluation form.
- d. Specific competency achievements in the area of personal and professional growth shall be noted with the final picture of the narrative of developing strengths and weaknesses of the student. Any significant discrepancies between the supervisor's and student's assessments will also be noted.
- e. Designated signatures will be obtained.

The Final Practicum Evaluation, with completed formal review will be shared with the student during a full supervisory session. The assessments and formal evaluation will be collected and returned to the Administrative Assistant for storage in the student's central MFT file. These documents will provide a continual source of feedback to the student throughout their learning career in the program.

Senior Integration Experience (SIE)

Graduation from the Louisville Presbyterian Theological Seminary Marriage and Family Therapy Program requires successful completion of the Senior Integration Experience (SIE). The purpose of this formal case presentation is to evaluate the student's readiness for entry-level professional practice as demonstrated by their clinical work. The SIE is completed by presenting a written case study with accompanying visual clips from client sessions to a review committee. This committee includes an External Consultant, an AAMFT Approved Supervisor not associated with the LPTS program. The SIE Committee will provide direct input on the quality of work demonstrated by the student. This information will be included in the faculty's final evaluation of students' readiness for graduation.

Guidelines for completing the SIE are presented in the Appendix. While the SIE report must be the student's independent work, the student's **current Clinical Supervisor of Record** will consult with the student on case selection and session clips. The Clinical Supervisor is the preliminary reviewer of the completed written case draft.



Group “Live” Supervision

“Live” provides a two-hour group supervision opportunity weekly during the fall and spring semesters and once a month during the summer. In this supervision format, a selected student presents a relational case from their clinical practice for consultation and supervision. The presenting therapist will prepare a written case summary with relevant information and will present a demonstration of their work with the client(s). The demonstration may be completed by having the client(s) attend the group supervision session, or by presenting portions of a previously recorded counseling session. (Beginning students are provided the document “How to Write an Intake Evaluation” as a guide for case write-ups. See Appendix for a copy of this document.) If clients will be present during the group supervisory session, the student will ensure that “Video Recording Release” form is in the client file for each client member participating in the session.

Group “Live” Supervision is required throughout the Practicum series. Each Live Supervision group consists of up to ten MFT students and an AAMFT Approved Supervisor. Students entering Practicum I are assigned to a “Live” Supervision group for the first semester. Group placements are maintained until the end of each semester when all MFT students are given opportunity to select a new group. Other group placement changes are made only for extraordinary circumstances, in consultation with the Director of Clinical Training. Spring group members continue to meet once a month during the summer.

Live Supervision / Individual Supervision

It is the policy of the Marriage and Family Therapy Program to integrate individual clinical supervision received with supervision received in Live Supervision. The following procedure assists this in happening:

1. A student shall inform their individual clinical supervisor prior to the live supervision session when scheduling a family for live supervision. Students are encouraged to talk with their clinical supervisor about which family would be appropriate and might benefit from live supervision.
2. Clinical supervisors will have access to the raw data presented in live supervision of cases for which they are responsible. Clinical supervisors are invited to live supervision sessions when possible. Students will make videotapes of live supervision sessions available to their clinical supervisors.

3. Students will process live supervision sessions with their clinical supervisors at the next supervision session following live supervision.
4. When a client attends live supervision for therapy, students will place documentation in the client's file of live supervision and a progress note reflecting this.
5. Case write-ups for presentations are not maintained in the client file.



ADMINISTRATION



MFT Faculty and Clinical Staff Meetings

Assuming that the best supervision is collaborative, supervisors are expected to consult regularly with the clinical staff about their work. Meetings for all MFT faculty and clinical staff are held twice monthly September–December/February–May, and once monthly June–August. These times are scheduled with agenda for student reviews, administrative concerns, consultation/supervision of one’s work in supervision and didactic/theoretical supervisory growth. These meetings are mandatory for clinical supervisors.

MFT Admissions Screening Interviews

Individuals wishing to enroll in Louisville Seminary’s Marriage and Family Therapy Program submit their applications in the spring of each year. The MFT Program Director, Director of Clinical Training and Seminary Admissions Committee members review completed applications and individuals eligible for a place in the program are invited to participate in the screening interview process. These interviews are held the Sunday of Spring Exploratory Weekend (usually the first Sunday in March) and other times as necessary. MFT/PCC faculty, clinical staff, and other seminary faculty members are divided into interview teams and meet with potential students to assess their personal experience, maturity, sense of ministry, and aptitude in the MFT field. Based on the results of these interviews, individuals are accepted into the MFT Program.

Supervision of Supervision

Supervisor Candidates are required to be in supervision at all times and will provide the MFT Program Director and Director of Clinical Training a copy of their supervision-of-supervision plan.

Continuing Education

Clinical supervisors are expected to pursue growth in their supervision skills. This will include completing continuing education programs in areas related to supervision within their specialty area. Supervisors are encouraged to share what they have learned from continuing education in supervisors’ meetings and other scheduled colloquia. All clinical supervisors are required to obtain 1 hour of continuing education in Kentucky Law for Supervisors annually.



ETHICAL AND PROFESSIONAL STANDARDS

Supervision at LPTS adheres to the codes of ethics of the American Association of Pastoral Counselors and the American Association for Marriage and Family Therapy. Supervisors are responsible for practicing within the boundaries of these codes of ethics. Supervisors are also responsible for assuring that interns they supervise are familiar with the codes of ethics and operate within them.

Failure to practice within ethical boundaries provided by these codes will result in removal from staff appointment and any other action demanded by the codes themselves. Supervisors are required to report their interns' ethical violations to the Director of Clinical Training for action according to the policies of the MFT Program Manual as follows:

- ***Failure to Demonstrate Appropriate Personal / Professional Development*** - Failure to demonstrate personal maturity necessary for clinical practice, failure to adhere to basic professional standards required of marriage and family therapists, evidence of serious problems with judgment related to the use of self in therapy, or conduct resulting in serious violations of the AAMFT or AAPC code of ethics will result in dismissal from the MFT Program.

Procedure

1. Action is required when a supervisor, MFT Program staff member, practicum site administrator, faculty member, student peer, client or other reliable party observes (in person or on DVD) the possibility of unprofessional behavior or violation of AAPC or AAMFT codes of ethics in a counseling session, at a practicum site, or in any other Marriage and Family Therapy Program context.
2. Supervision often confronts student difficulty with personal maturity, professional standards, use of self in therapy and ethical behavior. Learning to manage these is a regular function of supervised practice. Supervisors are responsible for helping students learn from these problems. In some cases—such as meeting professional standards or specific ethical violations--the supervisor will document both the problem and the supervisor's remedial plan and submit a copy to the Clinical Director for inclusion in the student's central MFT file.
3. When a problem and remedial plan is filed (2 above), the supervisor will consult with the body of supervisors and faculty in a regular bi-monthly meeting. This consultation will include review of the student problem, review of the remedial plan, and

consideration of any action necessary for follow-up. The supervisory group will document its conversation and collaborate with the supervisor to determine if the student should receive written feedback from the supervisor and faculty group or a verbal report only from the supervisor.

4. The supervisor will report the results of the consultation with the student. This may be a verbal report only or verbal and written report as determined by the supervisor in collaboration with the supervisory and faculty group. Any action taken will be documented and filed in the student's central MFT file.
5. If the student disagrees with his/her supervisor's assessment and/or the supervisor and collaborative plan, the student may petition the Director of Clinical Training for an intervention committee. Upon receiving this petition, the Director of Clinical Training will convene a committee composed of herself/himself, the clinical supervisor and the student. A formal remedial plan will be constructed with specific actions to be taken and including specific procedures and time limits for evaluation. This plan will be filed in the student's central MFT file. If the committee (including the student) cannot reach collaborative consensus about the problem or plan, the student will be referred to the Director of the MFT Program for further action (see 8 below).
6. A student failing to complete the remedial plan will be notified of such by the Director of Clinical Training. The Director will meet with the student and inform him/her of actions to be taken in the next meeting of the clinical supervisors and MFT/PCC faculty meeting and document this in the student file.
7. At the next regularly scheduled meeting of the clinical supervisors and MFT/PCC faculty, the student's progress will be discussed along with any recommendations to revise the remedial plan (return to #4 above). If remedial efforts are unsuccessful the Director of the MFT Program will convene an action committee composed of the Director, the Clinical Director, Dean of the Seminary, and the student's academic advisor. This committee will review the outcome of attempted remediation and make a final recommendation to the Dean of the Seminary for dismissal.
8. Students may file formal complaints or grievances with the Director of the Marriage and Family Therapy Program or Dean of the Seminary following the seminary's grievance procedure at any time during the above process.
9. Some professional development issues, ethical violations and standard of practice violations are so serious that they will be referred immediately to Director of the Marriage and Family Therapy Program for action with the Dean of the Seminary. Examples include (but are not limited to): Sexual contact with a client or client family member, serious breach of confidentiality, impairment of professional judgment related

to substance abuse, public misrepresentation of self, qualifications or the program, acts or threats of violence, falsification of documents or records, or other violation of the seminary's published standard of conduct.

Supervisors' Responsibility and Client Welfare

Supervisors are responsible for providing supervision appropriate to the intern and their context. This includes assessment of the intern, developmentally appropriate supervisory goals, appropriate methods of supervision for the intern and goals, and fair evaluations. While the intern's growth is the primary obligation of supervision, supervisors must also attend to the appropriateness of the intern's treatment of clients. Supervisors are responsible for monitoring the quality of client care and assisting the intern to assess the adequacy of their skill for treatment.

Informed Consent

Supervisors and interns must adhere to informed consent procedures. Supervisors must review with their interns the *Supervision Practices Agreement* (see Appendix) and sign. The completed form should be returned to the MFT Office as soon as possible.

Confidentiality in Supervision

Confidentiality is an important element in the supervisory process. Both interns and clients have a right to confidentiality, modified by the nature of the educational process. Supervisors are to inform interns of the limits of confidentiality in the supervisory process in the supervision plan. Generally, interns are assured of confidentiality within the training faculty, but not strict confidentiality with individual supervisors. This includes discussion of both the content and process of supervisory sessions. Interns should be informed that at times their supervision may be recorded.

Dual Relationships

Regarding dual relationships with students/supervisees, the AAMFT & AAPC Codes of Ethics state the following:

AAMFT

- 4.1 **Exploitation.** Marriage and family therapists who are in a supervisory role are aware of their influential positions with respect to students and supervisees, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships that could impair professional objectivity or increase the risk of exploitation. When the

risk of impairment or exploitation exists due to conditions or multiple roles, therapists take appropriate precautions.

- 4.2 **Therapy with Students or Supervisees.** Marriage and family therapists do not provide therapy to current students or supervisees.
- 4.3 **Sexual Intimacy with Students or Supervisees.** Marriage and family therapists do not engage in sexual intimacy with students or supervisees during the evaluative or training relationship between the therapist and student or supervisee. If a supervisor engages in sexual activity with a former supervisee, the burden of proof shifts to the supervisor to demonstrate that there has been no exploitation or injury to the supervisee.
- 4.6 **Existing Relationship with Students or Supervisees.** Marriage and family therapists avoid accepting as supervisees or students those individuals with whom a prior or existing relationship could compromise the therapist's objectivity. When such situations cannot be avoided, therapists take appropriate precautions to maintain objectivity. Examples of such relationships include, but are not limited to, those individuals with whom the therapist has a current or prior sexual, close personal immediate familial or therapeutic relationship.

AAPC

As members of AAPC we have an ethical concern for the integrity and welfare of our supervisees, students and employees. These relationships are maintained on a professional and confidential basis. We recognize our influential position with regard to both current and former supervisees, students and employees, and avoid exploiting their trust and dependency. We make every effort to avoid dual relationships with such persons what could impair our judgment or increase the risk of personal and/or financial exploitation.

- A. We do not engage in ongoing counseling relationships with current supervisees, students and employees.
- B. We do not engage in sexual or other harassment of supervisees, students, employees, research subjects or colleagues.
- C. All forms of sexual behavior with our supervisees, students, research subjects, and employees (except in employee situations involving domestic partners) are unethical. All forms sexual behavior or harassment with client are unethical, even when a client invites or consents to such behavior or involvement. Sexual behavior is defined as, but not limited to, all forms of overt and covert seductive speech, gestures, written communication, and behavior as well as physical contact of a sexual nature; harassment is defined as but not limited to, repeated comments, gestures, written communication, or physical contacts of a sexual nature.

Dual relationships DO exist in this sitting. However, supervisors should not

1. Provide therapy for interns in the MFT Program.
2. Supervise cases involving family, personal friends, colleagues, or former clients.

Questions regarding possible boundary issues should be discussed with the Director of Clinical Training. (See Appendix for copies of the AAMFT and AAPC Codes of Ethics)

Seminary Policy on Sexual Harassment

Louisville Presbyterian Theological Seminary, in accordance with Section 703 of the Civil Rights Act of 1964 and in recognition of its role as a theological education institution of the Presbyterian Church (U.S.A.) will not condone, disregard or treat lightly incidences of sexual harassment. Furthermore, the Marriage and Family Therapy Program affirms the right to bodily and emotional integrity as well as the principle of dignity in all interactions associated with teaching, supervision and counseling within the Marriage and Family Therapy Program. Professors, students and supervisors are encouraged to enhance mutual awareness of the various and subtle forms of harassment and hold one another accountable to the highest standards of mutual respect. **The Seminary policy for responding to sexual harassment is found in the Student Handbook.**

Seminary Policy on Inclusive Language

Learning is fundamentally concerned with communication, self-expression and personal and social transformation. Learning respects individuals, their feelings, their value and worth, and their particular potential for contribution to common knowledge and community virtue. Learning is fundamentally and intentionally inclusive.

Since all learning is inherently ethical and political, and theological discourse has been traditionally patriarchal and gender exclusive, the Seminary has established a policy, in the interest of constructing an inclusive and egalitarian community, that the language (symbols, metaphors) used in our class discussions and written work shall be gender inclusive and respectful of all persons and groups as valued human creatures of God.

Racism also permeates our society and is detrimental to any learning environment. The Seminary uses language, symbols, and metaphors that honor our commitment to racial inclusiveness.

Seminary Policy on Students with Disabilities

Louisville Seminary does not discriminate against applicants with disabilities. The Seminary will make reasonable accommodations, as required by federal law, to provide appropriate access so that students with documented disabilities are able to study and live at the Seminary. While the Seminary does not maintain academic programs specifically for persons with disabilities, it does provide support services and accommodations to all students in all programs who need those services and have a legal entitlement to them. Enrolled students who have questions about the Seminary's policies on students with disabilities should refer them to the Office of the Dean of the Seminary.

Appendix

SUPERVISION PRACTICES AGREEMENT

As you enter supervision at Louisville Presbyterian Theological Seminary, you must agree to certain expectations and understandings. These help form the foundation for an effective experience in training and in supervision.

1. As a foundation for supervision, you are expected to see clients in clinical practice.
 - a. Your individual supervisor will assess with you your level of development as a counselor and will help you determine the kinds of clients you should see and techniques you should employ at your particular skill level.
 - b. It is required, both as a program goal and as an ethical responsibility, for you to work within the boundaries established by you and your supervisor. This includes the kinds of clients, problems and techniques that are appropriate for your particular skill level.
2. You are expected to keep adequate clinical records for all clients you see. When your Practicum assignment is other than Louisville Seminary, you will abide by that agency's requirements for clinical record keeping. To meet supervisory requirements, these documents must be included in each client file:
 - a. Client intake form,
 - b. Written intake assessment,
 - c. Written treatment plan,
 - d. Progress notes for each session,
 - e. Other records as established by supervision contact.

These documents must be available for supervisory review. Your supervisor or the Director of Clinical Training will provide you with model forms, if needed.

3. As a student at Louisville Seminary, you are expected to abide by the highest ethical standards of clinical practice. This includes:
 - a. Assent to the Code of Ethics of the American Association of Pastoral Counselors and the American Association for Marriage and Family Therapy.
 - b. Assuring confidentiality for all clients by safeguarding records and adequate clinical practices around scheduling, dual relationships, etc.
 - c. Assuring informed consent by using an informed consent form along with telling clients

verbally about their treatment and rights, including:

- i. Your role and qualifications. This includes licensure or credentialing status and that you are working under supervision, and any implicit or explicit value assumptions that will determine treatment.
- ii. Procedures to be used in counseling.
- iii. Risks of treatment.
- iv. Benefits of treatment.
- v. Alternatives to treatment with you.
- vi. Statement that questions will be answered.
- vii. Assurance that consent can be withdrawn at any time.
- viii. A statement of clients' rights and limitations to confidentiality (i.e., child abuse, duty to warn) and another special considerations in being in therapy with you.

(Consult your supervisor or the program director for helpful forms in this process)

- d. Openness to raising ethical questions in supervision. You are encouraged to discuss ethical issues. Your supervisor will take responsibility for raising ethical issues when they are evident in the process of supervision.
 - e. Failure to comply with basic ethical and standard of practice principles will result in dismissal from the MFT program and termination of the supervision contract.
4. You are expected to establish with your supervisor an adequate plan for emergency procedures for all clients you will see.
 5. You and your supervisor will establish a learning contract/plan for supervision.
 - a. The contract will address your learning goals, goals your supervisor observes for your development as a therapist, goals established by accrediting agencies, and goals established by the philosophy and practice of Louisville Seminary.
 - b. The contract should be mutually negotiated between you and your supervisor.
 - c. The contract should help guide the procedures of supervision and learning. You and your supervisor will negotiate specific procedures for supervision--times, dates, use of video/audio tapes, live supervision, etc.

Practicum I

PC 416-01

Description

Practicum I is an entry level supervised clinical experience during which the student will learn basic counseling skills and procedures. Through structured exercises and beginning closely supervised counseling, students will learn basic attending skills, begin to establish therapeutic relationships, develop a beginning sense of self in the counseling process and learn how to use supervision. **Readiness for supervised clinical practice is established in Practicum I.** Practicum I includes a minimum of 100 hours of counseling at a ratio of 5 client hours to 1 supervision hour.

