Practicum & Internship
To our grandchildren:
Luke Boylan and Molly Senisi
Brenna, Katrina, and Nate Scott
Josie and Mica Swift
Riley and Aidan Scott

WE ARE TRULY BLESSED!
Contents

Preface .......................................................................................................................... xix
Acknowledgments .................................................................................................xxi
About the Authors ..............................................................................................xxiii

SECTION I THE PRACTICUM EXPERIENCE

1 Definitions, Phases, and Standards ................................................................. 3
   Prepracticum Considerations .............................................................................. 3
   Questions for the Practicum Professor .............................................................. 4
   Questions for the Practicum Student ................................................................. 4
   Questions for the Practicum Site Supervisor ................................................. 5
   Questions About the Standards Set by Professional Organizations, Certifying Boards, Accrediting Agencies, and University Programs ...... 5
   Definitions............................................................................................................. 6
   Phases of Practicum ............................................................................................ 7
   Development Reflected in the Program Structure ......................................... 7
   Development Reflected in the Learning Process ........................................... 8
   Development Reflected in Supervisor Interaction ....................................... 9
   Standards in Accreditation and Certification for Practicum and Internship ..... 9
   Professional Counselors .................................................................................. 10
   Community Counseling .................................................................................... 11
   Gerontological Specialization in Community Counseling ......................... 12
   Career Counseling Specialization in Community Counseling ................... 12
   Mental Health Counseling .............................................................................. 12
   Marriage and Family Counseling or Therapy .............................................. 12
   School Counseling ........................................................................................... 13
   Student Affairs Practice in Higher Education, College Counseling Emphasis ................................................................. 13
   Counseling Psychologists .............................................................................. 14
   Marriage and Family Therapists .................................................................... 14
   Rehabilitation Counselors .............................................................................. 15
   Pastoral Counselors ....................................................................................... 16
   Counselor Certification ................................................................................. 17
Implications ...................................................................................................... 18
Summary ...........................................................................................................19
Suggested Readings...........................................................................................19
References .........................................................................................................19

2 Preparation for Practicum ........................................................................... 21
Guidelines for Choosing a Practicum Site ......................................................... 21
  Professional Staff and Supervisor ................................................................. 22
  Professional Affiliations of the Site ............................................................... 22
  Professional Practices of the Site ................................................................. 23
  Site Administration ...................................................................................... 24
  Training and Supervision Values ................................................................. 25
  Theoretical Orientation of the Site and Supervisor ....................................... 26
  Client Population ....................................................................................... 26
Negotiating the Practicum Placement ................................................................. 27
Role and Function of the Practicum Student ....................................................... 29
Concepts in Practicum ....................................................................................... 29
Suggested Course Requirements ....................................................................... 32
  Class Meetings ........................................................................................... 33
  Counseling Sessions .................................................................................. 33
  Individual Supervision Sessions ............................................................... 34
  Tape Critiques ............................................................................................ 34
  Documenting Practicum Activities ............................................................ 40
Summary .......................................................................................................... 40
Suggested Readings.......................................................................................... 42
References ........................................................................................................ 42

3 Practicum Content Issues ........................................................................... 43
Initial Interaction With the Client ....................................................................... 43
  Establishing a Therapeutic Alliance ............................................................. 43
  Initial Contact, Structuring, and Assessment ............................................... 44
Assessment Activities ......................................................................................... 46
  Obtaining Authorizations .......................................................................... 46
  Obtaining Information From the Client and Others .................................... 47
  Assessing the Client's Mental Status ........................................................... 47
  Mental Status Categories of Assessment ..................................................... 48
  Recording Psychosocial History .................................................................. 49
Monitoring and Evaluating the Client's Progress .............................................. 49
  Building a Client Folder ............................................................................. 50
  Client Record Keeping .............................................................................. 51
  Case Notes .................................................................................................. 52
Processing Interview Notes ............................................................................... 53
Learning to Write Case Notes Using the SOAP Format, by Susan Cameron & Imani Turtle-Song ................................................................. 54
Case Summary Outline ..................................................................................... 67
Case Summary .......................................................................................... 68
Reporting Therapeutic Process ..................................................................... 69
Summary .......................................................................................................... 70
Suggested Readings ......................................................................................... 70
References ....................................................................................................... 71

4 Practicum Process Issues ................................................................. 73
Philosophy–Theory–Practice Continuum ..................................................... 73
Structured and Unstructured Interviews ..................................................... 75
Initial Client Contact .................................................................................... 76
Basic Helping Skills .................................................................................... 77
Asking Appropriate Questions .................................................................... 78
Assessment in Counseling .......................................................................... 79
Diagnosis in Counseling ............................................................................ 82
Diagnostic Classification System .................................................................. 84
Severity and Course Modifiers ..................................................................... 84
DSM-IV Codes and Classification .................................................................. 85
Case Conceptualization and Treatment Planning ....................................... 85
Models of Case Conceptualization: The Analytical Thinking Model ......... 86
Models of Case Conceptualization: The Stevens and Morris Model ......... 86
Models of Case Conceptualization: The “Linchpin” Model ....................... 88
Models of Case Conceptualization: The Inverted Pyramid Method .......... 89
Case Conceptualization: Applying Theory to Individuals ....................... 89
Treatment Planning ..................................................................................... 91
Goal Setting in Counseling ......................................................................... 95
Summary ....................................................................................................... 96
Suggested Readings ..................................................................................... 96
References ..................................................................................................... 96

5 Monitoring the Professional Development of Practicum Students .... 99
Role and Function of the Supervisor in Practicum ................................... 99
Beginning the Practicum Experience .......................................................... 101
Getting Started: Where Do I Begin? ......................................................... 101
I’ve Taken the Classes, but Do I Really Know What to Do? .................... 102
What If I Say Something Wrong? .............................................................. 102
How Do I Know When to Use the Right Techniques? ............................ 103
But I’m Just a Rookie! (Learning to Trust Yourself and Your Inner Voice) .............................................................................................................. 103
When in Doubt, Consult! (Your Faculty and Site Supervisors Are There to Help You) .......................................................... 104
The Supervisor–Supervisee Relationship .................................................. 105
Approaches to Supervision ......................................................................... 106
Contents

The Psychodynamic Model ................................................................. 106
The Behavioral Model ........................................................................ 107
The Cognitive Model .......................................................................... 107
The Discrimination Model of Supervision ........................................ 107
Identifying Professional Development Skill Areas ............................ 108
Counseling Performance Skills .......................................................... 108
  Basic and Advanced Helping Skills ............................................... 108
  Theory-Based Techniques ................................................................ 109
  A Review of Philosophy and Theories of Counseling ..................... 110
Identifying Your Theory and Techniques Preferences ...................... 114
Techniques Used in Counseling and Psychotherapy* ......................... 114
Procedural and Issue-Specific Skills .................................................. 125
  Cognitive Counseling Skills .......................................................... 125
  Self-Awareness ................................................................................. 127
  Developmental Level ....................................................................... 129
Assessment and Evaluation In Practicum .......................................... 129
  Self Assessment ............................................................................... 129
Goal Statement Agreement ............................................................... 132
  Peer Assessment ............................................................................. 133
Supervisor Assessment ....................................................................... 135
Summary .......................................................................................... 136
Suggested Readings .......................................................................... 137
References .......................................................................................... 137

SECTION II  ETHICS AND THE LAW

6 Ethics in Counselor Education ......................................................... 143
  Codes of Ethics: Multiplicity and Confusion .................................... 144
  Ethical Decision Making ................................................................. 144
  Ethical Issues .................................................................................... 146
  Ethics and the Law .......................................................................... 147
  2005 Code of Ethics ........................................................................ 147
    Purpose of the Code ..................................................................... 147
    Code of Ethics: Main Sections ...................................................... 147
    New Key Areas ............................................................................. 147
  Ethical Codes ................................................................................... 148
  Ethics and Counseling ................................................................. 148
  Definitions: Ethics, Morality, and Law .......................................... 149
  Ethical Principles .............................................................................. 149
    Autonomy ...................................................................................... 150
    Beneficence .................................................................................. 150
    Justice .......................................................................................... 150
    Nonmaleficence .......................................................................... 151
    Fidelity ......................................................................................... 151
Contents

Summary .........................................................................................................151
ACA Code of Ethics .......................................................................................152
  ACA Code of Ethics Preamble .................................................................153
  ACA Code of Ethics Purpose .................................................................153
Section A: The Counseling Relationship .....................................................154
Section B: Confidentiality, Privileged Communication, and Privacy ..........162
Section C: Professional Responsibility .......................................................168
Section D: Relationships With Other Professionals ................................172
Section E: Evaluation, Assessment, and Interpretation .............................174
Section F: Supervision, Training, and Teaching ......................................179
Section G: Research and Publication .......................................................186
Section H: Resolving Ethical Issues ..........................................................192
Glossary of Terms ......................................................................................194
Ethical Principles of Psychologists and Code of Conduct ..............................196
  Contents ..................................................................................................196
  Introduction and Applicability ...............................................................197
  Preamble ................................................................................................200
General Principles .......................................................................................200
  Principle A: Beneficence and Nonmaleficence ....................................200
  Principle B: Fidelity and Responsibility ..............................................200
  Principle C: Integrity ..........................................................................200
  Principle D: Justice ............................................................................201
  Principle E: Respect for People’s Rights and Dignity ............................201
Ethical Standards .......................................................................................201
  History and Effective Date Footnote ....................................................222
Code of Ethics of the American Mental Health Counselors Association 2000 Revision ..........................................................223
  Preamble ..............................................................................................223
Clinical Issues ............................................................................................224
  Principle 1: Welfare of the Consumer ...............................................224
  Principle 2: Clients’ Rights .................................................................228
  Principle 3: Confidentiality .................................................................229
  Principle 4: Utilization of Assessment Techniques ..............................231
  Principle 5: Pursuit of Research Activities .......................................234
  Principle 6: Consulting ......................................................................235
Professional Issues .....................................................................................235
  Principle 7: Competence .................................................................235
  Principle 8: Professional Relationships .............................................237
  Principle 9: Supervisee, Student, and Employee Relationships ..........238
  Principle 10: Moral and Legal Standards .........................................239
  Principle 11: Professional Responsibility ........................................239
  Principle 12: Private Practice ............................................................240
  Principle 13: Public Statements ..........................................................241
Principle 14: Internet On-Line Counseling ........................................... 242
Principle 15: Resolution of Ethical Problems .................................... 243
References .............................................................................................. 244

7 Legal Issues ......................................................................................... 247
The Law .................................................................................................... 247
Classifications of the Law ...................................................................... 248
Types of Laws .......................................................................................... 248
The Steps in a Lawsuit ............................................................................ 249
Confidentiality and Privileged Communication .................................... 249
Managed Care and the Counselor ......................................................... 251
Risk Management and Multiple Relationships ..................................... 253
Risk Management and the Counselor .................................................... 256
Elements of Malpractice ....................................................................... 257
Why Clients Sue .................................................................................... 258
Other Reasons to Sue ............................................................................ 258
Policy Development ................................................................................ 259
Client Records ........................................................................................ 259
The Use of Computers ......................................................................... 260
Liability Insurance ............................................................................... 261
Contracting for Therapy ....................................................................... 261
Informed Consent .................................................................................. 262
Release of Information ......................................................................... 263
Confidentiality ........................................................................................ 263
Privileged Communication .................................................................. 263
Summary .................................................................................................. 264
References .............................................................................................. 265

SECTION III THE INTERNSHIP EXPERIENCE

8 Guidelines for Interns Working With Special Populations and Crisis ............................................................. 269
The Client Who Is Potentially Harmful to Self .................................... 269
Definition of Suicide ............................................................................ 269
Myths about Suicide .............................................................................. 269
Ethical Mandates and Danger to Self .................................................... 270
Legal Mandates and Danger to Self ......................................................... 271
Characteristics of Potential Harm to Self ............................................. 272
Harm to Self ............................................................................................ 272
When You Fear Someone May Take Their Own Life ..................... 274
Take It Seriously .................................................................................... 275
Be Willing to Listen ............................................................................... 275
Seek Professional Help .......................................................................... 275
In Acute Crisis ...................................................................................... 275
Treatment Follow Up ............................................................................ 276
## Contents

What Is Treatment? ................................................................................. 296
  Stages of Recovery .......................................................................... 298
Assessment Instruments ......................................................................... 298
Counseling Recommendations ............................................................... 299
Preventing Relapse ............................................................................. 301
Conclusion .............................................................................................. 302

Crisis Intervention .......................................................................................... 302
Crisis Intervention: The Kanel Model.................................................... 303
Crisis Intervention: The Gilliland and James Model ............................. 304
Crisis Intervention: A Model for Teachers ............................................. 306
Teacher Guidelines for Crisis Response................................................. 308
  What Is a Crisis and What Is Crisis Response? .................................... 308
  Why a Crisis Response Plan? ........................................................... 308
  What Types of Behaviors/Reactions Can Teachers Expect From Their Students After a Crisis Situation Has Occurred? .......... 309
  What Types of Personal Reactions Can Teachers Expect After a Crisis Situation Has Occurred? ........................................... 312
  What Can Classroom Teachers Do to Address the Reactions of Their Students During a Crisis Situation? ........................... 313
  When Should Teachers Refer Students for More Individualized Assessment and Intervention? ................................................. 315
  Conclusion ....................................................................................... 316
Summary ......................................................................................................... 316
Suggested Readings ......................................................................................... 316
References ....................................................................................................... 322

9 Consultation in the Schools and Mental Health Agencies: Models and Methods .......................................................... 331
  Definition ............................................................................................. 332
  Mental Health Consultation ................................................................. 333
    Consultation ..................................................................................... 335
      Internal Versus External Consultation ...................................... 336
    Consultation or Collaboration? .................................................... 337
  School Consultation .................................................................................. 337
  Developmental Counseling and Therapy as a Model for School Counselor Consultation With Teachers, by Elisha Clemens .............. 340
  A Model of Solution-Focused Consultation for School Counselors, by Beverly B. Kahn ................................................................. 353
  Guidelines for Consultation .................................................................. 362
    Entry Into the System ..................................................................... 363
    Orientation to Consultation ............................................................. 364
    Problem Identification ................................................................... 364
    Consultation Intervention ............................................................ 365
**Assessing the Impact of Consultation** .....................................................367
Process and Content Models of Consultation ........................................ 368
  The Purchase-of-Expertise Model ..........................................................368
  The Doctor–Patient Model ................................................................. 368
  The Process Consultation Model ...................................................... 368
Resistance to Consultation ..................................................................... 369
Contracting and the Forces of Change in the Organization ................. 370
Summary .................................................................................................371
Suggested Readings ..................................................................................371
References .................................................................................................372

**SECTION IV  INTERNSHIP PREPARATION AND EXPERIENCE**

**10 Preparation for Internship** .............................................................379
Selection and Evaluation of an Internship Site .......................................379
Lousy Supervision...................................................................................382
  Overarching Principles ........................................................................ 383
  General Spheres ................................................................................... 383
The Internship Agreement .........................................................................383
Intern Roles and Responsibilities .............................................................384
  Individual Performance Plan ............................................................. 384
Beginning Counselor Supervision ............................................................385
Stages of Internship ..................................................................................386
  Anticipation .......................................................................................... 386
  Disillusionment ..................................................................................... 386
  Confrontation ....................................................................................... 387
  Competence ......................................................................................... 387
  Culmination ...........................................................................................387
Internship Experience ...............................................................................388
  Supervisees: What Should I Look for in Supervision? .................... 388
  Supervisee: How Am I to Be Evaluated? .......................................... 389
Summary ..................................................................................................389
Suggested Readings ................................................................................ 390
References .................................................................................................391

**11 Process and Evaluation in Internship** ............................................ 393
Field-Site-Based Supervision ..................................................................395
On-Campus Supervision .........................................................................395
Supervisor–Supervisee Relationship ...................................................... 396
Models of Supervision .............................................................................397
  The Triadic Model of Supervision ..................................................... 398
Extending the Intern’s Theory-Based Techniques ...................................400
  Solution-Focused Brief Therapy ..................................................... 401
  Strategic Solution-Focused Therapy .............................................. 402
Major Approaches to Brief Therapy ....................................................... 403
  Psychodynamic Approaches to Brief Therapy ......................................... 404
  Interpersonal Dynamic Brief Therapy .................................................. 404
  Interpersonal Psychotherapy ............................................................ 404
  Cognitive Behavioral Counseling ....................................................... 404
  Cognitive Restructuring Brief Therapy ............................................. 404
  Rational Emotive Therapy ..................................................................... 404
  Coping Skills Brief Therapy .............................................................. 405
  Tactical Brief Therapies ................................................................. 405
Developing the Intern's Personal Theory of Counseling ............................. 406
Assessment in Internship ..................................................................... 407
Self-Assessment .................................................................................. 407
Field Site Supervisor Evaluation of the Intern ........................................... 408
Faculty Supervisor Evaluation of the Intern ............................................. 408
Summary ............................................................................................ 409
Suggested Readings ............................................................................ 410
References .......................................................................................... 410

12 Final Evaluations ........................................................................... 415

Appendices .......................................................................................... 417

Index .................................................................................................. 463

FORMS
  Form 2.1 Letter to Practicum Site Supervisor
  Form 2.2 Practicum Contract
  Form 2.3 Student Profile Sheet
  Form 2.4 Student/Practicum/Internship Agreement
  Form 2.5 Tape Critique Form
  Form 2.6 Weekly Schedule
  Form 2.7 Monthly Practicum Log
  Form 3.1 Parental Release Form
  Form 3.2 Client Release Form
  Form 3.3 Initial Intake Form
  Form 3.4 Elementary School Counseling Referral Form
  Form 3.4a Elementary School Counseling Referral Short Form
  Form 3.5 Secondary School Counseling Referral Form
  Form 3.6 Mental Status Checklist
  Form 3.7 Psychosocial History
  Form 3.8 Therapy Notes
  Form 3.9 Therapeutic Progress Report
  Form 5.1 Self-Assessment of Basic Helping Skills And Procedural Skills
  Form 5.2 Counseling Techniques List
  Form 5.3 Self-Rating By the Student Counselor
<table>
<thead>
<tr>
<th>Form</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.4</td>
<td>Peer Rating Form</td>
</tr>
<tr>
<td>5.5</td>
<td>Goal Statement Agreement</td>
</tr>
<tr>
<td>5.6</td>
<td>Interviewer Rating Form</td>
</tr>
<tr>
<td>5.7</td>
<td>Site Supervisor's Evaluation of Student Counselor's Performance</td>
</tr>
<tr>
<td>5.8</td>
<td>Counselor Competency Scale</td>
</tr>
<tr>
<td>8.1</td>
<td>Suicide Consultation Form</td>
</tr>
<tr>
<td>8.2</td>
<td>Suicide Contract</td>
</tr>
<tr>
<td>8.3</td>
<td>Harm to Others Form</td>
</tr>
<tr>
<td>8.4</td>
<td>Child Abuse Reporting Form</td>
</tr>
<tr>
<td>8.5</td>
<td>Substance Abuse Assessment Form</td>
</tr>
<tr>
<td>9.1</td>
<td>Consultation Rating Form</td>
</tr>
<tr>
<td>10.1</td>
<td>Intern Site Preselection Data Sheet—School</td>
</tr>
<tr>
<td>10.2</td>
<td>Intern Site Preselection Data Sheet—Clinical</td>
</tr>
<tr>
<td>10.3</td>
<td>Internship Contract</td>
</tr>
<tr>
<td>11.1</td>
<td>Midterm and End-of-Term Summative Review of Intern Skill Levels</td>
</tr>
<tr>
<td>11.2</td>
<td>Individual Performance Plan</td>
</tr>
<tr>
<td>12.1</td>
<td>Internship Log</td>
</tr>
<tr>
<td>12.2</td>
<td>Student Evaluation Form</td>
</tr>
<tr>
<td>12.3</td>
<td>Client's Personal/Social Satisfaction With Counseling Assessment</td>
</tr>
<tr>
<td>12.4</td>
<td>Student Counselor Evaluation of Supervisor</td>
</tr>
<tr>
<td>12.5</td>
<td>Site Evaluation Form</td>
</tr>
</tbody>
</table>
Preface

The purpose of this text is to assist supervisors, practicum students, and interns in their practicum and internship training. This fourth edition of Practicum and Internship: Textbook and Resource Guide for Counseling and Psychotherapy contains theoretical components that are valuable and essential to the training of student counselors and psychotherapists. In addition to the theoretical aspects presented, training activities germane and necessary to the development of applied counseling skills are explicated.

This edition represents a major revision of previous editions. The text has been divided into chapters specific to practicum activities and internship activities. Within the text, excerpted professional guidelines and contributed articles from other sources appear as separate items. These can be used to reinforce discussions of the topics. To provide easy access, the authors compiled all forms referenced in the text at the end of the book and as files on the accompanying disk.

The first part of the text is designed to focus specifically on the activities needed for a successful practicum experience. The student is introduced to definitions, terms, and standards of the counseling profession, as well as to the required activities of a practicum experience. The authors provide examples of the variety of data-gathering and precounseling methods that are essential to the structuring of an initial counseling session. Similarly, a step-by-step process guides the student from his or her philosophical and theoretical orientation toward actual assessment, diagnosis, case conceptualization, and treatment planning. Methods and techniques for monitoring the development of the student in practicum are highlighted.

The second section of the text (chapters 6 and 7) focuses on the legal and ethical considerations essential for professional practice. In these chapters a variety of topics are discussed (ethical decision making, managed care and the counselor, risky behavior, and privilege communication).

The third section of text (chapters 8 and 9) provides specific guidelines for working with special populations (suicidal clients, victims of child and sexual abuse, substance abusing clients), as well as a presentation of models and methods of school and mental health consultation and collaboration.
The fourth part (chapters 10 and 11) specifically addresses the many issues involved in selecting, obtaining, and counseling in an internship experience. These chapters look at the models and methods of supervision coupled with up-to-date assessment activities and strategies.

In summary, the fourth edition of the textbook provides the student, counselor, and supervisor with a reader-friendly approach to the practicum and internship experience.

The new organization and revisions have resulted in a textbook that takes the student from the classroom to the actual requirements and mandates of practicum and internship experiences.
Acknowledgments

The authors gratefully appreciate the efforts of the following individuals, who were instrumental in the development of the fourth edition of this textbook:

Patrick Malley, Ph.D., and Eileen Petty Reilly, M.Ed., for permission to use their materials from the third edition of the textbook.

The graduate counseling students at Marywood University and the University of Pittsburgh for all they have contributed to our professional growth and enhancement.

Dana Bliss, Editor at Routledge, whose understanding and editorial suggestions were invaluable in the development of the textbook.

Christopher Tominich, Editorial Assistant, whose help in the initial stages of editing the book kept us on the right track.

Robert Sims, Project Editor, Production—our deepest appreciation and gratitude for your “amazing” editorial and organizational skills, without which this endeavor would not have been completed.

Stephen Burton, B.S., M.S., former principal at Fieldale-Collinsville High School, Collinsville, Virginia, for providing his considerable computer skills and being my conscience—he continually motivated me to keep working on the new edition.

Mariellen Kerr, Ph.D., for her helpful consultation regarding the ASCA 2003 National Model for Counseling and for her lively discussions about the need to train site supervisors in school counseling.
About the Authors

**John C. Boylan, Ph.D.,** is currently teaching part-time in the Department of Psychology and Sociology at Coastal Carolina University and in the Graduate Counseling Program at Webster University, Myrtle Beach, South Carolina. Dr. Boylan is a licensed psychologist, certified school counselor, and certified sex therapist. Prior to moving to South Carolina, Dr. Boylan was professor of counseling and psychology at Marywood University, Scranton, Pennsylvania. During his long tenure at Marywood, he served as chairperson of the Graduate Psychology and Counseling Program and director of Career Planning and Placement. In addition to his academic duties, Dr. Boylan maintained a private practice in individual, marital, and sex therapy in Clarks Summit and Scranton, Pennsylvania.

**Judith Scott, Ph.D.,** is a licensed psychologist and professor emeritus of the Department of Psychology in Education at the University of Pittsburgh. Dr. Scott maintains a private practice that specializes in outpatient individual psychotherapy in women's issues and fertility counseling. Her research focuses on counseling supervision and women's adult development.
The first five chapters of this textbook focus on the essential components of a practicum experience. Chapter 1 provides the student with the essential definitions, phases, and standards of practicum training. The education and training requirements of several national accreditation agencies are included. Chapter 2 provides guidelines for choosing a practicum site, as well as practical questions that will help the student in selecting an appropriate placement. The roles and responsibilities of both the intern and the supervisor are discussed. This chapter also provides forms to be used in the critical prepracticum data-gathering activities, as well as forms that the practicum student can use to record preliminary practicum activities. Chapter 3 addresses procedures for assisting the client, monitoring the client’s progress, and reporting cases. This chapter also includes forms that students may use in their work with clients as they begin the practicum experience. Chapter 4 takes the student through the steps of assessing, diagnosing, conceptualizing, and treating the client. Chapter 5 stresses the importance of understanding the function of supervision in the practicum and provides the student with an overview of the variety of approaches used in counseling supervision. Attention is also given to the monitoring of the student’s cognitive and performance skills. Forms that can be used for the purpose of self and peer assessment and rating, as well as other evaluation tools, are also referenced and can be found at the end of the book.
Chapter 1
Definitions, Phases, and Standards

The focus of this book is on fostering the development of qualified, competent practitioners of the helping professions. It is written for students registered in graduate programs in counselor education, mental health counseling, and psychology. It is our intent to aid both the student and the support personnel through the practicum and internship experiences. To this end, we have devoted part I (chapters 1 through 5) to the practicum experience, part II (chapters 6 and 7) to the legal and ethical issues pertinent to both the practicum student and intern, and part III (chapters 8 through 12) to the internship experience.

Practicum and internship experiences are required in a broad variety of preparation programs in the helping professions. Counselor education and psychology training programs, national associations, and the accrediting bodies related to these specializations continue to clarify and solidify the definitions of practicum and internship, along with their field experience requirements. They also specify activities, experiences, and knowledge-base requirements that are appropriate to each component of training. A review of Hollis and Dodson (2000) suggests that the number of clinical hours required for practicum and internship experiences is increasing. Similarly, national accrediting bodies specify the qualification and levels of experience of both field- and campus-based supervisors.

Prepracticum Considerations

All individuals involved in the applied training components of counseling and psychology need to carefully examine the expectations they bring to the practicum and internship. The practicum professor, practicum student, site supervisor, and professional accreditation agencies all have expectations about practicum and internship, which may vary. The following list of questions provides examples of those types of questions that could be directed toward each source.
Students should modify and adapt this list in keeping with their own training program and specific practicum situations.

**Questions for the Practicum Professor**

Following is a list of important questions for the practicum student to ask his or her practicum professor.

- How do students define the knowledge, skills, and activities appropriate to a practicum?
- What are the basic skills and content areas that are necessary to begin a practicum experience?
- What are the concepts that provide a foundation for the practicum experience?
- Does the professor have an established relationship with the field site?
- Does the professor serve as a liaison between the practicum course activities and the field site?
- How does the professor provide for field site-based and on-campus-based supervision?
- How is the student expected to demonstrate identified competencies, and how are they to be evaluated?
- Will the student be retained in practicum until minimal competencies are demonstrated?
- Will the student be responsible for audio- or videotaping at the field site?
- How much time will be spent in direct service activities with individual clients? With groups?
- How does the professor view the responsibility for site placement? Is the student’s responsibility clearly stated?
- What is the role of the professor in the field site experience? Instructional leader? Evaluator? Liaison? Role model? Resource person?

**Questions for the Practicum Student**

Following is a list of questions for practicum students to ask themselves before beginning the practicum experience.

- What kinds of experiences are expected and needed by the student? Are they clearly defined by both program and field site?
- What models, methods, or approaches are employed in a practicum?
- Will practicum experiences lead to the appropriate certification and licensing from the state and/or national certification and licensing boards?
- How do the experiences afforded in a practicum reflect the depth and breadth of professional counseling and psychology?
- Will both individual and group counseling or therapy be part of the practicum experience?
With what range and diversity of client can the student expect to work? Are these clients representative of the client population with whom the student expects to work when employed?

Who are the other practicum students? With what kinds of experiences and points of view might they add to group supervision sessions?

How will the students be evaluated? With what frequency? What kinds of records of counseling or therapy practice (written or taped) will be expected?

What are the guidelines and procedures for practicum placement?

What field site placements are recommended and available? Is there a list of approved field sites?

Are practicum students expected to have their own malpractice insurance?

Does the field site have materials that describe its program goals and objectives?

Questions for the Practicum Site Supervisor

Following is a list of useful questions for the student to ask a potential practicum site supervisor.

What are the credentials and supervisory experience of the site supervisor?

What are the supervisor’s views on counseling and psychology?

Is the supervisor active or inactive in professional organizations?

What model or method of supervision is employed?

How does the site supervisor define the role of the practicum student? How much time is expected for record keeping, report writing, and case conferences?

How much time each week will the supervisor devote to supervision and/or interaction with the student? To individual supervision? To group supervision?

How does the site supervisor communicate with the university training program?

Has the site had previous experience with practicum students from my program? From other programs?

Questions About the Standards Set by Professional Organizations, Certifying Boards, Accrediting Agencies, and University Programs

Following is a list of questions about professional standards that the practicum student should consider.

How many hours of practicum are required in the program, and what number of these hours is spent in direct service? What is the ratio of direct service to supervision?

What kinds of supervisory support are required? Are both individual and group supervision required or recommended? How many hours of supervision are needed?
- What kinds of procedures have been established for the protection of clients?
- How are the clients informed about practicum students working with them?
- What are the prerequisites for the practicum? Where in the program is it placed?
- What number of credit hours is devoted to the practicum? Do practicum hours include class on campus?

Definitions

Throughout this textbook the words counselor, student, site supervisor, and practicum professor are used to describe individuals involved in counseling and psychology training. A few terms must be defined to promote a clear understanding of the meanings intended in this text.

Counselor: Typically the counselor is an advanced graduate student in counseling or psychology who has fulfilled the necessary program requirements and who requires field-based training experiences as part of the program.

Practicum student: A practicum student is a student in training who is enrolled in a specific practicum course and fieldwork experience.

Intern: An intern is a student in training who has completed the academic and experiential prerequisites for an internship in counseling or psychology and is enrolled in the internship component of the program.

Student: This term is used in certain places in the text to refer to the person enrolled in either practicum or internship.

Practicum site supervisor: The practicum site supervisor is the person at the field site who shares or has primary responsibility for supervision of the practicum student at the site.

Practicum or internship professor: This is an agent of the university (generally a university faculty member) who is directly responsible for the university course in practicum or internship to which the student is assigned.

Practicum site: The practicum site is the place where the practicum experiences occur. The site may be within the university, such as a counseling practicum clinic or counseling center. Alternatively, the site may be within a school or community agency, for example, a correctional clinic, diagnostic center, mental hospital, employment agency, pastoral counseling agency, or rehabilitation agency.

Internship site: The internship site is the place where the internship experience occurs. The site meets the university training programs standards for internship experiences and provides the intern with the opportunity to perform all the activities that a regularly employed staff member who occupies the professional role to which the intern is aspiring would be expected to perform. The site may be within a school, university, or community agency.
Internship site supervisor: This is a clearly designated professional staff member at the internship site who is directly responsible for providing systematic, intensive on-site supervision of the intern's professional training activities and performance. The internship supervisor has professional credentials appropriate to the role to which the intern aspires.

**Phases of Practicum**

The phases of practicum can be described from a variety of perspectives. For example, one might describe the practicum from the categories of level of skill, such as beginning, intermediate, or advanced. Another way of categorizing phases of practicum might be according to functions, such as structuring, stating goals, acquiring knowledge, and refining skills and interventions. We prefer to describe practicum phases from a developmental perspective.

Several principles regarding development can be identified within practicum:

1. *Movement is directional and hierarchical.* Early learning in the program establishes a foundation (knowledge base) for later development in the program (applied skills).
2. *Differentiation occurs with new learning.* Learning proceeds from the more simplistic and straightforward (content) toward the more complex and subtle (process).
3. *Separation or individuation can be observed.* The learning process leads to progressively more independent and separate functioning on the part of the counselor or therapist.

These developmental principles can be identified within the specific program structure, the learning process, and the supervisory interaction encountered by the student.

**Development Reflected in the Program Structure**

Students in a counseling or psychology training program can expect to proceed through a well-thought-out experiential component of their programs. Generally experiences are orderly and sequentially planned. A typical sequence would be as follows:

Foundations of Counseling

  Prepracticum

  ↼ Practicum

  ↼ Internship

  ↼ Full professional status
Some variations exist in counseling and psychology programs regarding the number of credit hours required in each component of training. Some variations also exist in training programs regarding the range and depth of expected skills and competencies that are necessary before a student can move to the next component in the program. Generally, programs begin with courses that orient the student to the field. The history of the profession and its current status might well be a beginning point. Early courses tend to be more didactic and straightforward. As the student enters the prepracticum phase of the program, he or she can generally expect more interaction and active participation with the professor. In this stage, the focus is on basic skill development, role playing, peer interaction and feedback, and observation activities in a classroom or counseling laboratory. In the practicum component, the student is likely to be functioning at a field site with supervision and on campus in a practicum class with university faculty. The focus in both of these settings is on observation by functioning professionals as well as on initial interactions with clients. As time progresses, the student becomes more actively involved with a range of clients and is given increased opportunities to expand and develop the full range of professional behaviors. At the internship end of the continuum, the student is expected to be able to participate in the full range of professional counseling activities within the field site under supervision of an approved field site supervisor.

**Development Reflected in the Learning Process**

As practicum students progress in their training, they tend to progress across several stages or steps of learning. Initially, counselors often lack confidence in their skills and tend to imitate the type of supervision they receive. Counselors look to others for an indication of how they should function in the setting. Counselors tend to question their level of skill development. As time passes, they tend to fluctuate between feeling competent and professional and feeling inadequate. At this point, most counselors see the need to develop an internalized theoretical framework, to give them a sense of “grounding” and to help them to develop their own approach to counseling. Further learning helps counselors to develop confidence in their skills and an awareness of their strengths, weaknesses, and motivations. Finally, counselors develop a sense of self-confidence in their skills and can internalize and integrate their counseling behavior.

At the beginning stage of learning, the counselor’s role and professional behaviors are viewed as being taken in and learned from the outside. At the higher level of learning, the trainee integrates the role of counselor or therapist into his or her personal identity and becomes the one who knows. New methods, interventions, and techniques are reflected on, considered, and tried rather than merely read about and applied.
Development Reflected in Supervisor Interaction

Supervisory interaction between supervisor and student begins with a high level of dependence on the supervisor for instruction, feedback, and support. This interaction is modified as skill, personal awareness, and confidence increase for the student. The student becomes more likely to explore new modes of practice that reflect his or her own unique style. The interaction continues to move more gradually toward a higher level of independent judgment by the student and a more collegial and consultative stance on the part of the supervisor. The reader is directed to the chapters on the internship experience (chapters 8–12) for a fuller discussion of the supervisor-supervisee interaction.

Standards in Accreditation and Certification for Practicum and Internship

Accreditation of counselor preparation programs in the United States is a voluntary process; the accreditation bodies are independent from federal and state governments. In most cases, the accreditation body was initially established by a professional association. For example, the American Personnel and Guidance Association (now the American Counseling Association) established the Council for Accreditation of Counseling and Related Educational Programs (CACREP); the American Association for Marriage and Family Therapy (AAMFT) established the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE); the American Association of Pastoral Counselors (AAPC) became the accrediting body for pastoral counselors; and the Council on Rehabilitation Education (CORE) became the accrediting body for rehabilitation counselors (Hollis & Dodson, 2000, p. 21). Each accreditation body established criteria to be met by programs before accreditation. If a department offers more than one program, each program must be evaluated separately for accreditation. Thus a department may have some programs that are accredited and others that are not.

Graduation from an accredited program has a number of significant advantages for students. For example, accreditation programs

- ensure applicants and all concerned that the program meets high professional standards;
- maintain periodical review of the program;
- provide a base of pride for faculty, students, and the college or university as they become contributors to and involved in a nationally recognized program;
- offer graduates of the program the advantage of having graduated from an accredited program (Hollis & Dodson, 2000, p. 21).
The five accreditation bodies, the American Psychological Association (APA), CACREP, COAMFTE, CORE, and AAPC, have published standards that influence state certification and licensing of psychologists and counselors. These standards also encourage academic units to develop preparation programs that meet national standards. More and more hiring officials are recognizing what accreditation may mean in terms of a graduate’s choice of programs. This trend has caused students to seek admission to accredited programs, thus giving accreditation significantly more meaning in the past few years. The acceptance of national standards is not universal; however, standards are accepted widely and influence what is offered in counselor preparation programs (Hollis & Dodson, 2000).

The major experiential components in counselor preparation—practicum and internship—have undergone three major changes in the recent past: (a) the amount of time spent in practicum and internship has increased, (b) the setting in which the experience occurs has changed, and (c) the specifications for qualifications of the supervisor doing the clinical supervision of the practicum or internship student have become more stringent. These three aspects—clock hours spent, setting, and supervisor qualifications—could make major differences in the job opportunities, types of practice, clientele, philosophical orientation, and techniques emphasized throughout the student's professional life. For these reasons, as well as others (e.g., personalities involved, practicum and internship sites available), each student needs to give considerable attention to where he or she does practicum and internship, under whose clinical supervision, and for what period of time.

Each of the accreditation bodies, or national organizations, has established separate and somewhat different standards. Even though your interest may be in only one accreditation body, understanding the requirements of the other bodies will assist you in obtaining knowledge about the qualifications of other individuals in the helping professions.

**Professional Counselors**

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) is an independent council that was created in 1981 by the American Personnel and Guidance Association (now the American Counseling Association). It is the accrediting body for the world's largest association of counseling. At its inception, the council agreed to honor all previous accreditation decisions rendered by the Association for Counselor Education and Supervision (ACES) and those previously made by the California Association of Counselor Education and Supervision (CACES).

CACREP accredits entry-level programs at the master's degree level in five areas:

- community counseling (48 semester hours),
- marriage and family therapy or counseling (60 semester hours),
Definitions, Phases, and Standards

- mental health counseling (60 semester hours),
- school counseling (48 semester hours), and
- student affairs practice/counseling in higher education (48 semester hours).

Within the community counseling program, further specializations in gerontological counseling (48 semester hours) and career counseling (48 semester hours) are provided.

At the entry level, CACREP statements related to practicum and internship are as follows:

The program must provide curricular experiences and demonstrated knowledge and skill in different specialization areas so that the student may gain experience in the professional setting where the student intends to practice. The direct service hours required should include work with the population with whom the student intends to work. …

Practica will extend over a minimum of one academic year and should provide for the development of individual and group work skills. Individual and group supervision by approved faculty and field site supervisors should be provided on a weekly basis and include ongoing evaluation as well as a formal evaluation at the end of practicum. …

A supervised internship that provides opportunities for students to engage in both individual and group work is recommended. The internship provides an opportunity for the student to perform, under supervision, a variety of activities that a regularly employed staff member in the setting would expect to perform. A regularly employed staff member is defined as a person occupying the professional role to which the student is aspiring. …

Ordinarily, internships will be full time of a work week extended over a minimum of one academic term or half-time of a work week extended over two academic terms. Individual and group supervision by approved faculty and field site supervisors should be provided on a weekly basis. Formal evaluation of the student's performance during the internship by faculty and site supervisors is required. (CACREP, 2001)

The following descriptions provide summary information about the three primary aspects of practicum and internship in each of the counseling specializations.

Community Counseling

Setting: Community agency
Clock hours
Practicum: 100 hours, with 40 hours of direct client contact
Internship: 600 hours, with 240 hours of direct service to client, including but not limited to using preventive, developmental, and remedial
Practicum and Internship interventions with appropriate clientele and community interventions consistent with the program

Supervisor: National certified counselor (NCC) certification or a degree in a counseling-related field; a minimum of 2 years of pertinent experience

Gerontological Specialization in Community Counseling

Setting: Community agency serving older individuals (50 years of age or older)

Clock hours

Practicum: 100 hours, with 40 hours of direct contact working with older persons

Internship: 600 hours, with 240 hours of direct contact with clients (which is defined as older persons, their families, and caregivers)

Supervisor: NCC certification or a degree in a counseling-related field; a minimum of 2 years of pertinent experience

Career Counseling Specialization in Community Counseling

Setting: A setting where career counseling regularly occurs

Clock hours

Practicum: 100 hours, with 40 hours of direct client contact, including work with clients seeking career counseling

Internship: 600 hours, with 240 hours of direct client contact

Supervisor: NCC certification or degree in a counseling-related field; a minimum of 2 years of pertinent professional experience

Mental Health Counseling

Setting: A setting where the applicant is provided with opportunities to develop skills relevant to the practice of clinical mental health counseling

Clock hours

Practicum: 100 hours, with 40 hours of direct client contact, including individual and group work

Internship: 900 hours, with a minimum of 360 hours of direct client contact

Supervisor: 300 clock hours of supervised experience must be under the direct supervision of a qualified mental health professional (certified clinical mental health counselor [CCMHC], licensed psychologist with clinical credentials, or licensed clinical social worker)

Marriage and Family Counseling or Therapy

Setting: A setting that regularly offers counseling services to couples and families

Clock hours

Practicum: 100 hours, with 40 hours of direct client contact, including work with couples and families
Internship: 600 hours, with 240 hours of direct client contact, defined as work demonstrating systematic approaches and completed primarily with couples and families

Supervisor: NCC certification or degree in a counseling-related field; a minimum of 2 years of pertinent clinical experience

School Counseling
Setting: A school setting
Clock hours
Practicum: 100 hours, with 40 hours of direct client contact
Internship: 600 hours, with 240 hours of direct service, including but not limited to individual counseling, group work, developmental classroom guidance, and consultation

Supervisor: NCC certification or degree in a counseling-related field; or certified school counselor; a minimum of 2 years pertinent counseling experience

Student Affairs Practice in Higher Education, College Counseling Emphasis
Setting: Postsecondary setting
Clock hours
Practicum: 100 hours, with 40 direct service
Internship: 600 hours, with 240 hours of direct service, including but not limited to individual counseling, group work, career planning, consultation, student advisement, leadership training, and developmental programming

Supervisor: NCC certification or counseling-related degree; 2 years of pertinent counseling experience

CACREP also accredits counselor education programs at the Ph.D. and Ed.D. levels. The statement applicable to practicum and internship at this level is as follows:

Doctoral students are required to participate in a supervised advanced practicum in counseling. Doctoral students are required to complete at least one doctoral level counseling internship of 600 clock hours. The 600 hours may include supervised experience in clinical settings, teaching, and supervision and includes most of the activities of a regularly employed professional in the setting. (CACREP, 2001)

For more specific information on CACREP certification, contact
Council for Accreditation of Counseling and Related Educational Programs
5999 Stevenson Ave.
Alexandria, VA 22304-3302
Tel: (703) 823-9800, ext. 301
Fax: (703) 823-0252
E-mail: cacrep@aol.com
**Counseling Psychologists**

The APA has for several years accredited programs for the preparation of counseling psychologists at the doctoral level only. In addition, the APA has developed guidelines and requirements for accrediting doctoral-level internships. The trend is for employers and state licensing boards to require completion of an APA-approved internship or its equivalent. Accreditation criteria for practicum and internship are as follows:

*Setting*
- **Practicum:** Setting not specified but implied within a clinical setting
- **Internship:** An APA-approved site or its equivalent

*Clock hours*
- **Practicum:** 300 hours (division is currently considering raising this to 600 hours), 150 of these hours in direct service, with 75 hours of formally scheduled supervision
- **Internship:** Full-time for 1 academic or calendar year or part-time for 2 years, with a minimum of 2 hours per week for formally scheduled individual supervision

*Supervisor:* Psychologists who are licensed or certified in the state in which they work and who have completed an internship in the appropriate specialty; collaborative work with representatives of other disciplines is desirable


**Marriage and Family Therapists**

The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) was established by the American Association for Marriage and Family Therapy (AAMFT) and is recognized by the Department of Education as the accrediting agency for clinical training programs in marriage and family therapy. The major statements pertaining to practicum and internship are as follows:

Clinical training must integrate didactic with clinical material. A practicum is a part time clinical experience completed concurrently with didactic course work. A practicum typically results in 5–10 direct client contact hours per week; it also includes such activities as supervision, staff meetings, community relations, and record-keeping. …

Students are required to spend a minimum of 500 face to face hours with clients. Although students may treat individual clients, at least 50 percent of the 500 direct client hours must be completed with couples or families physically present in the therapy room. (COAMFTE, 1991)
In summary form, the following requirements are applicable:

**Setting:** Clinical setting implied

**Clock hours**

*Supervised clinical practice:* 500 direct contact hours, 50% of which are with couples or families; a minimum of 100 hours of supervision required

*Internship:* Required at the doctoral level, 9 to 12 months of no fewer than 30 hours per week comprising at least 500 client contact hours and a minimum of 100 hours of supervision

*Supervisor:* AAMFT-approved supervisor or supervisor in training; alternate supervision may be approved by AAMFT on a case-by-case basis

### Rehabilitation Counselors

The Council on Rehabilitation Education (CORE) is the accrediting body for master’s degree programs in rehabilitation counseling. The statements pertinent to practicum and internship are as follows:

Practicum includes instructional experiences (audio-video tapes and individual and group interaction) in a setting which emphasizes basic rehabilitation counseling skills with diverse disabled populations. In states that have specific practicum supervision requirements for licensure, the program will conform to these requirements.

Internship is a fieldwork experience in sites that provide rehabilitation counseling services to individuals with disabilities appropriate to the mission of the program. Experiences should include those that increase sensitivity to diverse populations. Supervisory requirements should comply with state licensure requirements. Supervisors should provide an average of one hour per week of individual supervision or 1½ hours per week of group supervision (maximum ten students per group). Interns should perform the tasks required of an employed rehabilitation counselor at the agency. (Council on Rehabilitation Counseling Certification, 2005)

In summary the requirements for this accreditation are as follows:

**Setting:** An agency or organization or facility that provides services to disabled persons from diverse populations

**Clock hours**

*Practicum:* 100 hours of supervised rehabilitation counseling experience, with 40 hours of direct service to persons with disabilities; an average of 1 hour per week of individual supervision or 1.5 hours per week of group supervision (minimum of 10 persons) by faculty or a qualified individual
**Internship:** 600 hours of applied experience in a rehabilitation agency or program with, 240 hours of direct service to individuals with disability; weekly on-site supervision by a certified rehabilitation counselor and an average of 1 hour per week of individual supervision or 1.5 hours per week of group supervision (maximum 10 persons) by faculty or a qualified individual

**Supervisor:** Certified rehabilitation counselor or rehabilitation counselor education faculty member

For more information regarding CORE requirements and standards, contact Council on Rehabilitation Education, Inc.
1835 Rohlwing Road, Suite E
Rolling Meadows, IL 60008
Tel: (850) 878-4966
Fax: (850) 878-3183
E-mail: patters@polaris.net

---

**Pastoral Counselors**

The American Association of Pastoral Counselors (AAPC) was founded in 1963 in response to the need for leadership and standards for involvement of religious organizations in mental health care (Hollis & Dodson, 2000, p. 22). Institutions can be accredited as training centers, service centers, or both. As of June 1998, 5 training programs and 28 service center training programs were certified. The following are statements that relate to supervised practice:

Educational preparation for certified membership should contribute to the pastoral counselor’s training and develop a broad experience related to the understanding of people. This should take place in a setting in which both the school and practical situation are in mutual relation. …

375 hours of pastoral counseling together with 125 hours of supervision of that counseling are required with one third of such supervision to have been with an AAPC approved Center for training in Pastoral Counseling or from a Diplomat of the Association. (AAPC, 2000, p. 7)

In summary form, the following requirements are applicable:

**Setting:** Not specified

**Clock hours:** 375 hours of pastoral counseling, with 125 hours of supervision

**Supervisor:** One third of supervision hours with AAPC-approved center or a diplomat of the association

For more information on AAPC requirements, contact American Association of Pastoral Counselors
9504 A. Lee Highway
Counselor Certification

Certifying bodies, in addition to accreditation organizations, are stipulating what is expected within the preparation program and are being more specific about practicum and internship experiences. As a result, counselors in training need to keep abreast of what these requirements and trends are, so as to obtain those practicum and internship experiences that will enable them to be eligible for the certificate(s) they may seek after graduation.

The National Board of Certified Counselors (NBCC) awards the designation of NCC to those applicants who successfully fulfill certain criteria. Applicants graduating from CACREP-accredited programs may sit for the National Counselor Examination (NCE) immediately upon completion of their master's degree program. Those who successfully pass the examination are awarded NCC status. Effective July 1, 1995, applicants graduating from programs that are not CACREP approved will need to complete a minimum of 48 semester or 72 quarter hours of graduate study in the practice of counseling or a related field. This requirement includes a master's degree from a regionally accredited counselor preparation program incorporating course work in eight identified areas and a minimum of two academic terms (3,000 hours) of supervised field experience in counseling at the post-master's level under the weekly supervision (100 hours face-to-face) of an NCC (or the equivalent as determined by the board), in addition to successful completion of the NCE.

The NBCC also awards specialty counseling credentials in career, gerontological, school, clinical mental health, and addictions counseling. The requirements for specialty certification require additional course work and experience, as well as the passing of an examination. With any NBCC specialty certification, the requirements for the general practice certification (NCC) are a prerequisite.

The Academy of Clinical Mental Health Counseling provides and implements standards for the independent practice of mental health counseling. Applicants for the certified clinical mental health counselor (CCMHC) credential must meet or exceed academy requirements in each of the following four areas: (a) academic preparation, (b) clinical experience and supervision, (c) examination, and (d) clinical skill. Preapplication requirements include completion of a CACREP-accredited 60-semester-hour master's degree program in mental health counseling or its equivalent and 2 years of clinical practice after the master's degree. This experience must include 3,000 hours of direct client contact in a supervised clinical setting. Applicants also must have documented 100 hours of face-to-face supervision by an academy-approved supervisor.
The Commission on Rehabilitation Counseling Certification (CORE) provides and implements standards for qualification as a certified rehabilitation counselor (CRC). Applicants who have completed a CORE-accredited master's degree program are eligible to take the CRC examination upon graduation. Those who have graduated from a rehabilitation master's degree program that is not fully accredited by CORE must complete a 600-hour internship supervised by a CRC and/or additional acceptable employment experience under the supervision of a CRC. Those not supervised by a CRC must complete a provisional supervision contract in addition to passing the examination.

The American Association for Marriage and Family Therapy (AAMFT) provides a professional credential titled clinical member status. The eligibility criteria require a master's or doctoral degree in marriage and family therapy or an equivalent degree, including a supervised practicum as defined by the AAMFT. In addition, a minimum of 2 years of post-master's degree experience in clinical work supervised by an AAMFT supervisor or supervisor in training is required. This post-master's degree experience includes 1,000 hours of face-to-face marriage and family therapy with individuals, couples, and families and at least 200 hours of supervision completed concurrently.

The AAPC has established certification guidelines delineated by membership status in the organization. Categories of membership are member, fellow, and diplomat. Each category of certified membership requires explicit levels of education and supervised practice, an oral examination, and an endorsement from a recognized religious body.

(The above-listed requirements for the five certification bodies was summarized and adapted from Hollis and Dodson [2000].)

**Implications**

Implications for students in preparation are becoming quite clear. In addition to requirements for practicum and internship as stipulated by the counselor preparation program, each student will need to give careful consideration to (a) the selection of sites where practicum and internship are experienced, (b) a review of required supervisory credentials, (c) a determination of the amount of supervisory time available, (d) the identification of a site that provides opportunities to work with one's chosen population, and (e) an understanding of the credentialing requirements of organizations with which the student hopes to affiliate.

As they develop, professional certification requirements are increasingly being established with more rigorous requirements than the standards set for graduation from the training program. Thus, when planning their future careers in counseling or psychotherapy, students must look beyond their college or university requirements and consider trends in certification by professional organizations, as well as state licensure and certification requirements.
Summary

In this chapter, we provided the basic definitions, phases, and standards that apply to students in a variety of counseling and psychology training programs. Specific attention was directed to the CACREP guidelines, and the APA, COAMFTE, CORE, and AAPC guidelines were also presented. In addition, the specific requirements of counselor certification were discussed. We hope that the information in this chapter will help the beginning counseling student to gain a fuller understanding of the professional training and certification requirements for counseling specializations.

Suggested Readings


References

Chapter 2

Preparation for Practicum

In chapter 1, we reviewed the definitions and summarized the professional standards that are currently influencing the applied practice components (practicum and internship) of counseling programs.

Chapter 2 has as its focus the process of selecting and negotiating a practicum site placement. The specific guidelines of the Council for Accreditation of Counseling and Related Educational Programs (CACREP) and the American Psychological Association (APA) are followed in the format presented. Students are reminded that adaptations in the format may need to be made to meet the particular and specific needs of the training institution and the internship site.

Guidelines for Choosing a Practicum Site

The practicum placement is often the first opportunity that the student has to gain the experience of working with a client population. Prior counseling experience usually occurs in prepracticum or practicum lab situations with volunteers or peer counseling interactions. Many counselor preparation programs offer the student an opportunity to have some say in determining practicum placement. In addition, the practicum student may be able to gain experience at more than one practicum site. The university practicum supervisor has the responsibility for deciding where the practicum student might gain the best experience for professional development based on his or her personal needs and professional goals. The practicum site personnel are responsible for selecting practicum students who they believe will benefit from the placement and who will best serve the needs of the site’s client population. The practicum student can select sites of interest to him or her and then, with the university supervisor’s approval, visit and apply for placement. A list of approved sites may be provided by the student’s training program.

The selection and application process of practicum sites can be confusing and at times overwhelming. To alleviate some of the frustration, the student might
find it helpful to have a set of criteria in mind. The criteria should stem from the following categories:

- professional staff and supervisor
- professional affiliations of the site
- professional practices of the site
- site administration
- training and supervision values
- theoretical orientation of the site and supervisor
- client population

In the sections that follow, we list questions pertaining to these categories that may be helpful in determining selection of a practicum site.

**Professional Staff and Supervisor**

- What are the professional credentials of the site personnel?
- Do their credentials meet the standards of your professional credentialing body?
- What are the educational backgrounds and ranges of experience of the director and practicum supervisor?

We noted in chapter 1 that the professional organization to which the practicum student aspires to be a professional member often requires the therapeutic supervisor to hold the appropriate credentials to perform such supervision. For example, a mental health professional who does not have the recommended and necessary credentials may not be recognized as an appropriate supervisor. Each practicum student benefits from a supervisor who holds the credentials specific to his or her profession. For example, a person who is training to be a school counselor is best served by a supervisor who has the experience and credentials appropriate for a school setting (National Certified School Counselor [NCSC]). Similarly, school psychologists are trained in assessment, placement, and program planning of students, and although the trainee benefits from understanding the role of the school psychologist, he or she must realize that the primary responsibility is to meet the developmental needs of schoolchildren. Thus the skills learned from supervision should be appropriate to the standards set by the trainee professional organization.

**Professional Affiliations of the Site**

- In what association does the site hold membership?
- Does the site hold approval of national certifying agencies?
- What is the reputation of the site among other organizations?
- Does the site have affiliations or working cooperations with other institutions?
Memberships in state and national certifying agencies carry with them specific guidelines for the operation and management of agency activities. Agencies that accredit counseling facilities include the Commission on Accreditation of Rehabilitation Facilities (CARF), the International Association of Counseling Services (IACS), and the Joint Commission on Accreditation of Health Care Agencies (JCAHO). Generally, agencies and schools that carry state and national certification have rigid standards for membership. Similarly, the reputation of the site among other organizations and cooperations with other institutions are important considerations for prospective practicum students. A practicum experience carried out at a well-recognized and respected facility provides the student with the best chance of having a worthwhile and professionally fulfilling experience.

**Professional Practices of the Site**

- Does the site follow the ethical guidelines of the appropriate profession (APA, American Counseling Association [ACA], etc.)? Which code(s) of ethics is followed?
- What kinds of resources are available to personnel (e.g., library, computer programs, ongoing research, professional consultation)?
- What are the client procedures, treatment modalities, and staffing and outreach practices? How are these practices consistent with the goals of the practicum?
- How are client records kept?
- What are the policies and procedures regarding taping (audio/video) and other practicum support activities?
- Do the staff members regularly update their skills and participate in continuing education?
- Are continuing education opportunities available to interns?

Each professional organization requires that professionals have a minimum number of hours to maintain their credentials as a practicing member of the organization. If professionals do not adhere to these requirements, they may be excluded from the profession and not permitted to practice under the auspices of the title they once had. If the professional is licensed and does not satisfy these requirements and continues to practice as a professional, he or she may be considered to be in a breach of legal duty and obligation. Membership in professional organizations carries with it the requirement that members adhere to the ethical guidelines of that organization. Agencies may follow several ethical guidelines depending on the specialization of the therapist; for example, counselors would follow the ethical guidelines established by the ACA, whereas psychologists would adhere to those of the APA.

It is also important for beginning practicum students to consider the types of resources available to personnel at the site. A well-managed school or agency should have a variety of resources available for the professional use of the intern.
In addition, it is important for the practicum student to understand the practices used by the site for the treatment of clients, as well as the site’s staffing and outreach practices. Knowledge of these essential practices is of the utmost importance to the beginning practicum student, as familiarity with the agency’s or school’s operation enables the student to make a positive transition from the educational environment to the practicum. The student should consider whether these practices are consistent with his or her goals. The degree of fit experienced by the practicum student is directly related to the consistency between the site practices and the student’s particular goals.

The student should also make certain that he or she is familiar with the site’s procedures and guidelines regarding keeping client records. Ethical guidelines mandate specific practices to ensure the confidentiality and security of client records. Particular attention should be paid to the policies regarding audio- and videotaping of clients and other support activities. Practicum students need to have a complete understanding of the site’s procedures regarding taping to ensure that appropriate ethical guidelines are followed.

It is important, as well, for the practicum student to consider what opportunities exist for continuing education. Continual professional development is essential for the maintenance of quality treatment for clients. The student can determine if the site encourages this level of professional development by determining if the staff members who work at the site regularly update their skills through continuing education. It is our experience that well-run placement sites provide students with in-service programming and permit them to participate in programming that is provided for full-time staff members.

**Site Administration**

- What resources, if any, are directed toward staff development?
- Does the administration of the site provide in-house funds for staff training or reinforcement for college credit?
- How is policy developed and approved (corporate structure, board of directors, contributions)?
- How stable is the site? (Does the site receive hard money or soft money support? What is the length of service of the director and staff? What is the site’s mission statement or purpose?)

Staff development and training are typically provided for employees in most cases. Thus it is important for the practicum student to consider this aspect of site administration. The availability of such opportunities should be an important preplacement consideration, and a lack of staff development and training opportunities for the staff should be weighed carefully in relation to the other opportunities provided.

Another important consideration in determining if a site is a good fit is the method of policy development and approval. Knowledge of how policy is
developed helps the student to understand the chain of command within the organization. In addition, the stability of the site is obviously of critical concern to the student. A quality practicum experience assumes that the student is placed in an established, well-organized, financially stable environment that effectively addresses the needs of its client population.

**Training and Supervision Values**

- What values regarding training and supervision are verbalized and demonstrated?
- Will the supervisor be available for individual supervision for a minimum of 1 hour per week?
- Will practicum students have opportunities for full participation?
- Are adequate facilities available for practicum students?

Practicum students should be aware that there are a variety of approaches to the supervision of counseling practice. Although there is no evidence to support claims that one training methodology is better than another, student practitioners may have experience with a particular method of supervision that they prefer. For example, if the counseling sessions are taped, some supervisors prefer to listen to the entire tape, whereas others may ask the practicum student to review the tape and make available several sequences of communication that exemplify work well done or work the student has questions about. Other supervisors may demand that students present work that demonstrates the area of competency that they consider essential to good counseling practice. For example, practicum students may be asked to demonstrate counseling skills of support and confrontation, an ability to work with thematic patterns that consistently surface in the client dynamics, and a capacity to relate to content and process and/or the facilitation of client decision making.

It is essential that the student and the supervisor reach a mutual understanding of their values regarding training and supervision. The roles, duties, and obligations of both parties should be clarified prior to the beginning of the practicum experience. In addition, it is important to recognize that individual supervision is a time-consuming process and that to address the task adequately the supervisor must have the time, motivation, and conscientiousness to do so. CACREP guidelines, as well as many program and university guidelines, insist on a minimum of 1 hour of individual supervision per week. If the site is a popular and busy one, however, the supervisor may have many supervisees and so may not be able to find the time needed for this work. It is important to remember when selecting a site that weekly supervision is a requirement, not an option, in most training programs.

It is also important to determine the level of participation that practicum students will have at the site, as well as whether the available facilities are adequate for the student’s particular needs. Generally, interns are provided with full participation in the professional activities of the site. However, participation is
determined on the basis of the student’s training and background and the agency’s ability to provide adequate supervision for those activities.

**Theoretical Orientation of the Site and Supervisor**

What are the special counseling or therapy interests of the practicum supervisor(s)? Many therapists are eclectic in their counseling practice, but many may also favor a particular therapeutic approach over others. Thus if students are exposed to a supervisor who favors and supports the use of a particular theoretical approach, it requires the student to have grounding in the knowledge base of that theory. Naturally the advantage of having one approach to counseling is that it affords the student the opportunity to become more proficient at it. Also, in mastering one approach, the student begins to develop a clearer, firmer professional identity regarding his or her goals in counseling practice. Conversely, the disadvantage of learning only one approach is that it limits the student’s opportunity to measure other approaches that could be more in keeping with his or her own style and personality.

**Client Population**

- What are the client demographics in the placement site?
- Who is the client population served? For example, is it a restricted open or group? Is the age range narrow or wide? Are clients predominately of a low, middle, or high socioeconomic level?
- Do clients require remedial, preventive, and/or developmental services?
- What opportunities exist for multicultural counseling?
- Does the site and its professional staff demonstrate high regard for human dignity and support the civil rights of clients?

Multicultural counseling skills have become increasingly important for the practicing school and mental health counselor. Constantine and Gloria (1999) noted that studies have suggested that interns’ “exposure to multicultural issues may increase sensitivity to and effectiveness with racially and ethically diverse clients” (p. 43). In addition, the demographic composition of clients is and will be of a different nature than it was a few years ago. Statistics from the U.S. Bureau of Census (1992) indicated the multicultural makeup of the country will be quite different in the year 2050 than it is today. Between 1992 and 2050, the African-American population in the United States will grow from 32 million (or 12% of the population) to 62 million (16%). In the same period, the Hispanic population will grow from 24 million (9%) to 81 million (21%), and the American Indian, Eskimo, and Aleut population will grow from 2.2 million (0.8%) to 41 million (11%), whereas the non-Hispanic White population will grow at a much slower rate, from 191 million (75%) in 1992 to 202 million (52%) in 2050.
The counseling skills required of an effective multicultural counselor have been explored by Sue, Arredondo, and McDavis (1992). Some of the common beliefs and attitudes of culturally skilled counselors follow.

- They demonstrate sensitivity to clients’ cultural heritage and how it affects their lives.
- They are comfortable with culturally different clients, are aware of their own negative emotional reactions, respect clients’ religious or spiritual beliefs, recognize minority community efforts, and value bilingualism.
- They understand how their own cultural heritage may contribute to their biases and how racism may affect their personality and work.
- They have information about the group with whom they are working, the institutional barriers that client population may face, minority family structures, and pertinent discriminatory practices in the community.
- They can seek consultative help, are familiar with relevant research, and are actively involved with clients outside the counseling setting. They can send and receive verbal and nonverbal communications accurately and appropriately.

It is clear that many counselor education programs have responded to these multicultural imperatives by examining their curricular offerings and reacting positively to the need for multicultural training. For programs that have not met the challenge, Ponterotto, Alexander, and Grieger (1995) developed a multicultural competency checklist that counseling training programs can use to examine their comprehensiveness. This checklist includes 22 items organized around six major themes. A summary of the list follows:

**Minority representation:** African Americans, Hispanic Americans, Asian Americans, Pacific Islanders, and Native Americans constitute at least 30% of students, faculty, and program support staff.

**Curricular issues:** Multicultural issues are incorporated into all facets of the curriculum.

**Counseling practice and supervision:** All trainees have caseloads with at least 30% minority clients.

**Research:** At least one faculty member is interested in multicultural research.

**Student and faculty competency evaluation:** Multicultural issues are included in exams.

**Physical environment:** Multicultural art is actively displayed in the campus environment.

**Negotiating the Practicum Placement**

The step after the initial stage of identifying, reviewing, and selecting a practicum site is negotiating the practicum placement. This process works best when
a written exchange of agreement is made so that all parties involved in the Practicum and Internship placement understand the roles and responsibilities involved. With regard to written contracts, most counselor or psychology training programs have developed their own practicum contracts. Specific guidelines followed in the practicum are stated as part of the agreement. Guidelines identified by national certifying agencies are often used or referenced in formalizing the practicum placement. For example, in APA practicum guidelines, statements concerning the development of the following capacities are included:

- an understanding of and commitment to professional and social responsibility as defined by statutes of the ethical code of the profession (see chapter 6 in this text);
- a capacity to conceptualize human problems;
- an awareness of the full range of human variability among the dimensions of ethnicity, subculture, affirmative action, race, religion, sexual preferences, handicap, sex, and age;
- an understanding of one’s own personality and biases and of one’s impact on others in professional interaction;
- skills in relevant interpersonal interactions such as systematic observation of behavior, interviewing, psychological testing, psychotherapy, counseling, and consultation; and
- an ability to contribute to current knowledge and practice.

In CACREP guidelines, the development of individual and group work skills is recommended. Statements related to practicum activities include the following:

- experience in individual and group interactions (at least one fourth of the direct service hours should be in group work);
- opportunities for students to counsel clients representative of the ethnic, lifestyle, and demographic diversity of their community and for familiarizing students with a variety of professional activities other than direct service work; and
- use of a variety of professional resources such as measurement instruments, computers, print and nonprint media, professional literature, and research.

State licensing boards and state departments of education also may provide guidelines and set standards regarding field experience activities and minimum number of hours required in practicum. In addition, university and program faculty may have their own guidelines for practicum. We suggest that the counselor preparation program identify the guidelines that it follows and include the guidelines in the practicum contract.

An example of a formal contract between the university and the practicum field site is included in the Forms section at the end of the book for your review. The sample Letter to Practicum Site Supervisor (Form 2.1) and the Practicum
Contract (Form 2.2) can be adapted to the specific needs of your training program. The contract includes a statement concerning guidelines to be followed, conditions agreed on by the field site, conditions agreed on by the counselor or psychologist preparation program, and a list of suggested practicum activities.

**Role and Function of the Practicum Student**

The practicum student who has been accepted to the field site will start as a novice in the counseling profession, but at the same time will be a representative of his or her university training program and of other student counselors and psychologists. The student is working in the setting as a guest of the practicum site. The site personnel have agreed to provide the student with appropriate counseling experiences with the clientele they serve.

Although the individual freedom of the student counselor is understood and respected, the overriding concern of the site personnel is to provide role-appropriate services to the client population. The role of the practicum student is to obtain practice in counseling or psychotherapy in the manner in which it is provided in the practicum setting. The student counselor is expected to adhere to any dress code or expected behaviors that are existent at the field site. In some instances, the student may disagree with some of the site requirements; however, the role of the student counselor is not to change the system but to develop his or her own abilities in counseling practice.

Occasionally tension or conflict may arise between the practicum student and site personnel. Although such events are upsetting to all involved, these events can provide an opportunity for the practicum student to develop personal insight and understanding into the problem. After all, practicum placement is real-life exposure to the realities of the counseling profession; however, should the tension or conflict persist, the student intern should consult with the faculty liaison who is available to assist the student in the process of understanding his or her role within the system and to facilitate the student's ability to function in the setting.

A Student Profile Sheet (Form 2.3) and a Student Practicum/Internship Agreement (Form 2.4) have been included in the Forms section. The profile sheet guides the documentation of the student counselor's academic preparation and relevant experience prior to practicum. The agreement form demonstrates the formal agreement being entered into by the student. Both of the forms can be a valuable resource for the site supervisor in assessing the student intern's preparation for practicum.

**Concepts in Practicum**

Concepts about the practicum experience influence the kinds and range of activities, the process of supervisory and consulting interaction, and the nature of the
teaching contract between the practicum student and the university professor. Such concepts provide the foundation of this beginning experiential component of professional training. Although no one right way exists to develop a conceptual framework for practicum, the university professor has the obligation to articulate the framework employed by the university in practicum education.

The remainder of this section presents a typical conceptual framework for practicum training that can be used as a reference for the student who is beginning the practicum experience. Some concepts may be used as a point of departure for discussion, and others may be modified and/or challenged.

1. **Practicum is a highly individualized learning experience in which the practicum student is met at a level of personal development, knowledge, and skills that he or she brings to the experience.** Initially, it is crucial for the practicum to focus on the present developmental level of the student, leaving other concerns for future consideration. In any group of practicum students, one can expect a wide range of talents, unique perspectives regarding human behavior, and varying capacities to perceive accurately and engage emotional content. One of the functions of the practicum professor is to role-model the optimal facilitative behavior to support the growth and development of students to increase the level of role functioning. The process parallels the counseling or therapy process. Students should remember that they and their practicum professor are partners in learning. As a partner in learning, the professor demonstrates respect for the student as a learner with a unique set of meanings, capable of accepting responsibility for his or her own learning. The student has the responsibility to bring in material about his or her counseling practice and to share any concerns related to practice.

2. **Practicum facilitates an understanding of one’s self, one’s biases, and one’s impact on others.** Counseling or therapy is an enterprise that has as its core the assumption that individuals develop by a process of differentiating self from others. It may be viewed as the process of bringing more of one’s experiences into the conscious domain. It may be viewed as being able to determine what is “my problem” and what is “your problem.” It may be viewed as challenging patterns of thinking that are inappropriately imposed on experience. Whatever the theoretical orientation of counseling, practicum students must personally examine those qualities about themselves that may enhance or impede their counseling. The practicum experience provides the setting in which personal qualities related to counseling practice can be examined. Therefore, activities that help clarify the counselor’s own feelings, values, background, and perceptions—in the context of the counseling work—are an appropriate and necessary part of the practicum experience. Focus in practicum is directed not only toward determining the dynamics and personal meaning of the client, but also on examining how the student views others and how his or her behaviors and attitudes affect others. Similarly, the internship experience, which this book discusses in later
chapters, provides the student with the opportunity to examine his or her own values in an on-the-job environment.

3. Each member of a practicum group is capable of and responsible for facilitating professional growth and development. The practicum experience usually involves dyadic, individual, and group activities designed to enhance the quality of counseling practice. Frequently, peer counseling and peer feedback are selected training activities. Group interaction provides a forum in which practicum members can give and receive feedback regarding counseling techniques, interventions, and concerns. Each member of the practicum participates not only as a student but also as someone who is able to provide valuable feedback to others regarding the impact particular responses and attitudes can have on clients. The practicum professor is not the only one among many whose responses can be examined. As a result, the practicum experiences tend to be more member centered than leader centered. High-quality interaction and feedback are essential for professional growth and development.

4. Practicum is composed of varied experiences, which are determined by the particular needs, abilities, and concerns of the practicum group members and the practicum professor. Two conditions contribute to the variety and kinds of learning activities that are part of the practicum. First, program considerations about how the practicum is placed within the overall curriculum are influential. In some programs, basic skills training is an integral part of practicum. In other programs, skill training activities are included in other courses. The Marywood University program, for example, has skill training activities very early in the student’s program; there, a course titled Applied Practice I focuses on basic skill development activities. Conversely, some training programs require more hours of field experience, with a practicum that is followed by an extensive internship, whereas in other training programs the practicum is the only experiential component of the program.

A second condition influencing the kinds and variety of experiences included in practicum is the unique needs that the student brings to the group. These may be personal concerns of the student or concerns related to client needs brought back to the practicum class for discussion. Therefore, practicum, by necessity, must have a flexible and formative approach to planning learning activities.

All practicum experiences provide a wide range of activities, such as

- structured skill development exercises;
- unstructured group interactions;
- role playing;
- peer counseling, taping, and critiquing;
- selected assigned reading regarding special problem areas;
- personal journals;
- videotaped and observed counseling sessions;
feedback activities;
preparation of case presentations; and
supervisor–supervisee interaction.

5. *Supervision and consultation form the central core of the practicum experience.* Intensive supervision and consultation allow the student to move more quickly toward competence and mastery in counseling or therapy. The supervisory interaction can help make the student more aware of obstacles to the counseling process so that they can be examined and modified. The supervisory interaction also provides the opportunity for the role-modeling process to be strengthened. The student can usually expect both intensive one-on-one supervision and regular group supervision to be standard parts of the practicum. These supervision sessions not only provide skill development opportunities but also implicitly guide the counselor or therapist toward an openness and appreciation for collegial supervision and self-supervision.

6. *Self-assessment by student and practicum professor is essential.* Because of the flexible and formative nature of the practicum, regular reviews need to be made of how the practicum experiences are meeting the learning needs of the student. Self-assessment allows the student to be consciously aware of and responsible for his or her own development and also provides information for the practicum professor in collaborating on appropriate practicum activities.

   The format for this self-assessment can be structured in a variety of ways. One possible approach is to identify current strengths, current weakness, and current concerns or confusions. The assessment should be defined as concretely as possible. Once the assessment of current functioning is described, a contract can be made with the practicum professor and other group members regarding the particular aspects of counseling practice that have been targeted by the student for improvement or development. Ongoing self-assessment is needed to give direction to the practicum.

7. *Evaluation is an integral and ongoing part of the practicum.* Evaluation in practicum provides both formative information and summative information about how the counseling development goals of the student and professor are being reached. A variety of activities support this evaluation process. Among these are self-assessment, peer evaluations, regular feedback activities, practicum site supervisor ratings, and audio- and videotape review. The attitude from which evaluations are offered is characterized by a “constructive” coaching perspective rather than a “critical” judgmental perspective.

**Suggested Course Requirements**

The practicum has been described as a complexly interwoven set of counseling practices and support activities designed to promote skill development, personal
Preparation for Practicum

growth, and application of knowledge on the part of the trainee. Activities entered into at the practicum site are directed and monitored by the practicum supervisor based on site opportunities and student abilities. During the first week of activities, the usual emphasis is on orientation to site policies and practice, observation of professional activities, and review of client records and treatment plans in preparation for counseling practice. As the practicum progresses through the several weeks, activities gradually are expanded to include intake interviewing, testing, client orientation, coleading, and contacts with referral sources. Individual counseling sessions are increased, group work and outreach are added, and the student participates in in-service and case conferences. In the final weeks of practicum, experiences include individual and group counseling or psychotherapy, as well as consultation and referrals.

