PSYCHOPATHOLOGY
PC 322-3
Spring 2019

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Course Description:

This course introduces students to current research, theory and clinical practices related to multicultural assessment of psychopathology in a systemic and critical theologically framework. This course will: (1) examine intrapersonal, systemic, neurobiological, biological, social and spiritual frameworks for understanding non-normative human behavior and its treatment; and (2) examine how psychiatric diagnosis interacts with oppression, discrimination and trauma, as well as racial, cultural, sexual and ethnic differences. Students will be introduced to assessment tools and practices appropriate to DSM 5 diagnosis and its use in Marriage and Family Therapy and pastoral counseling.

Objectives and Expected Student Learning Outcomes

By the end of the semester, students will:	***Student Learning Outcomes (SLO) & MFT Competency Domain (C:)***	Signature Assignment/Assessment
Understand the rationale, research and process for how major child and adult mental disorders are organized by psychiatrists and psychologists.	**SLO 1:** able to conduct multicultural, evidence-based therapy with individuals, couples and families that meets entry-level professional standards **Competencies: 2.3.1**	Attendance Mid-term and Final Examination
Understand and appropriate in clinical practice contemporary theories of how intrapsychic factors, interpersonal systems, medical/biology, gender and cultural norms, and systems of power contribute to how psychiatric diagnosis is organized and used.	**SLO 4:** able to use a multicultural approach to Marriage and Family Therapy that attends appropriately to religious, cultural, racial, economic, gender, and sexual orientation diversity in client systems, client-therapist systems, supervisory systems, and broader social systems. **Competencies: 2.3.1**	Attendance Diagnostic Evaluations Summaries
Be able demonstrate broad knowledge of major categories of mental illness and how these are organized in the DSM 5.	**SLO 1:** able to conduct multicultural, evidence-based therapy with individuals, couples and families that meets entry-level professional standards. **Competencies: 2.3.1**	Final Examination

Be able to demonstrate basic competency and awareness of MFT scope of practice in identifying and using appropriate assessment tools related to the DSM 5 and clinical diagnosis.	**SLO 1:** able to conduct multicultural, evidence-based therapy with individuals, couples and families that meets entry-level professional standards. **Competencies: 2.3.1, 5.1.1, 5.2.2**	Diagnostic Evaluations & Summaries Final Exam
Be able to complete a clinical assessment appropriately using the DSM 5 classification system in a family therapy context that incorporates a systemic and multicultural/multi-contextual frame for assessment.	**SLO 1:** able to conduct multicultural, evidence-based therapy with individuals, couples and families that meets entry-level professional standards. **SLO 4:** able to use a multicultural approach to Marriage and Family Therapy that attends appropriately to religious, cultural, racial, economic, gender, and sexual orientation diversity in client systems, client-therapist systems, supervisory systems, and broader social systems **Competencies: 2.2.3, 2.3.1, 2.3.6, 2.3.8, 9.0.1, 9.0.2**	Diagnostic Evaluations & Summaries
Be able to conduct risk assessment and referral needs.	**SLO 1:** be able to conduct multicultural, evidence-based therapy with individuals, couples and families that meets entry-level professional standards. **SLO 4:** will be able to use a multicultural approach to Marriage and Family Therapy that attends appropriately to religious, cultural, racial, economic, gender, and sexual orientation diversity in client systems, client-therapist systems, supervisory systems, and broader social systems. **Competencies: 2.3.1, 2.3.5**	Diagnostic Evaluations & Summaries
Demonstrate their ability to discuss ethical and critical pastoral and theological issues related to mental illness and diagnosis	**SLO 5:** able to use a theologically informed and clinically appropriate framework to integrate religious and spiritual factors into the practice of Marriage and Family Therapy. **Competencies: 8.0.2,**	Diagnostic Evaluations & Summaries