General and Specific Objectives

Practicum I consists of four primary activities: clinical work at Louisville Seminary Counseling Training Center and approved off-campus sites; individual clinical supervision; participation in a Live Supervision group; and participation in Interdisciplinary Case Conference. The objectives for Practicum will be addressed through these activities. The objectives for Practicum I are guided by the five Professional Marriage and Family Therapy Principles, as stated in the program description found in Section I of the MFT Manual. By the end of Practicum I, students will be able:

1. To initiate and establish a treatment relationship with clients judged as appropriate for student treatment by a supervisor. Evaluation points include the following:
 - √ Responds empathically with client(s) experience
 - √ Demonstrates warmth.
 - √ Attends to all family members
 - √ Demonstrates appropriate sense of humor
 - √ Reassures client / family that problem is of real importance.
 - √ Helps family define their needs.
 - √ Defines treatment relationship with clients
 - √ Expresses realistic expectations about therapy with family
 - √ Structures session appropriately under supervision
 - √ Understands joining at a beginning level and can identify this process in supervision

2. To demonstrate consistent use of basic attending skills in a counseling session. Evaluation points include the following:
 - ✓ Appropriate verbal following of client's story and self-presentation.
 - ✓ Uses verbal and non-verbal minimal encouragers to stimulate client's self-presentation.
 - ✓ Uses open-ended questions to encourage client disclosure.
 - ✓ Accurately paraphrases in session.
 - ✓ Accurately reflects feelings in session
 - ✓ Uses summarization appropriate in session
 - ✓ Appropriate use of body posture & gestures in session to facilitate counseling process.
3. To demonstrate a capacity to maintain self-differentiation when exposed to intimate systems adequate to maintain a beginning treatment relationship under supervision. Evaluation points include the following:
 - ✓ Is able to regulate own anxiety in counseling sessions without verbally or behaviorally impeding the session.
 - ✓ Can critically self-reflect in supervision about personal issues that impede or enhance therapy effectiveness.
 - ✓ Is willing to take responsibility for personal issues affecting sessions.
 - ✓ Respects boundaries with clients and organizational systems under supervision.
 - ✓ Can articulate boundary issues arising in their work and demonstrates conscious control of these under supervision.
4. To demonstrate the ability to make good use of clinical supervision. Evaluation points include the following:
 - ✓ Is open to supervision intervening with technical skills in session.
 - ✓ Is open to supervision intervening with use of self in a session.
 - ✓ Is open to supervisor presenting the need for critical self-reflection about feelings, behavior or personal issues affecting sessions.
 - ✓ Follows through on supervisory interventions.
 - ✓ Is able to engage supervisor and ask for what is needed.
5. To observe family and individual process and articulate a beginning understanding of those processes to a clinical supervisor. Evaluation points include the following:
 - ✓ Is able to make accurate structural observations – boundaries, generational hierarchies, etc.
 - ✓ Can identify simple family emotional processes – triangling, fusion, cut-off, etc.

- √ Accurately identifies power structures and issues in family process
 - √ Is able to translate observed family interaction in session into a process articulation
6. To develop a conceptualization of a clinical problem from a systemic viewpoint. Evaluation points include the following:
- √ Can use one theoretical orientation to conceptualize a case.
 - √ Is able to relate in-session behaviors to a clinical theory to organize observations most of the time.
 - √ Is able to relate clinical conceptualizations to plan for therapeutic behavior with the help of a supervisor.
7. To develop a beginning awareness of multi-cultural and gender issues in evaluating cases with the assistance of supervision.
8. To develop a beginning understanding of observed processes and how they relate to client complaints and the treatment process.
9. To establish a treatment plan or strategy with the aid of a supervisor. Evaluation points include the following:
- √ Is able to establish a clinically reasonable treatment plan that relates to observations and case conceptualization.
 - √ Can plan specific strategies for therapy.
10. To demonstrate a beginning ability to implement under supervision specific techniques or strategies in session that are directly related to the treatment plan. Evaluation points include the following:
- √ Is able to carry out specific techniques in session that are planned in supervision.
 - √ Can evaluate effectiveness of treatment interventions under supervision.
 - √ Can relate interventions / evaluation of interventions to treatment plan and strategy.
11. To demonstrate appropriate awareness and adherence to professional ethics, legal issues and standards of professional practice appropriate to a beginning counselor. Evaluation points include the following:
- √ Is aware of basic ethical issues for the practice of Marriage and Family Therapy – confidentiality, informed consent, boundaries in therapy, etc.
 - √ Understands basic therapeutic legal issues – duty to warn, child abuse, etc.

- √ Is able to adhere to the standard of practice appropriate to a beginning student under supervision – writes appropriate clinical records, professional and collegial collaboration, adherence to administrative procedures.
- 12. To demonstrate a beginning awareness of a pastoral identity as it relates to the practice of pastoral counseling. Evaluation points include the following:
 - √ Is beginning to conceptualize the practice of Marriage and Family Therapy in a pastoral context.
 - √ Has begun to explore personal pastoral identity in the context of “call” and its impact on persona/professional life.
 - √ Is beginning to consider “what makes counseling pastoral?”
- 13. To demonstrate a beginning ability to think theologically about the therapeutic experience, under supervision. Evaluation points include the following:
 - √ Can identify fundamental theological issues related to cases and personal experience in therapy – issues of grace, faith, etc.
 - √ Is beginning to find connections between theological studies and clinical casework.
- 14. To complete a minimum of 100 hours of family therapy under supervision.

Methods

- ◆ All Practicum I students will be assigned a clinical supervisor who is responsible for the student’s clinical work and who will evaluate the student’s progress in practicum.
- ◆ All Practicum I students will serve at Louisville Seminary Counseling Training Center and/or one of its off-campus sites.
- ◆ All Practicum I students will participate in a weekly LIVE Supervision group.
- ◆ All Practicum I students will participate in Interdisciplinary Case Conferences.
- ◆ All Practicum I students will demonstrate beginning integration of didactic materials with clinical practice.

Evaluation Policy

Passing from Practicum I to Practicum II is a result of action by the clinical staff and MFT faculty based on the Practicum I Evaluation. The student’s evaluation scores must be *Acceptable* for all areas.

Practicum II

PC 417-01

Description

Practicum II builds on the entry-level skills of Practicum I. Students entering Practicum II have mastered basic attending skills, established a working supervisory relationship, have a beginning self-awareness in the counseling crucible, and have begun to develop basic counseling skills. Experiences in Practicum II are designed to assist students in developing the foundations for more autonomous functioning as therapists. This includes focus on specific technical procedures and skills in therapy, specific attention to the therapeutic relationship and the therapist in that relationship, developing a clear beginning model of family therapy, and solidifying pastoral identity and theological skills.

General and Specific Objectives

Practicum II consists of four primary activities: clinical work at Louisville Seminary Counseling Training Center and approved off-campus sites; individual clinical supervision; participation in a Live Supervision group; and participation in Interdisciplinary Case Conference. The objectives for Practicum II will be addressed through these activities. The objectives for Practicum II are guided by the five Professional Marriage and Family Therapy Principles, as stated in the program description found in Section I of the MFT Manual. By the end of Practicum II, students will be able:

1. To initiate and establish a therapeutic relationship with a variety of families and clients. Evaluation points include the following:
 - ✓ Responds empathically to a wide variety of clients
 - ✓ Is able to respond empathically to all family members.
 - ✓ Is aware of gender and cultural differences and makes appropriate adjustments for a therapeutic relationship under supervision.
 - ✓ Provides a clear definition of the therapeutic relationship for clients.
 - ✓ Attends to differences of power between therapist and client/family with the help of supervision when establishing a therapeutic contract.
 - ✓ Attends to power differences within the client family when establishing a therapeutic relationship with the help of supervision.
 - ✓ Consistently provides good structure for sessions under supervision.
 - ✓ Joins with all family members well in most clinical situations.
 - ✓ Avoids offering simplistic advice or personal opinions.
 - ✓ Explores client stories with curiosity and demonstrates patience in developing interventions.

2. To use basic attending and influencing skills appropriately and effectively in most clinical situations. Evaluation points include the following:
 - √ Shows good verbal following, body posture and appropriate use of questions in most sessions.
 - √ Uses summarization and paraphrasing to focus sessions and center interventions with the help of supervision.
 - √ Asks questions, responds to client/family in a conversational and international way in most sessions.
 - √ Varies voice (tone, volume, rate, inflection) and non-verbal behavior (posture, gestures, etc.) to connect with clients.
3. To demonstrate the ability to observe and describe simple (i.e. non-complex) client/family processes taking place in counseling sessions with a supervisor. Evaluation points include the following:
 - √ Is able to make accurate structural observations (boundaries, generational hierarchies, etc.) consistently with most families.
 - √ Can identify family emotional processes (triangling, fusion, cut-off, etc.) within the immediate family and across generations independently with non-complex family systems.
 - √ Can independently identify and articulate issues of differentiation as manifested in a variety of non-complex family/individual self-presentations.
 - √ Accurately identifies power structures and issues in family process independently in non-complex family/individual self-presentations.
 - √ Can translate non-complex family interaction in a session into a process articulation independently.
 - √ At a beginning level can observe and articulate larger-systems issues as they impact family and individual process.
4. To articulate one consistent theoretical framework from which clinical observations and conceptualizations for practice are drawn. Evaluation points include the following:
 - √ Is able to identify a theoretical framework with consistently influences observation, conceptualization and treatment planning.
 - √ Is able accurately to articulate primary concepts, techniques and process of therapy expected from that frame of reference.
 - √ Can identify sources from which theory is drawn.
 - √ Is able to carry on a conversation in supervision from one theoretical perspective.
5. To organize observations of client/family processes **independently** into a **basic** explanatory conceptual framework (with beginning multi-cultural and empirical considerations) to guide treatment planning and evaluation of treatment, and begin to

conceptualize more complex cases with the aid of collegial consultation and supervision. Evaluation points include the following:

- ✓ Can consistently present in supervision conceptualizations of non-complex cases that makes “clinical sense” from one theoretical framework.
- ✓ Consistently relates observations of in-session behavior to clinical conceptualizations independently in non-complex cases.
- ✓ Is able to relate larger-systems issues to case conceptualization under supervision.
- ✓ Considers multi-cultural and gender issues with supervisor’s assistance.
- ✓ Considers empirical information and sources to understand observations with supervisor’s assistance.
- ✓ Uses collegial and consultative input to inform conceptualization and interpretation of observations.
- ✓ Is able to use formal assessment tools to inform conceptualizations under supervision and articulate a working clinical diagnosis.
- ✓ Is beginning to attend to family/individual’s multiple realities and integrates these into case conceptualization under supervision.
- ✓ Can begin to formulate clinical conceptualizations for multiple problem and complex families under supervision.
- ✓ Is beginning to conceptualize client/family problems in a systemic, non-pathological way independently.

6. To set appropriate treatment goals independently for **uncomplicated** clinical cases utilizing **basic** observational and conceptualization skills, and begin to set appropriate treatment goals with more complex cases with the aid of collegial consultation and supervision. Evaluation points include the following:

- ✓ Is able to establish a reasonable treatment plan related to observations and conceptualization independently with non-complex cases.
- ✓ Demonstrates clear, achievable goals with clear client contracts independently with non-complex cases.
- ✓ Includes consideration of multi-cultural, gender related and non-dominant culture expectations when establishing a treatment plan with the help of supervision.
- ✓ Includes conclusions from empirical information in establishing treatment goals.
- ✓ Establishes ongoing assessment procedures in treatment planning.
- ✓ Can establish effective treatment plans with complex, multi-problem families with the help of supervision.
- ✓ Relates treatment plan to specific strategies from one theoretical framework independently with non-complex cases.

7. To implement **basic** intervention techniques consistent with the student’s preferred theoretical frame of reference and with beginning multi-cultural and empirical

considerations independently with uncomplicated clinical cases, and begin to try new techniques as directed by a supervisor. Evaluation points include the following:

- ✓ Can implement basic therapeutic strategies independently with non-complex cases (i.e., can use coaching, sculpting, unbalancing, reframing, etc.) as appropriate to theoretical referent.
- ✓ Strategies chosen independently are consistently appropriate for treatment plan.
- ✓ Can evaluate the effectiveness of treatment interventions in non-complex cases effectively and consistently.
- ✓ Cooperates with supervisor and colleagues to extend repertoire of techniques and practices them under supervision.
- ✓ Accepts collegial input about effectiveness, appropriateness and skillful use of intervention techniques.
- ✓ Can implement basic techniques appropriately with complex and intense cases under supervision.
- ✓ Implements techniques with gender and multi-cultural sensitivity.

8. To demonstrate in session a **beginning** shift in self-other awareness illustrated by **increasing** ability to focus on client issues as separate from concerns with being a “good therapist” and/or being impeded by personal issues. Evaluation points include the following:

- ✓ Self-report and supervisor observation reveals a beginning shift away from concern for self as “good therapist” and toward awareness of client’s experience in therapy.
- ✓ Can identify personal issues that impact specific sessions in supervision.
- ✓ Takes responsibility with the help of supervisor to attend to personal issues affecting sessions.
- ✓ Respects boundaries with clients and organizational systems in most sessions and with most clients with minimal supervision.

9. To use supervision effectively. Evaluation points include the following:

- ✓ Actively solicits supervisory input as an opportunity for learning.
- ✓ Implements supervisory directives in session appropriately.
- ✓ Is able to challenge own premises and biases in the context of supervision.
- ✓ Is able to self-reveal cultural, gender, religious, and spiritual biases in supervision and make these available to evaluation.
- ✓ Demonstrates an understanding and respect for multiple perspectives (clients, team, supervisor, etc.).

10. To demonstrate the ability to adhere to a code of professional ethics and the beginning ability to operate according to a professional standard of practice. Evaluation points include the following:

- √ Is aware of basic ethical issues for the practice of Marriage and Family Therapy and practices within these boundaries.
 - √ Seeks consultation when unclear of ethical guidelines or behavior.
 - √ Abides by basic legal duties of MFT with consultation from supervisor.
 - √ Consistently conducts self in a professional and effective manner (attendance, punctuality, presentation of self).
 - √ Follows clinic policy with regard to paperwork, follow-up, referral issues, etc.
 - √ Carries an active caseload representative of clinic expectations.
11. To use a theological method for religious assessment of clients and for integrating clinical work, theology and personal faith under supervision. Evaluation points include the following:
- √ Can use one theological/pastoral method to understand client process and the meaning of therapeutic intervention.
 - √ Is able to articulate theological meaning discovered at the interface of clinical work, theology and personal faith.
 - √ Is able to conduct a religious assessment of individuals/families under supervision.
 - √ Demonstrates a beginning ability to relate to/work with spiritual and religious issues in session and under supervision.
12. To define and articulate a pastoral identity as it relates to the practice of pastoral counseling. Evaluation points include the following:
- √ Can articulate an understanding of marriage and family therapy as an expression of ministry.
 - √ Is beginning to define a personal understanding of self as minister, self as therapist.
 - √ Is beginning a process of socialization into professional identity as a pastoral counselor (i.e., AAPC process or other).
 - √ Is beginning to articulate independently a beginning understanding of integrating pastoral identity and professional practice as a marriage and family therapist.
 - √ Has some ideas about "What makes pastoral counseling pastoral?"
13. To complete a minimum of 175 hours of family therapy under supervision.
14. To complete a written case study, as described below, as part of the final Practicum Evaluation process.
- √ The case write-up will follow the guidelines prepared for the Senior Integration Experience with one exception: Maximum length is 5 pages.

- √ The draft of the case write-up will be due to the student's clinical supervisor and the Director of Clinical Training at the mid-point of the Practicum level.
- √ Copies of the completed final case write-up will be submitted to the student's clinical supervisor, the Director of Clinical Training and the MFT Office one week prior to the formal Final Practicum Evaluation process by the clinical supervisors and faculty. The completed case write-up must be reviewed and approved by the student's clinical supervisor and the Director of Clinical Training to successfully pass this practicum level.
- √ Student performance on the case study will be reported to the clinical staff and faculty as part of the student's Final Practicum Evaluation.
- √ During a regularly scheduled clinical staff meeting, a Final Practicum Evaluation of the student's work will be processed. The supervisor will include the approved case write-up as part of the student's Final Practicum Evaluation materials.

Methods

- ◆ All Practicum II students will be assigned to a clinical supervisor who is responsible for the student's clinical work and for evaluating the student's progress in practicum.
- ◆ All Practicum II students will serve at Louisville Seminary Counseling Training Center and/or one of its off-campus sites.
- ◆ All Practicum II students will carry an on-going caseload of clients, the size of which will be negotiated with the practicum site director and individual supervisor and be written into the supervision contract.
- ◆ All Practicum II students will receive supervision at a ratio of 1 hour of supervision per 5 clinical case hours.
- ◆ Practicum II students will participate in weekly Interdisciplinary Case Conferences, weekly individual supervision and in a weekly Live Supervision group.
- ◆ All Practicum II students will demonstrate integration of didactic materials with clinical practice.

Evaluation Policy

Passing from Practicum II to Practicum III is a result of action by the clinical staff and MFT faculty based on the Practicum II Evaluation. The student's evaluation scores must be *Acceptable* in all areas.

Practicum III

PC 418-02

Description

Practicum III extends the beginning therapy skills a student has acquired in Practicums I and II. Students enrolled in Practicum III are expected to develop *intermediate* level skills including increased autonomy in clinical practice, good use of collegial, consultative and supervisory relationships, an increased distinction between self and other in the therapy context, and critical evaluation of motivations for counseling practice. Intermediate counseling students will sharpen intervention skills learned in Practicums I and II, while also trying new techniques under supervision. Having a firm understanding of one theoretical and theological model, intermediate students are expected to begin exploring the horizons of expanded models of theology and therapy while in supervision. Experiences in Practicum III are designed to assist students with: 1) treating a variety of client families and problems, 2) managing an ongoing case load, 3) developing therapeutic autonomy, 4) deepening a sense of self as therapist, and 5) a beginning consolidation of identity as a pastoral counselor and marriage and family therapist. Most Practicum III students will be assigned to practicum sites away from the Seminary that will have their own administrative demands and reflections of professional standards of practice. By the end of Practicum III, students will have completed a minimum of 125 (375 total) hours of supervised clinical experience.

General and Specific Objectives

Practicum III consists of four primary activities: clinical work at Louisville Seminary Counseling Training Center and approved off-campus sites; individual clinical supervision; participation in a Live Supervision group; and participation in Interdisciplinary Case Conference. The objectives for Practicum III will be addressed through these activities. The objectives for Practicum II are guided by the five Professional Marriage and Family Therapy Principles, as stated in the program description found in Section I of the MFT Manual. By the end of Practicum III, students will be able:

1. To establish a therapeutic relationship consistently with most families and clients who present for treatment, and independently be able to assess when supervision is needed to examine difficulties in or failure to establish a therapeutic relationship. Evaluation points include the following:
 - √ Responds empathically to a wide variety of clients with non-anxious presence.
 - √ Is able to respond empathically to all family members.

- ✓ Utilizes knowledge of gender and cultural differences in responding to clients.
 - ✓ Negotiates a clear therapeutic contract with clients/families.
 - ✓ Attends to differences of power **between therapist and client/family** in most families with minimal supervision when establishing a therapeutic contract.
 - ✓ Attends to power differences **within the client family** when establishing a therapeutic relationship with most families.
 - ✓ Consistently provides good structure for sessions with minimal supervision.
 - ✓ Avoids offering simplistic advice or personal opinions, identifies exceptions in supervision.
 - ✓ Explores client stories with curiosity and demonstrates patience in developing interventions.
 - ✓ Appropriately seeks supervision when needed to assist with joining skills and therapeutic contract.
2. To demonstrate expert ability in using good attending and influencing skills independently in most clinical situations. Evaluation points include the following:
- ✓ Consistently uses good verbal following and **relational** questions in sessions.
 - ✓ Uses summarization, paraphrasing and **process questions** to focus sessions and interventions with minimal supervision.
 - ✓ Consistently asks questions, responds to client/family's frame of reference and values.
 - ✓ Demonstrates the ability to develop and maintain themes across sessions with supervision.
3. To demonstrate the ability to observe and describe a wide variety of client/family processes taking place in counseling sessions with a supervisor. Evaluation points include the following:
- ✓ Regularly makes accurate structural observations (boundaries, generational hierarchies, etc.) independently.
 - ✓ Can identify family emotional processes accurately (triangling, fusion, cut-off, etc.) within the immediate family and across generations with minimal supervision.
 - ✓ Can identify and articulate issues of differentiation in most situations with minimal supervision.
 - ✓ Accurately identifies power structures and issues in family process in most families independently with minimal supervision.
 - ✓ Can discriminate in supervision what information presented by clients' story or behavior is critical to the therapeutic process with supervision.
 - ✓ Can articulate larger-systems issues as they impact family and individual process.