In addition to actual site-based counseling practice, course requirements are designed to support and monitor the evolving skill and knowledge base of the student.

**Class Meetings**

Practicum students generally are expected to spend a minimum of 2 hours per week in a group session with the university supervisor. This time can include didactic and experiential activities and usually includes some form of review of counseling practices. A typical class session would begin by addressing any specific concerns a student has regarding his or her practicum. After immediate concerns are addressed, the student counselor might engage in any of the following:

- role-playing situations encountered at the practicum site,
- listening to and discussing various recorded counseling sessions,
- reviewing previously taped counseling sessions made by class members,
- discussing theories and techniques related to common problems and client work of concern to group members, and/or
- giving and receiving feedback with peers regarding personal and professional interaction.

**Counseling Sessions**

In addition to attending the weekly group meetings, students are required to engage in a specified number of counseling sessions each week. These may be both individual and group sessions. Early in the course, the typical amount of required sessions would be fewer in number than at the middle and final phases of the course. A specific minimum number of sessions are required for the course. One-time sessions with clients, as well as a continuing series of sessions with a client, are specified.
**Individual Supervision Sessions**

The student is expected to spend 1 or more hours per week throughout the length of the course in individual supervision with the site and/or university professor. These meetings provide an intensive focus on the student’s counseling and therapy work and are often regarded by the student counselor as one of the most valuable practicum components. Typical questions addressed during individual sessions include the following:

- Is the student counselor providing a facilitative interaction with the client?
- Is the student counselor accurately perceiving the needs of the client?
- What are the goals of the counseling process?
- Is the student counselor able to facilitate the desired growth or change in the client?
- What obstacles may be present in the counseling work?

**Tape Critiques**

If at all possible, practicum students are expected to tape (audio and video) their counseling sessions. Of course, permission must be obtained from each client prior to taping the session. The practicum site will have policies and procedures that must be followed to ensure the informed consent of the client (see Form 3.1 and Form 3.2 in the Forms section at the end of the book). The tapes are to be submitted weekly to the practicum and/or university supervisor to allow for sharing and evaluation. Each tape should be reviewed by the student prior to submission and be accompanied by a written or typed critique. The critique should consist of the following information:

- student counselor’s name;
- client identification and number of the session with the client;
- a brief summary of content of the session and intended goals;
- comments regarding the positive aspects of the counselor’s work during the session;
- comments regarding areas of the counselor’s work that need improvement;
- concerns, if any, regarding client dynamics; and
- plans for further counseling with the client.

Every effort must be taken to ensure the confidentiality of the counseling session. When the tape has been reviewed and discussed with the student counselor, appropriate notes regarding counseling performance can be made for the student’s records. The tape(s) should then be erased.

Blank copies of a Tape Critique Form (Form 2.5) have been included in the Forms section for students’ use. This form can be used to guide the student in developing a written review and analysis of taped therapy sessions. An example of a completed Tape Critique Form is provided in Figure 2.1.
TAPE CRITIQUE FORM

Jean Smith

Student counselor’s name

Tom D. Session #3

Client I.D. & no. of session

Brief summary of session content:
Tom is citing his reasons for being unhappy in his job situation and reviewing all he has attempted to do to make his boss like and respect his work.

Intended goals:
1. To help Tom explore all of his feelings and experiences related to the job situation.
2. To help Tom be able to assess and value his work from his own frame of reference rather than his boss’s.

Comment on positive counseling behaviors:
I was able to accurately identify Tom’s feelings and to clarify the connection of feelings to specific content.

Comments on areas of counseling practice needing improvement:
I sometimes became hooked into Tom’s thinking about how to please his boss and would work with him about problem solving in this way.

Concerns or comments regarding client dynamics:

Plans for further counseling with this client:
Continue weekly appointments; move focus back on to the client and try to identify other ways he worries about approval.

Tape submitted to _________________________________________

Date ______________________________________________

Figure 2.1. Sample completed Tape Critique Form (Form 2.5).
In addition the following sample syllabus is provided to give the counselor-in-training a representative example of a practicum syllabus. Students should note that additional and varied requirements may be included in the practicum experience.

(University Letterhead)

(Sample Practicum Syllabus)

Coun: 543-545

Applied Practice II
Fall 2007

Instructor: (Name)  ___________________________________________
E-mail address:  ______________________________________________
Office phone:  _______________________________________________

Office Hours: (Location)  _______________________________________
MON_______ TUES_______ WED_______ THUR_______ FRI_______

Course Objectives:

- To develop expertise in counseling, consulting, and guidance experiences
- To demonstrate an understanding of various counseling theories, techniques, and procedures
- To establish a facilitative and ongoing relationship with clients and on-site staff
- To demonstrate competence and skill in record keeping and case reporting
- To provide a safe place to share information and reactions about your practicum experiences
- To define your professional identity as a counselor
- To develop skills in identifying and monitoring your strengths and growth edges
- To identify and examine personal issues that affect your work with clients
- To improve understanding of how multicultural issues interact with counseling practice
- To demonstrate an understanding of the ethical standards of the ACA with respect to counseling practice

Required Reading:


The instructor may assign additional readings over the course of the semester.
Students must be familiar with and adhere to the American Counseling Association’s Code of Ethics.

**Course Grading:**

- 325 – 350 points = A
- 315 – 324 points = A–
- 304 – 314 points = B+
- 290 – 303 points = B
- 280 – 289 points = B–
- 269 – 279 points = C+
- 255 – 268 points = C

**Course Requirements:**

- A minimum of 100 hours of on-site counseling and counseling-related activities is required. The 100 hours must include a minimum of 40 hours of direct contact with clients and 60 hours administrative or “counseling-related activity” hours. *Time spent in individual or in-group supervision with the course instructor will not count toward completion of the remaining 60 hours of “counseling-related activities.”*
- A minimum of eight taped counseling sessions with at least two clients (for a total of 16 tapes) is required. Students may meet individually with clients only once per week. You will need a high-quality audio or video recorder. Please make sure your tapes are high quality. They *must be audible* for you to receive credit for them. You must have a signed release for each client you are working directly with prior to seeing them the first time (if client is a minor, you must also have a parent or guardian signature).
- A minimum of 1 hour per week of individual supervision with a Marywood University counseling supervisor is required. The supervision may be based on your audiotapes or direct observation with your supervisor. Additional formal meetings or other exchanges such as e-mail, instant messaging, phone conversations, and so on can be requested if needed.
- A minimum of 2 hours per week of group supervision with other counseling students (formal class meeting times) is required.

**Course Assignments:**

- *Classroom participation and attendance* (50 points): All students will be expected to actively and thoughtfully participate in group supervision and class activities. Furthermore, students will be expected to complete any assigned readings. Students who miss or are tardy will receive a deduction in their grade. Students, for any reason, who miss more than two group meetings will not receive a passing grade. If you must miss a class or supervision session, please notify your instructor by e-mail or phone in
advance. Announcements regarding schedule delays or closing of the university because of adverse weather conditions will be posted on the university home page. This course is a supervised practicum experience offered in several seminar sections, which focus on case conceptualization, client assessment and evaluation, oral and written case reporting, and evaluation of counseling performance in individual intervention. Each section of the practicum uses a concerns-based developmental group supervision model. In this model, students are expected to openly discuss current cases and professional issues in counseling, develop their own personal counseling styles, and participate in giving and receiving feedback. The methods of instruction will include minilectures, demonstrations, group discussions, and student presentations.

**Precourse self-assessment** (50 points): Write a four- to five-page paper assessing yourself as a developing counselor. The paper should include the following: (a) your strengths as a counselor in training, (b) growth edges, (c) learning goals for the semester, (d) countertransference issues requiring additional examination and work, and (e) theoretical orientation(s) to which you subscribe. The paper must be written using APA style. The precourse self-assessment paper is due ________________.

**Clinical case presentation** (100 points): Each student will make one major case presentation; due dates will be assigned on ______________. An oral description of the client should briefly address the information listed below. Focus of the presentation should be on discussing the unanswered questions. For the case presentation, students must bring the most recent videotaped session cued for viewing. The case presentation should be 20 to 30 minutes. Furthermore, a case conceptualization paper summarizing the information below will be submitted to the instructor on the assigned due date. The paper should be 8 to 10 pages in length. Grading will focus on relevance of content, depth of reflection, and quality of writing. The paper must be written using APA style.

I. Intake Summary
   A. Demographic Description
   B. Presenting Problems

II. Background Information
   A. History Relevant to Treatment
   B. Family Background
   C. Work and/or Education History
   D. Medical History
   E. Previous Mental Health Treatment

III. Clinical Impressions
   A. *DSM-IV* Diagnosis (full diagnosis)
   B. Description of Client Functioning
a. Cognitive
b. Affective
c. Behavioral
d. Physical Appearance
e. Strengths

C. Client–Therapist Match
   a. Dynamics Related to Gender, Race, Sexual Orientation, Age, Religion, etc.
   b. Countertransference Issues

IV. Treatment
   A. Conceptualization of Client’s Difficulties (integrate theory)
   B. Client’s Progress to Date (i.e., number of sessions, mutually agreed-on treatment goals, interventions that were effective and ineffective)
   C. Unanswered Questions (rank order most salient first)

Postcourse self-assessment (50 points): Write a four- to five-page paper reassessing yourself since you have completed your first semester as a counselor trainee. Please make note of areas that are similar to and different from your initial assessment. The paper should include the following: (a) strengths, (b) growth edges, (c) learning goals for future training, (d) countertransference issues, and (e) theoretical orientation(s). The paper must be written in APA style. The postcourse self-assessment paper is due _______________.

Logs and evaluation forms (100 points): This grade is dependent on the student’s (a) timely completion of all required paperwork and (b) demonstration of professional behaviors consistent with the expected competencies of this course and the ACA Code of Ethics.
   - Log sheets (see attached): To be completed weekly and submitted to the instructor every 5 weeks
   - Student evaluation from site supervisor (Form 12.2): To be completed at 50 and 100 hours (two times)
   - Student site evaluation (Form 12.5): To be completed at the conclusion of the practicum experience

For Students With Disabilities:

Any student with a documented disability may request an adjustment to course requirements and procedures. To request such an adjustment, you should contact (Name) _____________________________ (Phone) ________________________.

Reprinted with the permission of Megan Curcianni, M.S., NCC, LPC, and Janet Muse-Burke, Ph.D.
Department of Psychology and Counseling, Marywood University, Scranton, PA
Documenting Practicum Activities

Because of national accreditation guidelines and state and university requirements, it is necessary procedure to document both the total number of hours spent in practicum and the total number of hours spent in particular practicum activities. Two forms are provided here for your use in tracking the time spent at various activities. The Weekly Schedule (Form 2.6) can be used in two ways. First, the weekly schedule can be used by the practicum student and the practicum supervisor to plan the activities in which the student will participate from week to week. Second, the weekly schedule can be used to document the weekly activities the student has already completed. An example of a completed Weekly Schedule is provided in Figure 2.2.

The Monthly Practicum Log (Form 2.7) provides a summary of the number of hours of work per month in which the student has engaged within the activity categories established in the practicum contract. A file should be kept for each student for the duration of the practicum experience.

Summary

The information presented in this chapter is designed to assist the counseling student in the process of choosing and negotiating a practicum placement. Several aspects of the practicum experience need to be carefully considered by the student prior to making this important decision, and to this end, we have provided a number of questions that warrant attention. It is recommended that the student make an effort to answer these questions to understand fully the benefits and disadvantages of a particular site. Additional information concerning the role and function of the practicum student has been discussed. Finally, sample forms have been included for use in preselection planning and preliminary practicum activities, which the student can adapt to fit his or her own needs.
### WEEKLY SCHEDULE

<table>
<thead>
<tr>
<th>Day of week</th>
<th>Location</th>
<th>Time</th>
<th>Practicum activity</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mon</td>
<td>UUC</td>
<td>9–10</td>
<td>Intake interview</td>
<td>1st session</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10–11</td>
<td>Individual counseling</td>
<td>Problem exploration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11–12</td>
<td>Ind. supervision</td>
<td>Reviewed reports</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1–3</td>
<td>Group counseling</td>
<td>Tape critique</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3–4</td>
<td>Report writing</td>
<td>Eating disorder</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4–5</td>
<td>Testing</td>
<td>Group 3rd session</td>
</tr>
<tr>
<td>Wed</td>
<td>University</td>
<td>6–8</td>
<td>Group supervision</td>
<td>Case presentation</td>
</tr>
</tbody>
</table>

Student counselor name ________________________________________________

Week beginning _______________________ Ending ______________________

---

**Figure 2.2. Sample completed Weekly Schedule (Form 2.6).**
Suggested Readings


References

Chapter 3

Practicum Content Issues

Initial Interaction With the Client

This chapter is designed to assist the practicum student or intern in assessment and data-gathering activities conducted prior to and during the initial stages of counseling.

The following materials have been included to assist the school counselor, the mental health counselor, and the psychologist in preparation for their initial interaction with a client. It is our belief that issues such as initial interaction with the client, interview structure, interview assessment, note-taking strategies, and progress recording are essential elements that foster the development of a counseling relationship.

The gathering of client data, a requirement of both practicum and internship experiences, can be a difficult task for the beginning counselor or therapist. The amount of client data required, as well as the manner in which data are to be recorded in a client’s file, varies from institution to institution and from agency to agency. The practicum student or intern must first gain a working knowledge of the procedures that are followed and then develop his or her own framework and style of gathering data. Thus care must be taken to ensure that the student can process and report data in a clear and concise manner. Generally, most settings have developed clear guidelines for obtaining and recording client data. A review of these guidelines is the first step in the preparation for counseling practice.

Establishing a Therapeutic Alliance

The formation of a relationship with the client is one of the most critical initial steps in the therapeutic process. Essentially it involves the processes of developing trust, caring, and respect between the counselor and client to foster the client’s motivation to actively engage in the work of therapy. The building of
rapport and collaboration begins the moment the counselor and client make contact. Seligman (2001) suggested the following procedures and intervention that can promote rapport and development of a positive therapeutic alliance:

- Facilitate the client’s effort to begin treatment by providing a role induction, clarifying how treatment will proceed and the roles of clinician and client.
- Support the client decision to seek treatment, discuss the importance of taking the first step and the courage involved in seeking treatment.
- Establish and consistently follow session’s guidelines (i.e., starting times, client participation, homework assignments, etc.).
- Discuss the client expectations for treatment, encouraging realistic hope for positive change.
- Develop with the client goals that reflect those hopes and expectations.
- Understand and value the client’s perspective on the world.
- Communicate warmth, genuineness, and empathy for the client’s concerns.
- Demonstrate congruence and genuineness in verbal and nonverbal messages.
- Engage the client in the therapeutic process and begin to engender both a sense of empowerment in the client and confidence in treatment.
- Acknowledge and build on successes and support networks that the person has already established. (pp. 30–31)

**Initial Contact, Structuring, and Assessment**

The initial contact with the client is a crucial point in the process of counseling. It provides the counselor with the opportunity to begin structuring the therapeutic relationship. Methods of structuring vary according to the counselor’s style and theoretical approach to counseling. Ivey (1999) suggested a five-step process for the purpose of structuring the interview.

1. **Rapport and structuring** is a process that has as its purpose the building of a working alliance with the client to enable the client to become comfortable with the interviewer. Structuring is needed to explain the purpose of the interview and to keep the sessions on task. Structuring informs the client about what the counselor can and cannot do in therapy.
2. **Gathering information, defining the problem, and identifying client’s assets** is a process designed to assist the counselor in learning why the client has come for counseling and how he or she views the problem. Skillful problem definition and knowledge of the client’s assets gives the session purpose and direction.
3. **Determining outcomes** enables the counselor to plan therapy based on what the client is seeking in therapy and to understand, from the client’s viewpoint, what life would be like without the existing problem(s).
4. **Exploring alternatives and confronting incongruities** is the purposeful behavior on the part of the counselor to work toward resolution of the
client's problems. Generating alternatives and confronting incongruities with the client assists the counselor in understanding more about client dynamics. 5. *Generalization and transfer of learning* is the process whereby changes in the client's thoughts, feelings, and behaviors are carried out in everyday life by the client.

In a similar fashion, Hutchins and Cole (1992) suggested that structuring includes explaining to the client the kinds of events that can be expected to occur during the process of helping, from the initial interview through the termination and follow-up process. Some aspects of structure will occur in the initial phase of the helping process (initial greeting; discussion of time constraints, roles, confidentiality), whereas other aspects of structure may take place throughout the remainder of the helping process (clarification of expectations and actions both inside and outside the interview setting) (Hutchins & Cole, 1992, p. 50).

Weinrach (1989) suggested as a valuable time saver the method of committing to the process of structuring. Weinrach advocated basing written guidelines on the issues most frequently raised by clients as well as the areas in which potential conflicts may exist. These guidelines include the following common client inquiries:

- How often can I expect to have an appointment?
- How might I reach you if I feel that it is necessary?
- What happens if I forget an appointment?
- How confidential are therapy sessions?
- What do I do in an emergency?
- When is it time to end treatment?
- What are my financial responsibilities?
- How often do I obtain reimbursement from insurance?

According to Hutchins and Cole (1992), structuring such concerns in writing makes for effective and efficient use of time and stimulates open discussion about a variety of concerns before they become problems. They further suggested that the helper think through the kinds of things that are expected to happen in the helping process. The following list of questions can serve as a starting point (Hutchins & Cole, 1992):

- Am I personally and professionally qualified to work with this client who has this particular concern or problem in this specific situation?
- Do I understand the unique personal, educational, social, and cultural aspects of this client enough to be able to assist in this situation?
- Should the client be referred to a helping professional who has more or different specialized training or skills, such as a licensed psychologist, social worker, marriage and family specialist, drug and alcohol specialist, or other type of helping professional?
- What is my role of helper in this relationship?
What kinds of things do I see as important variables in the helping process?
What kind of behavior (thoughts, feelings, actions) do I expect of the client both in and outside of the therapy setting?
What kind of commitment do I expect of the client in terms of time, work, and responsibility?
What about confidentiality in the setting in which I work?
What legal, ethical, and moral considerations must be considered before working with this client? (p. 46)

These critical questions asked by the helper, counselor, or therapist, coupled with printed client concerns, can serve as a valuable asset and aid in the structuring of clinical interviews in the counseling or therapy process.

In summary, structuring the relationship entails defining for the client the nature, purpose, and goals of the therapeutic relationship. Critical to the structuring process is the therapist's ability to create an atmosphere that enables the client to know that the therapist is genuine, sincere, and empathic in his or her desire to assist the client. The therapist, in the process of preparing the client for data-gathering and assessment activities, employs attending skills and facilitative therapeutic techniques.

It is important to remember that interviewing with the client and having the client engage in other assessment procedures are only part of the overall assessment process in counseling and psychotherapy. Equally significant are the therapist’s own mental and covert actions that take place during the process. The therapist typically gathers great amounts of information from clients during this stage of counseling or therapy. However, data are of little or no value unless the counselor or therapist can integrate and synthesize the information.

The task of counselors and therapists during the assessment process requires that they know what information to obtain and how to obtain it and that they have both the ability to put it together in some meaningful way and the capacity to use it to generate clinical hunches. Such hunches, or hypotheses about client’s problems, can then allow counselors and therapists to develop tentative ideas for planning and treatment (Cormier & Cormier, 1998, p. 147).

**Assessment Activities**

The following is a description and format of typical assessment activities occurring prior to and during the initial stages of counseling or therapy.

**Obtaining Authorizations**

The first step in the process of counseling and psychotherapy is obtaining the appropriate authorizations prior to the start of therapy. Examples of authorization forms are included for this purpose in the Forms section at the end of the book.
The Parental Release Form (Form 3.1) should be used when initiating counseling with a child, and the Client Release Form (Form 3.2) should be used when initiating counseling with adults. These forms should be adapted for use by the practicum student or intern according to the specific field site and university requirements.

**Obtaining Information From the Client and Others**

A practical method to use in obtaining client information from others (parents, therapists, teachers) is to develop a form that focuses on the specific information to be obtained. For example, the Initial Intake Form (Form 3.3) tends to include medical, psychological, and psychiatric data that focus on the history and outcomes of treatment. Similarly, background and developmental data are obtained for the purpose of assessing the acuteness or chronicity of current complaints. The Initial Intake Form is designed to provide the counselor or therapist with initial identifying data about the client. Data about the client are obtained directly from the client at the initial interview.

In contrast, the Elementary School Counseling Referral Form (Form 3.4; Short Form 3.4a) and the Secondary School Counseling Referral Form (Form 3.5) tend to include more data regarding the academic history of the student and his or her behavior and demeanor in school. Aptitude, attitude, and interest toward school are typically stressed. The Elementary and Secondary School Counseling Referral Forms are designed to obtain appropriate precounseling data from sources other than the client. Typically, the professional making a referral of a school-age child for counseling or therapy is asked to describe and comment on his or her perceptions and knowledge of the pupil’s current academic and social standing.

**Assessing the Client’s Mental Status**

Mental health exams are rarely used by school counselors. However, mental health counselors, counseling psychologists, and professional counselors routinely use the mental status examination. These professionals often find that to gain insight into the client’s presenting condition, the client’s mental status may need to be assessed. The mental status examination is, therefore, designed to provide the therapist with signs that indicate the “functional” nature of the person’s psychiatric condition. In addition, the mental status examination can be used to provide the therapist with a current view of the client’s mental capabilities and deficits prior to and during the course of treatment and is beneficial to the beginning therapist who lacks the clinical experience to quickly assess the client’s mental status.

Many formats can be used to obtain a client’s mental status. However, all formats have common areas that are routinely assessed. The following is an example of items fairly typically covered, with an explanation of material generally included. The Mental Status Checklist (Form 3.6) can be used by students in evaluating these common areas of assessment.
**Mental Status Categories of Assessment**

**Appearance and behavior:** This category consists of data gathered throughout the interview so that the person reading the narrative has a “photograph” of the client during the interview. Data is gathered by direct observation of the client. To assess a client’s appearance and behavior, the counselor or therapist might employ the following questions: Is the client’s appearance age appropriate? Does the client appear to be his or her stated age? Is the client’s behavior appropriate to the surroundings? Is the behavior overactive or underactive? Is the behavior agitated or retarded? Is speech pressured? Retarded? Logical? Clear? What is the content of speech?

**Attention and alertness:** Is the client aware of his or her surroundings? Can the client focus attention on the therapist? Is the client highly distractible? Is the client scanning the environment? Is he or she hypervigilant?

**Affect and mood:** What is the quality of the client’s affect? Is the client’s affect expressive? Expansive? Blunted? Flat? Agitated? Fearful? Is the client’s affect appropriate to the current situation?

**Perception and thought:** Does the client have false ideas or delusions? Does the client experience his or her own thoughts as being controlled? Does the client experience people putting thoughts in his or her head? Does the client experience his or her own thoughts being withdrawn or taken away? Does the client feel that people are watching him or her? Out to get him or her? Does the client experience grandiose or bizarre delusions?

**Sensory perception:** Does the client hallucinate? Does the client experience visual, auditory, tactile, or gustatory false perceptions?

**Orientation:** Is the client oriented to persons, place, and time? Does the client know with whom he or she is dealing? Where he or she is? What day and time it is?

**Judgment:** Can the client act appropriately in typical social, personal, and occupational situations? Can the client show good judgment in conducting his or her own life?

**Attention and concentration:** Does the client have any memory disturbance?

**Recent memory:** Can the client remember information given a few minutes ago? (For example, give the client three or four things to remember and ask him or her to repeat back after several minutes.)

**Long-term memory:** Can the client remember or recall information from yesterday? From childhood? Can the client concentrate on facts given to him or her?

**Abstract ability:** Can the client recognize and handle similarities? Absurdities? Proverbs?

**Insight:** Is the client aware that he or she has a problem? Is he or she aware of possible causes? Possible solutions?
**Recording Psychosocial History**

The Psychosocial History (Form 3.7) is a part of the pretherapy assessment procedure employed by most community mental health agencies. The psychosocial history provides the therapist with a comprehensive view of the client over time. In most instances, the psychosocial history provides more data than the initial intake and is invaluable in examining the acuteness or chronicity of the client’s problem. Specific attention is directed toward the milestones or benchmarks in the client’s developmental history that have implications for the treatment strategies to be employed in therapy.

**Monitoring and Evaluating the Client’s Progress**

Monitoring of the client in therapy is a continuous process, beginning with the initial contact with the client and ending with therapy termination. Monitoring is an invaluable asset that allows the therapist to understand how the goals and objectives of the therapy are being met as well as the direction of the therapy and the progress taking place during therapy.

An adaptation of Kanfer and Schefft’s (1988, pp. 255–256) discussion of monitoring and evaluating client progress suggests doing the following:

- monitoring and evaluating the client’s behavior and environment session to session;
- assessing improvement in coping skills by noting the client’s use of the skills in relation to behavior and other activities;
- evaluating any change in the client’s status or in his or her relationships to significant others that resulted from treatment;
- utilizing available data to review progress, to strengthen gains, and to maintain the client’s motivation for completing the change process;
- negotiating new treatment objectives or changes in methods or the rate of progress if the evidence suggests the need for such changes; and
- attending to new conditions that have been created by the client’s change and that may promote or defeat further change efforts.

Furthermore, Kanfer and Schefft (1988, pp. 257–258), in examining treatment effectiveness, suggested that therapists ask themselves the following questions:

- Are the treatment interventions working? The therapist should note the client’s progress with respect to therapeutic objectives, as compared to the baseline data gathered at the beginning of treatment (initial assessment).
- Have other treatment targets been overlooked? By monitoring other changes and emergent problems, the therapist obtains cues for the necessity of renegotiating treatment objectives or treatment methods.
Is the therapeutic process on course? Individuals differ with regard to their rate of progress; plateaus may occur at various phases of therapy, and these need to be scrutinized.

Are subsidiary methods needed to enhance progress or to handle newly emerged problems? Are there gaps in the client’s basic skill level that is needed to execute the program?

Are the client’s problems and the treatment program being formulated effectively? Monitoring and evaluating by the therapist in process is crucial to successful treatment. Consultation with other professionals and colleagues is recommended.

**Building a Client Folder**

A valuable adjunct to the monitoring process is the building of a folder for the client. When carefully and properly developed and organized, the file folder serves as a quick reference to review session-by-session developments and is used to assist in the summarization and evaluating of the course of treatment.

In addition, practicum students and interns will also be responsible for contributing to the file folder maintained by the agency, institution, or school in which the counseling sessions are held. Each student needs to understand the format employed, the kinds of information desired, and the kinds of information to be added to the folder. To maintain effective client confidentiality, students must understand the specific security procedures to be followed in the agency or school. The procedures to be followed will depend on the policies of the agency, institution, or school.

The practicum or internship course objectives, in addition to those held by the agency, institution, or school in which the counseling is done, may necessitate a separate folder for the university supervisor. This folder should be maintained by the counselor and his or her school or agency site supervisor and should be available for review.

The purposes for having a separate folder for each client may include the following:

- to teach the student counselor the procedures for building a folder for each client similar to what will be required on the job,
- to foster organizational skills in the managing of critical client data,
- to assist the student counselor in gathering pertinent data applicable to the treatment of the client,
- to provide a vehicle for reviewing client progress made during the course of treatment,
- to summarize the therapeutic activities that have been performed by the counselor and client,
to serve as a format for the preparation and dissemination of summative data of all counseling activities that have taken place prior to and during treatment, and

to provide essential information when writing a termination report regarding the client.

The development of a client folder, whether for meeting overall professional development or for continuing information to the agency, is an invaluable asset to the practicum and internship student.

**Client Record Keeping**

The keeping of client records is essential to the maintenance of professional and ethical practice. What is contained in a client's record is oftentimes unclear to the beginning counselor. Piazza and Baruth (1990) suggested that client records fall within six distinct categories. The following is a summary and adaptation of those categories.

1. **Identifying or intake information:** This category includes essential, personal, and demographic data about the client (name, home address, phone number, date of birth, sex, race, ethnic origin, education, and marital status).
2. **Assessment information:** This is information gathered for the purpose of designing effective treatment plans consisting of five domains of assessment.
   a. **Psychological assessment:** This assesses the client's degree of lethality, motivation for therapy, emotional functioning and reasoning, intellectual and verbal capacity of benefiting from therapy, and client history of therapy.
   b. **Social family assessment:** This assesses the current level of the client's functioning in the family and community.
   c. **Vocational and educational assessment:** This is a review of the place, type, and duration and suitability of employment or educational placement.
   d. **Drug and alcohol use and assessment:** This assesses past and current use of these substances as well as use by family and friends.
   e. **Health assessment:** This is an assessment of recent medical and surgical procedures and current use of medications.
3. **Treatment plan:** This is an identification of the purpose and the anticipated results of counseling that includes a statement of the problem, goal(s) of counseling and intervention, and steps to reach the goal(s).
4. **Case notes:** Case notes are the documentation of progress and the log of activities in the sessions, including goals for the session, evaluation of the session (goal attainment), clinical impressions by the counselor, and an action plan for the next session.
5. **Termination summary:** This is a resume of the course of treatment and outcomes and a synopsis of assessment, identified problems and interventions, and outcomes of identified problems.

6. **Authorization and consent for treatment:** This includes any additional information on each client (test results, phone contacts, etc.).

**Case Notes**

The taking of case notes is an invaluable aid to the counselor in training. Case notes assist the counselor in focusing his or her attention on the most salient aspects of the counseling session. In addition, case notes can help the counselor to review significant developments from session to session. Presser and Pfost (1985) developed what they called the Individual Psychotherapy notes form. The focus of the form centers on documenting specific therapeutic processes. The following is an overview of each of the sections of that form.

1. **Brief summary of the session:** This provides an overview of the session. Entries in this section are more likely to be in the form of a sequential account of major events within the session.

2. **Client:** This section (and the following two) forces a clear distinction between database and inference. The first subsection is for recording of observations of the client’s verbal and nonverbal behavior. The therapist’s hypotheses and inferences are listed in the second subsection. The labeling of this subsection (interpretations and hypotheses) stresses both the speculative nature of such inferences as well as the desirability of further testing of hypotheses.

3. **Therapist:** This section encourages the therapist to examine his or her own behavior, retaining the distinction between database and inference. The use of this category appears likely to increase the therapist’s awareness of his or her own behavior and to alter the therapist’s perspective so that he or she is both subject and object. Information in this section also provides a basis for an evaluation of the internal consistency of a therapist’s behavior, correspondence to a theoretical stance, and the evolution of a therapist’s own style.

4. **Therapist–client interaction:** This section focuses on interpersonal rather than intrapersonal dynamics. Because of the process orientation, this section can be extremely valuable in its illumination of dynamics. It is especially helpful in assisting the therapist to conceptualize both parties’ behavior patterns and the degree to which these are specific or nonspecific to this relationship.

5. **Problem addressed:** This section refers to problems that were addressed in the session. This is consistent with the form’s focus on the analysis of events within a single session, but it links these events within the subsequent section.

6. **Progress made:** The assumption behind this section is that client progress is the ultimate criterion by which therapy is assessed. This section highlights the need for client movement for the continuation of the therapeutic relationship.
7. Plans: The focus of attention shifts from the present to a future focus to provide continuity from one session to the next. The section encourages the therapist to plan alternatives and conceptualize issues with which the client may need to deal with in the future.

8. Other: This may be considered an overflow section. It contains data that needs to be recorded, such as test data, correspondence, and so on.

**Processing Interview Notes***

During or following each counseling/therapy session, the student counselor or therapist will make notes of what occurred and comments regarding plans for therapy. With the large number of clients seen in therapy and seen over an extended period of time, the Therapy Notes (Form 3.8), completed after each session with a client, are an invaluable asset to the therapist. Therapy notes can serve various purposes:

1. The record of the interview can reacquaint the therapist with what previously had transpired in contacts with the client as well as with his or her initial impressions of the therapeutic process.
2. Notes may serve as valuable aids in helping a different therapist (who may take over therapy) understand the development nature of the previous contacts and gain knowledge of the kind of treatment or methods employed in therapy.
3. Of great importance is the value that therapy notes have as a self-learning device. Notes can help us check ourselves against the tendencies to be restricted, preoccupied, or sterile in our contacts. Notes have a decided utility in promoting a greater psychological understanding of behavior as displayed by a variety of clients. Much of this understanding can be accomplished by attempting to put into words our impressions and our feelings about the client, which too often have been implicitly assumed.
4. Therapy notes can be utilized in research and evaluation. They can aid in acquiring more ideas regarding the process itself and movement by the individual when certain techniques are used.
5. Notes serve to keep each helping professional in contact with the work and methods of other professional workers in the same settings. The knowledge gained from what others are doing may serve to help one become more flexible and productive in therapy.
6. Notes may serve as a type of legal protection for professionals because reference to these notes clarified what actually occurred during the course of therapy.

---

Thus, note-taking is an essential process in counseling. It has been our experience that very few programs have explicit training in note-taking as part of the training program. All too often, it is assumed that everyone can take clinical notes. Furthermore, knowing what kind and type of content notes should be recorded requires considerable experience and training in its own right.

The counseling literature provides little assistance and few guidelines for proper note-taking, yet the demand to document our accountability is an ever-present reality. The following article by Presser and Pfost has been included because it focuses on the clinician’s attention to certain aspects of the counseling or psychotherapy process, enabling him or her to record appropriate case notes.

Learning to Write Case Notes Using the SOAP Format*

Susan Cameron & Imani Turtle-Song

This article discusses how to use the SOAP (subjective, objective, assessment, and plan) note format to provide clear and concise documentation of the client’s continuum of care. Not only does this format allow for thorough documentation, but it also assists the counselor in representing client concerns in a holistic framework, thus permitting practitioners, paraprofessionals, and case managers to better understand the concerns and needs of the client. Whereas counselors working in certain settings (e.g., public funded institutions) are likely to find various recommendations in the article easy to incorporate into their current practice, the authors believe the recommendations are relevant to a wide array of settings.

In every mental health treatment facility across the country, counselors are required to accurately document what has transpired during the therapeutic hour. Over the course of the past few years, the importance of documentation has gained more emphasis as third-party payers have changed the use of documentation “from something that should be done well to something that must be done well” (Kettenbach, 1995, p. iii). In this era of accountability, counselors are expected to be both systematic in providing client services (Norris, 1995) and able to produce clear and comprehensive documentation of those clinical services rendered (Scalise, 2000). However, in my experience (i.e., first author), both as director of a mental health clinic and as one who audits client records, few counselors are able to write clear or concise clinical case notes, and most complain of feeling frustrated when trying to distinguish what is and is not important enough to be incorporated in these notes. Well-written case notes provide accountability, corroborate the delivery of appropriate services, support clinical decisions (Mitchell, 1991; Scalise, 2000), and, like any other skill, require practice to master. This article discusses how to accurately document rendered services and how to support clinical treatment decisions.

When counselors begin their work with the client, they need to ask themselves, What are the mental health needs of this client and how can they best be met? To answer this question, the counselor needs an organized method of planning, giving, evaluating, and recording rendered client services. A viable method of record keeping is SOAP noting (Griffith & Ignatavicius, 1986; Kettenbach, 1995). SOAP is an acronym for subjective (S), objective (O), assessment (A), and plan (P), with each initial letter representing one of the sections of the client case notes.

SOAP notes are part of the problem-oriented medical records (POMR) approach most commonly used by physicians and other health care professionals. Developed by Weed (1964), SOAP notes are intended to improve the quality and continuity of client services by enhancing communication among the health care professionals (Kettenbach, 1995) and by assisting them in better recalling the details of each client’s case (Ryback, 1974; Weed, 1971). This model enables counselors to identify, prioritize, and track client problems so that they can be attended to in a timely and systematic manner. But more important, it provides an ongoing assessment of both the client's progress and the treatment interventions. Although there are alternative case note models, such as data, assessment, and plan (DAP), individual educational programs (IEP), functional outcomes reporting (FOR), and narrative notes, all are variations of the original SOAP note format (Kettenbach, 1995).

To understand the nature of SOAP notes, it is essential to comprehend where and how they are used within the POMR format. POMRs consist of four components: database, problem list, initial plans, and SOAP notes (Weed, 1964). In many mental health facilities, the components of the POMR are respectively referred to as clinical assessment, problem list, treatment plan, and progress notes (Shaw, 1997; Siegal & Fischer, 1981). The first component, the clinical assessment, contains information gathered during the intake interview(s). This generally includes the reason the client is seeking treatment; secondary complaints; the client’s personal, family, and social histories; psychological test results, if any; and diagnosis and recommendations for treatment (Piazza & Baruth, 1990). According to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO, 2000), with special populations, as in the case of a child, the clinical assessment contains a developmental history; for individuals who present with a history of substance abuse, a drug and alcohol evaluation is included.

From the clinical assessments, a problem list (second component) is generated, which includes an index of all the problems, active or inactive, derived from the client’s history. Problems are defined as either major areas of concern for the client that are not within the usual parameters when compared with others from the client’s same age group or as areas of client concern that can be changed through therapeutic intervention (JCAHO, 2000). As problems are identified, they are numbered, dated, and entered on the list, and this problem list is attached to the inside cover of the client’s file, for easy reference. As the identified problems are resolved, they are dated and made “inactive.”
The third component of the POMR is the treatment plan, which is a statement of the possible therapeutic strategies and interventions to be used in dealing with each noted problem. Treatment plans are stated as goals and objectives and are written in behavioral terms in order to track the client’s therapeutic progress, or lack thereof (Kettenbach, 1995). The priority of each objective is expressed either as a long- or a short-term goal and corresponds to the problems list. Long-term goals are the expected final results of counseling, whereas short-term goals are those that can be accomplished within the next session or within a very limited time frame.

The fourth component is the progress notes, which are generally written using the SOAP format and serve to bridge the gap between the onset of counseling services and the final session. Using the SOAP format, the counselor is able to clearly document and thus support, through the subjective and objective sections, his or her decision to modify existing treatment goals or to fine-tune the client’s treatment plan. For example, if a client who has been in counseling for 4 months experiences the unexpected death of a loved one or is diagnosed with a potentially life threatening health problem, by recording this information in the progress notes the counselor provides justification/documentation for the sudden shift in therapeutic direction and is immediately able to address what is now the more pressing issue for the client.

The SOAP note format also provides a problem-solving structure for the counselor. Because SOAP notes require adequate documentation to verify treatment choices, they serve to organize the counselor’s thinking about the client and to aid in the planning of quality client care. For example, if the plan is to refer the client to a domestic violence group for perpetrators, the subjective and objective sections of the SOAP notes would chronicle the client’s history of physical aggression and violent behaviors, thus supporting the treatment direction. Although the SOAP format will not assure good problem-solving skills, it does provide a useful framework within which good problem solving is more likely to occur (Griffith & Ignatavicius, 1986). Thus, the intent of SOAP notes is multifaceted: to improve the quality and continuity of client services, to enhance communication among mental health professionals, to facilitate the counselor in recalling the details of each client’s case, and to generate an ongoing assessment of both the client’s progress and treatment successes (Kettenbach, 1995; Weed, 1968).

**Using the SOAP Note Format**

There are four components to SOAP notes. Data collection is divided into two parts: (S) subjective and (O) objective. The subjective component contains information about the problem from the client’s perspective and that of significant others, whereas the objective information consists of those observations made by the counselor. The assessment section demonstrates how the subjective and the objective data are being formulated, interpreted, and reflected upon, and the plan section summarizes the treatment direction. What follows is a description
of the content for each section of the SOAP notes, a brief clinical scenario with an example of how this approach might be written, and a short list of “rules” to remember when writing case notes.

**Subjective**

The data-gathering section of the SOAP format is probably the most troublesome to write because it is sometimes difficult to determine what constitutes subjective and objective content. The subjective portion of the SOAP notes contains information told to the counselor. In this section the client’s feelings, concerns, plans or goals, and thoughts, plus the intensity of the problem(s) and its impact on significant relationships in the client’s life are recorded. Pertinent comments supplied by family members, friends, probation officers, and so forth can also be included in this section. Without losing accuracy, the entry should be as brief and concise as possible; the client’s perceptions of the problem(s) should be immediately clear to an outside reader.

It is our opinion that client quotations should be kept to a minimum. First, when quotations are overused they make the record more difficult to review for client themes and to track the effectiveness of therapeutic interventions. Second, when reviewed by outside readers such as peer review panels, audit committees, or by a client’s attorney, the accuracy and integrity of the notes might be called into question. According to Hart, Berndt, and Caramazza (1985), the number of verbatim bits of information an individual is able to retain is quite small, 2 to 20 bits, with most estimates at the lower end. Other research suggests that information retained in short-term memory is only briefly held, 30 seconds to a few minutes at best, unless a very conscious effort is made to retain it (see Anderson & Bowers, 1973; Bechtel & Abrahamsen, 1990). This means that at the close of an hour-long counseling session, unless a quote is taken directly from an audio- or videotaped session, it is very unlikely that someone could accurately remember much information verbatim. In short, given this research, it seems a prudent practice to keep the use of quotations to a minimum.

If and when quotations are used, the counselor should record only key words or a very brief phrase. This might include client words indicating suicidal or homicidal ideation, a major shift in the client’s well-being, nonconforming behaviors, or statements suggesting a compromise in the type and quality of care the client will receive, such as when a client is unwilling or fails to provide necessary information. Quotations might also be used to document inappropriately aggressive or abusive language toward the counselor that seems threatening. Comments suggesting a potentially lethal level of “denial” should be documented. For instance, a father accused of shaking his 6-month-old daughter when she would not stop crying says, “I only scared her when I shook her, I didn’t hurt her.” Because the child’s life might be in jeopardy should the father repeat his behavior, his comments need to be recorded. For example, the counselor might write: “Minimizes the effects of shaking infant daughter. States, ‘I only scared her.’"
It is also important to document statements that suggest the client may be confused as to time, place, or person, or if he or she is experiencing a sudden change in mental status stability or level of functioning. For example, if during the session the client suddenly seems disoriented and unable to track the conversation, this information needs to be noted. To assess the client’s mental status, the counselor might ask the client the name of the current U.S. president. If the client responds incorrectly, this discrepancy should be noted in quotations within the client file.

Finally, a client’s negative or positive change in attitude toward counseling should be chronicled because it serves as a marker in the assessment of counseling effectiveness. A statement such as “Therapy is really helping me put my life into perspective” could be written as “Reports ‘therapy is really helping.’” This information is especially important if the client was initially resistant to therapy. The goal is not to give a verbatim account of what the client says, but rather to reflect current areas of client concern and to support or validate the counselor’s interpretations and interventions in the assessment and plan sections of the SOAP notes.

Given the open nature of client files to other health care professionals and paraprofessionals (e.g., certain managed care personnel), the counselor should be mindful of the type of client and family information included in the client’s record. Unless insidious family life and political, religious, and racial views are the focus of the problem(s), secondary details of such views should be omitted (Eggland, 1988; Philpott, 1986). The counselor should not repeat inflammatory statements critical of other health care professionals or the quality of services provided because these comments may compromise the client’s care by antagonizing the staff or might be interpreted as malicious or damaging to the reputation of another. Rather than using the names of specific people when recording the session, the counselor might use general words such as a “fellow employee” or “mental health worker,” and briefly and concisely report the themes of the client’s complaint(s). In addition, the names of others in the life of the client are typically unnecessary to record. It is important to remember that the names the client mentions during counseling (with few exceptions) are not a legitimate part of the client’s care and, as such, should be omitted from the client’s file.

The content in the subjective section belongs to the client, unless otherwise noted. For brevity’s sake, the counselor should simply write, “reports, states, says, describes, indicates, complains of,” and so on, in place of “The client says.” For instance, instead of writing, “Today the client says ‘I am experiencing much more trouble at home—in my marriage—much more marital trouble since the time before our last session,’” the counselor might write “client reports increased marital problems since last session.” Also, because it is implied that the counselor is the writer of the entry, it is not necessary for the counselor to refer to himself or herself, unless it is necessary to avoid confusion.
**Objective**

In a word, the “objective” portion of the SOAP format should be factual. It is written in quantifiable terms—that which can be seen, heard, smelled, counted, or measured. There are two types of objective data: the counselor's observations and outside written materials. Counselor observations include any physical, interpersonal, or psychological findings that the counselor witnesses. This could consist of the client's general appearance, affect and behavior, the nature of the therapeutic relationship, and the client's strengths. When appropriate, this might include the client's mental status, ability to participate in counseling, and his or her responses to the process. If they are available, outside written materials such as reports from other counselors/therapists, the results of psychological tests, or medical records can also be included in this section.

The counselor's findings are stated in precise and descriptive terms. Words that act to modify the content of the objective observations, such as “appeared” or “seemed,” should be avoided. If the counselor feels hesitant in making a definitive observational statement, adequate justification for the reluctance should be provided. The phrase as “evidenced by” is helpful in these situations. For example, one day the client arrives and is almost lethargic in her responses and has difficulty tracking the flow of the session. This behavior is markedly different from previous sessions in which the client was very engaged in the counseling process. When questioned, the client denies feeling depressed. In recording this observation, the counselor might chart, “Appeared depressed, as evidenced by significantly less verbal exchange; intermittent difficulty tracking. Hair uncombed; clothes unkempt. Denies feeling depressed.”

When recording observations, counselors should avoid labels, personal judgments, value-laden language, or opinionated statements (i.e., personal opinion rather than professional opinion). Words that may have a negative connotation, such as “uncooperative,” “manipulative,” “abusive,” “obnoxious,” “normal,” “spoiled,” “dysfunctional,” “functional,” and “drunk,” are open to personal interpretation. Instead, record observed behaviors, allowing future readers to draw their own conclusions. For example, one should not record, “Client arrived drunk to this session and was rude, obnoxious, and uncooperative.” Instead, one should simply record what is seen, heard, or smelled, for example, consider, “Client smelled of alcohol; speech slow and deliberate in nature; uncontrollable giggles even after stumbling against door jam; unsteady gait.”

**Assessment**

The assessment section is essentially a summarization of the counselor's clinical thinking regarding the client's problem(s). The assessment section serves to synthesize and analyze the data from the subjective and objective portions of the notes. The assessment is generally stated in the form of a psychiatric diagnosis.
based on the *Diagnostic and Statistical Manual of Mental Disorders–Text Revision (DSM-IV-TR)*; American Psychiatric Association, 2000) and is included in every entry. Although some counselors resist the idea of labeling their clients with a DSM-IV-TR diagnosis, third-party payers and accrediting bodies such as the Joint Commission on Accreditation of Hospitals require that this be done. According to Ginter and Glauser (2001), “Ignorance of the DSM system is not congruent with current expectations concerning counseling practice” (p. 70).

The assessment section can also include clinical impressions (i.e., a conclusion lacking full support) that are used to “rule out” and “rule in” a diagnosis. In more complex cases, in which insufficient information exists to support a particular diagnosis, clinical impressions work much like a decision tree, helping the counselor to systematically arrive at his or her conclusions. More important, when clinical impressions are used and stated, they enable outside reviewers and other health professionals to follow the counselor’s reasoning in selecting the client’s final diagnosis and treatment direction. When writing clinical impressions, counselors should identify them as such. For the sake of clarity, the relevant points from the data sections should be summarized. Doing this will assist the counselor in formalizing a tentative diagnosis and will demonstrate to outside reviewers the sequence of logic used to arrive at the final diagnosis.

There is debate regarding the use of clinical impressions. Piazza and Baruth (1990) and Snider (1987) recommended against their use, whereas Mitchell (1991) viewed the use of clinical impressions as a powerful entry. In place of clinical impressions, some counselors keep personal or shadow notes. These notes are kept separate from the client’s file, and the counselor uses them to record tentative impressions (Keith-Spiegel & Koocher, 1995; Thompson, 1990). This practice needs to be carefully reconsidered. The logistics of maintaining a separate set of notes are almost nightmarish, given the quantity of documentation required in most mental health clinics. Also, there are serious legal and ethical considerations. For the protection of the practitioner, client records need to demonstrate the counselor’s thinking and reasoning regarding the diagnosis selected and the elimination of other possible diagnoses (Swenson, 1993). Even though a counselor’s set of personal or shadow notes may be subpoenaed by the courts, by recording separate sets of notes the client’s record can lack a logical progression of evaluation, planning, and treatment of the problem(s). This leaves the counselor “with no evidence of competence when a lawsuit happens” (Swenson, 1993, p. 162). Simply stated, we believe that one set of notes should be kept and that it is appropriate to incorporate clinical impressions in the record.

An example of the appropriate use of clinical impressions is as follows. A counselor working in a family services agency is assessing a 7-year-old child who has been referred for possible attention-deficit/hyperactivity disorder. The report from the child’s teacher describes the child as being unable to stay on tasks for longer than 5 minutes, being frequently out of his chair, and not seeming to respect other children’s needs for “personal space.” When the case history
is taken, the child's mother provides the information that there were times when she drank frequently and excessively, sometimes to the point of "blackout," and the mother recalls that this "may have occurred" during the first trimester of her pregnancy. Although there is insufficient information with which to make a diagnosis, a reasonable clinical impression related to a tentative diagnosis is to "rule out fetal alcohol syndrome/effects (FAS/FAE)." Although the counselor is unable to make a definitive diagnosis, given the child's prenatal history, current level of hyperactivity, and decreased attention span, an entry subtitled "Clinical impression: Rule out FAS/FAE" clearly demonstrates the counselor's understanding of childhood psychopathology and developmental issues and supports a referral to a neurological team for evaluation. If the evaluation confirms FAS/FAE, this will determine the diagnosis rendered and the treatment direction.

The assessment portion of the SOAP notes is the most likely section to be read by others, such as outside reviewers auditing records. When making a diagnosis, the counselor needs to ask the question, "Are there adequate data here to support the client diagnosis?" If sufficient data have been collected, the subjective and the objective sections should reasonably support the clinical diagnosis. However, if the counselor is feeling uncomfortable or unsure regarding the accuracy of the diagnosis, this ambivalence might suggest that insufficient data have been collected or that a consultation with a senior colleague is in order.

**Plan**

The last portion of the SOAP notes is the plan. This section could be described as the parameters of counseling interventions used. The plan generally consists of two parts: the action plan and the prognosis. Information contained under the action plan includes the date of the next appointment, the interventions used during the session, educational instruction (if it was given), treatment progress, and the treatment direction for the next session.

Sometimes clients will benefit from a multiagency or multidisciplinary team approach. When such referrals are made, the names and agencies to which the client was referred are recorded (names involved in the referral should be recorded). If the counselor believes that a consultation is needed, it is documented in this section and includes the telephone contacts made to the consultant regarding the client.

The client prognosis is recorded in the plan section. The prognosis is a forecast of the probable gains to be made by the client given the diagnosis, the client's personal resources, and motivation to change. Generally, progress assessments are described in terms such as poor, guarded, fair, good, or excellent, followed by supporting reasons for the particular prognosis. The plan section brings the SOAP notes and the treatment direction full circle. Table 1 summarizes the SOAP noting format and provides examples for the reader.
### Legend for Chart

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Section</td>
<td>Definitions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Examples</td>
</tr>
</tbody>
</table>

### Subjective (S)

- What the client tells you
- What pertinent others tell you about the client
- Basically, how the client experiences the world
- Client's feelings, concerns, plans, goals, and thoughts
- Intensity of problems and impact on relationships
- Pertinent comments by family, case managers, behavioral therapists, etc.
- Client's orientation to time, place, and person
- Client's verbalized changes toward helping

### Objective (O)

- Factual
- What the counselor personally observes/witnesses
- Quantifiable: what was seen, counted, smelled, heard, or measured
- Outside written materials received
- The client's general appearance, affect, behavior
- Nature of the helping relationship
- Client's demonstrated strengths and weaknesses
- Test results, materials from other agencies, etc., are to be noted and attached.

### Assessment (A)

- Summarizes the counselor's clinical thinking
- A synthesis and analysis of the subjective and objective portion of the notes
- For counselors: Include clinical diagnosis and clinical impressions (if any).
- For care providers: How would you label the client's behavior and the reasons (if any) for this behavior?

### Plan (P)

- Describes the parameters of treatment
- Consists of an action plan and prognosis
- Action plan: Include interventions used, treatment progress, and direction. Counselors should include the date of next appointment.
- Prognosis: Include the anticipated gains from the interventions.

### Scenario and Sample SOAP Notes

The following is a very brief hypothetical scenario and a sample of how the SOAP notes might be written. Abbreviations have not been used because the use
and types of abbreviations vary from institution to institution. Finally, in this situation the counselor is responsible for the intake session.

**Scenario**

Cecil is a 34-year-old man who was mandated by the courts to obtain counseling to resolve his problems with domestic violence. He comes into the office, slams the door, and announces in a loud and irritated voice, “This counseling stuff is crap! There’s no parking! My wife and kids are gone! And I gotta pay for something that don’t work!”

Throughout most of the counseling session Cecil remains agitated. Speaking in an angry and aggressive voice, he tells you that his probation officer told him he was a good man and could get his wife and kids back. He demands to know why you are not really helping him get back what is most important to him. He insists that “Mary just screws everything up!” He goes on to tell you of a violent argument he and Mary had last night regarding the privileges of their daughter Nicole, who just turned 16. You are aware that there is a restraining order against Cecil.

During the session, you learn Cecil was raised in a physically and verbally abusive family until he was 11, at which time he was placed in protective custody by social services, where he remained until he was 18. He goes on to tell you that he has been arrested numerous times for “brawling” and reports that sometimes the littlest things make him angry and he just explodes, hitting whatever is available—the walls, his wife, the kids, and three guys at work. Cecil also reports prior arrests for domestic violence. He admits that at various times, he has been both physically and emotionally abusive to Mary and the children but insists that it was needed “to straighten them out.” Just before leaving your office, Cecil rushes from his chair and stands within a foot of you. Angrily, with his fists and jaw clenched, he says, “This is the same old B.S. You guys are just all talk.” He storms from the room.

**Sample SOAP Notes**

7/7/01: 2 p.m. (S) Reports counseling is not helping him get his family back. Insists the use of violence has been needed to “straighten out” family members. Reports history of domestic violence. Recent history: States he met and verbally fought with his wife yesterday regarding the privileges of oldest child. Personal history: childhood physical and mental abuse resulting in foster care placement, ages 11–18. (O) Generally agitated throughout the session. Toward the end of the session stood up, with clenched fists and jaw; angrily stated that counseling is “same old B.S.!” Rushed out of office. (A) Physical Abuse of Adult [V61.1, DSM code] and Child(ren) [V61.21]. Clinical impressions: Rule out Intermittent Explosive Disorder given bouts of uncontrolled rage with non-specific emotional trigger. (P) Rescheduled for 7/14/01 @ 2 p.m.; prognosis guarded due to low level of motivation to change. Continue cognitive therapy. Refer to Dr. Smith
General Guidelines for SOAP Noting

Client records are legal documents. For the most part, in a court of law, they represent the quality of services provided by the counselor (Mitchell, 1991; Scalise, 2000; Thompson, 1990). To ensure both the quality and the accuracy of the notes and to safeguard the integrity of the counselor, the following guidelines should be observed when writing SOAP notes.

Record the session immediately after the session while it is still fresh in your mind. This avoids the uncertainty, confusion, errors, or inaccuracies that are most likely to occur when you try to complete all the files at the day’s end. Start each entry with the date (month, day, and year) and time the session began. Make each entry legible and neat with no grammar, spelling, or punctuation errors. Finally, the client record should reflect the counselor’s level of training and expertise. For example, the counselor’s extensive use of psychoanalytic-based terminology without having received such training may cause other professionals to question the competency of the counselor. The American Counseling Association’s (ACA, 1995) Code of Ethics takes a clear position on counselors limiting practice to level of competence, and because records may be reviewed by others, the record’s language must be congruent with level of competence. These procedures will alleviate misunderstandings between professionals and minimize the potential of a lawsuit (Swenson, 1993).

All client contact or attempted contact should be recorded using the SOAP format. This includes all telephone calls, messages left on answering machines, or messages left with individuals who answered the phone. Letters that were mailed to the client would be noted in the record along with a photocopy of the signed letter. When recording a session, keep in mind that altered entries arouse suspicions and can create significant problems for the counselor in a court of law (Norris, 1995). If an error is made, never erase, obliterate, use correction fluid, or in any way attempt to obscure the mistake. Instead, the error should be noted by enclosing it in brackets, drawing a single line through the incorrect word(s), and writing the word “error” above or to the side of the mistake. The counselor should follow this correction with her or his initials, the full date, and time of the correction. The mistake should still be readable, indicating the counselor is only attempting to clarify the mistake, not cover it up. If not typed, all entries should be written in black ballpoint pen, which allows for easy photocopying should the file be requested at a later date. Furthermore, notes should never be written in pencil or felt-tipped pen because pencil can be easily erased or altered, whereas felt-tipped pen is easily smudged or distorted should something spill on the notes.

At the conclusion of the entry, the counselor needs to sign off using a legal signature—generally considered to be the first initial and last name followed by
Be brief and concise.
Avoid using names of other clients, family members, or others named by client.

Keep quotes to a minimum.
Avoid terms like seems, appears.

Use an active voice.
Avoid value-laden language, common labels, opinionated statements.

Use precise and descriptive terms.
Do not use terminology unless trained to do so.

Record immediately after each session.
Do not erase, obliterate, use correction fluid, or in any way attempt to obscure mistakes.

Start each new entry with date and time of session.
Do not leave blank spaces between entries.

Write legibly and neatly.
Do not try to squeeze additional commentary between lines or in margins.

Use proper spelling, grammar, and punctuation.

Document all contacts or attempted contacts.

Use only black ink if notes are handwritten.

Sign-off using legal signature, plus your title.

In this era of accountability, counselors are expected to use a more systematic approach in documenting rendered services (Ginter & Glauser, in press; Norris, 1995; Scalise, 2000) and demonstrating treatment effectiveness (JCAHO, 2000).
Good documentation is a fundamental part of providing minimal client care, and needs to be mastered like any other counseling skill. As the standards for recording receive increased scrutiny by both managed care organizations and the National Committee for Quality Assurance, the importance of documentation has changed “from something that should be done well to something that must be done well” (Kettenbach, 1995, p. iii), especially if counseling is to survive in this age of managed resources. SOAP notes are a proven and effective means of addressing this new mandate. We hope that this article will help others fulfill this dictate, for there is no substitute for concisely written and well-documented case notes.

References


---

**Case Summary Outline**

Case summaries are essential to synthesize information and to provide baseline data for the counseling process. Summaries enable one to analyze whether or not all essential data regarding the planning and treatment of the client have been considered. In addition, summaries cause one to identify potential problems, directions for action with the client, and possible guidelines for determining whether or not satisfactory progress is being made during the series of therapy sessions.

A case summary may also be written prior to the initial interview. As such, the summary serves as a base for integrating what is known, as a baseline for comparison of future information, and as a springboard for what might be done when the individual is seen in therapy.

In addition, a case summary may be written at various times during the interval over which several therapy sessions were held. The summary may be for the counselor's benefit and may be used as a benchmark for comparisons at a later date. Similarly, a summary may be needed to send to a referral person or to someone the client identified as needing information about his or her status and/or progress. With those clients being seen within legal conditions (court cases, detention homes, penal institutions), periodic case summaries may be required. The length of the case summary is dependent upon its purpose and the amount and type of information available. A report that is one to three pages in length, single spaced, and typewritten or computer generated is generally sufficient. When appropriate, copies of test data can be incorporated into or attached to the case summary.

A typical time for writing a case summary is after termination with the client. The summary will be a vehicle for the review of pertinent information if and when it is needed. The summary is placed in the client's folder and maintained along with other pertinent information gathered during the course of therapy.

Items to include in the case summary will be determined by such factors as the purpose of the summary, the individuals who will use it, and the professional expertise of those using the information. Even though items to be included in the

---

*This material was taken from K. Dimick & F. Krause (Eds), *Practicum Manual for Counseling and Psychotherapy*, 1980. Munice, IN: Accelerated Development. Reprinted with permission from the Editors.*
case summary will vary from report to report, an outline of topics to be considered is beneficial. A sample Case Summary Topical Outline is provided below.

**Case Summary**

*(Topical Outline)*

1. Identifying Data
   The name, date, address, and telephone number of the client. Includes agency or school coding (client number, client file, social security number).
   The background (highest level attained).

2. Reason for the Report
   A statement as to the purpose of the current report. Examples include: interim progress reports of therapy, background information gathered prior to the initial session with the client, referral report to another agency or school, and report of termination with client.

3. Source of Information
   The source and the manner in which data were obtained in the preparation of this report.

4. Statement of the Problem
   A succinct statement of the presenting problem in therapy. May include a statement reflecting the chronicity and acuteness of the symptomology.

5. Family and Home Background
   Identifying information about parents and siblings (names, ages, occupations, etc.). Client’s perceptions of the home environment and relationships within the family. Critical family incidents may be included.

6. Educational History
   Description of pertinent information in relation to educational background, including academic achievement, school instances that were significant for the understanding of the individual, and the client’s attitude toward education.

7. Physical Health History
   A statement of the client’s significant health history, current treatments and medications, familial medical history that may impact upon the client, and current treatments.

8. Social Interactions
   Client’s perception of the quality of his or her social interactions and interpersonal relationships.

9. Psychological Development
   A statement of critical benchmarks in the client’s psychological development, initial and current clinical impressions.

10. Testing Assessment
    Inclusion of the name, form, and other identifying information about each test administered to the client, about the tests administered previously by
others, and the results utilized during the therapy session. Scores obtained and identification of norms used in reporting percentiles or other test scores. Interpretation of results.

11. Occupational History
   Chronology of the client's work history, when pertinent, jobs held, and reasons for changes. Quality of work satisfaction and interest.

12. Hobbies, Recreational Activities
   Interests and self-expressive uses of time.

13. Sexual Adjustment
   Current status, significant problems or disturbances in functioning, alternative lifestyles.

14. Summary Statement
   Summative statement concerning client’s current disposition and status.

15. Diagnosis/Prognosis
   Statement of client's DSM-IV diagnosis and clinical prognosis.

16. Treatment
   Description of current treatment and/or recommendations for follow-up treatment.

17. Recommendations

**Reporting Therapeutic Process**

The practicum student or intern frequently may receive requests from others to provide diagnostic information and reports of therapeutic progress, and to make recommendations regarding a client.

The format for reporting data will vary according to the specific requests that are made. Each progress report needs to be prepared in keeping with the request, the client, and the person to whom the report is sent. Qualitative and quantitative differences will be based upon the professional preparation of the person requesting the data, and the orientation and training of the individual preparing the report.

Requests for diagnostic information oftentimes are used by the agency or institution for the purpose of assisting in the development of treatment plans for placement of clients into appropriate programs and for providing information for the final disposition of a therapy case. Knowledge of the purpose for which the request is made is invaluable in assisting in the writing of a progress report that specifically addresses the request.

A request for treatment recommendations is a vital part of most progress reports. In some instances, the total report consists basically of treatment.

---

recommendations. The specific purpose of this report may be simply to com-
municate recommendations to someone else who must make a disposition of the
case.

Requests for reports on the client’s therapeutic progress are often made by
the referring professional. In addition, other professionals who have made previ-
ous referrals of any kind for the client are appreciative of reports on progress
even if reports are not requested formally. In addition, others who are working
concurrently with the client find progress reports invaluable in fulfilling their
professional roles. Teachers, administrators, parents, and physicians can find an
appropriately prepared progress report from a fellow professional an important
source of assistance.

A Therapeutic Progress Report [Form 3.9], therefore, needs to include pertinent
data about the method of treatment employed as well as the client’s current sta-
tus. Treatment recommendations are especially helpful to those who must make
a final disposition of the case.

In summary, we have presented a number of instruments that can be used
to monitor the progress of the client in counseling. Many students have been
exposed to similar monitoring aids in their training programs. It is important to
remember that the instruments chosen to monitor clients’ progress are significant,
but the students’ skills in assessing the clients’ progress are critical.

Summary

Practicum content issues are fundamental ingredients in the student’s preparation
for working with clients. Effective initial interactions with the client, along with
the employment of assessment and monitoring activities, are essential for setting
the expectations and tone of the counseling experience. The proper recording
and processing of interview notes contribute to the counselor’s general impres-
sion of the client and the client’s progress throughout the therapy session, and
as such are important skills for the beginning counselor to master. We have
provided sample formats for use in making therapy notes, as well as other forms
that can be used in the recording of pertinent client data.

Suggested Readings

Hansen, N. E., & Freimuth, M. (1997). Piecing the puzzle together: A model for under-
15(4), 293–294.
Journal of Counseling and Development, 75(1), 64–68.


### References


Chapter 4
Practicum Process Issues

This chapter has been designed to help beginning practicum students to think about, conceptualize, and plan their initial counseling experience. The topics to be presented are not new to the student but are included here for the purpose of reviewing, in a systematized manner, a step-by-step process in preparation for counseling. The previous chapter dealt largely with the mechanics of counseling (getting permissions, building client folders, taking notes, etc.). This chapter focuses on the therapist and his or her personal approach to counseling and psychotherapy.

The completion of on-campus course work signals the beginning of the counselor's venture into the counseling profession. This initial step in counseling often brings with it a variety of concerns for students. Facing the task of applying their knowledge base to actual work with clients can cause considerable anxiety for beginning counselors. This chapter has been organized for the purpose of presenting and reviewing the major steps in the process of preparing for that first client.

Philosophy–Theory–Practice Continuum

Beginning counselors are confronted with the struggle to integrate the knowledge base of their training program into a coherent method of counseling. From the very beginning of the training programs, students are encouraged to examine their own values and beliefs as they become exposed to the various philosophical and theoretical approaches to counseling. The necessity for students to develop their own “theoretical approach” to working with clients is stressed for the purpose of sensitizing students to the need for a consistent, well-thought-out approach to counseling. The first step in this process is an examination of the variety of ways in which theories determine the methods and procedures that will be implemented in the therapeutic process.

Hansen and Freimuth (1997) discussed a seven-step model that delineates the different pathways through which theories of personality and psychotherapy
Practicum and Internship

affect case conceptualization and intervention. The following is an adaptation of their seven-step mode:

1. **Assumptive world:** This is basically the counselor's beliefs or “personal philosophy” about the world and how it works. One's assumptive world is shaped long before exposure to “theories of counseling,” and it represents the lens through which we view, understand, and selectively attend to data. Courses on the foundations of counseling often challenge students to get in touch with the particular way in which they see humankind and its development. An understanding of our own view of humankind is essential in the process of developing our own approach to counseling. A philosophical base provides students with an essential understanding of their views of humankind, from which they can then view the variety of theorists, theories, and interventions.

2. **School:** The school represents the premises of a worldview as applied to a given topic in psychology. For example, if a student's belief system stresses the subjective view of the individual rather than an objective view of the individual, it is likely that the student would follow a humanistic approach to therapy. Similarly, if a student viewed the individual from an objective perspective, then objective approaches such as those put forth by Freud and Skinner seem to be the preferred approach. Furthermore, schools are distinguished from one another on the basis of their assumptions. However, it is important to recognize that no school is validated by empirical means; rather, one believes a certain set of assumptions about human behavior and then adopts the change process that best fits with those assumptions (Freimuth, 1992).

3. **Theory:** The purpose of a theory is to give content and a sharper focus to the assumptions of a school. For example, Maloney (1991) divided the cognitive school into the rational cognitivists and the cognitive structivists; both give priority to cognition, but only the latter emphasizes affect.

4. **Theorist:** Theorists differ in their understanding of a theory's tenets. For an existentialist, does the work of May, Frankl, orBinswanger seem most valid? According to Maloney (1991) many therapists, especially novices, feel relief when they first identify a particular theorist whose ideas most closely parallel their own. The most complete understanding of the theory's tenets is accomplished by reading the original works of the theorist.

5. **Working hypothesis:** The interpretation of a particular client's problem and needs, as understood through the lens of the therapist's preferred theory, is referred to as the **working hypothesis**. Implicit in the working hypothesis is the theory-derived outcomes (self-actualization, decision making, “choosing,” etc.). It should also be noted that the manner in which the therapist conceptualizes an intake interview will often differ in emphasis based on the
theoretical grounding of the therapist. For example, a therapist grounded in Freudian theory will likely place an emphasis on developmental history.

6. **Strategy:** Strategy is method or steps taken in the therapy process to achieve the desired treatment outcomes. According to Hansen and Freimuth (1997), a therapist’s assumptive world, school, theory, and theorists influence the therapist’s thinking about theories and psychotherapy. However, the working hypothesis is the bridge between theory and psychotherapy and strategy and technique. Strategies represent what the therapist wants to accomplish through chosen interventions. Therapists choose and emphasize certain strategies based on their theoretical orientation and diagnostically specific working hypothesis (Messer, 1986).

7. **Techniques:** Techniques are defined as the actions therapists take to implement a given strategy. This area refers closely to what the therapist actually does with the client in session, actions such as listening, interpreting, mirroring, and questioning. The techniques chosen by the therapist are shaped by his or her chosen theory.

Therapists who organize their thoughts about therapy, beginning with their assumptions about the individual and culminating in the choosing of appropriate therapeutic techniques, are well on the way to gaining confidence about their own approach to the therapy session. The translation of the therapist’s knowledge base into workable therapeutic interventions is an essential part of the practice of counseling and psychotherapy.

**Structured and Unstructured Interviews**

The initial interview with the client requires the counselor to make a determination as to the type of interview to conduct. Will it be a structured interview? Unstructured interview or semistructured interview? According to Whiston (2000) there are advantages to all three types of interviews. The structured interview is one where the counselor has an established set of questions that he or she asks in the same manner with each client. This format is oftentimes used in agencies that require the same structure with each client. Furthermore, if the purpose of the interview is for screening clients to see if they are appropriate for the agency or clinic, then the structured interview is preferred.

The advantage of the unstructured interview is that it can be adapted to respond to the unique needs of the client. Similarly, if the purpose of the interview is to better understand the specifics of the individual client, then the unstructured interview may be preferred. Finally, the semistructured interview is a combination of the structured and unstructured interviews, wherein certain questions are always asked but there is room for exploration and additional questioning (Whiston, 2000, p. 119). Whiston (2000, p. 118) suggested several common guides for an initial interview:
Assure the client of confidentiality (clearly state any exceptions such as harm to themselves or someone else).

Ask questions in a courteous and accepting manner.

Word questions in an open-ended format rather than a closed format.

Avoid leading questions.

Listen attentively.

Consider the client’s cultural and ethnic background in structuring the interview.

Adjust your approach to the individual client (some clients are more comfortable than others).

Avoid “chatting” about unimportant topics.

Encourage clients to express feelings, thoughts, and behaviors openly.

Avoid psychological jargon.

Use voice tones that are warm and inviting, yet professional.

Allow sufficient time and don’t rush clients to finish complex questions.

If client responses drift from pertinent topics, gently direct them back to the appropriate topics.

Vary posture to avoid appearing static.

Initial Client Contact

The initial client contact is a crucial point in the process of counseling and psychotherapy. The initial interview or intake interview is an information-gathering process rather than a therapeutic process. Frequently, someone other than the counselor or therapist conducts the interview and passes critical information on to the counselor. Regardless of who does the interview, however, it is essential that certain data be collected to provide the counselor with the information necessary to understand the client’s presenting problem(s) and current life issues. According to Cormier and Cormier (1998), the most important areas of focus are as follows:

- identifying information about the client;
- general appearance and demeanor of the client;
- history related to the presenting problem(s);
- past counseling or psychiatric history;
- educational and job history;
- health and medical history;
- social and developmental history;
- family, marital, and sexual history;
- assessment of client communication patterns; and
- results of mental status or diagnostic history.

It is through this initial contact and data-gathering process that the counselor is challenged to use his or her personal talents through the application of appropriate interpersonal skills. The interviewer must demonstrate skills that promote
the understanding of self and others in an attempt to gather relevant data about the client and his or her concerns. The following skills are extremely helpful in gathering background history and relevant intake data and in promoting understanding of the client.

**Basic Helping Skills**

The following is a list of some of the basic helping skills used in the gathering of background history and relevant intake data, as well as in the promoting of client self-understanding.

*Attending:* Attending involves the therapist’s becoming aware of the client’s communication through undistracted attentiveness to the client. Attending helps the client feel listened to and understood.

*Listening:* Listening implies a passive act of taking in the content of the helper’s communication, but it actually involves a very active process of responding to total messages. Listening skills are basic to all interviewing, whether the purpose be gaining information, conducting structured in-depth interviews, or informal helping (Brammer, 1996). The following are four areas of listening responses: clarification, paraphrasing, reflecting, and summarization. These listening responses are described in further detail below.

*Clarification:* Clarification is the method of bringing vague material into sharper focus. Clarification is used when the therapist cannot make sense out of the client’s responses. Clarification requests should result in the therapist obtaining clearer statements from the client.

*Paraphrasing:* Paraphrasing is the method of restating the client’s basic message in a similar manner, but usually with fewer words. The main purpose of paraphrasing is for therapists to test their own understanding of what the client has said (Brammer & MacDonald, 1996).

*Reflecting:* Reflecting is a method of expressing to a client that the therapist is located within the client’s frame of reference and that he or she understands the client’s deep concerns. There are three areas of reflection: reflection of feeling, reflection of experience, and reflection of content (Brammer & MacDonald, 1996).

*Summarization:* Summarization is a skill that helps to indicate the therapist’s understanding of the client’s statements. Summarization indicates that attention has been paid to what the client says (content), how those statements are said (feeling), and the purpose, timing, and effect of those statements (process). Summarization gives the client a feeling of movement in exploring ideas and feelings, as well as an awareness of progress in learning and problem solving (Brammer & MacDonald, 1996).

These areas of listening responses are further illustrated in Table 4.1. In addition to providing a summary of their definitions and goals, the figure provides
examples of effective behavior and phrasing used by the therapist to employ these skills.

**Asking Appropriate Questions**

In addition to these basic helping skills, questioning is one of the most useful ways of understanding and helping the client, particularly when used in conjunction with the basic helping skills. Like all other counseling skills, effective questioning requires the counselor to be sensitive to the client’s emotional state, to demonstrate proper timing of questions, and to contain the questioning in an attempt to control the flow of information from the client. Questioning enables the counselor to gather information and to deepen the level of discussion with the client or to broaden its focus.