Multicultural Therapy Definition: Multicultural Therapy, according to D. W. Sue and Torino (2005, p 3) "..can be defined as both a helping role and process that uses modalities and defines goals consistent with the life experiences and cultural values of clients, recognizes client identities to include individual, group, and universal dimensions, advocates the use of universal and culture-specific strategies and roles in the healing process, and balances the importance of

individualism and collectivism in the assessment, diagnosis, and treatment of client and client systems." Multicultural competence as a therapist includes: (1) therapist awareness of personal assumptions, values and biases, (2) understanding the worldview of diverse clients, and (3) facility with appropriate strategies and interventions consistent with the life experiences and values of culturally different clients. (Sue & Sue 2008)
Evidence-based Practice Definition: EBP is a "…practice-friendly approach to using research to enhance family therapy" (Gehard, 2010, 133). This approach looks to research to help clinicians make decisions in therapy about care for individual clients, couples and families. Evidence-based practice will (1) look to research for information about what treatments are most effective for specific problems, (2) critically examine that research for its validity and applicability to specific cases, and (3) evaluate how effective a selected method is for specific clients, couples and families (for example, using the ORS/SRS).

Assignments:

Assignment	Details	Due Date
***Reading is Fundamental*! This course requires substantial reading. Focus most of your energy on Castonguay et al and Russo et al. The DSM-5 is a reference text. You will need to understand and use the ICD 10 codes and the diagnostic criteria found in the DSM-5. You will need to know how to use these to complete assignments for this class, case studies for the course of the MFT Program and for your work in Practicum. Bring any questions about DSM-5 and its use to class.**		
Diagnostic Evaluations (40% of grade) Review the *Writing a Professional Clinical Report* in Appendix B. **Be sure and use those principles for writing your Mental Status and Clinical Assessment reports**.		
➢ Mental Status Exam (10%)	1. Use the *Mental Status Exam Guide* in Appendix C complete a mental status examination of a client (if you have no clients, use a volunteer). ***Be sure to protect the identity of your client—do not use names or other identifiers.*** 2. Write a summary of your Mental Status Exam. NO MORE THAN 3 DOUBLE-SPACED PAGES.	2/27
➢ Individual Clinical Assessment 1 (15%)	1. Use the *Guide for Writing Individual Clinical Assessments for PC 3223 (*Appendix A) to complete an individual clinical assessment of a client. ***Be sure to protect the identity of your client—do not use names or other identifiers.*** 2. Write a summary of your clinical assessment. NO MORE THAN 5 DOUBLE-SPACED PAGES.	3/13
➢ Individual Clinical Assessment 2 (25%)	Same as Clinical Assessment 1	4/24

Midterm Content Examination (25% of grade)	4/10
Final *Comprehensive* Content Examination (25% of grade)	5/15-16
Regular attendance and participation in class is required. Participants are expected to be on time. Conflicts with scheduling clients or other avoidable schedule conflicts are not acceptable reasons to be late or miss class. Each class session accounts for one week of class, leaving little room for absences, excused or unexcused. Unexcused absences will affect class grade as per seminary policy.	

Required Texts and Reading:

Castonguay, L. G. and Oltmanns,T. F. (eds). (2013). *Psychopathology: From science to clinical practice.* NY: Guilford.

Preston, J. and Johnson, J. (2015). *Clinical Psychopharmacology made ridiculously simple, 8th ed.* Miami: MedMaster Inc.

Russo, J.A., Coker, J.K. & King, J.H. (eds). (2017). *DSM-5 and family systems.* NY: Springer Publishing Company.

Rodgerson, T. E. (2012). Apophatic attending: an essential for pastoral diagnosis. *The Journal of Pastoral Care and Counseling,* 66 (1), 1-8.

Townsend, L. L. (2013). Best practices: Rethinking pastoral diagnosis. *Sacred Spaces: The e-journal of the American Association of Pastoral Counselors, 5*, 66-101.

Essential References and Required Reading From:

American Psychiatric Association. (2013). *The diagnostic and statistical manual of mental disorders.* Washington, DC: The American Psychiatric Association.

Other Helpful Texts

Jordan, M. (1988). *Taking on the gods: The task of the pastoral counselor.* Nashville, TN: Abingdon.

Josephson, A. & Peteet, J. (2003). *Handbook of spirituality and worldview in clinical practice.* Arlington, VA: American Psychiatric Pub.