4. To explore a variety of theoretical frameworks from which clinical observations and conceptualizations for practice are drawn with supervisory assistance and with multi-cultural and empirical awareness. Evaluation points include the following:
 - √ Is able to understand observed client/family dynamics from several frames of reference to inform case conceptualization and treatment planning with the help of supervision.
 - √ In Interdisciplinary Case Conference, can discuss and describe cases concisely within a systemic framework using more than one theory.
 - √ In supervision, is able to articulate gender specific and multi-cultural concerns with regard to theoretical frameworks.
 - √ Attends to empirical sources for informing choice of theoretical framework or theoretical understandings.
 - √ Takes responsibility to read and explore theories and modalities to expand theoretical and clinical repertoire.
5. To **begin** organizing observations of client/family processes from an integrative, multi-cultural conceptual perspective utilizing a variety of empirical and theoretical frameworks with attention to the client's needs with the aid of a supervisor. Evaluation points include the following:
 - √ Can present in supervision conceptualizations of a variety of cases making use of multiple theoretical explanations.
 - √ Beginning spontaneously to attend to multi-cultural and gender factors in considering conceptualization and includes these in a beginning integrated model for case conceptualization with the help of a supervisor.
 - √ Is beginning spontaneously to include empirical sources in a developing integrated model that informs case conceptualization with the help of supervision.
 - √ Relates observations of in-session behavior to clinical conceptualizations that attend to multiple realities of clients, family members, and therapists with supervision.
 - √ Is able to relate larger-systems issues to case conceptualization with minimal supervision.
 - √ Regularly uses collegial and consultative input to inform conceptualization and interpretation of observations.
 - √ Can flexibly choose formal assessment tools to assist conceptualization informed by multiple theoretical understandings of the case.
 - √ Growing understanding of the use of working diagnosis in a non-pathological way that gives clarity to use of theoretical model of choice and interventions.
 - √ Integrates the family's/individual's multiple realities into clinical decisions, summaries and conclusions under supervision.

- √ Consistently conceptualizes client/family problems in a systemic, non-pathological way independently.
6. To set appropriate treatment goals using an integrative, empirically informed, multi-cultural perspective with a variety of clients with the aid of a supervisor. Evaluation points include the following:
- √ Is able to establish a reasonable treatment plan reflecting integrated conceptualization of complex cases under supervision.
 - √ Contracts with a variety of families/clients for clear, achievable goals with minimal supervision.
 - √ Includes gender and multi-cultural factors in establishing treatment plan.
 - √ Establishes and monitors ongoing assessment procedures in treatment planning.
 - √ Treatment plans reflect the multiple realities of clients and family members and reflect this complexity with some supervision.
 - √ Relates treatment plan to multiple and flexible strategies under supervision.
7. To expertly implement basic intervention techniques in most cases without direct supervision (to include awareness and consideration of gender, multi-cultural and empirical implications), and implement more complex integrative interventions, or try new techniques, with the aid of a supervisor. Evaluation points include the following:
- √ Can implement basic therapeutic strategies expertly with a variety of clinical cases (i.e., can use coaching, sculpting, unbalancing, reframing, etc., as appropriate to theoretical referent).
 - √ Tries new strategies reflective of an integrative understanding of therapy under supervision.
 - √ With supervisor's help, is aware of multi-cultural and gender implications for interventions selected.
 - √ Selects interventions informed by available empirical knowledge with the help of supervision.
 - √ Takes initiative to evaluate the effectiveness of therapeutic strategies and demonstrates flexibility in adjustment.
 - √ Cooperates with supervisor and colleagues to extend repertoire of techniques and weaves them into treatment in a smooth manner.
 - √ Seeks collegial input about effectiveness, appropriateness and skillful use of intervention techniques.
 - √ Can improve and expand basic techniques with increasing complexity and generalize these to a variety of clinical applications under supervision.

8. To demonstrate in session a fluctuating self-other awareness (i.e. concerns about being a good therapist [self-focus], vs. attending to client's self-presentation as the focus of internal attention [other focus]) and know when this is happening, and attend consciously in supervision to countertransference and personal issues guided by self-reflection on counseling sessions 50% of the time. Evaluations points include the following:
 - √ Self-reflects fluctuating focus on self as "good therapist" and focus on client's experience as the purpose of therapy.
 - √ Identifies issues and counter-transferences impacting responses to specific client populations.
 - √ Initiates work in supervision for personal and counter-transference issues.
 - √ Consistently respects boundaries with clients and organizational systems.
9. To take initiative in supervision to present learning needs and can articulate specific requests for specific supervisory input for assistance with complex cases. Evaluation points include the following:
 - √ Actively negotiate goals for supervision with supervisor.
 - √ Weaves supervisory input into therapeutic interactions in a smooth manner.
 - √ Challenges own and supervisor's premises/biases in supervision from a variety of theoretical/clinical realities.
 - √ Spontaneously contributes systemic ideas to group and individual supervision sessions.
 - √ Seeks a variety of supervisory consultation with awareness of supervisory strengths and client needs.
10. To demonstrate the ability to adhere to a code of professional ethics and the ability to operate according to a professional standard of practice, including managing an ongoing clinical caseload. Evaluation points include the following:
 - √ Consistently practices with an awareness of and adherence to the professional ethical standards.
 - √ Seeks consultation when unclear of ethical guidelines or behavior.
 - √ Reflects ethical consciousness by raising ethical concerns in supervision and Interdisciplinary Case Conference.
 - √ Consistently conducts self in a professional and effective manner (attendance, punctuality, presentation of self).
 - √ Follows clinic policy with regard to paperwork, follow-up, referrals, etc.
 - √ Carries an active caseload representative of clinic expectations.

11. To take initiative in using and expanding theological methods for religious assessment of clients and for integrating clinical work, theology and personal faith under supervision. Evaluation points include the following:
 - √ Flexibly uses a theological/pastoral method to understand client process and the meaning of therapeutic intervention.
 - √ Creatively seeks and articulates theological meanings discovered at the interface of clinical work, theology and personal faith.
 - √ Conducts, as a matter of course, a religious assessment of individuals and families.
 - √ Identifies spiritual and religious issues in session and takes initiative to integrate these into therapy under supervision.
12. To articulate a provisional definition of self as minister and pastoral counselor in the context of the practice of marriage and family therapy, and represents self as such to the professional and client public. Evaluation points include the following:
 - √ Articulates an understanding of marriage and family therapy as an expression of ministry.
 - √ Has established a provisional personal understanding of self as minister, pastoral counselor and therapist.
 - √ Is beginning a process of socialization into professional identity as a pastoral counselor (i.e., AAPC process or other).
 - √ Is beginning to articulate a self-representation that integrates pastoral identity and professional practice as a marriage and family therapist.
 - √ Can articulate a vision of “What makes pastoral counseling pastoral?”
13. To complete a minimum of 125 (375 total) hours of family therapy under supervision.
14. To complete a written case study, as described below, as part of the final Practicum Evaluation process.
 - √ The case write-up will follow the guidelines prepared for the Senior Integration Experience with one exception: Maximum length is 5 pages.
 - √ The draft of the case write-up will be due to the student’s clinical supervisor and the Director of Clinical Training at the mid-point of the Practicum level.
 - √ Copies of the completed final case write-up will be submitted to the student’s clinical supervisor, the Director of Clinical Training and the MFT Office one week prior to the formal Final Practicum Evaluation process by the clinical supervisors and faculty. The completed case write-up must be reviewed and approved by the student’s clinical supervisor and the Director of Clinical Training to successfully pass this practicum level.

- √ Student performance on the case study will be reported to the clinical staff and faculty as part of the student's Final Practicum Evaluation.
- √ During a regularly scheduled clinical staff meeting, a Final Practicum Evaluation of the student's work will be processed. The supervisor will include the approved case write-up as part of the student's Final Practicum Evaluation materials.

Methods

- ◆ All Practicum III students will be assigned to a clinical supervisor who is responsible for the student's clinical work and for evaluating the student's progress in practicum.
- ◆ All Practicum III students will serve at Louisville Seminary Counseling Training Center and/or one of its off-campus sites.
- ◆ All Practicum III students will carry an on-going caseload of clients, the size of which will be negotiated with the practicum site director and individual supervisor and be written into the supervision contract.
- ◆ All Practicum III students will receive supervision at a ratio of 1 hour of supervision per 5 clinical case hours.
- ◆ Practicum III students will participate in weekly Interdisciplinary Case Conferences, weekly individual supervision and in a weekly Live Supervision group.
- ◆ All Practicum III students will demonstrate integration of didactic materials with clinical practice.

Evaluation Policy

Passing from Practicum III to Practicum IV is a result of action by the clinical staff and MFT faculty based on the Practicum III Evaluation. The student's evaluation scores must be *Acceptable* in all areas.

Practicum IV

PC 419-02

Description

Students enrolled in Practicum IV are expected to develop *advanced* family therapy skills. These are expected to be at the entry level of professional practice, and include autonomy in clinical practice, good use of collegial, consultative and supervisory relationships, an appropriate distinction between self and other in the therapy context, and the ability to practice effectively in a clinical setting. Advanced students are expected to 1) display a solid sense of self as therapist and pastoral counselor, 2) demonstrate expertise in the basic procedures of pastoral and family counseling (observation, conceptualization and intervention), 3) demonstrate a beginning framework for an integrated personal theoretical and practical framework for therapy, 4) work collegially in an interdisciplinary framework, 5) operate autonomously within a clinical/agency framework, 6) be prepared for employment or full-time residency as a pastoral counselor/family therapist. Practicum IV students will be assigned to practicum sites away from the Seminary which will have their own administrative demands and reflections of professional standards of practice.

Practicum IV students must participate in a Live Supervision group and in Interdisciplinary Case Conference until they have completed all requirements to bring closure to Practicum IV.

1. Successfully complete *Senior Integration Experience*.
2. Complete Practicum IV contracted goals and required minimum clinical hours.
3. Successfully complete audit of all client records at Louisville Seminary Counseling Training Center (LSCTC), closing client accounts or transferring clients.
4. Erase or destroy client videotapes/DVDs.
5. Submit "Evaluation of the Supervisory Experience" to MFT Office.
6. Return LSCTC keys and badge, if applicable, to MFT Office.
7. Sign and return final evaluation for Practicum IV.
8. Submit final Practicum log to MFT Office.

General and Specific Objectives

Practicum IV consists of five primary activities: clinical work at Louisville Seminary Counseling Training Center and approved off-campus sites; individual clinical supervision; participation in a Live Supervision group; participation in Interdisciplinary Case Conference; and successful completion of the *Senior Integration Experience*. The objectives for Practicum IV will be addressed through these activities. The objectives for Practicum II are guided by the five

Professional Marriage and Family Therapy Principles, as stated in the program description found in Section I of the MFT Manual. By the end of Practicum IV, students will be able:

1. To establish a therapeutic relationship consistently in a multi-cultural context with most families and clients presenting for treatment. Evaluation points include the following:
 - √ Responds to a wide variety of clients with specific attention to multi-cultural dimensions of therapy relationships.
 - √ Is able to join with all family members in most situations.
 - √ Negotiates a clear therapeutic contract with clients/families in a manner that involves all relevant members and subsystems.
 - √ Attends to power differentials between family members and within the therapeutic system.
 - √ Discerns difficulties in establishing therapeutic contracts and seeks appropriate consultation.
 - √ Consistently provides good structure for sessions.
 - √ Affirms the complexity of human and family problems and conveys this to families appropriately.
 - √ Facilitates clients and families exploring their story with attention to constructing future intervention strategies.
 - √ Appropriately seeks supervision when needed to assist in joining with complex/multi-cultural families.
2. To demonstrate expert ability to use good attending and influencing skills independently, and provide leadership for less experienced therapists in developing these skills. Evaluation points include the following:
 - √ Expertly uses good verbal following and **relational** questions in sessions.
 - √ Shows expert skill in summarization, paraphrasing and **process questions** to focus sessions and interventions.
 - √ Regularly attends to client and family worldview, values and frame of reference with attending and influencing skills.
 - √ Demonstrates the ability regularly to develop and maintain themes across sessions.
 - √ Takes leadership in consultative groups to help less experienced therapists develop good attending and influencing skills.
3. To demonstrate the ability to observe and describe a wide variety of client/family processes in a multi-cultural context taking place in counseling sessions, and be able to describe family processes, personal dynamics and larger-systems influences on the client situation. Evaluation points include the following:

- ✓ Expertly makes accurate structural observations (boundaries, generational hierarchies, etc.) independently.
 - ✓ Can identify family emotional processes accurately (triangling, fusion, cut-off, etc.) within the immediate family and across generations without supervision.
 - ✓ Can identify and articulate issues of differentiation in most situations in a multi-cultural context.
 - ✓ Accurately identifies power structures and issues in family process independently in most families.
 - ✓ Can discriminate what information presented by clients' story or behavior is critical to the therapeutic process and focuses appropriately on these sources.
 - ✓ Articulates larger-systems issues as they impact family and individual process, and uses these in planning interventions.
 - ✓ Discerns when supervision and consultation is necessary to understand family process in a multi-cultural context, and utilizes it.
4. To define a beginning position for a personally integrated framework from which clinical observations and conceptualizations for practice are drawn. Evaluation points include the following:
- ✓ Is able to understand observed client/family dynamics from several frames of reference to inform case conceptualization and treatment planning.
 - ✓ In Interdisciplinary Case Conference, can discuss and describe cases concisely within a systemic framework using more than one theory.
 - ✓ Is able to draw together in an integrated conceptual framework a variety of understandings to inform observations, case conceptualization and intervention.
 - ✓ Articulates the limitations inherent in single-theory approaches to therapy.
5. To organize observations of client/family processes from an integrative, multi-cultural conceptual perspective utilizing a variety of theoretical frameworks and empirical information with attention to the client's needs. Evaluation points include the following:
- ✓ Can present in multidisciplinary case conferences conceptualizations of clinical work reflecting a beginning integration of theory into a personal model of therapy.
 - ✓ Relates observations of in-session behavior to clinical conceptualizations that attend to multiple realities of clients, family members and therapists.
 - ✓ Avoids simplistic explanations of client's realities and evaluates culturally bound frameworks that may be used to organize clinical observations.
 - ✓ Is able to relate larger-systems and multi-cultural issues to case conceptualization.
 - ✓ Regularly uses collegial and consultative input to inform conceptualization and interpretation of observations.

- √ Can flexibly choose formal assessment tools to assist conceptualization that undergird a developing personally integrated model of therapy and has a growing understanding of the use of working diagnosis in a non-pathological way that gives clarity to the use of theoretical model of choice and interventions.
 - √ Relates interventions to specific client problems drawing from empirical and theoretical sources.
 - √ Integrates the family/individual's multiple realities into clinical decisions, summaries and conclusions.
 - √ Consistently conceptualizes client/family problems in a systemic, non-pathological way independently.
 - √ Growing understanding of the use of working diagnosis in a non-pathological way that gives clarity to the use of theoretical model of choice and interventions.
6. To set appropriate treatment goals consistently using an integrative multi-cultural perspective that is empirically informed with a variety of clients. Evaluation points include the following:
- √ Is able to establish a reasonable treatment plan reflecting integrated conceptualization of complex cases.
 - √ Attends to therapist-as-person issues, transference and counter-transference issues in designing treatment plans.
 - √ Contracts with the family/client for clear, achievable goals with a variety of clients.
 - √ Attends to multi-cultural and larger system issues in designing treatment plans.
 - √ Establishes and monitors ongoing assessment procedures in treatment planning.
 - √ Treatment plans reflect the multiple realities of clients and family members and reflects multi-cultural complexity.
 - √ Treatment plans show attention to an empirical knowledge base for selecting interventions (i.e., what works for what clients, under what circumstances, for what problems).
 - √ Relates treatment plan to multiple and flexible strategies.
 - √ Uses collegial and interdisciplinary consultation to establish and evaluate treatment plans.
 - √ Discerns when supervision, collaboration or consultation is needed in establishing treatment plans and seeks it out.
7. To implement a variety of critically informed (i.e. multi-culturally and empirically) intervention techniques consistent with a developing personally integrated framework of therapy with collegial input. Evaluation points include the following:

- √ Can expertly implement basic therapeutic strategies with a variety of clinical cases (i.e., can use coaching, sculpting, unbalancing, reframing, etc., as appropriate to theoretical referent).
 - √ Ties strategies to an integrative understanding of therapy.
 - √ Explores and implements new therapeutic techniques guided by a developing personally integrated, multi-cultural informed, and empirically founded understanding of therapy.
 - √ Attends to multi-cultural and larger-system issues in treatment delivery, and expands repertoire to reflect this awareness (i.e., school contact, possible home interventions, etc.)
 - √ Regularly evaluates the effectiveness of therapeutic strategies and demonstrates flexibility in adjustment.
 - √ Discerns where supervision and collegial input is necessary for effectiveness and excellence in treatment delivery.
 - √ Can improved and expand therapeutic learning with increasing complexity and generalize these to a variety of clinical applications.
8. To demonstrate in session a solid self-other awareness (i.e. able to discern when attention is directed toward concern with own skills and when attention is directed toward client's concerns), conscientious attention to counter transference issues, and willingness to address these in interdisciplinary case settings or supervision. Evaluation points include the following:
- √ Has developed a good sense of self-other differentiation in therapy (i.e., can discern self-directed focus on being a "good therapist" from attending to client's treatment.
 - √ Attends conscientiously to personal issues and counter-transferences impacting responses to client families.
 - √ Accurately discerns where additional supervision or therapy is needed to protect clients and offer excellence in treatment.
 - √ Consistently respects boundaries with clients and organizational systems.
9. To define supervisory needs and take responsibility for contracting for appropriate supervision to assure excellence in client care and professional development. Evaluation points include the following:
- √ Demonstrates appropriate autonomy with colleagues, supervisor and clinic.
 - √ Discerns when supervision is necessary for quality treatment and client welfare.
 - √ Negotiates goals for supervision attending to professional growth and excellence.
 - √ Claims a developing personally integrated model of therapy in supervision and contracts for supervision to expand this.
 - √ Is open to new ideas, techniques and skills in supervision.