Two types of appropriate questions are the *open question* and the *closed question*. The two methods are designed to elicit different data. Open questions
encourage clients to share information and to talk freely. They serve to help clients describe how they think, feel, and act. Open questions are questions that cannot be answered with a “yes” or “no” response. Many open questions begin with words such as who, what, when, where, how, and why. For example,

- How did you get our number?
- When did you first start feeling depressed?
- What motivated you to make an appointment?
- Where are you currently working?
- How long have you been having family problems?

Closed questions are questions that can be answered with a simple “yes” or “no” response. Closed questions are generally easier to ask and can serve to help pinpoint information and bring closure. For example,

- Do you have a home phone?
- Are you currently going to school?
- Have you ever been to counseling before?
- Does anyone know about your concern?
- Is there a history of depression in your family?

A note of caution regarding the use of closed questions: The use of closed questions exclusively creates a notion in the client that you will ask questions and the client can merely respond in a yes or no fashion. Generally, the use of both open and closed questions is helpful. Combining open and closed questions can be used to gather data in one area before moving on to another topic.

**Assessment in Counseling**

The process of assessment centers on gathering information from the client for the purpose of identifying the problem or problems that the client brings to the counseling session. The results of assessment activities enable the counselor to integrate the information they have gathered into the treatment planning process. It should be noted that assessment activities are primarily for the benefit of the client, enabling him or her to come to an understanding of his or her problems and to cope with real-life concerns.

Assessment activities in counseling can take many forms. Regardless of the approach taken by the counselor, assessment needs to be viewed as an ongoing, continuous process that begins with the initial intake and culminates with the termination of counseling. All too often, the counselor learns that the presenting problem is only the tip of the iceberg and that new or more urgent needs arise during the therapy process. Viewing assessment as a continuous process enables the counselor to modify and adjust treatment plans, therapeutic goals, and intervention strategies as needed.
According to Juhnke (1995), continuous assessment includes qualitative, behavioral, and client record-reviewing activities. Qualitative assessment activities can include role playing, simulations, and games. These methods are employed for the purpose of gathering additional data from the client. The use of qualitative methods in session provides for the processing of information and feedback to the client. Behavioral assessment examines the overt behavior of the client. According to Galassi and Perot (1992), behavioral assessment emphasizes the identification of antecedents to problem behaviors and consequences that reduce their frequency or eliminate them. Indirect methods of behavior assessment might include talking to significant others about the client’s issues and problems. Direct behavioral methods involve observing the client, administering behavioral checklists, and having the client self-monitor his or her behavior. A review of the client’s records affords the counselor the opportunity to examine possible patterns of behavior. Likewise, it can provide the counselor with a history of past therapy experiences of the client, as well as an understanding of the client’s history in light of the client’s presenting concerns.

Assessment is not restricted to the use of objective, standardized, quantifiable procedures; rather it includes interviewing, behavioral observation, and other qualitative methods. A helpful resource in understanding assessment and assessment interviewing is provided by Howatt (2000), who suggested that a number of goals need to be kept in mind when conducting an assessment interview. These goals include the following:

1. to gather consistent and comprehensive information,
2. to identify and define a person’s major strengths,
3. to identify the problem(s) that bring the client to counseling,
4. to introduce a degree of order by prioritizing problems,
5. to teach the inadequacy of a quick fix to problems,
6. to clarify diagnostic uncertainty,
7. to measure cognitive functioning,
8. to differentiate treatment assignments,
9. to develop rapport and create a healthy working environment, and
10. to focus on the therapeutic interventions.

In a similar fashion, Patterson and Welfel (2000) discussed five components to the data-gathering and hypothesis-testing process of assessment. The following is a summary of those components (pp. 121–123):

1. **Understanding of the boundaries of the problem:** Both the counselor and the client need to recognize the scope and limits of the difficulty the client is experiencing. It is important to know the problem boundaries in current functioning as well as the history and duration of the problem.
2. **Mutual understanding of the patterns and intensity of the problem:** Recognition on the part of the counselor and client that problems are
not expressed at a uniform level all the time helps the client realize that understanding the pattern of the problem makes its causation clearer. Understanding the intensity of the problem helps the client to get a clearer sense of the dimensions of feelings and associated behavior.

3. **Understanding of the degree to which the presenting problem influences functioning in other parts of the client’s life:** The aim is to learn how circumscribed or diffused the difficulty is and to clarify the degree to which it is compromising other unrelated parts of the client’s experience.

4. **Examination of the ways of solving the client’s problem that he or she has already tried before entering counseling:** This process aids understanding of the impact of the problem’s history on the current status of the problem. It is also helpful in the selection of strategies for change.

5. **Understanding of the strengths and coping skills of the client:** This process helps in keeping a balanced perspective of the problem and aids in the client’s realization that he or she has the resources to bring about the resolution of problems.

In addition, Cormier and Nurius (2003) suggested the following categories for assessing a client’s problems:

1. **Explanation of the purpose of assessment:** rationale provided to the client;
2. **identification of a range of problems:** identify relevant issues to get “the big picture”;
3. **Prioritization and selection of issues and problems:** selecting the area of focus;
4. **Identification of present problem behaviors:** affective, somatic, behavioral, cognitive, contextual, and relational;
5. **Identification of antecedents:** sources of antecedents and effect on the problem;
6. **Identification of consequences:** identify sources of consequences and their effect on problem behavior;
7. **Identification of secondary gains:** variables that serve as “payoffs” to maintain problem behavior;
8. **Identification of previous solutions:** identify previous solutions and their effect on the problem;
9. **Identification of client coping skills:** identify past and present coping behaviors;
10. **Identification of client’s perception of the problem:** describe client’s understanding of the problem; and
11. **Identification of problem intensity:** client self-monitoring to identify the impact of the problem on the client’s life.

Finally, Cormier and Nurius (2003) acknowledge the role and function of assessment in counseling as a crucial component in the selection of appropriate strategies for intervention. They assert that it is naive to think that a single theoretical framework or strategy is appropriate for all clients. Beuler and Harwood (1995)
pointed out that research supports a departure from “one size fit all” counseling approaches. They further asserted that interventions that are based on specific client needs and problems, rather than on the preferred strategy of the counselor, tend to lead to better outcomes. Patterson (1997) argued that counseling would be beneficial when cases were conceptualized through a useful theory and when carefully selected techniques were used to address client specific difficulties. Nelson (2002) suggested that an eclectic selection model based on the premise that a single, one-dimensional approach is simply not appropriate for all clients who present for counseling and that individual clients can benefit from strategies that honor their particular needs and difficulties.

As a result, Nelson (2002) suggested the following:

1. **Identify initial counseling goals:** How does the client want to benefit from counseling? What are the counselor’s and client’s time constraints for counseling?
2. **Identify or rule out psychopathology:** Does the client have a biological illness? Does the client demonstrate signs of clinical depression or other disorders that require a consult with a physician or psychiatrist?
3. **Determine problem complexity:** Beutler et al. (1995) suggested that simple problems are found in clients who have had adequate support throughout life and need to address unwanted cognitive or behavioral symptoms related to situational life events. Complex problems stem from family-of-origin difficulties and often involve long-standing, complicated interpersonal difficulties that require greater analysis and time to address.
4. **Assess reactance level:** To what degree does the client resist counselor’s suggestions? Is it simply resistance to influence by an authority figure? Is it depression and a sense of hopelessness that triggers resistance?
5. **Assess capacity and desire for insight:** Nelson (2002) suggested that it is necessary to assess the degree of insight a client is either capable or desirous of pursuing. This is accomplished by employing a variety of interventions (using metaphors, simple interpretation, challenging cognitions, narrative approaches, etc.) to help the client gain insight and understanding.

Thorough assessment of the problem or problems that the client brings to therapy helps both the counselor and the client to understand the boundaries, patterns, and intensity of those problems in the client’s life.

**Diagnosis in Counseling**

The use of diagnosis by counselors has been a controversial issue in the training of counselors (Denton, 1990; Gladding, 1992). The controversy stems from the belief that in the counseling profession, counselors should follow the developmental model of treating clients with developmental concerns and should leave
more severe cases to other trained professionals. In addition, it is felt that the use of diagnosis contradicts some of the more accepted models of counseling (i.e., client centered, humanistic, etc.). However, it remains a fact that practicing counselors in schools, agencies, and mental health facilities are routinely asked to diagnose and treat clients who have severe mental health issues. This is especially true for counselors in private practice, who are routinely confronted with a managed care environment that requires the use of diagnosis for treatment consideration as well as for insurance coverage. In reality, this is nothing new. Every time a counselor treats a client, he or she is making a diagnosis when choosing and implementing therapeutic interventions. Whether it is through the use of the *Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition* (*DSM-IV*; American Psychiatric Association, 1994), the highly formalized diagnostic system, or some other system, diagnosis is a reality for trained counselors.

In a similar fashion, counselors are frequently asked to participate in collaborative mental health service teams that work together in planning, coordinating, evaluating, and providing direct service to clients. Geroski and Rodgers (1997) suggested that because school counselors interact with a large number of children and adolescents on a daily basis, they are uniquely able to identify students who manifest particularly worrisome behaviors possibly consistent with significant mental health issues. The counselor is able to provide direct interventions and support services for some of these students (Geroski & Rodgers, 1997, p. 231).

However, many school counselors lack training in the formal use of the *DSM-IV*. Hohenshil (1996) observed that it is rapidly becoming a necessity for all counselors to be skilled in the language of the *DSM-IV*, regardless of their employment setting. Thus to become a viable member of a collaborative mental health system, the counselor must at the very least become familiar with the language of the *DSM-IV*. Familiarity with the language of the *DSM-IV* is not, in any sense, a substitute for formal training in its use. However, a rudimentary knowledge of the *DSM-IV* can assist the counselor in student referral and collaborative mental health services.

Hohenshil (1996), in an editorial titled “Role of Assessment and Diagnosis in Counseling,” discussed the usefulness of diagnostic information and the reasons why counselors should diagnose. Hohenshil suggested that diagnosis is not a static process that occurs at a fixed point in time but that testing, assessment, and diagnosis are intertwined throughout the stages of the counseling process. The following is a summary of Hohenshil stages:

1. **Referral**: The collection of data begins at this stage, and counselors begin to hypothesize about possible diagnosis. Referral information often consists of self-reports and reports from educational, medical, and social records.

2. **Symptom identification**: Symptom information is obtained through the use of diagnostic interviews, problem checklists, mental status examinations, and behavioral observations and testing.
3. **Diagnosis**: Diagnosis is the process of comparing the client’s symptoms to the diagnostic criteria of some classification system. The *DSM-IV* classification system is the most widely used system of classification for counselors in agency and mental health systems.

4. **Treatment planning**: This process requires accurate diagnosis because intervention techniques correspond to particular developmental problems or mental disorders. Treatment planning normally includes the description of the behavior, treatment objectives and interventions, and the client’s prognosis.

5. **Treatment**: The treatment of the client follows the outline in the overall treatment plan. The use of assessment data is important in determining when treatment termination is in order.

6. **Follow-up**: Follow-up of the client is essential to determine if symptoms are in remission or if additional counseling is necessary for the client.

---

**Diagnostic Classification System**

Information on the *DSM-IV* is included here to provide an overview of this classification and coding system. We believe that school, agency, and mental health counselors must become familiar with the *DSM-IV*. Obviously, knowledge of the classification and coding is *not* a substitute for formal training in the use of the *DSM-IV*. Rather, the information is included in this text as a resource and reference to the classification system.

The *DSM-IV* employs five axes to record biological, social, and psychological assessment of the client. The first three axes are for the recording of mental and physical diagnoses; the others enable the counselor to note environmental problems and to provide an assessment of the client’s functioning over the course of the previous year. Following are descriptions of the five axes employed in the *DSM-IV*:

- **Axis I**: every mental diagnosis with the exception of personality disorders and mental illness,
- **Axis II**: personality disorders and mental retardation,
- **Axis III**: general medical conditions,
- **Axis IV**: psychosocial and environmental problems, and
- **Axis V**: global assessment of functioning BF (a 100-point scale reflecting the patient’s current overall occupational, social, and psychological functioning).

**Severity and Course Modifiers**

Following is a list of the severity and course modifiers employed in the *DSM-IV*:

- **Mild**: The patient has few symptoms other than those that meet the minimum criteria for diagnosis.
- **Moderate**: The patient experiences intermediate symptomatology between mild and severe.
Severe: The patient has many more symptoms than the minimum criteria for diagnosis or some symptoms are especially severe.

In partial remission: The patient previously met the full criteria for diagnosis but now the symptoms are too few to fulfill the criteria.

In full remission: The patient is considered symptom free.

The use of the multiaxial system facilitates comprehensive and systematic evaluation with attention to the various mental disorders and general medical conditions, psychosocial and environmental problems, and level of functioning that might be overlooked if the focus were on assessing a single presenting problem.

The use of a multiaxial system provides a convenient format for organizing and communicating clinical information, for capturing the complexity of the clinical situations, and for describing the heterogeneity of individuals presenting with the same diagnosis (American Psychiatric Association, 1999).

**DSM-IV Codes and Classification**

The following codes are intended to be used in conjunction with the text descriptions for each disorder found in the *DSM-IV*:

- **NOS** = Not Otherwise Specified.
- An “X” appearing in a diagnostic code indicates that a specific code number is required.
- An ellipsis (…) is used in the names of certain disorders to indicate that the name of a specific mental disorder or general medical condition should be inserted when recording the name (e.g., 293.0 Delirium Due to Hypothyroidism).
- Numbers in parentheses are page numbers.
- If criteria are currently met, one of the following severity specifiers may be noted after the diagnosis: mild, moderate, or severe.
- If criteria are no longer met, one of the following specifiers may be noted: in partial remission, in full remission, or prior history.

Students are directed to the appendices at the back of the textbook for the alphabetical and numerical listings of *DSM-IV-TR* codes and diagnoses.

**Case Conceptualization and Treatment Planning**

The process of case conceptualization and treatment planning can be a daunting task for beginning counselors. Determining how to best conceptualize a case and following through with an appropriate treatment plan requires the counselor to thoughtfully consider the development of his or her own strategy. To assist in that process, we now provide a variety of methods and models of case conceptualization and treatment planning for your consideration.
Models of Case Conceptualization: The Analytical Thinking Model

One of the first models of case conceptualization is found in the literature of social work. Wilson, in a textbook titled *Recording Guidelines for Social Workers* (1980), discussed the analytical thinking model (ATM) for use by students in analyzing case situations. The following is a summary of the steps and procedures of the ATM.

1. Mentally review everything that is known about the client up to the point of case conceptualization (i.e., intake interview, mental status, developmental history).
2. List, in outline form, 10 to 15 key factors known about the case. Sort out relevant from irrelevant data.
3. Review your list. Ask, “What feelings might my client be experiencing, knowing what I know about him or her?” For each feeling, try to determine at whom or what that feeling might be directed, why you think the client might have that feeling, and how the feeling might be manifested behaviorally.
4. Consider who the significant others are in the client’s life. Choose one or two people and follow step 3 for each of them. Examine interactional patterns between these people and your client.
5. Develop a treatment plan by listing any possible case outcomes or treatment goals, regardless of whether they are realistic or unrealistic. Label each plan or outcome as either realistic or unrealistic. For each realistic goal, do the following:
   a. State the goal.
   b. Break the goal down into subgoals that must be achieved before the overall goal can be achieved.
   c. State exactly what treatment techniques or interventions will be used to accomplish the goal or subgoal. Rank the treatment goals in order of priority and give an estimated time for completion of each.
   d. Finally, write a diagnostic statement that summarizes your thoughts in steps 2 through 4. Make a heading “Treatment Plan” and summarize what you came up with in step 5 (Wilson, 1980, pp. 144–146).

Models of Case Conceptualization: The Stevens and Morris Model

Stevens and Morris (1995) developed a format for case conceptualization to foster the systematic collection and integration of clinical data. Their 14-step format is adapted here to provide counselors in training with a framework from which they can develop their own approach to case conceptualization. Each step provides the therapist with an opportunity to focus on a specific area of client behavior or history; together, these steps allow the therapist to examine the client and his or her presenting problems as a whole, thus giving a more complete conceptualization of the client’s case.
1. **Background data:** This step includes the gathering of information typically asked for in a clinical intake, including the client’s age, sex, race, ethnicity, physical appearance, and marital status. Family background, educational and employment history, medical and mental health history, drug usage, and prior treatments are areas of focus in gathering this information.

2. **Presenting concern:** This focus area enables the therapist to consider the client’s own account of each of the client’s concerns as he or she views them. Such an exploration allows the therapist to help the client identify the affective, behavioral, cognitive, and interpersonal features of the problems. Examination of the parameters of the presenting concerns (prior occurrence, onset, duration, frequency, and severity) and a view of the client’s expectations, stressors, and support systems also takes place during this step.

3. **Verbal content:** In this step, the therapist focuses on identified theme(s) that have emerged. A main goal at this step is discrimination between central and peripheral data.

4. **Verbal style:** This area of focus involves the recognition of how something is said by the client rather than what is said. Tone of voice, volume, fluency, and so on are important indicators.

5. **Nonverbal behavior:** Here the counselor focuses on and recognizes the relevant nonverbal behavior of the client, such as eye contact, facial expression, and postures.

6. **Client’s emotional experience:** In this step, the counselor makes inferences about what and how the client felt in the session, based on the counselor’s own observation.

7. **Counselor’s experience of the client:** Here the counselor explores his or her own personal reaction to the client, such as boredom, interest, or confusion (Stevens & Morris, 1995, p. 82).

8. **Client–counselor interaction:** This step allows the summarization of patterns in the exchange between the counselor and client. Particularly relevant here is consideration of what the counselor and client do in relation to each other during the session; for example, Do they ask questions? Answer questions? Give advice? Receive advice?

9. **Test data and supporting materials:** Here the therapist examines all pertinent records of the client (i.e., educational, medical, psychological). A thorough assessment of the significant data and supporting materials enables the therapist to examine how such information converges or departs from other data, thus allowing more effective diagnosis and treatment planning.

10. **Diagnosis:** At this stage, the counselor gives his or her diagnostic impression using the *DSM-IV* multiaxial classification system.

11. **Inferences and assumption:** The therapist develops a working model based on observations and clinical hypotheses. A working model enables the development of a clear understanding of the client’s problems and how psychological mechanisms produce those problems.
12. **Goals of treatment:** This step involves the negotiation of short- and long-term goals of treatment between counselor and client.

13. **Intervention:** In this step, the therapist determines the most effective techniques and strategies that can be used for the attainments of the treatment goals negotiated in the previous step.

14. **Evaluation of outcomes:** Finally, the therapist establishes criteria for the evaluation of outcomes of treatment. Criteria can include things such as self-report, test data, grades, or reports of others.

### Models of Case Conceptualization: The “Linchpin” Model

Bergner (1998) suggested that using a linchpin concept would ideally culminate in the construction of an empirically grounded, comprehensive formulation for case conceptualization that would (a) organize all of the key factors of a case around one causal, explanatory source; (b) frame this source in terms of factors amenable to direct intervention; and (c) lend itself to being shared with the client to his or her considerable benefit (p. 287). According to Bergner (1998), a clinical case formulation would embody the following characteristics:

1. **Organize facts around a linchpin:** Clients generally tend to provide a great deal of information about themselves, often above and beyond the data initially sought by the counselor. In addition to the presenting complaint, clients provide a wealth of information about their problem, including their emotional state, personal history, goals, expectations, and history of their concerns. However, in most cases, clients have not organized this data into a theory of their problem(s). Similarly, relevant information about such factors as personal beliefs and values, which can create problems, has been left out of their discussion. Organizing around a linchpin helps to organize all the information obtained but also identifies the core state of affairs from which all the client's difficulties spring. According to Bergner (1998), a linchpin, as the metaphor implies, is what holds everything together; it is what, if removed, might cause destructive consequences to fall apart.

2. **Target factors amenable to intervention:** It is essential that the counselor look at factors that are currently maintaining the client's dysfunctional state and that are directly amenable to therapeutic intervention. The focus is to target the factors that currently maintain the problem and that permit translation into therapeutic factors.

3. **Share the data with the client:** The case formulation shared with the client results in (a) the client organizing his or her thinking about the problem, (b) the client identifying key or central maintaining factors in his or her dysfunction and making them the focal point of change efforts, and/or (c) maximizing the client's sense of control or power over what he or she is doing, sensing, and feeling. As a result, case formulation becomes a collaborative effort between the therapist and the client in an attempt to work through the client's problems.
Models of Case Conceptualization: The Inverted Pyramid Method

A different approach to case conceptualization was provided by Schwitzer (1996), who discussed the inverted pyramid method for client conceptualization. The purpose of this method is to identify and understand client concerns and to provide a diagram that visually guides the conceptualization process.

Step I: Problem identification. The first step involves the exploration of the client's functioning, with emphasis on the inclusion of any potentially useful descriptive information about the client's particular difficulty.

Step II: Thematic grouping. The second step involves the process of organizing the client's problems into intuitively logical groupings or constellations. Thematic grouping entails grouping together those of the client's problems that seem to serve similar functions or that operate in similar ways.

Step III: Theoretical inference about client concerns. The third step requires that the counselor make inferences by applying selective general principles to his or her reasoning about a client's situation. Previously identified symptom constellations are refined further, as the inverted pyramid implies, allowing the counselor to progress down to deeper aspects of the client's problems. This honing-down process emphasizes a smaller number of themes that are unifying, central, explanatory, causal, or underlying in nature (Schwitzer, 1996, pp. 259–260). As a result, these themes can then be made a focus of treatment.

Step IV: Narrowed inferences about client difficulties. Finally, the unifying, causal, or interpretive themes inferred from the previous process are honed into existential, fundamental, or underlying questions of life and death (suicidal ideation or behavior), deep-rooted shame, or rage. This step will help the beginning counselor to apply a theoretical framework to the client's most threatening or disruptive difficulties.

Finally, Murdock (1991) provided an excellent source of information on case conceptualization. Murdock presented a model that focuses on a thorough understanding of the student's counseling theory. As a first step in the process of case conceptualization, this process should be followed by integrating knowledge of the client into a clear conceptualization of the client and his or her concerns.

Case Conceptualization: Applying Theory to Individuals

Murdock (1991) developed a case conceptualization model that can be used with any theoretical orientation. Murdock cautioned that before applying a theory, the counselor must have some understanding of where the client should be going and why the client has come to counseling. Linked to this theoretically based construction are the specific areas of the client's presentation that are considered to be most important. Murdock (1991) further suggested some questions that can be used to help counselors obtain a sufficient level of understanding prior to application.
1. **What is the core motivation of human existence?** Implicitly or explicitly, theories tend to emphasize one major theme that directs or governs individuals’ lives.

2. **How is the core motivation expressed in healthy ways? What are the characteristics of a healthy personality?** Too often counselors find themselves focused on definitions of pathology. At least as important (and possibly more so) are definitions of health.

3. **How does the process of development get derailed or stuck? What are the factors that contribute to psychological dysfunction?**

4. **What stages of the client’s life are considered key in the development process?**

5. **Who are the critical individuals in the client’s presentation? Does the theory restrict the focus to the individual, or does it extend to interactions with family and acquaintances or to multigenerational issues?**

6. **What is the relative importance of affect, cognition, and behavior in this theory?**

In addition, Murdock also addressed the issue of putting together in a coherent way the pieces of the puzzle presented by the client. The counselor must translate the specific presentation of the client into theoretical terms. This process requires the counselor to carefully compare the client’s presentation to the theoretical structure to be used. The following are some questions to be considered:

1. **Do the details of the presenting problem fit the theory’s postulates concerning psychological dysfunction?**

2. **How do other aspects of the client’s presentation fit with the postulates of the theory and the presenting problem?**

3. **Based on this theory, where does the client need to go (i.e., what changes does the theory specify)?**

4. **How can I help the client get where he or she needs to go?**

5. **How will I know when the client is better?**

More recently Murdock (2004) presented a modified and updated version of her 1991 model. The model suggests that the therapist asks pertinent questions about three broad steps to case conceptualization.

**Step 1: Know Your Theory**

What does your theory say is the primary motivation of human behavior? Variance is based on how the theory’s examine man’s motivation.

What are the major constructs of the theory? Are they implicit? Explicit?

What is the process of development from the theory’s perspective? Are there specific stages? If so, what stages are key?

What is psychological health? What is dysfunction?

Are health and dysfunction defined or inferred? Do they consider the client’s cultural background in the conceptualization process?
Who are the important individuals in the client’s life? Parents? Siblings? Nuclear family?
How important are behavior, cognition, and affect in the client’s life?
How does the client present? Cognitively? Behaviorally? Affectively?

**Step 2: Know Your Client**

*General information:* age, sex, race, sexual orientation, religion, cultural background, and so on; and
*Theoretical information:* information based on your theoretical orientation (cognitive = thoughts; behavioral = action, etc.).

**Step 3: Putting It Together**

Does your client’s presenting problem fit with the views of the theory about psychological functioning?
Is it a process of translating the client’s presentation into terms of the theory (Murdock, 2004, pp. 24–27)?

**Treatment Planning**

The variety of case conceptualization models just presented should enable counselors to choose a model that best fits their view of counseling. In addition, the models presented can be adapted to serve as a starting point for the development of the counselor’s own way of viewing clients and their problems and then for determining the best course of treatment. Following the completion of the case conceptualization process, the counselor must decide how to plan effectively for the treatment of his or her client.

Treatment planning is an essential part of the overall process of developing a coherent approach to counseling an individual. According to Seligman (1993), treatment planning in counseling is a method of plotting out the counseling process so that both counselor and client have a road map that delineates how they will proceed from the point of origin (client’s presenting problem) to resolution, thus alleviating troubling and dysfunctional symptoms and patterns and establishing improved coping mechanisms and self-esteem. Seligman further explained how treatment planning plays many important roles in the counseling process:

- A carefully developed treatment plan, fully grounded in research on treatment effectiveness, provides assurance that treatment with a high likelihood of success is being provided.
- Written treatment plans allow counselors to demonstrate accountability without difficulty.
Treatment plans can substantiate the value of the work being done by a single counselor or by an agency and can assist in obtaining funding as well as providing a sound defense in the event of a malpractice suit.

Use of treatment plans that specify goals and procedures can help counselors and clients to track their progress; can determine if goals are being met as planned; and, if they are not, can reassess the treatment plan.

Treatment plans also provide a sense of structure and direction to the counseling process and can help counselors and clients to develop shared and realistic expectations for the process.

Earlier in 1990, Seligman developed a 12-step model for treatment planning. This process, called “DO A CLIENT MAP” (Seligman, 1996, pp. 187–188), includes the following:

D: Diagnosis. This step is the diagnosis of the problem, which employs the use of the DSM-IV as an essential instrument that provides the counselor with knowledge of the mental problems, conditions, stressors, and coping capacities of the client.

O: Objectives of treatment. This step is the determination of the objectives and goals of the client. This planning takes place early in the treatment process. It is essential that counselors and clients work together to establish objectives and goals.

A: Assessment. The counselor can employ the use of inventories of personality, abilities, interests, and values. Furthermore, the counselor can use other health professionals to assist in the process.

C: Clinical. This area includes the counselor qualities that are associated with positive outcomes in therapy.

L: Location. This step is the determination of the type of agency or practice (outpatient, inpatient, day treatment, etc.) most suited to the client.

I: Interventions. This area includes the theoretical orientation of the counselor and the specific techniques or interventions employed.

E: Emphasis. This area includes the level of directiveness and structure, the level of support and confrontation, and the level of exploration.

N: Number of people. Who are the people involved in counseling? Is the client involved in individual, group, or family therapy?

T: Timing. This step is the determination of the length of the counseling sessions. When will the counseling occur?

M: Medication. This step determines the reasons for use of medication with the client, as well as acknowledgment of any precautions that must be considered. Why does this client need medication?

A: Adjunctive services. This step determines the services that can help the client between sessions. Such adjunctive services can include skill development, focused counseling, personal growth, peer support groups, and alternative care.
Practicum Process Issues

P. Prognosis. The prognosis is determined by the natural course of the mental disorder, the presence of coexisting disorders, the highest level of functioning duration and the severity of the disorder, the pattern of onset, the client’s age at onset, the availability of support services, the experience of the therapist, and the client’s expectations and compliance with treatment.

In a similar fashion, Jongsma and Peterson, in *The Complete Psychotherapy Treatment Planner* (1995), discussed the utility of treatment planning and its benefits to the client, therapist, treatment team, and treatment agency. A summary of their points suggests the following:

- The client benefits from a written treatment plan because it delineates issues to be covered in treatment.
- Both client and therapist benefit because they are forced to think about therapy outcomes. Measurable and clear objectives allow the client to channel efforts into specific changes that lead to the long-term goal of problem resolution.
- Providers are aided by treatment plans because they are forced to think analytically about interventions that are best suited to the objective attainment of the client.
- Clinicians benefit from a treatment plan because it is a measure of protection from litigation.
- Agencies benefit from treatment planning by increasing the quality and uniformity of the documentation in a clinical record.

In addition to discussing the utility of treatment plans, Jongsma and Peterson (1995, pp. 2–6) identified six specific steps for developing a treatment plan. A summary of their steps includes the following:

1. Problem selection: During assessment procedures, a primary problem will usually emerge. Secondary problems may also become evident. When the problem selection becomes clear to the clinician, it is essential that the opinion of the client (his or her prioritization of issues) be carefully considered. Client motivation to participate in treatment can depend, to some extent, on the degree to which treatment addresses his or her need.
2. Problem definition: Each problem selected for treatment focus requires a specific definition about how it is evidenced in the client. The *DSM-IV* and *International Classification of Diseases* (ICD-9) offer specific definitions and statements to choose from or to serve as an example for the counselor to develop his or her own personally developed statements.
3. Goal development: These goal statements need not be crafted in measurable terms but can be global, long-term goals that indicate a desired positive outcome to the treatment procedures.
4. Objective construction: Objectives must be stated in behaviorally measurable terms. Each objective should be developed as a step toward attaining the
broad treatment goal. There should be two objectives for each problem, but
the clinician can construct them as needed for goal attainment. Target attain-
ment dates should be listed for each objective.
5. **Intervention creation:** Interventions are designed to help the client complete
the objectives. There should be one intervention for every objective. Inter-
ventions are selected on the basis of client needs and the treatment provid-
er's full repertoire.
6. **Diagnosis determination:** Determination of an appropriate diagnosis is based
on an evaluation of the client's complete clinical presentation. The clinician
must compare the behavioral, emotional, cognitive, and interpersonal symp-
toms that the client presents to the criteria for diagnosis of mental illness
conditions as described in the *DSM-IV*. The clinician's knowledge of *DSM-IV*
criteria and his or her complete understanding of the client's assessment data
contribute to the most reliable and valid diagnosis.

Sperry, Gudeman, Blackwell, and Faulkner (1992) offered another treatment plan
format that is quite elaborate. Sperry cited the “Seven Ps of Treatment Planning,”
or seven dimensions for articulating and explaining the nature and origins of the
patient's presentation. The Seven Ps are presentation, predisposition, precipitants,
pattern, perpetuates, plan, and prognosis. For our purposes, step 6, called treat-
ment planning, is most relevant. It includes the following:

1. **Patient expectations for current treatment, both outcome and method:** Take
note of the patient's formulation or explanation for his or her symptoms or
disorder.
2. **Treatment outcome goals** (*short term and long term*): These can be in bio-
logical, psychological, and social areas.
3. **Rationale for the treatment plan:** This includes the setting, format, duration,
frequency, and treatment strategy.

Finally, Cormier and Nurius (2003, p. 131) provided six guiding principles for use
in the preparation of treatment plans that reflect client characteristics:

- Make sure your treatment plan is culturally as well as clinically literate and
  relevant; that is, the plan should reflect the values and world view of the cli-
  ent's cultural identity, not your own.
- Make sure your treatment plan addresses the needs and impact of the cli-
  ent's social system as well as the individual client, including (but not limited
to) oppressive conditions within the client's system.
- Make sure your treatment plan considers the roles of important subsystems
  and resources in the client life, such as family structure and external support
  systems.
- Make sure your treatment plan addresses the client's view of health and
  recovery and ways of solving problems. Client's spirituality may play a role
  in this regard.
Consider the client's level of acculturation and language dominance and preference in planning treatment.
Make sure the length of your treatment matches the time perspective held by the client.

Goal Setting in Counseling

Setting goals is a vital component of the counseling process. Failure to set goals inhibits the ability of the counselor and client to determine the direction of counseling, to assess the success of counseling, and to know when counseling should be concluded. The setting of goals is mutually determined by the counselor and client. The counselor's training and experience coupled with the client's experience with the issues and personal insight into problems enables the process of goal setting to provide direction to the counselor and client.

The effectiveness of goal setting is determined to a large part by the ability of the counselor and client to choose goals that are relevant, realistic, and attainable and owned by the client. Dyer and Vriend (1988) emphasized specific criteria for judging the effectiveness of counseling goals. They include the following:

1. Goals are mutually agreed on by the counselor and client.
2. Goals are specific.
3. Goals are relevant to self-defeating behavior.
4. Goals are achievable and success oriented.
5. Goals are quantifiable and measurable.
6. Goals are behavioral and observable.
7. Goals are understandable and can be stated clearly.

It is important for the beginning counselor to understand that structured goal setting aids the client in translating his or her concerns into specific steps needed to achieve his or her goals. Beginning counselors are cautioned to make sure that initial goals are modest and capable of being attained by the client with minimal effort. For example, the client states that he is committed to practicing social skills by meeting 10 new people during the week. He is sure that he can complete the task as assigned. The cautious counselor might suggest that the client meet 5 new people during the week, a goal the counselor feels the client can accomplish with minimal effort. Success at accomplishing initial goals fosters future goal attainment.

Using goal setting is an effective way to direct the counselor's attention, to mobilize his or her efforts, and to develop new strategies and developmentally appropriate goals that are specific, measurable, and attainable. Finally, goal setting by the counselor helps reduce his or her anxieties by providing structure to the session and increases the counselor's level of self-confidence with measurable benchmarks of his or her intervention effort.
Summary

This chapter presented a review of some of the major components of effective planning for therapy. Students should add to this review the additional methods and approaches learned in their training programs in an effort to develop an overview of their own approach to counseling the individual.

Similarly, we believe that this chapter can be adapted for use by students in school counseling, agencies, and mental health counseling programs. Remember that assessment of the client and his or her problems and the manner in which the counselor conceptualizes and treats the problem are key aspects of any approach to counseling the individual. Finally, we hope that a review of the materials will enable counselors in training to choose for their use those materials that are in keeping with their understanding of the philosophy–theory–practice continuum.

Suggested Readings


References


Chapter 5
Monitoring the Professional Development of Practicum Students

Role and Function of the Supervisor in Practicum

According to the Association for Counselor Education and Supervision (ACES) guidelines, the role and function of the supervisor in practicum are threefold:

1. to observe ethical and legal protection of clients’ and supervisees’ rights,
2. to meet the training and professional development needs of supervisees in ways consistent with the client’s welfare and programmatic requirements, and

Supervisors are considered to be master practitioners who, because of their special clinical skills and experience, have been identified by the field site to monitor and oversee the professional activities of the counseling student.

University supervisors share a similar role in promoting applied skills but have an indirect or liaison relationship to the field site (Ronnestad & Skovholt, 1993). The function of the supervisor has been variously described in the literature. Dye (1994) suggested that supervision should provide high levels of encouragement, support, feedback, and structure. Psychotherapy supervisors undertake multiple levels of responsibility as teachers, mentors, and evaluators (Whitman & Jacobs, 1998). Bernard (1997), in her discrimination model of supervision, emphasized the need for supervisors to move in and out of the three roles of teacher, counselor, and consultant based on the needs of the counselor. When the focus is
on the counselor’s applied skills, the supervisor uses the teaching role. When
the focus is on the counselor’s anxiety, discomfort, or feelings of inadequacy,
the supervisor may move into a counseling role and help to identify and clarify
how the counselor’s personal dynamics affect the counseling process. When
the counselor and supervisor together focus on the client (identifying client patterns
or brainstorming possible interventions), the supervisor is functioning in the con-
sultant role. At the practicum level, the teaching and counseling roles are likely to
be prevalent.

The role that the supervisor takes with the counselor depends, optimally,
on the developmental level of the counselor (Pearson, 2000). Beginning-level
counselors tend to be uncertain about their counseling effectiveness and skills
and tend to need a great deal of support. Intermediate-level counselors tend to
fluctuate in their levels of confidence. High-level counselors are more consistent
in confidence and skill level. Practicum students are likely to move through the
developmental levels idiosyncratically, usually at the beginning or intermediate
levels. Some move more rapidly than others. Some progress, reach a plateau,
then progress again. Some stay at the beginning levels. Some progress, encounter
a new situation and regress, then stabilize and progress again. The supervisor
often structures the supervision in ways consistent with the developmental needs
of the practicum student.

The most controversial area of supervision lies in the contrast between clinical
functions and administrative supervision functions. Clinical supervision functions
emphasize counseling, consultation, and training related to the direct service
provided to the client by the counselor trainee. Administrative functions empha-
size work assignments, evaluations, and institutional and professional account-
ability in services and programs. For example, when clinical supervision is the
emphasis, the counselor trainee’s development of clinical skills is the focus of the
supervisor–supervisee interaction. Feedback is related to professional and ethical
standards and the clinical literature. In contrast, when administrative supervi-
sion is the focus, issues such as keeping certain hours, meeting deadlines, fol-
lowing policy and procedures, and making judgments about whether work is to
be accomplished at a minimally acceptable level are emphasized. Feedback is
related to institutional standards. Ideally it is recommended that the same per-
son should not provide both clinical supervision and administrative supervision.
Realistically, this is not always the case. Therefore, separate meetings should be
scheduled for clinical and administrative supervision.

The counselor trainee can expect to receive both clinical and administrative
feedback. However, the emphasis of this chapter is directed toward clinical super-
vision and the intervention, assessment, and evaluative techniques related to a
clinical supervisory situation. The student may want to reflect on the proportion
of clinical to administrative supervision that he or she is receiving in practicum.
Beginning the Practicum Experience

Getting Started: Where Do I Begin?

In my experience, the practicum course tends to bring out the most anxiety in students. Prior to the start, most students have not had the experience of interacting one-on-one with “real” clients, or, at the least, their exposure has been very limited. By this time, most students have completed several foundational classes including theory, techniques, and very structured applied work but have not yet begin a true ongoing counseling relationship. This can make students feel very apprehensive and anxious about their upcoming practicum experience.

It has also been my experience that once students break down the requirements and begin to work, the anxiety does begin to slowly rescind. As with most things, the anticipation is often much worse than the actual event. The key is for them to take things one step at a time so they don't become overwhelmed by details. Some common tips for students to consider prior to beginning the practicum course include the following:

1. **Choose an appropriate field site:** Students tend to choose a field site that they are most familiar with, which isn't always the best option. It is better to investigate possible field sites (whether in a school or an agency) to see what best fits with their personal style and learning goals. The field site should be a place where the students feel they will gain the most valuable experience and where they will get the best support in mentoring and supervision. If your university program chooses your site for you, it is best to arm yourself with as much information as possible about the mission, objectives, and goals of the field site. Find out everything you can so you are as prepared as possible, and show your site supervisor that you are prepared to hit the ground running.

2. **Be aware of course requirements:** Practicum course requirements can vary considerably from school to school and program to program. Some requirements are based on accreditation standards and others on professional ideology. For example, some programs may require sessions to be taped and monitored by a third party. A prospective practicum site supervisor needs to be aware of this requirement in the event the field site does not permit such practices. Most programs require a specific amount of direct contact hours and one-on-one sessions. These requirements must be communicated early.

*These sections were contributed by Megan Crucianni, M.A. NBCC, LPC, part-time faculty in the graduate program in counseling at Marywood University, Scranton, Pennsylvania.
in the process so that the field site supervisor can make provisions for these types of tasks to be available to the counselor trainee. It is imperative that students make the site supervisor aware of all class requirements so the student can be sure that all course objectives and requirements are attainable during the field placement.

3. Plan your time wisely. After you have been given all the specific requirements for your practicum course, be sure to create a realistic schedule to make the most of your time. Don't try to do too much in too short a period of time. We all know that unforeseen circumstances can arise, so be sure to give yourself room for unplanned situations. For example, if your course requires 100 on-site hours, you may want to plan for 120 hours of field work so in your schedule you have room to accommodate a variety of occurrences (illness, holidays, missed appointments, etc.) that may affect your scheduled time at the field site. Plan for extra time, and if you don't need it, be happy that you have completed your requirements without any difficulty.

I’ve Taken the Classes, but Do I Really Know What to Do?

Now that you've taken all the classes you need prior to moving on to your practicum experience, you are ready, confident, and completely sure of yourself, right? Most likely you are experiencing the exact opposite emotions as you get ready to begin your on-site-hours. Most students at this stage are feeling anxious, frightened, incompetent, and unsure of their skills. You would not be alone by any means if this description fits you at this point in your academic career, but hold on—there's hope!

So how do you deal with these feelings and jitters? First of all, take a long deep breath and relax (and feel free to repeat this as often as you deem necessary). You would not have gotten this far if you didn't successfully complete the critical components of your program. Remember, you chose this college or university for a reason, so have confidence in your training and in your professors' and instructors' support as you begin your field site experience.

What If I Say Something Wrong?

One of the greatest fears of many students is doing or saying something wrong to a client and not knowing when or how to use the appropriate techniques. One of the most frightening aspects is that this may depend to a large degree on the client's needs. In addition, there is no cookie-cutter way to perform successfully in a counseling session.

So what happens if you say something wrong? In most situations, honesty is the best policy. If it is a minor offense and you feel you may have slightly offended the client, apologize (“I'm very sorry, it appears that I may have offended you by asking that question. Please permit me to rephrase the question.”). It is important that your clients know you are being authentic and tuned into them.
and their needs. Remember, the counseling relationship is a two-way street. You need to be genuine with your clients if you expect them to reciprocate.

If you feel you have made an egregious error, consult with your faculty or site supervisor and have him or her assist you in coming up with a plan to deal with the situation. Remember, first and foremost, “do no harm,” and if you feel that somehow you have crossed into that territory, you need to deal with the issue as quickly and thoroughly as possible. Don’t be afraid to ask for help if you need it. Recognizing when this happens and seeking appropriate help are signs of a competent counselor.

**How Do I Know When to Use the Right Techniques?**

Finding the appropriate techniques can be difficult for beginning counselors. It is best if you review a perspective technique or intervention before using it and consult with your supervisor to get his or her input as to its suitability for the client and your ability to properly execute it. Chances are you have the capability to implement the technique but need some extra support and feedback as to how to use it and ensure its appropriateness.

As we stated before, there is no perfect cookie-cutter way to proceed in your treatment of clients. However, one of the greatest benefits of your practicum experience is your knowing that you have support from experienced professors and supervisors who are willing to provide you with the needed support in your effort to implement the appropriate techniques and strategies in your counseling session.

**But I’m Just a Rookie! (Learning to Trust Yourself and Your Inner Voice)**

When students are first beginning to work with clients in live sessions, it is common for them to try to recall all of the knowledge and skills they have learned in the classroom. Although this can be beneficial in some ways, it may actually stifle the session and the client.

If the student counselor is distracted by attempting to recall all of the information learned in course work, he or she may not be fully present with the client. It is critical to the counseling process that you are as completely present with the client as possible to ensure that the correct information is taken in and also to assure the client that you are listening attentively. The client should be encouraged by the fact that you are attentive and feel that what he or she is saying has value. In addition, the counseling process cannot proceed if you are not authentic to yourself. In other words, be yourself! If the client senses that you are not being genuine, he or she may reciprocate in kind. If you want the client to truly be himself or herself and to be open to you, you must be open yourself. The process becomes easier if you have the confidence in the knowledge and skills learned in your training program.
So how does one go about doing this? Of course it does take time and experience to relax and be yourself. The goal of the practicum experience is to assist student counselors in the honing of therapeutic skills and the building of a level of confidence and comfort in their counseling. It is important to note that the field site experience is the setting most appropriate for honing skills in a clinically supervised environment.

One of the most difficult aspects of counseling is the learning to trust one's own instincts or inner voice. This does occur over time, but like many other aspects of counseling, it often needs some tweaking in the beginning stages of counseling experience. To accomplish trust in oneself, the student must first listen to his or her inner voice and instincts, trust them, and then observe the outcome. Like learning techniques and interventions, there are trials and errors, but if you can learn to trust yourself and that inner voice, you will be more genuine in your counseling relationships, which will serve to greatly enhance the counseling process. It is only when you learn to listen to and use your inner voice that you can truly see the counseling process at work—and it can be really wonderful when you do.

When in Doubt, Consult! (Your Faculty and Site Supervisors Are There to Help You)

One of the most important aspects of counseling is your knowing when to seek professional or supervisory assistance. Throughout your course work, you have been taught to recognize your areas of strengths and weaknesses. This is vital to your success as a counselor. As mentioned in the previous section, your instinct or inner voice plays a large part in knowing when to seek assistance, because it can let you know when you are in over your head or if you are unsure of your boundaries.

If you are not certain of how to proceed with a client, if you feel your ethics may be at risk, or if you are dealing with an issue you know is a difficult one for you, it is important for you to seek consultation with another professional. Your practicum experience will help you with these issues because you are already receiving close supervision and support. When you are finished with your school requirements and are on your own, you will find it is still critical to seek consultation when you deem it necessary. This is always the best practice to be sure that you are helping your clients appropriately and professionally.

Consultation happens at all levels, not just at the novice level. Professionals who have been in the field for many years often consult with others when they feel it is necessary. It is a process that ensures that you have your client's best interest at heart. Consultation should never be seen as a sign of weakness or incompetence but rather be seen as the hallmark of a professional working ethically and responsibly. It is a truly professional counselor who realizes and accepts his or her limitations and is not too proud or overzealous to seek assistance and consultation from another professional. If you need to consult, it is important to be sure to consult with a trusted and ethical professional.
The Supervisor–Supervisee Relationship

In clinical supervision, the importance of developing a working relationship with the supervisor cannot be overstated. Thus, practicum students should assess their own attitudes, biases, and expectations as they enter into the supervisory process.

Kaiser (1997), in discussing the supervisor–supervisee relationship, suggested that supervision takes place in context of the relationship between supervisor and supervisee. Kaiser cited the following three components of the relationship: “the use of power and authority, creation of shared meaning, and creation of trust” (p. 16). It is essential that the counselor trainees recognize that supervisors do have power over them, primarily because they will be evaluating the trainees’ work. Thus trainees need to be open and honest with their supervisors to gain effective guidance and feedback. Similarly, the creation of shared meaning between supervisor and supervisee is related to understanding and agreement between the two parties. The degree to which understanding and agreement are obtained determines how the two parties can communicate. Finally, the creation of trust between supervisor and supervisee develops out of the creation of shared meaning and by building confidence in the mutual understanding between the two parties. Scott (1976) emphasized the importance of establishing a collegial relationship within the supervisor–supervisee interaction. The relationship is characterized by balance and a shared responsibility for understanding the counseling process. A disruption in this balance or an inability to establish collegiality should be open areas of discussion to identify learning problems. A general rule is that disruptions in the supervisor–supervisee relationship always take precedence.

Direct supervision of clinical work is perhaps the most important element in the training of a counselor or psychotherapist. Supervision is more than a didactic experience. It includes intensive interpersonal interaction with all of the potential complications that such relationships can include. Research has documented the importance of the supervisor–supervisee relationship. Several studies have related success in supervision to the quality of the relationship between the supervisor and the supervisee (Alpher, 1991; Freeman, 1993). Relationship qualities of warmth, acceptance, trust, and understanding are defined as fundamental to positive supervision. Good supervision must integrate both task-and relationship-oriented behavior. In positive supervision experiences, a critical balance exists between relationship and task focus. In negative supervision experiences, the total emotional focus is on the negative relationship.

The supervisee enters into the supervisory relationship with a number of predictable anxieties. Common sources of supervisee anxiety are (a) concerns over whether he or she will be successful in the practicum and (b) power issues within the supervisor–supervisee relationship. Concerns over performance and arrival by supervisors can lead to a defensive stance on the part of the student. It is not uncommon for trainees to react by criticizing their supervisors, therefore becoming resistant to supervisory feedback and evaluation. Borders (2001) emphasized that a safe environment that demonstrates mutual respect is
necessary for a supervisee to be open to feedback and be willing to learn and change.

The literature cited in the foregoing section may provide the practicum student with sufficient rationale and motivation to consider the supervisor-supervisee relationship as an important area on which to focus during supervision. Relational concerns and conflicts clearly detract from the amount of learning in supervision.

### Approaches to Supervision

The practicum student often approaches clinical supervision with mixed feelings. On the positive side, supervision can be regarded as a helpful supportive interaction that focuses on validating some practices. On the negative side, supervision can be regarded as an interaction that will expose inadequacies and leave the student with even more feelings of incompetence. Both sets of expectations coexist as the student approaches supervision. The tendency, particularly in the early stages of supervision, is for the student to work at proving himself or herself as a counselor so that the negative feelings of inadequacy will diminish. This is a natural and understandable tendency. However, giving full reign to this tendency would lead the supervision process away from ambiguous aspects of counseling which require clarification, and could lead to avoidance or defensiveness about aspects of the student’s approach to counseling that need improvement. Generally, the initial phases of supervision are spent establishing a working alliance between the supervisor and supervisee. This holds true for the various approaches to supervision that might be implemented. To reduce the practicum student’s anxieties about supervision and to facilitate the creation of a working alliance, we believe a preview of how supervision could be implemented is in order. Several major models of counseling supervision have been selected from the literature to provide the practicum student with an overview of models that he or she may expect in the supervision process (Barnard & Goodyear, 2002; Borders & Brown, 2005; Bradley & Ladany, 2001).

### The Psychodynamic Model

In the psychodynamic model, “counselor supervision is a therapeutic process focusing on the intrapersonal and interpersonal dynamics in the supervisee’s relationship with client, supervisors, colleagues, and others” (Bradley & Ladany, 2001, p. 148). Goals in this approach are to attain awareness of and acquire skills in the use of dynamics in counseling. The supervisee might expect to focus on a parallel process; that is, the idea that similar dynamics occur in the counselor–client dyad and the supervisor–supervisee dyad.

Another focus might be on the interpersonal dynamics between the supervisee and the client where the supervisor teaches the supervisee by modeling effective interpersonal dynamics. A third focus might be on the interpersonal...
dynamics occurring in the counseling situation. Here the supervisor brings attention to how internalized feelings, thoughts, and meanings are affecting the thoughts and meanings of the supervisee and the client.

**The Behavioral Model**

The behavioral model focuses on the skill behaviors of the supervisee. This includes the supervisee's thinking, feeling, and acting behaviors at difficulty levels from fundamental to advanced skills. Five steps are sequenced as follows: (a) establishing the supervisor–supervisee relationship, (b) analyzing skills and assessing, (c) setting supervisory goals, (d) constructing and implementing goals, and (e) evaluating. Experiences utilized in this approach might include self-appraisal, peer supervision, modeling, role playing, and microtraining (Bradley & Ladany, 2001, pp. 157–161).

**The Cognitive Model**

The cognitive model of supervision is grounded in cognitive theories that have a primary assumption that affect and behavior are determined by a person's cognitive structure of the world. Cognitive supervision is an “interpersonal process that encompasses both education in the techniques and methods of cognitive therapy and recognition of the thoughts and beliefs that contribute to emotional reactions in both the supervisory and the counseling process” (Bradley & Ladany, 2001, p. 166). Techniques in this approach might include mental practice, cognitive modeling, supervisee self-talk, and cognitive skills training (pp. 166–172).

**The Discrimination Model of Supervision**

Bernard's (1979, 1997) discrimination model is widely used in counseling supervision. In this model, the roles of teacher, counselor, and supervisor are taken by the supervisor as he or she focuses on any one of four areas of counseling: counseling performance skills, cognitive counseling skills, counselor self-awareness, and professional behavior.

Counseling performance is about what a counselor does during a session of interviewing and counseling. Cognitive counseling skills refer to how a counselor thinks about the counseling. The focus here is on case conceptualization or a comprehensive explanation of the client and his or her issues. Self-awareness refers to the supervisee's recognition of personal issues, beliefs, and motivations that may affect the counselor–client interaction. Finally, professional behaviors refer to knowledge, understanding, and application of ethical legal and professional guidelines (Borders & Brown, 2005, pp. 7–9). In this model, the supervisor has great flexibility in how each focus area is approached. For example, the supervisor may take the role of teacher when addressing a situation where the discussion is about how an ethical standard such as “duty to warn” may apply
to a client. In another situation, the supervisor may take on the role of counselor when the focus is on self-awareness, and the supervisor helps the counselor identify his or her feelings of anxiety when a client talks about acting out.

The approaches to supervision that have been reviewed are those that are most likely to be experienced by the practicum student. Because the trainee will probably have more than one supervisor during the field experiences, it is likely that he or she may be working with a university supervisor who utilizes the behavioral approach to supervision while simultaneously working with a field site supervisor who utilizes a cognitive approach to supervision. The trainee is advised to be open to any one of the approaches to supervision by recognizing the goals and advantages of each type of supervision.

**Identifying Professional Development Skill Areas**

In this section we will address the need for, the categories of, and the skills necessary for professional counselor development. We believe that the practicum student, the intern, and the practicing professional should continually strive to increase the depth and understanding of themselves and their area(s) of expertise. One never truly arrives at complete understanding. However, each session affords not only the client but also the counselor with the opportunity for growth and development. For this to occur, the student counselor must continually examine and reflect on his or her strengths and weaknesses. The framework presented here has been drawn from the work of Borders and Leddick (1997) and Borders and Brown (2005). Four broad skill areas have been identified as those within which self-assessment, peer assessment, supervisor assessment, goal identification, and evaluation can be implemented. These skill categories are (a) counseling performance skills, (b) cognitive counseling skills, (c) self-awareness, and (d) developmental level.

**Counseling Performance Skills**

Counseling performance skills refer to “what the counselor does during the session” (Borders & Brown, 2005, p. 8) or his or her counseling behaviors. This includes basic and advanced helping skills, theory-based techniques, and procedural and issue-specific skills.

**Basic and Advanced Helping Skills**

Egan (1994) presented a three-stage counseling model of problem identification, successful clarification, and goal setting. Incorporated into this model were the core facilitative skills for counseling, which include accurate empathy, genuineness, respect, concreteness, and attending skills.
Egan (1994) suggested that there are three levels of attending to clients. The first microskill or level deals with mechanics. What does the counselor do to attend? Egan used the abbreviation SOLER to remind counselors and trainees to do the following:

- **S**: Face the client *squarely*.
- **O**: Adopt an *open* posture.
- **L**: At times, *lean* toward the client.
- **E**: Maintain good *eye contact*.
- **R**: Try to be relatively *relaxed*.

The second level addresses the counselors’ ability to read or be attuned to the cues and messages they are sending through their bodies as they interact with the client. The third level addresses the quality of the total human experience between counselor and client.

The skills of paraphrasing, reflecting feelings, clarifying and summarizing, and appropriate questioning also facilitate counseling communication. Hunsaker and Alessandra (1986) suggested that there are two basic forms of questions: open questions, which are nondirective and inviting, and closed questions, which are directive. By utilizing these two basic forms of questions, the counselor can guide and structure the therapy session. The counselor may use clarifying questions to seek verification of content, developmental questions to draw out a broad response and invite client narrative and expansion, or closure questions to encourage agreement and/or successful implementation of a suggested plan or solution (p. 111). Appropriate use of questioning is usually characterized by emphasizing the use of open-ended questions.

Advanced helping skills presented in the Egan model are interpretation, self-disclosure, confrontation, and immediacy. This four-stage, skill-specific model is used widely in counselor training programs and provides a useful and concrete framework from which to provide feedback and ongoing evaluation in commenting on the practicum student’s counseling performance skills. Another useful model regarding similar skills is the microskills training model (Ivey, 1994; Ivey & Authier, 1978). This model identifies basic and advanced skills ranging from attending behavior to skill integration and developing one’s own style and theory. The microskills model can also provide a helpful framework for feedback and evaluation.

**Theory-Based Techniques**

Theory-based techniques are performance skills that the counselor or trainee uses to help the client address those gaps and distortions uncovered during therapy. For example, how does the trainee challenge a client’s irrational belief system? How does the trainee manage reluctance and resistance?

The techniques chosen by the trainee should be based on two considerations: (a) the goals of the therapy sessions, and (b) the style or theory the therapist or
trainee is implementing. The techniques used by a counselor or trainee practicing cognitive therapy will be very different from those used by someone who is practicing reality therapy. The importance here is not the validity of the different approaches but rather the appropriate use and understanding of varying techniques. Again, to remain professionals, counselors must continually seek supervision and evaluation of their skills, knowledge, and understanding in their area of expertise.

At this point, it is helpful if the counselor trainees review (a) their own philosophic view of the individual, (b) the theoretical framework that they will employ with this client, and (c) the specific techniques to be employed in the sessions. To that end the following section will present an overview of critical questions, theory components, and techniques that will assist trainees in reviewing their presession preparation. This review is helpful to trainees in providing a framework for the assessment of their performance skill assessment that will occur in clinical supervision. The review also contributes to the development of cognitive counseling skills emphasized in the next skill area.

A Review of Philosophy and Theories of Counseling

Counselors in training are frequently overwhelmed by the complexity and amount of theories and techniques that they are expected to learn and apply in counseling. Typically, training programs begin with courses that focus on the student’s biases, values, and beliefs. Generally, students are asked to write a paper focusing on their long-held, but usually not articulated, beliefs about man’s development. This initial exercise helps students to examine current values, beliefs, and biases in light of the many diverse theories to be studied. The authors have a long-standing belief that understanding your own beliefs and values is the first step in the development of a personal theory of counseling. Students are expected to reflect on and critically examine the theories to determine the degree of fit for them as they attempt to merge their own feelings about man with the theories studied. Students are further encouraged to discuss their personal theory of counseling with other students and to solicit their feedback about critical issues. Feedback and discussion helps students to clarify, modify, or change their personal theory of counseling in light of new information gained.

The following questions are provided to stimulate students’ interest in attitudes and beliefs about counseling:

- Is man good? Bad? Neutral?
- Is man determined? Does he have free will?
- Is man a pilot? Victim? Robot?
- Should I focus on the present? Past? Future?
- Should I be active? Directive? Supportive?
- Should I focus on thinking? Feeling? Behaving?
Should I determine the goals? Client? Both?
Do I view man subjectively? Do I view him objectively?
Do I focus on who man is? What he was? What he does?
Do my values influence my theoretical position?
Do I know and understand my values? Biases? Beliefs?
What is mental health? What is dysfunction?
Do I understand my culture? The client’s culture?
Do I know the ethical standards of my profession?

Answering these questions aids students in examining the key issues addressed in theories of counseling. In addition, Chart 5.1 is provided to give the student a basic overview of the key points addressed in theories of counseling and psychotherapy. Emphasis in this theory-based techniques section focuses on intervention strategies.

### Overview of Theories of Counseling and Psychotherapy

<table>
<thead>
<tr>
<th>Human Nature</th>
<th>Key Concepts</th>
<th>Intervention</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Freud</strong></td>
<td>id, ego, and superego, conscious, unconscious, preconscious, ego defense mechanisms, psychosexual stages, transference and free association</td>
<td>analysis of transference and counter-transference, resistance, dream interpretation</td>
<td>make unconscious conscious, apply appropriate defenses</td>
</tr>
<tr>
<td>man as biological organism, motivated to fulfill bodily needs, ruled by unconscious, instincts driving forces behind personality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Jung</strong></td>
<td>principle of entropy and equivalence, personal and collective unconscious, extraversion and introversion, thinking, sensing, feeling, intuiting</td>
<td>dream interpretation, use of symbols, word association</td>
<td>understand data from personal unconscious, resolve inner conflict, balance, and integrate</td>
</tr>
<tr>
<td>man motivated to grow and develop toward individuation, growth as lifelong process, tendency toward wholeness, unification of opposing aspects in the psyche</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Adler</strong></td>
<td>style of life, strive for superiority, birth order, early recollections</td>
<td>analysis of birth order, understanding style of life</td>
<td>development of socially useful goals, fostering social interest</td>
</tr>
<tr>
<td>inferiority feelings, free will to shape forces, unique style of life, strive for perfection, social interest</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Theories of Counseling and Psychotherapy (continued)

<table>
<thead>
<tr>
<th>Human Nature</th>
<th>Key Concepts</th>
<th>Intervention</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Erikson</strong></td>
<td>potential to direct our growth throughout our lives, personality affected by learning, experience over heredity</td>
<td>psychosocial stages of development, epigenetic principle of maturation, personality development throughout the lifespan, identity crisis in adolescence</td>
<td>analyzing basic weaknesses caused by ineffectual resolution of develop mental crisis. Adaptation</td>
</tr>
<tr>
<td><strong>Kelly</strong></td>
<td>optimistic, free to choose direction of our lives, development of constructs to view the world</td>
<td>anticipation of events, psychological processes directed by our constructs, ways of anticipating life events</td>
<td>assessment interview, self-characterization sketch, role construct repertory test</td>
</tr>
<tr>
<td><strong>Skinner</strong></td>
<td>people shaped more by external variables than genetic factors, behavior controlled by reinforcement, responsible for developing our own environment</td>
<td>functional analysis- assessing frequency of behavior—situation in which it occurs—and reinforcement associated with the behavior</td>
<td>direct observation of behavior, reinforcement schedules, operant conditioning</td>
</tr>
<tr>
<td><strong>Bandura</strong></td>
<td>behavior controlled by the person through cognitive processes and environment through external social situations</td>
<td>process of observational learning, attention, retention, production, and motivation</td>
<td>direct observation of behavior, self-report inventories, physiological measures</td>
</tr>
<tr>
<td><strong>Ellis</strong></td>
<td>tendency to think both rationally and irrationally, ability to develop self-enhancing thoughts, feelings, and behaviors</td>
<td>development of rational philosophy of life, testing one's assumptions and validity of beliefs</td>
<td>ABCD theory of change, cognitive, affective, and behavior interventions</td>
</tr>
</tbody>
</table>
Theories of Counseling and Psychotherapy (continued)

<table>
<thead>
<tr>
<th>Human Nature</th>
<th>Key Concepts</th>
<th>Intervention</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Allport</strong></td>
<td>uniqueness of the individual personality, people guided by the present and future, conscious control of life</td>
<td>traits are consistent and determine behavior, personal dispositions, functional autonomy, stages of development, the proprium</td>
<td>personal document technique, study of values</td>
</tr>
<tr>
<td><strong>Horney</strong></td>
<td>man is unique, innate potential for self-realization, ability to solve our own problems</td>
<td>basic anxiety, neurotic needs, moving toward, away, and against people</td>
<td>free association, dream interpretation, tyranny of the “shoulds”</td>
</tr>
<tr>
<td><strong>Fromm</strong></td>
<td>man can shape his own nature and destiny, innate ability to grow, develop, and reach his full potential</td>
<td>freedom versus security, interpersonal relatedness, basic psychological needs, character types</td>
<td>dream analysis, free association, interpretation of history, culture, and social events, clinical observation</td>
</tr>
<tr>
<td><strong>Murray</strong></td>
<td>personality determined by needs and environment, grow and develop and change our society</td>
<td>personology, id, ego, superego, stages of development, complexes</td>
<td>Thematic Appercetion Test, achievement and affiliation needs, techniques of assessment</td>
</tr>
<tr>
<td><strong>Cattell</strong></td>
<td>deterministic, the regularity and predictability of behavior, influence of nature and nurture, innate traits</td>
<td>life records (L data), questionnaire (Q data), personality test (T data), factor analysis</td>
<td>common and unique traits, ergs and sentiment, stages of development</td>
</tr>
<tr>
<td><strong>Maslow</strong></td>
<td>humanistic and free will to choose how we satisfy needs and fulfill potential</td>
<td>hierarchy of needs, peak experiences, self-actualization</td>
<td>physiological needs, safety needs, esteem needs, belongingness, and love</td>
</tr>
</tbody>
</table>
Theories of Counseling and Psychotherapy (continued)

<table>
<thead>
<tr>
<th>Human Nature</th>
<th>Key Concepts</th>
<th>Intervention</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rogers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>optimistic, free will in determining, understanding and improving oneself, innate tendency to grow and enhance</td>
<td>self-actualization tendency, organismic valuing process, conditions of worth, incongruency</td>
<td>unconditional positive regard, supportive dialogue, nonjudgmental therapeutic environment</td>
<td>to move toward self-actualization, responsibility for behavior</td>
</tr>
<tr>
<td>Existentialists</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>optimistic, freedom, choice, self-determination, creation of meaningful life</td>
<td>self-awareness, uniqueness and identity, being in the world, anxiety as a fact of life</td>
<td>understand client's current experience, techniques to increase client's awareness, choosing for oneself</td>
<td>accept freedom and responsibility for actions, to live an authentic life</td>
</tr>
</tbody>
</table>

Identifying Your Theory and Techniques Preferences

In the last several sections of this chapter, you have been asked to answer a number of questions regarding your values, beliefs, and views of man. Similarly, you have read over the above review of the major theories of counseling and psychotherapy. You are now asked to complete the following SELECTIVE THEORIES SORTER (STS) to help you determine your theoretical orientation (Table 5.1). The sorter was designed to give you insight into your theoretical preferences, and assess your views of pathology, the counseling process, and treatment modalities.

Techniques Used in Counseling and Psychotherapy*

Major growth has occurred in the counseling and psychotherapy professions in recent years. Different philosophical positions have given rise to new theories, which in turn have produced a search for additional approaches. The number of counselors, therapists, and clinicians has increased, while also expanding the scope of individuals to whom counseling services has [sic] been made available.

Because no one counseling technique is appropriate for all clients or is flexible enough to use at the various depths required in counseling, additional counseling techniques have become a necessity. Research and experimentation have led to new techniques and to an identification as to which techniques are most
### Table 5.1 Selective Theory Sorter (STS)

Read the following statements and indicate the strength of your beliefs in the white box following the statement. Your response for each item can range from −3 to +3 depending on the extent to which you believe a statement is not at all like you (−3) to a lot like you (+3). For example: If you believe the statement presented in item 30, “people are sexual beings,” is a lot like your view of counseling, your answer might look like this:

<table>
<thead>
<tr>
<th>30. People are sexual beings.</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Selections" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1. A counselor should use bits and pieces from different theoretical systems of counseling and psychotherapy that can be integrated.</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Selections" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. A major goal of therapy should be to assist the client in reaching a stage of unconditional self-acceptance by changing irrational beliefs.</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Selections" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. A warm relationship between the therapist and client is not a necessary or sufficient condition for effective personality change.</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Selections" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Behavior is a way to control perceptions.</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Selections" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Behavior is both consciously and unconsciously motivated by the environment and psychic energy.</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Selections" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Childhood events are the baseline for adult personality.</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Selections" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Childhood sexual attractions toward parents are responsible for later neurotic symptoms.</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Selections" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. Clients are capable of imagining which behaviors are desirable and then working to make those images a behavioral reality.</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Selections" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. Clients must take ultimate responsibility for the way their life is lived.</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Selections" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10. Coming to grips with the unconscious part of the personality is the only way to truly achieve individuation.</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Selections" /></td>
</tr>
</tbody>
</table>

(continued on next page)
### Table 5.1 (continued)  Selective Theory Sorter (STS)

<table>
<thead>
<tr>
<th>Not at all like me</th>
<th>Neutral</th>
<th>A lot like me</th>
</tr>
</thead>
<tbody>
<tr>
<td>-3</td>
<td>-2</td>
<td>-1</td>
</tr>
<tr>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>D</td>
<td>E</td>
<td>F</td>
</tr>
<tr>
<td>G</td>
<td>H</td>
<td>I</td>
</tr>
<tr>
<td>J</td>
<td>K</td>
<td>L</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11. Dream interpretation, free association, hypnotic techniques, and fantasizing are good ways of gaining access to the client’s unconscious.</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Each person determines the essence of his or her existence.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Each person is unique and has the ability to reach full potential.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Everyone is unique.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Feelings are neither good nor bad but are events, facts of our existence, real, and indisputable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Feelings may be changed through knowledge of their origin followed by a change in behavior.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Goals of therapy should include assisting the client in learning the consciousness of their responsibility, to bring unconscious spiritual factors to the conscious, and to recover meaning to existence.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. How a person thinks largely determines how one feels and behaves.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Human problems stem not from external events or situations but from people’s view or beliefs about them.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Humans are constantly striving to maintain equilibrium.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Humans are pulled by the future and are self-controlled.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Humans strive for actualization to maintain or promote growth.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Irrational beliefs are the principal of emotional disturbance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. It is important to fulfill one’s needs, and to do so in a way that does not deprive others of the ability to fulfill their needs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Maladaptive behaviors, like adaptive behaviors, are learned. They can also be unlearned.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 5.1 (continued)  Selective Theory Sorter (STS)

<table>
<thead>
<tr>
<th></th>
<th>Not at all like me</th>
<th>Neutral</th>
<th>A lot like me</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>–3</td>
<td>–2</td>
<td>–1</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
</tbody>
</table>

26. Maladjusted behavior results in losing effective control over perceptions and over entire lives.

27. Maladjustment can be determined by the degree of disturbance between personality constructs.

28. Movement toward psychological growth and self-actualizing is often sabotaged by self-defeating thoughts.

29. Mutual trust, acceptance, and spontaneity are important when building the counselor/client relationship.

30. People are sexual beings.

31. People control what they believe, not what actually exists.

32. People have both internal and external definitions of themselves.

33. People have the need to survive and reproduce basic biological needs.

34. Personality development is founded more on a progression of learned cognitions than on biological predispositions.

35. Personality is acquired through the use of negative and/or positive reinforcers.

36. Personality is constructed through the attribution of meaning.

37. Providing genuineness, unconditional positive regard, and empathic understanding are essential to promote growth in the client.

38. Recognizing cognitive processing in emotion and behavior is central in therapy.

39. Social urges take precedence over sexual urges in personality development.

40. Successful adaptation to life depends on the degree of social interest in goal striving.

41. The central focus of counseling should be the client's experiencing of feelings.

(continued on next page)
Table 5.1 (continued)  Selective Theory Sorter (STS)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not at all like me</th>
<th>Neutral</th>
<th>A lot like me</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-3</td>
<td>-2</td>
<td>-1</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>42. The conscious rather than unconscious is the primary source of ideas and values.</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>43. The counselor should assume that the client is the expert on his or her problems.</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>44. The human personality consists of three “figures”: child, parent, and adult.</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>45. The integration of the total person in his or her own unique field is essential in therapy.</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>46. The major goal of therapy is the gaining of client autonomy.</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>47. The past determines the present, even though human motivation should be focused on the future.</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>48. The process of individuation and self-realization should be the goal of living and of therapy.</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>49. The purpose of therapy is to bring the unconscious to the conscious.</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>50. The role in the family is one of the biggest influences in determining the personality characteristics of the client.</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>51. The unconscious contains more than repressed material; it is a place of creativity, guidance, and meaning.</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>52. The ways people form, organize, and interpret their basic cognitive structures determine how they will perceive and behave.</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>53. Therapy is unique, humanistic, cognitive, and existential.</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>54. Therapy should be here-and-now based, where every moment of life matters.</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>55. Therapy should focus on living more honestly and being less caught up in trivialities.</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>56. There are no underlying causes for maladjustment. Maladjustive behavior can be directly defined and attacked.</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
</tbody>
</table>
### Table 5.1 (continued)  Selective Theory Sorter (STS)

<table>
<thead>
<tr>
<th></th>
<th>Not at all like me</th>
<th>Neutral</th>
<th>A lot like me</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-3</td>
<td>-2</td>
<td>-1</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
</tbody>
</table>

| 57. There is no one best approach or strategy when it comes to therapy. |
| 58. There is no one true path to effective psychotherapy. |
| 59. There is no such thing as free will or voluntary behavior. |
| 60. Viewing an event or situation out of context is one of the systematic errors in cognitive reasoning. |

#### Column Totals

<table>
<thead>
<tr>
<th>Theory</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Psychoanalytic</td>
<td></td>
</tr>
<tr>
<td>B. Adlerian</td>
<td></td>
</tr>
<tr>
<td>C. Jungian</td>
<td></td>
</tr>
<tr>
<td>D. Client-Centered</td>
<td></td>
</tr>
<tr>
<td>E. Gestalt</td>
<td></td>
</tr>
<tr>
<td>F. Transactional Analysis</td>
<td></td>
</tr>
<tr>
<td>G. Behaviorism</td>
<td></td>
</tr>
<tr>
<td>H. REBT</td>
<td></td>
</tr>
<tr>
<td>I. Reality</td>
<td></td>
</tr>
<tr>
<td>J. Cognitive-Behavioral</td>
<td></td>
</tr>
<tr>
<td>K. Integrative</td>
<td></td>
</tr>
<tr>
<td>L. Existential</td>
<td></td>
</tr>
</tbody>
</table>

#### Scoring the Selective Theory Sorter (STS)

Use the following instructions to score the STS:

1. To score the STS, add the scores in each column on each page. Be sure to accurately count both positive and negative numbers.
2. Transfer the column totals to the corresponding theories listed below:
appropriate when using a specific theoretical base with a client in the remedial, preventive, or developmental area. Thus, the counseling profession has developed to the stage where each counselor can select techniques according to his or her own philosophical base and according to the client’s needs. When the counselor recognizes his or her own limitations in using a wide range of techniques, this knowledge enables the counselor to refer certain clients, seek consultation when working with some clients, request that a co-counselor or co-therapist work with specific clients, or limit one’s practice to clients who can be assisted with the competencies of the counselor.

The Counseling Techniques List (Form 5.1) provides a list of counseling and psychotherapy techniques, which, while not all-inclusive, does represent techniques used by a broad spectrum of philosophical bases. The number of counseling techniques used by any one counselor varies. If a counselor reviews his or her tape recordings from several sessions with different clients, ten to fifteen different techniques may be identified that were used frequently with competence. An additional ten to fifteen may be identified that were used but were used with less frequency or, in some cases, with less professional competence.
Suggestions for using the accompanying Counseling Techniques List are dependent upon one's professional development. However, students in courses used the list primarily in two ways:

1. To check out and expand their knowledge about counseling techniques, and
2. To introspect into their own counseling, philosophical bases, and treatment approaches.

For further information about using the Counseling Techniques List please read the directions at the beginning of Form 5.1. These directions should be read in their entirety before proceeding with the completion of the form.

**COUNSELING TECHNIQUES LIST**

**Directions**

1. First, examine the techniques listed in the first column. Then, technique by technique, decide the extent to which you use or would be competent to use each. Indicate the extent of use or competency by circling the appropriate letter in the second column. If you do not know the technique, then mark an “X” through the “N” to indicate that the technique is unknown. Space is available at the end of the techniques list in the first column to add other techniques.