L'Abate, L. *Family assessment: A psychological approach*. Thousand Oaks, CA: Sage.

Mackenna, C. (2013). Some theological, psychoanalytic and cultural reflections on the practice of christian deliverance ministry in the light of clinical and pastoral experience. In C. H. Cook (Ed.), *Spirituality, theology and mental health* (pp. 75-93). London: SCM Press.

Oates, W. E. (1970). *When religion gets sick*. Philadelphia: Westminster Press.

Oates, W. E. (1987). *Behind the masks: Personality disorders in religious behavior*. Philadelphia: Westminster Press.

Podmore, S. D. (2013). My god, my god, why have you forsaken me? Between consolation and desolation. In C. H. Cook (Ed.), *Spirituality, theology and mental health*. London: SCM Press.

Pruyser, P. (1976). *The minister as diagnostician.* Philadelphia: Westminster Press.

Rigazio-DiGilio, et.al. (2005). *Community genogram: Using individual, family and cultural narratives with clients.* New York: Teachers College Press.

Roth, A. & Fonagy, P. (2005). *What works for whom?* NY: Guildford Press.
Ryan, C. E., Epstein, N. B., Keitner, G.I., Miller, I.W., Bishop, D.S. (2005). *Evaluating and treating families: the McMaster approach.* NY: Routledge.

Schedule

Schedule may be adjusted based on progress through material during the semester

Date	***Reading***	***Lecture and Discussion***
2/13	Session 1: Castonguay, Ch. 1 - Townsend (2013) -DSM 5, pp. 1-24; 733-759 Session 2: Lecture and discussion	Session 1 Introduction to Psychopathology Psychopathology & Cultural Problematics Diagnosis—Systemic, multicultural, contextual, theological framework Process of Diagnosis & use of DSM 5 Medical science and theology Session 2 Neurobiological Foundations
2/20	Session 1 & 2: Lecture and discussion	Session 1: Neurobiological Foundations continued Session 2: Mental Status Exam Clinical Interviewing Inventories & cross-cutting measures Writing Assessment Reports
2/27	Session 1 & 2: Castonguay, Ch. 3 DSM 5, 222-226 Russo, Ch. 5113-134	Session 1: Generalized Anxiety Disorder Session 2: Social Anxiety Disorder **Due: Mental Status Report**
3/6	Session 1: Castonguay, Ch. 4 DSM 5, 208-221 Session 2: Clinical Applications	Session 1: Panic & Phobias Session 2: Clinical Concerns—Assessment procedures, report writing, legal and ethical, etc.
3/13	Session 1: Castonguay, Ch. 5 DSM-5, 235-36 Russo, Ch. 6 Session 2: Castonguay, Ch. 6 DSM 5,.271-280 Russo, Ch. 7	Session 1: Obsessive Compulsive Disorder Session 2: Posttraumatic Stress Disorder **Due: Clinical Assessment 1**
3/20	Research and Study	
3/27	Session 1: DSM-5, 591-643 Russo, Ch. 1 Session 2 DSM-5 Russo, Ch. 17	Session 1: Neurodevelopmental disorders: Guest speaker, Kent Hicks Session 2: Neurocognitive disorders Guest speaker, Kent Hicks
4/3	Session 1&2 Castonguay, Ch. 2 DSM 5, 160-171	Session 1 & 2: Depressive Disorders

	Russo, Ch. 4	
4/10	Session 1: Castonguay, Ch. 10 DSM 5, 123-139 Russo, Ch 3 Session 2: Castonguay, Ch. 7 DSM 5, 338-350 Russo, Ch. 10	Session 1: Bipolar Disorders (I and II) Session 2: Feeding and Eating Disorders **Due: Midterm exam taken in the library any time this week**
4/17	Session 1 & 2 Castonguay, Ch. 11-12 DSM 5, 99-122 Russo, Ch. 2	Session 1 & 2: Schizophrenia & Psychosis Spectrum
4/24	Session 1 Castonguay, Ch. 8 DSM 5, 483-587 Russo, Ch. 16 Session 2 Craighead, et al Ch. 18 DSM-5 361-442 Russo, Ch. 12	Session 1: Substance-Related & Addictive Disorders Session 2: Sleep Disorders **Due: Clinical Assessment 2**
5/1	Session 1: DSM 5, Russo Ch. 15 Session 2: Castonguay, Ch. 9; DSM 5, 645-684 Russo, Ch. 18	Session 1: Disruptive, Impulse-Control & Conduct Disorders Session 2: Personality Disorders
5/8	Session 1: Sexual Disorders, DSM-5 pp. 423-450; 685-705) Session 2: Conclusion: Integrating pastoral and theological concerns in diagnosis	Session 1: Sexual Dysfunction & Paraphilias Session 2: Class Discussion **Due: Clinical Assessment 3**
5/15-16	**Due: Final comprehensive exam on computers in library**	