- √ Contributes systemic ideas and contributions from a developing personally integrated model of therapy to group supervision sessions.
 - √ Seeks supervisory consultation with awareness of supervisory strengths and their own personal/therapeutic growth needs.
10. To demonstrate the ability to adhere to a code of professional ethics and consistently to operate according to a professional standard of practice that reflects integrity and excellence. Evaluation points include the following:
- √ Consistently practices with an awareness of and adherence to the professional ethical standards.
 - √ Seeks consultation when unclear of ethical guidelines or behavior.
 - √ Reflects ethical concern for excellence by raising ethical concerns in supervision and case conference.
 - √ Consistently conducts self in a professional and effective manner (attendance, punctuality, presentation of self) reflecting a concern for excellence in practice.
 - √ Follows clinic policy with regard to paperwork, follow-up, referral issues, etc., and seeks the highest standards of practice as reflected in these.
 - √ Carries an active caseload representative of clinic expectations.
11. To autonomously use and expand theological methods for religious assessment of clients and for integrating clinical work, theology and personal faith. Evaluation points include the following:
- √ Flexibly uses a theological/pastoral method to understand client process and the meaning of therapeutic intervention.
 - √ Can articulate a critically evaluated method for how theology informs selection of theory and therapeutic procedure, and how behavioral sciences inform theological understandings.
 - √ Conducts as a matter of course a religious assessment of individuals and families.
 - √ Can articulate how personal faith and religious commitments are integrated effectively and critically into therapeutic sessions with a variety of clients.
 - √ Can describe and discuss critically the interfaith of personal spirituality and counseling practice.
12. To articulate a definition of self as minister and pastoral counselor in the context of the practice of marriage and family therapy, and represents self as such to the professional and client public. Evaluation points include the following:
- √ Articulates an integrated and advanced understanding of marriage and family therapy as an expression of ministry.

- √ Has established an understanding of self as minister, pastoral counselor and therapist.
 - √ Is completing a process of socialization into professional identity as a pastoral counselor (i.e., AAPC process or other).
 - √ Publicly represents self in a way that integrates pastoral identity and professional practice as a marriage and family therapist.
 - √ Can articulate and describe how their work as pastoral counselor/marriage and family therapist is “pastoral,” and what it means to be a pastor in these vocations.
13. To complete a minimum of 125 hours (500 total hours) of supervised clinical experience.
14. To successfully complete the *Senior Integration Experience*.

Methods

- ◆ All Practicum IV students will be assigned to a clinical supervisor who is responsible for the student’s clinical work and for evaluating the student’s progress in practicum.
- ◆ All Practicum IV students will serve at Louisville Seminary Counseling Training Center and/or one of its off-campus sites.
- ◆ All Practicum IV students will carry an on-going caseload of clients, the size of which will be negotiated with the practicum site director and individual supervisor and be written into the supervision contract.
- ◆ All Practicum IV students will receive supervision at a ratio of 1 hour of supervision per 5 clinical case hours.
- ◆ Practicum IV students will participate in weekly Interdisciplinary Case Conferences, weekly individual supervision and in a weekly Live Supervision group.
- ◆ All Practicum IV students will successfully complete the *Senior Integration Experience* which requires a formal final case presentation and an evaluation of that presentation by an AAMFT Approved Supervisor and/or AAPC Fellow or Diplomate not associated with the LPTS program and who is unfamiliar with the student’s readiness for graduation. (See “Senior Integration Experience”.)

Evaluation Policy

Passing of Practicum IV is a result of action by the clinical staff and MFT faculty based on the results of the student’s *Senior Integration Experience* and the Practicum IV Evaluation (scores must be *Acceptable* in all areas).

SUPERVISION CONTRACT – Practicum Section I

Student: _____ Phone: _____

Supervisor: _____ Phone: _____

Starting Date: _____

1. Administrative and Clinical Responsibilities

Learn how to complete all necessary client paperwork, within LSCTC timeframe, including writing an acceptable treatment plan with supervisor assistance; Learn and follow LSCTC procedures and guidelines for organization of client files; Conduct therapy sessions with individuals, couples, families, and groups accepted as clients

2. Specific Measurable Goals

Demonstrate good use of clinical supervision, including individual clinical supervision, Live Supervision and Interdisciplinary Case Conference; Demonstrate a beginning understanding of professional ethical codes and standards of professional practice; Demonstrate basic listening and attending skills; Demonstrate ability to initiate and establish a treatment relationship with clients; Be able to observe family and individual processes and articulate a beginning understanding of those processes with a clinical supervisor; Maintain awareness of multicultural/ gender issues with all persons; Develop a beginning awareness of self-differentiation and maintain ability to manage one's own anxiety; Demonstrate a beginning awareness of a pastoral identity and theological reflection as it relates to the practice of pastoral counseling.

3. Specific Actions to Reach Objectives

Present client paperwork in a timely manner to clinical supervisor for review and signature. Present a minimum of 10 videotapes of 10 separate sessions from at least three different client families.

4. Method of Evaluation for Each Goal

Supervisor and student will meet regularly where student will present videotapes, audiotapes or case reports. Supervisor will observe if possible or necessary. A Mid-Practicum Evaluation and Clinical Staff Review will be completed. A final evaluation will be completed at the end of this Practicum level.

Student Date

Supervisor Date

SUPERVISION CONTRACT – Practicum Section II, III, IV

Student: _____ Supervisor: _____

Contract Beginning Date: _____

1. Administrative and Clinical Responsibilities

Present raw data, audiotape or videotape during the supervisory time each week, maintaining a 1:5 ratio. Administrative paperwork will be completed in a timely fashion. Policies and procedures for Counseling Training Center will be followed.

2. Specific Measurable Goals

3. Specific Actions to Reach Goals (What student therapist will do)

4. Method of Evaluation for Each Goal

Supervisor and student will meet regularly where student will present case reports, audiotape or videotape. Supervisor will observe if possible or necessary. A Mid-Practicum Evaluation and Clinical Staff Review will be completed. A final evaluation will be completed at the end of the Practicum level.

Student Date

Supervisor Date

MAMFT Senior Integration Experience Student Guide

Purpose of the Senior Integration Experience (SIE)

Graduation from the Louisville Presbyterian Theological Seminary Marriage and Family Therapy Program requires successful completion of the Senior Integration Experience (SIE). The purpose of this formal case presentation is to evaluate the student's readiness for entry-level professional practice as demonstrated by their clinical work. The SIE is completed by presenting a written case study with accompanying visual clips from client sessions to a review committee. This committee includes an External Consultant, an AAMFT Approved Supervisor not associated with the LPTS program. The SIE Committee will provide direct input on the quality of work demonstrated by the student. This information will be included in the faculty's final evaluation of students' readiness for graduation.

The Senior Integration Experience Process

The following timeline is provided to assist the student in meeting the multiple demands of the SIE process.

Timeline of MAMFT Senior Integration Experience

1. At least one semester prior to anticipated graduation **COMPLETED:** _____
 - ✓ In consultation with the Clinical Supervisor of Record and the Academic Advisor, select a Senior Integration Experience (SIE) date and time as offered by the MFT Program. (MAMFT students will reserve 1.5 hour and dual degree students will reserve 2 hours for the presentation, committee discussion, and feedback.)
 - ✓ Dual degree students contact non-MFT faculty member to sit on the SIE Committee.
 - ✓ Confirm selected SIE date by obtaining signatures of all committee members, excluding the External Consultant, and submitting the signed SIE Committee form to MFT Administrative Assistant.
 - ✓ Meet with the Director of Clinical Training to discuss graduation plans.
 - ✓ Attend SIE preparation meeting with Administrative Assistant.

2. At least 2 months before SIE presentation

COMPLETED: ____

- ✓ While the SIE case write-up must be the student's independent work, the student will consult with his/her current Clinical Supervisor of Record on case selection and session clips. Priority should be given to presenting either a couple or a family. An individual client will suffice if significant attention is given to systemic formulation.
- ✓ **Write-Up:** Using the "Senior Integration Experience Case Study Format" and "Rubric for Evaluation of Clinical Case Write-Ups," prepare a formal case study and a one-page summary of the selected client case. The write-up must fully document the process of therapy and demonstrate how the session clips (see below) fit into the course of therapy.
- ✓ **Session Clips:** To accompany the SIE case study write-up, a DVD of session clips demonstrating work with the selected client family is required. A DVD showing work with a co-therapist is acceptable, as long as the student is shown leading the therapeutic work. The clips should demonstrate the therapist working toward the goals of therapy in the broader context of multiple sessions.
- ✓ Schedule consultation appointment with External Supervisor. The date should be a minimum of two weeks prior to the SIE presentation date.
- ✓ Select one LPTS faculty member OR one clinical supervisor, in addition to the current Clinical Supervisor of Record, to serve as a Reader for the SIE draft and submit "Reader's Selection" form to MFT Office. **(See section, *Required ASE Consultation and Selection of Additional Reader, for further information on Reader's role and responsibilities.*)**
- ✓ Submit written case draft to Academic Support Center for review and consultation. This must be completed before submitting the draft to the Clinical Supervisor of Record for review and consultation.
- ✓ Submit the completed written case draft to the Clinical Supervisor of Record for review and consultation.

Attention: Students may not perform a mock SIE presentation in Live Supervision. Students may present their SIE case in regular Live Supervision format.

3. At least one month prior to the SIE presentation

COMPLETED: ____

- ✓ After making revisions as suggested by ASC and Clinical Supervisor of Record, submit the completed written case draft to selected Reader for review and consultation.

4. A minimum of two weeks before SIE presentation

COMPLETED: ____

- ✓ Deliver final SIE case write-up with summary page to MFT Office. No changes may be made to the write-up after submission.

- ✓ Deliver final case write-up with summary page to External Consultant during the scheduled consultation. A DVD of selected session clips should be available. The External Consultant may request that additional information be prepared prior to the SIE presentation date. The original SIE case write-up may not be altered. Any additional requested information will be prepared by the student as an addendum to be included with the final SIE case write-up when distributed to committee members.

5. One week before SIE presentation

COMPLETED: ____

- ✓ Deliver SIE case write-up and any addendum materials to:
 - Clinical Supervisor of Record
 - Academic Advisor
 - Director of Clinical Training
 - Selected non-MFT faculty member, for dual degree students only
- ✓ Deliver any addendum materials to MFT Administrative Assistant.
- ✓ Plan a devotional for the SIE presentation.

6. Day of final presentation

COMPLETED: ____

- ✓ Provide a 1 page summary for the committee members to review.
- ✓ Deliver devotional and convene Senior Integration Experience Committee.
- ✓ Deliver SIE presentation supported by session clips to demonstrate the course of treatment and intervention for the client family.
- ✓ Respond to questions from committee members regarding course of treatment and any issues relevant to professional development, clinical competence or management of the case presented.

Following final presentation

- ✓ The committee will briefly release the student from the room to reflect on the presentation and prepare comments regarding the presentation giving special attention to the presenter's readiness to enter the therapeutic community as a new colleague. Readiness is defined as the student's ability to articulate and demonstrate (by session clips, written case study, and committee interaction) their therapy style, an understanding of MFT theory presented in their work, interventions, critical systemic analysis, diagnostic skill, theological reflection, and clinical summary.
- ✓ The committee will determine one of the following:
 - Full approval
 - Conditional Approval with prescribed remediation
 - Non-acceptance of the presentation with or without remedial work
- ✓ The committee will review their comments and decision with the student. If required, the committee will explain any additional information required to the final case write-up or additional session clips needed and provide a timeframe

for completion. Any additional material will be prepared as an addendum to be added to the original case write-up.

- ✓ Within two weeks of the final committee decision date, the External Consultant will prepare a written evaluation of the student's presentation reflective of the Senior Integration Experience Committee's comments and using the "Senior Integration Experience: External Consultant Report Guide." The report will be reflective of the Committee's comments and guidelines presented in "Senior Integration Experience: Committee Participation and Report." The written evaluation will be forwarded to:

Director of Clinical Training
1044 Alta Vista Road
Louisville, KY 40205

- ✓ The MAMFT faculty will include the Graduation Evaluation Committee's assessment and recommendations, if any, in evaluating the student's readiness for graduation.

Required ASC Consultation and Selection of Additional Reader

While the SIE case report must be a student's independent work, it is understood that consultation regarding format and content is important. Therefore, students shall submit their case write-ups to the Academic Support Center (ASC) for review and consultation as part of the educational experience and to provide consistency over all SIE writers.

The student will also select one individual to review their work and provide feedback in addition to their Clinical Supervisor of Record. This reader will be either a LPTS faculty member OR a MFT clinical supervisor. The Reader will offer the student detailed constructive feedback, in one face-to-face meeting, regarding the entire first SIE draft submitted to them only. Consultation about the SIE report may be given in oral and/or written form at the face-to-face meeting. The Reader will refer to the *Rubric for Evaluating Clinical Case Write-Ups* as a guide for their feedback. The Reader is not to provide any further assistance following this meeting with the SIE candidate.

SIE Committee Composition and Roles

The SIE Committee is comprised of six individuals. With the exception of the Student Presenter, committee members have an active vote in the final recommendation.

- Following the timeline and guidance provided in this document, the **Student Presenter** is responsible for managing all aspects of the SIE Process.

- The **External Consultant** is contracted with the MAMFT program. The Consultant provides an external voice to the readiness of the presenter to be a professional in the fields of marriage and family therapy and pastoral counseling. The External Consultant reviews the case study write-up and session clips and consults with the student on their work prior to the SIE presentation. Based upon the presentation, the External Consultant evaluates the presenter's ability to integrate theory into therapeutic interventions and process; utilize theological reflection and critical thinking; understand theory of choice from the field of theories and distinguish the differences. The External Consultant prepares the written report, reflecting the SIE Committee's comments and decisions, and submits the report to the Director of Clinical Training within two weeks following the final case presentation.
- While the SIE report must be the student's independent work, the student's **current Clinical Supervisor of Record** will consult with the student on case selection and session clips. The Clinical Supervisor is the preliminary reviewer of the completed written case draft.
- The student's **MFT/PCC faculty advisor** provides a link between academic and clinical work. The faculty advisor brings an overall picture of the student's academic educational goals, ability, and career direction.
- The **Director of Clinical Training** brings an overall picture of the student's clinical work, ICC participation, and Practicum transitions to the committee.

Note: When the Director of Clinical Training serves as the Clinical Supervisor of Record for a SIE presenter, the presenter's Practicum I-II clinical supervisor shall serve as a member of the SIE Committee.

- An LPTS **non-MFT/PCC faculty member** sits on the SIE Committee for dual degree students only. The faculty member reviews the SIE case write-up prior to the presentation. The faculty member comments on the student's theological, biblical, and/or ministerial thinking and practice from the perspective of the non-MFT/PCC faculty member's discipline. (For example, does the student use appropriate exegesis or hermeneutical principles in their theological reflection? Is their interpretation of religious context appropriate? Have they attended to religious symbolism in their case effectively? Have they considered the intersection of liturgy and worship in their assessment of the client or in interventions?)

**MAMFT SENIOR INTEGRATION EXPERIENCE
CASE STUDY FORMAT**

Format: *Limit Case Study Write-up to no more than 8-10 pages. Use only 12 point font with 1.5 line spacing. From the prepared 8-10 page case study, prepare an additional 1 page summary of the case. Response to all six sections required.*

CAUTION: *Protect confidentiality by disguising names and other identifying information.*

I. Identifying Information

- ☐ A. Provide a one paragraph description of the individual, couple or family presented. Include ages, ethnic and gender information, vocational or educational information and any other important details that will help provide a picture of the context for treatment of this case.
- ☐ B. Indicate how many sessions you have had with each member of the system at the time of this write-up.

II. Presenting Problem

Provide a concise summary of what the individual/couple/family perceived as the motivating factor bringing them to therapy. Also include perceptions provided by referral source and treating therapist.

III. Clinical/Pastoral Assessment

- ☐ A. Summarize your initial observations of client behavior, self-report, and any formal assessments you have done that inform your understanding of what is happening with your client (i.e. spiritual, drugs/alcohol, depression/anxiety, etc.).
- ☐ B. Include the individual's/couple's/family's genogram and summarize ***briefly*** conclusions about family emotional process and structure drawn from it; areas to address include the following:
 - relevant transgenerational issues: family themes, myths, legacies, debts, scripts, etc.
 - relevant information from family of origin, personal history and relationship history

- relevant family life cycle, individual life cycle, developmental tasks, etc.
 - relevant structural, power and communication dynamics
 - relevant gender, racial-ethnic, class, age and other multi-cultural issues
- ☐ C. Identify any legal or ethical problems or dilemmas related to this case.
- ☐ D. Include a working diagnosis related to symptoms presented and your rationale.
- E. Briefly summarize the empirical/research information you have gained relevant to understanding or treating this case.
- ☐ F. Conclusion: Prepare a one-paragraph Clinical/Pastoral Assessment summary.

IV. Summary of Treatment to Date

- ☐ A. State your treatment plan for this individual/couple/family, including specific and measurable goals.
- ☐ B. State your contract with the individual/couple/family.
- ☐ C. Outline your treatment strategy to date.
- ☐ D. Evaluate the effectiveness of your strategy to date.

V. Theological Reflection

- ☐ A. Describe theological, spiritual and faith issues integral to this individual/couple/family's self-presentation.
- ☐ B. Describe how your own value system, personal belief system, personal faith and faith tradition interact with the client's or inform your work with this individual/couple/family.
- ☐ C. Describe your process of theologically evaluating the theories, methods and interventions you selected to work with this individual/couple/family.
- ☐ D. Describe how you see your work with this individual/couple/family as pastoral or a form of ministry.
- ☐ E. Provide a brief theological statement about how you see what you are doing to be healing and or helpful.

VI. Outline Personal or Use of Self Issues Relevant to Your Treatment of This Case. (Countertransference, Transference, Differentiation, Enmeshment, etc.)

MAMFT Senior Integration Experience *Presentation Timeline*

Below are the maximum time increments for each section of the Senior Integration Experience presentation. Section times may be shortened but times for remaining sections may not be increased as a result. Section times must be completed as described. (Not all SIEs will begin at 8 a.m.)

SIE Schedule for MAMFT Student Presenters: total time 1 hour 20 minutes

- 8:00 Five minute devotional
- 8:05 Five minute case introduction
- 8:10 Twenty minutes for video presentation including introduction of videos
- 8:30 Twenty-five minutes for questions and discussion with SIE Committee
- 8:55 Fifteen minutes for Committee review and discussion
- 9:10 Ten minutes for feedback to student
- 9:20 Completion of SIE

SIE Schedule for Dual Degree Student Presenters: total time 1 hour 50 minutes

- 8:00 Five minute devotional
- 8:05 Ten minute case introduction to include theological component
- 8:15 Twenty minutes for video presentation including introduction of video
- 8:35 Thirty-five minutes for questions and discussion with SIE Committee
- 9:10 Twenty minutes for Committee review and discussion
- 9:30 Twenty minutes for feedback to student
- 9:50 Completion of SIE

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Prepared July 11, 2013

Rubric for Evaluation Clinical Case Write-Up - SIE

Categories	Levels of Quality		
	Excellent	Acceptable	Marginal
Identifying Information/Description of Client	Description is clear, concise and includes all clients present. Any outstanding features of clients are briefly described (apparent handicaps, other personal dimensions that may affect therapy).	Description is present and describes basic attributes of clients. Presents information in a logical manner.	Description is absent, excessive, disorganized, or misses important primary information.
Identifying Information Score <div style="text-align: center;"> ----- 100 </div>			
Presenting Problem	Presenting Problem is identifiable, precise, and concise, and reflects clients' description of what brings them to therapy. Few wasted words; reader can quickly determine why clients came to therapy.	Presenting problem is stated in understandable terms; client's voice may not be clear, but is present. Presenting problem may be obscured by descriptions or explanations.	Presenting problem is unclear or vague; problem statement demonstrates that counselor lacks clear understanding of what brings the client to counseling.
Presenting Problem Score <div style="text-align: center;"> ----- 100 </div>			
Clinical/Pastoral Assessment ¹	1. Family assessment relates directly to client presenting problem and/or history. Initial observations are clear & concise.	1. Family assessment is present with a coherent strategy that relates to client problem or history. Initial observations are included.	1. Family assessment procedures and summaries are insufficient or lack a consistent logic. Initial observations are absent or lack specificity.
	Rating for #1 <div style="text-align: center;"> ----- 100 </div>		
	2. Guiding theoretical model for assessment is clear and consistent.	2. Guiding theoretical model is present but may lack specificity.	2. Theoretical model that guides assessment is either unclear or misrepresented.