2. Second, after examining the list and indicating your extent of use or competency, go through the techniques list again and circle in the third column the theory or theories with which each technique is appropriate. The third column, of course, can be marked only for those techniques with which you are familiar.

3. The third task is to become more knowledgeable about the techniques that you do not know—the ones marked with an “X.” As you gain knowledge relating to each technique, you can decide whether you will use it and, if so, with which kinds of clients and under what conditions.

4. The final task is to review the second and third columns and determine whether techniques in which you have competencies are within one or two specific theories. If so, are these theories the ones that best reflect your self-concept? Do those techniques marked reflect those most appropriate, as revealed in the literature, for the clients with whom you want to work?

**Key**

- **N** = None
- **M** = Minimal
- **A** = Average
- **E** = Extensive
<table>
<thead>
<tr>
<th>Technique</th>
<th>Extent use or competency</th>
<th>Theory with which technique is most appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptance</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Active imagination</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Active listening</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Advice giving</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Alter-ego</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Analysis</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Analyzing symbols</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Assertiveness training</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Audiotape recorded models</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Authoritarian approach</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Aversion-aversive conditioning</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Behavior modification</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Bibliotherapy</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Break-in, break-out</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Bumping in a circle</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Cajoling</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Case history</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Catharsis</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Clarifying feelings</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Cognitive restructuring</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Commitment</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Conditioning techniques</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Confession</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Confrontation</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Congruence</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Contractual agreements</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Cotherapist</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Counterpropaganda</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Countertransference</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Crying</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Decision making</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Democratic</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Desensitization</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Detailed inquiry</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Diagnosing</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Doubling</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Dream interpretation</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Technique</td>
<td>Extent use or competency</td>
<td>Theory with which technique is most appropriate</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>--------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Dreaming</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Drugs</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Empathy</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Encouragement</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Environmental manipulation</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Explaining</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Fading</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Family chronology</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Family group counseling</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Fantasizing</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Feedback</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Filmed models</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>First memory</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Free association</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Frustration</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Game theory techniques</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Group centered</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Group play</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Homework</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Hot seat</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Identification of an animal, defend it</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Identification of self as great personage</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Imagery</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Inception inquiry</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Informativity</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Interpersonal process recall (IPR)</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Interpretation</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Irrational behavior identification</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Laissez-faire groups</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Life space</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Live models</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Magic mirror</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Misinterpretation, deliberate</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Modeling</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Multiple counseling</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Natural consequences</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Negative practice</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Negative reinforcement</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Orientative</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Technique</td>
<td>Extent use or competency</td>
<td>Theory with which technique is most appropriate</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>--------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Paradoxical intention</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Play therapy</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Positive regard</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Positive reinforcement</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Predicting</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Probing</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Problem solving</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Processing</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Prognosis</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Progressive relaxation</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Projection</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Psychodrama</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Punishment</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Questioning</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Rational</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Reality testing</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Reassurance</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Recall</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Reciprocity of affect</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Reconsience</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Reeducation</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Reflection</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Regression</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Reinforcement</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Relaxation</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Release therapy</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Restatement of content</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Reward</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Rocking or cradling above head trust</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Role playing</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Role reversal</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Self-modeling</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Sensitivity exercises</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Sensitivity training</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Shaping</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Silence</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Simulation</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Sociodrama</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Sociometrics</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Stimulation</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Structuring</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>SUD (subjective unit of discomfort)</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Summarization</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Technique</td>
<td>Extent use or competency</td>
<td>Theory with which technique is most appropriate</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>--------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Supporting</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Systematic desensitization</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Termination</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Transference</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Transparency</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Trust walk</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Urging</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Value clarification</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Value development</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Verbal shock</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Vicarious learning</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Warmth</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>ADD YOUR OWN:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Procedural and Issue-Specific Skills***

Procedural skills refer to the way the counselor manages the opening and closing of sessions. Does the session open easily and proceed into the ongoing work of the counseling, or does it begin with chit chat about the weather or other content unrelated to the focus of the counseling work? How does the counselor conclude the session? Is there a brief summary, a review of agreed-on homework, a suggestion to pay attention to some feelings or interpersonal processes that came up in the counseling session? Issue-specific skills refer to responding to issues such as drug abuse, suicide concerns, and other issues mentioned in the chapters on special concerns and legal and ethical issues.

**Cognitive Counseling Skills**

Cognitive counseling skills refer to the counselor's ability to think about the counseling session and to form a comprehensive explanation of the client and the client's issues (Borders & Brown, 2005, p. 9).

---

A cornerstone in cognitive counseling skills is the awareness, observation, and recognition of relevant data from which to formulate an accurate description and then an explanation of the client. Relevant data refer not only to specific content gleaned through a review of the records, self-report of the client, and anecdotes, incidents, and interaction shared by the client or others but also to process data such as how the client relates a story, what kind of affect is revealed, and what the client avoids talking about.

The practicum student must observe the emotions of the client and identify what would be relevant information in understanding the client’s personal dynamic. This may include observations and inferences from the client’s nonverbal behaviors. It may include the client’s labeled or expressed emotions or the counselor’s impression of the client’s overall emotional state. The practicum student’s ability to elicit, observe, and note relevant emotional data in the process of the counseling session contributes to his or her ability to formulate an accurate description of the client, which can then lead to potential explanations and hypotheses about the emotional development of the client and possible strength or problem areas.

As the counselor facilitates the client’s telling his or her story or concerns, he or she is also noticing patterns and themes in the way that the client describes himself or herself in relationship to the world, the recurring range of choice of behavior and thoughts when confronted with problems, and the strengths in coping with a variety of situations. The counselor is also noting how the client interacts with the counselor; that is, is he or she expansive or monosyllabic, selective or evasive in responses, emotionally responsive and open or cautious and suspicious?

This commentary emphasizes that a first step in establishing cognitive counseling skills is the recognition of and selection of relevant data when beginning to form an impression and then an explanation of the client and his or her issues. A helpful practice after each counseling session is to write notes about the client, where you ask yourself the following:

1. What do I know about my client and how he or she thinks, acts, and feels about who he or she is in the world as he or she sees it?
2. What would it be like to be in my client’s shoes?
3. What are the influences that may have led to my client’s being who he or she is at this time in this circumstance?
4. What other information or observation would be helpful for me to understand this client?

The practice of writing such notes after each session helps the practicum student to develop cognitive counseling skills by regularly focusing on questions that will help him or her formulate a comprehensive explanation of the client and his or her issues. These notes can be used in individual, group, or peer supervision, and the questions can be expanded or discussed as appropriate.
A more structured approach to developing cognitive counseling skills is to use the case conceptualization format. We suggest that practicum students once again review the section on philosophy and theories of counseling presented earlier in this chapter. Chapter 4 presents a variety of case conceptualization models as part of the philosophy–theory practice continuum reviewed in chapter 4. Murdoch (1991, pp. 355–357) suggested that practicum students begin to present their theoretical perspectives by answering the six questions she outlined:

1. What is the core motivation of human existence?
2. How is the core motivation expressed in healthy ways? What are the characteristics of a healthy personality?
3. How does the process of development get derailed or stuck? What are the factors that contribute to psychological dysfunction?
4. What stages of a client’s life are considered key in the developmental process?
5. Who are the critical individuals in the client’s presentation? Does your theory restrict the focus to the individual, or does it extend to interactions with family and acquaintances or to multigenerational issues?
6. What is the relative importance of affect, cognition, and behavior in this theory?

Murdoch then recommended that practicum students conceptualize cases based on the guidelines of the model they have articulated via the six questions. Several other practices presented in chapter 3 can be helpful in facilitating the development of cognitive counseling skills. These practices are the Therapy Notes form (Form 3.8) and the SOAP (subjective, objective, assessment, plan) clinical notes format.

**Self-Awareness**

“Self Awareness involves a supervisee’s recognition of personal issues, beliefs and motivations that may influence in-session behavior as well as case conceptualization” (Borders & Brown, 2005, p. 8).

Not only is the practicum student experiencing the client in a counseling session, but the student is also experiencing his/her own personality dynamics in response.

Clients bring to the counseling sessions many varied and sundry dynamics, some of which are not in their conscious awareness. Just as the practicum student must learn to anticipate the presentation of just about any problem her/she could imagine, so too must the practicum student expect that he/she will have reactions to the problem, as well as to the client. The practicum student must learn the developmental skill of being separate, but not distant, from the client. Being drawn into a client’s dynamics will cause the student to lose perspective on the counseling process.

Practicum students are not expected to have the wherewithal to automatically or instinctively address any cognitive or affective responses they have to their
clients’ problems or their reactions to their client’s problems or personalities. What students are expected to do is to recognize just what reactions they might have would be averse to appropriate therapeutic intervention and to openly work through these reactions with their peers and supervisor.

Clients may bring problems to the practicum student such as their admitted physical and/or sexual abuse of their children or bigotry. At times practicum students may find problems of this nature disconcerting. Student counselors should be well aware that sometimes their clients will respond to them in ways that the will find offensive or degrading. The more intimate and revealing sessions become, the more emotional intensity is generated between the practicum counselor and client; this emotional intensity will sometimes be directly or inadvertently directed to the student counselor. It is the nature of the counseling process that clients who have unmet needs will expect these needs to be met by the counselor. The fact of the matter is that part of the counseling process is to educate the client about the fact that each person is accountable and responsible for meeting his or her own emotional needs.

The practicum student only provides a structure that is receptive to and facilitative of a situation that allows clients to determine what choices can be made that are in their best interest and will meet their needs. The structure the practicum student provides for the client is implicitly and explicated formed to allow and afford clients the dignity and respect indigenous to their right to make their own decisions. When, over time, a client does not find a quick fix to his or her problems, the practicum student may anticipate that the client will utilize whatever ineffective coping mechanisms he or she has used in the past to get results. Consequently the client may arrive late to the counseling session, scream at the practicum student, or in any other way create some sabotage in the place of his or her work.

Practicum Students must be ready for any and all forms of seductive and manipulative behavior from the client and must be prepared to stand their ground against such actions. The Practicum student must learn how to help the client with this issue, rather than hiding from it or running away from the client.

Many client behaviors are geared toward testing the competency level of the student. Practicum students should be well aware that one of the major issues that they will face, given the complexity of the counseling process, is that of their own thoughts and feelings about their competency.

Just as a facilitative structure is provided for the client by the practicum student, so too is a facilitative structure provided for the practicum student by the program in which he or she is matriculating. Practicum students are expected, through unstructured sessions with their peers and supervisors, to be open to the many cognitive, affective experiences associated with the counseling process that they might find perplexing. In some ways, to become a better therapist, the practicum student must pass through a similar process as the one that his or her client must pass through to become a better person, and both will need support.
Both student and client must be open to the proffered support to succeed in their endeavors.

**Developmental Level**

Developmental level refers to how supervisees function on a continuum of dependence on the supervisor to collegiality with the supervisor. It refers to a continuum of simplistic to integrated thinking about their client and their counseling practice. It refers to a continuum of low self-confidence and low self-awareness and anxiety to integration of one’s personal and professional identity. The early stage of development is characterized by black-and-white thinking; simplistic thinking; low awareness of strengths, weaknesses, and motivation; lack of confidence in skills; and high anxiety. Supervisees functioning at the middle stage of development often show confusion or conditional dependency or autonomy. They are a bit more flexible and variable in interventions, conceptualizations, and treatment plans and have greater confidence and awareness of their strengths and weaknesses. At the higher developmental stage of integration, supervisees demonstrate more complex and comprehensive client conceptualizations, a comfort with paradoxes of clinical work, and an ease in integrating and examining self-awareness issues inherent in professional practice (Borders & Brown, 2005, pp. 12–14). Supervision at this advanced level is collegial and performed primarily in the consulting role. The practicum student is most likely to function at the early and sometimes intermediate stages of development.

We suggest that the practicum student spend time early and often in the supervisory interaction discussing the four skill categories presented here. This discussion will facilitate the self-assessment process. At the early phases of practicum, it is possible that the performance skills area will be the focus, with an occasional self-awareness focus. As practicum advances toward internship, however, the performance skills may be more background as self-awareness and cognitive counseling skills become the focus. Developmental level is the process aspect of the skill areas and is usually inferred from an assessment of where the supervisee is on the various continuums and by the usual role of either teacher, counselor, or consultant taken by the supervisor (see Figure 5.1).

**Assessment and Evaluation In Practicum**

**Self Assessment**

Continuing reflection upon the assessment of one’s counseling practices (frequently termed self supervision) are an integral part of the practicum experience, and indeed of any level of counseling experience. Professional self assessment is a career-long process that occurs while transcribing interview notes, reviewing tapes of counseling sessions, preparing for a session, and keeping journals
of personal feeling and attitudes about counseling practice. It is important that the practicum student begins early to build strong habits of self supervision. The authors suggest that such ongoing assessment be organized into the four identified skill areas of counseling performance skills, cognitive counseling skills self awareness and developmental level.

We recommend that the practicum student prepare for the supervisory process by reflecting on all previous experiences that he/she brings to the current field training situation. These would include educational preparation, related work experience, volunteer activities, paraprofessional counseling activities and supervision related to counseling. When entering into supervision, the practicum student should be prepared to provide peers and supervisors with his/her perceptions of the skill areas in which he/she is well grounded and also of the areas that need more development.

Several forms cited in previous chapters of this manual, forms at the end of the book and the Goal Statement Agreement Sample at the end of the chapter are excellent aids for focusing self assessment. The Self Assessment of Basic Helping Skills and Procedural Skills (Form 5.1 at the end of the book) can assist the practicum student in assessing counseling performance skills. Similarly, the Counseling Techniques Checklist presented earlier in the chapter provides a structure for identifying theory based counseling techniques for focus in supervision. The Self Rating by the Student Counselor (Form 2.5) provides a systematic approach to reviewing and assessing sessions that can be audio or video taped.

Figure 5.1. Schematic representation of relative goal emphasis in supervision and the shift in goal emphasis as the student progresses from prepracticum to completion of internship.
The Therapy Notes (Form 3.8) and the Case Summary in chapter 3 provide an organization for written review of counseling sessions. These can be used to demonstrate cognitive counseling skills. The practicum student can also refer back to the Selected Theory Sorter to identify current theoretical perspectives which he/she identifies as a lot like his/her personal theory of counseling. Spend time reviewing six questions identified in Murdock’s case conceptualization model (1991) which is reviewed earlier in this chapter. Are the answers to some of these questions easier to answer than others? Where are the gaps in the development of your own personal theory of counseling?

Self Awareness skill and developmental level are often assessed by using a 5 point Likert Scale which identifies various aspects of these skill areas. For example, A Self Awareness Likert Scale may include items such as:

<table>
<thead>
<tr>
<th>Willingness to explore self</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is aware of how personal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitudes impact the client</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Avoids imposing personal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needs on the client</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Other items for assessing self awareness skills may be added to by the practicum student; or the list can list can be developed by the members of the group supervision class as this skill area is highlighted and discussed in supervision.

Similarly, a Likert Scale assessing items related to developmental level can be developed. An example would be

<table>
<thead>
<tr>
<th>Depends on supervisor for direction</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is confident in working with a variety of clients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Feels anxious during supervision sessions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Refer back to the section on developmental level for ideas about items to be included on the scale. Once again, the items list can be developed by the members of the group supervision class as this skill area is discussed.

Finally, A Goal Statement Agreement (Figure 5.2; Form 5.5 at end of book) can be completed to give focus and direction to the supervision process during practicum. The practicum student completes the form which identifies both short-term and long-term goals to be accomplished within each of the four skill areas. After collaboration and discussion with the supervisor, this agreement becomes a focus of the supervision process and provides an outline for both formative and summative evaluation. This agreement is a starting point and can be renegotiated as goals are met and new goals are identified.
Goal Statement Agreement

Directions: The student completes the agreement in duplicate and submits one copy to the supervisor.

Student’s name ______________________ Supervisor’s name ______________________
Date submitted _________________________

Short-Term Goals

Self-Awareness Skills  To think about any biases that would affect my counseling.

Counseling Performance Skills  Demonstrate application of facilitative and challenging skills in client interviews.

Cognitive Counseling Skills  Demonstrate awareness in important client information.

Developmental Level  Decrease anxiety concerning supervision.

Long-Term Goals

Self-Awareness Skills  To examine any countertransference issues encountered in my counseling.

Counseling Performance Skills  Demonstrate ability to integrate and apply skills related to client self-exploration, goal-setting, and action.

Cognitive Counseling Skills  Demonstrate ability to analyze client and counselor interaction from at least one theoretical frame of reference.

Developmental Level  Demonstrate ability to collaborate and discuss with supervisor regarding appropriate application of an identified counseling method.

Figure 5.2. Sample completed Goal Statement Agreement (Form 5.5).
Peer Assessment

Peer supervision and assessment has been identified as a valuable aid in the supervision process. This modality is, however, recommended with some precautions. Peer supervision should be used only as a supplement to regular supervision and seems best utilized with the counseling performance skills area. The peer supervisor can promote skill awareness through ratings and shared perceptions, but it is important to make sure that any peer supervision activities that are initiated occur after group supervision has provided sufficient training and practice (Boyd, 1978). After a particular counseling skill has been introduced, modeled, and practiced within the group context, peer rating of tapes can be implemented. We suggest that the peer critique of tapes be structured to focus on the rating of specific skills. For instance, the target skills might be identified as one or more of the facilitative skills such as basic empathy, asking open ended questions, or concreteness. Other target skills could be the recognition and handling of positive or negative affect or the effective use of probes. The Peer Rating Form (Form 5.4) and the Interview Rating Form (Form 5.6) used to structure the use of peer rating activities have been included in the Forms section.

Another approach to improving the use of functional basic skills is to teach students to identify their dysfunctional counseling behaviors and then to minimize those behaviors (Collins, 1990). Instead of rating functional skills, peer reviewers can measure the incidence of dysfunctional skills such as premature problem solving or excessive questioning in their review of counseling tapes. The goal would be for the counselor to decrease or eliminate dysfunctional counseling behaviors in actual sessions. Collins (1990, p. 68), in a study of the occurrence of dysfunctional counseling behaviors in both role playing and real client interviews of social work students, identified the following as dysfunctional behaviors:

- **Poor beginning statements**: the session starts with casual talk or chitchat instead of engagement skills;
- **Utterances**: counselor’s responses consist of short utterances or one-word responses such as “uh-huh,” “yeah,” “okay,” or “sure”; two different types of utterance responses rated were utterances (alone) and utterances (preceding a statement);
- **Closed questions**: the counselor asks questions that require one-word answers by clients, such as yes or no or their age or number of children;
- **Why questions**: the counselor asks statements starting with the word “why”;
- **Excessive questioning**: the counselor asks three or more questions in a row without any clear reflective component to the questions (*reflective component* refers to restating content the client has expressed in his or her statement to the counselor);
Premature advice or premature problem solving: the counselor gives advice that is considered premature, that is, advice given in the first 10 minutes of the session or after the first interview, judgmental statements, or problem solving where the counselor is doing the work for the client; and

Minimization: the counselor downplays the client’s problem, gives glib responses, or offers inappropriate comments such as “Life can’t be all that bad.”

Carmichael (1992) developed a Peer Supervision Rating Sheet, which was created for use in group supervision. Items included on the rating sheet were drawn from the work of Wittmer and Myrick (1974), Ivey and Gluckstern (1974), Egan (1986), and Cormier and Hackney (1987). Consistent with the previously mentioned precautions regarding the use of peer supervisors, this rating sheet was intended to keep the peer supervisor focused during observations and to reinforce the learning of counseling skills. Prior to using the rating sheet, each element in the rating sheet was discussed, and students generated examples of what would constitute level 1, 3, and 5 ratings. Although this rating sheet was developed and used to rate student-role-played counseling sessions, it could also be used to rate real counseling session tapes.

Elements included on Carmichael’s Peer Supervision Rating Sheet are rated on a continuum from 1, which is the poorest, to 5, which is the strongest. These elements are as follows (p. 61):

- Establishes rapport
- Keeps focus
- Explores problem
- Reflects feeling
- Makes open-ended statements
- Communicates clearly
- Does not use questions
- Displays congruent nonverbal and verbal behavior
- Uses problem-solving model
- Attains closure
- Summarizes
- Clarifies
- Generates alternatives
- Confronts
- Uses humor appropriately

Borders (1991) has presented a Structured Peer Group Supervision Model which is based on case presentation approach. In this model the counselor identifies questions about the client or the taped session and requests feedback. The peers are assigned roles, perspectives or tasks for reviewing the taped session. For a focus on Cognitive Counseling Skills, the counselor question and the peer assignment is on theoretical perspectives regarding:
1. the assessment of the client
2. the conceptualization of the issue or problem
3. the goals of counseling
4. the choice of intervention
5. the evaluation of progress (Borders & Brown, 2005, pp. 62-63)
6. After the counselor presents the taped segment of the counseling session, the group members give feedback from their theoretical perspectives. The presenting counselor then summarizes the feedback. This process facilitates the development of cognitive counseling skills and gives the supervisor the opportunity to observe the complexity and accuracy of the theoretical perspectives which are offered.

**Supervisor Assessment**

Assessment is provided by the supervisor at various times throughout the practicum. Continuing assessment of the student's work occurs regularly during weekly individual and or group supervision session at both the field site and the university setting. This regularly occurring feedback to the practicum student about his/her work is called formative assessment. The supervisor is constantly assessing the student on a variety of skills, abilities and cognitions. These evaluations can range from comments about a counseling technique to dialogue about a case conceptualization. These formative evaluations are usually verbal and the supervisor often keeps notes on the content and process of the supervision. We recommend that these notes by organized using the four categories of counseling performance skills, cognitive counseling skills, self awareness and developmental level. These notes can be reviewed at midpoint to allow for renegotiation of goals and at the end of the semester to provide data for assessment about the practicum student's progress toward full professional status.

Summative evaluation is usually provided at the midpoint and completion of each term of practicum and internship. The supervisor can give a narrative report of the student's progress or he/she can use a standardized assessment instrument. The supervisor is referred to the *Handbook of Counseling Supervision* (Borders & Leddick, 1987) for examples of standardized assessment and evaluation instrument which have been used in the past. More recently, two summative evaluation examples are provided in the *New Handbook of Counseling and Supervision* (Borders & Brown, 2005, pp. 94-96). One example is a 5 point Likert Scale Practicum Counselor Evaluation Form and the other is a narrative evaluation report. Bernard and Goodyear (1998) stated that there are nearly as many evaluation forms as there are training program because supervisors tend to develop their own evaluation forms. We suggest this as an option to be used by the supervisor after a review of the above mentioned standardized assessment resources, as well as a review of the evaluation forms included in the “Forms” section at the end of this book.
The authors recommend that individual and group supervision begin with a review of the four skill area of counseling performance skills, cognitive counseling skills, self awareness skills and developmental level to clarify and make operational the ways in which the practicum student can identify personal goals within each skill category. The practicum student then completes a Goal Statement Agreement (Figure 5.2 at the end of the chapter, Form 5.5 at end of book). This goal statement is presented to and discussed with the supervisor. Based on this discussion, The Goal Statement Agreement, and the use of standardized measures (if preferred), a framework for supervision is established. The goal statements become the context within which the professional development of the counselor is assessed.

Two additional rating forms have been included (see Forms section) in order to provide structured ratings of the trainee at the midpoint and endpoint of the practicum. The Site Supervisor’s Evaluation of Student Counselor’s Performance (Form 5.7) is recommended for use at the midpoint of practicum. This can be used as an adjunct to the Goal Statement (Form 5.5) and can be interpreted within the goal statement categories. The more extensive Counselor Competence Scale (Form 508) is recommended for use at the endpoint of practicum. This scale provides a broader array of performance and cognitive skill to be rated we recommend using this scale in addition to the final assessment of progress toward the student’s goal statement objectives.

Summary

Practicum students are not expected to have the wherewithal to automatically or instinctively address all of their clients’ problems. Students are, however, expected to strive to develop a meaningful helping relationship with their clients. In order to recommend that the practicum student move on to an internship placement, the following guidelines are suggested. The practicum student

1. consistently demonstrates the use of basic helping skills
2. has the ability to appropriately use additional theory based techniques consistent with at least one theoretical framework
3. demonstrates an ease in opening and closing sessions and managing continuity between sessions
4. has cognitive skills of awareness, observation, and recognition of relevant data to explain some client dynamics.
5. has begun to articulate a personal theory of counseling
6. recognizes how several of his/her personal dynamics may impact a client and the counseling session.
7. demonstrates moderate to low levels of anxiety and moderate to low levels of dependency on supervisor direction during supervision sessions.
Suggested Readings


References


Part II addresses the ethical and legal issues of concerns to the practicum student and the professional counselor or therapist. In addition, ethical decision making and ethics in counselor education are highlighted. A discussion of the American Counseling Association Code of Ethics as well as the complete ethical codes for the American Counseling Association, the American Psychological Association, and the American Mental Health Association are included. Chapter 7 discusses the preparation and implementation of the counseling relationship and includes discussions of confidentiality and privileged communication, managed care and the counselor, and risk management and multiple relationships.
Chapter 6
Ethics in Counselor Education

The importance of ethics education in counselor training has been cited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) in the 2001 standards for training. It is required that counseling ethics be addressed in core and specialized areas curricula. In 2004 Urofsky and Sowa developed a survey study of the content and instructional methodology in ethics courses taught in CACREP-accredited counseling programs (pp. 37–47). The participants of the study were 148 CACREP-accredited programs. The liaisons of the individual institutions were asked to forward the surveys to instructors teaching the primary courses addressing ethics or to whichever instructor had a primary interest in ethics education.

Ninety-five programs returned the surveys. Results of analysis conducted are as follows: Counselor educators (39%) indicated that ethics education was primarily combined with legal issues as a topic, 31% of the programs reported stand-alone ethics courses, and only 11% reported that ethics was infused as a topic across the curriculum. In addition, the assessment of student knowledge of counseling ethics was conducted in a variety of ways. Forty-three percent used ethics case presentations for evaluation, and 60% used presentations and analysis of ethical dilemmas. Personal reflection papers on ethical decision-making style (29%) and ethical beliefs (30%) were also required. Nineteen percent reported using written examinations as an evaluation procedure in the courses taught. In addition, 10% of counselor educators used participation in sample ethics hearings or required interviews with counseling practitioners (9%), lawyers (2%), and ethics board members (1%) (Urofsky & Sowa, 2004, p. 41). The results of the study indicated that a majority of programs are offering stand-alone ethics courses or a combined topics course such as ethical and legal issues in counseling (p. 43).
Codes of Ethics: Multiplicity and Confusion

Codes of ethics for counseling professionals are found in the American Counseling Association (ACA) and its divisions, national certification boards (CRCC, Council for Rehabilitation Counseling Certification; NBCC, National Board of Certified Counselors), state licensure laws, and ACA specialties (rehabilitation, school, gerontological, college, mental health, community, and marriage and family and career counseling). The proliferation of ethical standards and codes has created a number of problems for counselors and consumers. Herlihy and Remley (1995) suggested that an analysis of all the sets of ethical standards for professional counselors yields the conclusion that the standards are redundant, lack completeness, and sometimes conflict with one another. This situation has led to difficulty in enforcing the codes and has created considerable confusion for consumers of counseling services and for professional counselors themselves (p. 130).

The authors further stated that forces within the counseling profession must work hard to develop a consensus around issues within counseling. The ACA as a professional association, CACREP and the Council on Rehabilitation Education (CORE) as graduate program accrediting bodies, and NBCC and CRCC as national voluntary certifying boards must recognize that everyone benefits when separate autonomous groups within the profession reach agreement on professional issues (p. 131). It is hoped that the future holds a single, unified Code of Ethics that will present a clearer picture of the ethical obligations of professional counselors.

Ethical Decision Making

Ethical behavior begins with the counselor’s familiarity with the professional Code of Ethics. It is the first source for standards regarding the appropriate behaviors and responsibilities inherent in the counseling profession. Developing sensitivity to ethical principles in the code enables the counselor to feel more secure when faced with situations that are ethically problematic. Ethical decision making is rarely an easy task for the counselor. Ethical decision making involves the application of the Code of Ethics coupled with one’s own values and morals and one’s own interpretation of what is in the best interest of the client. Welfel (1992) and Kitchener (1992) suggested that the following five basic principles underlie ethical codes:

1. Benefit others (implying a responsibility to do well).
2. Do no harm to others.
3. Respect the autonomy of others (including freedom of thought and freedom of action).
4. Act in a fair and just manner (meaning that the rights and interests of one individual must be balanced against the rights and interests of others).
5. Be faithful (implying trustworthiness, loyalty, and ability to keep promises).
Corey, Corey, and Callahan (2003) presented an eight-step model of ethical decision making to aid counselors in applying ethical codes to the many issues that arise in treatment. The following is a summary of those recommendations.

1. **Identify the problem or dilemma:** Is it an ethical, legal, moral, professional, or clinical problem? Is it a combination of these? Did you consult with your supervisor or other professional? Did you document this consultation?

2. **Identify potential issues involved in the dilemma:** Assess the “rights and responsibilities and welfare” of those involved and affected by your decision (p. 20).

3. **Review the relevant ethical codes:** ACA? American Psychological Association (APA)? If necessary, consult with ethical boards of your professional organization or the state of your employment.

4. **Review relevant laws and regulations:** Check with your organization regarding any regulatory guidelines. Be particularly attuned to the laws of your state regarding professional practice issues.

5. **Obtain consultation:** This is an indication of your efforts at ascertaining what other professionals would do in a similar situation.

6. **Consider possible and probable courses of action:** Brainstorm all solutions without judging or evaluating them.

7. **Establish the possible consequences of various decisions:** Weigh the benefits and risks of each solution for all those affected by your decision.

8. **Decide on what seems the best possible course of action:** The best course is the one with the most benefits at the least cost and the one that puts the client’s well-being first, without violating ethical or legal codes.

Corey (1996) suggested that developing a sense of professional and ethical responsibility is never-ending. It demands that the professional must periodically review a number of ethical issues. According to Corey these issues are as follows:

1. Counselors need to be aware of what their own needs are, what they are getting from their work, and how their needs and behaviors influence their clients. It is essential that the therapist’s own need not be met at the client’s expense.

2. Counselors should have the training and experience necessary for the assessments they make and the interventions they attempt.

3. Counselors need to become aware of the boundaries of their competence, and they should seek qualified supervision or refer clients to other professionals when they recognize that they have reached their limit with a given client. They should make themselves familiar with the resources in the community so that they can make appropriate referrals.

4. Although practitioners know the ethical standards of their professional organizations, they also must be aware that they must exercise their own
judgment in applying these principles to particular cases. They realize that many problems have no clear-cut answers, and they accept the responsibility of searching for appropriate solutions.

5. It is important for counselors to have some theoretical framework of behavior change to guide them in their practice.

6. Counselors need to recognize the importance of finding ways to update their knowledge and skills through various forms of continuing education.

7. Counselors should avoid any relationships with clients that are clearly a threat to therapy.

8. It is the counselor's responsibility to inform clients of any circumstances that are likely to affect the confidentiality of their relationship and other matters that are likely to negatively influence the relationship.

9. It is imperative that counselors be aware of their own values and attitudes, recognize the role that their belief system plays in their relationships with clients, and avoid imposing these beliefs, either subtly or directly.

10. It is important for counselors to inform their clients about matters such as the goals of counseling, techniques and procedures that will be employed, possible risks associated with entering the relationship, and any other factors that are likely to affect the client's decision to begin therapy.

11. Counselors must realize that they teach their clients through a modeling process. Thus, they should attempt to practice in their own lives what they encourage in their clients.

12. Counseling takes place in the context of the interaction of cultural backgrounds. Counselors bring their culture to the counseling relationship, and clients' cultural values also operate in the process.

13. Counselors need to learn a process of thinking about and dealing with ethical dilemmas, realizing that most ethical issues are complex and defy simple solutions. The willingness to seek consultation is a sign of professional maturity (Corey, 1996, pp. 79–80).

**Ethical Issues**

All mental health professionals should be knowledgeable about the specific ethical codes of their profession. Copies of the codes appropriate for one's profession can be obtained through the professional organization that represents each of the various specialties of professional practice. In this chapter excerpts of ethical codes are provided to explicate the various professional positions.

As Huber and Baruth (1987) noted, “Ethics is concerned with the conduct of human beings as they make moral decisions” (p. 37). Beauchamp and Childress (1994) defined it this way: “Ethics is a generic term for various ways of understanding and examining the moral life” (p. 4).
**Ethics and the Law**

The following is an overview of the special section “2005 Code of Ethics: Ethical Challenges in a Complex World” (Kocet, 2006).

The process of revising the 1995 Code of Ethics took place from 2002 to 2005. Mandates from the CACREP certification board require counselors in training to become familiar with and to abide by the guidelines of the current Code of Ethics (2005). To that end, the following method is suggested. Students should follow this overview by reading the Code of Ethics as cited in the following presentation.

**2005 Code of Ethics**

**Purpose of the Code**

*Aspirational introductions* set the tone for that particular section and serve as a starting point that invites reflection on the ethical mandates contained in each part of the ACA code.

*New introductions* acknowledge that reasonable differences can occur among counseling professionals whose values, ethical principles, and ethical standards should be applied when faced with certain situations (Glosoff & Kocet, 2006).

*Glossary and index* (back of code) provide definitions and basic terminology and where to find it in the code.

**Code of Ethics: Main Sections**

A. Counseling Relationships  
B. Confidentiality, Privileged Communication, and Privacy  
C. Professional Responsibilities  
D. Relationships With Other Professionals  
E. Supervision, Training, Teaching  
F. Evaluation, Assessment, Interpretation  
G. Research and Publication  
H. Resolving Ethical Issues

**New Key Areas**

*Counseling Plans (A.1.c)*: The joint development of plans with reasonable promise of success. The regular review of plans to assess their viability.  
*Potentially Beneficial Interaction (A.5.d)*: Guards against nonprofessional interaction with clients.  
*Advocacy (A.6.a)*: To examine barriers and obstacles that inhibit the growth and development of the client.
End-of-Life Care for Terminally Ill Clients (A.9): Quality of care and informed decision making. Self-determination is implied.

Technology Applications (A.12): Benefits and limits of technology.

Deceased Clients (B.3.f): Confidentiality of deceased clients.

Counselor Incapacitation or Termination of Practice (C.2.h): Prepared plan for client files.

Historical and Social Prejudices in the Diagnosis of Pathology (E.5.c): Awareness and recognition of social prejudice.

Multicultural Issues-Diversity in Assessment (E.8): Attain proper perspective regarding diversity.


Change From the Use of the Term Research Subjects to Participants (Sec. G).

Plagiarism (G.5.b): Definition.

Conflict Between Ethics and Laws (H.1.b): Refers to the Code of Ethics.

**Ethical Codes**

Ethical codes are the written set of ethical standards for the professional mental health provider. Each profession (psychology, social work, counseling, etc.) has a code specific to its particular client relationships. The codes are both national and regional. Mental health professionals have an obligation to behave in ways that do not violate these codes. Violations of the standards by a mental health worker can result in sanctions or loss of licensure.

The primary obligation of mental health professionals is to promote the well-being of their clients, and ethical codes were developed to protect the integrity of this process. They allow mental health professionals to police their own members, thus reducing the need for government regulation of the profession. These codes are normative in nature in that they prescribe what mental health professionals ought to do. If a counselor finds himself or herself facing an ethical dilemma, he or she can refer to the codes for guidance.

**Ethics and Counseling**

The ACA and the APA Codes of Ethics address a broad range of behavior in counseling and psychology. Most important, they serve to educate counseling and psychological practitioners about the responsibilities inherent in their profession practice and serve to protect clients from unethical practices. In addition, Seligman (2004) suggested that having knowledge of and familiarity with and abiding by those ethical standards are essential to sound clinical practice. The many reasons include the following:
Ethics in Counselor Education

Ethical standards give strength and credibility to the mental health profession. Ethical guidelines help clinicians make sound decisions.

Providing clients with information on when clinicians can and cannot maintain confidentiality, as well as other important ethical guidelines, affords clients safety and predictability and enables them to make informed choices about their treatment.

Practicing in accord with established ethical standards can protect clinicians in the event of malpractice suits or other challenges to their competence.

Demonstrated knowledge of relevant ethical and legal standards is required for licensing and certification as a counselor, psychologist, or social worker.

Similarly, Van Hoose and Kottler (1985) offered three other reasons for the existence of codes of ethics:

Ethical standards protect the profession from government. They allow the profession to regulate itself and to function autonomously instead of being controlled by legislation.

Ethical standards help control internal disagreements and bickering, thus promoting stability within the profession.

Ethical standards protect the practitioner from the public, especially in regard to malpractice issues.

Definitions: Ethics, Morality, and Law

**Ethics** involves making decisions of a moral nature about people and their interaction with society (Kitchner, 1986, p. 306). Ethics is generally defined as a philosophical discipline that is concerned with human conduct and moral decision making (Van Hoose & Kottler, 1985, p. 3). Ethics are normative in nature and focus on principles and standards that govern relationships between individuals, such as between counselors and clients.

**Morality** involves judgment or the evaluation of action. It is associated with the employment of such words as *good*, *bad*, *right*, *wrong*, *ought*, and *should* (Brandt, 1959; Grant, 1992).

**Law** is the precise codification of governing standards that are established to ensure legal and moral justice (Hummell, Talbutt, & Alexander, 1985).

Ethical Principles

Should ethical codes not be specific or thorough enough to answer a question, one should employ ethical principles in evaluating the situation. Ethical principles are used to make decisions about moral issues inherent in a particular ethical dilemma. An ethical dilemma is a situation in which one must make a choice between competing and contradictory ethical mandates. The ethical codes do not
and cannot always provide solutions to such dilemmas. Ethical principles estab-
lish a moral structure to solve dilemmas and guide future ethical thinking.

The ethical principles described in this section are based on the work of
Beauchamp and Childress (1994) and Kitchener (1984). They have their roots
in commonsense morality, and they detail a structure of prima facie obligation;
that is, they are considered adequate to solve ethical dilemmas unless they are
refuted. If they prove to be inadequate, given the complexity of the dilemma,
one must consult ethical theory.

**Autonomy**

The principle of autonomy says that individuals are free to direct the course of
their lives, so long as their choices do not interfere with the autonomy of others.
If people want to be treated as autonomous beings, they must also respect and
treat others as autonomous beings. Autonomy also implies the freedom to make
one's own judgments. The concept of autonomy assumes the ability to make rati-
onal judgments. Autonomy provides the foundation for many psychological tenets.
Mental health professionals must enter practice with respect for the following:

- the client and individual differences,
- the client's ability to make his or her own decisions,
- the client's right to privacy,
- the client's autonomous nature, and
- the client's competence.

**Beneficence**

Sound ethical practices require that mental health professionals work for the
health and welfare of their clients. Clients who contract for professional psycho-
logical services must be able to expect positive benefits from the interactions.
This assumes an expectation of competence. Thus, mental health professionals
should never contract with clients whose problems are outside their areas of exper-
tise. They should also be careful not to become paternalistic with their clients.
Paternalism involves an assumption that one knows what is best for another and
attempts to regulate behavior according to one's personal prejudices.

**Justice**

The meaning of justice as an ethical principle is said to have originated with
Aristotle (Beauchamp & Childress, 1994), who suggested that justice means treat-
ing equals equally and unequals unequally but in proportion to their relative
differences. Thus, equal people have the right to be treated equally, and non-
equal people have the right to be treated differently if the inequality is relevant
to the issue in question. For example, politicians may be equal as persons but
have different party affiliations. Should these politicians need medical care, they should be treated equally and fairly. Should they aspire to office and run for reelection, they may be treated differently by their constituents.

**Nonmaleficence**

The principle of nonmaleficence requires that one refrain from intentionally inflicting harm or taking actions that might harm another. Nonmaleficence, like the Hippocratic oath, requires, first, that one do no harm.

**Fidelity**

Issues of fidelity arise for mental health professionals when two people voluntarily enter into a client–counselor relationship. Fidelity involves keeping promises. It also involves the issue of loyalty.

**Summary**

The ethical issues presented by the authors in this chapter are critical for the establishment and maintenance of the counseling relationship. Knowledge of the ethical codes for counselors and psychologists ensures that the practitioner is well aware of the standards for conducting proper therapeutic activities. To this end, the codes of ethics and professional standards of the ACA, AMHC (The American Mental Health Counseling Association), and APA have been presented in full. It is our hope that students will take the time to become familiar with the terms of these codes to ensure that their services will comply with the appropriate professional standards.
ACA Code of Ethics

As approved by the ACA Governing Council

2005

American Counseling Association (http://www.counseling.org)

Mission

The mission of the American Counseling Association is to enhance the quality of life in society by promoting the development of professional counselors, advancing the counseling profession, and using the profession and practice of counseling to promote respect for human dignity and diversity.

© 2005 by the American Counseling Association.

All rights reserved. Note: This document may be reproduced without permission for educational purposes.

Contents

ACA Code of Ethics Preamble 3
ACA Code of Ethics Purpose 3

Section A

The Counseling Relationship 4

Section B

Confidentiality, Privileged Communication, and Privacy 7

Section C

Professional Responsibility 9

Section D

Relationships With Other Professionals 11

Section E

Evaluation, Assessment, and Interpretation 11

Section F

Supervision, Training, and Teaching 13

Section G

Research and Publication 16

Section H

Resolving Ethical Issues 18
Glossary of Terms 20
**ACA Code of Ethics Preamble**

The American Counseling Association is an educational, scientific, and professional organization whose members work in a variety of settings and serve in multiple capacities. ACA members are dedicated to the enhancement of human development throughout the life span. Association members recognize diversity and embrace a cross-cultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts.

Professional values are an important way of living out an ethical commitment. Values inform principles. Inherently held values that guide our behaviors or exceed prescribed behaviors are deeply ingrained in the counselor and developed out of personal dedication, rather than the mandatory requirement of an external organization.

**ACA Code of Ethics Purpose**

The *ACA Code of Ethics* serves five main purposes:

1. The *Code* enables the association to clarify to current and future members, and to those served by members, the nature of the ethical responsibilities held in common by its members.
2. The *Code* helps support the mission of the association.
3. The *Code* establishes principles that define ethical behavior and best practices of association members.
4. The *Code* serves as an ethical guide designed to assist members in constructing a professional course of action that best serves those utilizing counseling services and best promotes the values of the counseling profession.
5. The *Code* serves as the basis for processing of ethical complaints and inquiries initiated against members of the association.

The *ACA Code of Ethics* contains eight main sections that address the following areas:

- Section A: The Counseling Relationship
- Section B: Confidentiality, Privileged Communication, and Privacy
- Section C: Professional Responsibility
- Section D: Relationships With Other Professionals
- Section E: Evaluation, Assessment, and Interpretation
- Section F: Supervision, Training, and Teaching
- Section G: Research and Publication
- Section H: Resolving Ethical Issues

Each section of the *ACA Code of Ethics* begins with an Introduction. The introductions to each section discuss what counselors should aspire to with regard to
ethical behavior and responsibility. The Introduction helps set the tone for that particular section and provides a starting point that invites reflection on the ethical mandates contained in each part of the *ACA Code of Ethics*.

When counselors are faced with ethical dilemmas that are difficult to resolve, they are expected to engage in a carefully considered ethical decision-making process. Reasonable differences of opinion can and do exist among counselors with respect to the ways in which values, ethical principles, and ethical standards would be applied when they conflict. While there is no specific ethical decision-making model that is most effective, counselors are expected to be familiar with a credible model of decision making that can bear public scrutiny and its application.

Through a chosen ethical decision-making process and evaluation of the context of the situation, counselors are empowered to make decisions that help expand the capacity of people to grow and develop.

A brief glossary is given to provide readers with a concise description of some of the terms used in the *ACA Code of Ethics*.

**Section A**

*The Counseling Relationship*

Introduction

Counselors encourage client growth and development in ways that foster the interest and welfare of clients and promote formation of healthy relationships. Counselors actively attempt to understand the diverse cultural backgrounds of the clients they serve. Counselors also explore their own cultural identities and how these affect their values and beliefs about the counseling process.

Counselors are encouraged to contribute to society by devoting a portion of their professional activity to services for which there is little or no financial return (pro bono publico).

A.1. Welfare of Those Served by Counselors

A.1.a. Primary Responsibility

The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients.

A.1.b. Records

Counselors maintain records necessary for rendering professional services to their clients and as required by laws, regulations, or agency or institution procedures. Counselors include sufficient and timely documentation in their client records to facilitate the delivery and continuity of needed services. Counselors take reasonable steps to ensure that documentation in records accurately reflects client progress and services provided. If errors are made in client records, counselors
take steps to properly note the correction of such errors according to agency or institutional policies. (See A.12.g.7., B.6., B.6.g., G.2.j.)

A.1.c. Counseling Plans
Counselors and their clients work jointly in devising integrated counseling plans that offer reasonable promise of success and are consistent with abilities and circumstances of clients. Counselors and clients regularly review counseling plans to assess their continued viability and effectiveness, respecting the freedom of choice of clients. (See A.2.a., A.2.d., A.12.g.)

A.1.d. Support Network Involvement
Counselors recognize that support networks hold various meanings in the lives of clients and consider enlisting the support, understanding, and involvement of others (e.g., religious/spiritual/community leaders, family members, friends) as positive resources, when appropriate, with client consent.

A.1.e. Employment Needs
Counselors work with their clients considering employment in jobs that are consistent with the overall abilities, vocational limitations, physical restrictions, general temperament, interest and aptitude patterns, social skills, education, general qualifications, and other relevant characteristics and needs of clients. When appropriate, counselors appropriately trained in career development will assist in the placement of clients in positions that are consistent with the interest, culture, and welfare of clients, employers, and/or the public.

A.2. Informed Consent in the Counseling Relationship
(See A.12.g., B.5., B.6.b., E.3., E.13.b., F.1.c., G.2.a.)

A.2.a. Informed Consent
Clients have the freedom to choose whether to enter into or remain in a counseling relationship and need adequate information about the counseling process and the counselor. Counselors have an obligation to review in writing and verbally with clients the rights and responsibilities of both the counselor and the client. Informed consent is an ongoing part of the counseling process, and counselors appropriately document discussions of informed consent throughout the counseling relationship.

A.2.b. Types of Information Needed
Counselors explicitly explain to clients the nature of all services provided. They inform clients about issues such as, but not limited to, the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the counselor's qualifications, credentials, and relevant experience; continuation of services upon the incapacitation or death of a counselor; and other pertinent information. Counselors take steps to ensure that clients understand the
implications of diagnosis, the intended use of tests and reports, fees, and billing arrangements. Clients have the right to confidentiality and to be provided with an explanation of its limitations (including how supervisors and/or treatment team professionals are involved); to obtain clear information about their records; to participate in the ongoing counseling plans; and to refuse any services or modality change and to be advised of the consequences of such refusal.

A.2.c. Developmental and Cultural Sensitivity
Counselors communicate information in ways that are both developmentally and culturally appropriate. Counselors use clear and understandable language when discussing issues related to informed consent. When clients have difficulty understanding the language used by counselors, they provide necessary services (e.g., arranging for a qualified interpreter or translator) to ensure comprehension by clients. In collaboration with clients, counselors consider cultural implications of informed consent procedures and, where possible, counselors adjust their practices accordingly.

A.2.d. Inability to Give Consent
When counseling minors or persons unable to give voluntary consent, counselors seek the assent of clients to services, and include them in decision making as appropriate. Counselors recognize the need to balance the ethical rights of clients to make choices, their capacity to give consent or assent to receive services, and parental or familial legal rights and responsibilities to protect these clients and make decisions on their behalf.

A.3. Clients Served by Others
When counselors learn that their clients are in a professional relationship with another mental health professional, they request release from clients to inform the other professionals and strive to establish positive and collaborative professional relationships.

A.4. Avoiding Harm and Imposing Values
A.4.a. Avoiding Harm
Counselors act to avoid harming their clients, trainees, and research participants and to minimize or to remedy unavoidable or unanticipated harm.

A.4.b. Personal Values
Counselors are aware of their own values, attitudes, beliefs, and behaviors and avoid imposing values that are inconsistent with counseling goals. Counselors respect the diversity of clients, trainees, and research participants.

A.5. Roles and Relationships With Clients
(See F.3., F.10., G.3.)
A.5.a. Current Clients
Sexual or romantic counselor–client interactions or relationships with current clients, their romantic partners, or their family members are prohibited.

A.5.b. Former Clients
Sexual or romantic counselor–client interactions or relationships with former clients, their romantic partners, or their family members are prohibited for a period of 5 years following the last professional contact. Counselors, before engaging in sexual or romantic interactions or relationships with clients, their romantic partners, or client family members after 5 years following the last professional contact, demonstrate forethought and document (in written form) whether the interactions or relationship can be viewed as exploitive in some way and/or whether there is still potential to harm the former client; in cases of potential exploitation and/or harm, the counselor avoids entering such an interaction or relationship.

A.5.c. Nonprofessional Interactions or Relationships (Other Than Sexual or Romantic Interactions or Relationships)
Counselor–client nonprofessional relationships with clients, former clients, their romantic partners, or their family members should be avoided, except when the interaction is potentially beneficial to the client. (See A.5.d.)

A.5.d. Potentially Beneficial Interactions
When a counselor–client nonprofessional interaction with a client or former client may be potentially beneficial to the client or former client, the counselor must document in case records, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit, and anticipated consequences for the client or former client and other individuals significantly involved with the client or former client. Such interactions should be initiated with appropriate client consent. Where unintentional harm occurs to the client or former client, or to an individual significantly involved with the client or former client, due to the nonprofessional interaction, the counselor must show evidence of an attempt to remedy such harm. Examples of potentially beneficial interactions include, but are not limited to, attending a formal ceremony (e.g., a wedding/commitment ceremony or graduation); purchasing a service or product provided by a client or former client (excepting unrestricted bartering); hospital visits to an ill family member; mutual membership in a professional association, organization, or community. (See A.5.c.)

A.5.e. Role Changes in the Professional Relationship
When a counselor changes a role from the original or most recent contracted relationship, he or she obtains informed consent from the client and explains the right of the client to refuse services related to the change. Examples of role changes include
1. changing from individual to relationship or family counseling, or vice versa;
2. changing from a nonforensic evaluative role to a therapeutic role, or vice versa;
3. changing from a counselor to a researcher role (i.e., enlisting clients as research participants), or vice versa; and
4. changing from a counselor to a mediator role, or vice versa.

Clients must be fully informed of any anticipated consequences (e.g., financial, legal, personal, or therapeutic) of counselor role changes.

A.6. Roles and Relationships at Individual, Group, Institutional, and Societal Levels

A.6.a. Advocacy
When appropriate, counselors advocate at individual, group, institutional, and societal levels to examine potential barriers and obstacles that inhibit access and/or the growth and development of clients.

A.6.b. Confidentiality and Advocacy
Counselors obtain client consent prior to engaging in advocacy efforts on behalf of an identifiable client to improve the provision of services and to work toward removal of systemic barriers or obstacles that inhibit client access, growth, and development.

A.7. Multiple Clients
When a counselor agrees to provide counseling services to two or more persons who have a relationship, the counselor clarifies at the outset which person or persons are clients and the nature of the relationships the counselor will have with each involved person. If it becomes apparent that the counselor may be called upon to perform potentially conflicting roles, the counselor will clarify, adjust, or withdraw from roles appropriately. (See A.8.a., B.4.)

A.8. Group Work
(See B.4.a.)

A.8.a. Screening
Counselors screen prospective group counseling/therapy participants. To the extent possible, counselors select members whose needs and goals are compatible with goals of the group, who will not impede the group process, and whose well-being will not be jeopardized by the group experience.

A.8.b. Protecting Clients
In a group setting, counselors take reasonable precautions to protect clients from physical, emotional, or psychological trauma.
A.9. End-of-Life Care for Terminally Ill Clients

A.9.a. Quality of Care
Counselors strive to take measures that enable clients

1. to obtain high quality end-of-life care for their physical, emotional, social, and spiritual needs;
2. to exercise the highest degree of self-determination possible;
3. to be given every opportunity possible to engage in informed decision making regarding their end-of-life care; and
4. to receive complete and adequate assessment regarding their ability to make competent, rational decisions on their own behalf from a mental health professional who is experienced in end-of-life care practice.

A.9.b. Counselor Competence, Choice, and Referral
Recognizing the personal, moral, and competence issues related to end-of-life decisions, counselors may choose to work or not work with terminally ill clients who wish to explore their end-of-life options. Counselors provide appropriate referral information to ensure that clients receive the necessary help.

A.9.c. Confidentiality
Counselors who provide services to terminally ill individuals who are considering hastening their own deaths have the option of breaking or not breaking confidentiality, depending on applicable laws and the specific circumstances of the situation and after seeking consultation or supervision from appropriate professional and legal parties. (See B.5.c., B.7.c.)

A.10. Fees and Bartering

A.10.a. Accepting Fees From Agency Clients
Counselors refuse a private fee or other remuneration for rendering services to persons who are entitled to such services through the counselor’s employing agency or institution. The policies of a particular agency may make explicit provisions for agency clients to receive counseling services from members of its staff in private practice. In such instances, the clients must be informed of other options open to them should they seek private counseling services.

A.10.b. Establishing Fees
In establishing fees for professional counseling services, counselors consider the financial status of clients and locality. In the event that the established fee structure is inappropriate for a client, counselors assist clients in attempting to find comparable services of acceptable cost.

A.10.c. Nonpayment of Fees
If counselors intend to use collection agencies or take legal measures to collect fees from clients who do not pay for services as agreed upon, they first inform clients of intended actions and offer clients the opportunity to make payment.
A.10.d. Bartering
Counselors may barter only if the relationship is not exploitive or harmful and does not place the counselor in an unfair advantage, if the client requests it, and if such arrangements are an accepted practice among professionals in the community. Counselors consider the cultural implications of bartering and discuss relevant concerns with clients and document such agreements in a clear written contract.

A.10.e. Receiving Gifts
Counselors understand the challenges of accepting gifts from clients and recognize that in some cultures, small gifts are a token of respect and showing gratitude. When determining whether or not to accept a gift from clients, counselors take into account the therapeutic relationship, the monetary value of the gift, a client's motivation for giving the gift, and the counselor's motivation for wanting or declining the gift.

A.11. Termination and Referral
A.11.a. Abandonment Prohibited
Counselors do not abandon or neglect clients in counseling. Counselors assist in making appropriate arrangements for the continuation of treatment, when necessary, during interruptions such as vacations, illness, and following termination.

A.11.b. Inability to Assist Clients
If counselors determine an inability to be of professional assistance to clients, they avoid entering or continuing counseling relationships. Counselors are knowledgeable about culturally and clinically appropriate referral resources and suggest these alternatives. If clients decline the suggested referrals, counselors should discontinue the relationship.

A.11.c. Appropriate Termination
Counselors terminate a counseling relationship when it becomes reasonably apparent that the client no longer needs assistance, is not likely to benefit, or is being harmed by continued counseling. Counselors may terminate counseling when in jeopardy of harm by the client, or another person with whom the client has a relationship, or when clients do not pay fees as agreed upon. Counselors provide pre-termination counseling and recommend other service providers when necessary.

A.11.d. Appropriate Transfer of Services
When counselors transfer or refer clients to other practitioners, they ensure that appropriate clinical and administrative processes are completed and open communication is maintained with both clients and practitioners.
A.12. Technology Applications

A.12.a. Benefits and Limitations
Counselors inform clients of the benefits and limitations of using information technology applications in the counseling process and in business/billing procedures. Such technologies include but are not limited to computer hardware and software, telephones, the World Wide Web, the Internet, online assessment instruments and other communication devices.

A.12.b. Technology-Assisted Services
When providing technology-assisted distance counseling services, counselors determine that clients are intellectually, emotionally, and physically capable of using the application and that the application is appropriate for the needs of clients.

A.12.c. Inappropriate Services
When technology-assisted distance counseling services are deemed inappropriate by the counselor or client, counselors consider delivering services face to face.

A.12.d. Access
Counselors provide reasonable access to computer applications when providing technology-assisted distance counseling services.

A.12.e. Laws and Statutes
Counselors ensure that the use of technology does not violate the laws of any local, state, national, or international entity and observe all relevant statutes.

A.12.f. Assistance
Counselors seek business, legal, and technical assistance when using technology applications, particularly when the use of such applications crosses state or national boundaries.

A.12.g. Technology and Informed Consent
As part of the process of establishing informed consent, counselors do the following:

1. Address issues related to the difficulty of maintaining the confidentiality of electronically transmitted communications.
2. Inform clients of all colleagues, supervisors, and employees, such as Informational Technology (IT) administrators, who might have authorized or unauthorized access to electronic transmissions.
3. Urge clients to be aware of all authorized or unauthorized users including family members and fellow employees who have access to any technology clients may use in the counseling process.
4. Inform clients of pertinent legal rights and limitations governing the practice of a profession over state lines or international boundaries.
5. Use encrypted Web sites and e-mail communications to help ensure confidentiality when possible.
6. When the use of encryption is not possible, counselors notify clients of this fact and limit electronic transmissions to general communications that are not client specific.
7. Inform clients if and for how long archival storage of transaction records is maintained.
8. Discuss the possibility of technology failure and alternate methods of service delivery.
9. Inform clients of emergency procedures, such as calling 911 or a local crisis hotline, when the counselor is not available.
10. Discuss time zone differences, local customs, and cultural or language differences that might impact service delivery.
11. Inform clients when technology-assisted distance counseling services are not covered by insurance. (See A.2.)

A.12.h. Sites on the World Wide Web
Counselors maintaining sites on the World Wide Web (the Internet) do the following:

1. Regularly check that electronic links are working and professionally appropriate.
2. Establish ways clients can contact the counselor in case of technology failure.
3. Provide electronic links to relevant state licensure and professional certification boards to protect consumer rights and facilitate addressing ethical concerns.
5. Obtain the written consent of the legal guardian or other authorized legal representative prior to rendering services in the event the client is a minor child, an adult who is legally incompetent, or an adult incapable of giving informed consent.
6. Strive to provide a site that is accessible to persons with disabilities.
7. Strive to provide translation capabilities for clients who have a different primary language while also addressing the imperfect nature of such translations.
8. Assist clients in determining the validity and reliability of information found on the World Wide Web and other technology applications.

Section B
Confidentiality, Privileged Communication, and Privacy

Introduction
Counselors recognize that trust is a cornerstone of the counseling relationship. Counselors aspire to earn the trust of clients by creating an ongoing partnership, establishing and upholding appropriate boundaries, and maintaining confidentiality. Counselors communicate the parameters of confidentiality in a culturally competent manner.
B.1. Respecting Client Rights

B.1.a. Multicultural/Diversity Considerations
Counselors maintain awareness and sensitivity regarding cultural meanings of confidentiality and privacy. Counselors respect differing views toward disclosure of information. Counselors hold ongoing discussions with clients as to how, when, and with whom information is to be shared.

B.1.b. Respect for Privacy
Counselors respect client rights to privacy. Counselors solicit private information from clients only when it is beneficial to the counseling process.

B.1.c. Respect for Confidentiality
Counselors do not share confidential information without client consent or without sound legal or ethical justification.

B.1.d. Explanation of Limitations
At initiation and throughout the counseling process, counselors inform clients of the limitations of confidentiality and seek to identify foreseeable situations in which confidentiality must be breached. (See A.2.b.)

B.2. Exceptions

B.2.a. Danger and Legal Requirements
The general requirement that counselors keep information confidential does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed. Counselors consult with other professionals when in doubt as to the validity of an exception. Additional considerations apply when addressing end-of-life issues. (See A.9.c.)

B.2.b. Contagious, Life-Threatening Diseases
When clients disclose that they have a disease commonly known to be both communicable and life threatening, counselors may be justified in disclosing information to identifiable third parties, if they are known to be at demonstrable and high risk of contracting the disease. Prior to making a disclosure, counselors confirm that there is such a diagnosis and assess the intent of clients to inform the third parties about their disease or to engage in any behaviors that may be harmful to an identifiable third party.

B.2.c. Court-Ordered Disclosure
When subpoenaed to release confidential or privileged information without a client’s permission, counselors obtain written, informed consent from the client
or take steps to prohibit the disclosure or have it limited as narrowly as possible due to potential harm to the client or counseling relationship.

B.2.d. Minimal Disclosure
To the extent possible, clients are informed before confidential information is disclosed and are involved in the disclosure decision-making process. When circumstances require the disclosure of confidential information, only essential information is revealed.

B.3. Information Shared With Others

B.3.a. Subordinates
Counselors make every effort to ensure that privacy and confidentiality of clients are maintained by subordinates, including employees, supervisees, students, clerical assistants, and volunteers. (See F.1.c.)

B.3.b. Treatment Teams
When client treatment involves a continued review or participation by a treatment team, the client will be informed of the team’s existence and composition, information being shared, and the purposes of sharing such information.

B.3.c. Confidential Settings
Counselors discuss confidential information only in settings in which they can reasonably ensure client privacy.

B.3.d. Third-Party Payers
Counselors disclose information to third-party payers only when clients have authorized such disclosure.

B.3.e. Transmitting Confidential Information
Counselors take precautions to ensure the confidentiality of information transmitted through the use of computers, electronic mail, facsimile machines, telephones, voicemail, answering machines, and other electronic or computer technology. (See A.12.g.)

B.3.f. Deceased Clients
Counselors protect the confidentiality of deceased clients, consistent with legal requirements and agency or setting policies.

B.4. Groups and Families

B.4.a. Group Work
In group work, counselors clearly explain the importance and parameters of confidentiality for the specific group being entered.
B.4.b. Couples and Family Counseling
In couples and family counseling, counselors clearly define who is considered “the client” and discuss expectations and limitations of confidentiality. Counselors seek agreement and document in writing such agreement among all involved parties having capacity to give consent concerning each individual’s right to confidentiality and any obligation to preserve the confidentiality of information known.

B.5. Clients Lacking Capacity to Give Informed Consent
B.5.a. Responsibility to Clients
When counseling minor clients or adult clients who lack the capacity to give voluntary, informed consent, counselors protect the confidentiality of information received in the counseling relationship as specified by federal and state laws, written policies, and applicable ethical standards.

B.5.b. Responsibility to Parents and Legal Guardians
Counselors inform parents and legal guardians about the role of counselors and the confidential nature of the counseling relationship. Counselors are sensitive to the cultural diversity of families and respect the inherent rights and responsibilities of parents/guardians over the welfare of their children/charges according to law. Counselors work to establish, as appropriate, collaborative relationships with parents/guardians to best serve clients.

B.5.c. Release of Confidential Information
When counseling minor clients or adult clients who lack the capacity to give voluntary consent to release confidential information, counselors seek permission from an appropriate third party to disclose information. In such instances, counselors inform clients consistent with their level of understanding and take culturally appropriate measures to safeguard client confidentiality.

B.6. Records
B.6.a. Confidentiality of Records
Counselors ensure that records are kept in a secure location and that only authorized persons have access to records.

B.6.b. Permission to Record
Counselors obtain permission from clients prior to recording sessions through electronic or other means.

B.6.c. Permission to Observe
Counselors obtain permission from clients prior to observing counseling sessions, reviewing session transcripts, or viewing recordings of sessions with supervisors, faculty, peers, or others within the training environment.
B.6.d. Client Access
Counselors provide reasonable access to records and copies of records when requested by competent clients. Counselors limit the access of clients to their records, or portions of their records, only when there is compelling evidence that such access would cause harm to the client. Counselors document the request of clients and the rationale for withholding some or all of the record in the files of clients. In situations involving multiple clients, counselors provide individual clients with only those parts of records that related directly to them and do not include confidential information related to any other client.

B.6.e. Assistance With Records
When clients request access to their records, counselors provide assistance and consultation in interpreting counseling records.

B.6.f. Disclosure or Transfer
Unless exceptions to confidentiality exist, counselors obtain written permission from clients to disclose or transfer records to legitimate third parties. Steps are taken to ensure that receivers of counseling records are sensitive to their confidential nature. (See A.3., E.4.)

B.6.g. Storage and Disposal After Termination
Counselors store records following termination of services to ensure reasonable future access, maintain records in accordance with state and federal statutes governing records, and dispose of client records and other sensitive materials in a manner that protects client confidentiality. When records are of an artistic nature, counselors obtain client (or guardian) consent with regards to handling of such records or documents. (See A.1.b.)

B.6.h. Reasonable Precautions
Counselors take reasonable precautions to protect client confidentiality in the event of the counselor’s termination of practice, incapacity, or death. (See C.2.b.)

B.7. Research and Training
B.7.a. Institutional Approval
When institutional approval is required, counselors provide accurate information about their research proposals and obtain approval prior to conducting their research. They conduct research in accordance with the approved research protocol.

B.7.b. Adherence to Guidelines
Counselors are responsible for understanding and adhering to state, federal, agency, or institutional policies or applicable guidelines regarding confidentiality in their research practices.
B.7.c. Confidentiality of Information Obtained in Research
Violations of participant privacy and confidentiality are risks of participation in research involving human participants. Investigators maintain all research records in a secure manner. They explain to participants the risks of violations of privacy and confidentiality and disclose to participants any limits of confidentiality that reasonably can be expected. Regardless of the degree to which confidentiality will be maintained, investigators must disclose to participants any limits of confidentiality that reasonably can be expected. (See G.2.e.)

B.7.d. Disclosure of Research Information
Counselors do not disclose confidential information that reasonably could lead to the identification of a research participant unless they have obtained the prior consent of the person. Use of data derived from counseling relationships for purposes of training, research, or publication is confined to content that is disguised to ensure the anonymity of the individuals involved. (See G.2.a., G.2.d.)

B.7.e. Agreement for Identification
Identification of clients, students, or supervisees in a presentation or publication is permissible only when they have reviewed the material and agreed to its presentation or publication. (See G.4.d.)

B.8. Consultation
B.8.a. Agreements
When acting as consultants, counselors seek agreements among all parties involved concerning each individual’s rights to confidentiality, the obligation of each individual to preserve confidential information, and the limits of confidentiality of information shared by others.

B.8.b. Respect for Privacy
Information obtained in a consulting relationship is discussed for professional purposes only with persons directly involved with the case. Written and oral reports present only data germane to the purposes of the consultation, and every effort is made to protect client identity and to avoid undue invasion of privacy.

B.8.c. Disclosure of Confidential Information
When consulting with colleagues, counselors do not disclose confidential information that reasonably could lead to the identification of a client or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided. They disclose information only to the extent necessary to achieve the purposes of the consultation. (See D.2.d.)
Section C

Professional Responsibility

Introduction
Counselors aspire to open, honest, and accurate communication in dealing with the public and other professionals. They practice in a non-discriminatory manner within the boundaries of professional and personal competence and have a responsibility to abide by the ACA Code of Ethics. Counselors actively participate in local, state, and national associations that foster the development and improvement of counseling. Counselors advocate to promote change at the individual, group, institutional, and societal levels that improve the quality of life for individuals and groups and remove potential barriers to the provision or access of appropriate services being offered. Counselors have a responsibility to the public to engage in counseling practices that are based on rigorous research methodologies. In addition, counselors engage in self-care activities to maintain and promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities.

C.1. Knowledge of Standards
Counselors have a responsibility to read, understand, and follow the ACA Code of Ethics and adhere to applicable laws and regulations.

C.2. Professional Competence
C.2.a. Boundaries of Competence
Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Counselors gain knowledge, personal awareness, sensitivity, and skills pertinent to working with a diverse client population. (See A.9.b., C.4.e., E.2., F.2., F.11.b.)

C.2.b. New Specialty Areas of Practice
Counselors practice in specialty areas new to them only after appropriate education, training, and supervised experience. While developing skills in new specialty areas, counselors take steps to ensure the competence of their work and to protect others from possible harm. (See F.6.f)

C.2.c. Qualified for Employment
Counselors accept employment only for positions for which they are qualified by education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Counselors hire for professional counseling positions only individuals who are qualified and competent for those positions.
C.2.d. Monitor Effectiveness
Counselors continually monitor their effectiveness as professionals and take steps to improve when necessary. Counselors in private practice take reasonable steps to seek peer supervision as needed to evaluate their efficacy as counselors.

C.2.e. Consultation on Ethical Obligations
Counselors take reasonable steps to consult with other counselors or related professionals when they have questions regarding their ethical obligations or professional practice.

C.2.f. Continuing Education
Counselors recognize the need for continuing education to acquire and maintain a reasonable level of awareness of current scientific and professional information in their fields of activity. They take steps to maintain competence in the skills they use, are open to new procedures, and keep current with the diverse populations and specific populations with whom they work.

C.2.g. Impairment
Counselors are alert to the signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until such time it is determined that they may safely resume their work. Counselors assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients. (See A.11.b., F.8.b.)

C.2.h. Counselor Incapacitation or Termination of Practice
When counselors leave a practice, they follow a prepared plan for transfer of clients and files. Counselors prepare and disseminate to an identified colleague or “records custodian” a plan for the transfer of clients and files in the case of their incapacitation, death, or termination of practice.

C.3. Advertising and Soliciting Clients
C.3.a. Accurate Advertising
When advertising or otherwise representing their services to the public, counselors identify their credentials in an accurate manner that is not false, misleading, deceptive, or fraudulent.

C.3.b. Testimonials
Counselors who use testimonials do not solicit them from current clients nor former clients nor any other persons who may be vulnerable to undue influence.
C.3.c. Statements by Others
Counselors make reasonable efforts to ensure that statements made by others about them or the profession of counseling are accurate.

C.3.d. Recruiting Through Employment
Counselors do not use their places of employment or institutional affiliation to recruit or gain clients, supervisees, or consultees for their private practices.

C.3.e. Products and Training Advertisements
Counselors who develop products related to their profession or conduct workshops or training events ensure that the advertisements concerning these products or events are accurate and disclose adequate information for consumers to make informed choices. (See C.6.d.)

C.3.f. Promoting to Those Served
Counselors do not use counseling, teaching, training, or supervisory relationships to promote their products or training events in a manner that is deceptive or would exert undue influence on individuals who may be vulnerable. However, counselor educators may adopt textbooks they have authored for instructional purposes.

C.4. Professional Qualifications
C.4.a. Accurate Representation
Counselors claim or imply only professional qualifications actually completed and correct any known misrepresentations of their qualifications by others. Counselors truthfully represent the qualifications of their professional colleagues. Counselors clearly distinguish between paid and volunteer work experience and accurately describe their continuing education and specialized training. (See C.2.a.)

C.4.b. Credentials
Counselors claim only licenses or certifications that are current and in good standing.

C.4.c. Educational Degrees
Counselors clearly differentiate between earned and honorary degrees.

C.4.d. Implying Doctoral-Level Competence
Counselors clearly state their highest earned degree in counseling or closely related field. Counselors do not imply doctoral-level competence when only possessing a master's degree in counseling or a related field by referring to themselves as “Dr.” in a counseling context when their doctorate is not in counseling or related field.

C.4.e. Program Accreditation Status
Counselors clearly state the accreditation status of their degree programs at the time the degree was earned.
C.4.f. Professional Membership
Counselors clearly differentiate between current, active memberships and former memberships in associations. Members of the American Counseling Association must clearly differentiate between professional membership, which implies the possession of at least a master’s degree in counseling, and regular membership, which is open to individuals whose interests and activities are consistent with those of ACA but are not qualified for professional membership.

C.5. Nondiscrimination
Counselors do not condone or engage in discrimination based on age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital status/partnership, language preference, socioeconomic status, or any basis proscribed by law. Counselors do not discriminate against clients, students, employees, supervisees, or research participants in a manner that has a negative impact on these persons.

C.6. Public Responsibility
C.6.a. Sexual Harassment
Counselors do not engage in or condone sexual harassment. Sexual harassment is defined as sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with professional activities or roles, and that either

1. is unwelcome, is offensive, or creates a hostile workplace or learning environment, and counselors know or are told this; or
2. is sufficiently severe or intense to be perceived as harassment to a reasonable person in the context in which the behavior occurred.

Sexual harassment can consist of a single intense or severe act or multiple persistent or pervasive acts.

C.6.b. Reports to Third Parties
Counselors are accurate, honest, and objective in reporting their professional activities and judgments to appropriate third parties, including courts, health insurance companies, those who are the recipients of evaluation reports, and others. (See B.3., E.4.)

C.6.c. Media Presentations
When counselors provide advice or comment by means of public lectures, demonstrations, radio or television programs, prerecorded tapes, technology-based applications, printed articles, mailed material, or other media, they take reasonable precautions to ensure that
1. the statements are based on appropriate professional counseling literature and practice,
2. the statements are otherwise consistent with the ACA Code of Ethics, and
3. the recipients of the information are not encouraged to infer that a professional counseling relationship has been established.

C.6.d. Exploitation of Others
Counselors do not exploit others in their professional relationships. (See C.3.e.)

C.6.e. Scientific Bases for Treatment Modalities
Counselors use techniques/procedures/modalities that are grounded in theory and/or have an empirical or scientific foundation. Counselors who do not must define the techniques/procedures as “unproven” or “developing” and explain the potential risks and ethical considerations of using such techniques/procedures and take steps to protect clients from possible harm. (See A.4.a., E.5.c., E.5.d.)

C.7. Responsibility to Other Professionals
C.7.a. Personal Public Statements
When making personal statements in a public context, counselors clarify that they are speaking from their personal perspectives and that they are not speaking on behalf of all counselors or the profession.

Section D
Relationships With Other Professionals
Introduction
Professional counselors recognize that the quality of their interactions with colleagues can influence the quality of services provided to clients. They work to become knowledgeable about colleagues within and outside the field of counseling. Counselors develop positive working relationships and systems of communication with colleagues to enhance services to clients.

D.1. Relationships With Colleagues, Employers, and Employees
D.1.a. Different Approaches
Counselors are respectful of approaches to counseling services that differ from their own. Counselors are respectful of traditions and practices of other professional groups with which they work.

D.1.b. Forming Relationships
Counselors work to develop and strengthen interdisciplinary relations with colleagues from other disciplines to best serve clients.
D.1.c. Interdisciplinary Teamwork
Counselors who are members of interdisciplinary teams delivering multifaceted services to clients keep the focus on how to best serve the clients. They participate in and contribute to decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of the counseling profession and those of colleagues from other disciplines. (See A.1.a.)

D.1.d. Confidentiality
When counselors are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, they clarify role expectations and the parameters of confidentiality with their colleagues. (See B.1.c., B.1.d., B.2.c., B.2.d., B.3.b.)