Class Policies

Grading: Grade Scale and Philosophy

A	96.6-100
A-	93.6-96.5
B+	90.6-93.5
B	87.6-90.5
C	85.6-87.5
C+	83.6-85.5
C	81.6-83.5
C-	79.6-81.5
D	70.6-79.5

F Below 70.6

Individuals admitted to graduate study are expected to perform consistently and well in academic work. This is translated into grades in the following way:

1. Basic mastery of the body of knowledge at a level expected in graduate study will earn scores in the B to B+ range.

2. Grades of A- are granted for work which demonstrates

    - basic mastery of the body of knowledge, and
    - independent thought about the subject matter.

3. Grades of A are granted for work which demonstrates

    - mastery of the required body of knowledge,
    - independent thought about the subject matter, and
    - creative/integrative use of the material, exceptional writing which integrates the material into a student's own system of thought, and/or exceptionally well done or articulate research.

Seminary Policies

Excerpted from the Faculty Handbook

Use of Inclusive Language

In accordance with seminary policy, students are to use inclusive language in class discussions and in written and oral communication by using language representative of the whole human community in respect to gender, sexual orientation, ethnicity, age, and physical and intellectual capacities. Direct quotations from theological texts and translations of the Bible do not have to be altered to conform to this policy. In your own writing, however, when referring to God, you are encouraged to use a variety of images and metaphors, reflecting the richness of the Bible's images for God. More discussion about inclusive language can be accessed from the Academic Support Center and from the section of the LPTS web site with information for current students.

Academic Honesty

All work turned in to the instructors is expected to be the work of the student whose name appears on the assignment. Any borrowing of the ideas or the words of others must be acknowledged by quotation marks (where appropriate) and by citation of author and source. Use of another's language or ideas from online resources is included in this policy, and must be attributed to author and source of the work being cited. Failure to do so constitutes plagiarism, and may result in failure of the course. Two occurrences of plagiarism may result in dismissal from the Seminary. Students unfamiliar with issues related to academic honesty can find help from the staff in the Academic Support Center. For more information, see the Policy for Academic Honesty in the Student Handbook.

Special Accommodations

Students requiring accommodations for a documented physical or learning disability should be in contact with the Director of the Academic Support Center during the first two weeks of a semester (or before the semester begins) and should speak with the instructor as soon as possible to arrange appropriate adjustments. Students with environmental or other sensitivities that may affect their learning are also encouraged to speak with the instructor.

Citation Policy

Citations in your papers should follow Seminary standards, which are based on these guides:

American Psychological Association. *Publication Manual of the American Psychological Association*. 6th ed. Washington, DC: American Psychological Association, 2010.

Turabian, Kate L., Wayne C. Booth, Gregory G. Colomb, and Joseph M. Williams. *A Manual for Writers of Research Papers, Theses, and Dissertations: Chicago Style for Students and Researchers*. 8th ed. Chicago: University of Chicago Press, 2013.

The Chicago Manual of Style. 16th ed. Chicago: University of Chicago Press, 2010.

Copies of these guides are available at the library and in the Academic Support Center.

Attendance Policy

According to the Seminary catalog, students are expected to attend class meetings regularly. In case of illness or emergency, students are asked to notify the instructor of their planned absence from class, either prior to the session or within 24 hours of the class session. Six or more absences (1/4 of the course) may result in a low or failing grade in the course.