¹ Assessment: Case conceptualization reflects therapist integration of assessment data with client history and presenting problem in logical language reflecting therapist's theoretical stance.

Clinical/Pastoral Assessment (Continued)	Rating for #2 ----- 10 0		
	3. Assessment has a coherent strategy (i.e. uses clinical interview and any other useful self report instruments, and formal assessments, such as lethality assessments, screening tools, etc., that make sense for the case).	3. Assessment tools (clinical interview and other self-report instruments and formal assessments) are appropriate to the client's presenting problem.	3. Little evidence of use of assessment tools or tools are insufficient.
	Rating for #3 ----- 10 0		
	4. Assessment reflects clear systemic analysis (attention to interactional, emotional, structural systems; awareness of circularity, system levels and rules). Genogram clearly reflects observations of family history, structure, and systemic issues.	4. Assessment includes attention to systemic analysis, including description of systemic elements, circularity, system levels or rules. Genogram is present with evidence of attention to systemic issues.	4. Assessment lacks sufficient systemic awareness. Genogram fails to provide clarity around family systems.
	Rating for #4 ----- 10 0		
	5. Assessment write-up provides clear description of procedures, logical coherent assessment procedures used, and contains a clear summary.	5. Assessment write-up is present, with description of procedures, coherence, and a clear summary is provided.	5. Assessment write-up lacks adequate description of procedures, consistent logic, or clear summary.
	Rating for #5 ----- 10 0		
	6. Assessment summary attends to client's social location, including: relevant structural, power and communication dynamics; and relevant gender, racial-ethnic, class, age and other multi-cultural issues.	6. Assessment summary contains basic information about client's social location, including multi-cultural issues or other relevant concerns.	6. Assessment summary contains little attention to client's social location, multi-cultural issues or other relevant concerns.
	Rating for #6		

<p>-----</p> <p>10 0</p>		
7. Assessment summary attends to religious, spiritual, theological, or meaning issues.	7. Assessment summary attends to client's spiritual and religious life in basic or limited terms.	7. Assessment summary lacks sufficient attention to religious, spiritual life or issues of meaning.
<p>Rating for #7</p> <p>-----</p> <p>10 0</p>		
8. Legal and/or ethical problems or dilemmas related to the case are identified and summarized in clear and concise language.	8. Legal and/or ethical problems or dilemmas related to the case are identified with some description provided.	8. Legal or ethical issues are poorly identified or description lacks clarity.
<p>Rating for #8</p> <p>-----</p> <p>10 0</p>		
9. Empirical/research information is summarized in clear and concise language and is relevant to the understanding or treatment of the case.	9. Empirical/research information is present with some description of connection to client case.	9. Empirical/research information is not present or does not clearly connect to client case.
<p>Rating for #9</p> <p>-----</p> <p>10 0</p>		
10. Conclusion uses specific assessment data to construct a clear and concise statement of what the "client problem" is that can be used to construct a treatment plan.	10. Conclusion uses basic assessment data to construct a statement regarding the nature of the "client problem."	10. Conclusion uses weak or no data to construct a statement regarding the nature of the "client problem."
<p>Rating for #10</p> <p>-----</p> <p>10 0</p>		
11. DSM-V diagnosis is complete, appropriate and accurate in relation to statement of "client problem."	11. DSM-V diagnosis is provided and relates to statement of "client problem."	11. DSM-V diagnosis is absent, incomplete or inappropriate in relation to statement of "client problem."
<p>Rating for #11</p> <p>-----</p> <p>10 0</p>		

Clinical/Pastoral Assessment Overall Score			
<div style="text-align: center;"> <div style="display: flex; justify-content: space-between; width: 100%;"> ----- </div> <div style="display: flex; justify-content: space-between; width: 100%;"> 10 0 </div> </div>			
Treatment Plan	1. Treatment Plan is clear, concise, and "doable." - Includes no more than three goals that are directly related to presenting problem and assessment findings. - Goals are specific and measurable.	1. Treatment plan is present and provides a trajectory for future treatment. - Goals are clear, measurable, and connect to presenting problem, assessment and interventions planned.	1. Treatment plan lacks coherence or clarity. - Little connection exists between problem, assessment and intervention. - Goals are not clear or measurable.
	Rating for #1 <div style="text-align: center;"> <div style="display: flex; justify-content: space-between; width: 100%;"> ----- </div> <div style="display: flex; justify-content: space-between; width: 100%;"> 10 0 </div> </div>		
	2. The contract with the client family system is stated in clear and concise language.	2. The contract with the client family is present and stated in general terms.	2. The contract with the client family is absent, unclear or too wordy.
	Rating for #2 <div style="text-align: center;"> <div style="display: flex; justify-content: space-between; width: 100%;"> ----- </div> <div style="display: flex; justify-content: space-between; width: 100%;"> 10 0 </div> </div>		
	3. Treatment plan reflects exemplary systemic analysis established in evaluation and follows through with appropriate and well-described systemic interventions.	3. Treatment plan includes basic systemic analysis established in evaluation with appropriate systemic interventions.	3. Treatment plan marginally reflects systemic analysis or appropriate intervention.
	Rating for #3 <div style="text-align: center;"> <div style="display: flex; justify-content: space-between; width: 100%;"> ----- </div> <div style="display: flex; justify-content: space-between; width: 100%;"> 10 0 </div> </div>		
	4. Treatment strategy is clearly outlined with planned interventions described for each goal.	4. Treatment strategy is present with descriptions of interventions.	4. Treatment strategy is absent or fails to correspond with stated goals.
	Rating for #4 <div style="text-align: center;"> <div style="display: flex; justify-content: space-between; width: 100%;"> ----- </div> <div style="display: flex; justify-content: space-between; width: 100%;"> 10 0 </div> </div>		
	5. Treatment plan shows clear distinction between goals (expected outcomes of therapy) and interventions (what client and/or therapist will do to accomplish goals).	5. Treatment plan includes stated goals and interventions with little confusion.	5. Treatment plan fails to distinguish between goals and interventions.

Treatment Plan (Continued)	Rating for #5 ----- 10 0		
	6. Each goal statement has a way to observe and measure when a goal is met. Effectiveness of strategy is stated in clear and concise language.	6. How goals will be measured and observed is present but may lack clarity. Effectiveness of strategy is defined in general language.	6. Goal statements lack attention to observations or measures for therapy outcome. Effectiveness of strategy is absent or unclear.
	Rating for #6 ----- 10 0		
Treatment Plan Overall Score ----- 10 0			
Ongoing Assessment (including Evidence-Based Assessment of Client Progress)	- Shows client(s)' progress toward specific, measureable goals. - Integrates and uses SRS and ORS in evaluating client progress and revising treatment plan.	- Shows some client progress. - Use of SRS and ORS in evaluating client progress and treatment planning.	- Client progress is not evident. - SRS and ORS are not used consistently. - No evidence of ongoing treatment planning.
Ongoing Assessment Score ----- 10 0			
Theological Reflection	- Theological, spiritual, and faith issues integral to the client family system & self-presentation are described in clear and concise language and demonstrate a contextually sensitive ² theological position for understanding client experience, assessment and treatment. - Attends to therapist's own faith location, recognizes	- Theological, spiritual, and faith issues integral to the client family system & self-presentation are described and are contextually sensitive. - Attends to therapist self understanding or faith experience. - Material generated by theological reflection impacts treatment. - Description of therapeutic work with client as pastoral	- Theological, spiritual, and faith issues integral to the client family system & self-presentation are unclear or poorly described. - Lacks attention to therapist self-understanding or faith experience. - Description of therapeutic work with client as ministry is poorly written or states inadequate reflection. Therapist fails to see self as

² Gender, race, class, sexual orientation, differently abled, etc.

	appropriate differences with client's faith location and uses interaction to inform therapeutic work. - Shows how material generated from theological reflection impacts treatment. - Description of therapeutic work with client as pastoral ministry is clear and concise.	ministry is present. Reflects sense of therapeutic presence as ministry.	minister of healing and help.
Theological Reflection Score <div style="text-align: center;"> ----- 100 </div>			
Outline Personal or Use of Self Issues Relevant to Your Treatment of this Case	Clearly and concisely identifies and appropriately addresses issues of countertransference, transference, differentiation, enmeshment, etc.	Identifies some issues of countertransference, transference, differentiation, enmeshment, etc. with recognized attempts to address these concerns.	Inadequately recognizes issues of countertransference, transference, differentiation, enmeshment, etc. and fails to address them appropriately.
Personal or Use of Self Issues <div style="text-align: center;"> ----- 100 </div>			
Clear, effective writing	Report uses brief, well formed sentences that are direct and to the point. Each paragraph has a purpose which is accomplished with parsimony. Report has a "logical flow" that begins in a clear problem, shows how the problem is related to client history, how problem and history stimulate and guide assessment, and how assessment culminates in a treatment plan for specific outcomes.	Report is drafted with appropriate language and logical flow for each section. Information demonstrates sound clinical treatment planning for specific outcomes within the case study.	Report is too wordy trying to make a case for each section or lacks sufficient information to demonstrate good clinical logic. Organization and attention to logical flow are absent with no specificity around treatment planning for outcomes.
Writing Score <div style="text-align: center;"> ----- 100 </div>			

Senior Integration Experience
 Case Write-Up Overall Score: _____

Rubric for Senior Integration Experience Presentation

Category	Levels of Quality		
	Excellent	Acceptable	Marginal
Oral Case Presentation	1. Intern description of client problem, assessment and diagnosis, treatment, plan, and treatment to date is clear and concise.	1. Intern description is present and describes basic attributes of clients. Information lacks clarity, includes extraneous data or lacks logical organization.	1. Intern description is absent, disorganized, or misses important primary information.
	Rating for #1: ----- <div style="display: flex; justify-content: space-between;">100</div>		
	2. Intern is fluent and flexible in describing theories and models of MFT used for assessment and treatment.	2. Intern can describe theories and models of MFT used for assessment and treatment, but lacks flexibility or fluency.	2. Intern is unable to describe or poorly describes theories and models of MFT used for assessment and treatment.
	Rating for #2: ----- <div style="display: flex; justify-content: space-between;">100</div>		
	3. Intern responds thoughtfully, appropriately and flexibly to questions or challenges to the case, assessment, or treatment using good clinical reasoning with the SIE evaluators.	3. Intern responds rigidly, incompletely, or in a disorganized manner to challenges to the case, assessment, or treatment using basic clinical reasoning with the SIE evaluators.	3. Intern is unable to respond to questions or challenges to the case assessment, or treatment; uses poor clinical reasoning with the SIE evaluators.
	Rating for #3: ----- <div style="display: flex; justify-content: space-between;">100</div>		
	4. Intern selection of video clips demonstrates clear connection between the therapist's description of assessment and treatment, and action in therapy.	4. Intern selection of video clips shows a marginal connection between the therapist's description of assessment and treatment, and action in therapy.	4. Intern selection of video clips shows little or no connection to therapist's description of assessment and treatment, and action in therapy.
	Rating for #4: ----- <div style="display: flex; justify-content: space-between;">100</div>		

	5. Intern orally demonstrates good ability to use her/his framework for theological or spiritual reflection on the case and elements of treatment.	5. Intern is able to speak marginally to her/his framework for theological or spiritual reflection on the case and elements of treatment.	5. Intern cannot articulate how her/his framework for theological or spiritual reflection relates to the case and elements of treatment.
	Rating for #5: <div style="text-align: center;"> ----- 100 </div>		
Oral Presentation Overall Score			

Senior Integration Experience

Case Write-Up Total Score: _____

Oral Presentation Total Score: _____

SIE Final Score: _____

Recommendation: ☐ Full Approval
 ☐ Conditional Approval – remedial work required
 ☐ Non-Acceptance of Presentation

Revised July 2013

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MAMFT Senior Integration Experience

Committee Checklist

Committee members may use this checklist as the presentation is given to note inclusion of material. Comments may be written for use in final report.

- ☐ Articulation and demonstration of self as therapist and pastoral counselor, including personal issues and/or countertransference issues relevant to this case:

- ☐ Recognizing gender and power issues related to “self”; multicultural and diversity issues
- ☐ Appropriate boundary setting related to “self” and client
- ☐ Development of “joining”
- ☐ Ability to recognize and address transference and countertransference issues

Comments: _____

- ☐ Articulation and demonstration of their therapy style, drawn from a broader understanding of theories:

- ☐ Case conceptualization demonstrates beginning level, integrated theory of therapy and understanding of theory of choice compared/contrasted to other theories

Comments: _____

- ☐ Articulation and demonstration of who is being treated and overall therapy including clarification of ethical and legal concerns related to overall presentation:

- ☐ Use of flexible, multicultural framework
- ☐ Use of dialogue with colleagues, supervisors, and consultant and ability to integrate where appropriate in presentation
- ☐ Consideration of larger systems issues

Comments: _____

- ☐ Articulate and demonstration of diagnostic skill related to the symptoms presented:
- ☐ Demonstration of theory of preference
 - ☐ Understanding of how family or origin issues, previous relationships and losses, give meaning to the present systemic circumstances
 - ☐ Patterns of behavior that create opportunities to be “stuck”
 - ☐ Use of interventions
 - ☐ Create opportunities for “joining,” build on therapeutic alliance
 - ☐ Recognition of current cluster of symptoms, what meaning clients give to the symptoms, and use of appropriate assessments and corresponding working diagnosis
 - ☐ Good clinical use of observation
 - ☐ Use of appropriate and adequate assessment tools
 - ☐ Use of genogram and understanding of client(s) belief system (religious orientation) reflected in written material and oral presentation
 - ☐ Larger systems issues and their impact on the present for client(s), including multi-cultural and community issues
 - ☐ Appropriate use of interventions, carried out in a professional and personally integrated way

Comments: _____

- ☐ Articulation and demonstration of a defined goal and outcomes for this particular session relevant to treatment plan, interventions, and overall therapeutic goal:
- ☐ Coherent treatment plan
 - ☐ Treatment plan manageable and appropriate for this particular client(s) system and issues
 - ☐ Videotaping relevant to and demonstrates consistency with conceptualization and treatment plan
 - ☐ Demonstration of professional appropriate boundary setting, therapist’s behavior, therapist’s focus (reflective of ethical codes)

Comments: _____

- ☐ Articulation and demonstration of theological reflection related to the self as therapist and present client system:
 - ☐ Indicates how the client(s) – individual – and systemic belief system’s meaning of the problem or symptoms contribute to or hinder therapeutic progress
 - ☐ Indicates how the client(s) expectations of intimacy, roles, rules, concepts of equality and power, issues of diversity, and influence of social economic factors challenge or parallel the therapist’s belief system
 - ☐ Integrates (and still differentiates) their own personal belief system and faith tradition

Comments: _____

- ☐ Articulation and demonstration of critical thinking skills:
 - ☐ Case conceptualization
 - ☐ Integration of theory into clinical work and ability to articulate purpose
 - ☐ Integration of presenting problem and symptom cluster(s) into larger system’s issues
 - ☐ Ability to self-evaluate, utilization of supervision, recognition of growing edges

Comments: _____

Articulation of clinical summary:

MAMFT Senior Integration Experience

Committee Recommendation with Highlighted Reflections and Comments

Student Presenter: _____ Date & Time: _____

Committee's Determination:

_____ Full Approval

_____ Conditional Approval: Student must accomplish the following _____

_____ Must be completed by: _____
(Date)

_____ Non-Acceptance of Presentation

Signatures:

Dr. Joe Brown, External Consultant

MFT/PCC Faculty Member

Jennifer A. Schiller, Director of Clinical Training

Clinical Supervisor

Dual Degree: _____
LPTS Faculty Member

The following Committee reflections and comments will be used by External Consultant in producing the final evaluation report.

Articulation and demonstration of self as therapist and pastoral counselor, including personal issues and/or countertransference issues relevant to this case:

Articulation and demonstration of their therapy style, drawn from a broader understanding of theories:

Articulation and demonstration of who is being treated and overall therapy including clarification of ethical and legal concerns related to overall presentation:

Articulate and demonstration of diagnostic skill related to the symptoms presented:

Articulation and demonstration of a defined goal and outcomes for this particular session relevant to treatment plan, interventions, and overall therapeutic goal:

Articulation and demonstration of theological reflection related to the self as therapist and present client system:

Articulation and demonstration of critical thinking skills:

Articulation of clinical summary:

Mid Practicum I Evaluation

Student: _____ Date of Report: _____

Clinical Supervisor: _____ LIVE Group Supervisor: _____

Clinical Placement: _____ Administrative Supervisor: _____

Instructions

This assessment of a student's progress toward mastering Practicum I competencies should be completed at the mid-point of the level. Rate the student with the following in mind:

Acceptable is a passing score – the student demonstrates skills commensurate with the mid-point of clinical experience. **Unacceptable** is a failing score--the student does not, or is unable to, demonstrate the skill commensurate with what one would expect at the mid-point of this supervised practice. The student's contract for Practicum I can be altered at this time to reflect any recommendations to meet deficiencies noted.

Objectives	Ratings	
1. Initiates & establishes treatment relationships	Unacceptable	Acceptable
<u>Evaluation points include:</u> <ul style="list-style-type: none">✓ Responds empathically with client(s) experience✓ Demonstrates warmth.✓ Attends to all family members✓ Demonstrates appropriate sense of humor✓ Reassures client / family that problem is of real importance.✓ Helps family define their needs.✓ Defines treatment relationship with clients✓ Expresses realistic expectations about therapy with family✓ Structures session appropriately under supervision✓ Understands joining at a beginning level and can identify this process in supervision		
2. Basic attending skills	Unacceptable	Acceptable
<u>Evaluation points include:</u> <ul style="list-style-type: none">✓ Appropriate verbal following of client's story and self-presentation.✓ Uses verbal and non-verbal minimal encouragers to stimulate client's self-presentation.✓ Uses open-ended questions to encourage client disclosure.✓ Accurately paraphrases in session.✓ Accurately reflects feelings in session✓ Uses summarization appropriate in session✓ Appropriate use of body posture & gestures in session to facilitate counseling process.		