D.1.e. Establishing Professional and Ethical Obligations
Counselors who are members of interdisciplinary teams clarify professional and ethical obligations of the team as a whole and of its individual members. When a team decision raises ethical concerns, counselors first attempt to resolve the concern within the team. If they cannot reach resolution among team members, counselors pursue other avenues to address their concerns consistent with client well-being.

D.1.f. Personnel Selection and Assignment
Counselors select competent staff and assign responsibilities compatible with their skills and experiences.

D.1.g. Employer Policies
The acceptance of employment in an agency or institution implies that counselors are in agreement with its general policies and principles. Counselors strive to reach agreement with employers as to acceptable standards of conduct that allow for changes in institutional policy conducive to the growth and development of clients.

D.1.h. Negative Conditions
Counselors alert their employers of inappropriate policies and practices. They attempt to effect changes in such policies or procedures through constructive action within the organization. When such policies are potentially disruptive or damaging to clients or may limit the effectiveness of services provided and change cannot be effected, counselors take appropriate further action. Such action may include referral to appropriate certification, accreditation, or state licensure organizations, or voluntary termination of employment.

D.1.i. Protection From Punitive Action
Counselors take care not to harass or dismiss an employee who has acted in a responsible and ethical manner to expose inappropriate employer policies or practices.
D.2. Consultation

D.2.a. Consultant Competency
Counselors take reasonable steps to ensure that they have the appropriate resources and competencies when providing consultation services. Counselors provide appropriate referral resources when requested or needed. *(See C.2.a.)*

D.2.b. Understanding Consultees
When providing consultation, counselors attempt to develop with their consultees a clear understanding of problem definition, goals for change, and predicted consequences of interventions selected.

D.2.c. Consultant Goals
The consulting relationship is one in which consultee adaptability and growth toward self-direction are consistently encouraged and cultivated.

D.2.d. Informed Consent in Consultation
When providing consultation, counselors have an obligation to review, in writing and verbally, the rights and responsibilities of both counselors and consultees. Counselors use clear and understandable language to inform all parties involved about the purpose of the services to be provided, relevant costs, potential risks and benefits, and the limits of confidentiality. Working in conjunction with the consultee, counselors attempt to develop a clear definition of the problem, goals for change, and predicted consequences of interventions that are culturally responsive and appropriate to the needs of consultees. *(See A.2.a., A.2.b.)*

Section E

Evaluation, Assessment, and Interpretation

Introduction
Counselors use assessment instruments as one component of the counseling process, taking into account the client personal and cultural context. Counselors promote the well-being of individual clients or groups of clients by developing and using appropriate educational, psychological, and career assessment instruments.

E.1. General

E.1.a. Assessment
The primary purpose of educational, psychological, and career assessment is to provide measurements that are valid and reliable in either comparative or absolute terms. These include, but are not limited to, measurements of ability, personality, interest, intelligence, achievement, and performance. Counselors recognize the need to interpret the statements in this section as applying to both quantitative and qualitative assessments.
E.1.b. Client Welfare
Counselors do not misuse assessment results and interpretations, and they take reasonable steps to prevent others from misusing the information these techniques provide. They respect the client’s right to know the results, the interpretations made, and the bases for counselors’ conclusions and recommendations.

E.2. Competence to Use and Interpret Assessment Instruments
E.2.a. Limits of Competence
Counselors utilize only those testing and assessment services for which they have been trained and are competent. Counselors using technology–assisted test interpretations are trained in the construct being measured and the specific instrument being used prior to using its technology-based application. Counselors take reasonable measures to ensure the proper use of psychological and career assessment techniques by persons under their supervision. (See A.12.)

E.2.b. Appropriate Use
Counselors are responsible for the appropriate application, scoring, interpretation, and use of assessment instruments relevant to the needs of the client, whether they score and interpret such assessments themselves or use technology or other services.

E.2.c. Decisions Based on Results
Counselors responsible for decisions involving individuals or policies that are based on assessment results have a thorough understanding of educational, psychological, and career measurement, including validation criteria, assessment research, and guidelines for assessment development and use.

E.3. Informed Consent in Assessment
E.3.a. Explanation to Clients
Prior to assessment, counselors explain the nature and purposes of assessment and the specific use of results by potential recipients. The explanation will be given in the language of the client (or other legally authorized person on behalf of the client), unless an explicit exception has been agreed upon in advance. Counselors consider the client’s personal or cultural context, the level of the client's understanding of the results, and the impact of the results on the client. (See A.2., A.12.g., F.1.c.)

E.3.b. Recipients of Results
Counselors consider the examinee’s welfare, explicit understandings, and prior agreements in determining who receives the assessment results. Counselors include accurate and appropriate interpretations with any release of individual or group assessment results. (See B.2.c., B.5.)
E.4. Release of Data to Qualified Professionals
Counselors release assessment data in which the client is identified only with the consent of the client or the client’s legal representative. Such data are released only to persons recognized by counselors as qualified to interpret the data. (See B.1., B.3., B.6.b.)

E.5. Diagnosis of Mental Disorders
E.5.a. Proper Diagnosis
Counselors take special care to provide proper diagnosis of mental disorders. Assessment techniques (including personal interview) used to determine client care (e.g., locus of treatment, type of treatment, or recommended follow-up) are carefully selected and appropriately used.

E.5.b. Cultural Sensitivity
Counselors recognize that culture affects the manner in which clients’ problems are defined. Clients’ socioeconomic and cultural experiences are considered when diagnosing mental disorders. (See A.2.c.)

E.5.c. Historical and Social Prejudices in the Diagnosis of Pathology
Counselors recognize historical and social prejudices in the misdiagnosis and pathologizing of certain individuals and groups and the role of mental health professionals in perpetuating these prejudices through diagnosis and treatment.

E.5.d. Refraining From Diagnosis
Counselors may refrain from making and/or reporting a diagnosis if they believe it would cause harm to the client or others.

E.6. Instrument Selection
E.6.a. Appropriateness of Instruments
Counselors carefully consider the validity, reliability, psychometric limitations, and appropriateness of instruments when selecting assessments.

E.6.b. Referral Information
If a client is referred to a third party for assessment, the counselor provides specific referral questions and sufficient objective data about the client to ensure that appropriate assessment instruments are utilized. (See A.9.b., B.3.)

E.6.c. Culturally Diverse Populations
Counselors are cautious when selecting assessments for culturally diverse populations to avoid the use of instruments that lack appropriate psychometric properties for the client population. (See A.2.c., E.5.b.)
E.7. Conditions of Assessment Administration

(See A.12.b., A.12.d.)

E.7.a. Administration Conditions
Counselors administer assessments under the same conditions that were established in their standardization. When assessments are not administered under standard conditions, as may be necessary to accommodate clients with disabilities, or when unusual behavior or irregularities occur during the administration, those conditions are noted in interpretation, and the results may be designated as invalid or of questionable validity.

E.7.b. Technological Administration
Counselors ensure that administration programs function properly and provide clients with accurate results when technological or other electronic methods are used for assessment administration.

E.7.c. Unsupervised Assessments
Unless the assessment instrument is designed, intended, and validated for self-administration and/or scoring, counselors do not permit inadequately supervised use.

E.7.d. Disclosure of Favorable Conditions
Prior to administration of assessments, conditions that produce most favorable assessment results are made known to the examinee.

E.8. Multicultural Issues/Diversity in Assessment
Counselors use with caution assessment techniques that were normed on populations other than that of the client. Counselors recognize the effects of age, color, culture, disability, ethnic group, gender, race, language preference, religion, spirituality, sexual orientation, and socioeconomic status on test administration and interpretation, and place test results in proper perspective with other relevant factors. (See A.2.c., E.5.b.)

E.9. Scoring and Interpretation of Assessments
E.9.a. Reporting
In reporting assessment results, counselors indicate reservations that exist regarding validity or reliability due to circumstances of the assessment or the inappropriateness of the norms for the person tested.

E.9.b. Research Instruments
Counselors exercise caution when interpreting the results of research instruments not having sufficient technical data to support respondent results. The specific purposes for the use of such instruments are stated explicitly to the examinee.
E.9.c. Assessment Services
Counselors who provide assessment scoring and interpretation services to support the assessment process confirm the validity of such interpretations. They accurately describe the purpose, norms, validity, reliability, and applications of the procedures and any special qualifications applicable to their use. The public offering of an automated test interpretations service is considered a professional-to-professional consultation. The formal responsibility of the consultant is to the consultee, but the ultimate and overriding responsibility is to the client. (See D.2.)

E.10. Assessment Security
Counselors maintain the integrity and security of tests and other assessment techniques consistent with legal and contractual obligations. Counselors do not appropriate, reproduce, or modify published assessments or parts thereof without acknowledgment and permission from the publisher.

E.11. Obsolete Assessments and Outdated Results
Counselors do not use data or results from assessments that are obsolete or outdated for the current purpose. Counselors make every effort to prevent the misuse of obsolete measures and assessment data by others.

E.12. Assessment Construction
Counselors use established scientific procedures, relevant standards, and current professional knowledge for assessment design in the development, publication, and utilization of educational and psychological assessment techniques.

E.13.a. Primary Obligations
When providing forensic evaluations, the primary obligation of counselors is to produce objective findings that can be substantiated based on information and techniques appropriate to the evaluation, which may include examination of the individual and/or review of records. Counselors are entitled to form professional opinions based on their professional knowledge and expertise that can be supported by the data gathered in evaluations. Counselors will define the limits of their reports or testimony, especially when an examination of the individual has not been conducted.

E.13.b. Consent for Evaluation
Individuals being evaluated are informed in writing that the relationship is for the purposes of an evaluation and is not counseling in nature, and entities or individuals who will receive the evaluation report are identified. Written consent to be evaluated is obtained from those being evaluated unless a court orders evaluations to be conducted without the written consent of individuals being evaluated.
When children or vulnerable adults are being evaluated, informed written consent is obtained from a parent or guardian.

E.13.c. Client Evaluation Prohibited
Counselors do not evaluate individuals for forensic purposes they currently counsel or individuals they have counseled in the past. Counselors do not accept as counseling clients individuals they are evaluating or individuals they have evaluated in the past for forensic purposes.

E.13.d. Avoid Potentially Harmful Relationships
Counselors who provide forensic evaluations avoid potentially harmful professional or personal relationships with family members, romantic partners, and close friends of individuals they are evaluating or have evaluated in the past.

Section F

Supervision, Training, and Teaching

Introduction
Counselors aspire to foster meaningful and respectful professional relationships and to maintain appropriate boundaries with supervisees and students. Counselors have theoretical and pedagogical foundations for their work and aim to be fair, accurate, and honest in their assessments of counselors-in-training.

F.1. Counselor Supervision and Client Welfare
F.1.a. Client Welfare
A primary obligation of counseling supervisors is to monitor the services provided by other counselors or counselors-in-training. Counseling supervisors monitor client welfare and supervisee clinical performance and professional development. To fulfill these obligations, supervisors meet regularly with supervisees to review case notes, samples of clinical work, or live observations. Supervisees have a responsibility to understand and follow the ACA Code of Ethics.

F.1.b. Counselor Credentials
Counseling supervisors work to ensure that clients are aware of the qualifications of the supervisees who render services to the clients. (See A.2.b.)

F.1.c. Informed Consent and Client Rights
Supervisors make supervisees aware of client rights including the protection of client privacy and confidentiality in the counseling relationship. Supervisees provide clients with professional disclosure information and inform them of how the supervision process influences the limits of confidentiality. Supervisees make clients aware of who will have access to records of the counseling relationship and how these records will be used. (See A.2.b., B.1.d.)
F.2. Counselor Supervision Competence

F.2.a. Supervisor Preparation
Prior to offering clinical supervision services, counselors are trained in supervision methods and techniques. Counselors who offer clinical supervision services regularly pursue continuing education activities including both counseling and supervision topics and skills. (See C.2.a., C.2.f)

F.2.b. Multicultural Issues/Diversity in Supervision
Counseling supervisors are aware of and address the role of multiculturalism/diversity in the supervisory relationship.

F.3. Supervisory Relationships

F.3.a. Relationship Boundaries With Supervisees
Counseling supervisors clearly define and maintain ethical professional, personal, and social relationships with their supervisees. Counseling supervisors avoid nonprofessional relationships with current supervisees. If supervisors must assume other professional roles (e.g., clinical and administrative supervisor, instructor) with supervisees, they work to minimize potential conflicts and explain to supervisees the expectations and responsibilities associated with each role. They do not engage in any form of nonprofessional interaction that may compromise the supervisory relationship.

F.3.b. Sexual Relationships
Sexual or romantic interactions or relationships with current supervisees are prohibited.

F.3.c. Sexual Harassment
Counseling supervisors do not condone or subject supervisees to sexual harassment. (See C.6.a)

F.3.d. Close Relatives and Friends
Counseling supervisors avoid accepting close relatives, romantic partners, or friends as supervisees.

F.3.e. Potentially Beneficial Relationships
Counseling supervisors are aware of the power differential in their relationships with supervisees. If they believe nonprofessional relationships with a supervisee may be potentially beneficial to the supervisee, they take precautions similar to those taken by counselors when working with clients. Examples of potentially beneficial interactions or relationships include attending a formal ceremony; hospital visits; providing support during a stressful event; or mutual membership in a professional association, organization, or community. Counseling supervisors engage in open discussions with supervisees when they consider entering into relationships with them outside of their roles as clinical and/or administrative
supervisors. Before engaging in nonprofessional relationships, supervisors discuss with supervisees and document the rationale for such interactions, potential benefits or drawbacks, and anticipated consequences for the supervisee. Supervisors clarify the specific nature and limitations of the additional role(s) they will have with the supervisee.

F.4. Supervisor Responsibilities
F.4.a. Informed Consent for Supervision
Supervisors are responsible for incorporating into their supervision the principles of informed consent and participation. Supervisors inform supervisees of the policies and procedures to which they are to adhere and the mechanisms for due process appeal of individual supervisory actions.

F.4.b. Emergencies and Absences
Supervisors establish and communicate to supervisees procedures for contacting them or, in their absence, alternative on-call supervisors to assist in handling crises.

F.4.c. Standards for Supervisees
Supervisors make their supervisees aware of professional and ethical standards and legal responsibilities. Supervisors of postdegree counselors encourage these counselors to adhere to professional standards of practice. (See C.1.)

F.4.d. Termination of the Supervisory Relationship
Supervisors or supervisees have the right to terminate the supervisory relationship with adequate notice. Reasons for withdrawal are provided to the other party. When cultural, clinical, or professional issues are crucial to the viability of the supervisory relationship, both parties make efforts to resolve differences. When termination is warranted, supervisors make appropriate referrals to possible alternative supervisors.

F.5. Counseling Supervision Evaluation, Remediation, and Endorsement
F.5.a. Evaluation
Supervisors document and provide supervisees with ongoing performance appraisal and evaluation feedback and schedule periodic formal evaluative sessions throughout the supervisory relationship.

F.5.b. Limitations
Through ongoing evaluation and appraisal, supervisors are aware of the limitations of supervisees that might impede performance. Supervisors assist supervisees in securing remedial assistance when needed. They recommend dismissal from training programs, applied counseling settings, or state or voluntary professional credentialing processes when those supervisees are unable to provide competent professional services. Supervisors seek consultation and document their decisions to dismiss or refer supervisees for assistance. They ensure that
supervisees are aware of options available to them to address such decisions. (See C.2.g.)

F.5.c. Counseling for Supervisees
If supervisees request counseling, supervisors provide them with acceptable referrals. Counselors do not provide counseling services to supervisees. Supervisors address interpersonal competencies in terms of the impact of these issues on clients, the supervisory relationship, and professional functioning. (See F.3.a.)

F.5.d. Endorsement
Supervisors endorse supervisees for certification, licensure, employment, or completion of an academic or training program only when they believe supervisees are qualified for the endorsement. Regardless of qualifications, supervisors do not endorse supervisees whom they believe to be impaired in any way that would interfere with the performance of the duties associated with the endorsement.

F.6. Responsibilities of Counselor Educators
F.6.a. Counselor Educators
Counselor educators who are responsible for developing, implementing, and supervising educational programs are skilled as teachers and practitioners. They are knowledgeable regarding the ethical, legal, and regulatory aspects of the profession, are skilled in applying that knowledge, and make students and supervisees aware of their responsibilities. Counselor educators conduct counselor education and training programs in an ethical manner and serve as role models for professional behavior. (See C.1., C.2.a., C.2.c.)

F.6.b. Infusing Multicultural Issues/Diversity
Counselor educators infuse material related to multiculturalism/diversity into all courses and workshops for the development of professional counselors.

F.6.c. Integration of Study and Practice
Counselor educators establish education and training programs that integrate academic study and supervised practice.

F.6.d. Teaching Ethics
Counselor educators make students and supervisees aware of the ethical responsibilities and standards of the profession and the ethical responsibilities of students to the profession. Counselor educators infuse ethical considerations throughout the curriculum. (See C.1.)

F.6.e. Peer Relationships
Counselor educators make every effort to ensure that the rights of peers are not compromised when students or supervisees lead counseling groups or provide
clinical supervision. Counselor educators take steps to ensure that students and supervisees understand they have the same ethical obligations as counselor educators, trainers, and supervisors.

F.6.f. Innovative Theories and Techniques
When counselor educators teach counseling techniques/procedures that are innovative, without an empirical foundation, or without a well-grounded theoretical foundation, they define the counseling techniques/procedures as “unproven” or “developing” and explain to students the potential risks and ethical considerations of using such techniques/procedures.

F.6.g. Field Placements
Counselor educators develop clear policies within their training programs regarding field placement and other clinical experiences. Counselor educators provide clearly stated roles and responsibilities for the student or supervisee, the site supervisor, and the program supervisor. They confirm that site supervisors are qualified to provide supervision and inform site supervisors of their professional and ethical responsibilities in this role.

F.6.h. Professional Disclosure
Before initiating counseling services, counselors-in-training disclose their status as students and explain how this status affects the limits of confidentiality. Counselor educators ensure that the clients at field placements are aware of the services rendered and the qualifications of the students and supervisees rendering those services. Students and supervisees obtain client permission before they use any information concerning the counseling relationship in the training process. (See A.2.b.)

F.7. Student Welfare
F.7.a. Orientation
Counselor educators recognize that orientation is a developmental process that continues throughout the educational and clinical training of students. Counseling faculty provide prospective students with information about the counselor education program’s expectations:

1. the type and level of skill and knowledge acquisition required for successful completion of the training;
2. program training goals, objectives, and mission, and subject matter to be covered;
3. bases for evaluation;
4. training components that encourage self-growth or self-disclosure as part of the training process;
5. the type of supervision settings and requirements of the sites for required clinical field experiences;
6. student and supervisee evaluation and dismissal policies and procedures; and
7. up-to-date employment prospects for graduates.

F.7.b. Self-Growth Experiences
Counselor education programs delineate requirements for self-disclosure or self-growth experiences in their admission and program materials. Counselor educators use professional judgment when designing training experiences they conduct that require student and supervisee self-growth or self-disclosure. Students and supervisees are made aware of the ramifications their self-disclosure may have when counselors whose primary role as teacher, trainer, or supervisor requires acting on ethical obligations to the profession. Evaluative components of experiential training experiences explicitly delineate predetermined academic standards that are separate and do not depend on the student’s level of self-disclosure. Counselor educators may require trainees to seek professional help to address any personal concerns that may be affecting their competency.

F.8. Student Responsibilities
F.8.a. Standards for Students
Counselors-in-training have a responsibility to understand and follow the ACA Code of Ethics and adhere to applicable laws, regulatory policies, and rules and policies governing professional staff behavior at the agency or placement setting. Students have the same obligation to clients as those required of professional counselors. (See C.1., H.1.)

F.8.b. Impairment
Counselors-in-training refrain from offering or providing counseling services when their physical, mental, or emotional problems are likely to harm a client or others. They are alert to the signs of impairment, seek assistance for problems, and notify their program supervisors when they are aware that they are unable to effectively provide services. In addition, they seek appropriate professional services for themselves to remediate the problems that are interfering with their ability to provide services to others. (See A.1., C.2.d., C.2.g.)

F.9. Evaluation and Remediation of Students
F.9.a. Evaluation
Counselors clearly state to students, prior to and throughout the training program, the levels of competency expected, appraisal methods, and timing of evaluations for both didactic and clinical competencies. Counselor educators provide students with ongoing performance appraisal and evaluation feedback throughout the training program.
F.9.b. Limitations
Counselor educators, throughout ongoing evaluation and appraisal, are aware of and address the inability of some students to achieve counseling competencies that might impede performance. Counselor educators

1. assist students in securing remedial assistance when needed,
2. seek professional consultation and document their decision to dismiss or refer students for assistance, and
3. ensure that students have recourse in a timely manner to address decisions to require them to seek assistance or to dismiss them and provide students with due process according to institutional policies and procedures. (See C.2.g.)

F.9.c. Counseling for Students
If students request counseling or if counseling services are required as part of a remediation process, counselor educators provide acceptable referrals.

F.10. Roles and Relationships Between Counselor Educators and Students
F.10.a. Sexual or Romantic Relationships
Sexual or romantic interactions or relationships with current students are prohibited.

F.10.b. Sexual Harassment
Counselor educators do not condone or subject students to sexual harassment. (See C.6.a.)

F.10.c. Relationships With Former Students
Counselor educators are aware of the power differential in the relationship between faculty and students. Faculty members foster open discussions with former students when considering engaging in a social, sexual, or other intimate relationship. Faculty members discuss with the former student how their former relationship may affect the change in relationship.

F.10.d. Nonprofessional Relationships
Counselor educators avoid nonprofessional or ongoing professional relationships with students in which there is a risk of potential harm to the student or that may compromise the training experience or grades assigned. In addition, counselor educators do not accept any form of professional services, fees, commissions, reimbursement, or remuneration from a site for student or supervisee placement.

F.10.e. Counseling Services
Counselor educators do not serve as counselors to current students unless this is a brief role associated with a training experience.
F.10.f. Potentially Beneficial Relationships
Counselor educators are aware of the power differential in the relationship between faculty and students. If they believe a nonprofessional relationship with a student may be potentially beneficial to the student, they take precautions similar to those taken by counselors when working with clients. Examples of potentially beneficial interactions or relationships include, but are not limited to, attending a formal ceremony; hospital visits; providing support during a stressful event; or mutual membership in a professional association, organization, or community. Counselor educators engage in open discussions with students when they consider entering into relationships with students outside of their roles as teachers and supervisors. They discuss with students the rationale for such interactions, the potential benefits and drawbacks, and the anticipated consequences for the student. Educators clarify the specific nature and limitations of the additional role(s) they will have with the student prior to engaging in a nonprofessional relationship. Nonprofessional relationships with students should be time-limited and initiated with student consent.

F.11. Multicultural/Diversity Competence in Counselor Education and Training Programs

F.11.a. Faculty Diversity
Counselor educators are committed to recruiting and retaining a diverse faculty.

F.11.b. Student Diversity
Counselor educators actively attempt to recruit and retain a diverse student body. Counselor educators demonstrate commitment to multicultural/diversity competence by recognizing and valuing diverse cultures and types of abilities students bring to the training experience. Counselor educators provide appropriate accommodations that enhance and support diverse student well-being and academic performance.

F.11.c. Multicultural/Diversity Competence
Counselor educators actively infuse multicultural/diversity competency in their training and supervision practices. They actively train students to gain awareness, knowledge, and skills in the competencies of multicultural practice. Counselor educators include case examples, role-plays, discussion questions, and other classroom activities that promote and represent various cultural perspectives.

Section G

Research and Publication

Introduction
Counselors who conduct research are encouraged to contribute to the knowledge base of the profession and promote a clearer understanding of the conditions that
lead to a healthy and more just society. Counselors support efforts of researchers by participating fully and willingly whenever possible. Counselors minimize bias and respect diversity in designing and implementing research programs.

**G.1. Research Responsibilities**

**G.1.a. Use of Human Research Participants**
Counselors plan, design, conduct, and report research in a manner that is consistent with pertinent ethical principles, federal and state laws, host institutional regulations, and scientific standards governing research with human research participants.

**G.1.b. Deviation From Standard Practice**
Counselors seek consultation and observe stringent safeguards to protect the rights of research participants when a research problem suggests a deviation from standard or acceptable practices.

**G.1.c. Independent Researchers**
When independent researchers do not have access to an Institutional Review Board (IRB), they should consult with researchers who are familiar with IRB procedures to provide appropriate safeguards.

**G.1.d. Precautions to Avoid Injury**
Counselors who conduct research with human participants are responsible for the welfare of participants throughout the research process and should take reasonable precautions to avoid causing injurious psychological, emotional, physical, or social effects to participants.

**G.1.e. Principal Researcher Responsibility**
The ultimate responsibility for ethical research practice lies with the principal researcher. All others involved in the research activities share ethical obligations and responsibility for their own actions.

**G.1.f. Minimal Interference**
Counselors take reasonable precautions to avoid causing disruptions in the lives of research participants that could be caused by their involvement in research.

**G.1.g. Multicultural/Diversity Considerations in Research**
When appropriate to research goals, counselors are sensitive to incorporating research procedures that take into account cultural considerations. They seek consultation when appropriate.

**G.2. Rights of Research Participants**

*(See A.2, A.7)*
G.2.a. Informed Consent in Research
Individuals have the right to consent to become research participants. In seeking consent, counselors use language that

1. accurately explains the purpose and procedures to be followed,
2. identifies any procedures that are experimental or relatively untried,
3. describes any attendant discomforts and risks,
4. describes any benefits or changes in individuals or organizations that might be reasonably expected,
5. discloses appropriate alternative procedures that would be advantageous for participants,
6. offers to answer any inquiries concerning the procedures,
7. describes any limitations on confidentiality,
8. describes the format and potential target audiences for the dissemination of research findings, and
9. instructs participants that they are free to withdraw their consent and to discontinue participation in the project at any time without penalty.

G.2.b. Deception
Counselors do not conduct research involving deception unless alternative procedures are not feasible and the prospective value of the research justifies the deception. If such deception has the potential to cause physical or emotional harm to research participants, the research is not conducted, regardless of prospective value. When the methodological requirements of a study necessitate concealment or deception, the investigator explains the reasons for this action as soon as possible during the debriefing.

G.2.c. Student/Supervisee Participation
Researchers who involve students or supervisees in research make clear to them that the decision regarding whether or not to participate in research activities does not affect one’s academic standing or supervisory relationship. Students or supervisees who choose not to participate in educational research are provided with an appropriate alternative to fulfill their academic or clinical requirements.

G.2.d. Client Participation
Counselors conducting research involving clients make clear in the informed consent process that clients are free to choose whether or not to participate in research activities. Counselors take necessary precautions to protect clients from adverse consequences of declining or withdrawing from participation.

G.2.e. Confidentiality of Information
Information obtained about research participants during the course of an investigation is confidential. When the possibility exists that others may obtain
access to such information, ethical research practice requires that the possibility, together with the plans for protecting confidentiality, be explained to participants as a part of the procedure for obtaining informed consent.

G.2.f. Persons Not Capable of Giving Informed Consent
When a person is not capable of giving informed consent, counselors provide an appropriate explanation to, obtain agreement for participation from, and obtain the appropriate consent of a legally authorized person.

G.2.g. Commitments to Participants
Counselors take reasonable measures to honor all commitments to research participants. (See A.2.c.)

G.2.h. Explanations After Data Collection
After data are collected, counselors provide participants with full clarification of the nature of the study to remove any misconceptions participants might have regarding the research. Where scientific or human values justify delaying or withholding information, counselors take reasonable measures to avoid causing harm.

G.2.i. Informing Sponsors
Counselors inform sponsors, institutions, and publication channels regarding research procedures and outcomes. Counselors ensure that appropriate bodies and authorities are given pertinent information and acknowledgment.

G.2.j. Disposal of Research Documents and Records
Within a reasonable period of time following the completion of a research project or study, counselors take steps to destroy records or documents (audio, video, digital, and written) containing confidential data or information that identifies research participants. When records are of an artistic nature, researchers obtain participant consent with regard to handling of such records or documents. (See B.4.a, B.4.g.)

G.3. Relationships With Research Participants (When Research Involves Intensive or Extended Interactions)
G.3.a. Nonprofessional Relationships
Nonprofessional relationships with research participants should be avoided.

G.3.b. Relationships With Research Participants
Sexual or romantic counselor–research participant interactions or relationships with current research participants are prohibited.

G.3.c. Sexual Harassment and Research Participants
Researchers do not condone or subject research participants to sexual harassment.
G.3.d. Potentially Beneficial Interactions
When a nonprofessional interaction between the researcher and the research participant may be potentially beneficial, the researcher must document, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit, and anticipated consequences for the research participant. Such interactions should be initiated with appropriate consent of the research participant. Where unintentional harm occurs to the research participant due to the nonprofessional interaction, the researcher must show evidence of an attempt to remedy such harm.

G.4. Reporting Results
G.4.a. Accurate Results
Counselors plan, conduct, and report research accurately. They provide thorough discussions of the limitations of their data and alternative hypotheses. Counselors do not engage in misleading or fraudulent research, distort data, misrepresent data, or deliberately bias their results. They explicitly mention all variables and conditions known to the investigator that may have affected the outcome of a study or the interpretation of data. They describe the extent to which results are applicable for diverse populations.

G.4.b. Obligation to Report Unfavorable Results
Counselors report the results of any research of professional value. Results that reflect unfavorably on institutions, programs, services, prevailing opinions, or vested interests are not withheld.

G.4.c. Reporting Errors
If counselors discover significant errors in their published research, they take reasonable steps to correct such errors in a correction erratum, or through other appropriate publication means.

G.4.d. Identity of Participants
Counselors who supply data, aid in the research of another person, report research results, or make original data available take due care to disguise the identity of respective participants in the absence of specific authorization from the participants to do otherwise. In situations where participants self-identify their involvement in research studies, researchers take active steps to ensure that data is adapted/changed to protect the identity and welfare of all parties and that discussion of results does not cause harm to participants.

G.4.e. Replication Studies
Counselors are obligated to make available sufficient original research data to qualified professionals who may wish to replicate the study.
G.5. Publication

G.5.a. Recognizing Contributions
When conducting and reporting research, counselors are familiar with and give recognition to previous work on the topic, observe copyright laws, and give full credit to those to whom credit is due.

G.5.b. Plagiarism
Counselors do not plagiarize, that is, they do not present another person's work as their own work.

G.5.c. Review/Republication of Data or Ideas
Counselors fully acknowledge and make editorial reviewers aware of prior publication of ideas or data where such ideas or data are submitted for review or publication.

G.5.d. Contributors
Counselors give credit through joint authorship, acknowledgment, footnote statements, or other appropriate means to those who have contributed significantly to research or concept development in accordance with such contributions. The principal contributor is listed first and minor technical or professional contributions are acknowledged in notes or introductory statements.

G.5.e. Agreement of Contributors
Counselors who conduct joint research with colleagues or students/supervisees establish agreements in advance regarding allocation of tasks, publication credit, and types of acknowledgment that will be received.

G.5.f. Student Research
For articles that are substantially based on students' course papers, projects, dissertations or theses, and on which students have been the primary contributors, they are listed as principal authors.

G.5.g. Duplicate Submission
Counselors submit manuscripts for consideration to only one journal at a time. Manuscripts that are published in whole or in substantial part in another journal or published work are not submitted for publication without acknowledgment and permission from the previous publication.

G.5.h. Professional Review
Counselors who review material submitted for publication, research, or other scholarly purposes respect the confidentiality and proprietary rights of those who submitted it. Counselors use care to make publication decisions based on
valid and defensible standards. Counselors review article submissions in a timely manner and based on their scope and competency in research methodologies. Counselors who serve as reviewers at the request of editors or publishers make every effort to only review materials that are within their scope of competency and use care to avoid personal biases.

Section H

Resolving Ethical Issues

Introduction

Counselors behave in a legal, ethical, and moral manner in the conduct of their professional work. They are aware that client protection and trust in the profession depend on a high level of professional conduct. They hold other counselors to the same standards and are willing to take appropriate action to ensure that these standards are upheld.

Counselors strive to resolve ethical dilemmas with direct and open communication among all parties involved and seek consultation with colleagues and supervisors when necessary. Counselors incorporate ethical practice into their daily professional work. They engage in ongoing professional development regarding current topics in ethical and legal issues in counseling.

H.1. Standards and the Law

(See F.9.a.)

H.1.a. Knowledge

Counselors understand the ACA Code of Ethics and other applicable ethics codes from other professional organizations or from certification and licensure bodies of which they are members. Lack of knowledge or misunderstanding of an ethical responsibility is not a defense against a charge of unethical conduct.

H.1.b. Conflicts Between Ethics and Laws

If ethical responsibilities conflict with law, regulations, or other governing legal authority, counselors make known their commitment to the ACA Code of Ethics and take steps to resolve the conflict. If the conflict cannot be resolved by such means, counselors may adhere to the requirements of law, regulations, or other governing legal authority.

H.2. Suspected Violations

H.2.a. Ethical Behavior Expected

Counselors expect colleagues to adhere to the ACA Code of Ethics. When counselors possess knowledge that raises doubts as to whether another counselor is acting in an ethical manner, they take appropriate action. (See H.2.b., H.2.c.)
H.2.b. Informal Resolution
When counselors have reason to believe that another counselor is violating or has violated an ethical standard, they attempt first to resolve the issue informally with the other counselor if feasible, provided such action does not violate confidentiality rights that may be involved.

H.2.c. Reporting Ethical Violations
If an apparent violation has substantially harmed, or is likely to substantially harm a person or organization and is not appropriate for informal resolution or is not resolved properly, counselors take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, voluntary national certification bodies, state licensing boards, or the appropriate institutional authorities. This standard does not apply when an intervention would violate confidentiality rights or when counselors have been retained to review the work of another counselor whose professional conduct is in question.

H.2.d. Consultation
When uncertain as to whether a particular situation or course of action may be in violation of the ACA Code of Ethics, counselors consult with other counselors who are knowledgeable about ethics and the ACA Code of Ethics, with colleagues, or with appropriate authorities.

H.2.e. Organizational Conflicts
If the demands of an organization with which counselors are affiliated pose a conflict with the ACA Code of Ethics, counselors specify the nature of such conflicts and express to their supervisors or other responsible officials their commitment to the ACA Code of Ethics. When possible, counselors work toward change within the organization to allow full adherence to the ACA Code of Ethics. In doing so, they address any confidentiality issues.

H.2.f. Unwarranted Complaints
Counselors do not initiate, participate in, or encourage the filing of ethics complaints that are made with reckless disregard or willful ignorance of facts that would disprove the allegation.

H.2.g. Unfair Discrimination Against Complainants and Respondents
Counselors do not deny persons employment, advancement, admission to academic or other programs, tenure, or promotion based solely upon their having made or their being the subject of an ethics complaint. This does not preclude taking action based upon the outcome of such proceedings or considering other appropriate information.
H.3. Cooperation With Ethics Committees

Counselors assist in the process of enforcing the *ACA Code of Ethics*. Counselors cooperate with investigations, proceedings, and requirements of the ACA Ethics Committee or ethics committees of other duly constituted associations or boards having jurisdiction over those charged with a violation. Counselors are familiar with the *ACA Policy and Procedures for Processing Complains of Ethical Violations* and use it as a reference for assisting in the enforcement of the *ACA Code of Ethics*.

**Glossary of Terms**

**Advocacy:** promotion of the well-being of individuals and groups, and the counseling profession within systems and organizations. Advocacy seeks to remove barriers and obstacles that inhibit access, growth, and development.

**Assent:** to demonstrate agreement, when a person is otherwise not capable or competent to give formal consent (e.g., informed consent) to a counseling service or plan.

**Client:** an individual seeking or referred to the professional services of a counselor for help with problem resolution or decision making.

**Counselor:** a professional (or a student who is a counselor-in-training) engaged in a counseling practice or other counseling-related services. Counselors fulfill many roles and responsibilities such as counselor educators, researchers, supervisors, practitioners, and consultants.

**Counselor Educator:** a professional counselor engaged primarily in developing, implementing, and supervising the educational preparation of counselors-in-training.

**Counselor Supervisor:** a professional counselor who engages in a formal relationship with a practicing counselor or counselor-in-training for the purpose of overseeing that individual’s counseling work or clinical skill development.

**Culture:** membership in a socially constructed way of living, which incorporates collective values, beliefs, norms, boundaries, and lifestyles that are co-created with others who share similar worldviews comprising biological, psychosocial, historical, psychological, and other factors.

**Diversity:** the similarities and differences that occur within and across cultures, and the intersection of cultural and social identities.

**Documents:** any written, digital, audio, visual, or artistic recording of the work within the counseling relationship between counselor and client.

**Examinee:** a recipient of any professional counseling service that includes educational, psychological, and career appraisal utilizing qualitative or quantitative techniques.
Forensic Evaluation: any formal assessment conducted for court or other legal proceedings.

Multicultural/Diversity Competence: a capacity whereby counselors possess cultural and diversity awareness and knowledge about self and others, and how this awareness and knowledge is applied effectively in practice with clients and client groups.

Multicultural/Diversity Counseling: counseling that recognizes diversity and embraces approaches that support the worth, dignity, potential, and uniqueness of individuals within their historical, cultural, economic, political, and psychosocial contexts.

Student: an individual engaged in formal educational preparation as a counselor-in-training.

Supervisee: a professional counselor or counselor-in-training whose counseling work or clinical skill development is being overseen in a formal supervisory relationship by a qualified trained professional.

Supervisor: counselors who are trained to oversee the professional clinical work of counselors and counselors-in-training.

Teaching: all activities engaged in as part of a formal educational program designed to lead to a graduate degree in counseling.

Training: the instruction and practice of skills related to the counseling profession. Training contributes to the ongoing proficiency of students and professional counselors.

Note: Reprinted from ACA Code of Ethics. Copyright 2005 by the American Counseling Association. Reprinted with permission. No further reproduction authorized without written permission from the American Counseling Association.
Ethical Principles of Psychologists and Code of Conduct

2002

Contents

INTRODUCTION AND APPLICABILITY
PREAMBLE
GENERAL PRINCIPLES
Principle A: Beneficence and Nonmaleficence
Principle B: Fidelity and Responsibility
Principle C: Integrity
Principle D: Justice
Principle E: Respect for People’s Rights and Dignity
ETHICAL STANDARDS
1. Resolving Ethical Issues
1.01 Misuse of Psychologists’ Work
1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority
1.03 Conflicts Between Ethics and Organizational Demands
1.04 Informal Resolution of Ethical Violations
1.05 Reporting Ethical Violations
1.06 Cooperating With Ethics Committees
1.07 Improper Complaints
1.08 Unfair Discrimination Against Complainants and Respondents
2. Competence
2.01 Boundaries of Competence
2.02 Providing Services in Emergencies
2.03 Maintaining Competence
2.04 Bases for Scientific and Professional Judgments
2.05 Delegation of Work to Others
2.06 Personal Problems and Conflicts
3. Human Relations
3.01 Unfair Discrimination
3.02 Sexual Harassment
3.03 Other Harassment
3.04 Avoiding Harm
3.05 Multiple Relationships
3.06 Conflict of Interest
3.07 Third-Party Requests for Services
3.08 Exploitative Relationships
3.09 Cooperation With Other Professionals
3.10 Informed Consent
3.11 Psychological Services Delivered to or Through Organizations
3.12 Interruption of Psychological Services
4. Privacy and Confidentiality
4.01 Maintaining Confidentiality
4.02 Discussing the Limits of Confidentiality
4.03 Recording
4.04 Minimizing Intrusions on Privacy
4.05 Disclosures
4.06 Consultations
4.07 Use of Confidential Information for Didactic or Other Purposes
5. Advertising and Other Public Statements
5.01 Avoidance of False or Deceptive Statements
5.02 Statements by Others
5.03 Descriptions of Workshops and Non-Degree-Granting Educational Programs
5.04 Media Presentations
5.05 Testimonials
5.06 In-Person Solicitation
6. Record Keeping and Fees
6.01 Documentation of Professional and Scientific Work and Maintenance of Records
6.02 Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work
6.03 Withholding Records for Nonpayment
6.04 Fees and Financial Arrangements
6.05 Barter With Clients/Patients
6.06 Accuracy in Reports to Payors and Funding Sources
6.07 Referrals and Fees
7. Education and Training
7.01 Design of Education and Training Programs
7.02 Descriptions of Education and Training Programs
7.03 Accuracy in Teaching
7.04 Student Disclosure of Personal Information
7.05 Mandatory Individual or Group Therapy
7.06 Assessing Student and Supervisee Performance
7.07 Sexual Relationships With Students and Supervisees
8. Research and Publication
8.01 Institutional Approval
8.02 Informed Consent to Research
8.03 Informed Consent for Recording Voices and Images in Research
8.04 Client/Patient, Student, and Subordinate Research Participants
8.05 Dispensing With Informed Consent for Research
8.06 Offering Inducements for Research Participation
8.07 Deception in Research
8.08 Debriefing
8.09 Humane Care and Use of Animals in Research
8.10 Reporting Research Results
8.11 Plagiarism
8.12 Publication Credit
8.13 Duplicate Publication of Data
8.14 Sharing Research Data for Verification
8.15 Reviewers
9. Assessment
9.01 Bases for Assessments
9.02 Use of Assessments
9.03 Informed Consent in Assessments
9.04 Release of Test Data
9.05 Test Construction
9.06 Interpreting Assessment Results
9.07 Assessment by Unqualified Persons
9.08 Obsolete Tests and Outdated Test Results
9.09 Test Scoring and Interpretation Services
9.10 Explaining Assessment Results
9.11 Maintaining Test Security
10. Therapy
10.01 Informed Consent to Therapy
10.02 Therapy Involving Couples or Families
10.03 Group Therapy
10.04 Providing Therapy to Those Served by Others
10.05 Sexual Intimacies With Current Therapy Clients/Patients
10.06 Sexual Intimacies With Relatives or Significant Others of Current Therapy Clients/Patients
10.07 Therapy With Former Sexual Partners
10.08 Sexual Intimacies With Former Therapy Clients/Patients
10.09 Interruption of Therapy
10.10 Terminating Therapy

Introduction and Applicability

The American Psychological Association’s (APA's) Ethical Principles of Psychologists and Code of Conduct (hereinafter referred to as the Ethics Code) consists of an Introduction, a Preamble, five General Principles (A–E), and specific Ethical Standards. The Introduction discusses the intent, organization, procedural considerations, and scope of application of the Ethics Code. The Preamble and General Principles are aspirational goals to guide psychologists toward the highest ideals of psychology. Although the Preamble and General Principles are
not themselves enforceable rules, they should be considered by psychologists in arriving at an ethical course of action. The Ethical Standards set forth enforceable rules for conduct as psychologists. Most of the Ethical Standards are written broadly, in order to apply to psychologists in varied roles, although the application of an Ethical Standard may vary depending on the context. The Ethical Standards are not exhaustive. The fact that a given conduct is not specifically addressed by an Ethical Standard does not mean that it is necessarily either ethical or unethical.

This Ethics Code applies only to psychologists’ activities that are part of their scientific, educational, or professional roles as psychologists. Areas covered include but are not limited to the clinical, counseling, and school practice of psychology; research; teaching; supervision of trainees; public service; policy development; social intervention; development of assessment instruments; conducting assessments; educational counseling; organizational consulting; forensic activities; program design and evaluation; and administration. This Ethics Code applies to these activities across a variety of contexts, such as in person, postal, telephone, Internet, and other electronic transmissions. These activities shall be distinguished from the purely private conduct of psychologists, which is not within the purview of the Ethics Code.

Membership in the APA commits members and student affiliates to comply with the standards of the APA Ethics Code and to the rules and procedures used to enforce them. Lack of awareness or misunderstanding of an Ethical Standard is not itself a defense to a charge of unethical conduct.

The procedures for filing, investigating, and resolving complaints of unethical conduct are described in the current Rules and Procedures of the APA Ethics Committee. APA may impose sanctions on its members for violations of the standards of the Ethics Code, including termination of APA membership, and may notify other bodies and individuals of its actions. Actions that violate the standards of the Ethics Code may also lead to the imposition of sanctions on psychologists or students whether or not they are APA members by bodies other than APA, including state psychological associations, other professional groups, psychology boards, other state or federal agencies, and payors for health services. In addition, APA may take action against a member after his or her conviction of a felony, expulsion or suspension from an affiliated state psychological association, or suspension or loss of licensure. When the sanction to be imposed by APA is less than expulsion, the 2001 Rules and Procedures do not guarantee an opportunity for an in-person hearing, but generally provide that complaints will be resolved only on the basis of a submitted record.

The Ethics Code is intended to provide guidance for psychologists and standards of professional conduct that can be applied by the APA and by other bodies that choose to adopt them. The Ethics Code is not intended to be a basis of civil liability. Whether a psychologist has violated the Ethics Code standards does not by itself determine whether the psychologist is legally liable in a court action, whether a contract is enforceable, or whether other legal consequences occur.
The modifiers used in some of the standards of this Ethics Code (e.g., reasonably, appropriate, potentially) are included in the standards when they would (1) allow professional judgment on the part of psychologists, (2) eliminate injustice or inequality that would occur without the modifier, (3) ensure applicability across the broad range of activities conducted by psychologists, or (4) guard against a set of rigid rules that might be quickly outdated. As used in this Ethics Code, the term reasonable means the prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge the psychologist had or should have had at the time.

In the process of making decisions regarding their professional behavior, psychologists must consider this Ethics Code in addition to applicable laws and psychology board regulations. In applying the Ethics Code to their professional work, psychologists may consider other materials and guidelines that have been adopted or endorsed by scientific and professional psychological organizations and the dictates of their own conscience, as well as consult with others within the field. If this Ethics Code establishes a higher standard of conduct than is required by law, psychologists must meet the higher ethical standard. If psychologists’ ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to this Ethics Code and take steps to resolve the conflict in a responsible manner. If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing authority in keeping with basic principles of human rights.

Preamble

Psychologists are committed to increasing scientific and professional knowledge of behavior and people’s understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching, and publication. They strive to help the public in developing informed judgments and choices concerning human behavior. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness. This Ethics Code provides a common set of principles and standards upon which psychologists build their professional and scientific work.

This Ethics Code is intended to provide specific standards to cover most situations encountered by psychologists. It has as its goals the welfare and protection of the individuals and groups with whom psychologists work and the education of members, students, and the public regarding ethical standards of the discipline.

The development of a dynamic set of ethical standards for psychologists’ work-related conduct requires a personal commitment and lifelong effort to act
ethically; to encourage ethical behavior by students, supervisees, employees, and colleagues; and to consult with others concerning ethical problems.

**General Principles**

This section consists of General Principles. General Principles, as opposed to Ethical Standards, are aspirational in nature. Their intent is to guide and inspire psychologists toward the very highest ethical ideals of the profession. General Principles, in contrast to Ethical Standards, do not represent obligations and should not form the basis for imposing sanctions. Relying upon General Principles for either of these reasons distorts both their meaning and purpose.

**Principle A: Beneficence and Nonmaleficence**

Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research. When conflicts occur among psychologists’ obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because psychologists’ scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence. Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work.

**Principle B: Fidelity and Responsibility**

Psychologists establish relationships of trust with those with whom they work. They are aware of their professional and scientific responsibilities to society and to the specific communities in which they work. Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage conflicts of interest that could lead to exploitation or harm. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work. They are concerned about the ethical compliance of their colleagues’ scientific and professional conduct. Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage.

**Principle C: Integrity**

Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not
steal, cheat, or engage in fraud, subterfuge, or intentional misrepresentation of fact. Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques.

**Principle D: Justice**

Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists. Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices.

**Principle E: Respect for People’s Rights and Dignity**

Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making. Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.

**Ethical Standards**

1. Resolving Ethical Issues

1.01 Misuse of Psychologists’ Work
If psychologists learn of misuse or misrepresentation of their work, they take reasonable steps to correct or minimize the misuse or misrepresentation.

1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority
If psychologists’ ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to the Ethics Code and take steps to resolve the conflict. If the conflict is unresolvable
via such means, psychologists may adhere to the requirements of the law, regulations, or other governing legal authority.

1.03 Conflicts Between Ethics and Organizational Demands
If the demands of an organization with which psychologists are affiliated or for whom they are working conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code and, to the extent feasible, resolve the conflict in a way that permits adherence to the Ethics Code.

1.04 Informal Resolution of Ethical Violations
When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual, if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved. (See also Standards 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority, and 1.03, Conflicts Between Ethics and Organizational Demands.)

1.05 Reporting Ethical Violations
If an apparent ethical violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution under Standard 1.04, Informal Resolution of Ethical Violations, or is not resolved properly in that fashion, psychologists take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, to state licensing boards, or to the appropriate institutional authorities. This standard does not apply when an intervention would violate confidentiality rights or when psychologists have been retained to review the work of another psychologist whose professional conduct is in question. (See also Standard 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority.)

1.06 Cooperating With Ethics Committees
Psychologists cooperate in ethics investigations, proceedings, and resulting requirements of the APA or any affiliated state psychological association to which they belong. In doing so, they address any confidentiality issues. Failure to cooperate is itself an ethics violation. However, making a request for deferment of adjudication of an ethics complaint pending the outcome of litigation does not alone constitute noncooperation.

1.07 Improper Complaints
Psychologists do not file or encourage the filing of ethics complaints that are made with reckless disregard for or willful ignorance of facts that would disprove the allegation.
1.08 Unfair Discrimination Against Complainants and Respondents
Psychologists do not deny persons employment, advancement, admissions to academic or other programs, tenure, or promotion, based solely upon their having made or their being the subject of an ethics complaint. This does not preclude taking action based upon the outcome of such proceedings or considering other appropriate information.

2. Competence

2.01 Boundaries of Competence
a. Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.

b. Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies.

c. Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.

d. When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study.

e. In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm.

f. When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles.

2.02 Providing Services in Emergencies
In emergencies, when psychologists provide services to individuals for whom other mental health services are not available and for which psychologists have
not obtained the necessary training, psychologists may provide such services in order to ensure that services are not denied. The services are discontinued as soon as the emergency has ended or appropriate services are available.

2.03 Maintaining Competence
Psychologists undertake ongoing efforts to develop and maintain their competence.

2.04 Bases for Scientific and Professional Judgments
Psychologists’ work is based upon established scientific and professional knowledge of the discipline. (See also Standards 2.01e, Boundaries of Competence, and 10.01b, Informed Consent to Therapy.)

2.05 Delegation of Work to Others
Psychologists who delegate work to employees, supervisees, or research or teaching assistants or who use the services of others, such as interpreters, take reasonable steps to (1) avoid delegating such work to persons who have a multiple relationship with those being served that would likely lead to exploitation or loss of objectivity; (2) authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided; and (3) see that such persons perform these services competently. (See also Standards 2.02, Providing Services in Emergencies; 3.05, Multiple Relationships; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.02, Use of Assessments; 9.03, Informed Consent in Assessments; and 9.07, Assessment by Unqualified Persons.)

2.06 Personal Problems and Conflicts
a. Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.
b. When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties. (See also Standard 10.10, Terminating Therapy.)

3. Human Relations
3.01 Unfair Discrimination
In their work-related activities, psychologists do not engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law.
3.02 Sexual Harassment
Psychologists do not engage in sexual harassment. Sexual harassment is sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with the psychologist's activities or roles as a psychologist, and that either (1) is unwelcome, is offensive, or creates a hostile workplace or educational environment, and the psychologist knows or is told this or (2) is sufficiently severe or intense to be abusive to a reasonable person in the context. Sexual harassment can consist of a single intense or severe act or of multiple persistent or pervasive acts. (See also Standard 1.08, Unfair Discrimination Against Complainants and Respondents.)

3.03 Other Harassment
Psychologists do not knowingly engage in behavior that is harassing or demeaning to persons with whom they interact in their work based on factors such as those persons' age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status.

3.04 Avoiding Harm
Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

3.05 Multiple Relationships
a. A multiple relationship occurs when a psychologist 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 psychologist 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.

A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.

Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.

b. If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code.

c. When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative
proceedings, at the outset they clarify role expectations and the extent of confidentiality and thereafter as changes occur. (See also Standards 3.04, Avoiding Harm, and 3.07, Third-Party Requests for Services.)

3.06 Conflict of Interest
Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence, or effectiveness in performing their functions as psychologists or (2) expose the person or organization with whom the professional relationship exists to harm or exploit.

3.07 Third-Party Requests for Services
When psychologists agree to provide services to a person or entity at the request of a third party, psychologists attempt to clarify at the outset of the service the nature of the relationship with all individuals or organizations involved. This clarification includes the role of the psychologist (e.g., therapist, consultant, diagnostician, or expert witness), an identification of who is the client, the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality. (See also Standards 3.05, Multiple Relationships, and 4.02, Discussing the Limits of Confidentiality.)

3.08 Exploitative Relationships
Psychologists do not exploit persons over whom they have supervisory, evaluative, or other authority such as clients/patients, students, supervisees, research participants, and employees. (See also Standards 3.05, Multiple Relationships; 6.04, Fees and Financial Arrangements; 6.05, Barter With Clients/Patients; 7.07, Sexual Relationships With Students and Supervisees; 10.05, Sexual Intimacies With Current Therapy Clients/Patients; 10.06, Sexual Intimacies With Relatives or Significant Others of Current Therapy Clients/Patients; 10.07, Therapy With Former Sexual Partners; and 10.08, Sexual Intimacies With Former Therapy Clients/Patients.)

3.09 Cooperation With Other Professionals
When indicated and professionally appropriate, psychologists cooperate with other professionals in order to serve their clients/patients effectively and appropriately. (See also Standard 4.05, Disclosures.)

3.10 Informed Consent
a. When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons, except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards 8.02, Informed Consent
b. For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.

c. When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.

d. Psychologists appropriately document written or oral consent, permission, and assent. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

3.11 Psychological Services Delivered to or Through Organizations

a. Psychologists delivering services to or through organizations provide information beforehand to clients and when appropriate those directly affected by the services about (1) the nature and objectives of the services, (2) the intended recipients, (3) which of the individuals are clients, (4) the relationship the psychologist will have with each person and the organization, (5) the probable uses of services provided and information obtained, (6) who will have access to the information, and (7) limits of confidentiality. As soon as feasible, they provide information about the results and conclusions of such services to appropriate persons.

b. If psychologists will be precluded by law or by organizational roles from providing such information to particular individuals or groups, they so inform those individuals or groups at the outset of the service.

3.12 Interruption of Psychological Services

Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist's illness, death, unavailability, relocation, or retirement or by the client's/patient's relocation or financial limitations. (See also Standard 6.02c, Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work.)

4. Privacy and Confidentiality

4.01 Maintaining Confidentiality

Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium,
recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship. (See also Standard 2.05, Delegation of Work to Others.)

4.02 Discussing the Limits of Confidentiality
a. Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (See also Standard 3.10, Informed Consent.)
b. Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.
c. Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.

4.03 Recording
Before recording the voices or images of individuals to whom they provide services, psychologists obtain permission from all such persons or their legal representatives. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing With Informed Consent for Research; and 8.07, Deception in Research.)

4.04 Minimizing Intrusions on Privacy
a. Psychologists include in written and oral reports and consultations only information germane to the purpose for which the communication is made.
b. Psychologists discuss confidential information obtained in their work only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters.

4.05 Disclosures
a. Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law.
b. Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. (See also Standard 6.04e, Fees and Financial Arrangements.)
4.06 Consultations
When consulting with colleagues, (1) psychologists do not disclose confidential information that reasonably could lead to the identification of a client/patient, research participant, or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and (2) they disclose information only to the extent necessary to achieve the purposes of the consultation. (See also Standard 4.01, Maintaining Confidentiality.)

4.07 Use of Confidential Information for Didactic or Other Purposes
Psychologists do not disclose in their writings, lectures, or other public media confidential, personally identifiable information concerning their clients/patients, students, research participants, organizational clients, or other recipients of their services that they obtained during the course of their work, unless (1) they take reasonable steps to disguise the person or organization, (2) the person or organization has consented in writing, or (3) there is legal authorization for doing so.

5. Advertising and Other Public Statements

5.01 Avoidance of False or Deceptive Statements
a. Public statements include but are not limited to paid or unpaid advertising, product endorsements, grant applications, licensing applications, other credentialing applications, brochures, printed matter, directory listings, personal resumes or curricula vitae, or comments for use in media such as print or electronic transmission, statements in legal proceedings, lectures and public oral presentations, and published materials. Psychologists do not knowingly make public statements that are false, deceptive, or fraudulent concerning their research, practice, or other work activities or those of persons or organizations with which they are affiliated.

b. Psychologists do not make false, deceptive, or fraudulent statements concerning (1) their training, experience, or competence; (2) their academic degrees; (3) their credentials; (4) their institutional or association affiliations; (5) their services; (6) the scientific or clinical basis for, or results or degree of success of, their services; (7) their fees; or (8) their publications or research findings.

c. Psychologists claim degrees as credentials for their health services only if those degrees (1) were earned from a regionally accredited educational institution or (2) were the basis for psychology licensure by the state in which they practice.

5.02 Statements by Others
a. Psychologists who engage others to create or place public statements that promote their professional practice, products, or activities retain professional responsibility for such statements.
b. Psychologists do not compensate employees of press, radio, television, or other communication media in return for publicity in a news item. (See also Standard 1.01, Misuse of Psychologists' Work.)
c. A paid advertisement relating to psychologists' activities must be identified or clearly recognizable as such.

5.03 Descriptions of Workshops and Non-Degree-Granting Educational Programs
To the degree to which they exercise control, psychologists responsible for announcements, catalogs, brochures, or advertisements describing workshops, seminars, or other non-degree-granting educational programs ensure that they accurately describe the audience for which the program is intended, the educational objectives, the presenters, and the fees involved.

5.04 Media Presentations
When psychologists provide public advice or comment via print, Internet, or other electronic transmission, they take precautions to ensure that statements (1) are based on their professional knowledge, training, or experience in accord with appropriate psychological literature and practice; (2) are otherwise consistent with this Ethics Code; and (3) do not indicate that a professional relationship has been established with the recipient. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)

5.05 Testimonials
Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence.

5.06 In-Person Solicitation
Psychologists do not engage, directly or through agents, in uninvited in-person solicitation of business from actual or potential therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence. However, this prohibition does not preclude (1) attempting to implement appropriate collateral contacts for the purpose of benefiting an already engaged therapy client/patient or (2) providing disaster or community outreach services.

6. Record Keeping and Fees
6.01 Documentation of Professional and Scientific Work and Maintenance of Records
Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law. (See also Standard 4.01, Maintaining Confidentiality.)
6.02 Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work
a. Psychologists maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium. (See also Standards 4.01, Maintaining Confidentiality, and 6.01, Documentation of Professional and Scientific Work and Maintenance of Records.)
b. If confidential information concerning recipients of psychological services is entered into databases or systems of records available to persons whose access has not been consented to by the recipient, psychologists use coding or other techniques to avoid the inclusion of personal identifiers.
c. Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists' withdrawal from positions or practice. (See also Standards 3.12, Interruption of Psychological Services, and 10.09, Interruption of Therapy.)

6.03 Withholding Records for Nonpayment
Psychologists may not withhold records under their control that are requested and needed for a client's/patient's emergency treatment solely because payment has not been received.

6.04 Fees and Financial Arrangements
a. As early as is feasible in a professional or scientific relationship, psychologists and recipients of psychological services reach an agreement specifying compensation and billing arrangements.
b. Psychologists' fee practices are consistent with law.
c. Psychologists do not misrepresent their fees.
d. If limitations to services can be anticipated because of limitations in financing, this is discussed with the recipient of services as early as is feasible. (See also Standards 10.09, Interruption of Therapy, and 10.10, Terminating Therapy.)
e. If the recipient of services does not pay for services as agreed, and if psychologists intend to use collection agencies or legal measures to collect the fees, psychologists first inform the person that such measures will be taken and provide that person an opportunity to make prompt payment. (See also Standards 4.05, Disclosures; 6.03, Withholding Records for Nonpayment; and 10.01, Informed Consent to Therapy.)

6.05 Barter With Clients/Patients
Barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative. (See also Standards 3.05, Multiple Relationships, and 6.04, Fees and Financial Arrangements.)
6.06 Accuracy in Reports to Payors and Funding Sources
In their reports to payors for services or sources of research funding, psychologists take reasonable steps to ensure the accurate reporting of the nature of the service provided or research conducted, the fees, charges, or payments, and, where applicable, the identity of the provider, the findings, and the diagnosis. (See also Standards 4.01, Maintaining Confidentiality; 4.04, Minimizing Intrusions on Privacy; and 4.05, Disclosures.)

6.07 Referrals and Fees
When psychologists pay, receive payment from, or divide fees with another professional, other than in an employer–employee relationship, the payment to each is based on the services provided (clinical, consultative, administrative, or other) and is not based on the referral itself. (See also Standard 3.09, Cooperation With Other Professionals.)

7. Education and Training
7.01 Design of Education and Training Programs
Psychologists responsible for education and training programs take reasonable steps to ensure that the programs are designed to provide the appropriate knowledge and proper experiences, and to meet the requirements for licensure, certification, or other goals for which claims are made by the program. (See also Standard 5.03, Descriptions of Workshops and Non-Degree-Granting Educational Programs.)

7.02 Descriptions of Education and Training Programs
Psychologists responsible for education and training programs take reasonable steps to ensure that there is a current and accurate description of the program content (including participation in required course- or program-related counseling, psychotherapy, experiential groups, consulting projects, or community service), training goals and objectives, stipends and benefits, and requirements that must be met for satisfactory completion of the program. This information must be made readily available to all interested parties.

7.03 Accuracy in Teaching
a. Psychologists take reasonable steps to ensure that course syllabi are accurate regarding the subject matter to be covered, bases for evaluating progress, and the nature of course experiences. This standard does not preclude an instructor from modifying course content or requirements when the instructor considers it pedagogically necessary or desirable, so long as students are made aware of these modifications in a manner that enables them to fulfill course requirements. (See also Standard 5.01, Avoidance of False or Deceptive Statements.)

b. When engaged in teaching or training, psychologists present psychological information accurately. (See also Standard 2.03, Maintaining Competence.)
7.04 Student Disclosure of Personal Information
Psychologists do not require students or supervisees to disclose personal information in course- or program-related activities, either orally or in writing, regarding sexual history, history of abuse and neglect, psychological treatment, and relationships with parents, peers, and spouses or significant others except if (1) the program or training facility has clearly identified this requirement in its admissions and program materials or (2) the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training- or professionally related activities in a competent manner or posing a threat to the students or others.

7.05 Mandatory Individual or Group Therapy
a. When individual or group therapy is a program or course requirement, psychologists responsible for that program allow students in undergraduate and graduate programs the option of selecting such therapy from practitioners unaffiliated with the program. (See also Standard 7.02, Descriptions of Education and Training Programs.)

b. Faculty who are or are likely to be responsible for evaluating students’ academic performance do not themselves provide that therapy. (See also Standard 3.05, Multiple Relationships.)

7.06 Assessing Student and Supervisee Performance
a. In academic and supervisory relationships, psychologists establish a timely and specific process for providing feedback to students and supervisees. Information regarding the process is provided to the student at the beginning of supervision.

b. Psychologists evaluate students and supervisees on the basis of their actual performance on relevant and established program requirements.

7.07 Sexual Relationships With Students and Supervisees
Psychologists do not engage in sexual relationships with students or supervisees who are in their department, agency, or training center or over whom psychologists have or are likely to have evaluative authority. (See also Standard 3.05, Multiple Relationships.)

8. Research and Publication

8.01 Institutional Approval
When institutional approval is required, psychologists provide accurate information about their research proposals and obtain approval prior to conducting the research. They conduct the research in accordance with the approved research protocol.

8.02 Informed Consent to Research
a. When obtaining informed consent as required in Standard 3.10, Informed Consent, psychologists inform participants about (1) the purpose of the
research, expected duration, and procedures; (2) their right to decline to participate and to withdraw from the research once participation has begun; (3) the foreseeable consequences of declining or withdrawing; (4) reasonably foreseeable factors that may be expected to influence their willingness to participate such as potential risks, discomfort, or adverse effects; (5) any prospective research benefits; (6) limits of confidentiality; (7) incentives for participation; and (8) whom to contact for questions about the research and research participants’ rights. They provide opportunity for the prospective participants to ask questions and receive answers. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing With Informed Consent for Research; and 8.07, Deception in Research.)

b. Psychologists conducting intervention research involving the use of experimental treatments clarify to participants at the outset of the research (1) the experimental nature of the treatment; (2) the services that will or will not be available to the control group(s) if appropriate; (3) the means by which assignment to treatment and control groups will be made; (4) available treatment alternatives if an individual does not wish to participate in the research or wishes to withdraw once a study has begun; and (5) compensation for or monetary costs of participating including, if appropriate, whether reimbursement from the participant or a third-party payor will be sought. (See also Standard 8.02a, Informed Consent to Research.)

8.03 Informed Consent for Recording Voices and Images in Research
Psychologists obtain informed consent from research participants prior to recording their voices or images for data collection unless (1) the research consists solely of naturalistic observations in public places, and it is not anticipated that the recording will be used in a manner that could cause personal identification or harm, or (2) the research design includes deception, and consent for the use of the recording is obtained during debriefing. (See also Standard 8.07, Deception in Research.)

8.04 Client/Patient, Student, and Subordinate Research Participants
a. When psychologists conduct research with clients/patients, students, or subordinates as participants, psychologists take steps to protect the prospective participants from adverse consequences of declining or withdrawing from participation.

b. When research participation is a course requirement or an opportunity for extra credit, the prospective participant is given the choice of equitable alternative activities.

8.05 Dispensing With Informed Consent for Research
Psychologists may dispense with informed consent only (1) where research would not reasonably be assumed to create distress or harm and involves (a) the study of normal educational practices, curricula, or classroom management
methods conducted in educational settings; (b) only anonymous questionnaires, naturalistic observations, or archival research for which disclosure of responses would not place participants at risk of criminal or civil liability or damage their financial standing, employability, or reputation, and confidentiality is protected; or (c) the study of factors related to job or organization effectiveness conducted in organizational settings for which there is no risk to participants’ employability, and confidentiality is protected; or (2) where otherwise permitted by law or federal or institutional regulations.

8.06 Offering Inducements for Research Participation
a. Psychologists make reasonable efforts to avoid offering excessive or inappropriate financial or other inducements for research participation when such inducements are likely to coerce participation.
b. When offering professional services as an inducement for research participation, psychologists clarify the nature of the services, as well as the risks, obligations, and limitations. (See also Standard 6.05, Barter With Clients/Patients.)

8.07 Deception in Research
a. Psychologists do not conduct a study involving deception unless they have determined that the use of deceptive techniques is justified by the study’s significant prospective scientific, educational, or applied value and that effective nondeceptive alternative procedures are not feasible.
b. Psychologists do not deceive prospective participants about research that is reasonably expected to cause physical pain or severe emotional distress.
c. Psychologists explain any deception that is an integral feature of the design and conduct of an experiment to participants as early as is feasible, preferably at the conclusion of their participation, but no later than at the conclusion of the data collection, and permit participants to withdraw their data. (See also Standard 8.08, Debriefing.)

8.08 Debriefing
a. Psychologists provide a prompt opportunity for participants to obtain appropriate information about the nature, results, and conclusions of the research, and they take reasonable steps to correct any misconceptions that participants may have of which the psychologists are aware.
b. If scientific or humane values justify delaying or withholding this information, psychologists take reasonable measures to reduce the risk of harm.
c. When psychologists become aware that research procedures have harmed a participant, they take reasonable steps to minimize the harm.

8.09 Humane Care and Use of Animals in Research
a. Psychologists acquire, care for, use, and dispose of animals in compliance with current federal, state, and local laws and regulations, and with professional standards.
b. Psychologists trained in research methods and experienced in the care of laboratory animals supervise all procedures involving animals and are responsible for ensuring appropriate consideration of their comfort, health, and humane treatment.

c. Psychologists ensure that all individuals under their supervision who are using animals have received instruction in research methods and in the care, maintenance, and handling of the species being used, to the extent appropriate to their role. (See also Standard 2.05, Delegation of Work to Others.)

d. Psychologists make reasonable efforts to minimize the discomfort, infection, illness, and pain of animal subjects.

e. Psychologists use a procedure subjecting animals to pain, stress, or privation only when an alternative procedure is unavailable and the goal is justified by its prospective scientific, educational, or applied value.

f. Psychologists perform surgical procedures under appropriate anesthesia and follow techniques to avoid infection and minimize pain during and after surgery.

g. When it is appropriate that an animal's life be terminated, psychologists proceed rapidly, with an effort to minimize pain and in accordance with accepted procedures.

8.10 Reporting Research Results

a. Psychologists do not fabricate data. (See also Standard 5.01a, Avoidance of False or Deceptive Statements.)

b. If psychologists discover significant errors in their published data, they take reasonable steps to correct such errors in a correction, retraction, erratum, or other appropriate publication means.

8.11 Plagiarism

Psychologists do not present portions of another's work or data as their own, even if the other work or data source is cited occasionally.

8.12 Publication Credit

a. Psychologists take responsibility and credit, including authorship credit, only for work they have actually performed or to which they have substantially contributed. (See also Standard 8.12b, Publication Credit.)

b. Principal authorship and other publication credits accurately reflect the relative scientific or professional contributions of the individuals involved, regardless of their relative status. Mere possession of an institutional position, such as department chair, does not justify authorship credit. Minor contributions to the research or to the writing for publications are acknowledged appropriately, such as in footnotes or in an introductory statement.

c. Except under exceptional circumstances, a student is listed as principal author on any multiple-authored article that is substantially based on the student's doctoral dissertation. Faculty advisors discuss publication credit with
students as early as feasible and throughout the research and publication process as appropriate. (See also Standard 8.12b, Publication Credit.)

8.13 Duplicate Publication of Data
Psychologists do not publish, as original data, data that have been previously published. This does not preclude republishing data when they are accompanied by proper acknowledgment.

8.14 Sharing Research Data for Verification
a. After research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release. This does not preclude psychologists from requiring that such individuals or groups be responsible for costs associated with the provision of such information.

b. Psychologists who request data from other psychologists to verify the substantive claims through reanalysis may use shared data only for the declared purpose. Requesting psychologists obtain prior written agreement for all other uses of the data.

8.15 Reviewers
Psychologists who review material submitted for presentation, publication, grant, or research proposal review respect the confidentiality of and the proprietary rights in such information of those who submitted it.

9. Assessment
9.01 Bases for Assessments
a. Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)
b. Except as noted in 9.01c, psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions. When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions, and appropriately limit the nature and extent of their conclusions or recommendations. (See also Standards 2.01, Boundaries of Competence, and 9.06, Interpreting Assessment Results.)
c. When psychologists conduct a record review or provide consultation or supervision and an individual examination is not warranted or necessary for the opinion, psychologists explain this and the sources of information on which they based their conclusions and recommendations.

9.02 Use of Assessments
a. Psychologists administer, adapt, score, interpret, or use assessment techniques, interviews, tests, or instruments in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.

b. Psychologists use assessment instruments whose validity and reliability have been established for use with members of the population tested. When such validity or reliability has not been established, psychologists describe the strengths and limitations of test results and interpretation.

c. Psychologists use assessment methods that are appropriate to an individual’s language preference and competence, unless the use of an alternative language is relevant to the assessment issues.

9.03 Informed Consent in Assessments
a. Psychologists obtain informed consent for assessments, evaluations, or diagnostic services, as described in Standard 3.10, Informed Consent, except when (1) testing is mandated by law or governmental regulations; (2) informed consent is implied because testing is conducted as a routine educational, institutional, or organizational activity (e.g., when participants voluntarily agree to assessment when applying for a job); or (3) one purpose of the testing is to evaluate decisional capacity. Informed consent includes an explanation of the nature and purpose of the assessment, fees, involvement of third parties, and limits of confidentiality and sufficient opportunity for the client/patient to ask questions and receive answers.

b. Psychologists inform persons with questionable capacity to consent or for whom testing is mandated by law or governmental regulations about the nature and purpose of the proposed assessment services, using language that is reasonably understandable to the person being assessed.

c. Psychologists using the services of an interpreter obtain informed consent from the client/patient to use that interpreter, ensure that confidentiality of test results and test security are maintained, and include in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, discussion of any limitations on the data obtained. (See also Standards 2.05, Delegation of Work to Others; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.06, Interpreting Assessment Results; and 9.07, Assessment by Unqualified Persons.)
9.04 Release of Test Data
   a. The term *test data* refers to raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recordings concerning client/patient statements and behavior during an examination. Those portions of test materials that include client/patient responses are included in the definition of *test data*. Pursuant to a client/patient release, psychologists provide test data to the client/patient or other persons identified in the release. Psychologists may refrain from releasing test data to protect a client/patient or others from substantial harm or misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is regulated by law. (See also Standard 9.11, Maintaining Test Security.)
   b. In the absence of a client/patient release, psychologists provide test data only as required by law or court order.

9.05 Test Construction
Psychologists who develop tests and other assessment techniques use appropriate psychometric procedures and current scientific or professional knowledge for test design, standardization, validation, reduction or elimination of bias, and recommendations for use.

9.06 Interpreting Assessment Results
When interpreting assessment results, including automated interpretations, psychologists take into account the purpose of the assessment as well as the various test factors, test-taking abilities, and other characteristics of the person being assessed, such as situational, personal, linguistic, and cultural differences, that might affect psychologists' judgments or reduce the accuracy of their interpretations. They indicate any significant limitations of their interpretations. (See also Standards 2.01b and c, Boundaries of Competence, and 3.01, Unfair Discrimination.)

9.07 Assessment by Unqualified Persons
Psychologists do not promote the use of psychological assessment techniques by unqualified persons, except when such use is conducted for training purposes with appropriate supervision. (See also Standard 2.05, Delegation of Work to Others.)

9.08 Obsolete Tests and Outdated Test Results
   a. Psychologists do not base their assessment or intervention decisions or recommendations on data or test results that are outdated for the current purpose.
   b. Psychologists do not base such decisions or recommendations on tests and measures that are obsolete and not useful for the current purpose.
9.09 Test Scoring and Interpretation Services
a. Psychologists who offer assessment or scoring services to other professionals accurately describe the purpose, norms, validity, reliability, and applications of the procedures and any special qualifications applicable to their use.
b. Psychologists select scoring and interpretation services (including automated services) on the basis of evidence of the validity of the program and procedures as well as on other appropriate considerations. (See also Standard 2.01b and c, Boundaries of Competence.)
c. Psychologists retain responsibility for the appropriate application, interpretation, and use of assessment instruments, whether they score and interpret such tests themselves or use automated or other services.