Appendix A

Guide for Writing Individual Clinical Assessments for PC 3223

Use the following subheadings:

1. **Presenting Problem** (Very brief summary of primary concern or problem that brings client to session)
2. **Interview Observations** (how the client appeared and interacted in session)
3. **Assessment observations and conclusions**
    - **Mental status** (use ***Mental Status Guide*** to organize your observations from session)
    - **Brief summary of symptoms described by client** (used to support any diagnostic conclusion)
    - **Brief summary of signs/symptoms observed in session** (used to support any diagnostic conclusion)
    - **History of the problem and relevant social, psychological, educational, vocational, spiritual history**
    - **Relevant medical history (**conditions, problems, diagnosis or concerns that need to be evaluated)
    - **Results of any general screening tools that support or contradict diagnostic conclusions below** (Cross-cutting measures, SLC 90, etc.)
    - **Results of any specific assessment tools that support or contradict diagnostic conclusions below** (depression, anxiety, ADHD, trauma, mood disorder etc. scales)
    - **Systemic factors related to individual problem, symptoms, signs, self-presentation etc.**
    - **Spiritual/Religious/Theological observations and concerns**
4. **Client Strengths and Resources**
5. **Diagnostic Conclusions**
    - **DSM-5 Diagnosis(es) and ICD 10 codes**
    - **Any additional consultation needed**
6. **Spiritual/Religious/Theological factors**
7. **Safety procedures indicated or taken as a result of assessment** (suicide and self-harm, domestic violence, etc.)
8. **Recommendations and intended outcomes for treatment** (be brief and make sure recommendations are consistent with and indicated by observations and diagnostic conclusions.
9. **Implicit and/or explicit theological or pastoral issues and concerns related to the case.**

Appendix B

Writing a Professional Clinical Report

1. Professional reports have specific purposes:

    - To document your professional
        - Observations (includes in-session observations and test/self-report instruments),
        - Conclusions (assessment outcomes, diagnoses, assessment of couple/family problems), and
        - Actions based on your observations and conclusions (treatment plan, safety plan, plan for further assessment, plan for referral etc.).
    - To communicate with other professionals who may need to interact with you about your client, your observations, your conclusions and actions.
    - To provide legal documentation showing that you have met professional standards
        - In how you made observations,
        - In how you based your conclusions in specific observations,
        - In how proposed actions (e.g. goals and treatment plan) are justified by your observations and conclusions.

2. Professional reports should:

    - Be organized by clear subject headings that reflect central areas of care and professional standards of practice (for LPTS, see the Case Study rubric).
    - Use subject headings as ***boundaries***. For instance, if you are writing in Presenting Problem, address ONLY the presenting problem in that section. Do not stray into history, personal or family dynamics, explanations of "why," etc.
    - Demonstrate clear, concise writing saying as much as possible about observations, conclusions and actions ***with as few words as possible*** (rule of parsimony). Busy professional consultants do not appreciate having to sort through an "essay about therapy," therapist musing about appropriate diagnosis or treatment options, or excessive description of what the experienced in specific sessions. Such musings and excessive description also opens you to unnecessary liability. You want to represent your professional work in a clear, linear fashion—what you observed, what observations mean (conclusion and diagnoses), how conclusions lead to action.
    - When possible, use therapeutic terms as a "shorthand" for what otherwise would be lengthy description of client behavior or interactions. For instance, use "observed couple detouring conflict through children," or "parent's passivity appeared to reinforce child's tantrum behavior", or "couple appeared mutually to reject bids for attention in session."
    - Use client words when possible, ***BUT*** select them carefully to give clients voice and illustrate something essential to your report. Do this sparingly and use as few words as possible.
    - Clearly articulate ***what you observe and know***; ***do not speculate about what you cannot observe and what you do not know***.