Mid-Practicum I Evaluation

Objectives	Ratings
3. Capacity to maintain self-differentiation when exposed to intimate systems, under supervision	Unacceptable Acceptable
<p><u>Evaluation points include:</u></p> <ul style="list-style-type: none"> ✓ Is able to regulate own anxiety in counseling sessions without verbally or behaviorally impeding the session. ✓ Can critically self-reflect in supervision about personal issues that impede or enhance therapy effectiveness. ✓ Is willing to take responsibility for personal issues affecting sessions. ✓ Respects boundaries with clients and organizational systems under supervision. ✓ Can articulate boundary issues arising in their work and demonstrates conscious control of these under supervision. 	
4. Ability to make good use of clinical supervision	Unacceptable Acceptable
<p><u>Evaluation points include:</u></p> <ul style="list-style-type: none"> ✓ Is open to supervision intervening with technical skills in session. ✓ Is open to supervision intervening with use of self in a session. ✓ Is open to supervisor presenting the need for critical self-reflection about feelings, behavior or personal issues affecting sessions. ✓ Follows through on supervisory interventions. ✓ Is able to engage supervisor and ask for what is needed. 	
5. Ability to observe and articulate family / individual process.	Unacceptable Acceptable
<p><u>Evaluation points include:</u></p> <ul style="list-style-type: none"> ✓ Is able to make accurate structural observations – boundaries, generational hierarchies, etc. ✓ Can identify simple family emotional processes – triangling, fusion, cut-off, etc. ✓ Accurately identifies power structures and issues in family process ✓ Is able to translate observed family interaction in session into a process articulation 	
6. Conceptualization of clinical problem from a system viewpoint	Unacceptable Acceptable
<p><u>Evaluation points include:</u></p> <ul style="list-style-type: none"> ✓ Can use one theoretical orientation to conceptualize a case. ✓ Is able to relate in-session behaviors to a clinical theory to organize observations most of the time. ✓ Is able to relate clinical conceptualizations to plan for therapeutic behavior with the help of a supervisor. 	

Mid-Practicum I Evaluation

Objectives	Ratings	
7. Awareness of multi-cultural and gender issues in evaluating cases, with supervision	Unacceptable	Acceptable
8. Understanding of observed processes and how they relate to client complaints and treatment	Unacceptable	Acceptable
9. Establishes treatment plans under supervision	Unacceptable	Acceptable
<u>Evaluation points include:</u> ✓ Is able to establish a clinically reasonable treatment plan that relates to observations and case conceptualization. ✓ Can plan specific strategies for therapy.		
10. Implementation / Technical skill	Unacceptable	Acceptable
<u>Evaluation points include:</u> ✓ Is able to carry out specific techniques in session that are planned in supervision. ✓ Can evaluate effectiveness of treatment interventions under supervision. ✓ Can relate interventions / evaluation of interventions to treatment plan and strategy.		
11. Professional ethics, legal issues and standards of practice	Unacceptable	Acceptable
<u>Evaluation points include:</u> ✓ Is aware of basic ethical issues for the practice of Marriage and Family Therapy – confidentiality, informed consent, boundaries in therapy, etc. ✓ Understands basic therapeutic legal issues – duty to warn, child abuse, etc. ✓ Is able to adhere to the standard of practice appropriate to a beginning student under supervision – writes appropriate clinical records, professional and collegial collaboration, adheres to admin. procedures.		
12. Pastoral Identity	Unacceptable	Acceptable
<u>Evaluation points include:</u> ✓ Is beginning to conceptualize the practice of Marriage and Family Therapy in a pastoral context. ✓ Has begun to explore personal pastoral identity in the context of “call” and its impact on persona/professional life. ✓ Is beginning to consider “what makes counseling pastoral?”		

Mid-Practicum I Evaluation

Objectives	Ratings
13. Beginning ability to think theologically about clients, counseling and own process	Unacceptable Acceptable
<u>Evaluation points include:</u> ✓ Can identify fundamental theological issues related to cases and personal experience in therapy – issues of grace, faith, etc. ✓ Is beginning to find connections between theological studies and clinical casework.	

14. Clinical practice, supervision & integration	
a. Student has regularly and appropriately participated in Interdisciplinary Case Conference.	Unacceptable X Acceptable ICC Leader <u>Jenny Schiller</u>
b. Student has regularly and appropriately participated in LIVE Supervision.	Unacceptable Acceptable LIVE Leader _____

Supervisor Comments:

Mid-Practicum I Evaluation

Student Comments:

Supervisor

Date

Student

Date

Final Practicum I Evaluation
Clinical Supervisor's Assessment of Student Work

Student: _____ Date of Report: _____

Clinical Supervisor: _____ LIVE Group Supervisor: _____

Clinical Placement: _____ Administrative Supervisor: _____

Evaluation Procedure:

The clinical supervisor will determine when the competencies and contracted goals for Practicum I have been met. At that time, the following procedure will be followed:

1. Based on an assessment of the student's progress toward achievement of appropriate level competencies as demonstrated by self-reports, presentations of raw data, and an Administrative Supervisor evaluation, the clinical supervisor will complete Section 1 of the Evaluation.
2. The student will complete a self-assessment of their progress toward achievement of competencies, providing supportive comments as desired. The student will submit their self-assessment to their supervisor to be included in the Clinical Staff formal review.
3. During a scheduled meeting of the clinical staff and MFT/PCC faculty, a formal review of the student's progress in the MFT Program will be held.
 - a. The clinical supervisor will present the completed Section 1 of this form and provide a verbal report regarding the student's achievements and areas of growth.
 - b. The student's self-assessment of achievements and identified areas of growth will be entered into the review process.
 - c. The student's live supervisor will present an assessment of the student's progress in group supervision.
 - d. MFT/PCC faculty members, Director of Clinical Training, and Administrative Assistant may provide additional input regarding observations, didactic progress, or performance in clinical settings. These comments will be added to the Final Evaluation form.
 - e. Achievements and areas of growth will be noted on the Final Evaluation form. Any significant discrepancies between the supervisor's and student's assessments will also be noted.
 - f. Designated signatures will be obtained.
4. Following the formal review, the clinical supervisor will review the completed evaluation with the student and discuss comments noted. If there are no concerns, the student and supervisor will sign the form and return it to the MFT Office. If concerns are raised, they will be reported to the Director of Clinical Training and a plan for resolution will be developed.

Final Practicum I Evaluation: Clinical Supervisor's Assessment

Section 1: Rating Scale Criteria: Evaluation is directly related to stated competencies and to *beginning* skills. **Acceptable** is a passing score – skills demonstrated are commensurate with beginning clinical experience. **Unacceptable** is a failing score – the skill and competencies expected at a beginning level have not been demonstrated.

Objectives	Ratings	
1. Initiates & establishes treatment relationships	Unacceptable	Acceptable
<p><u>Evaluation points include:</u></p> <ul style="list-style-type: none"> ✓ Responds empathically with client(s) experience ✓ Demonstrates warmth. ✓ Attends to all family members ✓ Demonstrates appropriate sense of humor ✓ Reassures client / family that problem is of real importance. ✓ Helps family define their needs. ✓ Defines treatment relationship with clients ✓ Expresses realistic expectations about therapy with family ✓ Structures session appropriately under supervision ✓ Understands joining at a beginning level and can identify this process in supervision 		

2. Basic attending skills	Unacceptable	Acceptable
<p><u>Evaluation points include:</u></p> <ul style="list-style-type: none"> ✓ Appropriate verbal following of client's story and self-presentation. ✓ Uses verbal and non-verbal minimal encouragers to stimulate client's self-presentation. ✓ Uses open-ended questions to encourage client disclosure. ✓ Accurately paraphrases in session. ✓ Accurately reflects feelings in session ✓ Uses summarization appropriate in session ✓ Appropriate use of body posture & gestures in session to facilitate counseling process. 		

3. Capacity to maintain self-differentiation when exposed to intimate systems, under supervision	Unacceptable	Acceptable
<p><u>Evaluation points include:</u></p> <ul style="list-style-type: none"> ✓ Is able to regulate own anxiety in counseling sessions without verbally or behaviorally impeding the session. ✓ Can critically self-reflect in supervision about personal issues that impede or enhance therapy effectiveness. ✓ Is willing to take responsibility for personal issues affecting sessions. ✓ Respects boundaries with clients and organizational systems under supervision. ✓ Can articulate boundary issues arising in their work and demonstrates conscious control of these under supervision. 		

Final Practicum I Evaluation: Clinical Supervisor's Assessment

Objectives	Ratings	
4. Ability to make good use of clinical supervision	Unacceptable	Acceptable
<p><u>Evaluation points include:</u></p> <ul style="list-style-type: none"> ✓ Is open to supervision intervening with technical skills in session. ✓ Is open to supervision intervening with use of self in a session. ✓ Is open to supervisor presenting the need for critical self-reflection about feelings, behavior or personal issues affecting sessions. ✓ Follows through on supervisory interventions. ✓ Is able to engage supervisor and ask for what is needed. 		
5. Ability to observe and articulate family / individual process.	Unacceptable	Acceptable
<p><u>Evaluation points include:</u></p> <ul style="list-style-type: none"> ✓ Is able to make accurate structural observations – boundaries, generational hierarchies, etc. ✓ Can identify simple family emotional processes – triangling, fusion, cut-off, etc. ✓ Accurately identifies power structures and issues in family process ✓ Is able to translate observed family interaction in session into a process articulation 		
6. Conceptualization of clinical problem from a system viewpoint	Unacceptable	Acceptable
<p><u>Evaluation points include:</u></p> <ul style="list-style-type: none"> ✓ Can use one theoretical orientation to conceptualize a case. ✓ Is able to relate in-session behaviors to a clinical theory to organize observations most of the time. ✓ Is able to relate clinical conceptualizations to plan for therapeutic behavior with the help of a supervisor. 		
7. Awareness of multi-cultural and gender issues in evaluating cases, with supervision	Unacceptable	Acceptable
8. Understanding of observed processes and how they relate to client complaints and treatment	Unacceptable	Acceptable

Final Practicum I Evaluation: Clinical Supervisor's Assessment

Objectives	Ratings	
9. Establishes treatment plans under supervision	Unacceptable	Acceptable
<u>Evaluation points include:</u> <ul style="list-style-type: none"> √ Is able to establish a clinically reasonable treatment plan that relates to observations and case conceptualization. √ Can plan specific strategies for therapy. 		
10. Implementation / Technical skill	Unacceptable	Acceptable
<u>Evaluation points include:</u> <ul style="list-style-type: none"> √ Is able to carry out specific techniques in session that are planned in supervision. √ Can evaluate effectiveness of treatment interventions under supervision. √ Can relate interventions / evaluation of interventions to treatment plan and strategy. 		
11. Professional ethics, legal issues and standards of practice	Unacceptable	Acceptable
<u>Evaluation points include:</u> <ul style="list-style-type: none"> √ Is aware of basic ethical issues for the practice of Marriage and Family Therapy – confidentiality, informed consent, boundaries in therapy, etc. √ Understands basic therapeutic legal issues – duty to warn, child abuse, etc. √ Is able to adhere to the standard of practice appropriate to a beginning student under supervision – writes appropriate clinical records, professional and collegial collaboration, adherence to administrative procedures. 		
12. Pastoral Identity	Unacceptable	Acceptable
<u>Evaluation points include:</u> <ul style="list-style-type: none"> √ Is beginning to conceptualize the practice of Marriage and Family Therapy in a pastoral context. √ Has begun to explore personal pastoral identity in the context of “call” and its impact on persona/professional life. √ Is beginning to consider “what makes counseling pastoral?” 		

Final Practicum I Evaluation: Clinical Supervisor's Assessment

Objectives	Ratings
13. Beginning ability to think theologically about clients, counseling and own process	Unacceptable Acceptable
<u>Evaluation points include:</u> ✓ Can identify fundamental theological issues related to cases and personal experience in therapy – issues of grace, faith, etc. ✓ Is beginning to find connections between theological studies and clinical casework.	

14. Clinical practice, supervision & integration	
a. Student has responsibly attended to management of case records, professional behavior at LSCTC and timely completion of administrative paperwork.	<div style="text-align: center;">Unacceptable Acceptable</div> LSCTC Director _____
b. Student has regularly and appropriately participated in Interdisciplinary Case Conference.	<div style="text-align: center;">Unacceptable Acceptable</div> ICC Leader _____
c. Student has regularly and appropriately participated in LIVE Supervision.	<div style="text-align: center;">Unacceptable Acceptable</div> LIVE Leader _____
d. Student has demonstrated beginning integration of didactic materials with clinical practice.	<div style="text-align: center;">Unacceptable Acceptable</div> Clinical Supervisor _____
e. Student has completed a minimum of 75 hours of supervised experience.	Yes _____ No _____ Admin. Assistant _____

Section 2: FORMAL CLINICAL REVIEW SUMMARY

General Observations: _____

Final Practicum I Evaluation: Clinical Supervisor's Assessment

Clinical Strengths: _____

Clinical Concerns: _____

RECOMMENDATION

Pass to Practicum II **Yes** **No**

If no, what remediation is necessary?

Comments:

Supervisor Date

Student Date

Recorder Date

PRACTICUM RECORD LOG
(Logs are due in the MFT Office by the 10th of the month.)

Month & Year of this Record: _____

Student Name: _____ Clinical Supervisor: _____

Report of Client Contact Hours at LSCTC and _____

Clinical Hours Completed at LSCTC									
Constellation	Individual		Relational				Total Columns		
	Ind	Ind-CC	Couple	Couple-CC	Family	Family-CC	Total Hrs. Relational	Total Hrs. CC	Total Clinical Hrs. LSCTC*
Single									
Group of . . .									
Alternative									
Total Hrs.									

Clinical Hours Completed at Off-Campus Site									
Constellation	Individual		Relational				Total Columns		
	Ind	Ind-CC	Couple	Couple-CC	Family	Family-CC	Total Hrs. Relational	Total Hrs. CC	Total Clinical Hrs. Off Site*
Single									
Group of . . .									
Alternative									
Total Hrs.									
GRAND TOTAL									

Report of Clinical Supervision Hours through LSCTC

	Raw Data					
	Client Present in Supervision	Video	Audio	Total Raw Data	Case Report	Total Supervision (Raw Data & Case Report)
Individual						
Group						
Total Hrs.						

Student Signature: _____

Clinical Supervisor: _____

Administrative Supervisor: _____

* Total of all clinical hours completed at this site.

** Definitions for client and supervisory sessions appear on the back.

Created 7/18/13

Definitions

Constellation of Client Contact

Single - Single constellation of client contact occurs when one individual, one couple, or one family is seen in session.

Group – A group constellation of client contact occurs when a group of non-related individuals a group of couples, or a group of families is seen in session.

Standard Practicum Log Definitions – Client Contact

Individual - A session with a single individual or a group of non-related individuals.

Couple - Two individuals considered as intimately joined together who function socially as a unit. The word “couple” is a universal description of the link and bond between two people.

Counting Hours: Two persons **must** be in the counseling room. Focus is relational, systemic and contextual.

Family – A social system characterized and/or constructed by affective ties that may include biological, mutual care, or long-term household relationships formed by kinship, commitment, or legal obligation, such as foster care or institutional placement.

Counting Hours: More than one person **must** be in the counseling room, usually different from “couple”. Focus is relational, systemic and contextual.

Cross-Cultural - When two or more individuals are gathered together, diversity exists. Each individual is a unique creation endowed with specific differences. In regards to this form, clients who are diverse from their therapist by age, ethnicity, class, sexual orientation, or physical or mental ability are considered cross-cultural.

Counting Hours: Sessions held with cross-cultural clients, as defined above, are recorded in the CC column under the appropriate heading of Individual, Couple, or Family.

Alternative- Two or more members of a systemic group attending session to address concerns related to the group.

Examples of alternative hours: A session held with a teacher and one or more students to address a classroom concern; A nurse and one member of a patient’s family meeting to discuss care of the patient; Two or more employees from an institution meeting to discuss an issue.

Team Meetings – Team meetings at Practicum sites where an LPTS intern’s or other team member’s client is present and/or client family members are present may count as direct client contact time, at the intern’s clinical supervisor’s discretion.

Constellation of Supervision

Individual – An individual constellation for supervision occurs when 1-2 students work with the supervisor (clinical supervision).

Group – A group constellation for supervision occurs when 3-6 students work with the supervisor (Live Supervision).

Types of Supervision

Client Present - when the supervisor observes a student conducting therapy through a one-way mirror, TV monitor, or other observation device.

Video/Audio - When the supervisor observes/listens to a videotape/audiotape of the student conducting therapy.

Case Report - All form of supervision NOT based on raw data.

Attendance Register and Payment Log

	CLIENT INFORMATION	SESSION INFORMATION		
Therapist's Last Name(s)	Student Last Name or Group Name	Type	Session Date	Length of Session (1/2 - 1 hr)
Totals:				

[illegible]

Off-Campus Site Log

Intern Signature

Off-Campus Supervisor Signature

How to Write an Intake Evaluation

(Under revision, Fall 2013)

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How to Write an Intake Evaluation

Philosophy of intake evaluations.

An intake evaluation documents a foundation for treatment. It provides a logical, inferential chain that links: 1) your clinical observations, 2) selection of methods, 3) action in therapy, and 4) expected outcome. A good intake evaluation protects your client by assuring that you have the information required to design appropriate treatment. It protects you by documenting that you assessed your client adequately and justifies your approach to treatment. The intake assessment is a legal document showing that you performed your clinical responsibilities and met an adequate standard of professional practice. Most important, good intake evaluation helps you clarify your clinical reasoning provides a logic for care. Finally, good intake evaluations lets colleagues and supervisors assess your clinical thinking and help you develop your treatment logic.

Good intake evaluations are usually 2- 6 single-spaced typewritten pages long, depending on what formal clinical measures you may use and summarize. Your goal should be clarity and good information. You should write enough to establish the inferential chain and let a supervising/evaluating reader know that you know enough about the case to justify the treatment you are proposing. A good guide to writing the intake is, "If my supervisor read this, could they follow my thinking and agree with my conclusions and proposed treatment? Could I justify my treatment of this case simply by what I've written here?"

Step One:

Name:

Address:

Telephone Number:

Relevant contact information (physician, emergency contact person)

Step Two: Identifying Information

This section of the intake evaluation/case study should be simple and straight-forward. It is meant to orient the reader to who your client is and their sociological context. Include basic information about your client such as: name(s), age(s), gender(s), marital status, children, family constellation, vocation, racial and ethnic identity(ies), and social class observations or self-report. Referral information is also included. The point of this section is briefly to identify your clients and cast your evaluation of their presenting problem within a family and cultural context.

Example: The Smith family consists of stepfather Larry (age 42), Lisa (age 37), Lisa's son John (12), and Lisa's daughter Michelle (7) who live in Anchorage, KY. Larry and Lisa have been married for 1 year. Larry is Asian-American, Lisa is Euro-American as are her children. Larry is an attorney, Lisa is a social-worker. John and Michelle attend private Catholic schools, though the couple reports they attend a local Methodist church. The couple and family were referred by their pastor.