9.10 Explaining Assessment Results
Regardless of whether the scoring and interpretation are done by psychologists, by employees or assistants, or by automated or other outside services, psychologists take reasonable steps to ensure that explanations of results are given to the individual or designated representative unless the nature of the relationship precludes provision of an explanation of results (such as in some organizational consulting, preemployment or security screenings, and forensic evaluations), and this fact has been clearly explained to the person being assessed in advance.

9.11. Maintaining Test Security
The term test materials refers to manuals, instruments, protocols, and test questions or stimuli and does not include test data as defined in Standard 9.04, Release of Test Data. Psychologists make reasonable efforts to maintain the integrity and security of test materials and other assessment techniques consistent with law and contractual obligations, and in a manner that permits adherence to this Ethics Code.

10. Therapy
10.01 Informed Consent to Therapy
a. When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers. (See also Standards 4.02, Discussing the Limits of Confidentiality, and 6.04, Fees and Financial Arrangements.)
b. When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the
voluntary nature of their participation. (See also Standards 2.01e, Boundaries of Competence, and 3.10, Informed Consent.)

c. When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.

10.02 Therapy Involving Couples or Families

a. When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist's role and the probable uses of the services provided or the information obtained. (See also Standard 4.02, Discussing the Limits of Confidentiality.)

b. If it becomes apparent that psychologists may be called on to perform potentially conflicting roles (such as family therapist and then witness for one party in divorce proceedings), psychologists take reasonable steps to clarify and modify, or withdraw from, roles appropriately. (See also Standard 3.05c, Multiple Relationships.)

10.03 Group Therapy

When psychologists provide services to several persons in a group setting, they describe at the outset the roles and responsibilities of all parties and the limits of confidentiality.

10.04 Providing Therapy to Those Served by Others

In deciding whether to offer or provide services to those already receiving mental health services elsewhere, psychologists carefully consider the treatment issues and the potential client's/patient's welfare. Psychologists discuss these issues with the client/patient or another legally authorized person on behalf of the client/patient in order to minimize the risk of confusion and conflict, consult with the other service providers when appropriate, and proceed with caution and sensitivity to the therapeutic issues.

10.05 Sexual Intimacies With Current Therapy Clients/Patients

Psychologists do not engage in sexual intimacies with current therapy clients/patients.

10.06 Sexual Intimacies With Relatives or Significant Others of Current Therapy Clients/Patients

Psychologists do not engage in sexual intimacies with individuals they know to be close relatives, guardians, or significant others of current clients/patients. Psychologists do not terminate therapy to circumvent this standard.
10.07 Therapy With Former Sexual Partners
Psychologists do not accept as therapy clients/patients persons with whom they have engaged in sexual intimacies.

10.08 Sexual Intimacies With Former Therapy Clients/Patients
a. Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy.
b. Psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances. Psychologists who engage in such activity after the two years following cessation or termination of therapy and of having no sexual contact with the former client/patient bear the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including (1) the amount of time that has passed since therapy terminated; (2) the nature, duration, and intensity of the therapy; (3) the circumstances of termination; (4) the client's/patient's personal history; (5) the client's/patient's current mental status; (6) the likelihood of adverse impact on the client/patient; and (7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a posttermination sexual or romantic relationship with the client/patient. (See also Standard 3.05, Multiple Relationships.)

10.09 Interruption of Therapy
When entering into employment or contractual relationships, psychologists make reasonable efforts to provide for orderly and appropriate resolution of responsibility for client/patient care in the event that the employment or contractual relationship ends, with paramount consideration given to the welfare of the client/patient. (See also Standard 3.12, Interruption of Psychological Services.)

10.10 Terminating Therapy
a. Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service.
b. Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship.
c. Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate.

History and Effective Date Footnote
This version of the APA Ethics Code was adopted by the American Psychological Association's Council of Representatives during its meeting, August 21, 2002, and
is effective beginning June 1, 2003. Inquiries concerning the substance or interpretation of the APA Ethics Code should be addressed to the Director, Office of Ethics, American Psychological Association, 750 First Street, NE, Washington, DC 20002-4242. The Ethics Code and information regarding the Code can be found on the APA Web site, http://www.apa.org/ethics. The standards in this Ethics Code will be used to adjudicate complaints brought concerning alleged conduct occurring on or after the effective date. Complaints regarding conduct occurring prior to the effective date will be adjudicated on the basis of the version of the Ethics Code that was in effect at the time the conduct occurred.

The APA has previously published its Ethics Code as follows:


Request copies of the APA's Ethical Principles of Psychologists and Code of Conduct from the APA Order Department, 750 First Street, NE, Washington, DC 20002-4242, or phone (202) 336-5510.


**Code of Ethics of the American Mental Health Counselors Association 2000 Revision**

**Preamble**

Mental health counselors believe in the dignity and worth of the individual. They are committed to increasing knowledge of human behavior and understanding of
themselves and others. While pursuing these endeavors, they make every rea-
sonable effort to protect the welfare of those who seek their services, or of any
subject that may be the object of study. They use their skills only for purposes
consistent with these values and do not knowingly permit their misuse by oth-
ers. While demanding for themselves freedom of inquiry and community, mental
health counselors accept the responsibility this freedom confers: competence,
objectivity in the application of skills, and concern for the best interest of clients,
colleagues, and society in general. In the pursuit of these ideals, mental health
counselors subscribe to the following principles:

Principle 1: Welfare of the Consumer
Principle 2: Clients’ Rights
Principle 3: Confidentiality
Principle 4: Utilization of Assessment Techniques
Principle 5: Pursuit of Research Activities
Principle 6: Consulting
Principle 7: Competence
Principle 8: Professional Relationships
Principle 9: Supervisee, Student, and Employee Relationships
Principle 10: Moral and Legal Standards
Principle 11: Professional Responsibility
Principle 12: Private Practice
Principle 13: Public Statements
Principle 14: Internet On-Line Counseling
Principle 15: Resolution of Ethical Problems

Clinical Issues

Principle 1: Welfare of the Consumer

A. Primary Responsibility

1. The primary responsibility of the mental health counselor is to respect
the dignity and integrity of the client. Client growth and development are
encouraged in ways that foster the client’s interest and promote welfare.
2. Mental health counselors are aware of their influential position with respect
to their clients, and avoid exploiting the trust and fostering dependency of
their clients.
3. Mental health counselors fully inform consumers as to the purpose and
nature of any evaluation, treatment, education, or training procedure and
they fully acknowledge that the consumer has the freedom of choice with
regard to participation.
B. Counseling Plans
Mental health counselors and their clients work jointly in devising integrated, individual counseling plans that offer reasonable promise of success and are consistent with the abilities and circumstances of the client. Counselors and clients regularly review counseling plans to ensure their continued viability and effectiveness, respecting the client's freedom of choice.

C. Freedom of Choice
Mental health counselors offer clients the freedom to choose whether to enter into a counseling relationship and determine which professionals will provide the counseling. Restrictions that limit clients' choices are fully explained.

D. Clients Served by Others
1. If a client is receiving services from another mental health professional or counselor, the mental health counselor secures consent from the client, informs that professional of the arrangement, and develops a clear agreement to avoid confusion and conflicts for the client.
2. Mental health counselors are aware of the intimacy and responsibilities inherent in the counseling relationship. They maintain respect for the client and avoid actions that seek to meet their personal needs at the expense of the client. Mental health counselors are aware of their own values, attitudes, beliefs, and behaviors, and how these apply in a diverse society. They avoid imposing their values on the consumer.

E. Diversity
1. Mental health counselors do not condone or engage in any discrimination based on age, color, culture, disability, ethnic group, gender, race, religion, sexual orientation, marital status, or socioeconomic status.
2. Mental health counselors will actively attempt to understand the diverse cultural backgrounds of the clients with whom they work. This includes learning how the counselor's own cultural/ethical/racial/religious identity impacts his or her own values and beliefs about the counseling process. When there is a conflict between the client's goals, identity, and/or values and those of the mental health counselor, a referral to an appropriate colleague must be arranged.

F. Dual Relationships
Mental health counselors are aware of their influential position with respect to their clients and avoid exploiting the trust and fostering dependency of the client.

1. Mental health counselors make every effort to avoid dual relationships with clients that could impair professional judgement or increase the risk of harm.
Examples of such relationships may include, but are not limited to: familial, social, financial, business, or close personal relationships with the clients.

2. Mental health counselors do not accept as clients individuals with whom they are involved in an administrative, supervisory, and evaluative nature. When acting as supervisors, trainers, or employers, mental health counselors accord recipients informed choice, confidentiality, and protection from physical and mental harm.

3. When a dual relationship cannot be avoided, counselors take appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that judgement is not impaired and no exploitation has occurred.

G. Sexual Relationships

Sexual relationships with clients are strictly prohibited. Mental health counselors do not counsel persons with whom they have had a previous sexual relationship.

H. Former Clients

Counselors do not engage in sexual intimacies with former clients within a minimum of two years after terminating the counseling relationship. The mental health counselor has the responsibility to examine and document thoroughly that such relations did not have an exploitative nature based on factors such as duration of counseling, amount of time since counseling, termination circumstances, the client’s personal history and mental status, adverse impact on the client, and actions by the counselor suggesting a plan to initiate a sexual relationship with the client after termination.

I. Multiple Clients

When mental health counselors agree to provide counseling services to two or more persons who have a relationship (such as husband and wife, or parents and children), counselors clarify at the outset which person or persons are clients, and the nature of the relationship they will have with each involved person. If it becomes apparent that counselors may be called upon to perform potentially conflicting roles, they clarify, adjust, or withdraw from roles appropriately.

J. Informed Consent

Mental health counselors are responsible for making their services readily accessible to clients in a manner that facilitates the clients’ abilities to make an informed choice when selecting a provider. This responsibility includes a clear description of what the client can expect in the way of tests, reports, billing, therapeutic regime and schedules, and the use of the mental health counselor’s statement of professional disclosure. In the event that a client is a minor or possesses disabilities that would prohibit informed consent, the mental health counselor acts in the client’s best interest.
K. Conflict of Interest
Mental health counselors are aware of possible conflicts of interests that may involve the organization in which they are employed and their client. When conflicts occur, mental health counselors clarify the nature of the conflict and inform all parties of the nature and direction of their loyalties and responsibilities, and keep all parties informed of their commitments.

L. Fees and Bartering
1. Mental health counselors clearly explain to clients, prior to entering the counseling relationship, all financial arrangements related to professional services, including the use of collection agencies or legal measures for nonpayment.
2. In establishing fees for professional counseling services, mental health counselors consider the financial status of their clients and locality. In the event that the payment of the mental health counselor’s usual fees would create undue hardship for the client, assistance is provided in attempting to find comparable services at an acceptable cost.
3. Mental health counselors ordinarily refrain from accepting goods or services from clients in return for counseling service because such arrangements create inherent potential for conflicts, exploitation, and distortion of the professional relationship. Participation in bartering is only used when there is no exploitation, if the client requests it, if a clear written contract is established, and if such an arrangement is an accepted practice among professionals in the community.

M. Pro Bono Service
Mental health counselors contribute to society by devoting a portion of their professional activity to services for which there is little or no financial return.

N. Consulting
Mental health counselors may choose to consult with any other professionally competent person about a client. In choosing a consultant, the mental health counselor should avoid placing the consultant in a conflict of interest situation that would preclude the consultant from being a proper party to the mental health counselor’s effort to help the client.

O. Group Work
1. Mental health counselors screen prospective group counseling/therapy participants. Every effort is made to select members whose needs and goals are compatible with goals of the group, who will not impede the group process, and whose well being will not be jeopardized by the group experience.
2. In the group setting, mental health counselors take reasonable precautions to protect clients from physical and psychological harm or trauma.
3. When the client is engaged in short term group treatment/training programs, i.e., marathons and other encounter type or growth groups, the members ensure that there is professional assistance available during and following the group experience.

**P. Termination and Referral**

Mental health counselors do not abandon or neglect their clients in counseling. Assistance is given in making appropriate arrangements for the continuation of treatment, when necessary, during interruptions such as vacation and following termination.

**Q. Inability to Assist Clients**

If mental health counselors determine that their services are not beneficial to the client, they avoid entering or terminate immediately a counseling relationship. Mental health counselors are knowledgeable about referral sources and appropriate referrals are made. If clients decline the suggested referral, mental health counselors discontinue the relationship.

**R. Appropriate Termination**

Mental health counselors terminate a counseling relationship, securing a client’s agreement when possible, when it is reasonably clear that the client is no longer benefiting, when services are no longer required, when counseling no longer serves the needs and interests of the client, when clients do not pay fees charged, or when agency or institution limits do not allow provision of further counseling services.

**Principle 2: Clients’ Rights**

The following apply to all consumers of mental health services, including both in- and out-patients and all state, county, local, and private care mental health facilities, as well as clients of mental health practitioners in private practice.

The client has the right:

A. To be treated with dignity, consideration, and respect at all times;
B. To expect quality service provided by concerned, trained, professional, and competent staff;
C. To expect complete confidentiality within the limits of the law, and to be informed about the legal exceptions to confidentiality; and to expect that no information will be released without the client’s knowledge and written consent;
D. To a clear working contract in which business items, such as time of sessions, payment plans/fees, absences, access, emergency procedures, and third-party reimbursement procedures are discussed;
E. To a clear statement of the purposes, goals, techniques, rules of procedure and limitations, as well as the potential dangers of the services to be performed, and all other information related to or likely to affect the ongoing mental health counseling relationship;

F. To appropriate information regarding the mental health counselor's education, training, skills, license, and practice limitations and to request and receive referrals to other clinicians when appropriate;

G. To full, knowledgeable, and responsible participation in the ongoing treatment plan to the maximum extent feasible;

H. To obtain information about their case record and to have this information explained clearly and directly;

I. To request information and/or consultation regarding the conduct and progress of their therapy;

J. To refuse any recommended services and to be advised of the consequences of this action;

K. To a safe environment free of emotional, physical, and sexual abuse;

L. To a client grievance procedure, including requests for consultation and/or mediation; and to file a complaint with the mental health counselor's supervisor and/or the appropriate credentialing body; and

M. To a clearly defined ending process, and to discontinue therapy at any time.

**Principle 3: Confidentiality**

Mental health counselors have a primary obligation to safeguard information about individuals obtained in the course of practice, teaching, or research. Personal information is communicated to others only with the person's written consent or in those circumstances where there is clear and imminent danger to the client, to others, or to society. Disclosure of counseling information is restricted to what is necessary, relevant, and verifiable.

A. At the outset of any counseling relationship, mental health counselors make their clients aware of their rights in regard to the confidential nature of the counseling relationship. They fully disclose the limits of, or exceptions to, confidentiality, and/or the existence of privileged communication, if any.

B. All materials in the official record shall be shared with the client, who shall have the right to decide what information may be shared with anyone beyond the immediate provider of service and be informed of the implications of the materials to be shared.

C. Confidentiality belongs to the clients. They may direct the mental health counselor, in writing, to release information to others. The release of information without the consent of the client may only take place under the most extreme circumstances. The protection of life, as in the case of suicidal or
homicidal clients, exceeds the requirements of confidentiality. The protection of a child, an elderly person, or a person not competent to care for themselves from physical or sexual abuse or neglect requires that a report be made to a legally constituted authority. The mental health counselor complies with all state and federal statutes concerning mandated reporting of suicidality, homicidality, child abuse, incompetent person abuse, and elder abuse. The protection of the public or another individual from a contagious condition known to be fatal also requires action that may include reporting the willful infection of another with the condition.

The mental health counselor (or staff member) does not release information by request unless accompanied by a specific release of information or a valid court order. Mental health counselors will comply with the order of a court to release information but they will inform the client of the receipt of such an order. A subpoena is insufficient to release information. In such a case, the counselor must inform his client of the situation and, if the client refuses release, coordinate between the client's attorney and the requesting attorney so as to protect client confidentiality and one's own legal welfare.

In the case of all of the above exceptions to confidentiality, the mental health counselor will release only such information as is necessary to accomplish the action required by the exception.

D. The anonymity of clients served in public and other agencies is preserved, if at all possible, by withholding names and personal identifying data. If external conditions require reporting such information, the client shall be so informed.

E. Information received in confidence by one agency or person shall not be forwarded to another person or agency without the client's written permission.

F. Service providers have the responsibility to ensure the accuracy and to indicate the validity of data shared with their parties.

G. Case reports presented in classes, professional meetings, or publications shall be so disguised that no identification is possible unless the client or responsible authority has read the report and agreed in writing to its presentation or publication.

H. Counseling reports and records are maintained under conditions of security, and provisions are made for their destruction when they have outlived their usefulness. Mental health counselors ensure that all persons in his or her employ, volunteers, and community aides maintain privacy and confidentiality.

I. Mental health counselors who ask that an individual reveal personal information in the course of interviewing, testing, or evaluation, or who allow such information to be divulged, do so only after making certain that the person or authorized representative is fully aware of the purposes of the interview, testing, or evaluation, and of the ways in which the information will be used.

J. Sessions with clients may be taped or otherwise recorded only with their written permission or the written permission of a responsible guardian. Even with a guardian's written consent, one should not record a session against
the expressed wishes of a client. Such tapes shall be destroyed when they have outlived their usefulness.

K. Where a child or adolescent is the primary client, or the client is not competent to give consent, the interests of the minor or the incompetent client shall be paramount. Where appropriate, a parent(s) or guardian(s) may be included in the counseling process. The mental health counselor must still take measures to safeguard the client’s confidentiality.

L. In work with families, the rights of each family member should be safeguarded. The provider of service also has the responsibility to discuss the contents of the record with the parent and/or child, as appropriate, and to keep separate those parts, which should remain the property of each family member.

M. In work with groups, the rights of each group member should be safeguarded. The provider of service also has the responsibility to discuss the need for each member to respect the confidentiality of each other member of the group. He must also remind the group of the limits on and risk to confidentiality inherent in the group process.

N. When using a computer to store confidential information, mental health counselors take measures to control access to such information. When such information has outlived its usefulness, it should be deleted from the system.

Principle 4: Utilization of Assessment Techniques

A. Test Selection

1. In choosing a particular test, mental health counselors should ascertain that there is sufficient evidence in the test manual of its applicability in measuring a certain trait or construct. The manual should fully describe the development of the test, the rationale, and data pertaining to item selection and test construction. The manual should explicitly state the purposes and applications for which the test is intended, and provide reliability and validity data about the test. The manual should furthermore identify the qualifications necessary to properly administer and interpret the test.

2. In selecting a particular combination of tests, mental health counselors need to be able to justify the logic of those choices.

3. Mental health counselors should employ only those tests for which they judge themselves competent by training, education, or experience. In familiarizing themselves with new tests, counselors thoroughly read the manual and seek workshops, supervision, or other forms of training.

4. Mental health counselors avoid using outdated or obsolete tests, and strive to remain current regarding test publication and revision.

5. Tests selected for individual testing must be appropriate for that individual in that appropriate norms exist for variables such as age, gender, and race. The test form must fit the client. If the test must be used in the absence of available information regarding the above subsamples, the limitations of generalizability should be duly noted.
B. Test Administration

1. Mental health counselors should faithfully follow instructions for administration of a test in order to ensure standardization. Failure to consistently follow test instructions will result in test error and incorrect estimates of the trait or behavior being measured.

2. Tests should only be employed in appropriate professional settings or as recommended by instructors or supervisors for training purposes. It is best to avoid giving tests to relatives, close friends, or business associates, in that doing so constructs a dual professional/personal relationship, which is to be avoided.

3. Mental health counselors should provide the test taker with appropriate information regarding the reason for assessment, the approximate length of time required, and to whom the report will be distributed. Issues of confidentiality must be addressed, and the client must be given the opportunity to ask questions of the examiner prior to beginning the procedure.

4. Care should be taken to provide an appropriate assessment environment in regard to temperature, privacy, comfort, and freedom from distractions.

5. Information should be solicited regarding any possible handicaps, such as problems with visual or auditory acuity, limitations of hand/eye coordination, illness, or other factors. If the disabilities cannot be accommodated effectively, the test may need to be postponed or the limitations of applicability of the test results noted in the test report.

6. Professionals who supervise others should ensure that their trainees have sufficient knowledge and experience before utilizing the tests for clinical purposes.

7. Mental health counselors must be able to document appropriate education, training, and experience in areas of assessment they perform.

C. Test Interpretation

1. Interpretation of test or test battery results should be based on multiple sources of convergent data and an understanding of the tests' foundations and limits.

2. Mental health counselors must be careful not to make conclusions unless empirical evidence is present to justify the statement. If such evidence is lacking, one should not make diagnostic or prognostic formulations.

3. Interpretation of test results should take into account the many qualitative influences on test-taking behavior, such as health, energy, motivation, and the like. Description and analysis of alternative explanations should be provided with the interpretations.

4. One should not make firm conclusions in the absence of published information that establishes a satisfactory degree of test validity, particularly predictive validity.

5. Multicultural factors must be considered in test interpretation and diagnosis, and formulation of prognosis and treatment recommendations.

6. Mental health counselors should avoid biased or incorrect interpretation by assuring that the test norms reference the population taking the test.
7. Mental health counselors are responsible for evaluating the quality of computer software interpretations of test data. Mental health counselors should obtain information regarding validity of computerized test interpretation before utilizing such an approach.

8. Supervisors should ensure that their supervisees have had adequate training in interpretation before entrusting them to evaluate tests in a semi-autonomous fashion.

9. Any individual or organization offering test scoring or interpretation services must be able to demonstrate that their programs are based on sufficient and appropriate research to establish the validity of the programs and procedures used in arriving at interpretations. The public offering of an automated test interpretation service will be considered a professional-to-professional consultation. The formal responsibility of the consultant is to the consultee, but his or her ultimate and overriding responsibility is to the client.

10. Mental health counselors who have the responsibility for making decisions about clients or policies based on test results should have a thorough understanding of counseling theory, assessment techniques, and test research.

11. Mental health counselors do not represent computerized test interpretations as their own and clearly designate such computerized results.

D. Test Reporting

1. Mental health counselors should write reports in a clear fashion, avoiding excessive jargon or clinical terms that are likely to confuse the lay reader.

2. Mental health counselors should strive to provide test results in as positive and nonjudgmental manner as possible.

3. Mindful that one’s report reflects on the reputation of oneself and one’s profession, reports are carefully proofread so as to be free of spelling, style, and grammatical errors as much as is possible.

4. Clients should be clearly informed about who will be allowed to review the report and, in the absence of a valid court order, must sign appropriate releases of information permitting such release. Mental health counselors must not release the report or findings in the absence of the aforementioned releases or order.

5. Mental health counselors are responsible for ensuring the confidentiality and security of test reports, test data, and test materials.

6. Mental health counselors must offer the client the opportunity to receive feedback about the test results, interpretations, and the range of error for such data.

7. Transmissions of test data or test reports by fax or e-mail must be accomplished in a secure manner, with guarantees that the receiving device is capable of providing a confidential transmission only to the party who has been permitted to receive the document.
8. Mental health counselors should train his or her staff to respect the confidentiality of test reports in the context of typing, filing, or mailing them.

9. Mental health counselors (or staff members) do not release a psychological evaluation by request unless accompanied by a specific release of information or a valid court order. A subpoena is insufficient to release a report. In such a case, the counselor must inform his/her client of the situation and, if the client refuses release, coordinate between the client’s attorney and the requesting attorney so as to protect client confidentiality and one’s own legal welfare.

**Principle 5: Pursuit of Research Activities**

Mental health counselors who conduct research must do so with regard to ethical principles. The decision to undertake research should rest upon a considered judgment by the individual counselor about how best to contribute to counseling and to human welfare. Mental health counselors carry out their investigations with respect for the people who participate and with concern for their dignity and welfare.

1. The ethical researcher seeks advice from other professionals if any plan of research suggests a deviation from any ethical principle of research with human subjects. Such deviation must still protect the dignity and welfare of the client and places on the researcher a special burden to act in the subject’s interest.

2. The ethical researcher is open and honest in the relationship with research participants.
   a. The ethical researcher informs the participant of all features of the research that might be expected to influence willingness to participate and explains to the participant all other aspects about which the participant inquires.
   b. Where scientific or human values justify delaying or withholding information, the investigator acquires a special responsibility to assure that there are no damaging consequences for the participants.
   c. Following the collection of the data, the ethical researcher must provide the participant with a full clarification of the nature of the study to remove any misconceptions that may have arisen.
   d. As soon as possible, the participant is to be informed of the reasons for concealment or deception that are part of the methodological requirements of a study.
   e. Such misinformation must be minimized and full disclosure must be made at the conclusion of all research studies.
   f. The ethical researcher understands that failure to make full disclosure to a research participant gives added emphasis to the researcher’s abiding responsibility to protect the welfare and dignity of the participant.

3. The ethical researcher protects participants from physical and mental discomfort, harm, and danger. If the risks of such consequences exist, the
investigator is required to inform the participant of that fact, secure consent before proceeding, and take all possible measures to minimize the distress.

4. The ethical researcher instructs research participants that they are free to withdraw their consent and from participation at any time.

5. The ethical researcher understands that information obtained about research participants during the course of an investigation is confidential. When the possibility exists that others may obtain access to such information, the participant must be made aware of the possibility and the plans for protecting confidentiality as a part of the procedure for obtaining informed consent.

6. The ethical researcher gives sponsoring agencies, host institutions, and publication channels the same respect and opportunity for informed consent that they accord to individual research participants.

7. The ethical researcher is aware of his or her obligation to future research workers and ensures that host institutions are given feedback information and proper acknowledgment.

**Principle 6: Consulting**

A. Mental health counselors acting as consultants must have a high degree of self-awareness of their own values, knowledge, skills, and needs in entering a helping relationship that involves human and/or organizational change. The focus of the consulting relationship should be on the issues to be resolved and not on the personal characteristics of those presenting the consulting issues.

B. Mental health counselors should develop an understanding of the problem presented by the client and should secure an agreement with the consultation client, specifying the terms and nature of the consulting relationship.

C. Mental health counselors must be reasonably certain that they and their clients have the competencies and resources necessary to follow the consultation plan.

D. Mental health counselors should encourage adaptability and growth toward self-direction. Mental health counselors should avoid becoming a decision-maker or substitute for the client.

E. When announcing consultant availability for services, mental health counselors conscientiously adhere to professional standards.

F. Mental health counselors keep all proprietary information confidential.

G. Mental health counselors avoid conflicts of interest in selecting consultation clients.

**Professional Issues**

**Principle 7: Competence**

The maintenance of high standards of professional competence is a responsibility shared by all mental health counselors in the best interests of the public and
the profession. Mental health counselors recognize the boundaries of their particular competencies and the limitations of their expertise. Mental health counselors only provide those services and use only those techniques for which they are qualified by education, techniques, or experience. Mental health counselors maintain knowledge of relevant scientific and professional information related to the services they render, and they recognize the need for ongoing education.

A. Mental health counselors accurately represent their competence, education, training, and experience.
B. As teaching professionals, mental health counselors perform their duties based on careful preparation in order that their instruction is accurate, up to date, and educational.
C. Mental health counselors recognize the need for continued education and training in the area of cultural diversity and competency. Mental health counselors are open to new procedures and sensitive to the diversity of varying populations and changes in expectations and values over time.
D. Mental health counselors and practitioners recognize that their effectiveness depends in part upon their ability to maintain sound and healthy interpersonal relationships. They are aware that any unhealthy activity would compromise sound professional judgment and competency. In the event that personal problems arise and are affecting professional services, they will seek competent professional assistance to determine whether they should limit, suspend, or terminate services to their clients.
E. Mental health counselors have a responsibility both to the individual who is served and to the institution within which the service is performed to maintain high standards of professional conduct. Mental health counselors strive to maintain the highest level of professional services offered to the agency, organization, or institution in providing the highest caliber of professional services. The acceptance of employment in an institution implies that the mental health counselor is in substantial agreement with the general policies and principles of the institution. If, despite concerted efforts, the member cannot reach an agreement with the employer as to acceptable standards of conduct that allows for changes in institutional policy conducive to the positive growth and development of counselors, then terminating the affiliation should be seriously considered.
G. Ethical behavior among professional associates, mental health counselors, and non-mental health counselors is expected at all times. When information is possessed that raises serious doubts as to the ethical behavior of professional colleagues, whether association members or not, the mental health counselor is obligated to take action to attempt to rectify such a condition. Such action shall utilize the institution's channels first and then utilize procedures established by the state licensure board.
H. Mental health counselors are aware of the intimacy of the counseling relationship, maintain a healthy respect for the integrity of the client, and avoid
engaging in activities that seek to meet the mental health counselor’s personal needs at the expense of the client. Through awareness of the negative impact of both racial and sexual stereotyping and discrimination, the member strives to ensure the individual rights and personal dignity of the client in the counseling relationship.

**Principle 8: Professional Relationships**

Mental health counselors act with due regard for the needs and feelings of their colleagues in counseling and other professions. Mental health counselors respect the prerogatives and obligations of the institutions or organizations with which they associate.

A. Mental health counselors understand how related professions complement their work and make full use of other professional, technical, and administrative resources that best serve the interests of consumers. The absence of formal relationships with other professional workers does not relieve mental health counselors from the responsibility of securing for their clients the best possible professional services; indeed, this circumstance presents a challenge to the professional competence of mental health counselors, requiring special sensitivity to problems outside their areas of training, and foresight, diligence, and tact in obtaining the professional assistance needed by clients.

B. Mental health counselors know and take into account the traditions and practices of other professional groups with which they work and cooperate fully with members of such groups when research, services, and other functions are shared, or in working for the benefit of public welfare.

C. Mental health counselors treat professional colleagues with the same dignity and respect afforded to clients. Professional discourse should be free of personal attacks.

D. Mental health counselors strive to provide positive conditions for those they employ and to spell out clearly the conditions of such employment. They encourage their employees to engage in activities that facilitate their further professional development.

E. Mental health counselors respect the viability, reputation, and proprietary rights of organizations that they serve. Mental health counselors show due regard for the interest of their present or perspective employers. In those instances where they are critical of policies, they attempt to effect change by constructive action within the organization.

F. In pursuit of research, mental health counselors are to give sponsoring agencies, host institutions, and publication channels the same respect and opportunity for giving informed consent that they accord to individual research participants. They are aware of their obligation to future research workers and ensure that host institutions are given feedback information and proper acknowledgment.
G. Credit is assigned to those who have contributed to a publication, in proportion to their contribution.

H. Mental health counselors do not accept or offer referral fees from other professionals.

I. When mental health counselors violate ethical standards, mental health counselors who know firsthand of such activities should, if possible, attempt to rectify the situation. Failing an informal solution, mental health counselors should bring such unethical activities to the attention of the appropriate state licensure board committee on ethics and professional conduct. Only after all professional alternatives have been utilized will mental health counselors begin legal action for resolution.

**Principle 9: Supervisee, Student, and Employee Relationships**

Mental health counselors have an ethical concern for the integrity and welfare of supervisees, students, and employees. They maintain these relationships on a professional and confidential basis. They recognize the influential position they have with regard to both current and former supervisees, students, and employees. They avoid exploiting their trust and dependency.

A. Mental health counselors do not engage in ongoing counseling relationships with current supervisees, students, and employees.

B. All forms of sexual behavior with supervisees, students, and employees are unethical. Further, mental health counselors do not engage in sexual or other harassment of supervisees, students, employees, or colleagues.

C. Mental health counselor supervisors advise their supervisees, students, 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.

D. Mental health counselors make every effort to avoid dual relationships with supervisees, students, and employees that could impair their judgment or increase the risk of personal or financial exploitation. When a dual relationship cannot be avoided, mental health counselors take appropriate professional precautions to make sure that judgment is not impaired. Examples of such dual relationships include, but are not limited to, a supervisee who receives supervision as a benefit of employment, or a student in a small college where the only available counselor on campus is an instructor.

E. Mental health counselors do not disclose supervisee confidences except:
   1. To prevent clear and eminent danger to a person or persons.
   2. As mandated by law.
      a. As in mandated child or senior abuse reporting.
      b. Where the counselor is a defendant in a civil, criminal, or disciplinary action.
c. In educational or training settings where only other professionals who will share responsibility for the training of the supervisee are present.
d. Where there is a waiver of confidentiality obtained in writing prior to such a release of information.

F. Supervisees must make their clients aware in their informed consent statement that they are under supervision and they must provide their clients with the name and credentials of their supervisor.

G. Mental health counselors require their supervisees, students, and employees to adhere to the Code of Ethics. Students and supervisees have the same obligations to clients as those required of mental health counselors.

**Principle 10: Moral and Legal Standards**

Mental health counselors recognize that they have a moral, legal, and ethical responsibility to the community and to the general public. Mental health counselors should be aware of the prevailing community standards and the impact of professional standards on the community.

A. To protect students, mental health counselors/teachers will be aware of diverse backgrounds of students and will see that material is treated objectively and fairly to reflect the multicultural community in which they live.

B. Providers of counseling services conform to the statutes relating to such services as established by their state and its regulating professional board(s).

C. As employees, mental health counselors refuse to participate in an employer’s practices that are inconsistent with the moral and legal standards established by federal or state legislation regarding the treatment of employees. In particular and for example, mental health counselors will not condone practices that result in illegal or otherwise unjustified discrimination on the basis of race, sex, religion, or national origin in hiring, promotion, or training.

D. In providing counseling services to clients, mental health counselors avoid any action that will violate or diminish the legal and civil rights of clients or of others that may be affected by the action.

E. Sexual conduct, not limited to sexual intercourse, between mental health counselors and clients is specifically in violation of this Code of Ethics. This does not, however, prohibit the use of explicit instructional aids including films and videotapes. Such use is within excepted practices of trained and competent sex therapists.

**Principle 11: Professional Responsibility**

In their commitment to the understanding of human behavior, mental health counselors value objectivity and integrity, and in providing services they maintain the highest standards. They accept responsibility for the consequences of their work and make every effort to ensure that their services are used appropriately.
A. Mental health counselors accept ultimate responsibility for selecting appropriate areas for investigation and the methods relevant to minimize the possibility that their finding will be misleading. They provide thorough discussion of the limitations of their data and alternative hypotheses, especially where their work touches on social policy or might be misconstrued to the detriment of specific age, sex, ethnic, socioeconomic, or other social categories. In publishing reports of their work, they never discard observations that may modify the interpretation of results. Mental health counselors take credit only for the work they have actually done. In pursuing research, mental health counselors ascertain that their efforts will not lead to changes in individuals or organizations unless such changes are part of the agreement at the time of obtaining informed consent. Mental health counselors clarify in advance the expectations for sharing and utilizing research data. They avoid dual relationships that may limit objectivity, whether theoretical, political, or monetary, so that interference with data, subjects, and milieu is kept to a minimum.

B. As employees of an institution or agency, mental health counselors have the responsibility to remain alert to institutional pressures that may distort reports of counseling findings or use them in ways counter to the promotion of human welfare.

C. When serving as members of governmental or other organizational bodies, mental health counselors remain accountable as individuals to the Code of Ethics of the American Mental Health Counselors Association.

D. As teachers, mental health counselors recognize their primary obligation to help others acquire knowledge and skill. They maintain high standards of scholarship and objectivity by presenting counseling information fully and accurately, and by giving appropriate recognition to alternative viewpoints.

E. As practitioners, mental health counselors know that they bear a heavy social responsibility because their recommendations and professional actions may alter the lives of others. They therefore remain fully cognizant of their impact and alert to personal, social, organizational, financial, or political situations or pressures that might lead to the misuse of their influence.

F. Mental health counselors provide reasonable and timely feedback to employees, trainees, supervisors, students, clients, and others whose work they may evaluate.

**Principle 12: Private Practice**

A. A mental health counselor should assist, where permitted by legislation or judicial decision, the profession in fulfilling its duty to make counseling services available in private settings.

B. In advertising services as a private practitioner, mental health counselors should advertise the services in such a manner so as to accurately inform the public as to services, expertise, profession, and techniques of counseling
in a professional manner. Mental health counselors who assume an executive leadership role in the organization shall not permit their name to be used in professional notices during periods when not actively engaged in the private practice of counseling. Mental health counselors advertise the following: highest relevant degree, type and level of certification or license, and type and/or description of services or other relevant information. Such information should not contain false, inaccurate, misleading, partial, or out of context descriptive material or statements.

C. Mental health counselors may join in partnership/corporation with other mental health counselors and/or other professionals provided that each mental health counselor of the partnership or corporation makes clear his/her separate specialties, buying name in compliance with the regulations of the locality.

D. Mental health counselors have an obligation to withdraw from an employment relationship or a counseling relationship if it is believed that employment will result in violation of the Code of Ethics, if their mental capacity or physical condition renders it difficult to carry out an effective professional relationship, or if the mental health counselor is discharged by the client because the counseling relationship is no longer productive for the client.

E. Mental health counselors should adhere to and support the regulations for private practice in the locality where the services are offered.

F. Mental health counselors refrain from attempts to utilize one’s institutional affiliation to recruit clients for one’s private practice. Mental health counselors are to refrain from offering their services in the private sector when they are employed by an institution in which this is prohibited by stated policy that reflects conditions of employment.

Principle 13: Public Statements

Mental health counselors in their professional roles may be expected or required to make public statements providing counseling information or professional opinions; or supply information about the availability of counseling products and services. In making such statements, mental health counselors take into full account the limits and uncertainties of present counseling knowledge and techniques. They represent, as accurately and objectively as possible, their professional qualifications, expertise, affiliations, and functions, as well as those of the institutions or organizations with which the statements may be associated. All public statements, announcements of services, and promotional activities should serve the purpose of providing sufficient information to aid the consumer public in making informed judgements and choices on matters that concern it. When announcing professional counseling services, mental health counselors may describe or explain those services offered but may not evaluate as to their quality or uniqueness and do not allow for testimonials by implication. All public statements should be otherwise consistent with this Code of Ethics.
Principle 14: Internet On-Line Counseling

Mental health counselors engaged in delivery of services that involve the telephone, teleconferencing, and the Internet in which these areas are generally recognized, standards for preparatory training do not yet exist. Mental health counselors take responsible steps to ensure the competence of their work and protect patients, clients, students, research participants and others from harm.

A. Confidentiality
Mental health counselors ensure that clients are provided sufficient information to adequately address and explain the limitations of computer technology in the counseling process in general and the difficulties of ensuring complete client confidentiality of information transmitted through electronic communications over the Internet through on-line counseling. Professional counselors inform clients of the limitations of confidentiality and identify foreseeable situations in which confidentiality must be breached in light of the law in both the state in which the client is located and the state in which the professional counselor is licensed. Mental health counselors shall become aware of the means for reporting and protecting suicidal clients in their locale. Mental health counselors shall become aware of the means for reporting homicidal clients in the client’s jurisdiction.

B. Mental Health Counselor Identification
Mental health counselors provide a readily visible notice advising clients of the identities of all professional counselor(s) who will have access to the information transmitted by the client. Mental health counselors provide background information on all professional communications, including education, licensing and certification, and practice information.

C. Client Identification
Professional counselors identify clients, verify identities of clients, and obtain alternative methods of contacting clients in emergency situations.

D. Client Waiver
Mental health counselors require clients to execute client waiver agreements stating that the client acknowledges the limitations inherent in ensuring client confidentiality of information transmitted through on-line counseling and acknowledges the limitations that are inherent in a counseling process that is not provided face-to-face. Limited training in the area of on-line counseling must be explained and the client’s informed consent must be secured.

E. Electronic Transfer of Client Information
Mental health counselors electronically transfer client confidential information to authorized third-party recipients only when both the professional counselor and the authorized recipient have “secure” transfer and acceptance communication capabilities; the recipient is able to effectively protect the confidentiality of the
client's confidential information to be transferred; and the informed written consent of the client, acknowledging the limits of confidentiality, has been obtained.

F. Establishing the On-Line Counseling Relationship

1. Appropriateness of On-line Counseling: Mental health counselors develop an appropriate in-take procedure for potential clients to determine whether on-line counseling is appropriate for the needs of the client. Mental health counselors warn potential clients that on-line counseling services may not be appropriate in certain situations and, to the extent possible, inform the client of specific limitations, potential risks, and/or potential benefits relevant to the client's anticipated use of on-line counseling services. Mental health counselors ensure that clients are intellectually, emotionally, and physically capable of using on-line counseling services, and of understanding the potential risks and/or limitations of such services.

2. Counseling Plans: Mental health counselors develop individual on-line counseling plans that are consistent with both the client's individual circumstances and the limitations of on-line counseling. Mental health counselors who determine that on-line counseling is inappropriate for the client should avoid entering into or immediately terminate the on-line counseling relationship and encourage the client to continue the counseling relationship through a traditional alternative method of counseling.

3. Boundaries of Competence: Mental health counselors provide on-line counseling services only in practice areas within their expertise. Mental health counselors do not provide services to clients in states where doing so would violate local licensure laws or regulations.

G. Legal Considerations

Mental health counselors confirm that the provision of on-line services are not prohibited by or otherwise violate any applicable state or local statutes, rules, regulations or ordinances, codes of professional membership organizations and certifying boards, and/or codes of state licensing boards.

Principle 15: Resolution of Ethical Problems

Neither the American Mental Health Counselors Association, its Board of Directors, nor its National Committee on Ethics investigate or adjudicate ethical complaints. In the event a member has his or her license suspended or revoked by an appropriate state licensure board, the AMHCA Board of Directors may then act in accordance with AMHCA's National By-Laws to suspend or revoke his or her membership.

Any member so suspended may apply for reinstatement upon the reinstatement of his or her licensure.

References


Chapter 7

Legal Issues

American cinema offers a classic depiction of the advent of justice from the American frontier. Two gunfighters square off in the street. Before they draw, the bad guy snarls, “Your days are over,” to which the good guy responds, “The difference between you and me is, I know it.” In short, the good guy knows that the days for settling disputes by violence are coming to an end—he knows that disputes can be settled only by law. Through the years, societies have learned that consistency, predictability, and fairness are harbingers of “life, liberty, and the pursuit of happiness”; without them, life is chaotic.

The law, as arbitrated through the court system, is society’s attempt to ensure predictability, consistency, and fairness. Its purpose is to offer an alternative to private action in settling disputes. As Swenson (1997) noted, “The question is not whether mental health professionals will interact with laws and legal professionals; it is how they will interact both now and in the future in which intercessions by legal professionals into mental health practice become even more intrusive” (p. 32). Therefore, it is imperative that mental health professionals understand the legal system.

The Law

The law should be viewed as dynamic, not as static. It is not an entity that rigidly adheres to historically derived rules, but neither does it deny their relevance to current disputes. Legal principles derive from social interactions. At the same time, the law places a great deal of importance on precedence. Many laws are based on natural law, that is, law promulgated by prominent philosophers as an expression of man’s innate moral sense. Natural law is considered absolute and unconditional. Courts usually accept prior judicial decisions as truths when they fit or appear to fit natural law (Horowitz & Willging, 1984).
As enforced through the legal system, the law can be seen as an instrument of concern by the state for the social well-being of the people. Its primary concerns are predictability, stability, and fairness; at the same time, the system must be sensitive to expansion and readaptation. Laws are a consensus of rules to be followed in a civilized society.

**Classifications of the Law**

Laws are classified as constitutional laws, statues passed by legislatures, regulations, or case laws. The distinctions between these four classifications are explained in the following descriptions:

- **Constitutional laws** are those found in state constitutions and in the U.S. Constitution.
- **Statutory laws** are those written by legislatures.
- Statutory laws may have enabling clauses that permit administrators to write regulations to clarify them. Once written, these regulations become laws.
- Finally, decisions by appeals courts create *case laws* for the people who reside in their jurisdictions. If a legal problem manifests itself and parties differ on how to solve it, they may go to a trial court. The decision made in the trial court is not published and does not become law. However, if lawyers do not believe the trial court (the lower court) interpreted the law correctly, they may bring their case to an appeals court (a higher court). The function of the appeals court is to determine whether the trial court applied the law correctly. The members of the appeals court publish the decision, and the majority decision becomes the law for that jurisdiction. The appeals court is then said to have set a precedent for that jurisdiction.

**Types of Laws**

Laws are enacted to settle disputes that occur in society. They arise out of social interactions as members of society develop values that are necessary to the maintenance of order and justice. They come into being based on the common thoughts and experiences of people. They are antecedents to judgments regarding right and wrong. The person who claims to have been wronged is called the *plaintiff*; the person accused of committing the wrong is the *defendant*. The dispute is known as a *lawsuit*.

Functionally, we can define three types of law: civil law, criminal law, and mental health law (Swenson, 1997), as described in the following:

- **Civil law** is applicable, for the most part, to disputes between or among people. Losing the lawsuit usually means losing money. If a person fails to obey the stipulations made as an analogue to a civil lawsuit, he or she may
be subject to a criminal charge called *contempt of court*. An example would be a mother or father who does not pay child support.

- **Criminal law** is applicable to disputes between the state and people. Losing defendants often face a loss of liberty. The standard of proof is higher in a criminal case than in a civil case.

- **Mental health law** regulates how the state may act regarding people with mental illnesses. These laws enact a permission from the state to protect people from serious harm to themselves or others. They allow the state to act as a guardian for those with mental disorders and to institutionalize them if necessary. Most experts believe mental health law is part of civil law.

### The Steps in a Lawsuit

A lawsuit proceeds through standard steps. Each step has serious legal consequences and rules that must be followed. It is important to remember that most lawsuits do not go to trial; instead, they are settled at an earlier stage.

First, the plaintiff files a complaint through a lawyer to a court in the appropriate jurisdiction. Jurisdiction is determined by geographical and substantive factors. Filing this complaint initiates the legal proceeding.

Once the complaint is filed, the plaintiff must make a judicial effort to inform the defendant of his or her intentions (legal notice). This proceeding is called *due process*. The reason for this procedure is to allow the defendant to rebut the accusation.

Once valid due process is accomplished, a *discovery process* is in order. At this point the lawyers involved investigate the facts of the case.

To obtain the facts, the lawyers may use a *subpoena*. The subpoena demands access to the facts and to the presence of witnesses at court hearings. On the basis of this information, the two sides may settle the dispute, or they may proceed to litigation.

If the attorneys and clients decide to proceed with the lawsuit, the next step is to have *pretrial hearings*. At this step the judge determines how the laws apply to the facts. The lawsuit may be settled at this point. “The general policy of most courts is to promote settlements and, in fact, disputants settle about 90% of all cases” (Swenson, 1997, p. 46).

In the *trial phase*, each side presents evidence and attempts to discredit the evidence of the opponent.

Ultimately, the lawsuit is decided by a judge or jury. If either party is dissatisfied with the verdict, he or she may claim that the law was not correctly applied and appeal to a higher court (Swenson, 1997).

### Confidentiality and Privileged Communication

The client entering the counseling relationship has the expectation that thoughts, feelings, and information shared with the counselor will not be disclosed to others (Smith-Bell & Winslade, 1996). The nondisclosure in the counseling
relationship can be viewed from the vantage point of three separate concepts: privacy, confidentiality, and privilege.

Privacy: Privacy, when used in the context of counseling, is the “freedom or right of clients to choose the time, circumstances and information others may know about them” (Corey, Williams, & Moline, 1995).

Confidentiality: Confidentiality is an ethical responsibility and affirmative legal duty on the part of the counselor not to disclose client information without the client’s prior consent (Smith-Bell & Winslade, 1996).

Privilege: Privilege is a common law and statutory concept that protects confidential communication made with certain special relationships from disclosure in legal proceedings (Hackney, 2000, p. 123).

It must be carefully noted that exceptions to confidentiality and privilege may vary from jurisdiction to jurisdiction. It is crucial that the counselor be familiar with the laws of the state in which they practice as they related to these concepts. Privileged communication is not absolute, and a wide range of exceptions to privilege exists (Glosoff, Herlihy, & Spence, 2000). In their research, these authors studied the statutory codes in all 50 states and the District of Columbia and determined that exceptions to these concepts are numerous and varied across jurisdictions. However, they concluded that several categories of exceptions were found in 15% of the jurisdictions (see Glosoff et al., 2000, for the listing state by state). In addition, it is important to note that statutes and rules regulating privileged communication and its exceptions must be interpreted with caution because of the fact that in some codes rules are not readily apparent and existing statutes are continually modified. With these facts in mind, Glosoff et al. (2000) found the following nine categories of exception:

1. When there is a dispute between client and counselor: This is the most frequent exception, found in 30 jurisdictions wherein clients filed complaints either in court or with licensing boards. In 30 jurisdictions, clients can be considered to have waived their privilege when they bring complaints of malpractice against their counselor(s).

2. When the client raises the issue of mental condition in a court proceeding: This was found in 21 jurisdictions, with two primary circumstances: (a) the individual raises the insanity defense in response to a criminal charge, and (b) the individual claims in court that he or she has been emotionally damaged and the damage required he/she to seek mental health treatment.

3. When the client’s condition poses a danger to self or others: This was found in 20 jurisdictions. Counselors who work with clients who pose a danger to self or others cannot rely solely on knowledge of statutory law. Case law may affect the status of their duty to warn and the requirements to breach confidentiality.
4. **Child abuse or neglect:** This was found in 20 jurisdictions. All states and U.S. jurisdictions have mandatory child-abuse- and neglect-reporting statutes of some type. Counselors must know the exact language of the statutes in their state because the laws vary significantly.

5. **Knowledge that a client is contemplating commission of a crime:** Seventeen jurisdictions waive privilege when the counselor knows that the client is contemplating the commission of a crime (Glosoff et al., 2000).

6. **Court-ordered examinations:** This was found in 15 jurisdictions. Communication made during ordered examinations are specifically exempted from privilege.

7. **Involuntary hospitalization:** Thirteen jurisdictions waive privilege when counselors participate in seeking the commitment of a client to a hospital.

8. **Knowledge that a client has been a victim of a crime:** Eight states waive privilege.

9. **Harm to vulnerable adults:** Eight jurisdictions waive privilege when the counselor suspect abuse or neglect of older people, adults with disabilities, residents of institutions, or other adults who are presumed to have limited ability to protect themselves (Glosoff et al., 2000, pp. 454–462).

Finally, it is crucial that you have knowledge of your state statutes to protect yourself and client from breaching privilege and confidentiality.

### Managed Care and the Counselor

Managed mental health care rules and regulations have a significant impact on how counselors provide counseling services and often determine whether the services provided are reimbursable. Considerable debate has arisen over the effectiveness of mental health care. Cummings, Budman, and Thomas (1998) believed that managed care was a realistic method of controlling costs while maintaining quality health care. In contrast Johnson (1994) thought that cost-containment initiatives would reduce consumer insurance premiums while covering costs for the insurance industry. However, as cost in health care increased so did the number of restrictions placed by insurers on reimbursement for mental health services (Cooper & Gottlieb, 2004). In addition, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (American Psychiatric Association [APA], 1994) contains a variety of diagnostic codes that are not reimbursable. As a result, counselors struggle to meet the mental health needs of clients while at the same time recognizing the demands of managed care. The denial of services based on the DSM codes is widespread. Glosoff (1998) pointed out that managed mental health care often denies benefits and reimbursement for adjustment disorders, for disorders requiring long-term counseling, and for diagnostic codes that bear exclusively Axis II status. Codes assigned on Axis I when they are the
primary focus of clinical attention (i.e., relational problems and other conditions) are denied reimbursement. As a result of these rules and regulations, many counselors are tempted and in some cases do misdiagnose to get reimbursement. Their misguided efforts are an attempt to provide services for those clients who, without insurance reimbursement, would otherwise terminate therapy, and unfortunately, in some cases, to enhance the number of clients seen in therapy.

Braun and Cox (2005), in an article titled “Managed Mental Health Care: Intentional Misdiagnosis of Mental Disorders for Reimbursement,” discussed the ethics and legal statutes of the consequences of intentional misdiagnosis of mental disorders. These authors suggested that many counselors believe that it is in the client’s best interest when they agree to intentionally misdiagnose mental status to receive reimbursement (p. 426). They further stated that by intentionally misdiagnosing clients’ mental statuses, they abuse their position of power and break client trust because intentional misdiagnosis involves deceptive behavior (p. 425).

A review of the American Counseling Association (ACA), American Mental Health Counselors Association (AMHCA), and APA codes of ethics points to the fact that misdiagnosis is a violation of moral and legal standards and may also violate state and federal statutes.

In summary, the misdiagnosis of a client’s mental status for reimbursement is an ethical violation as well as a violation of legal statutes. Intentional misdiagnosis of mental disorders for reimbursement is considered health care fraud (Infanti, 2000). The provisions of the 1986 False Claims Act, embodied in the U.S. Code 31, chapter 37, subsection III, allow the government to investigate individuals (i.e., counselors) with the requisite knowledge who (a) submit false claims; (b) “cause” such claims to be submitted, (c) make or use false statements to get false claims paid (i.e., intentional misdiagnosing of mental disorders), or (d) “cause” false statements to be made or used (Slade, 2000, in Braun & Cox, 2005). Remember: The dilemma of attempting to counsel a client who otherwise could not afford treatment without reimbursement simply does not justify insurance fraud and the violation of professional ethics. DON’T BE TEMPTED.

Finally, in addition to the problem of misdiagnosis, a variety of other significant issues need the counselor’s thoughtful consideration when confronted with legal and moral issues. Braun and Cox (2005) suggested that counselors grapple with ethical and legal challenges involving the following:

1. **Informed consent**: Clients in the world of managed care may not know and understand their mental health benefits.

2. **Confidentiality**: Clients may be unaware that counselors can no longer ensure privacy of disclosure because managed care organizations may require client information for determining treatment and insurance reimbursement (Cooper & Gottlieb, 2000; Danzinger & Welfel, 2001).

3. **Client autonomy**: Under managed care, providers and types of treatment are oftentimes determined by policies and utilization reviews (Weinberger, 1998).
4. **Competence:** Managed care organizations emphasize brief therapy models. When counselors have not received adequate training in brief therapy techniques and interventions, they may not be able to effectively provide services when a managed care organization limits counseling to only five sessions (Cooper & Gottlieb, 2000).

5. **Treatment plans:** “The first task of mental health psychotherapy is to accommodate treatment parameters of the benefit package” (Austad & Hoyt, as cited in Miller, 1996, p. 356).

6. **Termination:** The termination of counseling services may be imposed by managed care limitations (Cooper & Gottlieb, 2000).

### Risk Management and Multiple Relationships

Dual relationships are troublesome dilemmas for many professional counselors (Hackney, 2000). This is especially true when counseling individuals in locations (rural, small towns) wherein the counselor may have a relationship other than therapeutic with the client. Nevertheless, the ACA Code of Ethics specifically addresses the issue in A.5.c of the code when it discusses nonprofessional interactions or relationships (other than sexual or romantic relationships).

Counselors’ nonprofessional relationships with clients, former patients, their romantic partners, or their family members should be avoided, except when the interaction is potentially beneficial to the client (e.g., the changing of roles by the counselor to consultant, assessor etc.). Furthermore, section A.5.d of the code states,

When a counselor-client nonprofessional interaction with a client or former client may be potentially beneficial to the client or former client, the counselor must document in case records, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit, and anticipated consequences for the client or former client and other individuals significantly involved with the client or former client. Such interactions should be initiated with appropriate client consent. Where unintentional harm occurs to the client or former client, or to an individual significantly involved with the client or former client, due to the nonprofessional interaction, the counselor must show evidence of an attempt to remedy such harm. Examples of potentially beneficial interactions include, but are not limited to, attending a formal ceremony (e.g., a wedding/commitment ceremony or graduation); purchasing a service or product provided by a client or former client (excepting unrestricted bartering); hospital visits to an ill family member; mutual membership in a professional association, organization, or community.

In a similar fashion, the APA Code of Ethics and Conduct addresses multiple relationships in section 3.05 of the code:
a. A multiple relationship occurs when a psychologist 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 psychologist 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. A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.

Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.

b. If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code.

c. When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, at the outset they clarify role expectations and the extent of confidentiality and thereafter as changes occur.

In addition, the AMHCA Code of Ethics addresses dual relationships in section F of the code. Mental health counselors are aware of their influential position with respect to their clients and avoid exploiting the trust and fostering of dependency of the client. To that end,

1. Mental health counselors make efforts to avoid dual relationships with clients that could impair professional judgment or increase the risk of harm. Examples of such relationships may include, but are not limited to, familial, social, financial, business, or close personal relationships with the client.

2. Mental health counselors do not accept as clients individuals with whom they are involved in administrative, supervisory, and evaluative nature. When acting as a supervisor/trainer or employer, mental health counselors accord recipients informed choice, confidentiality, and protection from physical and mental harm.

3. When dual relationships cannot be avoided, counselors take appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no exploitation has occurred.

The Codes of Ethics cited above appears to address dual or multiple relationships in a similar fashion. However, not all practicing counselors, psychologists, or mental health counselors agree to the extent that dual relationships are
inappropriate. Some practitioners feel that dual relationships can foster client growth and development, and, more important, these types of relationships may be unavoidable. To that point Youngren and Gottlieb (2004) suggested that good risk management is consistent with good clinical and ethical practices. Therefore when choosing to engage in dual or multiple relationships, the prudent practitioner should address the following questions:

1. Have I adequately documented the decision-making process in the treatment record?
2. Did I obtain informed consent regarding the risks of engaging in the dual relationship?
3. Does the record show adequate evidence of professional consultation?
4. Does the record reflect a patient-oriented decision-making process?
5. Are the sources of consultation credible?
6. Do diagnostic issues matter when considering a dual relationship?
7. Does knowledge of the patient support the establishment of a dual relationship?
8. Does one’s theoretical orientation matter when considering a dual relationship?

A key consideration for practitioners who are faced with deciding whether they should participate in a multiple relationship or who inadvertently find themselves already in such relationship involves thoughtful analysis of the potential hazards (Youngren & Gottlieb, 2004, pp. 255–260). These authors presented the following key points with the goal of assisting the practitioner in thinking through these issues in a systematic fashion.

1. Engaging in multiple relationships has a high potential for harming patients and as a general matter should be avoided (APA, 2002).
2. Psychologists have many different types of professional relationships, and not all of them involve psychotherapy patients. However, it should be understood that psychologists who perform other services (consultation, assessment, forensic evaluations) should also ask the question regarding entering into a multiple relationship.
3. Some multiple relationships are completely unavoidable, such as those that occur in the military. Psychologists have a dual role by virtue of the role they play (administrator or evaluating clients they treat).
4. Practitioners create risk for their patients when they make decisions in a vacuum. We assume that consultation with trusted and knowledgeable colleagues should underlie all steps in the decision-making process. Those who give consideration to entering a dual relationship should make consultation central to that process.
5. Good risk management also means providing good care, and these notions are not viewed as mutually exclusive. If one assumes good care is care that is satisfactory to the patient, we know that satisfied consumers become
originators of litigation and disciplinary complaints far less often than those who are disgruntled (Hickson et al., 2002).

6. When panels such as ethics committees or state regulatory boards evaluate cases alleging harmful multiple relationships, they must retrospectively focus on the clinician’s behavior. It is important to see how, in the future, those adjudicators in entirely different settings and circumstances react to clinicians’ past conduct.

**Risk Management and the Counselor**

Counseling, like many other professions, has some inherent risk of liability. Recognizing liability can be an asset that enables the counselor to examine carefully the level of risk in one’s decision-making processes in therapy. Risk management is an action practitioners can take that will reduce the risk of liability in the form of a lawsuit for malpractice and disciplinary action before the review board of an institution or an ethics challenge before a state licensing board or professional organization. According to Hackney (2000), a number of counselor actions can be helpful in minimizing liability risks. Hackney grouped these actions according to the following themes:

1. **Competence:** This is awareness on the part of the counselor of the limits of his or her training and not practicing outside the boundaries of his or her competence (Corey et al., 1995). That is, taking on a client whose treatment and needs are beyond the counselor’s skill level is both unethical and a major liability risk.

2. **Communication and attention:** Communicating and paying attention to the therapeutic relationship with clients helps the counselor to minimize the risks of mistakes and misunderstanding in the counseling process. Particularly important is the ongoing process of informed consent, which helps with the avoidance of client misunderstandings about therapy and with clients who have unrealistic expectations for treatment or who may be generally dissatisfied with the counseling received. The counselor must remain open to discussing these issues openly and honestly throughout the therapy process.

3. **Supervision and consultation:** Feedback from colleagues, supervisors, and consultants is invaluable in gaining insight on clinical problems of a legal or ethical nature. Weiner and Wettstein (1993) maintained that establishing relationships with other mental health professionals before the need to consult arises is an important consideration. Active involvement in professional organizations can also be an excellent source of information on legal and ethical matters.

4. **Record keeping:** Record keeping is an axiom of practitioners of risk management; that is, if it isn’t written down, it didn’t occur (Knapp, 1997). In an action against a mental health practitioner, accurate, contemporaneous records enhance the practitioner’s testimony in a deposition or at trial.
(Weiner & Wettstein, 1993). They further implied that the pitfalls of over-documentation and under-documentation should be understood by the counselor. Over-documentation includes irrelevant or sensitive material or observations disparaging to the client or others. Under-documentation is the failure to document phone calls, significant events, decisions, and disclosures for informed consent and failure to obtain and review prior records.

5. **Insurance:** It goes without saying that obtaining liability insurance is an absolute practice essential. Counselors also need to understand their insurance policies, especially regarding exclusions, limits of liability, requirements to report claims, or circumstances that may give rise to a claim.

6. **Knowledge of ethics and relevant laws:** Familiarity with ethical and legal guidelines aids in the avoidance of liability claims and problems. ACA and APA Web sites frequently contain information about ethics, the law, and ethical decision making.

7. **Practitioner self-care:** The stress and tension generated by situations that present a potential for counselor liability necessitate that counselors address their own health and emotional well-being, which can help to ensure that they can maintain perspective and balance (pp. 133–136).

### Elements of Malpractice

As a legal term, *malpractice* describes complaints in which a professional is accused of negligence within a special relationship. The law of malpractice refers to *torts*. A tort is a wrongful act, injury, or damage (not including a breach of contract) for which a civil action can be brought.

To win a malpractice or tort law claim, the plaintiff must prove the following:

1. A legal duty to care was owed by the defendant to the plaintiff. A professional (special) relationship was formed between the mental health professional and the client.
2. There is a standard of care, and the mental health professional breached that duty.
3. The client suffered harm or injury (demonstrated and established).
4. The mental health professional's breach of duty was the proximate cause of the harm or injury. Thus, the harm or injury was a reasonably foreseeable consequence of the breach.

When does the special relationship begin? A formal contract is not always a necessary component of the special relationship. The legal theory to establish duty comes from the *theory of contracts*. In the eyes of the law, an implicit act can create a contract (a special relationship). Payment is not necessary to determine the relationship. Rather, the simple act of ministering to clients admitted to a hospital (voluntarily or involuntarily), making notes on charts, or giving
treatment in emergency rooms can be construed as behavioral manifestations of contract creations. For example, in a Utah case in which a mental health professional provided therapy to a postsurgery patient, the state Supreme Court said that 1 hour of therapy was enough to create a special relationship (Farrow v. Health Services Corp., 1979, cited in Swenson, 1997).

Why Clients Sue

We live in a litigious society. Mental health professionals do therapy with clients who are emotionally distraught. Clinical expertise is needed on the part of the mental health professional (Bednar, Bednar, Lambert, & Waite, 1991). Good relationships with clients reduce the likelihood of lawsuits. Counselors should, thus, use their skills to create positive feelings between themselves and the clients they serve. People do not want to sue someone they like or someone who is acting in their best interests.

Suicide is a factor in 50% of psychiatric malpractice actions (Hirsch & White, 1982). Because blaming and anger are nearly universal reactions by family survivors, the mental health professional is particularly vulnerable. Swenson (1997) noted, “About 1 malpractice claim [is filed] for every 200 mental health professionals” (p. 167). The parties settled most of these claims out of court, or the courts dismissed them (Schwitzgebel & Schwitzgebel, 1980). Psychiatric litigation accounts for only 3% of medical malpractice suits (Hirsch & White, 1982).

Other Reasons to Sue

Breaking a contract is essentially the same as breaking a promise. If the breach causes damage or injury, the law may provide a monetary remedy. A client who is angry does not have to show negligence on the part of the mental health professional, only that the therapy did not achieve the purpose it was intended to achieve (Schwitzgebel & Schwitzgebel, 1980). Damages typically involve at least the cost of the therapy.

Injury to a person’s reputation may occur when derogatory words or written statements are made to a third party about the person. Such injurious statements are called defamation of character; slander is spoken defamation, and libel is written defamation. In a recent unpublished case, a trade school counselor made a public remark to the effect that a student had missed classes because she had a venereal disease contracted while working as a prostitute. In fact, the disease was the result of a rape. Because of stress related to gossip, the girl quit school, went into therapy, and sued the school district. The school settled the case, paying $50,000 in damages for the injury. The school also fired the counselor (Swenson, 1997).

Mental health professionals should be extremely careful about information given in letters of recommendation, notes on educational records, or any other oral comments to students. Communication of an opinion, when it can be said to
imply a false and damaging statement, could be judged as slanderous or libelous (Milkovich v. Lorain, 1990).

**Policy Development**

Before a mental health professional begins to see clients, he or she should think through and articulate a policy toward various situations that may manifest themselves in counseling relationships. One’s attitudes and values concerning advertising, client referral, termination, billing, and record keeping, for example, should be clearly articulated. Naturally these policies must conform to the accepted ethical and legal standards. Therefore, if one is not familiar with these standards, one must make the effort to become so. For those employed in an agency or school, these policies should already be extant. However, the potential for conflict between one’s own ethical standards and institutionalized standards is always present.

**Client Records**

Naturally, mental health professionals should keep records for each client. Records provide an excellent inventory of information for assisting the mental health professional in managing client cases. They also serve as documentation of a therapist’s judgments, type of treatment, recommendations, and treatment outcomes.

Therapists must also keep financial records. Financial records are necessary to obtain third-party reimbursement for the counselor or the client. The content of records may be defined by agency policy, state licensing laws, statutory laws, or regulation laws. Records may be read in open court, and, as a result, derogatory comments about clients should never be included.

In most jurisdictions, the paper belongs to the agency, but the information on the paper belongs to the client. Clients can request copies of their records. Some jurisdictions limit access to records if such access would be harmful to a client’s mental health.

The evolving standard of practice is to keep records for 7 years, although some suggest they should be kept forever. The appropriate regulatory agencies in one’s jurisdiction should be consulted regarding record retention and disposition. The following lists some types of information that should be kept in client records:

1. basic identifying information, such as the client’s name, address, telephone number; also, if the client is a minor, the names of parents or legal guardians should be recorded;
2. signed informed consent for treatment;
3. history of the client, both medical and psychiatric, if relevant;
4. dates and types of services offered;
5. signature and title of the person who rendered the therapy;
6. a description of the presenting problem;
7. a description of assessment techniques and results;
8. progress notes for each date of service documenting the implementation of the treatment plan and changes in the treatment plan;
9. documentation of sensitive or dangerous issues, alternatives considered, and actions taken;
10. a treatment plan with explicit goals;
11. consultations with other professionals, consultations with people in the client's life, clinical supervision received, and peer consultation;
12. release of confidential information forms signed by the client; and
13. fees assessed and collected.

**The Use of Computers**

Data on clients can be stored in word processors and database program files. In addition, the computer can be used to store information on grants, payroll accounts, fiscal planning, payments, and preparation of research. With macros and style sheets, computer programs can reduce the need for reentry of information and can make updating a client's files much faster and easier. Computer technology provides increased convenience for mental health professionals but also commands new responsibilities, knowledge, and accountability.

The use of computers also allows mental health professionals to access diagnostic categories and to offer computerized versions of various personality tests. Professionals who use these new electronic programs must be careful not to violate federal or state copyright laws that police the use of software. "A conviction for violating a computer crime statute may result in a fine, imprisonment, or both" (Atcherson, 1993, p. 36). Atcherson listed the following behaviors that may be considered illegal:

1. unauthorized access to or alterations of electronic communication;
2. unauthorized use of or access to computer resources or information;
3. unauthorized disclosure of computer-based information obtained by wiretapping, eavesdropping, or browsing through personnel data;
4. unauthorized modification or destruction of computer resources (hardware, software, or data);
5. theft of storage media or printouts;
6. user misuse, such as unauthorized copying of software or use of computer resources in committing a misdemeanor or felony;
7. misuse of local communication links or other communication links; and
8. intentional spread of computer viruses.

Mental health professionals who use computers are held ethically responsible for making sure the information their clients are given is accurate. Psychological tests administered by computer programs must be treated like any other tests. They should not be used by untrained personnel. Also, data entries must be
made carefully so inaccurate results do not arise. Ethical codes also stress the responsibility of mental health professionals in their use of computers:

Counselors are responsible for the appropriate application, scoring, interpretation, and use of assessment instruments relevant to the needs of the client, whether they score and interpret such assessments themselves or use technology or other services. (American Counseling Association, 2002, E.2.b)

Psychologists select scoring and interpretation services (including automated services) on the basis of evidence of the validity of the program and procedures as well as on other appropriate consideration. (American Psychological Association, 2002, 9.09.b)

Psychologists retain appropriate responsibility for the appropriate application, interpretation, and use of assessment instrument, whether they score and interpret such tests themselves or use automated or other services. (American Counseling Association, 2002, E.2)

Certified counselors must ensure that computer-generated test administration and scoring programs function properly, thereby providing clients with accurate test results. (National Board for Certified Counselors, 1997, C.12)

**Liability Insurance**

All mental health professionals should purchase liability insurance before they begin practice. An *occurrence-based policy* covers incidents no matter when the claim is made, as long as the policy was in force during the year of the alleged incident. Thus, if a therapist is accused today of an infraction alleged to have occurred 2 years ago (when the policy was in effect), he or she is covered, even if the policy is not in force at present. A *claims-made policy* covers only claims made while the policy is in force. However, if a counselor previously had a claims-made policy, he or she may purchase *tail-coverage insurance*, which covers him or her if an alleged incident occurring during the period the policy was in effect is reported after the policy has expired.

**Contracting for Therapy**

Not long ago, most contracts between mental health professionals and clients were oral. More formalized contracts were seen as alienating to the client. Also, common law principles, under which those agreements were governed, did not require written forms (Bednar et al., 1991). In 1985, only 29% of therapists in
private practice reported using written contracts (Handelsman & Galvin, 1988). Numerous lawsuits, based on the absence of informed consent, have since changed that (Bednar et al., 1991). Counselors are now required to inform their clients in writing of the relevant facts about therapy. The clients must understand the information and sign any forms voluntarily.

**Informed Consent**

A written informed consent form is a contract and a promise made by the mental health professional to perform the therapy competently. There are three basic legal elements of informed consent:

1. The client must be competent. Competence refers to the legal capacity to give consent. If, because of age or mental ability, a client does not have the capacity to give consent, the therapist should consult another person or a judicial body who can legally assume responsibility for the client.
2. Both the substance of the information regarding therapy and the manner in which it is given are important. The substance of the information should include the relevant facts about therapy. This information should be presented to the client in a manner that is easily understood.
3. The client must volunteer for therapy and must not be coerced or forced to participate.

Some common themes in consent forms that should be explicated prior to therapy include the following:

1. The client should be given a description of the services to be provided, including their goals and procedures. This should be done in simple language to inform the client exactly what the mental health professional will attempt to do in the therapy sessions. The client should be appraised as to what, if any, behavior or action will be required of the client, such as homework. The client also should know how interruptions in therapy will be handled.
2. Any anticipated results—beneficial and negative—should be explained. The therapist should state that there is no guarantee of success but that specific behaviors will be targeted and goals will be set. If more than one type of therapy seems appropriate, the therapist should describe the various types.
3. The therapist should estimate the duration of the therapy and the frequency of appointments.
4. A timetable for review of client progress should be established. The client should be informed that he or she has the right to withdraw from therapy at any time and that no additional costs will result, unless such costs have been previously explicated.
5. The basis for services should be explained to the client. A timely system for collecting fees should be established.
6. The therapist should give a statement regarding confidentiality and privileged communication (these issues are dealt with in more detail below).
7. A statement acknowledging the client’s informed consent should be signed by the client or by his or her parent or legal guardian.

**Release of Information**

The essence of a counseling relationship is trust. Mental health professionals must protect the information they receive from clients. They must keep confidential communications secret unless a well-defined exception applies.

Confidential information may be disclosed if the client (or the client’s parent or legal representative) agrees and signs a consent form for such a disclosure. A consent to waiver does not always have to be in writing, but it is best if it is. The client should be informed of any and all implications of the waiver.

**Confidentiality**

Therapists should provide an environment in which their clients feel they can communicate honestly about their thoughts, feelings, and behaviors. To feel safe in this process, most people want assurance that information about their private lives will be kept confidential. Confidentiality is the foundation of effective therapy. Should there be no prior consent or legal mandate, the only disclosure of confidential information that is ethical is that which promotes the welfare of the client. Hass and Malouf (1989, p. 30) listed some of the situations in which a decision to breach confidentiality may be made:

- court subpoenas;
- duty to warn, protect, or report;
- requests for information from family members;
- seeing clients in groups;
- when there are problems defining the “client”;
- sharing information with other staff members within one’s agency; and
- personal or professional needs of practicality (consultation, teaching, support).

**Privileged Communication**

When a competent client presents for therapy, any disclosure he or she makes may be protected from legal disclosure. Such communication is considered privileged. The issue at hand is the conflict between the individual’s right to privacy and the need of the public to know certain information. The client is considered the holder of the privilege, and he or she is the only one who can waive that right.

Privileged communication is established by statutory law enacted by legislators. Client communication with a specified group of mental health professionals may
be privileged in some states but not in others. Also, statutes may specify a wide range of exceptions to privileged communication. For instance, privileged communication laws are abrogated, in all states, by an initial report of child abuse.

Mental health professionals generally do not have legal grounds for maintaining confidentiality if they are called on to testify in court, unless they are asked to provide communication protected by privileged communication statutes. Clients should be told whether any information they reveal will be protected by privileged communication laws before therapy begins. In the following example, the therapist (an intern) implies that the information the client is about to reveal is privileged. The court later ruled it was not. Had the client been informed that his communications were not privileged, he may not have revealed what he did.