        - Avoid speculation about causation. You can ***never*** know the "root cause" of a problem or be certain that certain kinds of interactions produced certain kinds of behavior or problems.
        - Feel free to describe intrapersonal dynamics, interpersonal dynamics, couple and family dynamics and draw conclusions, but do this as simply and clearly as possible without excess speculation or suggesting causation.
- Be written in third person. (Exception: In sections of case studies that include theological reflection and/or countertransference issues first person is fine. Note that these reflections would ***never*** be included in a professional report sent outside of a training program like ours.
- Be written with appropriate tense—
    - past tense for events taking place before the session ("Client has worked at G.E. of the past 38 years," or "clients reported intense conflict over the past six years of their marriage," etc.)
    - past tense for observations made during a past session ("during the session the client was tearful," or "therapist observed tongue thrusting and rolling hand motions typical of tardive dyskinesia," or "client stated…."
    - present tense for things that are presently true for the client ("client is 38 years old, has three children, married, etc.)
    - future tense for expected future events, treatment goals, and intervention plans ("client plans to visit her parents next week," or "at the end of therapy, clients will report that they are able to talk co-parenting their children weekly without conflict over a two month period," or "Plan: in the next session therapist will introduce Dreams within Conflict intervention," or "therapist will administer Dyadic Adjustment Scale in the next session."
- Be signed with your name and professional qualifications.

Appendix C

THE MENTAL STATUS EXAMINATION
Adapted from University of Chicago

I. Appearance (Observed)
- Possible descriptors: Gait, posture, clothes, grooming

II. Behavior (Observed)
- Possible descriptors: Mannerisms, gestures, psychomotor activity, expression, eye contact, ability to follow commands/requests, compulsions

III. Attitude (Observed)
- Possible descriptors: Cooperative, hostile, open, secretive, evasive, suspicious, apathetic, easily distracted, focused, defensive

IV. Mood (Inquired and observed) A sustained state of inner feeling
- Possible questions/observations for client:
  - "How are your spirits?"
  - "How are you feeling?"
  - "Have you been discouraged/depressed/low/blue lately?"
  - "Have you been energized/elated/high/out of control lately?"
  - "Have you been angry/irritable/edgy lately?"

V. Affect (Observed) An observed expression of inner feeling.
- Possible descriptors:
  - Appropriateness to situation: Consistency with mood, congruency with thought content.
  - Fluctuations: Labile, even
  - Range: Broad, restricted
  - Intensity: Blunted, flat, normal intensity
  - Quality: Sad, angry, hostile, indifferent, euthymic, dysphoric, detached, elated, euphoric, anxious, animated, irritable.

VI. Level of Consciousness (Observed)
- Possible descriptors: Vigilant, alert, drowsy, lethargic, stuporous, asleep, comatose, confused, fluctuating.

VII. Orientation (Inquired or observation)
- Possible questions or observe client's awareness of:
  - "What is your full name?"
  - "Where are we at (floor, building, city, county, and state)?"
  - "What is the full date today (date, month, year, day of the week, and season)?"
  - "How would you describe what we are here to do?"

VIII. Attention (Inquired/Observed)
- Possible observations:
  - Attention appropriate to situation and conversation
  - Able/unable to concentrate in interview

- Distractibility

IX. Speech and Language (Observed)

- Quantity. Possible descriptors: Talkative, spontaneous, expansive, paucity, poverty
- Rate. Possible descriptors: Fast, slow, normal, pressured
- Volume (Tone). Possible descriptors: Loud, soft, monotone, weak, strong.
- Fluency and Rhythm. Possible descriptors: Slurred, clear, with appropriately placed inflections, hesitant, with good articulation, aphasic.

X. Thought Processes or Thought Form (Inquired/Observed). Includes logic, relevance, organization, flow and coherence of thought in response to general questioning during the interview.

- Possible descriptors: Linear, goal-directed, circumstantial, tangential, loose associations, incoherent, evasive, racing, blocking, perseveration, neologisms.