Step Three: Presenting Problem

This section provides a brief statement about why the clients came to therapy. Stick as closely as possible to the *clients'* statement of why they came to therapy now. Usually, this section will include a client statement and a brief history of the problem that resulted in a call for therapy. Useful questions for this section:

- What brings you in for counseling?
- What prompted you to call for counseling?
- What made you decide to call for counseling on the day you called for an appointment?
- How long has this problem been with you?

Note: Use client statements when possible and avoid therapist theoretical interpretation. Interpretation comes *after* assessment.

Example: Larry reported that he and Lisa have been in serious conflict about rules in their home. Lisa recalls fighting with Larry and her children over chores almost every day for the past three months. This is complicated because she and Larry disagree about expectations for the children. Larry indicated that he feels Lisa does not expect enough from the children, while Lisa believes Larry expects too much. Larry stated that the kids are "rebellious and won't follow directions," while Lisa believes Larry is too "gruff" with the children. Both children reported that they fight daily about chores and don't like Larry. Lisa stated that she called for an appointment after Larry said he was "fed up with the whole mess" and stayed overnight in a motel.

Step Four: Relevant history

This section should report personal and family events that illustrate the personal/family narrative. While brief, it should include reference to social, marital, important school and vocational histories, and family landmarks that give the person/family their history. Areas of success and struggle can be named, particularly those areas that help the clinician understand the families' dominant narrative and any subjugated narratives that might be evident at intake. This section should also briefly describe how the problem developed within the families' story.

Step Five: Assessment

- I. Assessment requires a preliminary theoretical consideration. Given what you know about the case **at this point** what theoretical approach seems appropriate to guide your assessment? (Remember, since evaluation is continuous in all forms of therapy, you can later determine that the case should be evaluated from another standpoint as well.)
 - What is the appropriate “unit of analysis?”
 1. Family therapy?
 2. Couples therapy?
 3. Individual therapy?
 - Given the nature of the problem what **theoretical orientation** appears most appropriate at this point? Remember that all models of assessment are built on theoretical assumptions. You need to have a clear rationale about *why* your selected method of assessment is appropriate for this presenting problem. You should have some rationale other than it is the only model you know. Some possible assessment schemas:
 1. Family: Structural (family maps, interview protocols, marking boundaries, assessing structural configurations); Bowenian (genogram, extensive history taking, etc.); Functional/behavioral (FAD, behavioral checklists, family roles, etc.); Strategic (assessing interactions); Solution-focused (clear, precise problem definition); Narrative (charting relative influence, landscape of meaning and action, etc.).
 2. Couples: (Most of above plus:) Gottman (assessment protocol); EFT (interviews, questionnaires, assessment of attachment styles and interactional positions).
 3. Individual: Symptom checklists, referral for individual testing, structured interview, other individual measures of temperament (MBTI) or relational functioning (FIRO-B) etc.
 4. Pastoral: Include such things as how clients express religious heritage, current commitments, faith community, concepts of God or the Holy, religious or spiritual conflicts, concerns about faith, religious spiritual strengths/resources, etc.

II. Assessment Procedure

- Implement an evaluation protocol using structured interviews, formal tools, etc. that are appropriate to your theoretical stand and the problems the client(s) is (are) reporting (i.e. genogram, Gottman evaluation tools, family map, etc.). Include additional screening tools you might believe are necessary for this particular case (for instance, the SCL 90 if you believe psychological problems may be present).

The following screening should ALWAYS be done as a matter of course:

- ***Suicide evaluation.*** Because of the inevitable risk of harm to self or others when clients are experiencing emotional distress, therapists should ALWAYS ask about depression as part of the formal intake interview and have clients complete some form of objective depression/suicide screening.

-Protocol: 1) Use interview and Beck or Hamilton depression scales to evaluate depressive symptoms. 2) If depressive symptoms are present, ask about suicidal thoughts. 3) If suicidal thoughts are present, complete a lethality assessment. If family therapy, ask family members about fears that others may act impulsively to harm self or others. ***Document this protocol and your conclusions.***

- ***Brief mental status evaluation*** to evaluate general psychological functioning and assess co-morbidity of problems.

-Protocol: Use the Brief Mental Status screening tool (attached) as part of your interview guide. Make appropriate observations and ask questions so you can summarize.

- ***Drug and alcohol screening.*** Use the SMAST for brief alcohol screening. Ask direct questions about other substances (marijuana, other drugs, inhalants, etc.).
- ***For all couples:*** Remember, research suggests that about 50% of all couples presenting for couples therapy have had episodes of marital violence. ***ALWAYS*** assess for marital violence.

-Protocol: Use the **Intimate Justice Scales** for screening or the Conflict Tactic Scales. Consider using individual interviews with both individuals to provide safety so marital violence can be reported. ***Always document your findings.***

- ***Pastoral Assessment:*** Ask specific questions about religious affiliations, commitments, religious or spiritual concerns, and how the client's religious faith

is (or is not) a resource for them. Why did they choose a pastoral counselor? What do they hope they will gain by this choice? Specifically, what does the client want to happen (or not happen) in their religious life as a result of therapy?

III. Assessment Summary:

- Assessment findings must be summarized in a concise, coherent manner. Usually, this means:
 1. A brief summary (no more than one brief paragraph each) for **each** assessment tool you used (i.e. genogram, paper and pencil self-report inventory, CTS, screening tools, mental status review). This summary should state what each tool revealed.
 2. A brief summary (one or two short paragraphs) of your interview **findings**. This should *not* be a verbatim of the session. *Do* summarize relevant observations, critical comments made by the client, and your clinical impressions of the client/couple/family. Remember, this is not a creative writing project. It is a clinical summary.
 3. A brief **pastoral** summary that highlights *your* evaluation of religious or spiritual issues at stake for the client in therapy.
- Conclude with a one or two sentence statement of your evaluation of what this individual/couple/family needs from therapy. Part of this may be expressed as DSM IV category. While this summary is the result of your assessment is a professional statement justifying treatment, it must also be connected to actual client statements about what they want *changed* by therapy. **State what therapeutic modality is needed, justified by your assessment—e.g. individual, couples, or family therapy (pay attention to Empirically Supported Treatments).**

Step Six: Preliminary Treatment Plan

Once assessment is complete, goals can be established. Goals must be **directly** related to your assessment: What is(are) the problem(s) you observed in assessment? What do clients say they want? Goals **must** be negotiated with clients and expressed in client's words when possible.

- Establish preliminary goals. **Goals are expectations of OUTCOME.** Goals must be observable and measurable. They become the standard by which the success of your therapy is measured. **Remember, goals can be revised at any time during the treatment process.**

1. State one or two (certainly no more than two) “long-term” outcome goals. This relates to the overall end result the clients want. For instance:

“At the end of therapy Larry and Lisa will report that they have established a way to manage conflict over the children’s chores that is satisfactory to both of them.”

2. State one or two short-term or intermediate goals that are easily attainable and lead to the long-term goal. New short-term goals needed to reach the long-term goal will be set when these are completed. For instance:

“At the end of one month, Larry and Lisa will report they have had at least one conversation outside of therapy about children’s chores during which neither felt blamed, condemned, or stone-walled.”

- Define an intervention to reach each short-term goal. For example:

Goal: “At the end of one month, Larry and Lisa will report they have had at least one conversation outside of therapy about children’s chores during which neither felt blamed, condemned, or stone-walled.”

Intervention: “Larry and Lisa will engage in couple’s therapy to learn to manage ongoing conflict about children’s chores. Therapy will assist the couple to identify and manage damaging behavior during conflict (blaming, contempt, stonewalling, etc.), establish a procedure for mediating physiological arousal and emotional flooding, and identify negative secondary reactive positions that each take during conflict. During therapy, the couple will explore and practice alternatives. Therapy will also focus on increasing positive sentimental override in the relationship by homework designed to facilitate positive and enjoyable experiences for the couple.

Step Seven: Review and Evaluation of Treatment

Set a date when therapeutic progress will be reviewed and the treatment plan revised. This evaluation will examine the preliminary goals and assess what progress has been made toward the goals. At this time, any additional information that adds to client assessment can be added; goals can be changed or renewed. This should be added to the intake as an “addendum” or “update.”

Always sign (followed by your degree and license status) and date your intake evaluation.

Progress Notes:

Progress notes **must** be related to the treatment plan. They provide the evidence that your assessment is appropriate, that you are working on the goals stated, and that you are being faithful to your contract with your client to work on the problems you together established in the initial evaluation. In general, progress notes should include:

1. What the clients say about their progress in treatment since the last session.
2. Your objective observation of progress the clients have made toward goals since last session.
3. A short description of intervention in *this* session. (What did you do, how did clients respond?)
4. Notation of any change needed in the treatment plan.
5. Plan for activity between sessions and/or for next session (record any homework or issues that need to be raised in next meeting).

Always sign (followed by your degree or license status) and date your progress notes.

Appendix 1

Brief Mental Status Screening

RATING SCALE

The rating scale used is:

1 – Not present

5 – Moderately severe

2 – Very mild

6 – Severe

3 – Mild

7 – Extremely severe

4 - Moderate

THOUGHT DISORDER CORE SYMPTOMS:

Conceptual disorganization

... degree to which the thought processes are confused, disconnected or disorganized. Rate on the basis of integration of the verbal products of the patient; do not rate on the basis of the patient's subjective impression of his own level of functioning.

1 2 3 4 5 6 7

Hallucinatory behavior

...perceptions without normal external stimulus correspondence. Rate only those experiences which are reported to have occurred within the last week and which are described as distinctly different from the thought and imagery processes of normal people.

1 2 3 4 5 6 7

Unusual thought content

... unusual, odd, strange, or bizarre thought content. Rate here the degree of unusualness, not the degree of disorganization of thought processes.

1 2 3 4 5 6 7

THOUGHT DISORDER ASSOCIATED SYMPTOMS:

Blunted affect

... reduced emotional tone, apparent lack of normal feeling or involvement.

1 2 3 4 5 6 7

Emotional withdrawal

... deficiency in relating to the interviewer and the interview situation. Rate only degree to which the patient gives the impression of failing to be in emotional contact with other people in the interview situation.

1 2 3 4 5 6 7

Suspiciousness

... belief (delusional or otherwise) that others have now, or have had in the past, malicious or discriminatory intent toward the patient. On the basis of verbal report, rate only those suspicions which are currently held whether they concern past or present circumstances.

1 2 3 4 5 6 7

Grandiosity

... exaggerated self-opinion, conviction of unusual ability or powers. Rate only on the basis of patient's statements about himself or self-in-relation-to-others, not on the basis of his demeanor in the interview situation.

1 2 3 4 5 6 7

ANXIETY-DEPRESSION CORE SYMPTOMS:**Tension**

... physical and motor manifestations of tension, "nervousness," and heightened activation level. Tension should be rated solely on the basis of physical signs and motor behavior and not on the basis of subjective experiences of tension reported by the patient.

1 2 3 4 5 6 7

Anxiety

... worry, fear, or over-concern for present or future. Rate solely on the basis of verbal report patient's own subjective experiences. Do not infer anxiety from physical signs or from neurotic defense mechanisms.

1 2 3 4 5 6 7

Somatic concern

... degree of concern over present bodily health. Rate the degree to which physical health is perceived as a problem by the patient, whether complaints have realistic basis or not.

1 2 3 4 5 6 7

Depression mood

... despondency in mood, sadness. Rate only degree of despondency; do not rate on the basis of inferences concerning depression based upon general retardation and somatic complaints.

1 2 3 4 5 6 7

ANXIETY-DEPRESSION ASSOCIATED SYMPTOMS:**Guilt feelings**

... over-concern or remorse for past behavior. Rate on the basis of the patient's subjective experiences of guilt as evidenced by verbal report with appropriate affect; do not infer guilt feelings from depression, anxiety, or neurotic defenses.

1 2 3 4 5 6 7

Uncooperativeness

... evidence of resistance, unfriendliness, resentment, and lack of readiness to cooperate with the interviewer. Rate only on the basis of the patient's attitude and responses to the interviewer and the interview situation; do not rate on basis of reported resentment or uncooperativeness outside the interview situation.

1 2 3 4 5 6 7

Hostility

... animosity, contempt, belligerence, disdain for other people outside the inter-view situation. Rate solely on the basis of the verbal report of feelings and actions of the patient toward others; do not infer hostility from neurotic defenses, anxiety (or) somatic complaints. (Rate attitude toward interviewer under "uncooperativeness.")

1 2 3 4 5 6 7

Motor retardation

... reduction in energy level evidenced in slowed movements and speech, reduced body tone, decreased number of movements. Rate on the basis of observed behavior of the patient only; do not rate on basis of patient's subjective impression of own energy level.

1 2 3 4 5 6 7

Mannerisms and posturing

... unusual and unnatural motor behavior, the type of motor behavior which causes certain mental patients to stand out in a crowd of normal people. Rate only abnormality of movements; do not rate simple heightened motor activity here.

1 2 3 4 5 6 7

Appendix 2

Hamilton Depression Scale

Patient's Name _____

Date _____

Comments _____

Instructions:

This checklist is to assist you in recording your evaluations of each patient with respect to degree of depression and pathologic condition. Please fill in the appropriate rating for each item.

0 None 1 Mild 2 Moderate 3 Severe

4 Extreme

Item	Rating
1. Depressed Mood Sadness, hopelessness, gloomy, pessimistic, weeping, worthless. Behavior: Facies, postures, weeping voice.	
2. Guilt Feelings Pathologic guilt, not rationalizing, self-blame, feelings of self-reproach.	
3. Suicide Recurrent thoughts of death: life is empty, not worth living, isolation, suicide gestures, threats or attempts.	
4. Initial Insomnia Difficulty getting to sleep after going to bed.	
5. Middle Insomnia Difficulty staying asleep.	
6. Delayed Insomnia Early-morning awakening.	
7. Work and Interest Apathy, loss of pleasure and interest in work, hobbies, social activities, recreation, inability to obtain satisfaction, decreased performance at work and in home duties. (Do not rate fatigue or loss of energy.)	
8. Retardation Psychomotor: Slowing of thoughts speech, and movement.	
9. Agitation Psychomotor fidgeting, restlessness or pacing, clenching fists, kicking feet, wrinkling hands, biting lips, pulling hair, gesturing with arms,	

Item	Rating
picking at hands and clothes.	
10. Anxiety (Psychologic) Tense, unable to relax, irritable, easily startled, worrying over trivia. Phobic symptoms, apprehensive of impending doom, fear of loss of control, panic episodes.	
11. Anxiety (Somatic) Physiologic concomitants of anxiety: Effects of autonomic overactivity, "butterflies," indigestion, stomach cramps, belching, diarrhea, palpitations, hyperventilation, paresthesia, sweating, flushing, tremor, headache, urinary frequency.	
12. Loss of Appetite	
13. Anergia Fatigability, feels tired or exhausted, loss of energy, heavy or dragging feelings in arms or legs.	
14. Loss of Libido Impairment of sexual performance	
15. Hypochondriasis Morbid preoccupation with real or imagined bodily symptoms or functions	
16. Weight Loss Since onset of illness or since last visit.	
17. Loss of Insight Denial of "nervous" illness, attributes illness to virus, overwork, climate, or physical symptoms. Does not recognize symptoms are "nervous" in origin.	

Item	Rating
18. Diurnal Variation Change in mood	
19. Hypersomnia (More Time Spent in Bed) Retires earlier and/or rises later than usual, not necessarily sleeping longer.	
20. Hypersomnia (Oversleeping) Sleeping more than usual.	
21. Hypersomnia (Napping) Naps, excessive daytime sleepiness	
22. Increased Appetite Change in appetite marked by increased food intake or excessive cravings.	

Item	Rating
23. Weight Gain Since onset of illness or since last visit.	
24. Psychic Retardation Slowness of speech and thought process, inhibition of will or feeling as if thought processes are paralyzed.	
25. Motor Retardation Slowness of movement and affective expression.	

25-ITEM TOTAL

Appendix 3

Lethality Assessment

- I. Observe for signs and symptoms of depression:
 - A. Depressed Mood
 - B. Diminished interest or pleasure in activities formerly enjoyable
 - C. Observations by others of apathy
 - D. Significant weight loss or gain (+-5%)
 - E. Insomnia or hypersomnia
 - F. Psychomotor agitation or retardation
 - G. Fatigue or loss of energy
 - H. Feelings of worthlessness or excessive and inappropriate guilt
 - I. Diminished ability to think or concentrate, or indecisiveness
 - J. Thought of death
- II. If depressive symptoms are present, always ask client if they have considered harming themselves or have had fantasies of escape. If possible, interview family members or close friends about the client's depression and behavior.
- III. If client affirms thoughts, assess lethality. Each step represents a higher risk of suicide.
 - A. Client has had suicidal thoughts
 - B. Client has considered suicide as a legitimate option
 - C. Client has thought about how they might best kill themselves
 - D. Client has formed a distinct plan about ending their life
 - E. Client has the means to carry out plan (i.e. has pills, gun, etc.)
 - F. Client has planned when the suicide will take place
 - G. Client has made arrangements to carry out suicide, or has made arrangements for their death
 - H. Client is feeling helpless, hopeless and hapless, OR client has suddenly found new energy in making a decision to die
- IV. Suicide risk is increased if any of the following factors are present:
 - A. Client has made a previous suicide attempt
 - B. Client lives alone
 - C. Client takes psychotropic medication
 - 1. Any recent change in medication?
 - 2. Has client discontinued medication?
 - D. A family member of the client has previously committed suicide
 - E. A close family member has recently died
 - F. The client uses alcohol or drugs
 - G. Client has a history or has recently begun self-mutilation (cutting, burning, etc.)
 - H. The client demonstrates any form of psychotic process

Intimate Justice Scale*

Read each item below to see if it describes how your partner usually treats you. Then circle the number that best describes how strongly you agree with whether it applies to you.

Circling a one (1) indicates that you do not agree at all, while circling five (5) indicates that you agree strongly. Your answers are confidential and will not be shared with your partner.

	I do not agree at all			I strongly agree	
1. My partner never admits when she or he is wrong.	1	2	3	4	5
2. My partner is unwilling to adapt to my needs and expectations.	1	2	3	4	5
3. My partner is more insensitive than caring.	1	2	3	4	5
4. I am often forced to sacrifice my own needs to meet my partner's needs.	1	2	3	4	5
5. My partner refuses to talk about problems that make him or her look bad.	1	2	3	4	5
6. My partner withholds affection unless it would benefit her or him.	1	2	3	4	5
7. It is hard to disagree with my partner because she or he gets angry.	1	2	3	4	5
8. My partner resents being questioned about the way he or she treats me.	1	2	3	4	5
9. My partner builds himself or herself up by putting me down.	1	2	3	4	5
10. My partner retaliates when I disagree with him or her.	1	2	3	4	5
.					
11. My partner is always trying to change me.	1	2	3	4	5
.					
12. My partner believes he or she has the right to force me to do things.	1	2	3	4	5
.					
13. My partner is too possessive or jealous.	1	2	3	4	5
.					
14. My partner tries to isolate me from family and friends.	1	2	3	4	5
.					
15. Sometimes my partner physically hurts me.	1	2	3	4	5
.					