“Can I ask for this to be strictly confidential?” he said. The graduate student replied, “Okay, I can say this much, Reid … whatever you say here is confidential; and we’re real selective about what the courts have access to.” [The client then said,] “It’s just not [like] myself to be thinking like this, to ah … I think a lot about, ah, rape. I think a lot about killing somebody.” He then added that the impulse to kill someone with a knife was “so strong I wonder sometimes if I wouldn’t actually do it, you know, if the situation was ever right … and then later on I’ll feel terrible about it [these feelings].” (Kane & Keeton, 1985, pp. 52–53)

Ten months later, Donna Lyn Allen was killed. Reid Hall’s fantasies, acquired from the graduate student’s tape recording of the session, were read in open court and were described by his lawyer as the most damaging evidence leading to his conviction for murder. The judge ruled that, because the counselor was a graduate student and not a licensed professional, Hall’s communications were not covered by privileged communication law. Informed consent forms at the University of Georgia now state that client–therapist privileged communication may not apply to students in training (Kane & Keeton, 1985).

Summary

The legal issues addressed in this chapter were aimed at the major considerations necessary to ensure that counselors are able to protect both themselves and their clients from legal liability. It is important that all counselors and therapists have a complete understanding of the meaning of the special relationship, dual relationships, confidentiality, and privileged communication and the rights and responsibilities of helping professionals in legal situations. In addition, mental health professionals should be familiar with the steps in a lawsuit, the issue of negligence, and the elements of malpractice in an effort to avoid the liability that results from such claims. Important considerations that relate to the special
relationship, including contracting for therapy with the client and the handling of sensitive data, were also presented. Before beginning the practicum and internship experience, students will want to familiarize themselves with the critical issues presented in this chapter.

References


Part III of this textbook is designed to provide the student with information critical to the internship experience. Chapter 8 provides interns with strategies for dealing with special populations they will encounter most frequently in their work. Populations discussed include clients who are harmful to themselves, clients who are a threat to others, abused children, sexual abuse victims, and substance abusing clients. Forms for use with these client populations are included for the student’s reference and use. Chapter 9 discusses the various models and methods of consultation in those two settings and provides a form for use in rating the consultation process.
Chapter 8

Guidelines for Interns Working With Special Populations and Crisis

The Client Who Is Potentially Harmful to Self

Definition of Suicide

Beauchamp (1985) defined suicide this way:

- the person intentionally brings about his or her own death,
- the person is not coerced by others to take the action, and
- death is caused by conditions arranged by the person for the specific purpose of bringing about his or her own death.

Myths about Suicide

There are a number of commonly held myths about suicide. According to Fujimura et al. (1985), and Schneidman, Farberow, and Litman (1976, p. 130), the following is a representative sample of some of those myths.

- Discussing suicide will cause the client to move toward doing it.
- Clients who threaten suicide don't do it.
- Suicide is an irrational act
- Persons who commit suicide are insane
- Suicide runs in families — it is an inherited tendency
- Once suicidal always suicidal
- When a person has attempted suicide and pulls out of it, the danger is over.
A suicidal person who begins to show generosity and share personal possessions is showing signs of renewal and recovery.

Suicide is always an impulsive act.

Greene (1994) identified five additional myths surrounding childhood suicide:

- Children under the age of six do not commit suicide
- Suicide in the latency years is extremely rare
- Psychodynamically and developmentally, true depression is not possible in childhood
- Children are cognitively and physically incapable of implementing a suicide plot successfully

**Ethical Mandates and Danger to Self**

The ethical codes from several professional organizations clearly address the welfare of clients as paramount, as shown in the statements that follow:

>[The school counselor] informs the appropriate authorities when the counselee’s condition indicates a clear and imminent danger to the counselee or others. This is to be done after careful deliberation and, where possible, after consultation with other professionals. The counselor informs the counselee of actions to be taken so as to minimize confusion and clarify expectations. (American School Counselor Association, 1992, p. 10)

Marriage and family therapists may not disclose client confidences except (a) as mandated by law; (b) to prevent a clear and immediate danger to a person or persons; (c) where the therapist is a defendant in a civil, criminal, or disciplinary action arising from the therapy (in which case client confidences may be disclosed only in the course of that action); or (d) if there is a waiver previously obtained in writing, and then such information may be revealed only in accordance with the terms of the waiver. In circumstances where more than one person in a family receives therapy, each such family member who is legally competent to execute a waiver must agree to the waiver required by subparagraph (d). Without such a waiver from each family member legally competent to execute a waiver, a therapist cannot disclose information received from any family member. (American Association for Marriage and Family Therapy, 1991, 2.1)

Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose, such as (1) to provide needed professional services to the
patient or the individual or organizational client, (2) to obtain appropriate professional consultations, (3) to protect the patient or client or others from harm, or (4) to obtain payment for services, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. (American Psychological Association [APA], 1995, 5, 501)

Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person or when laws or regulations require disclosure without a client's consent. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed. (National Association of Social Workers, 1997, 1, 105)

The general requirement that counselors keep information confidential does not apply when disclosure is required to prevent clear and imminent danger to the client or others or when legal requirements demand that confidential information be revealed. Counselors consult with other professionals when in doubt as to the validity of an exception. (American Counseling Association, 1995, B.2.a.)

**Legal Mandates and Danger to Self**

Again, the mental health professional's special relationship with the client creates the context for the legal accountability for negligent malpractice with potentially suicidal patients. A therapist is assumed to possess superior knowledge and skills beyond those of the average person and may be considered by the courts to be responsible for the suicide of his or her patient. The client's dependence on the counselor alone is enough to shift some of the weight of the responsibility for the client's actions to the mental health professional.

This was not always the case. In England, for example, toward the latter part of the 19th century, suicide was considered self-murder, and authorities buried the bodies of those who committed suicide at the side of the road with a stake through the heart (Bednar, Bednar, Lambert, & Waite, 1991). In contrast, today a mental health professional who does not take appropriate action to prevent a suicide can be sued. The most important consideration for the courts is this: Was the suicide foreseeable? Consider the following case as an example:

A medical patient experienced hallucinations after surgery. The patient requested psychiatric help, and a therapist conducted an hour of
therapy and made no recommendations to the hospital staff. Sometime later, the patient jumped from a sixth-floor window. Injuries from the fall left him a quadriplegic. The Utah Supreme Court concluded that after an hour of therapy, a special relationship was formed. It held the therapist liable for negligently failing to accurately diagnose the patient’s condition and for failing to take appropriate protective steps. (Farrow v. Health Services Corp., 1979)

On the other hand, liability has not been found when apparently cooperative patients suddenly attempt suicide (Carlino v. State, 1968; Dalton v. State, 1970) or when an aggressive patient does not reveal any suicidal symptoms (Paridies v. Benedictine Hospital, 1980). In determining liability, courts also must decide whether the recommendations of a mental health professional were followed. In one case, a hospital was found liable when the staff did not follow the psychiatrist’s recommendations (Comiskey v. State of New York, 1979).

Liability may be imposed if a therapist is determined to be negligent in his or her treatment of a patient. Negligence is found when the mental health professional does not perform his or her duties according to the standard of care for that particular profession. As a consequence, mental health professionals should adhere to the following model, similar to the one presented later in this chapter, in the section on the Tarasoff case (see “The Potentially Dangerous Client” section below):

1. Make an assessment of the danger. This assessment is based on the client interview.
2. Determine what action is reasonable. The therapist may need to intensify treatment, change medication, advise voluntary commitment, or authorize involuntary commitment.
3. Make sure the recommendation is followed.

**Characteristics of Potential Harm to Self**

Because suicidal behavior is such a pressing issue for therapists, it is important that they be able to identify common characteristics of clients who may potentially cause harm to themselves. As the following section indicates, there are myriad risk factors that could indicate a client’s lethality.

**Harm to Self**

According to Connor et al. (2004), the denial of suicide ideation is all too frequently the only documentation of a suicide risk assessment in the clinical notes of a patient who is dead. Sentinel event reviews reveal that usually the clinician has made this notation following a number of sophisticated evaluations of recent events, psychiatric history, mental status, and some assessment of the patient’s
statements about suicide intentions (Connor et al., 2004). Unfortunately, suicide assessment appears to be impressionistic and fails to consider pertinent information regarding a person's lethality.

According to McGlothlin, Rainey, and Kindsvalter (2005), to assess lethality, one must take into consideration at least five aspects for all clients: (a) plan, (b) intent, (c) means, (d) prior attempt, and (e) substance use.

1. The verbalization of a plan of how clients would attempt suicide certainly suggests suicide lethality; the more detailed and concrete the plan, the higher the lethality level.
2. The intent or dedication to follow through on a suicide plan also suggests suicide lethality level; the higher the intent, the higher the lethality level.
3. The means by which these clients plan to harm themselves suggests lethality; the more deadly or accessible the means, the greater the lethality level.
4. Previous suicide attempts suggest that these clients would be more likely to complete a suicide; therefore, if previous attempts exist, the greater the lethality level.
5. Any substance use or abuse that would increase lethality would increase suicide lethality.

Furthermore, these authors suggested the following general guidelines to estimate overall suicide lethality:

1. Low lethality: Suicidal ideation is present but intent is denied, and the client does not have a concrete plan and has never attempted suicide in the past.
2. Moderate lethality: More than one general risk factor for suicide is present, suicidal ideation and intent are present but a clear plan is denied, and the client is motivated to improve his or her psychological state if possible.
3. High lethality: Several general risk factors for suicide are present, the client has verbalized suicidal ideation and intent, he or she has communicated a well-thought-out plan with immediate access to resources needed to complete the plan.
4. Very high lethality: The client verbalizes suicidal ideation and intent, and he or she has communicated a well-thought-out plan with immediate access to resources needed to complete the plan, demonstrates cognitive rigidity and hopelessness for the future, denies any available suicide support, and has made previous suicide attempts in the past (Connor et al., 2004).

Bonner (1990) recommended three essential steps in assessing suicide. First is the clinical interview, wherein the counselor investigates the client's mental state, affective state, and psychosocial context during the clinical interview. Mental state refers to the client's thinking about suicide. According to Bonner, it is important to determine if these suicidal thoughts are brief and fleeting or intense and pervasive. Affective state refers to the client's mood (Is the client depressed?).
Physical context refers to the individual’s interactions with others. In addition, issues regarding life stressors, social isolation, marital status, and living conditions need to be evaluated to determine the client’s degree of future and hope (p. 233).

Second is the use of empirical evaluation. The use of suicide scales, checklists, and other psychological instruments can be helpful in determining suicidal risk (Junke, 1994). Empirical instruments are excellent resources for those who may be inexperienced in dealing with suicide.

Finally, consultation and discussions with a more experienced supervisor, therapist, or treatment team help promote a multifaceted approach and decrease the probability of suicide resulting from flawed treatment interventions (Bonner, 1990, p. 53).

According to Captain (2006, p. 233), most suicide attempts are expressions of extreme distress, not bids for attention. Suicidal behavior develops along a continuum.

**Ideation:** This is the beginning of the continuum. Ideation is the process of contemplating suicide or the methods used without acting on these thoughts. At this stage the patient may not talk about these thoughts unless repressed.

**Suicidal gestures:** These are actions that aren’t likely to be lethal, such as taking a few pills or making superficial cuts on the wrist. They suggest that the person is ambivalent about dying or hasn’t planned to die. He or she has the will to survive, wants to be rescued, and is experiencing a mental conflict. A suicidal gesture is oftentimes called “a cry for help” because the individual is struggling with unmanageable stress.

**Suicide attempts:** This is the act of intentionally killing oneself and may follow prior attempts, but about 30% of those who commit suicide are believed to have done it on their first attempt. Suicide results when the person sees no other option for relief from unbearable emotional or physical pain.

Captain (2006) went on to state that one should not be afraid to ask about suicidal thoughts. Most patients who are suicidal are relieved to talk about their feelings and to be assured that they aren’t crazy for thinking this way.

She further suggested that you should first assess the patient for depression by asking a question such as this: Are you feeling depressed [or sad or discouraged]? If the answer is yes, then you’d ask the standard suicide assessment questions: How long have you felt like this? Are you thinking of acting on that feeling by hurting yourself or taking your own life? Do you have a suicide plan? Can you tell me about your plan? It is important to ask detailed information if the patient has a plan (p. 45).

**When You Fear Someone May Take Their Own Life**

Most suicidal individuals give some warning of their intentions. The most effective way to prevent a friend or loved one from taking his or her own life is to
recognize when someone is at risk, take the warning signs seriously, and know how to respond. The depression and emotional crisis that so often precede suicides are in most cases both recognizable and treatable.

**Take It Seriously**

- Seventy-five percent of all suicidal people give some warning of their intention to a friend or family member.
- All threats and attempts of suicide must be taken seriously.

**Be Willing to Listen**

- Take the initiative to ask what is troubling the person and persist to overcome any reluctance to talk about it.
- If professional help is indicated, the person you care about is more apt to follow such a recommendation if you have listened to him or her.
- If your friend or loved one is depressed, don't be afraid to ask whether he or she is considering suicide or even if he or she has a particular plan or method in mind.
- Do not attempt to argue anyone out of suicide. Rather, let the person know that you care and understand, that he or she is not alone, that suicidal feelings are temporary, that depression can be treated, and that problems can be solved. Avoid the temptation to say, “You have so much to live for” or “Your suicide will hurt your family.”

**Seek Professional Help**

- Be actively involved in encouraging the person to immediately see a physician or mental health professional. Individuals contemplating suicide often don't believe they can be helped, so you have to do more. For example, a suicidal college student resisted seeing a psychiatrist until his roommate offered to accompany him on the visit. A 17-year-old accompanied her younger sister to a psychiatrist because her parents refused to become involved.
- You can make a difference by helping the person in need of help find a knowledgeable mental health professional or reputable treatment facility.

**In Acute Crisis**

- In an acute crisis, take your friend or loved one to an emergency room or walk-in clinic at a psychiatric hospital.
- Do not leave that person alone until help is available.
- Remove from the vicinity any firearms, drugs, or sharp objects that could be used in a suicide attempt.
Hospitalization may be indicated and may be necessary, at least until the crisis abates. If these options are unavailable, call your local emergency number or the National Suicide Prevention Lifeline at 1-800-273-TALK.

**Treatment Follow Up**

- Suicidal patients are often hesitant to seek help and may run away or avoid it after an initial contact unless there is support for their continuing treatment.
- If medication is prescribed, take an active role to make sure they are taking the medication and be sure to notify the physician about any unexpected side effects. Often, alternative medication can be prescribed. (Copyright 2007. Permission granted by American Foundation for Suicide Prevention.)

**Risk Factors for Suicide**

**Psychiatric Disorders**

At least 90% of people who kill themselves have a diagnosable and treatable illness, such as major depression, bipolar depression, or some other depressive illness, including the following:

- Schizophrenia
- Alcohol or drug abuse, particularly when combined with depression
- Post-traumatic stress disorder or some other anxiety disorder
- Bulimia or anorexia nervosa
- Personality disorders especially borderline or antisocial

**Past History of Attempted Suicide**

Between 20% and 50% of people who kill themselves had previously attempted suicide. Those who have made serious suicide attempts are at much higher risk for actually taking their lives.

**General Predisposition**

The general predisposition includes a family history of suicide, suicide attempts, depression, or other psychiatric illness.

**Neurotransmitters**

A clear relationship has been demonstrated between low concentrations of the serotonin metabolite 5-hydroxyindoleactic acid (5-HIAA) in cerebrospinal fluid and increased incidence of attempted and completed suicide in psychiatric patients.
**Impulsivity**

Impulsive individuals are more apt to act on suicidal impulses.

**Demographics**

*Sex*: Males are three to five times more likely to commit suicide than females.

*Age*: Elderly Caucasian males have the highest suicide rate.

**Suicide Crisis**

A *suicide crisis* is a time-limited occurrence signaling immediate danger of suicide. *Suicide risk*, by contrast, is a broader term that includes the factors of age and sex, psychiatric diagnosis, past suicide attempts, and traits such as impulsivity. The signs of crisis are as follows.

**Precipitating Event**

A recent event that is particularly distressing, such as the loss of loved one or career failure, or the individual's own behavior can precipitate the event; for example, a man's abusive behavior while drinking causes his wife to leave him.

**Intense Affective State in Addition to Depression**

This state can include desperation (anguish plus urgency regarding need for relief), rage, psychic pain or inner tension, anxiety, guilt, hopelessness, or acute sense of abandonment.

**Changes in Behavior**

*Speech* can suggest that the individual is close to suicide. Such speech may be indirect. Be alert to such statements as “My family would be better off without me.” Sometimes those contemplating suicide talk as if they are saying good-bye or going away.

*Actions* can range from buying a gun to suddenly putting one's affairs in order. There can be a *deterioration* in functioning at work or social situations, an increased use of alcohol, other self-destructive behavior, loss of control, and rage explosions. (Copyright 2007 by the American Foundation of Suicide Prevention.)

**Warning Signs of Suicide**

Suicide can be prevented. Although some suicides occur without any outward warning, most people who are suicidal do give warnings. Prevent the suicide of
loved ones by learning to recognize the signs of someone at risk, taking those signs seriously, and knowing how to respond to them.

**Observable Signs of Serious Depression**

- Unrelenting low moods
- Pessimism
- Hopelessness
- Desperation
- Anxiety, psychic pain, and inner tension
- Withdrawal
- Sleep problems
- Increased alcohol or other drug use
- Recent impulsiveness and unnecessary risk taking
- Threats of suicide or an expression of a strong wish to die
- A plan
- The giving away of prized possessions
- A sudden and impulsive purchase of a firearm
- The obtaining of other means of killing oneself such as poisons or medications
- Unexpected rage or anger

The emotional crises that usually precede suicide are often recognizable and treatable. Although most depressed people are not suicidal, most suicidal people are depressed. Serious depression can be manifested in obvious sadness, but often it is rather expressed as a loss of pleasure or withdrawal from activities that had been enjoyable. One can help prevent suicide through early recognition and treatment of depression and other psychiatric illnesses. (Copyright 2007. Permission granted by the American Foundation for Suicide Prevention.)

**Interventions**

Listed below are some techniques generally recognized by therapists to facilitate the counseling process for suicidal clients:

- Listen intelligently, sensitively, and carefully to the client.
- Accept and understand the client’s suicidal thoughts.
- Don’t give false assurances such as, “Everything is going to be all right.”
- Be supportive.
- Assure the client of your availability.
- Be firm and caring at the same time.
- Don’t use euphemisms. Ask direct questions such as, “Would you like to kill yourself?” rather than using vague expressions.
- Bring out any ambivalence the client has. Try to increase his or her choices.
If the client is in crisis, don’t leave him or her alone.  
Intervene to dispose of any weapons the client has.  
Tell others, especially those who would be concerned and can help. (You already have informed the client of the limits of confidentiality.)  
Help the client develop support systems.  
Trust your own judgment.  
Know the suicide hotline numbers.  
Be aware of commitment procedures in your area.  
Have the client sign a nonsuicide contract.

If you determine that the client is potentially suicidal and he or she will not consent to hospitalization, the case may be serious enough to warrant attempting an involuntary commitment to a treatment center. The procedures for commitment, whether voluntary or involuntary, vary a great deal from area to area. Laws on commitment procedures are different from state to state. Mental health professionals should be familiar with the legal aspects of commitment in their areas. Copies of a Suicide Consultation Form (Form 8.1) and a Suicide Contract (Form 8.2) are included in the Forms section at the end of this book; students may use these forms, in consultation with their supervisors, to facilitate their counseling of clients who are potentially harmful to themselves.

**School-Based Suicide Prevention Programs**

As stated previously, suicide among American youths is growing at an alarming rate. Currently, it is the fastest growing cause of death among adolescents in the United States (Sheeley & Herlihy, 1989). Suicide is the third-leading—in some states the second-leading—cause of death among young people (Rosenberg, Smith, Davidson, & Conn, 1987; Strother, 1986). Although the number of adolescent suicides has increased 300% in the past 30 years (Peach & Reddick, 1991), actual cases are considered underreported because of the tendency to disguise these cases as accidents (Capuzzi & Golden, 1988). Some researchers believe suicides to be underreported by a ratio of 4 to 1 (Davis, 1985).

The tragedy of suicide is further complicated by the strong possibility that it can be prevented (Eisenberg, 1984). Professionals concur that most potential suicide victims want to be saved and often send out signals for help. Considering the magnitude of this problem, schools have a moral imperative to develop suicide prevention programs (Celotta, Golden, Keys, & Cannon, 1988). These are most effective when they are comprehensive and systematic—in short, when they are proactive (Kush, 1990).

The literature suggests that, to be effective, school-based programs must be comprehensive and systematic and include strategies for suicide prevention, intervention during, and postintervention following a completed suicide. Comprehensive and systematic programs also must be ongoing, intact, and continuously updated. Many researchers who have developed models of school-based
programs share this position. A review of recent literature reveals the following components as those most often recommended for school-based adolescent suicide prevention and intervention programs:

- a written formal policy statement for reacting to suicide and suicidal ideation,
- staff in-service training and orientation for the program,
- mental health professionals on-site,
- a mental health team,
- prevention materials for distribution to parents,
- prevention materials for distribution to students,
- psychological screening programs to identify at-risk students,
- prevention-focused classroom discussions,
- mental health counseling for at-risk students,
- suicide prevention and intervention training for school counselors,
- faculty training for detection of suicide warning signs,
- postintervention component in the event of an actual suicide,
- written statement describing specific criteria for counselors to assess the lethality of a potential suicide, and
- written policy describing how the program will be evaluated.

**Suicide Intervention in the School**

More and more, the courts have been called on to decide liability issues in relation to suicidal clients and the responsibility of school counselors. The Maryland Court of Appeals ruled that school counselors have a legal duty to prevent the suicide of a student client if the counselor foresees a danger of suicide (Pate, 1992). Appropriate intervention steps cannot be implemented, however, until lethality is determined. The following process should be followed as soon as a student is suspected of being suicidal:

1. **Ask directly during a session.** Ask the student, without hesitation, if he or she is thinking about killing himself or herself. If the student claims to have had suicidal ideation, the strength of the intent should be determined. Continue with the questioning.
2. **Ask if he or she has attempted suicide before.** If so, ask how many times attempts were made and when were they made. The more attempts and the more recent the attempts, the more serious the situation becomes.
3. **Ask how the previous attempts were made.** If the student took aspirin, for example, ask how many. One? Six? Twenty? Then ask about the consequences of the attempts. For example, was there medical intervention?
4. **Ask why.** Why did the student attempt suicide before? Why the suicidal thoughts now?
5. **Does the student have a plan?** Ask about the details. The more detailed the plan is, the more lethal it is. Does the student know when and how the attempt will be made? Assess the lethality of the method. This assessment is critical. Does the student have a weapon? Using a gun or hanging oneself leaves little time for medical help.

6. **Ask about the student’s preoccupation with suicide.** Does he or she think about it only at home or during a particular incident—or does it go beyond all other activities?

7. **Ask about drug use.** Drug use complicates the seriousness of the situation because people tend to be less inhibited when under the influence of drugs. Although the student may deny drug use, try to get as much information as possible.

8. **Observe nonverbal actions.** Is the student agitated, tense, or sad? Is he or she inebriated? Use caution if the student seems to be at peace. This peaceful state may be the result of having organized a suicide plan, with completion being the next step.

9. **Try to gauge the level of depression.** A student may not be depressed because he or she is anxious about completing the plan.

This process will help you determine the level of suicide risk for a student. A low-risk student may have thoughts about suicide but has never attempted suicide in the past, does not have a plan, is not taking drugs, and is not preoccupied with the ideation. Most students at low risk will agree to the therapist’s contacting their parents, which should be done. The statements must be monitored closely, however, as a low-risk student can quickly become a high-risk student.

A typical high-risk student has a plan but may or may not have attempted suicide in the past. Of course, a previous attempt is an important factor in assessing lethality, especially if the attempt was recent. But counselors should remember that many first-time attempts are successful. The current situation must never be minimized. The plan of a high-risk student usually is detailed and the ideation frequent. At this point, other people need to become involved, including the counselor’s supervisor, principal, and school nurse.

Ideally, the school will have some type of suicide intervention policy. The goal in a high-risk situation is to have the student undergo a psychiatric evaluation as soon as possible, whether by voluntary or by involuntary commitment. The student’s parents must be notified; confidentiality is not an issue if the limits of confidentiality were explained previously via informed consent. Although confidentiality laws vary from state to state, a counselor usually is not bound if the client intends to harm himself or herself or someone else (Kane & Keeton, 1985). It is absolutely imperative, however, that school counselors discuss confidentiality limits at the beginning of every client intake session.

Mental health professionals may encounter crisis situations in three different ways, and each requires some specific guidelines.
1. First, the student may attempt suicide on school premises. The counselor should refer to the school’s policy regarding this intervention.

2. Second, the student may disclose suicidal ideation directly to the therapist. In this case, the counselor should assess lethality using the process outlined previously.

3. Third, peers may inform the counselor of a suicidal student. Seven out of 10 students will tell a peer about suicidal ideation before telling anyone else. It is especially important to take this information seriously. The decision by the Maryland Court of Appeals mentioned earlier involved a peer’s informing a counselor of another student’s intention to kill herself. The counselor confronted the teen, but she denied any problems, so the counselor did not notify her parents. The failure to inform the parents was deemed to be negligence (Pate, 1992).

Below are some guidelines for each of the situations listed above:

1. If a suicide attempt occurs on the premises, involve appropriate school personnel, then notify the police and an ambulance service. Also notify the parents (or guardian). Let them know where their child is being taken. If the parents (or guardian) are not available, notify the next closest relative. See to it that the student receives proper medical and psychiatric care. Often, the hospital will send the student back to the school after the crisis without a psychiatric evaluation. Counselors should guard against this occurrence.

2. If the student discloses suicidal ideation to you, first consult your supervisor or another mental health professional. Go over the assessment of lethality with the student. This process will help you establish the standard of care. Call the parents (or guardian) and tell them to go to the appropriate psychiatric facility. Explain to the parents and the student that an evaluation or diagnosis does not necessarily mean commitment. If the parents resist this process, you may need to contact your local Children and Youth Services for assistance. Be sure to contact the parents in the presence of the child, to eliminate the “he said–she said” phenomenon.

3. If a peer tells you about another student’s suicidal intent, confront the student. If the student admits the suicidal ideation, follow the procedure outlined above. If the student denies the ideation, notify the parents (or guardian). Of course, you must inform the student about this disclosure.

The Potentially Dangerous Client

The Tarasoff Case

The Events

Prosenjit Poddar was a graduate student at the University of California, Berkeley. In 1968, Poddar attended dancing classes at the International House in Berkeley,
where he met a woman named Tatiana (Tanya) Tarasoff. This meeting quickly led to an obsessive, one-sided love affair. After a friendly New Year’s Eve kiss under the mistletoe, Poddar began harassing Ms. Tarasoff, calling and pestering her continually. He was consistently and repeatedly rebuffed by the young woman.

In the summer of 1969, Tarasoff went to Brazil. When she returned, Poddar went to her home and again was rebuffed. Tarasoff became emotional and screamed at him. Poddar drew a pellet gun and shot at her. Desperate, the young woman ran from the house, only to be chased down and caught by Poddar, who fatally stabbed her with a kitchen knife. This tragic chain of events unleashed some unforeseen and shocking consequences for mental health professionals.

While Tarasoff was in Brazil, Poddar sought help for depression at Cowell Memorial Hospital, an affiliate of the University of California, Berkeley. His intake interview was conducted by Dr. Stuart Gold, a psychiatrist, and his therapy was conducted by a psychologist, Dr. Lawrence Moore.

In August 1969, Poddar told Dr. Moore he was going to kill Tarasoff when she returned from Brazil. Moore immediately consulted his supervisor, and they agreed that Poddar should be involuntarily committed. Dr. Moore called the police, who detained Poddar, but after questioning the man, police officials decided he was rational and released him. His freedom led directly to Tarasoff’s death.

**Implications of the Case**

In late 1974, the California Supreme Court ruled there was cause for action for negligence against the therapist, the university, and the police for the failure to warn (*Tarasoff v. Regents of the University of California*, 1974). This case is commonly known as *Tarasoff I*. The court, apparently under pressure from various professional groups, agreed to a rehearing in 1976 (*Tarasoff v. Regents of the University of California*, 1976). This case is commonly known as *Tarasoff II*.

Whenever we mention the *Tarasoff* case throughout this book, we are citing *Tarasoff II*. In the court’s final decision, presented in *Tarasoff II* on July 1, 1976, it set a new standard for therapists. The mandate was clear: “Therapists who know or should know of patients’ dangerousness to identifiable third persons have an obligation to take all reasonable steps necessary to protect the potential victims [italics added]” (Appelbaum, 1985, p. 425).

Various writers on the subject of *Tarasoff* have defined the term therapist to include psychologists; counselors; child, marriage, and family therapists; and community mental health counselors. As Stone (cited in Waldo & Malley, 1992) noted,

> Many mental health professionals and paraprofessionals, including social workers, psychiatric social workers, psychiatric nurses, occupational therapists, pastoral counselors, and guidance counselors, provide some form of therapy. ... How many of these millions of therapist–patient contacts each year are intended to be covered by the court’s decision is unclear. (p. 59)
What Tarasoff Did Not Require

Researchers have looked extensively at what the Tarasoff ruling requires and does not require of mental health professionals. VandeCreek and Knapp (1993) addressed this issue head on:

Because the Tarasoff decision has been subject to so many misinterpretations, it is important to know what the Tarasoff court did not say. The court did not require psychotherapists to issue a warning every time a patient talks about an urge or fantasy to harm someone. On the contrary, the court stated that “a therapist should not be encouraged routinely to reveal such threats … unless such disclosure is necessary to avert danger to others” (Tarasoff, p. 347). Finally, the court did not specify that warning the intended victim was the only required response when danger arises; on the contrary, the court stated that the discharge of such duty may require the therapist to take one or more of various steps. (p. 6)

Post-Tarasoff

Since the Tarasoff trial, other courts have ruled that liability should not be imposed on the therapist if a victim was not identified (Thompson v. County of Alemeda, 1980). However, other courts have ruled that the potential victim need only be foreseeably identifiable (Jablonski v. United States, 1983) or that the danger need only be foreseeable (Hedlund v. Superior Court of Orange County, 1983; Lipari v. Sears Roebuck, 1980). Mental health professionals have been found liable for not using prior patient records to predict violence (Jablonski v. United States, 1983) and for keeping inadequate records (Peck v. The Counseling Service of Addison County, 1985). A Florida appellate court ruled that Tarasoff should not be imposed because the relationship of trust and confidence, necessary for the therapeutic process, would be harmed if mental health professionals were required to warn potential victims (Boynton v. Burglass, 1991).

It is the special relationship between mental health professionals and clients that sets the stage for therapist liability. The Tarasoff case is binding only in California, and it is impossible to predict what courts in other states will do. Some states have expanded the Tarasoff reasoning, whereas others have rejected it. However, as Appelbaum and Rosenbaum (cited in Monahan, 1993, p. 243) stated,

In jurisdictions in which appellate courts have not yet ruled on the question, the prudent clinician is well advised to proceed under the assumption that some version of Tarasoff liability will be imposed. The duty to protect, in short, is now a fact of professional life for nearly all American clinicians and potentially for clinical researchers as well.
Assessing Danger to Others

Appelbaum (1985) presented a model for fulfilling the Tarasoff obligation, urging that clinicians treating potentially dangerous patients undertake a three-stage process of assessment, selection of a course of action, and implementation.

1. The first stage, assessment of the patient, has two components:
   a. First, the therapist must gather the data to evaluate the level of danger.
   b. Second, he or she must make a determination of dangerousness on the basis of that data.

2. In the second stage, the clinician who has determined that a patient is likely to be dangerous must choose a course of action to protect potential victims.

3. In the third stage, the therapist must implement his or her decisions appropriately. This requirement has two components:
   a. First, the therapist must take action to protect potential victims.
   b. Second, he or she must monitor the situation on a continuing basis to assess the success or failure of the initial response, the likelihood that the patient will be violent, and the need for further measures (Applebaum, 1985, p. 426).

The First Stage: Assessment

Information needed to assess the level of anger can be found in the client’s past and current records or gathered in the counseling interview. The following questions and guidelines can be used to help determine the potential for violent behavior:

1. Does the client have a history of violent behavior? Past violence is the best predictor of future violence.
2. Does the client have a history of violent conduct with a previous assessment or diagnosis of mental illness?
3. Does the client have a history of arrests for violent conduct?
4. Does the client have a history of threats associated with violent conflict?
5. Has the client ever been diagnosed with a mental disorder for which violence is a common symptom?
6. Has the client had at least one inpatient hospitalization associated with dangerous conduct, whether voluntary or involuntary?
7. Does the client have any history of dangerous conduct, apparently unprovoked and not stress related?
8. If the client has a history of dangerous conduct, how long ago was the incident? The more recent the dangerous behavior, the more likely it is that the behavior will be repeated.
9. If you consider the client dangerous to someone else, note any threats and your observations and notify the person you think might be harmed. Those acts that have a high degree of intent or intensity are most likely to recur.
10. Determine if any serious threats, attempts, or acts harmful to others have been related to drug or alcohol intoxication.

11. Ask the client direct and focused questions, such as, “What is the most violent thing you have ever done?” and “How close have you come to becoming violent?” (Monahan, 1993, p. 244).

12. Use the reports of significant others. Often family members can provide valuable information about a client’s potential for violence. Again, ask direct questions, such as, “Are you worried that your loved one is going to hurt someone?” (Monahan, 1993, p. 244).

13. Has the client threatened others?
14. Does the client have access to weapons?
15. What is the client’s relationship to the intended victim(s)?
16. Does the client belong to a social support group that condones violence?

The Second Stage: Selecting a Course of Action

Once the mental health professional has assessed the danger a client poses to others, he or she must decide what to do. Use the following guidelines to help form an action plan:

1. **If you don’t consider the danger to be imminent, keep the client in intensified therapy.** Deal with the client’s aggression as part of the treatment. However, if the client does not adhere to the treatment plan—that is, if he or she discontinues therapy—the danger level should be considered higher.

2. **Invite the client to participate in the disclosure decision.** This process often makes the client feel more in control. It also is prudent to contact the third party in the presence of the client. This may vitiate problems of paranoia over what has been communicated.

3. **Attempt environmental manipulations.** Medication may be initiated, changed, or increased. Have the client get rid of any lethal weapons.

4. **Keep careful records.** When recording information relevant to risk, note the source of the information (e.g., the name of the spouse), the content (e.g., the character of the threat and the circumstances under which it was disclosed), and the date on which the information was disclosed. Finally, include your rationale for any decisions you make.

5. **If warning a third party is unavoidable, disclose only the minimum amount necessary to protect the victim or the public.** State the specific threat, but reserve any opinions or predictions.

6. **Consult with your supervisor.** Your agency or school should have a contingency plan for such problems that is derived in consultation with an informed attorney, an area psychiatric facility, and local police.
The Third Stage: Monitoring the Situation

You should constantly monitor any course of action to ensure that the objectives of the initial implementation are satisfied. Follow-up procedures should be scrupulously adhered to and well documented. The Harm to Others Form (Form 8.3), which can be used in the facilitation of the monitoring process, is included in the Forms section at the end of the book.

Patient’s Past Criminal Acts

Applebaum and Meisel (1986) reported that therapists’ legal obligations to report past criminal acts differ under state and federal laws. Under federal law, therapist obligations fall under a statute of “misprision of a felony.” Applebaum and Meisel noted these conditions as necessary to establish guilt for a misprision of a felony:

1. The principal committed and completed the felony alleged.
2. The defendant had full knowledge of the fact.
3. The defendant failed to notify authorities.
4. The defendant took an affirmative step to conceal the crime.

The mere failure to report the crime does not appear to meet the criteria of affirmative concealment. If the mental health professional is questioned by law enforcement officials, he or she must respond truthfully but is not obligated to break confidentiality; it does not appear that the mental health professional has an obligation to say anything at all. Few states have statutes addressing misprision of a felony. Most do require the reporting of gunshot wounds, child abuse, or other specified evidence of certain crimes. The strong trend is for courts to reject the crime of misprision (Applebaum & Meisel, 1986).

Child Abuse

School and mental health counselors frequently encounter cases of suspected child abuse. Approximately 5 million cases of child abuse were reported to child protective agencies during the year 2000 (Zerbe Enns, 2003). In addition, it can be conservatively estimated that at least five students have been or will be reported as being possible victims of abuse in a typical teacher’s classroom per year in the United States. The U.S. Advisory Board on Child Abuse and Neglect (1996) estimated that 18,000 children per year sustain permanent disabilities as a result of child abuse.

In addition, the 1999 position statement for the American School Counselor Association on Child Abuse and Neglect defined abuse as “the infliction of physical harm upon the body of a child by other than accidental means, continual
psychological damage or denial of emotional needs (i.e., extensive bruises/patterns; burn/patterns, lacerations, welts or abrasions, injuries inconsistent with information offered; sexual abuse involving molestation or exploitation; including but not limited to rape, carnal knowledge, sodomy or unnatural sexual practices, emotional disturbance caused by continuous friction in the home, marital discord, or mentally ill patient, and cruel treatment).83

Furthermore, neglect is defined as the failure to provide necessary food, care, clothing, shelter, supervision or medical attention for a child (i.e., malnourished, ill-clad, dirty, without proper shelter or sleeping arrangements, lacking appropriate health care, unattended, lacking adequate supervision, ill and lacking essential medical attention; irregular or illegal absences from school; exploited, overworked, lacking essential psychological nurturing; abandonment.

**Recognizing Child Abuse**

**The Child**

You should consider the possibility of abuse when the child

- shows sudden changes in behavior or school performance;
- has not received help for physical or medical problems brought to the parents' attention;
- has learning problems that cannot be attributed to specific physical or psychological causes;
- is always watchful as though preparing for something to happen;
- lacks adult supervision;
- is overly compliant, an overachiever, or too responsible; or
- comes to school early, stays late, and does not want to go home.

**The Parent**

You should consider the possibility of abuse when the parent

- shows little concern for the child, rarely responding to the school's request for information, for conferences, or for home visits;
- denies the existence of or blames the child for the child's problems in school or at home;
- asks the classroom teacher to use harsh physical discipline if the child misbehaves;
- sees the child as entirely bad, worthless, or burdensome;
- demands perfection or a level of physical or academic performance the child cannot achieve; or
- looks primarily to the child for care, attention, and satisfaction of emotional needs.
The Parent and Child

You should consider the possibility of abuse when the parent and child

- rarely touch or look to each other,
- consider their relationship entirely negative, or
- state that they do not like each other.

None of these signs proves that child abuse is present in a family. Any of them may be found in any parent or child at one time or another; but when these signs appear repeatedly or in combination, they should cause the educator to take a closer look at the situation and to consider the possibility of child abuse. That second look may reveal further signs of abuse or signs of a particular kind of child abuse.

Signs of Physical Abuse

Consider the possibility of physical abuse when the child

- has unexplained burns, bites, bruises, broken bones, or black eyes;
- has fading bruises or other marks noticeable after an absence from school;
- seems frightened of the parents and protests or cries when it is time to go home from school;
- shrinks at the approach of an adult; or
- reports injury by a parent or another adult caregiver.

Consider the possibility of physical abuse when the parent or other adult caregiver

- offers conflicting, unconvincing, or no explanation for the child's injury;
- describes the child as “evil” or in some other very negative way;
- uses harsh physical discipline with the child; or
- has a history of abuse as a child.

Signs of Neglect

You should consider the possibility of neglect when the child

- is frequently absent from school;
- begs or steals food or money from classmates;
- lacks needed medical or dental care, immunizations, or glasses;
- is constantly dirty or has severe body odor;
- lacks sufficient clothing for the weather;
- abuses alcohol or other drugs; or
- states that there is no one at home to provide care.
You should consider the possibility of neglect when the parent or caregiver

- appears to be indifferent to the child,
- seems apathetic or depressed,
- behaves irrationally or in a bizarre manner, or
- is abusing alcohol or other drugs.

**Signs of Sexual Abuse**

You should consider the possibility of sexual abuse when the child

- has difficulty sitting or walking;
- suddenly refuses to change for gym or to participate in physical activities;
- demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior;
- becomes pregnant or contracts a venereal disease, particularly if younger than 14 years of age;
- runs away; or
- reports sexual abuse by a parent or another adult caregiver.

You should consider the possibility of sexual abuse when the parent or caregiver

- is unduly protective of the child and severely limits the child's contact with other children, especially of the opposite sex,
- is secretive and isolated, or
- describes marital difficulties involving family power struggles or sexual relations.

**Signs of Emotional Maltreatment**

Consider the possibility of emotional maltreatment when the child

- shows extremes in behavior, such as overly compliant or demanding behavior, extreme passivity, or aggressiveness;
- is either inappropriately adult (e.g., parenting other children) or inappropriately infantile (e.g., frequently rocking or head banging);
- is delayed in physical or emotional development;
- has attempted suicide; or
- reports a lack of attachment to the parent.

Consider the possibility of emotional maltreatment when the parent or other adult caregiver

- constantly blames, belittles, or berates the child;
- is unconcerned about the child and refuses to consider offers of help for the child's school problems; or
- overly rejects the child

Permission to reprint granted by Prevent Child Abuse America.


**Reporting Child Abuse**

Mandated reporters usually are professionals who interact with children in the course of their work. The Federal Child Abuse Prevention and Treatment Act requires that sexual, physical, and mental exploitation of children be reported. *Any circumstance that indicates serious harm or threat to a child's welfare must be reported.* Suspicion alone may not be obligatory. The existence of a *reasonable cause* to believe or suspect triggers the mandate (Besharov, 1988). “Reasonable” is what any prudent professional would do in the situation.

Confidentiality and privileged communication are not legal reasons for failing to report abuse. The laws against child abuse supersede the laws of privilege and the ethical mandates of confidentiality. If the abuse is reported in good faith, most states do not allow retribution; that is, the mental health professional cannot be sued for defamation of character even if the abuse is unfounded.

Child abuse must be reported even if the child does not want it reported and even if the mental health professional does not feel it is in the best interest of the child to do so (Weinstock & Weinstock, 1989). Most states do not have a statute of limitations on child abuse cases, unless the abuse was reported before and the charges were dismissed. “This seems to mean that the mental health professional must report abuse that occurred many years ago” (Swenson, 1997, p. 414). Liability has been imposed on mental health professionals for damages caused by not reporting child abuse (Schroeder, 1979).

Therapists who decide to file a child abuse report typically do so by calling the appropriate social service agency. They must file a written report subsequent to the call. A caseworker will be assigned to the case by the child protective services agency. If the caseworker finds probable evidence that neglect or abuse has occurred, he or she refers the case to a law enforcement agency. At that point, the state either begins a criminal prosecution or takes a civil action. If someone other than a parent or caretaker accuses a parent of sexually abusing a child, authorities may initiate both criminal and civil proceedings simultaneously (Buckley, 1988).

A Child Abuse Reporting Form (Form 8.4) is included in the Forms section. This asks the therapist to record basic information required to make an initial call to the authorities and to file a formal written report. The Child Abuse Reporting Form shows the required information a counselor needs to have prior to filing a report of child abuse.

**Interviewing Children Who May Have Been Sexually Abused**

Therapists working with young children on possible sexual abuse must be aware that the language, cognition, and logic systems of children are different from those of adults; in other words, children are not miniature adults. A child’s vocabulary is much more limited, which means that children understand much more than they can say. Counselors must learn specific interviewing techniques
and clinical skills to work with young children. For instance, the use of pronouns, double negatives, and compound sentences should not be employed in the interview. Instead, the counselor should focus on familiar events; for example, “Did this take place after your birthday or before your birthday?”

Children remember what happened, but their causal connections are not the same as those of adults. If they have been sexually abused, they may think (indeed, they most often do) that they caused the abuse. In addition, children often are afraid they will no longer be loved; are guilty, ashamed, and afraid they will get into trouble; and may even fear harm or death (their own or others’) if the sexual abuse is disclosed.

**Before the Interview**

It is not possible to predetermine how long the interview should be. The ideal time is one that allows the truth of the matter to purge itself. The therapist should have information pertinent to the history of the case before starting the interview. Information such as the child’s name, nicknames, family members’ names, and when and where the disclosure was made will contribute to the counselor’s efficacy before and during the interview.

**Interviewing the Child**

The main ingredient for veracity in an interview is the introduction of support and rapport. Casual clothes are appropriate most of the time. Anatomically correct dolls, hand puppets with mouths that open, and coloring paper and crayons should be immediately accessible. It is important that the therapist appear to be on the same level as the child. This requires an atmosphere that is comfortable. The counselor should be able to get down on the floor or on a pillow and make eye contact with the child. Eye contact is essential when communicating to a child that he or she is not at fault and that what happened was an injustice of the worst type. It is important to remember that the effects of sexual abuse are pervasive and emotionally difficult for the rest of the child’s life.

The interviewer must not overreact to any statements the child makes. Some interviews may include interested third parties. The third party may even be the perpetrator or someone from whom the child is keeping a secret. Third parties should be directed to go to the side of the room, where they are not directly part of the interview. The therapist should arrange the parties so that eye contact is not possible between the child and adult. Above all, third parties must be instructed that they are not to be part of the interview.

Therapists must be careful not to ask leading questions. Brainer, Reyna, and Brandse (1996) reported how easy it was to implant memories of events that never happened in 5- to 8-year-old children by suggestion alone. What is more, the implanted false memories often were remembered in more detail than real
memories. The biggest danger in examinations of potential sexual abuse is the interviewer who asks leading questions. Questions should be specific; most important, they should not suggest an answer. Questions such as “Is it true your Uncle John did this to you?” are leading and may put pressure on the child to answer affirmatively.

If the child says, “Uncle John touched me,” a more appropriate response would be “Where did Uncle John touch you?” Asking, “Did he touch you on your private parts?” is leading the child. Interviewing children is a clinical art form; mental health professionals who conduct such interviews should receive considerable supervised training in this area.

**Counseling the Sexually Abused**

Harrison (2001) discussed several general considerations for therapy with sexual abuse survivors.

1. On the basis of statistics, survivors of sexual abuse are probably telling the truth, so the counselor begins treatment with each client by adopting this assumption.
2. It is not the survivor's fault in any way. The responsibility for the assault or abuse rests solely with the perpetrator.
3. The counselor's initial goal is help the survivor regain a sense of personal control. He or she has had personal power taken away in a manner that affected him or her emotionally, physically, and spiritually.
4. Secondary goals of therapy include building self-esteem, moving toward autonomy, and training in coping skills, anger management, and assertive skills aimed at prevention of sexual abuse in the future (pp. 91–92).

Harrison (2001) further suggested an expansive list of dos and don'ts of therapy. The list was compiled using content from the Minnesota Coalition Against Sexual Assault (1994), Mosak (1977), and Slavik, Carlson, and Sperry (1993).

1. Do ensure a safe environment and presence in sessions. If it appears that the abuse is ongoing, enlist help from the appropriate social service agencies to remove the client from an abusive environment so that healing may begin.
2. Do return a sense of control by encouraging clients to solve problems, elicit new choices, and then trust their own judgments to arrive at their own decisions. Also distinguish between then, when the client felt helpless during the sexual abuse, and now.
3. Do not minimize the client's experience. A client once said that a previous therapist’s reaction had been to say, “Well, at least he didn't beat you up when he raped you.”
4. Do listen to, support, acknowledge, and validate feelings.
5. Do not be a caretaker or rescuer.
6. Do not address the myths about sexual abuse and reeducate clients, especially the prevalent myth that victims are at least partially to blame for the sexual abuse.
7. Do trust the healing and support process, and ask a client to do so, reminding his or her that the time frame will vary with each individual.
8. Do model setting boundaries, for example, by starting and stopping sessions on time.
9. Do be aware of your own blind spots and question your assumptions.
   Don’t assume that the perpetrator was of the opposite sex or that the act involved penetration.
10. Don’t judge or use a patronizing manner. Many clients who have been sexually abused have later become very sexually active, some involved in group sex, pornography, and prostitution. If you see yourself as on the same plane as your client, then you will not be patronizing. Many clients verbalize that they take little or no enjoyment in sex, even with a caring partner, yet they feel obligated to perform sexual acts. You must be aware that this hypersexual behavior is based not on self-gratification but on mistaken ideas.
11. Do confer with colleagues and practice self-care.
12. Do listen with a calm curiosity about the sexual assault or abuse when the client is ready to discuss it.
13. Do accept unconditionally the client’s ambivalent feelings about discussing the abuse.
14. Do not treat the revelation of sexual abuse as a crisis, because it is important that clients see themselves as having survived something that happened in the past and that they are now able to move forward toward their goals.
15. Do see clients as capable of new ways of thinking, feeling, and acting and expect them to be competent and creative.
16. Do not see clients as fragile, although they may act as if they are.
17. Do help clients get in touch with unexpressed anger to combat depression and teach them how they make choices about using their anger constructively rather than destructively.
18. Do help clients to redefine themselves apart from their role relationships and to explore fears about potential role changes.
19. Do encourage clients to nurture themselves, and reframe this self-focus as essential to healing, not as selfish.
20. Do be specific in giving positive feedback. Note any improvement in grounding skills, especially with a client who may experience either dissociative states or flashbacks. Other examples might include client’s improvement in “discussing goals” and determining an issue on which to work, bodily awareness, interpersonal skills, keeping social supports, work skills, and parenting skills (Slavek et al., 1993, p. 114).
The Counselor and the Substance Abusing Client

Understanding Addiction

Alcohol and drug use occur along a continuum. Not everyone who uses substances is addicted. Levels of use generally are identified as use, abuse, and dependence.

Addiction to alcohol and drugs may be physical or psychological. Physical dependency refers to physical changes in the body, such as tolerance or withdrawal. The symptoms of physical dependency vary by type of drug used. Psychological dependency refers to the perceived need for the alcohol and drugs to feel good, function, or keep from feeling bad.

Poly drug use (more than one drug, or alcohol and drugs combined) is a common pattern of use among substance abusers.

Alcohol and drug addiction are diseases that over time cause changes in the person's body, mind, and behavior, and the individual is unable to control his or her use of substances despite the harm that it causes. The chronicity and relapsing of the disease means that addictions are never cured and that substance use may persist or reappear over the course of an individual's life (Breshears et al., 2004).

Alcohol and Drug Abuse

The abuse of alcohol or drugs includes the occurrence of at least one of these factors in the past 12 months:

- recurrent substance use resulting in failure to fulfill obligations at work, home, or school;
- recurrent substance use in situations that are physically hazardous;
- recurrent substance-related legal problems; or
- continued substance use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the substance (American Psychiatric Association, 2000).

Dependence, also known as addiction, is a pattern of use that results in three or more of the following symptoms in a 12-month period:

- tolerance, or the need for more of the drug or alcohol to get high;
- withdrawal, or physical symptoms that occur when alcohol or drugs are not used, such as tremors, sweating, nausea, and shakiness;
- the substance is taken in larger amounts and over a longer period than intended;
- a persistent desire or unsuccessful effort to cut down or control substance use;
- a great deal of time is spent in activities related to obtaining the substance, use of the substance, or recovering from its effect;
important social, occupational, or recreational activities are given up or reduced because of substance use; or

- substance use is continued despite knowledge of persistent or recurrent physical or psychological problems caused or exacerbated by the substance.

Substance abuse is a pattern of substance use that results in at least one of four consequences:

1. failure to fulfill role obligations,
2. placing one in danger (i.e., driving under the influence),
3. legal consequences, or
4. interpersonal and social problems.

Substance dependence is a pattern of use that results in at least three of seven criteria:

1. tolerance,
2. withdrawal,
3. unplanned use,
4. persistent desire or failure to reduce use,
5. a great deal of time spent using,
6. activities sacrificed so one can use, or
7. physical or psychological problems related to use (Breshears, Yeh, & Young, 2004).

What Is Treatment?

A number of alcohol and drug treatment models are used successfully; treatment can include a variety of services and activities. Levels of treatment can range from outpatient, day treatment, and short- and long-term residential programs to inpatient hospital-based programs. Prior to beginning treatment, some individuals require detoxification and stabilization. Other individuals may need outreach services to help overcome barriers to treatment. Treatment may involve a single service or a combination of therapies and services. The following is a partial list of treatment services:

- assessment and treatment planning;
- prescription of certain drugs, such as antabuse for alcohol dependence or methadone and buprenephrine for heroin addiction;
- crisis intervention;
- case management to coordinate among the treatment providers;
- individual and group counseling and psychotherapy;
- alcohol and drug abuse recovery programs;
- medical assessment and care;
diet, physical exercise, and other nontraditional programs;
- self-help groups or 12-step programs; or
- trauma-specific services or other mental health services.

The duration of treatment can range from weeks to years. The type, length, and intensity of treatment is determined by the severity of the addiction, type of drugs used, support systems available, personality, and other behavioral, physical, or social problems of the addicted person. It is important to think about treatment as management of a lifelong disease such as diabetes or high blood pressure rather than as crisis intervention such as emergency treatment for a broken leg. The treatment plan should be developed based on information gathered in the substance abuse assessment process (Breshears, Yeh, & Young, 2004).

The National Institute on Drug Abuse has developed a number of research-based treatment principles that are important to the recovery process:

- No single treatment is appropriate for all individuals. Treatment and services should be matched to the person’s problems and needs.
- Treatment needs to be readily available.
- Effective treatment attends to multiple needs of the individual, not just to her or her drug use.
- Medical, psychological, social, vocational, and legal problems must be addressed in addition to substance addiction.
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
- Treatment does not need to be voluntary to be effective. Court-ordered treatment, an employment mandate, or family insistence can increase treatment entry, retention, and success.
- Possible drug use during treatment must be monitored continuously. Monitoring can help reduce desire to use and provide early warning of use if a slip or relapse occurs.
- Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, and counseling to help patients modify or change behaviors that place them or others at risk for infection.
- Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment. Relapses often occur during or after successful treatment episodes. Relapse prevention plans, self-help groups, and other supports can help minimize relapse and support abstinence.

What Is Recovery?

Treatment does not equal recovery. Treatment is an important part of recovery, but recovery is much more than obtaining sobriety. Recovery is a process of making lifestyle changes to support healing and to regain control of one’s life. Recovery involves being accountable and accepting responsibility for one’s
behavior. It is the process of establishing and reestablishing patterns of healthy living. Former addicts talk about being “in recovery” as opposed to having “recovered,” because recovery is viewed as an ongoing process. Persons in recovery monitor their feelings, physical changes, and relationships to make healthier choices and to reduce the risk of relapse. Hence the Alcoholic Anonymous adage, “Recovery happens one day at a time … for the rest of your life.”

**Stages of Recovery**

There are different stages of recovery. A person who has been drug free for a week and one who has been drug free for a year experience different issues. Recovery is complicated. It may be helpful to view recovery as a developmental process. The developmental model of recovery describes stages and tasks as part of recovery:

- **Transition**: The person recognizes that his or her attempts to control substance use are not working.
  - **Stabilization**: The person goes through physical withdrawal and begins to regain control of his or her thinking and behavior.
  - **Early recovery**: The person changes addictive behaviors and develops relationships that support sobriety and recovery.
  - **Middle recovery stage**: The person builds a more effective lifestyle and repairs lifestyle damage that occurred during substance use.
  - **Last recovery stage**: The person examines his or her childhood, family patterns, and beliefs that supported a dysfunctional lifestyle, and the person learns to grow and recover from childhood and adult trauma.
- **Maintenance stage**: The person learns to cope in a productive and responsible way without reverting to substance use.

**Assessment Instruments**

Mental health professionals who counsel clients for psychoactive substance pathology may find it useful to acquaint themselves with standardized assessment instruments as an adjunct to clinical interviews and observation. Two instruments that have good reliability and validity and that can be scored and interpreted quickly are the *Drug Abuse Screening Test–20* (DAST-20; Skinner, 1982) and the *Addiction Severity Index* (ASI; McClellan, Luborsky, & Cacciola, 1985; Orvaschel, 1993).

The DAST-20 is a 20-item self-report inventory that provides a quantitative index of the degree of consequences and severity of drug abuse. The DAST-20 yields a total cumulative score with severity intervals (i.e., *none*, *low*, *moderate*, *substantial*, and *severe*).

The ASI is a structured interview instrument that provides a multidimensional assessment of degree of impairment in various areas due to substance use.
Guidelines for Interns Working With Special Populations and Crisis

(medical, employment, severity of chemical use, family/social relationships, and legal and psychiatric status).

The ASI requires both administration and interviewer severity rating skills; therefore, counselors must have adequate training to use this instrument. The DAST-20, on the other hand, requires only a tabulation of item scores, and the interpretation is objective. Although neither instrument is independently adequate to provide an accurate diagnosis, both are valuable tools for gleaning additional information as well as for identifying specific areas for treatment focus.

A Substance Abuse Assessment Form (Form 8.5) is included in the Forms section at the end of the book. This form provides questions for the student or intern to use when working with substance abusing or dependent clients. The form also includes a confidential informed release statement, which should be signed by the client prior to the therapist's disclosing any confidential information to a third party.

Counseling Recommendations

It is important for counselors who work with substance abusing or dependent clients to adopt an objective and factual approach to assessment interviews. As many clients enter treatment for substance-related problems because of external pressures (i.e., family, employers, the legal system), the counselor must convey an impression that he or she is an ally to the client in addressing his or her problems. In asking assessment questions, the counselor should use the objective criteria as a guideline and proceed in a nonjudgmental and matter-of-fact way. He or she should avoid asking leading questions such as, “You don't abuse drugs or alcohol, do you?” (Bukstein, 1990).

Initial interviewing goals include establishing a flow of information and disclosure about the client’s level of motivation for treatment and obtaining the necessary information to formulate an objective impression.

The mental health professional must realize that substance abusing clients frequently enter treatment with a strong sense of ambivalence, which affects treatment motivation. The key to working through ambivalence is to foster engagement and trust as early as possible, which can be done by discussing treatment ambivalence and emphasizing the client’s presenting negative consequences from substance use.

The counselor should relay the results of the assessment interview to the client in the same objective fashion and emphasize that the assessment is based on the information the client provided and from data from assessment instruments. This process may help the client work though treatment resistance as well as reinforce the therapeutic alliance. Below are some general guidelines for working with substance abusing clients:
1. **Understand the emotional role the substance of choice plays for the client.**
   A central challenge for the counselor is to identify the client’s rationale for using a mood-altering substance. Almost invariably that rationale has an affective base (i.e., substance use to avoid or escape negative situations or to acquire a desired affective state). Once the affective motivation is established, the counselor can undertake treatment to develop adaptive coping responses. As depth-psychology-oriented treatment may be difficult with substance dependent clients because of relapse risk, therapists should be cautious in immediately addressing traumatic issues if the client has had only a brief period of abstinence or if affect tolerance or modulation appears tenuous.

2. **Identify the internal and external triggering events for substance cravings and impulses.** Substance using impulses often are precipitated by events that may or may not be evident to the client. The counselor needs to detect the internal (i.e., thoughts, feelings, memories, attitudes) and external (i.e., interpersonal conflicts, social isolation, interpersonal/existential losses) antecedents for the client’s substance use impulses and cravings. Helping the client identify these triggers when they occur allows him or her to implement substance-avoidance behaviors. Once substance triggers are identified, specific operationalized behavior plans for coping with them can be constructed.

3. **Confront internal versus external locus of control regarding substance using behaviors.** Many substance abusing clients rationalize their substance use by either relinquishing responsibility for control (“I can’t help it”) or externalizing control over their behavior (“My boss makes me use—he’s so demanding”). The counselor must confront the client by reflecting that he or she ultimately chooses to use a substance regardless of the circumstances. Once clients accept this reality, controlling the impulses to use becomes a treatment focus.

4. **Challenge substance-dependence-reinforcing cognitions (i.e., beliefs and thinking styles).** Many substance abusing clients present belief systems that reinforce chemical dependency (“Without my crack, I can’t deal with life” or “I need a drink to control myself”). The counselor should challenge such maladaptive cognitions.

5. **Help the client learn and apply abstaining behaviors.** Coping with cravings and impulses is a vital therapeutic goal. A useful resistance skill is for the client to focus on previous negative consequences of substance use when he or she experiences cravings or impulses. This technique shifts the psychological focus from the desired and expected immediate mood-altering effect to the association of the substance with emotionally negative events. This technique of “thinking the craving through” can divert clients from impulsiveness and make them aware of adaptive options. Counselors should review with clients the distinctions between thinking, feeling, and doing (physical action). Clients need to realize that they can have substance-oriented cravings and impulses and not carry them out.
6. **Practice therapeutic rather than antagonistic confrontation.** As treatment engagement on the part of the client is critical, the counselor must be careful not to confuse confrontation with intolerance. Therapeutic confrontation occurs when the counselor presents the client with concrete examples of clinical material representative of the disorder. Therapeutic confrontation is based on objective data or behavior that the client presents, not on a conflict of personal values. Attempts to impose guilt or shame on the client increase the potential for treatment dropout. Reflecting clinical observations back to the client in a nonthreatening and constructive way increases the probability that the client will accept and work with the intervention.

7. **Establish healthy developmental goals.** An important part of counseling substance abusing clients is addressing the frequent developmental disturbances that accompany maladaptive patterns of substance use (dropping out of school, getting fired from jobs, having family disruptions, etc.). Part of the treatment plan should include a return (perhaps gradually) to normal and productive functioning. Frustration and anxiety tolerance may be a central focus, depending on the severity and duration of psychosocial disturbances.

**Preventing Relapse**

Relapse prevention is defined as “a self-management program designed to enhance the maintenance stage of the habit-change process” (Marlatt, 1985a, 1985b). Behaviorally, relapse prevention can be seen as one set of operationalized target behaviors implemented and practiced consistently over time that results in another set of targeted undesired behaviors being discontinued. Below are some general framework suggestions for an operationalized psychoactive substance relapse prevention program:

1. **Help the client identify high-risk situations.** High-risk situations may include attending social events where substance use is prominent or spending time at places where substances are readily available. Being aware of high-risk situations alerts the client to consider avoidance or to apply specific behavior plans for increasing controls to maintain abstinence.

2. **Help the client make necessary lifestyle changes and relationship modifications.** The client must gain awareness of specific lifestyle behaviors (theft, prostitution, drug sales, etc.) that are specifically related to the substance using pattern. Often the client must change those behavior patterns to maximize the prognosis for abstinence. Likewise, specific relationships that reinforce substance use must be confronted, modified, or even discontinued until the client has gained sufficient behavioral and impulse controls to withstand the influence of others who advocate substance use.

3. **Reduce access to psychoactive substances.** A strategic component of relapse prevention is reducing access to psychoactive substances. This may occur
by removing psychoactive substances from the client’s residence, eliminating routine purchases of substances (alcohol), or identifying specific places (high-risk situations) where substances are readily available or promoted.

4. **Address any underlying psychopathology.** Untreated psychiatric disorders (or psychopathology) constitute one of the most common reasons for psychoactive substance relapse (McClellan, 1986). Mood, anxiety, or personality disorders or other forms of psychopathology that persist into the abstinence period should be formally evaluated and treated. Using simultaneous combination treatments (psychotherapy, pharmacotherapy, family therapy, and self-help groups) may be most advantageous.

5. **Help the client rebound from a relapse.** Relapses happen; in specific patient subtypes (i.e., severe personality disorders, untreated mood or anxiety disorders), they may be common. The counselor must be clinically prepared for relapse and assure the client that a relapse should not be viewed fatalistically but rather as a mistake with the current treatment focus. The client should be encouraged to resume abstinence and to gain an understanding of the dynamics of the relapse. Relapses can be used as restarting points in treatment if therapeutic engagement is maintained.

**Conclusion**

The etiology of substance abuse disorders is not clear. Genetic disposition, underlying pathology, personality and environmental factors, impulse or behavior disorders, and other biopsychosocial factors are some of the reasons given for substance abuse. Mental health professionals should strive to understand the emotional role the substance of choice plays for the client, identify internal and external triggering events, and help the client learn and apply abstaining behaviors.

**Crisis Intervention**

Crisis intervention first appeared in the literature in the 1940s. Eric Lindeman studied the grief reactions of victims in the famous fire at the Coconut Grove in Boston, Massachusetts. Later, Lindeman and Gerald Caplan established a community-based mental health program in Cambridge, Massachusetts, named the Wellesley Project (Kanel, 1999).

Crisis intervention, along with the movement aimed at providing mental health services support, evolved with the passage of the Community Mental Health Centers Act of 1963. The act was designed to serve chronic mental health patients. The Lanterman Petris Short Bill of 1968 established specific requirements for the provision of mental health services in the community. The focus of the bill was short-term crisis intervention for clients who were not chronically mentally ill. Today, crisis intervention is an established practice in most community agencies.
The following sections are examples of three models of crisis intervention that will provide a representative sample of crisis intervention models and the critical stages in crisis intervention.

**Crisis Intervention: The Kanel Model**

The ABC model of crisis intervention (Kanel, 1999) is a method of conducting very brief mental health interviews with clients whose functioning level has decreased following a psychosocial stressor. It is a problem-focused approach and is effectively applied within 4 to 6 weeks of the stressor. Kanel’s model is designed around three specific stages: (A) developing and maintaining contact, (B) identifying the problem, and (C) developing coping strategies for the client. The following is a summary of the key points of the ABC model:

A. *Developing and maintaining contact:* Essential to the establishment of crisis intervention strategies is the development of rapport with the client. Like in any other counseling interview, the client must feel understood and accepted by the counselor before the client has a willingness to trust and effectively communicate. It is in this phase that counselors are reminded of the effectiveness of the basic attending skills learned early in their training programs. These skills include eye contact, body posture, vocal style, warmth, empathy, and genuineness. Skill in the use of open and closed questions and the skills of clarifying, reflecting, and summarizing are all used to develop and maintain contact with the person in crisis.

B. *Identifying the problem:* By identifying the precipitating event, the counselor can gain information regarding the trigger(s) of the client’s crisis. The actual cause of the crisis can vary from a recent event to an event that occurred several weeks or even months ago. The time of the event—the beginning of the crisis—is important to determine. Kanel uses the following diagram to illustrate the process of crisis formulation:

```
Precipitating Event —— Perception —— Subjective Distress ——
Lowered Functioning
```

- *Perception of the event:* How the individual views the stressful situation causes him or her to be in a stressful state. The meaning and assumptions the person makes about the crisis event serve to color and magnify the meaning for the client. Careful perception checking of the client’s view of the precipitating event must be thoroughly considered.

- *Subjective distress:* The level of distress experienced by the client is an essential area of inquiry. Symptoms can effect academic, behavioral, occupational, social, and family functioning. Discussing the affected functional area(s) and the degree to which the crisis event affects them is crucial (Kanel, 1999, pp. 64–82).
Lowered functioning: It is essential that pre- and postlevels of functioning are understood so that the counselor can ascertain the client’s realistic level of coping and the severity of the crisis to the person.

C. Developing coping strategies of the client: The counselor assesses the past, present, and future coping behaviors of the client. Included in such an assessment are the client’s unsuccessful coping strategies so that alternate coping strategies can be developed. Clients are encouraged to propose their own coping strategies in addition to learning the new or alternative strategies proposed by the counselor.

Crisis Intervention: The Gilliland and James Model

Gilliland and James (1997), in their textbook Crisis Intervention Strategies, defined crisis as a perception of an event or situation as an intolerable difficulty that exceeds the person’s resources and coping mechanisms. Unless the person obtains relief, the crisis has the potential to cause severe affective, cognitive, and behavioral malfunctioning.

Gilliland and James suggested that the three models of crisis intervention discussed by Leitner (1974) and Belkin (1984) serve as a foundation for most intervention strategies. The following is a summary of those three models:

- **The Equilibrium Model**: This model suggests that people in crisis are in a state of disequilibrium, and as a result the coping mechanisms they usually employ fail to meet their needs. The equilibrium model seems most appropriate in the beginning of a crisis, when the person is out of control, disoriented, and unable to make good choices. The focus is on stabilizing the individual (Gilliland & James, 1997, p. 22).

- **The Cognitive Model**: This model maintains that crises are rooted in faulty thinking about the events or situations that surround the crisis. The major point is that people can gain control of their lives by correcting this faulty thinking. The model’s tenets are found in the works of rational-emotive and cognitive therapists.

- **The Psychosocial Model**: This model assumes that individuals are products of their heredity endowment coupled with the learning they have absorbed from their social environment. The goal is for the therapist to collaborate with the individual in his or her assessment of the internal and external difficulties contributing to the crisis and to obtain workable alternatives to problems.

The following is a summary of the six-step model of crisis intervention developed by Gilliland and James (1997):

1. **Build a helping relationship**: The counselor needs to develop an understanding of the events that precipitated the crisis and the meaning that it has for
the client. It is therefore essential that a helping relationship be established. The use of basic attending skills with empathy, positive regard, and concreteness, coupled with the counselor’s calm and direct approach, can help the client see that something is being done to alleviate the problem.

2. **Assure safety**: Assessing how dangerous the client is to himself or herself or to others is one of the first concerns in crisis intervention (Aguilera, 1988). The myriad reasons why the client comes to the counseling office need to be explored. Suicidal ideation, homicidal ideation, danger from a third party, and fear of being harmed are potential reasons. It is essential that direct questioning focus on these possible motivators. Having determined the client’s risk, the counselor can then, if needed, involve others, seek the support of family and friends, hospitalize the client, and protect intended victims. In conducting an assessment, the counselor inquires as to the event that precipitated the crisis, the meaning it has for the client, the support systems available to the client, and the level of functioning prior to the crisis (Aguilera, 1998). Aguilera further suggested that the assessment process begins with a direct question that elicits the client’s reasons for coming to counseling, such as “What happened today?” and “Why today?” The counselor needs to determine what may have been the “last straw” for the client. Proceeding with the techniques of concreteness, leading, structuring, and questioning, the counselor can narrow the focus to the precipitating event. Determining what the client is feeling (rage, confusion, anger, hopelessness) gives the counselor an understanding of the meaning that the crisis event had for the client. Once the meaning is understood, it is necessary, according to Roberts (1990, p. 12), to listen for and to note cognitive distortions, overgeneralizations, misconceptions, and irrational belief statements. Attention should focus on the client’s physical appearance, behavior, mood, and any signs of distress. These are keys to recognizing the degree of client preoccupation with the crisis event. In addition, the counselor must assess the client’s coping mechanisms, decision-making skills, and stress management skills. A knowledge of the client’s precrisis level of coping will help in the selection of strategies and interventions with the greatest potential for success.

3. **Give support**: It is essential to assess the client’s support systems. The client who has inadequate support in his or her environment needs support from someone who cares about him or her. Seeking out these individuals is imperative to provide the needed environmental support. Unfortunately, if the client lacks supportive people in his or her life, then it is essential that the counselor communicate support to the individual. Providing the client with emergency contacts and phone numbers is critical.

4. **Examine alternatives**: The counselor helps the client explore a wide variety of available options. Often, the client feels as though there are no available options. However, it is not necessary to provide the client with a multitude of options. It is more effective to discuss options that are reasonable, appropriate, and realistic to the client’s situation.
5. Assist with an action plan: The counselor can lessen the client’s apprehensions and fears about what can be done to solve or cope with the problem. The counselor must tenaciously hold the client’s attention on one problem whose moderation will begin to restore equilibrium. The counselor attempts to get the client to look at possible alternatives or solutions. It is also helpful to elicit from the client precrisis coping strategies that can then be modified. The counselor can help in the selection and generation of positive strategies for the client. Before ending the crisis session, the counselor must assess the degree to which the client understands and can describe the action plan that has been developed. It is important to remember that client ownership of the plan is crucial. Clients need to feel autonomous and powerful in their action planning.

6. Obtain commitment: The counselor demonstrates the need to carry out the action plan. Commitment should go well if the previous steps have been carried out successfully. Follow-up contact or telephone contact with the client will aid the counselor in determining the client’s status, whether or not the action plan has been implemented, and the degree to which the client has progressed toward a resolution.

Crisis Intervention: A Model for Teachers

Callahan (1998), in an article titled “Crisis Intervention: A Model for Teachers,” discussed the need for teachers to engage in crisis intervention. The following is an adaptation of that article.

Callahan felt that teachers are in a unique position to gather information and note danger symptoms of children who are prone to violence. Information and hunches should be passed on to other teachers, counselors, and administrators who may be able to observe and take the necessary action when violence is about to erupt (Callahan, 1998, p. 227). Accordingly, teachers need to understand acting out and how to manage aggressive behavior. Similarly, the teacher must know that when an individual hits a state of disequilibrium (lack of judgment and control), his or her body is in a defensive state of readiness to attack or flee. Normal processes, such as the ability to hear, think logically, and react normally, may be limited, and the more upset an individual is, the less likely it is that the individual will be able to respond to others. When a person in crisis becomes alarmed and moves into a resistance stage, the person is closer to acting out and becoming unmanageable (p. 228). Callahan suggested that teachers need to understand this response and conduct an immediate assessment of the student and the situation. Callahan also cited the suggestions of Greenstone and Leviton (1993) with respect to assessing the situation and problem of a student in crisis:

1. The teacher should assess the situation to determine what is troubling the student, at this time, by engaging the student in conversation about what is
going on. The teacher needs to keep a reasonable, controlled, matter-of-fact tone during the discussion.

2. The teacher should attempt to discover specifically what is leading the student into crisis right at this time.

3. The teacher should determine the most pressing problem or need from the student’s point of view and remember to always keep the student’s subjective interpretation in mind and never negate or belittle any problems presented by the student in crisis.

4. The teacher should outline those problems that can be immediately managed.

5. The teacher should think through variables that might hinder the problem-solving process.

6. The teacher should ask what can be done most effectively in the least amount of time to diffuse the crisis situation.

7. The teacher should understand the similarities between the present situation and previous incidents of stress.

Callahan (1998) suggested further that if a crisis is occurring outside the classroom, the teacher should follow safety guidelines, which include the following:

1. The teacher should intervene with a partner, especially if there is more than one person involved in the crisis.

2. The teacher should approach the crisis situation slowly and judiciously.

3. The teacher should help the student(s) involved in the crisis with the student positioned in front of him or her and should not turn his or her back on the student in crisis.

4. The teacher should visually check out the person to determine if there is any weapon available.

5. The teacher should note any objects that could be used as a weapon.

6. The teacher should be prepared for unexpected behavior.

7. The teacher should note entrances and exits in the area. If the situation turns to violence or becomes dangerous, the teacher may need to escape or herd other students to safety.

8. The teacher should remove audiences from escalating situations when possible. A crowd may be egging on a fight or causing a person to act out or save face. If possible, the teacher should separate any students who are having a problem by establishing authority with onlookers and then moving into a position to catch the attention of the student(s) in crisis.

9. The teacher should know where he or she can find assistance. If possible, before intervening in a crisis situation outside a classroom, the teacher should know where other adults might be so that the teacher will know where to possibly seek assistance.