XI. Thought Content (Inquired/Observed)

- Possible questions/observations for client:
  - "What do you think about when you are sad/angry?"
  - "What's been on your mind lately?"
  - "Do you find yourself ruminating about things?"
  - "Are there thoughts or images that you have a really difficult time getting out of your head?"
  - "Are you worried/scared/frightened about something or other?"
  - "Do you have personal beliefs that are not shared by others?" (Delusions are fixed, false, unshared beliefs.)
  - "Do you ever feel detached/removed/changed/different from others around you?"
  - "Do things seem unnatural/unreal to you?"
  - "Do you think someone or some group intend to harm you in some way?"
  - [In response to something the client says] "What do you think they meant by that?"
  - "Does it ever seem like people are stealing your thoughts, or perhaps inserting thoughts into your head? Does it ever seem like your own thoughts are broadcast out loud?"
  - "Do you ever see (visual), hear (auditory), smell (olfactory), taste (gustatory), and feel (tactile) things that are not really there, such as voices or visions?" (Hallucinations are false perceptions)
  - "Do you sometimes misinterpret real things that are around you, such as muffled noises or shadows?" (Illusions are misinterpreted perceptions)

XII. Memory (Inquired and observed)

- Recent Memory – Possible observations/questions for client:
  - "What is my name?"
  - "What time was your appointment with me for today?"
- Remote Memory – Possible observations/questions for client:
  - "Where were you on 9/11?
  - "What were the dates of your graduation from high school, college, graduate school?"

- "When and where did you get married?"
- Immediate Memory (also see XIII.-A. above) and New Learning
  - "I am going to ask you to remember three words (color, object, animal – e.g., blue, table, and horse) and I will ask you to repeat them to me in 5 minutes. Please repeat them now after me: blue, table, and horse." – 5 minutes elapse – "What were those three words I asked you to remember?" [Monitor accuracy of response, awareness of whether responses are correct, tendency to confabulate or substitute other words, ability to correct themselves with category clue and multiple choice].

XIII. Insight and Judgment (Inquired/Observed)

- Possible questions/observations for client:
  - "What brings you here today?"
  - "What seems to be the problem?"
  - "What do you think is causing your problems?"
  - "How do you understand your problems?"
  - "How would you describe your role in this situation?"
  - "Do you think that these thoughts, moods, perceptions, are abnormal?"
  - "How do you plan to get help for this problem?"
  - "What will you do when _____ occurs?"
  - "How will you manage if _____ happens?"
  - 'If you found a stamped, addressed envelope on the street, what would you do with it?"
  - "If you were in a movie theater and smelled smoke, what would you do?"

XIV. Intellectual (Inquired/Observed)

- Information and Vocabulary: Observe general knowledge, social awareness, vocabulary appropriate to educational level, ability to abstract, ability to generalize appropriately, ability to see similarities and differences

XV. Suicidality and Homicidality

- Suicidality – Possible questions/observations for client:
  - "Do you ever feel that life isn't worth living? Or that you would just as soon be dead?"
  - "Have you ever thought of doing away with yourself? If so, how?"
  - "What would happen after you were dead?"
- Homicidality – Possible questions/observations for client:
  - "Do you think about hurting others or getting even with people who have wronged you?"
  - 'Have you had desires to hurt others? If so, how?"

Adapted from the University of Chicago: http://psychclerk.bsd.uchicago.edu/mse.pdf

Appendix B

MFT Competency Domains

Competency Domain 1-- Foundations of Treatment: Knowledge of system concepts, skills to establish therapeutic relationships.

Competency Domain 2--Clinical Assessment and Diagnosis: Skills related to activities focused on the identification of the problems and concerns to be addressed in therapy.

Competency Domain 3--Treatment Planning and Case Management: Skills related to treatment planning with client/client family, managing case from intake to termination including referral and safety planning.

Competency Domain 4--Therapeutic Interventions: Skills used to ameliorate clinical problems and help client/client families with desired changes.

Competency Domain 5--Legal Issues, Ethics, and Professional Standards: All aspects of therapy that involve statutes, regulations, principles, values, and mores of MFTs.

Competency Domain 6--Research Application: Use of current MFT and behavioral health research to inform evidence-based clinical practice.

Competency Domain 7--Self of Therapist: Awareness and management of personal reactions to clients and treatment process and how these impact observation, intervention and clinical outcomes.

Competency Domain 8--Theological and Spiritual Integration: Attending to pastoral, theological and spiritual dimensions of therapy and therapist-client interactions.

Competency Domain 9-- Multi-contextual engagement: Ability to integrate multicultural considerations and social engagement into treatment.