*Jory, B. (2004). Journal of Marital and Family Therapy, Vol. 30, No. 1, 29-44

Appendix 5

Short Michigan Alcoholism Screening Test (SMAST)²

Name:		Date:	
		Yes	No
1.	Do you feel you are a normal drinker?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Does your wife/husband, a parent, or other near relative ever worry or complain about your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Do you ever feel guilty about your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Do friends or relatives think you are a normal drinker?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Are you able to stop drinking when you want?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have you ever attended a meeting of Alcoholics Anonymous?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Has drinking ever created problems between you and your wife/husband, a parent, or other near relative?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Have you ever gotten into trouble at work because of drinking?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Have you ever neglected your obligations, your family, or your work for 2 or more days in a row because you were drinking?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Have you ever gone to anyone for help about your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Have you ever been in a hospital because of drinking?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Have you ever been arrested, even for a few hours, because of other drunken behavior?	<input type="checkbox"/>	<input type="checkbox"/>
Total number of shaded checks			

Scoring:

0-1 shaded checks:	nonalcoholic
2 shaded checks:	possibly alcoholic
3 or more shaded checks	probably alcoholic

For patients with two or more checks in the shaded areas, an alcoholism evaluation by a substance abuse professional is recommended.

References

1. Ewing JA. Detecting alcoholism: the CAGE questionnaire. *JAMA*. 1984; 252:1905-1907.
2. Selzer ML, Vinokur A, Van Rooijen L. A self-administered short Michigan alcoholism screening test (SMAST). *Journal of Studies on Alcohol*. 36;1:117-126.

AAPC CODE OF ETHICS
AMERICAN ASSOCIATION OF PASTORAL COUNSELORS
(Amended April, 2012)

PRINCIPLE I - PROLOGUE

1 The AAPC Code of Ethics may be reproduced only after contacting the AAPC Association Office to insure that the most current copy of the Code can be provided.

2 The use of “member”, “we”, “us”, and “our” refers to and is binding upon all levels of individual and institutional membership and affiliation of AAPC.

PRINCIPLE I – PROLOGUE

As members² of the American Association of Pastoral Counselors, we are respectful of the various theologies, traditions, and values of our faith communities and committed to the dignity and worth of each individual. We are dedicated to advancing the welfare of those who seek our assistance and to the maintenance of high standards of professional conduct and competence. As pastoral counselors and pastoral counseling students we are accountable for our work regardless of our professional functions, the settings in which we work, or the populations which we serve. This accountability is expressed in our conduct of relationships with clients, colleagues, students, our faith communities, and through the acceptance and practice of the principles and procedures of this Code of Ethics. The Code articulates standards that the Association will use to determine whether pastoral counselors have engaged in unethical conduct. In subscribing to this Code, pastoral counselors are required to be knowledgeable of these standards, cooperate with association procedures for responding to complaints of ethical misconduct, participate in AAPC adjudication proceedings, and abide by any AAPC disciplinary rulings or sanctions. The Ethics Code is not intended to be a basis of civil liability. Whether a pastoral counselor has violated the Ethics Code standards does not by itself determine whether the pastoral counselor is legally liable in a court action, whether a contract is enforceable, or whether other legal consequences occur.

- A. To affirm the importance of being both spiritually grounded and psychologically informed.
- B. To maintain responsible association with the faith group with which we identify and in which we may have ecclesiastical standing.
- C. To avoid discriminating against or refusing employment, educational opportunity or professional assistance to anyone on the basis of race, ethnicity, gender identity, sexual orientation, religion, health status, age, disabilities or national origin; provided that nothing herein shall limit a member or center from utilizing religious requirements or exercising a religious preference in employment decisions.
- D. As members of AAPC we recognize our responsibility to stay current with research that affects our understanding of clinical issues and the conduct of our practice. We agree at all levels of membership to continuing education and professional growth including supervision, consultation, and active participation in the meetings and affairs of the Association.
- E. To seek out and engage in collegial relationships, recognizing that isolation can lead to a loss of perspective and judgment.
- F. To manage our personal lives in a healthful fashion and to seek appropriate assistance for our own personal problems or conflicts
- G. To assess/evaluate, diagnose or provide treatment only for those problems or issues that are within the reasonable boundaries of our competence.
- H. To establish and maintain appropriate professional relationship boundaries. We will make every effort to be transparent with congregations and other public constituencies about the boundaries we hold.
- I. To remain abreast of and to comply with appropriate regulatory statutes that governs our pastoral

counseling activities. Whenever the AAPC Code differs with legal mandates, pastoral counseling licensure laws, or with ecclesiastical policies, the more stringent of the two applies.

- J. To promote racial justice and develop multicultural competence as part of our practice.

PRINCIPLE II - PROFESSIONAL PRACTICES

In all professional matters members of AAPC maintain practices that protect the public and advance the profession.

- A. We use our knowledge and professional associations for the benefit of the people we serve and not to secure unfair personal advantage.
- B. We clearly represent our level of membership and limit our practice to that level. Publication of practice or agency material clearly explains the levels of membership that apply to individuals.
- C. Fees and financial arrangements, as with all contractual matters, are always discussed without hesitation or equivocation at the onset and are established in a straight-forward, professional manner.
- D. We are prepared to render service to individuals and communities in crisis without regard to financial remuneration when necessary.
- E. We neither receive nor pay a commission for referral of a client.
- F. We conduct our practice, agency, regional and association fiscal affairs with due regard to recognized business and accounting procedures. We respect the prerogatives and obligations of the institutions, agencies, or organizations by whom we are employed or with which we associate.
- G. Upon the transfer of a pastoral counseling practice or the sale of real, personal, tangible or intangible property or assets used in such practice, the privacy and well being of the client shall be of primary concern.
 - a. Client names and records shall be excluded from the transfer or sale.
 - b. Any fees paid shall be for services rendered, consultation, equipment, real estate, and the name and logo of the counseling agency.
 - c. We provide recent and current clients information regarding the closing or transferring of our practice and assure the confidentiality of their records.
- H. We are careful to represent facts truthfully to clients, referral sources, and third party payers regarding credentials and services rendered. We shall correct any misrepresentation of our professional qualifications or affiliations.
- I. We do not malign other professionals, nor do we plagiarize or otherwise present, distribute, or publish another's work as our own.

PRINCIPLE III - CLIENT RELATIONSHIPS

It is the responsibility of members of AAPC to maintain relationships with clients on a professional basis. We take all reasonable steps to avoid harming our clients and to safeguard the welfare of those with whom we work.

- A. We do not abandon or neglect clients. We make reasonable efforts to ensure continuity of services in the event that services are interrupted by factors such as unavailability, relocation, illness, or disability. If we are unwilling for appropriate reasons, to provide professional help or continue a professional relationship, every reasonable effort is made to arrange for continuation of treatment with another professional. Prior to leaving an agency or practice we complete all files and paper work is documented and signed.

- B. We make only realistic statements regarding the pastoral counseling process and its outcome. We inform our clients of the purpose of the counseling, risks related to counseling, possible limits to the services because of third party payer limits, reasonable alternatives, clients rights to refuse or withdraw consent, and the time frame covered by the consent. We take reasonable steps to make sure the client understands the counseling process and has the opportunity to ask questions.
- C. We show sensitive regard for the moral, social, and religious values and beliefs of clients and communities. We avoid imposing our beliefs on others, although we may express them when appropriate in the pastoral counseling process.
- D. Counseling relationships are continued only so long as it is reasonably clear that the clients are benefiting from the relationship.
- E. We recognize the trust placed in and unique power of the therapeutic relationship. While acknowledging the complexity of some pastoral relationships, we avoid exploiting the trust and dependency of clients. We avoid those dual or multiple relationships with clients which could impair our professional judgment, compromise the integrity of the treatment, and/or use the relationship for our own gain. A multiple relationship occurs when a pastoral counselor is in a professional role with a person and 1) at the same time is in another role with the same person, 2) at the same time is in a relationship with a person closely associated with or related to the person with whom the pastoral counselor has the professional relationship, or 3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person. In instances when dual or multiple relationships are unavoidable, particularly within congregations or in family or couples counseling, we take reasonable steps to protect the clients and are responsible for setting clear and appropriate boundaries.
- F. We do not engage in harassment, abusive words or actions, or exploitative coercion of clients or former clients.
- G. All forms of sexual behavior or harassment with clients are unethical, even when a client invites or consents to such behavior or involvement. Sexual behavior is defined as, but not limited to, all forms of overt and covert seductive speech, gestures, written communication, and behavior as well as physical contact of a sexual nature; harassment is defined as but not limited to, repeated comments, gestures, written communication, or physical contacts of a sexual nature.
- H. We recognize that the therapist/client relationship involves a power imbalance, the residual effects of which are operative following the termination of the therapy relationship. Therefore, all sexual behavior or harassment as defined in Principle III G, with former clients is unethical.

Interactive long-distance counseling delivery, when the client resides in one location and the pastoral counselor in another, may be utilized to supplement but not to completely replace face-to-face therapy. We take all reasonable steps to ensure that the client understands the limits of long-distance therapy, the computer application, what it is used for, and its possible effects.

PRINCIPLE IV - CONFIDENTIALITY

As members of AAPC we respect the integrity and protect the welfare of all persons with whom we are working and have an obligation to safeguard information about them that has been obtained in the course of the counseling process. We have a responsibility to know and understand civil laws and administrative rules that govern confidentiality requirements of our profession in the setting of our work.

- A. All records kept on a client are stored under lock and key and are disposed of in a manner that assures security and confidentiality. Records should be maintained for the number of years required appropriate government regulatory statutes.
- B. We take reasonable steps to ensure that documentation in records is accurate and reflects the services provided. Such documentation is intended to facilitate provision of services later by other professionals,

meet institutional requirements, ensure accuracy of billing and payments, and ensure compliance with law.

- C. We recognize that confidentiality belongs to the client. We treat all communications from clients with professional confidence and take reasonable precautions to protect confidential information obtained through or stored in any medium. These precautions include an awareness of the limited confidentiality guarantees of electronics communication.
- D. Except in those situations where the identity of the client is necessary to the understanding of the case, we use only the first names of our clients when engaged in supervision or consultation. It is our responsibility to convey the importance of confidentiality to the supervisor/consultant; this is particularly important when the supervision is shared by other professionals, as in a supervisory group.
- E. We do not disclose client confidences to anyone, except: as mandated by law; to prevent a clear and immediate danger to someone; in the course of a civil, criminal or disciplinary action arising from the counseling where the pastoral counselor is a defendant; for purposes of supervision or consultation; or by previously obtained written permission. In cases involving more than one person (as client) written permission must be obtained from all legally accountable persons who have been present during the counseling before any disclosure can be made.
- F. We disclose confidential information for appropriate reasons only with valid written consent from the client or a person legally authorized to consent on behalf of a client. We obtain informed written consent of clients before audio and/or video tape recording or permitting third party observation of their sessions.
- G. We do not use these standards of confidentiality to avoid intervention when it is necessary, e.g., when there is evidence of abuse of minors, the elderly, the disabled, the physically or mentally incompetent.
- H. When current or former clients are referred to in a publication, while teaching or in a public presentation, their identity is thoroughly disguised.
- I. We as members of AAPC agree that as an express condition of our membership in the Association, Association ethics communications, files, investigative reports, and related records are strictly confidential and waive their right to use same in a court of law to advance any claim against another member. Any member seeking such records for such purpose shall be subject to disciplinary action for attempting to violate the confidentiality requirements of the organization. This policy is intended to promote pastoral and confessional communications without legal consequences and to protect potential privacy and confidentiality interests of third parties.

PRINCIPLE V - SUPERVISEE, STUDENT & EMPLOYEE RELATIONSHIPS

As members of AAPC we have an ethical concern for the integrity and welfare of our supervisees, students and employees. These relationships are maintained on a professional and confidential basis. We recognize our influential position with regard to both current and former supervisees, students and employees, and avoid exploiting their trust and dependency. We make every effort to avoid dual relationships with such persons that could impair our judgment or increase the risk of personal and/or financial exploitation.

- A. We do not engage in ongoing counseling relationships with current supervisees, students and employees.
- B. We do not engage in sexual or other harassment of supervisees, students, employees, research subjects or colleagues.
- C. All forms of sexual behavior, as defined in Principle III.G, with our supervisees, students, research subjects and employees (except in employee situations involving domestic partners) are unethical.
- D. We advise our students, supervisees, and employees against offering or engaging in, or holding themselves out as competent to engage in, professional services beyond their training, level of experience and competence.
- E. Supervisors have a responsibility to provide timely and fair evaluations of their supervisees and

employees.

- F. We do not harass or dismiss an employee who has acted in a reasonable, responsible and ethical manner to protect, or intervene on behalf of, a client or other member of the public or another employee.
- G. To protect the public, employers and supervisors who have dismissed employees and supervisees for ethical cause must report that fact as part of any official report of service or enrollment in a pastoral counseling center or training program.
- H. We are sensitive to the requirements of an organization with which we are affiliated or for whom we are working. In case of conflict with the Code of Ethics and the organization, we clarify the nature of the conflict, make known our commitment to the Code of Ethics, and to the extent feasible, resolve the conflict in a way that permits adherence to the Code.

PRINCIPLE VI - INTERPROFESSIONAL RELATIONSHIPS

As members of AAPC we relate to and cooperate with other professional persons in our community and beyond. We are part of a network of health care professionals and are expected to develop and maintain interdisciplinary and interprofessional relationships.

- A. We do not offer ongoing clinical services to persons currently receiving treatment from another professional without prior knowledge of and in consultation with the other professional, with the clients' informed consent. Soliciting such clients is unethical.
- B. We exercise care and interprofessional courtesy when approached for services by persons who claim or appear to have inappropriately terminated treatment with another professional.

PRINCIPLE VII - ADVERTISING

Any advertising by or for a member of AAPC, including announcements, public statements and promotional activities, is undertaken with the purpose of helping the public make informed judgments and choices.

- A. We do not misrepresent our professional qualifications, affiliations and functions, or falsely imply sponsorship or certification by any organization.
- B. We may use the following information to describe ourselves and the services we provide: name; highest relevant academic degree earned from an accredited institution; date, type and level of certification or licensure; AAPC membership level, clearly stated; address and telephone number; office hours; a brief review of services offered, e.g., individual, couple and group counseling; fee information; languages spoken; and policy regarding third party payments. Additional relevant information may be provided if it is legitimate, reasonable, free of deception and not otherwise prohibited by these principles. We may not use the initials "AAPC" after our names in the manner of an academic degree.
- C. Announcements and brochures promoting our services describe them with accuracy and dignity, devoid of all claims or evaluation. We may send them to professional persons, religious institutions and other agencies, but to prospective individual clients only in response to inquiries.
- D. We do not make public statements which contain any of the following:
 - 1. A false, fraudulent, misleading, deceptive or unfair statement.
 - 2. A misrepresentation of fact or a statement likely to mislead or deceive because in context it makes only a partial disclosure of relevant facts.
 - 3. A testimonial from a client regarding the quality of services or products.
 - 4. A statement intended or likely to create false or unjustified expectations of favorable results.

5. A statement implying unusual, unique, or one-of-a-kind abilities, including misrepresentation through sensationalism, exaggeration or superficiality.
 6. A statement intended or likely to exploit a client's fears, anxieties or emotions.
 7. A statement concerning the comparative desirability of offered services.
 8. A statement of direct solicitation of individual clients.
- F. We do not compensate in any way a representative of the press, radio, television or other communication medium for the purpose of professional publicity and news items. A paid advertisement must be identified as such, unless it is contextually apparent that it is a paid advertisement. We are responsible for the content of such advertisement. Any advertisement to the public by radio or television is to be pre-recorded, approved by us and a recording of the actual transmission retained in our possession.
- G. Advertisements, web postings or announcements by us of workshops, clinics, seminars, growth groups or similar services or endeavors, are to give a clear statement of purpose and a clear description of the experiences to be provided. The education, training and experience of the provider(s) involved are to be appropriately specified.

PRINCIPLE VIII - RESEARCH

- A. Pastoral Counselors who are conducting research are responsible for assuring informed consent for all human subjects. Research participants must be informed about:
1. Purpose and sponsorship of the research, expected duration, expected procedures, and the manner and scope of reporting on the findings of the research.
 2. Their right to withdraw from participation at any time.
 3. Any consequences of withdrawing from a research project.
 4. Any discomfort or adverse effects of research procedures that would influence a subject's willingness to participate.
 5. Any benefits from participating in a research project.
 6. A contact person for questions about the project or participant's rights.

- B. Pastoral Counselors take appropriate measures to protect research subjects who may also be receiving pastoral counseling services in schools, agencies, private practices, or churches in which research is conducted.

This includes:

1. Taking steps to protect client/participants from any adverse consequences of declining or withdrawing a study.
 2. Taking steps to assure clients are not exploited by research-related dual relationships.
 3. Assuring that therapeutic services are not compromised by research procedures or goals.
 4. To the extent that services may be compromised by participation in research, investigators seek the ethical advice of qualified professionals not directly involved in the investigation and observe safeguards to protect the rights of research participants.
- C. Pastoral Counselors guarantee confidentiality of information obtained from a research participant unless confidentiality is waived in writing. When it is possible that information might be recognized by others (including family members) researchers disclose a plan for protecting confidentiality as part of informed consent.
1. Pastoral Counselors consider the effects of research procedures on communities in which it takes place, and take adequate precautions to protect the integrity of these communities.
 2. Pastoral Counselors comply with Federal standards and local institutional review procedures governing human subject research. When AAPC is a principal investigator, the Judicial Ethics Panel of AAPC will act as a review board to ensure compliance.
 3. Pastoral Counselors are truthful in reporting research results.

Pastoral Counselors:

- a. Do not plagiarize by presenting another's work or data as one's own;
- b. Assure that research results are not presented or published in a deceptive or manipulative manner;
- c. Pastoral counselors do not withhold their research data, methods of analysis, or procedures from other qualified researchers who in good faith wish to replicate or validate research results, to the extent that confidentiality of research subjects can be guaranteed.

PRINCIPLE IX – PROCEDURES

- A. The Association will develop and maintain a set of procedures for receiving, investigating and adjudication complaints of ethical misconduct against a member.
 1. AAPC will direct the Executive Director and his/her staff in the association office to receive complaints.
 2. AAPC will establish and maintain a Judicial Ethics Panel to investigate and adjudicate complaints.
- B. AAPC will take complaints of ethical misconduct with the utmost seriousness and will exercise appropriate care and diligence in responding to the complainant and the member.

Please Note:

The AAPC Code of Ethics and the Ethics Committee Procedures were separated by action of the AAPC membership on April 17, 1993. The Board of Directors is now authorized to modify ethics committee procedures without further action by the membership. Members should note that the substantive rule from the Code of ethics to be applied to an alleged violation will continue to be determined by the date of the alleged violation and not the date the complaint is received. However, as a result of the action taken, the current procedures in effect will be followed for all complaints brought after April 17, 1993, regardless of the date of alleged violation.