10. The teacher should remove any objects or clothing that a violent student could use against him or her (pencils, neckties, earrings) (Callahan, 1998, pp. 226–227).
**Teacher Guidelines for Crisis Response**


**What Is a Crisis and What Is Crisis Response?**

A crisis is a traumatic event that is typically unpredicted and overwhelming for those who experience it. This situation may be volatile in nature and, at times, may involve threat to the survival of an individual or groups of individuals. Moreover, a crisis state may result upon exposure to drastic and tragic change in an individual's environment which has become common and familiar to them. This alteration in the status quo is unwanted, frightening, and often renders a person with a sense of vulnerability and helplessness. Ultimately, with successful intervention, the equilibrium is restored between the environment and the individual's perception of their world as a safe and secure place. Examples of crises that can potentially have a large scale effect on the students, faculty and administrators in a school building or district include: an accident involving a student or faculty member, a suicide or death of a student or faculty member, severe violence (e.g., gang fight), hostage taking, fire at school, or a natural disaster (e.g., hurricane).

Crisis response, as it pertains to the school environment, is a proactive, organized and well thought out plan to a crisis situation that has adversely affected many individuals in a school district, including students, faculty, and administrators.

**Why a Crisis Response Plan?**

Research has revealed that schools are increasingly more prone to crisis situations that adversely affect large numbers of students and faculty. The rise in adolescent suicide, increased assaults on teachers, high levels of substance abuse among students, and increased violence in the schools are some of the reasons cited. Research has also indicated that today's school districts need to contend with reactions to new types of trauma/disasters. For example, hostage taking, sniper attacks, murders, terrorist activities, and bomb scares were almost nonexistent in the schools 30 years ago, but today occur with greater frequency. Thus, it is strongly recommended that school districts need to be prepared for a crisis situation that can potentially affect the functioning of their students, faculty, and administrators. Lerner (1997) comments:

> There are two kinds of beach front homeowners on the south shore of Long Island: those who have faced serious erosion, and those who will. Similarly, there are two kinds of schools: those that have faced a serious crisis situation, and those that will.
Research has emerged over the past ten years supporting a proactive approach to a crisis, as opposed to one that is reactive in nature. Such an approach is much better in dealing effectively with a large scale crisis situation. A reactive approach is spontaneous, and not fully thought out, planned, or practiced, and can result in the response that is less effective in meeting the immediate, and possibly the long-term needs of the students, faculty, and administrators.

In summary, a proactive approach to a crisis is one that is organized, planned, and practiced and more likely results in a response that can have a dramatic effect on reducing the short- and long-term consequences of the crisis on the individuals in a school district.

**What Types of Behaviors/Reactions Can Teachers Expect From Their Students After a Crisis Situation Has Occurred?**

The manner in which people react to crisis situations is dependent upon a number of variables including personal history, personality variables, severity and proximity of the event, level of social support, and the type and quality of intervention. While no two people respond to situations, including crisis situations, in exactly the same manner, the following are often seen as immediate reactions to a significant crisis:

- shock or numbness,
- denial or inability to acknowledge the situation has occurred,
- dissociative behavior—appearing dazed, apathetic, expressing feelings of unreality,
- confusion,
- disorganization,
- difficulty making decisions, and
- suggestibility.

It is important to note that most children will recover from the effects of a crisis with adequate support from family, friends, and school personnel. Their response to a crisis can be viewed as “a normal response to an abnormal situation.” While the emotional effects of the crisis can be significant and can potentially influence functioning for weeks to months, most children will evidence a full recovery.

Following are descriptions of responses likely to observed in children:

- *Regression in behavior:* Children who have been exposed to a crisis often exhibit behaviors that are similar to children younger than themselves. This is especially true of toddlers, preschool, and elementary school children. They may return to behavior that was abandoned long ago (e.g., thumb sucking, bed-wetting, fears of the dark). Traumatized children may also exhibit separation anxiety, clinging to parents and resistance to leaving the parents’ side. They may resist going to bed alone. Bladder and bowel control may be temporarily lost in younger children.
- **Increase in fears and anxiety:** Children also exhibit an increase in their fears and worries. They may again become afraid of situations they mastered long ago. As mentioned above, they may become fearful of the dark and refuse to go to bed alone. A school phobia may emerge where the child refuses to go to school for fear of something happening and/or fear of leaving his/her parents. They may openly verbalize their fear of the crisis occurring again in the school. It is important that parents do not allow the child to remain home as a means to deal with his/her anxiety. This will result in the anxiety increasing once the child needs to return to school. Due to the increase in fears, additional demands are made for parent attention and support. Adolescents may experience a more generalized anxiety and not the specific types of fears that are seen in younger children.

- **Decreased academic performance, and poor concentration:** Given the increase in anxiety and the disruption a crisis can have on children's sense of safety and security, there is a decrease in the amount of mental energy and focus available to learn and complete academic assignments.

- **Increased aggression and oppositional behavior, and decreased frustration tolerance:** Children who have been exposed to a crisis can experience difficulty controlling their anger and frustration. Situations that would not have caused a heightened emotional response prior to the crisis can post-crisis result in an aggressive response and/or expression of frustration. Adolescents may also exhibit an increase in oppositional behavior, refusing to live by the rules and regulations of school and home, and/or meet their responsibilities (e.g., chores, academic assignments). Some adolescents may resort to antisocial behavior (e.g., stealing).

- **Increased irritability, emotional liability and depressive feelings:** Children can also exhibit stronger and more variable emotional responses to situations. There could be symptoms of depression that include general sense of sadness, difficulty falling and remaining asleep or sleeping more than normal, change in eating habits, loss of interest in activities once enjoyed, social withdrawal, mental and physical fatigue, and/or suicidal ideation. In younger children there may be an increase in irritability and moodiness.

- **Denial:** In an effort to cope with the psychological and emotional ramifications of a crisis, certain children and adolescents will deny that a crisis has occurred and/or deny the significance of a crisis. A child whose mother has died suddenly may demand that he can return home so that they can watch their favorite television program together. An adolescent whose favorite teacher was badly injured in a car accident may insist that he will recover fully, despite the medical evidence that indicates that this will not happen. Children who continue to utilize denial to cope may need to be confronted in a sensitive but straightforward manner. Anger and resentment may be expressed when confronting the child with the reality. In time, and with support, children do come to accept the reality of a situation.
Understanding the typical reactions of individuals exposed to a crisis situation is a critical step in identifying people who may be in need of further professional assistance. Several investigators (Greenstone & Levittown, 1993; Klingman, 1987; Weaver, 1995) have described *age-appropriate reactions* of individuals exposed to a traumatic event. Although there is heterogeneity in the reactions of individuals surrounding a crisis, most of these responses are expected reactions and subside in several weeks following the crisis.

**Preschool Children (Ages 1 Through 5)**
- thumb sucking
- speech difficulties
- bed-wetting
- decreases or increases in appetite
- fear of the dark
- clinging and whining
- loss of bladder control
- separation difficulties

**Childhood (Ages 5 Through 11)**
- sadness and crying
- school avoidance
- physical complaints (e.g., headaches)
- poor concentration
- irritability
- fear of personal harm
- regressive behavior (clinging, whining)
- nightmares
- aggressive behavior at home or school
- bed-wetting
- anxiety and fears
- confusion
- eating difficulty
- withdrawal/social isolation
- attention-seeking behavior

**Early Adolescence (Ages 11 Through 14)**
- sleep disturbance
- withdrawal/isolation from peers
- increase or decrease in appetite
- loss of interest in activities
- rebelliousness
- generalized anxiety
- school difficulty, including fighting
- fear of personal harm
physical ailments (e.g., bowel problems)
- poor school performance
- depression
- concentration difficulties

Adolescence (Ages 14 Through 18)
- numbing
- intrusive recollections
- sleep disturbance
- anxiety and feelings of guilt
- eating disturbance
- poor concentration and distractibility
- psychosomatic symptoms (e.g., headaches)
- antisocial behavior (e.g., stealing)
- apathy
- aggressive behavior
- agitation or decrease in energy level
- poor school performance
- depression
- peer problems
- withdrawal
- increased substance abuse
- decreased interest in the opposite sex
- amenorrhea or dysmenorrhea

What Types of Personal Reactions Can Teachers Expect After a Crisis Situation Has Occurred?

As in the case of children, the answer to this question is dependent on a number of variables including personal history, personality variables, severity and proximity of the event, level of social support, and type and quality of intervention. The fact that some of the possible immediate adult reactions to a crisis are confusion, disorganization, and difficulty in decision making underscores the need for a preplanned, practiced, and organized response plan. Longer term reactions that are experienced by adults are as follows:

Adulthood
- denial
- feelings of detachment
- unwanted, intrusive recollections
- depression
- concentration difficulty
- anxiety
- psychosomatic complaints
Since teachers are likely to be affected by the crisis situation, it is imperative that they receive the appropriate support and intervention. Without such intervention, they will be limited in their ability to meet the needs of their students. It is important that teachers have a forum to discuss their own feelings and reactions to the crisis and receive support. Teachers usually look to other teachers, and possibly school support personnel (e.g., psychologist, social worker, guidance counselor) to share their feelings. Family and friends outside the school environment can also serve as important sources of support. As with their students, most teachers will show a full recovery from the crisis situation. However, if the symptoms outlined above persist and continue to interfere with functioning, professional consultation may be beneficial.

What Can Classroom Teachers Do to Address the Reactions of Their Students During a Crisis Situation?

Teachers are on the “front lines” during and following a crisis situation. They have spent the most time with their students and often know them better than anyone in the school. Therefore, teachers are likely to be in a good position to provide early and ongoing intervention. However, they are also in a very difficult position because they need to remain composed and in control for their students at a time when they themselves may be experiencing a flood of emotions in response to the crisis. Classroom teachers can find this especially difficult if they are not trained in crisis response and/or are not familiar with how to address the needs of their students following a crisis. Following are interventions that teachers can provide to address the reactions of their students to a crisis situation:

- After obtaining the facts regarding the crisis, as well as permission from the principal to disclose them, classroom teachers should accurately and honestly explain what has happened to their students. Their students should be told the information in a manner that they can understand, taking such variables as age and functioning levels into consideration.
- Teachers can, and most of the time should, consult with school personnel who are trained in crisis response and crisis intervention (e.g., school
psychologist, school social worker, guidance counselor) on how to most effectively address their students’ reactions to the crisis.

- It is often helpful when teachers model appropriate expression of feelings for their students and let them know that they have permission to verbalize what they are experiencing. It is important that teachers remain in control of their own emotions while dealing with their students, a task that may be difficult given that teachers themselves may have been significantly affected by the crisis. Children tend to look toward adults to assess how to react to a situation. A teacher who is experiencing difficulty may not model the optimal ways of coping and expressing feelings.

- If a teacher is unable to function adequately and meet the immediate needs of his/her students, another school official may need to replace the teacher temporarily or help him/her deal with the students. Every attempt should be made to keep the classroom teacher with his/her students.

- Education of students regarding likely responses to the crisis is essential. Students should not feel they are “abnormal” or that they are “going crazy.” Explaining to students that they will likely have a “normal reaction to an abnormal situation” can be helpful for them. Teachers may wish to share the age appropriate reactions described in this document.

- Students need to be warned that they may experience waves of strong emotions and coached on how to effectively deal with them (e.g., by talking to others, looking to others for support).

- The strong emotional reactions to a crisis situation are usually overcome in one to six weeks following the crisis. The long-term effects outlined above, however, could take weeks to months to dissipate.

- Classroom teachers should be vigilant for students who are experiencing significant difficulty in comparison to peers, and who may require additional and more individualized crisis intervention. Criteria for determining which students require additional intervention are outlined below.

- It is imperative that students, as a group, be given the opportunity to discuss their feelings and reactions to the crisis situation. The world as they know it has been threatened, their security undermined. They need to be able to discuss these feelings and know that their fears and reactions are shared by others.

- When students are discussing their feelings, teachers need to listen in a noncritical and nonjudgmental manner, with empathy and support. It is important that teachers communicate to the students that they understand the students’ feelings and, as previously indicated, that their feelings are normal reactions to an abnormal situation. Students who are hesitant to verbalize their feelings should be encouraged to do so but demands to verbalize should be avoided.

- The students should be given the opportunity to express themselves through other modes of communication (e.g., writing, and perhaps drawing for
younger children), especially those students who are hesitant to verbalize their feelings.

- Teachers can develop classroom activities and assignments, and homework assignments that address students’ feelings regarding the crisis. Assignments that are a catalyst for group discussion are best and may facilitate empowerment at a time when many individuals feel a sense of hopelessness and vulnerability.

- Crisis intervention is ongoing. Therefore, future discussions may need to ensue and address residual feelings regarding the crisis. Some students may not experience a reaction to the crisis until days or weeks later. Teachers need to remain sensitive to this fact and remain vigilant to reactions for some time after the crisis. Some students may even try to convince others that they were not affected, and then suddenly show a strong emotional reaction.

**When Should Teachers Refer Students for More Individualized Assessment and Intervention?**

With support from school personnel and their families, and the passage of time, most students will be able to recover from the effects of a crisis and return to precrisis functioning. They will be able to meet the demands of their environment, most particularly the school environment. However, there are those students, due to their own psychological makeup (including history and ability to obtain and respond to support), and the severity and proximity of the precipitating event, who will continue to experience difficulties which interfere with functioning. These students are in need of further, and probably more individualized intervention.

The following are guidelines for determining which students should be referred to counselors for additional intervention:

- students who cannot engage adequately in classroom assignments and activities after a sufficient amount of time has passed since the crisis and after a majority of their peers are able to do so,
- students who continue to exhibit high levels of emotional responsiveness (e.g., crying, tearfulness) after a majority of their peers have discontinued to do so,
- students who appear depressed, withdrawn, and noncommunicative,
- students who continue to exhibit poorer academic performance and decreased concentration,
- students who express suicidal or homicidal ideation, or students who are intentionally hurting themselves (e.g., cutting themselves),
- students who exhibit an apparent increased usage of alcohol or drugs,
- students who gain or lose a significant amount of weight in a short period of time,
- students who exhibit significant behavioral changes, and
- students who discontinue attending to their hygienic needs.
Conclusion

The immediacy and unpredictability of crisis situations often leave individuals with a sense of worry, vulnerability, and distrust. A school system is unique in that it brings together individuals of all ages and professionals from numerous disciplines. Effective response to a crisis capitalizes on the resources within the school environment. A Crisis Response Team that identifies and responds to a crisis in a unified and collaborative manner can alter the aftermath of a crisis.

Summary

This chapter addressed the key issues in dealing with special populations, such as clients who are harmful to themselves or others, abused clients, survivors of sexual abuse, substance abusing clients, and victims of crisis. These are the populations that are most commonly encountered in standard therapeutic settings and that the student will likely work with most often through the duration of the internship. Because these populations are encountered with relative frequency, it is important that interns familiarize themselves with the issues that can arise in therapy and the special considerations that must be made when determining appropriate interventions. The intervention strategies and clinical forms that are provided were designed to assist the counselor or therapist in the treatment and reporting of critical client data.

Suggested Readings


Guidelines for Interns Working With Special Populations and Crisis


**References**


Krug, R. S. (1989). Adult male reports of childhood sexual abuse by mothers: Case
descriptions, motivations, and long-term consequences. Child Abuse and Neglect, 13,
111–119.
intervention programs: Program components and the role of the school counselor.
counselors. Professional School Counseling, 8(3), 249.
Report, 17, 23.
Guidance and Counseling, 4, 283–287.
& G. C. Forrest (Eds.), Alcoholism and substance abuse (pp. 3–48). New York: Free
Press.
409–420.
Gordon (Eds.), Relapse prevention (pp. 128–193). New York: Guilford.
Marlatt, A. (1985b). Relapse prevention: Theoretical rationale and overview of the
model. In G. A. Marlatt & J. R. Gordon (Eds.), Relapse prevention (pp. 3–67). New
York: Guilford.
students: A harm-reduction approach. In G. M. Boyd, J. Howard, & R. A. Zucker
(Eds.), Alcohol problems among adolescents: Current directions in prevention
research (pp. 147–172). Hillsdale, NJ: Erlbaum.
257–261.
abuse treatments. In R. E. Meyer (Ed.), Psychopathology and addictive disorders
(pp. 97–135). New York: Guilford.
Severity Index: Reliability and validity in three centers. Journal of Nervous and
Mental Disease, 173(7), 36–47.
Vatican II. Washington, DC: Georgetown University Press.
model for considering supervisor roles. Counselor Education and Supervision, 45,
134–146.


Paridies v. Benedictine Hospital, 431 N.Y.S.2d 175 (APP.Div. 1980).


Chapter 9

Consultation in the Schools and Mental Health Agencies: Models and Methods

This chapter was included in this textbook for the purpose of providing students with a basic understanding of consultation in schools and mental health agencies. A review of the history of consultation and of the current models of consultation is presented for the students’ inspection. The authors included two articles that examine systems and integrated approaches to consultation in the schools. The seminal work of Gerald Caplan (1970) is presented as a representative sample of mental health consultation.

It has been the authors’ experience that many counselor preparation programs do not have specific courses designed to focus on consultation. Generally, consultation methods and models find their way into a variety of counselor preparation courses. Those students who have taken course work in consultation will find the material presented here to be a review. For other students, the material presented will familiarize them with some of the processes and procedures common to both school and agency consultation.

Consultation has become one of the most sought after services rendered by psychologists and counselors in mental health agencies. Consultation was born out of the Mental Health Act of 1962 and the subsequent writings of Caplan’s (1970) *The Theory and Practice of Mental Health Consultation*. School counselors have probably been providing consultation informally for as long as there have been counselors; however, a formal consultation role has been an important part of the school counselor’s function since the late 1970s (Baker, 2000). This formalized consulting role for school counselors evolved when other helping professionals started branching out from one-to-one relationships to work with caretakers, who then worked with clients. Consultation is a way counselors can use their skills to influence other professionals in schools (parents, teachers, administrators) to facilitate the emotional, academic, and career development of students.
Definition

With the growth of consultation, a diversity of opinion has developed with regard to the definition of consultation. A review of the literature by Alpert and Meyers (1983) failed to provide an agreed-on definition of consultation. Ohlsen (1983) defined consultation as an activity in which a professional helps another person in regard to a third person or party. Caplan (1970) viewed consultation as a collaborative process between two professionals who each has his or her own area of expertise. Albee (1982) defined consultation in terms of a preventive approach to service delivery in mental health. Kirby (1985, p. 9) defined consultation in terms of four relationship conditions: (a) the relationship is voluntary, (b) the focus of attention is on the problem situation as articulated by the consultee(s), (c) the consultant is not functioning as a part of the structural hierarchy, and (d) the power that resides in the consultant’s expertise is sufficient to facilitate change. Dinkmeyer, Carlson, and Dinkmeyer (1994) defined consultation as follows: “Consultation is when the main focus of the relationship is a third person (often a student) and when the relationship is characterized by collaboration on ways to help this third person” (pp. 89–90). For purposes of clarity, the definition provided by Meyers, Parsons, and Martin (1979) will be used in this chapter:

Consultation is a helping or problem solving process occurring between a professional help giver and help seeker who has responsibility for the welfare of another person. It is a voluntary relationship in which the help giver and the help seeker share in solving a current problem of the help seeker. The help seeker profits from the relationship in such a way that future problems may be handled more positively and skillfully. (p. 4)

In addition to trying to solve the problem of defining consultation, early authors (Alpert, 1977; Caplan, 1970) disagreed as to the focus of consultation. The disagreement centered around consultation as a direct or an indirect service. It is important to remember that counselors and psychologists traditionally were involved in direct service to clients; that is, consultation that focused on the individual clients and interpersonal factors affecting them.

In the 1980s, attention focused on the counselor’s and psychologist’s providing preventive approaches to service delivery (Coyne, 1987). The indirect service approach stressed consultation efforts directed toward understanding the environment of the client, with interventions aimed at assisting the professional who has responsibility for a caretaker role with the individual. With the development of indirect service approaches, the counselor or psychologist must ensure that role confusion does not hamper the delivery of mental health services. It is important to ensure that counseling and consultation are seen as different and complementary forms of intervention. Bloom (1977) suggested that consultation
differs from counseling or therapy in that the consultant does not assume the full responsibility for the final outcome of consultation. The consultant's role is to develop and enhance the role of the consultee, in contrast to counseling, where the focus is on the personal improvement of the client. The consultant must remember that the relationship established with the consultee is not primarily therapeutic in nature. Rather, the consultant serves in the capacity of collaborator and facilitator, to assist the consultee in performing his or her duties and responsibility in a more productive and effective manner (p. 156).

Bloom (1977) recognized the importance of distinguishing consultation from other forms of mental health activities. He stated that consultation is different from supervision on the grounds that (a) the consultant may not be of the same professional specialty as the consultee, (b) the consultant has no administrative responsibility for the work of the consultee, (c) consultation may be more irregular than continuous in character, and (d) the consultant is not in a position of power with respect to the consultee. Similarly, Bloom (1977) differentiated consultation from counseling because in the process of counseling a clear contractual relationship exists between an individual designated as client and another individual designated as counselor. Also, the goal of consultation is improved work performance, whereas in counseling the goal is personal adjustment (p. 136).

The remainder of this chapter provides an overview and discussion of mental health consultation and school consultation models that are applicable to the practicum student and intern in counseling and psychology.

**Mental Health Consultation**

Mental health consultation has been widely influenced by the writing of Gerald Caplan. With the writing of the book *The Theory and Practice of Mental Health Consultation* in 1970, Caplan identified four consultation types that are employed in mental health settings.

The four types of consultation are summarized here to provide the practicum student and intern with an overview of the mental health models.

- **Client-centered case consultation:** A consultee has difficulty in dealing with the mental health aspects of one of his or her clients and calls in a specialist to investigate and advise on the nature of the difficulties and on how the consultee's work difficulty relates to the management of a particular case or group of cases. The consultant makes an assessment of the client's problem and recommends how the consultee should proceed.

- **Program-centered administrative consultation:** The consultant is invited by an administrator to help with a current problem of program development, with some predicament in the organization of an institution, or with
planning and implementation of organizational policies, including personnel policies. The consultant is expected to provide feedback to the organization in the form of a written report.

- **Consultee-centered case consultation:** The consultee's work problem relates to the management of a particular client, and he or she invokes the consultant's help to improve handling of the case. The consultant's primary focus is on clarifying and remedying the shortcomings in the consultee's professional functioning that are responsible for the present difficulties with the case about which he or she is seeking help.

- **Consultee-centered administrative consultation:** The consultant helps the administrative staff of an organization deal with current problems in organizational policies. The focus of attention is the consultee's work difficulties and attempts to help improve his or her problem-solving skills (Caplan, 1970, pp. 109–150).

Caplan further described what he considered to be the characteristics of mental health consultation. A summary of Caplan's characteristics is presented to give students a clear understanding of the consultation model in mental health settings.

1. Mental health consultation is a method for use between two professionals in respect to a lay client or a program of such clients.
2. The consultee's work problem must be defined by him or her as being in the mental health area; that is, relating to (a) a mental disorder or personality idiosyncrasies of the client, (b) the promotion of mental health in the client, or (c) interpersonal aspects of the work situation.
3. The consultant has no administrative responsibility for the consultee's work or professional responsibility for the outcome of the client's case.
4. The consultee is under no compulsion to accept the consultant's ideas or suggestions.
5. The basic relationship between the two is coordinate. No built-in hierarchical authority tension exists.
6. The coordinate relationship is fostered by the consultant's usually being a member of another profession and coming briefly into the consultee's institution from the outside.
7. Consultation is usually given as a short series of interviews, which take place intermittently in response to the consultee's awareness of current need for help with the work problem.
8. Consultation is expected to continue indefinitely.
9. A consultant has not predetermined a body of information that he or she intends to impart on a particular consultee.
10. The twin goals of consultation are to help the consultee improve his or her handling or understanding of the current work difficulty and to increase his or her capacity to master future problems of a similar type.
11. The aim is to improve the consultee’s job performance, not his or her sense of well-being.
12. Consultation does not focus overtly on the personal problems and feelings of the consultee.
13. This doesn’t mean that the consultant does not pay attention to the feelings of the consultee. The consultant is particularly sensitive to these and to the disturbance of task functioning produced by personal problems.
14. Consultation is usually only one of the professional functions of a specialist, even if he or she is formally titled “consultant.”
15. Finally, mental health consultation is a method of communication between a mental health specialist and other professionals (Caplan, 1970, pp. 28–30).

An understanding of the stages and types of consultation and the characteristics of mental health counseling enables the student to begin to conceptualize an approach to consultation in light of his or her own needs as well as the needs of the consultee. The necessity of understanding a wide range of theoretical perspectives in consultation was stressed by Jacobson, Ravlin, and Cooper (1983). These authors conceptualized mental health consultation as a multilinear model:

1. The first step in the model is the development and implementation of a formal intervention plan requiring the consultant to have summarized the available information into a useful systems assessment.
2. The second step is entry into the system, which denotes the first formal contact between the two systems regarding the current consultation. Entry must be seen in the context of the agency’s history.
3. The third step, relationship building, is a long-term process that transcends the time constraints of a particular consultation agreement; thus it is conceptualized as an ongoing process.
4. In the fourth step, formal interventions follow the mediation of a consultation agreement.
5. In the fifth step, though the agreement often is negotiated earlier in the consultation process, the agreement generally undergoes repeated modification in the course of the intervention process based on the ongoing system assessment and program evaluation.
6. The sixth step, conclusion of the services provided by specific consultation, is often the precursor to subsequent cycling of the consultative process. As a consequence, the termination of a consultative agreement rarely is as final as it is in clinical interventions (Jacobson et al., 1983, pp. 58–60).

**Consultation**

Since the 1970s, Gerald Caplan’s definition of consultee-centered consultation has been adapted by many professionals in the field. Caplan and Caplan (1993)
published Mental Health Consultation and Collaboration that included a reconfiguration of his consultation model. More recently, Lambert, Hylander, and Sandoval (2003) suggested that consultee-centered consultation has outgrown its focus on a psychodynamic orientation.

The special issue of the Journal of Educational and Psychological Consultation (2003) focused on current research in consultee-centered consultation. Between 1996 and 2001, two international seminars in Sweden and California dealt with trainers’ and consultants’ current understanding of the consultee-centered model. Their definitions follow:

1. Consultee-centered consultation emphasizes a nonhierarchical helping role relationship between a resource (consultant) and a person or group (consultee) who seeks professional help with a work problem involving a third party (client).
2. The work problem is the topic of concern for the consultee, who has direct responsibility for the learning, development, or productivity of the client.
3. The primary task of the consultant is to help the consultee pinpoint critical information and then consider multiple views about well-being, development, and interpersonal, intrapersonal, and organizational effectiveness appropriate to the consultee’s work setting. Ultimately the consultant may reframe his or her prior conceptualization of the work problem.
4. The goal of the consultation process is the joint development of a new way of conceptualizing the work problem, so that the repertoire of the consultee is expanded, and the professional relationship between the consultee and the client is restored or improved. As the problem is jointly reconsidered, new ways of approaching the problem may lead to acquiring new means to address the work dilemma (Knotek & Sandoval, 2003).

**Internal Versus External Consultation**

Caplan’s consultation model has been regarded as especially beneficial in school-based practice. The model’s preventive focus and its nonhierarchical relationship orientation fits well in school-based consultation (Caplan, Caplan, & Erchul, 1999). A look at how the Caplan model has evolved over the past 30 years reveals how the original conceptualization, that the consultant’s base of operations is outside the consultee’s work setting, has changed.

More recently, mental health consultants have frequently been employed as in-house staff members. Caplan, Caplan, and Erchul (1995) suggested that it is difficult for an in-house consultant to behave in the hierarchy of a school in which he or she has an official status superior to many potential consultees and more knowledge about the instructional process than many teachers. In-school consultants may not find it easy to permit the consultee the freedom to reject “expert views” about a case when they share responsibility for the outcomes and when the two are forced to promote effective action regarding a case of policy.
The school situation obliges the consultant to adopt a “hands-on” direct action approach, although, in addition, they may help educate fellow staff members about the psychological dimensions of their work (p. 28).

Consultation or Collaboration?

The use of in-house consultants is not without controversy, especially regarding the consultee’s freedom to accept or reject advice from the consultant. Might it be more appropriate to examine mental health collaboration as a method to intervene in the system? Distinctions between consultation and collaboration are necessary to clarify the role and function of these separate approaches.

In collaboration, the specialist-collaborator shares equal responsibility for the overall outcome of the client but primary responsibility for the mental health outcome, and the consultee-collaborator does not have the freedom to accept or reject advice because the best possible course of action must be selected and implemented to improve the client’s condition (Caplan et al., 1999, p. 28).

In mental health collaboration, the specialist-collaborator becomes a fully participating team member (with coworkers, group, other professionals), acting as a hands-on clinician or advisor and making the best use of his or her specialized diagnostic and remedial skills to improve mental health outcomes of the case (p. 28). Because the specialist-collaborator (unlike an outside consultant) is held accountable for the welfare of the client, he or she is expected to direct colleagues’ attention to relevant aspects of the efforts to ensure positive outcomes (Caplan et al., 1999).

School Consultation

In the review on mental health consultation, the consultation models focus on a work problem where the consulting relationship facilitates a problem-solving process. Schmidt (2003) stated, “School counselors use consultation in a broader context that includes educational, information and problem solving relationships” (p. 176). He went on to frame the school consultation process as a triadic relationship between the counselor-consultant, the consultee (student, teachers, parents, etc.), and a situation with a third party or an external situation (prevention, development, remediation) (p. 176).

In a consultation where helping schools prevent problems is the focus, educational or informational consultation is implemented. Counselors often include large group instruction for parents, students, and teachers to give information or teach new skills. This educational consultation does not include evaluation and thus facilitates asking questions and sharing opinions. These consulting activities differ from direct counseling because the goal is to remedy a situation that is external to the relationships between the consultant and the consultee. Informational consulting situations occur when students, parents, and teachers
have a need regarding community and school resources, career and educational materials, or other referrals. In other words, the counselor has contacts in the community and knowledge of the location of resources where the consultee can get information that is needed.

Kurpius and Fuqua (1993) outlined four generic modes of consulting that identify the different roles counselors take when performing consulting functions. The first role is "expert." In this role, counselors either provide answers to problems by giving expert information to parents, students, and teachers or use direct skills to fix the problem. The second mode is that of the "prescriptive role," where the counselor collects information, makes a diagnosis, and recommends solutions. The third role is that of "collaborator," where the counselor works in partnership with consultees to define concerns and develop strategies to change or improve an external situation. The consulting role of collaborator assumes an equal relationship among participants to facilitate change. This role is often used when consulting with students, parents, and teachers as well as with administrators and other professionals. The collaborative role can be more broadly defined when it includes the initiation and formation of collegial relationships with a variety of educational, medical, and other professionals who provide auxiliary services to school populations. These alliances benefit all parties concerned as they work to create circumstances that facilitate the healthy development of children. They also ensure the availability of outside services for students, parents, and teachers who interact with school counselors (Schmidt, 2003, p. 163). The fourth mode in the Kurpius and Fuqua (1993) framework is that of "mediator." As mediator, the counselor facilitates conflict resolution between two or more persons or between persons and an outside situation. The goal is to find common ground and compromise.

Baker (2000) proposed basic consulting competencies for school counselors as proceeding through stages parallel to those proposed in Egan's (1998) three-stage helping paradigm for problem-solving counseling. Egan's paradigm has been restated for consulting stages, and the word consultee was used where the word client was used in the original counseling model.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>The consultee's problem situation and unused opportunities are identified and clarified.</td>
</tr>
<tr>
<td>II</td>
<td>Hopes for the future become realistic goals to which the consultee is committed.</td>
</tr>
<tr>
<td>III</td>
<td>Strategies for reaching goals are devised and implemented.</td>
</tr>
</tbody>
</table>

Baker (2000) proposed the basic skills of a comprehensive consulting model in the context of the three stages of identification/clarification, goal setting/commitment, and action.
In the identification/clarification stage of consulting, an opening interview is held. The skills in this consulting interview are the same skills counselors use in an initial client interview: strategies that encourage sharing, identifying, and clarifying. Next the counselor-consultant invites the consultee to share tier-targeted problems while establishing a facilitative working alliance. As the problem is clarified, the consultant determines the mode of consulting that fits the problem: expert, prescriptive, collaborative, or mediator. The consultant clarifies the problem as he or she understands it, explains his or her understanding of the consultee’s motives, and negotiates the role the consultant will take.

The second stage of goal setting/commitment follows. Implicit in proceeding to this stage is the decision to consult. Assuming this decision is made, further exploration of the problem issues and possible solutions is undertaken. Basic challenging skills of information sharing, immediacy and confrontation are brought in at this stage. If consultants are using the collaborative mode, brainstorming hypotheses and solutions follow. As many hypotheses and solutions as possible are identified without analysis. In the prescriptive mode, consultants explain their treatment plan and then brainstorm who will implement them. When solutions have been identified, alternatives are evaluated using workability, reasonability, and motivation as criteria. Sometimes more information about the problem is needed before final goals can be established. A shift occurs as the consultant encourages and supports the consultee’s understanding of and commitment to the goal.

The final stage in this consulting process is action strategies. The consultee may need help with the final decision making. Depending on the mode of consulting, counseling for rational thinking may apply, or competence enhancement regarding child and adolescent development or classroom management skill training may be deemed appropriate. When mediation is the appropriate mode selected, counselors respond directly to requests from two or more parties to facilitate a mutual agreement or reconciliation. Basic counseling skills, challenging skills, and knowledge of interpersonal communication are requisite skills for mediation. Mediation can be between student and parent, student and student, student and teacher, teacher and administrator—any two parties engaged in the educational endeavor. As with any counseling process, reluctance and/or resistance can be handled using the same skills as those used in counseling interactions (Baker, 2000).

Consulting processes also include a closing phase. Consulting goals that have been established provide the criteria for whether the expected results have occurred. Consultees can also give feedback about their satisfaction with the consulting process and, upon reflection, make suggestions about how things could have been more helpful (Baker, 2000, pp. 178–190).

In the 21st century, school counselors are faced with ever-increasing responsibilities on the job. At-risk students, reintegration of special students, and the job of coordinating the school and community services are but a few of the
Practicum and Internship

added responsibilities of the school counselor. The American School Counselors Association’s (ASCA’s) (2003) national model advocates that the school counseling program be established as an integral component in the academic mission of the school, with academic development, personal development, and career development as the foci. Schools are directed to design, develop, implement, and evaluate a comprehensive school counseling program. Historically, counselors have focused their efforts on at-risk or high achieving students. The ASCA’s national model outlines a program advocating that school counselors direct services to every student. Delivery systems include (a) a guidance curriculum infused into the school’s curriculum to provide all students with knowledge and skills appropriate to their developmental level; (b) responsive services that meet the individual student’s needs and provide counseling, consultation, referral, peer helping, or information; (c) individual student planning where counselors coordinate system activities designed to assist students individually to establish personal goals and future plans; (d) administration and management to sustain the total counseling program.

An outline of a comprehensive school counseling program for the state of Alabama (Alabama Department of Education, 1996) identified consultation as a counselor’s role in implementing a guidance curriculum in responsive services and in systems support. Other articles propose that the counselor expand the educational consulting role to include peer facilitator training, counselor–teacher consultation to plan and implement a guidance curriculum, the training and coordination of teacher advisory programs, and others (Campbell, 2000; Dahir, Sheldon, & Valiza, 1998; Gonzales & Myrick, 2000; Myrick, 1997). It is not a leap to conclude that the consulting role for school counselors may become equal to the counseling practice role as the ASCA model is adopted by more school systems (see the Consultation Rating Form [Form 9.1] in the Forms section in the back of this book). In addition, the authors included two articles that give examples of consultation models and practices for counselor consultation in the schools.

---

*Developmental Counseling and Therapy as a Model for School Counselor Consultation With Teachers*

Elisha Clemens

Referral requests for individual counseling pose a threat to the implementation of comprehensive school counseling programs (Jackson & White, 2000). Consulting with teachers is one way that school counselors can efficiently respond to some referrals while also providing system support. Using a developmental counseling and therapy-based consultation model, school counselors can assess how a teacher is conceptualizing a student’s behavior, respond to the stress a teacher may feel connected to that behavior, and indirectly effect change in a classroom system.

The allocation of school counselors’ time is among the emphases of comprehensive school counseling program models (e.g., Gysbers & Henderson, 2000). Burnham and Jackson (2000) found that the percentage of time school counselors spend on individual counseling is elevated compared to the recommended percentage discussed by Gysbers and Henderson. Jackson and White (2000) indicated that “requests for individual counseling pose the biggest threat to developmental and preventative counseling programs” (p. 278). Furthermore, they found that teacher referrals for students’ individual counseling are frequently guided by the belief that the school counselor’s role is to solve students’ current behavior problems rather than to prevent future problems. Offering to serve as a consultant to a teacher is one way that school counselors can reframe referral requests into an opportunity to intervene at the systems level and emphasize prevention.

Consultation is an integral activity for school counselors working in comprehensive, developmental programs. They can use consultative techniques to provide both responsive services and system support (American School Counselor Association, 2005). For example, a school counselor can respond to a teacher’s request for consultation regarding a student concern, and through that interaction the teacher might gain skills, knowledge, or insight that can help him or her to be better prepared to respond to or prevent a similar situation in the future (Parsons & Kahn, 2005). Thus, consultation can be both a preventative measure (Jackson & White, 2000) and an efficient use of a school counselor’s time (Brigman, Mullis, Webb, & White, 2005; Parsons & Kahn, 2005).

Through consultation with a teacher, school counselors can target the individual who is most likely in a position to effect change in the classroom environment. If a teacher implements changes that make the classroom system function more effectively, then the frequency or intensity of some student behaviors may decrease (Marzano & Marzano, 2003). Changing the system not only may help a student to make immediate behavioral changes but also might help a student to sustain those changes (Ivey, 1991). Furthermore, classroom management affects not only the student identified in the referral but also the class as a whole and has a substantial effect on students’ achievement (Marzano & Marzano, 2003; Wang, Haertel, & Walberg, 1993).

**Teachers’ Stress**

There is a plethora of literature indicating that students’ behavior and classroom discipline are significant sources of teachers’ stress (Kyriacou, 2001; Montgomery & Rupp, 2005; Wiley, 2000). Specifically, student behaviors that are emotionally charged and social (e.g., impulsivity, anxiety, hostility, and aggressiveness) rather than academic in nature are the “most significant and universal of teaching stressors” (Greene, Abidin, & Kmetz, 1997, p. 240). Although there is limited agreement on the definition of stress in the education literature, Wiley, in a synthesis of research on teachers’ stress, offered the definition “job related factors [that] interact with the worker to change her psychological or physiological condition
such that she is forced to deviate from normal functioning” (p. 1). It may be important to address the stress that some teachers feel in relation to student behavior because stress may impact a teacher’s ability to manage a classroom effectively (Wiley, 2000).

Greene et al. (1997) hypothesized that the stress teachers experience relative to student behavior is both person-specific and situation-specific. These characteristics of teachers’ stress are among the factors that might guide school counselors toward considering developmental counseling and therapy (DCT) as a basis for a consultation with teachers. DCT parallels Green et al.’s hypothesis; the way an individual initially makes meaning and emotionally experiences a situation can be person- and situation-specific (Ivey, Ivey, Myers, & Sweeney, 2005). Applying DCT to consultation is likely to help school counselors respond to the person- or situation-specific emotional experience of teachers while helping teachers to consider alternate ways of understanding and working with student behaviors that may be stressful.

**Developmental Counseling and Therapy**

Developmental counseling and therapy and the assessment of meaning making are grounded in Piagetian theory and the metaphorical interpretation of Plato’s allegory of the cave (Ivey, Ivey, Myers, et al., 2005; Myers, 1998). DCT offers a means of clinical assessment and intervention, which has been successfully adapted to serve a variety of populations (Cashwell, Myers, & Shurts, 2004; Ivey, 1991; Ivey et al., 2005; Myers, 1998; Myers, Shoffner, & Briggs, 2002). A relevant strength of DCT is the speed through which a counselor who is proficient in the use of this theory can assess how an individual makes meaning of a specific situation and expand his or her understanding, “build a more solid foundation,” or “reach more complex ways of thinking” (Ivey et al., 2005, p. 140). The theory’s strength in developing more complex ways of making meaning out of a situation and the generalization of learning is likely to meet the goals of school-based consultation (e.g., helping teachers to become more self-reliant problem solvers; Brigman et al., 2005). Four primary cognitive developmental modalities are used to understand ways in which individuals make meaning of situations and explain their experiences.

**Cognitive Developmental Modalities**

Ivey (1991, 1993, 1999; Ivey, Ivey, Myers, et al., 2005), much like Piaget, articulated four cognitive developmental modalities that individuals use to understand and explain the world. The cognitive developmental modalities are sensorimotor, concrete, formal-operational, and dialectic/systemic. The sensorimotor modality consists of an emotional and physiological response frequently described as an embedded feeling. The emotion is intertwined with the experience and behaviors are often erratic and irrational. Individuals using the concrete modality to tell
their stories explain details in a linear manner and articulate causal relationships. Typically the stories are told with great detail and in the past tense. The formal-operational modality is characterized by the identification of patterns of thinking, feeling, or behaving. Absolute language (e.g., “always”) punctuates the stories and meaning is reflected in the described patterns. Finally, the dialectic/systemic perspective includes understanding patterns within patterns or interacting systems. Stories typically reflect multiple perspectives and emotions change in response to the perspective taken.

Preferences and Developmental Blocks

Individuals might use all of these cognitive developmental modalities, but specific situations often yield preferences (Ivey, Ivey, Myers, et al., 2005; Myers et al., 2002). Preferences are not intentional choices that individuals make about how to conceptualize a situation but rather the most comfortable modality for understanding or explaining a given situation. These preferences are typically demonstrated through the modality in which a story is initially told (Ivey et al., 2005). For example, if a teacher’s situation-specific preference is concrete, he or she will likely begin by describing the situation in a detailed, linear manner. Although a teacher may be able to process a situation in multiple modalities, he or she is likely to return to preferred modalities at different points in the consultation process.

Some situations also create blocks in processing the experience (Ivey, Ivey, Myers, et al., 2005). A block is defined as a situation-specific inability to function in a particular cognitive developmental modality (Myers et al., 2002). A block can represent an inability either to access a particular cognitive developmental modality or to move outside of a particular cognitive developmental modality, and it can limit the way a teacher makes sense of a student’s behavior. For example, both the inability to see patterns emerging in the classroom and only seeing patterns might be blocks in the formal-operational modality. The classification of cognitive developmental modalities is fully articulated by Ivey and Rigazio-DiGilio (2005).

Examples of Cognitive Developmental Modalities in the Classroom

Understanding the strengths and limitations of each cognitive developmental modality is a necessary precursor to developing an intervention (Ivey, Ivey, Myers, et al., 2005). The following case examples are used to conceptualize how the same event might precipitate different responses by teachers with different cognitive developmental preferences.

Sensorimotor. Mr. S’s description of Johnny’s behavior can be categorized by a here-and-now reaction. Overwhelmed, Mr. S is unable to separate his emotions from the experience. He paces around the school counselor’s office, his face is red, and he is short of breath. “I can’t take it anymore! He’s just got to go! I’m so angry at Johnny; this is unacceptable!” Mr. S’s description is disjointed and does
not follow a logical pattern. It is difficult for the school counselor to understand what actually happened in class. Mr. S is likely, however, to recognize his stress associated with Johnny's behavior, and he identifies the need for change.

**Concrete.** If Ms. C’s preferred cognitive developmental modality is concrete, she might describe a classroom disruption in a linear manner. For example:

I started to go over the homework. I asked the students to open their books to the page assigned and to hold their questions until we got to that number. I put the answer to number 1 on the blackboard. Johnny raised his hand and blurted out a question about number 3. I reminded him we were on question number 1, and it happened again. I was frustrated because we talked about the appropriate time to ask questions just minutes before.

Ms. C's story is linear and detailed. Her emotions are described in the past tense. Ms. C is explaining the current situation to the counselor and the behavior that caused her frustration. A limitation is that Ms. C is focused only on the current situation and is not considering the patterns that have emerged in her classroom. She is also not considering Johnny's perspective or that of other students in the room.

**Formal-operational.** Mr. F might describe the same event differently if he is functioning in the formal-operational cognitive developmental modality:

Johnny always interrupts me when I'm talking. He never waits his turn. He can't seem to contain himself no matter what the format of class. When I think about it I get angry with him and just want him out of my class forever.

Mr. F is responding to the patterns he sees in Johnny’s behavior. He is able to generalize and his emotions reflect responses to more than one similar situation. He understands that Johnny’s behavior is not just an isolated incident but the pervasive inability to delay gratification and that his hyperactivity crosses multiple instructional formats. A limitation is that Mr. F’s frustration is not specific to what Johnny did or did not do in this instance in class. The anger and frustration might be disproportionate to today’s infraction, because it is not viewed in isolation but as part of a pervasive pattern.

**Dialectic/systemic.** Ms. D describes Johnny’s behavior in a reflective manner and looks for patterns within patterns, or a systemic approach to making meaning out of his behavior and her response:

I want all my students to be excited about math and seek to understand the why's behind the right answers. It is difficult to balance each of their needs and respond to them as individuals in the context of such a large class. This is one of the problems of our educational system and
the high student-to-teacher ratio. My frustration is a result of not feeling like I'm serving Johnny well and my entire class at the same time.

Ms. D is likely to overanalyze her emotions and the situation. She is looking to systemic reasons to explain her frustration and might lose sight of the “if–then” relationship (e.g., “if Johnny interrupted, then I felt frustrated”). Ms. D may present as a cool, calm, and collected teacher but might miss what she is doing to increase or decrease the classroom disruption.

The case examples of teachers telling their stories of the same student behavior from different cognitive developmental perspectives illustrate how a preference or a block might limit the ability of a teacher to respond holistically to a student, or to manage his or her classroom effectively. Each of the aforementioned teachers is using only one of the cognitive developmental modalities. It is likely that functioning solely in any one of the modalities, as illustrated by the case examples, would limit a teacher's ability to manage stress related to challenging student behaviors.

When teachers report feeling stress as a result of students' behaviors or classroom situations, it may be an indicator that they are not able to consider the situation from enough modalities. “It is the interaction between the person and the environment that determines whether an individual has adequate access to enough orientations to adapt to or influence the environment” (Myers, 1998, p. 3). The DCT-based consultation model is designed to increase teachers' access to cognitive developmental modalities so they may successfully respond to individual students, decrease their own stress, and manage the classroom environment.

**DCT Model for Consultation**

The DCT model for consultation seeks to effect second-order change (i.e., help teachers to consider a situation from a different modality or perspective) while emphasizing accurate assessment of the problem and protecting the emotional experience of the consultee. The consultation model might best be conceptualized as a blend of DCT's clinical and educational uses. DCT as a clinical intervention guides the assessment component of the consultation model. The complete clinical interview is published in Ivey, Ivey, Myers, et al. (2005). The application of DCT to education (Ivey, 1991) guides the consultative emphasis on affecting work-related performance. The integration of the clinical and educational uses of DCT directs the process of utilizing DCT in school-based consultation.

**DCT-Based Consultation Steps**

The first step of the DCT consultation intervention is assessing the current modality a teacher is using to describe a student's behavior. Ivey (1991) indicated that counselors can assess preferred modalities in as few as 50 to 100 words.
The second step involves determining which modality might help the teacher to understand the situation in a way that is likely to effect change in the classroom environment. For example, a teacher whose preference is concrete might benefit from seeing patterns emerging in his or her classroom (i.e., formal-operational). Similarly, a teacher whose modality preference is formal-operational might not initially identify a cause-and-effect relationship between his or her behavior and student behavior (i.e., concrete). The third step is co-constructing a professional development plan that is grounded in the assessment of preferred modalities.

**DCT-Based Consultation Questions**

Once a school counselor has assessed a teacher’s preferred cognitive developmental modality and the goal of consultation (e.g., movement from the sensorimotor modality to the concrete modality), the following questions can be used as a guide for facilitating movement from one cognitive developmental modality to another (Myers, 1998). Teachers who move from one preferred cognitive developmental modality to another will ultimately perceive their concern differently. Facilitating second-order change through DCT consultation is a developed professional skill. Accurate assessment and goal setting takes practice (Ivey, Ivey, Myers, et al., 2005); therefore, school counselors may choose to use supervision as a means for honing their usage of the DCT consultation model. The questions outlined below are adapted from Ivey, Ivey, and Rigazio-DiGilio’s (2005) standard cognitive/emotional developmental interview and are modified to fit the school environment and the consultation delivery system.

**Sensorimotor goal.** The purpose of helping a teacher to experience a situation in the sensorimotor modality is for him or her to explore emotions associated with a student’s behavior. Locating the embedded feeling or the physiological response to stress is likely to help a teacher to recognize more easily the stress associated with a specific person or situation. Nagel and Brown (2003) noted that for teachers, acknowledging the source of stress can be the first step in managing factors that create it. The exploration of a teacher’s stress within the sensorimotor modality is grounded in identifying a specific event and delving into what is seen, heard, and felt in that moment (Ivey, Ivey, Myers, et al., 2005). The DCT consultation questions listed below, paired with present-tense reflections and mirrored body language, are likely to help facilitate a sensorimotor experience. The use of present-tense language and mirroring assists the consultee in exploring the emotions in the here-and-now (Ivey et al., 2005).

- What are you seeing and hearing?
- What does the classroom look like? Describe in detail.
- Who else is present?
- What are they doing?
- Where are you in the room?
What are you feeling?
Where are you feeling X in your body?

Re-creating the emotional and physiological experience of the stress related to a specific incident might help a teacher to understand fully and to acknowledge his or her stress. Because the consultation relationship between a teacher and a school counselor is collegial and not therapeutic (Brigman et al., 2005), maintaining an awareness of the consultee’s emotional experience is an important task of school counselors choosing to facilitate sensorimotor experiences (Ivey, Ivey, Myers, et al., 2005). If the stress a teacher is experiencing extends substantially beyond job-related stress or if the school counselor assesses that the support a teacher needs is more therapeutic than consultative, making a referral might be necessary.

**Concrete goal.** The purpose of helping a teacher to describe a situation from the concrete perspective might include (a) establishing a linear account of what happened and documenting the incident, (b) separating the emotion from the experience, and (c) establishing a causal or if–then relationship (Ivey, Ivey, Myers, et al., 2005). DCT consultation questions that might guide the facilitation of a concrete storytelling modality are as follows:

Can you think of a specific example?
Tell me what happened just before the student did X.
What happened just after the student did X?
What did you do or say?
How did you feel?
So when you did Y, then the student did X and you felt Z?

These questions are designed to facilitate a detailed and linear description of the event and work toward a causal relationship that includes the teacher as part of the environment. School counselors summarizing the story should use the teacher’s language to further the process rather than paraphrasing (Ivey, Ivey, Myers, et al., 2005). When possible, school counselors should highlight the teacher’s interaction with the student rather than simply focusing on the problem student behavior. The emphasis on the teacher’s interactions maintains the focus on what the teacher can directly control (e.g., his or her reaction to an event).

**Formal-operational goal.** The formal-operational cognitive developmental modality is useful in creating connections between multiple situations (Ivey, Ivey, Myers, et al., 2005). The formal-operational modality might help to validate strong emotional responses experienced by a teacher as it takes into account not only the current situation but also the pattern emerging in the classroom. If the formal-operational modality is a goal, it is necessary to first generate multiple situations from which patterns can emerge. Generating multiple examples might best be achieved in the concrete modality, because the concrete modality is characterized by linear accounts of events and emotions are often less intense than
in other modalities (Ivey et al., 2005). Once two or more examples are identified, the following DCT consultation questions might help school counselors to facilitate movement into the formal-operational modality:

- Is this a pattern for the student/teacher?
- Does this happen a lot in your classroom?
- What are the exceptions to these patterns?
- What are you saying to yourself when this type of situation occurs?
- How do you act or respond?

The emphases of processing an experience in the formal-operational modality are to identify patterns and exceptions to the patterns and to understand the cognitions and the behaviors that occur for both a teacher and the students in his or her classroom. It is likely that those patterns of thinking and behaving can be used to understand systemic issues through dialectic processing.

**Dialectic/systemic goal.** Processing in the dialectic/systemic modality involves considering the interactions among systems as well as taking into account multiple perspectives (Ivey, Ivey, Myers, et al., 2005). Using the dialectic/systemic modality might help a teacher to understand a student's behavior more holistically than through other modalities. Consultation questions drawn from the DCT interview (Ivey, Ivey, & Rigazio-DiGilio, 2005) that guide movement into this complex modality include the following:

- What purpose do you think the student's behavior is serving?
- How do you think the student learned this way of acting in the classroom?
- How did you learn your way of responding to this pattern of behavior?
- What else might be impacting your response to this particular situation?
- What is the rule or the cognition that guides your response?
- What are the limitations of that rule?

The dialectic/systemic modality might allow a teacher to analyze a situation in the context of the classroom or school system. The teacher then might be able to understand better the purpose of a student's behavior, the impact on other students, and his or her response to students.

**A Case Study**

The following case study illustrates a school counselor's use of DCT-based consultation. The high school science teacher (consultee) experienced stress related to inattentive behavior exhibited by a student with attention-deficit/hyperactivity disorder. Through consultation the school counselor assessed the teacher's access to and preference for cognitive developmental modalities, facilitated movement to a new modality, and, with the teacher, co-constructed a professional development plan.
Ms. K is a high school science teacher who stopped by the school counselor’s office following second period to make a referral based on her class. The school counselor asked how he could help, and Ms. K began to tell her story:

I don’t know what to do with Rob anymore. He was unprepared for class again today, which frustrated me. His failure to complete assignments keeps him from earning the privilege of participating in lab. He needs a lab science credit to graduate; I want to see him succeed. My class requirements and the school system are not working for him; I don’t know how I can help him be successful. Sometimes I’m frustrated with Rob and other times I’m angry with the system.

The school counselor assessed Ms. K’s description as dialectic/systemic. Ms. K is considering the system and her emotions shift to reflect the perspective taken.

School counselor: “I’m happy to talk with Rob, but if you are interested maybe we could work together to consider how you might respond to this and similar situations in the future.”

Ms. K agreed. The school counselor reminded Ms. K of confidentiality in consultation and its limits as well as his system for tracking consultation with teachers (as recommended in Brigman et al., 2005). The school counselor decided to begin the consultation by gaining a clear understanding of what happened that day as well as the pattern of behavior (concrete, then formal-operational).

School counselor: “You said he was unprepared for class today. Can you tell me what that looked like?” (Concrete.)

Ms. K: “Sure. I asked the students to pull out their pre-work for lab and switch with a partner to grade it. Earning 80% or better on the pre-work is the students’ ticket into lab because the pre-work is based on the lab activity for the day.”

School counselor: “You asked the students to pull out their pre-work for lab, and then what happened?” (Concrete.)

Ms. K: “Rob dug through his bag for a few minutes; papers were falling out everywhere. And then he stated he did the homework but could not find it. I’m frustrated because I spent an hour with Rob last week organizing his biology notebook!”

School counselor: “So papers were falling out everywhere, and Rob said he did his homework but could not find it. You are frustrated because you spent an hour with him last week organizing his notebook.”

Ms. K: “Yes.”
School counselor: “So what did you do next?” (Concrete.)

Ms. K: “We graded the pre-work and then I dismissed everyone but Rob to the lab. Rob lost credit and lab time for that day. I felt terrible.”

School counselor: “Is this a pattern?” (Moving toward formal-operational.)

Ms. K: “For me or for Rob?”

School counselor (jokingly): “Yes. …”

Ms. K: “Of course! I get frustrated when I spend time helping students get organized and they can’t seem to maintain the systems. My job is to prepare them for college and if I can’t teach students how to get their homework to class, then how are they going to succeed in college?”

School counselor: “So your job is to prepare them for college, and you get frustrated when students can’t maintain the systems you put in place.”

Ms. K: “Yes.”

School counselor: “What are you saying to yourself when this happens?” (Formal-operational.)

Ms. K: “I’m not doing my job well.”

The school counselor better understands Ms. K’s problem. She is telling herself that it is her job to prepare students for college and she has systems in place to help them. Yet, when the students do not use the systems, Ms. K gets frustrated and feels terrible because the end goal of the lab experience is not being met. The school counselor has a hunch that as an experienced teacher, Ms. K has developed a repertoire of organizational interventions that work for most students and the frustration might be connected to feeling like she is failing the students when the strategies do not work.

Ms. K’s preferred cognitive developmental modality is dialectic; however, she demonstrated through DCT consultation that she can understand this situation through concrete and formal-operational modalities as well. As the school counselor shifts his focus to co-constructing a professional development plan, he uses the cognitive developmental modalities as a guide. For example, the school counselor in this case draws upon Ms. K’s ability to consider the problem in an abstract and reflective manner (formal-operational).

School counselor: “What would your classroom look like if this problem was fixed and you were a successful teacher?”

Ms. K: “All my students would be participating in lab and meeting the requirements for graduation.”
School counselor: “So for you to feel successful, all your students need to be participating in lab on a daily basis, which helps them meet graduation requirements.”

Ms. K: “Yes.”

School counselor: “What's keeping students like Rob from participating in lab?”

Ms. K: “Losing or forgetting the pre-work ticket.”

School counselor: “And what purpose is the ticket to lab serving?”

Ms. K: “It ensures that students are prepared to participate in lab.”

School counselor: “So you need your students to be prepared for lab and to participate in lab. Are there other ways of reaching that goal?”

Ms. K: “I hadn't thought about that; I've gotten stuck on being frustrated when students like Rob lose their ticket and try to change their behaviors.”

School counselor: “Is changing the classroom system something you are willing to consider?”

Ms. K: “Yes, I may talk with some of my science department colleagues and try to figure out alternative ways of meeting the goal of full participation in lab. Thanks.”

Implications and Recommendations for Practice

Some teachers may seek consultation when they feel stress related to a student’s behavior or patterns of disruptive or inappropriate behavior in their classroom. The reality, however, is that teaching can be a lonely and isolating profession (Schlichte, Yssel, & Merbler, 2005), and it is likely that some teachers feel stress but do not ask directly for help. Because written referral documents are one way that school counselors encourage teachers to communicate their needs, considering both the content and stylistic aspects of these student referral documents in the context of historical referral data from each teacher might be helpful in determining when to reach out to teachers and offer consultation.

Sensorimotor-like characteristics emerging in written referrals might be a window into the stress a teacher is experiencing in relation to the student’s behavior. For example, fragmented or exaggerated writing styles, such as short disconnected sentences or the use of multiple underlines, exclamation points, and all-capital letters, might reflect the emotions a teacher experienced while writing the referral. Comparing the current referral to other referral documents written by the same teacher may be helpful to contextualize the writing style of the referral.
If the sensorimotor-like characteristics of a written referral diverge substantially from past referrals made by a teacher, it may serve as an indicator of the teacher's stress level and checking in with that teacher could be helpful.

Conversely, characteristics associated with the concrete developmental modality may mask a teacher's stress level. A referral document that includes a detailed linear account of a classroom event might not include allusions to the teacher's affective experience. It is likely that a teacher utilizing the concrete modality to make sense out of a classroom event is separating his or her emotions from the experience. Multiple referrals based on similar student behavior from one teacher, however, might suggest that there may be a systemic or stress-related component to the referral that can be addressed through consultation (Brigman et al., 2005) despite the teacher's presentation as an objective observer of student behavior.

Absolute language such as “always” that punctuates the formal-operational cognitive developmental modality might be considered in the context of the pattern of referrals (or lack of referrals) received in reference to an individual student. If multiple teachers report that a student frequently engages in a particular set of inappropriate or disruptive behaviors, then working directly with that student or with a team of his or her teachers might be more appropriate than consulting individually with one teacher. Alternatively, absolute language that does not fit contextually with other teachers' reports may be an indicator of an individual teacher's difficulty managing a particular student's behavior or type of student behavior in the classroom. Functional behavioral assessments are also a good resource, when available, for determining the frequency and intensity of a student's behavior across classrooms (Kampwirth, 2006).

Of course, consultation is not an appropriate response to all teachers' referrals or requests for individual counseling. Consultation, however, might be particularly helpful when there are factors indicating that providing support to a teacher in an effort to help him or her directly facilitate change might positively impact not only the referred student but also groups of students (e.g., a class). Ultimately, a school counselor's choice to offer DCT-based consultation to a teacher who refers a student for counseling should be guided by a determination of whether or not the teacher is limited in his or her conceptualization of the situation.

**Conclusion**

A DCT-based consultation model provides a practical and efficient approach to consulting with teachers. The DCT model for consultation is an assessment, used to simultaneously understand a problem and also the consultee's range of access to the four cognitive developmental modalities. It is also an intervention that can facilitate a teacher's access to more cognitive developmental modalities and direct future professional development. DCT-based consultation can help school counselors to maximize their time and provide support to teachers while also empowering teachers to effect positive change in their classrooms.
Models of consultation as a collaborative,* problem-solving process dominate the literature and practice of school-based consultation for counselors (Dustin & Ehly, 1992; Keys, Beak, Carpenter, & King-Sears, 1998; Kurpius, 1978; Myrick, 1977; Parsons, 1996; Umansky & Holloway, 1984). While encompassing both remediation and prevention, these models highlight a problem-solving approach. These approaches focus on deficits, with an exploration of weaknesses, before proceeding to goals and solutions. This article proposes an extension of the solution-focused approach to consultation, shifting traditional emphasis from problems and deficits to solutions and strengths. It enumerates the basic assumptions of a solution-focused approach, provides a rationale for why the school setting and solution-focused consultation (SFC) work well together, and proposes steps for an SFC model. Numerous solution-focused techniques are explained followed by a case example demonstrating how the SFC approach can be employed in a school setting.

**Solution-Focused School Interventions and Assumptions**

Solution-focused interventions and schools seem to fit together naturally, as this approach is future-oriented, positive, and shifts the focus from the nature of the problem and places attention on goals and solutions. Solution-focused school interventions have been used successfully in individual counseling (Metcalf, 1995; Mostert, Johnson, & Mostert, 1997; Murphy, 1994, 1997; Sklare, 1997; Van, 1999), in small group counseling (LaFountain & Gerner, 1996), in supervision (Juhnke, 1996; Santa Rita, 1996), and in school leadership (Paull & McGrebin, 1996). These interventions have been used successfully with varied student populations, including minority, multiethnic, and at-risk students (Van, 1999). At the core of solution-focused interventions are certain beliefs and assumptions about the structure of reality, the nature of problems, and the dynamics of change. The assumptions frame the unique qualities of a solution-focused approach as compared to more traditional approaches (see Table 9.1).

Fundamental to a solution-focused approach is the belief that reality is, in part, a social construction, created and maintained through the use of language (Guterman, 1996; Vygotsky, 1962; Wittgenstein, 1968). Through language, certain events can be framed as problematic. Such experiences are perpetuated and reaffirmed as problems by the way one thinks about them and describes them to others. A physical disability or a skill deficiency, for example, becomes problematic because it is framed (constructed) in the most negative, debilitating, and pessimistic manner. Through this construction, the problem becomes an objective reality.*

Table 9.1 Assumptions of Solution-Focused Interventions Versus Traditional Interventions

<table>
<thead>
<tr>
<th>Solution-Focused</th>
<th>Traditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>De-emphasizes diagnosis; solution-focused</td>
<td>Emphasizes diagnosis; problem-focused</td>
</tr>
<tr>
<td>Future-oriented</td>
<td>Past-oriented</td>
</tr>
<tr>
<td>Helper viewed as facilitator, collaborator, coach</td>
<td>Helper viewed as expert</td>
</tr>
<tr>
<td>Build on strengths (past successes)</td>
<td>Develop new behaviors</td>
</tr>
<tr>
<td>Problems do not require a proportional amount of time to solve related to their complexity</td>
<td>Problems do require a proportional amount of time to solve related to their complexity</td>
</tr>
<tr>
<td>Language constructs reality and new meanings for change</td>
<td>Insight is typically used as instrument for change</td>
</tr>
</tbody>
</table>

whose cause must be discovered and resolved in order for remediation to occur. The solution-focused approach suggests that just as one can construct problems and frame difficulties as obstacles to be overcome, one can also choose to think about (reconstruct or reframe) difficulties in manageable and even positive ways.

Solution-focused approaches propose that one can choose to disregard the difficulty or problem entirely and instead focus on how one would like things to be and how one has successfully approached that desired state in the past. This constructivist orientation (de Shazer, 1985, 1988; de Shazer & Berg, 1992; Guterman, 1994) replaces problem construction (and reconstruction as one explores the problem in detail) with a new, positive construction—the absence of the problem or even more favorably, the desired state. Thus, a solution-focused approach shifts attention from the problem to the goal and solution. Evidence suggests that focus upon the desired condition or goal creates a positive reality that is reinforced by even minute indications of movement toward that desired goal (Bandura, 1997; Kanfer & Hagerman, 1987).

Although there are numerous citations of school-based interventions using a solution focus, the literature on merging consultation and a solution-focused orientation is minimal (LaFountain & Gerner, 1998; Metcalf, 1997; Van, 1999). This may be due, in part, to the triadic relationship in consulting, including consultant (i.e., counselor), consultee (i.e., teacher or parent), and the client (i.e., student, class, or larger system) (Parsons, 1996). Implementing a solution-focused orientation is more difficult because goals and exceptions for both the consultee and client must be considered. Supervision is another type of triadic relationship. Extrapolation from the literature on solution-focused supervision (Juhnke,
1996; Santa Rita, 1996; Triantafillou, 1997) can provide one with the basis for a beginning model of SFC. Included in the model and illustrated in the consultation example are the following solution-focused techniques: (a) highlighting the consultee's positive and productive behaviors, (b) presuppositional language that assumes change will happen, (c) goal defining, (d) scaling, and (e) the consultee trying new behaviors that are out of the ordinary.

**Solution-Focused Consultation: An Evolving Model**

As is the case with solution-focused counseling, SFC accentuates the positive by helping consultees identify and use their strengths, resources, and past successes to formulate desired goals. Solutions, including past successes and exceptions (times when the problem did not exist), are constructed to achieve those goals. A characteristic of the model is a strong working alliance between consultant and consultee; they should be actively involved and connected. Similar to the balanced relationship of solution-focused supervision, the consultant should build on life, experience, and training of the consultee rather than deliver or teach expertise from a hierarchically superior position (White & Epston, 1990).

SFC also differs from more traditional models in the degree of focus on the client/student. Although goals for the student are specified, the goals in an SFC should be primarily within the control of the consultee/teacher or parent. Achieving the designated goals should not be dependent solely on correct student change (Thomas, 1996). An assumption behind this focus is that a small change on the part of the teacher or parent will cause rippling effects throughout the entire system, including the students' behaviors.

This approach is not defined by the discrete stages of traditional consultation models (Kurpius, 1978; Parsons, 1996) in which a certain content must be achieved before advancing to the next stage; instead, it is a process in which steps flow into each other and techniques are used simultaneously. The steps in the SFC process may be completed within one session or may extend over many sessions. Juhnke’s (1996) approach to solution-focused supervision can be adapted to the following steps of a consultation model: (a) presession and initial structuring, (b) establishing consultation goals, (c) examining exceptions, (d) helping consultee decide on a solution, and (e) summarizing and complimenting.

**Presession and Initial Structuring**

The goals of this first step include orienting the consultee to a solution-focused approach, helping the consultee identify strengths and resources, and setting initial goals. The consultant uses what de Shazer (1985) calls the “language of change” to carefully form questions and guide the consultee through the process. Because the use of language is so important to a solution-focused approach, the school counselor should introduce this language to the consultee prior to their first session. Consultants/counselors can orient faculty and parents to this
approach during in-service and parent-orientation meetings or through the use of a presession consultation questionnaire. Juhnke (1996) proposed using a presession supervision questionnaire that can easily be adapted as a consultation questionnaire. On this questionnaire, consultees are asked to identify the strengths and resources that they bring to the consultation. For example, a teacher would describe the teaching skills and interpersonal strengths that she brings to the consultation. The teacher would also be asked to write beginning goals, first for the client, and then for herself. Questions to which she would respond include: “How would you like the student to be?” “How would you like to be with your student?” “With your class?” and “How will you know when the consultation is successful?” This presuppositional language uses such words as when and will and sets the stage for future change, while instilling hope.

As the consultant and consultee enter the initial meeting, the stage has already been set for a solution-focused approach. The consultee has been oriented to the use of presuppositional language, to the emphasis on strengths, and to the importance of goals. If a presession questionnaire is not used, a question such as “What do you hope will happen as a result of our meeting today?” will help focus the consultee.

The technique of authentifying presession change can also be used in this step. Weiner-Davis, de Shazer, and Gingerich (1987) noted that two thirds of their outpatient clients reported a positive change from the time they made the decision for therapy to the time of the first session. These authors suggest the use of “scaling” as a way to highlight positive changes. It is similarly important for the consultant to recognize, reinforce, and amplify such presession changes to help assure lasting effects. Using scaling, a consultant could ask the teacher/consultee, “If one is at the time you made the decision to come for consultation, and ten is when you no longer need to come, at what number are you now?” Such a scale focuses the consultee on positive change and is based on the belief that the decision to seek help is the actual beginning to the change process. The consultant reinforces these changes as worthwhile and authentic by asking “future-oriented” questions such as: “How did you do that?” “How can you do more of that?” and “How do you know you can do that?” (de Shazer, 1991).

**Establishing Consultation Goals**

Compared to traditional consultation, there is minimal exploration of the problem before establishing consultation goals. The assumption is that exploring the problem only tells the consultation team more about the problem and not necessarily about solutions. Exploration of the past focuses on exceptions, times in which the problem did not occur.

After a brief discussion of the problem, consultation goals for the client and the consultee are considered. Goals should be realistic, yet perceived as important and “hard work” for the consultee (Berg, 1994). Goals should be expressed in the consultee’s own words. They should be defined in affirmative action
(e.g., “I will call on Sara when her hand is up”). They should be defined as a presence (positive) and not an absence (negative) of behavior (e.g., substituting “he will raise his hand” instead of “he won’t call out”). They should be defined in concrete, behavioral, and measurable terms. An example is, “Fran will invite one friend to play at recess daily. She will use direct eye contact, a smile, and friendly voice tone.” O’Hanlon and Wilk (1987) have used the technique of “video-talking” to help the client better formulate goals in a concrete manner. Asking the consultee, “If you were video-taping your student achieving his goal, what would you see him doing? What would he be saying?” Consultees sometimes come to consultation with a vague sense of goals. This may be for two reasons—resistance to the process or a lack of clarity about what needs to be accomplished.

In a solution-focused session, resistance is reframed as the consultee’s lack of ownership in the problem and solutions (de Shazer, 1984). Consultees join the process on a continuum of involvement at various points depending on their motivation and commitment to solve the problem (Fisch, Weakland, & Segal, 1982). Murphy (1997) describes three levels of involvement in the continuum: visitor, complainant, and customer.

Visitors are consultees who come to the consultation because they are somehow forced by another person (such as an administrator or court). They are generally uncommitted to change and may not even acknowledge their part in the problem. Complainants are consultees who acknowledge the problem, are willing to talk about it, but are unwilling to take responsibility to change. Parents and teachers frequently come to the consultation as complainants, believing that the responsibility respectively lies with the school or the home. Customers are consultees who have a definite desire to do something about their problems. When establishing goals, consultants need to meet consultees where they are on the involvement continuum and gradually move them to the position of customer. This can be accomplished through the use of such questions as: “What’s the minimal amount of change that you are willing to accept?” or “What are you willing to do to make your life easier in the classroom?” The reality is, however, that some consultees never move from the visitor position. In those cases, another type of intervention (i.e., individual or group counseling, assessment, or referral) may provide a more effective outcome for the client.

Examining Attempted Solutions and Exceptions

After goal setting, attempted solutions and exceptions are examined. Berg (1994) stressed the importance of solutions coming from the consultee, noting that: (a) the consultee is generally more committed to these solutions; (b) the solutions come from the consultee’s existing resources, and they fit naturally with the way things are done; (c) the solutions are more likely to be congruent with the consultee’s lifestyle than newly learned behaviors; and (d) the consultee is less likely to relapse. This is best accomplished through a review of exceptions, times when the problem did not occur.
Consultees are sometimes at a loss to recall any exceptions. A question such as “When was a time that it happened just a little?” allows them to examine small changes and build from there. If the consultee truly cannot find the exception, the consultant could (a) give the teacher a homework assignment of looking for exceptions throughout the coming week; (b) ask the consultee to recall or imagine a master teacher (How would this person handle the problem?); and (c) ask the consultee for permission to observe in the classroom and provide feedback about exceptions.

**Helping Consultees Decide on a Solution**

In this step the consultant helps the consultee decide on a solution, based on past exceptions. Berg (1994) offered three rules to help in this decision: “(1) If it ain’t broke, don’t fix it; (2) Once you know what works, do more of it; and (3) If it does not work, don’t do it again; do something different” (p. 16). In the following sequence of questions, the consultant helps the consultee in the decision, while moving the emphasis of change from the student’s behavior to the teacher’s behavior: “When was the last time you found him doing what you want?” “What was different?” “How did you get him to do that?” and “What do you need to do to make that happen again?”

As in goal setting, solutions must be defined behaviorally and concretely. “Who is doing what, when, how, and where?” The initial solution may not be where the consultee wants to be at the end of the consultation, but it should be a small step in that direction. The consultant helps the teacher choose the best solution through questions such as: “Which solution is best, given your resources? the student’s resources? the time of the year? the cooperation of the family? the severity of the problem?”

**Summarizing and Complimenting**

While this is the final step in the model, summarizing and complimenting actually take place throughout the process and can serve as the beginning for the next consultation session. The consultant summarizes goals and the chosen solution(s). “What will the student be doing?” “What will you do to enable that to happen?”

Berg (1994) defined giving compliments as acknowledging what clients say, feel, and believe while affirming and respecting attitudes about the issues they discuss. Included in complimenting is giving praise for successful exceptions in the past. Complimenting is an excellent way to end an initial consultation session or terminate a consultation case. Complimenting which describes specific behavioral accomplishments and what the teacher did to foster such accomplishments better enables the teacher to attribute successes internally. If a similar problem arises in the future, the teacher will be more likely feel that she has the necessary resources for success.
If consultation sessions continue, these first basic steps are repeated with continual goal re-evaluation and examination of exceptions. Scaling allows for evaluation from session to session. Beginning the next session with the simple phrase, “What’s better?” allows the teacher to focus on positive changes. The consultation is concluded when goals are attained, with the door left open for future consultations.

**Case Consultation: An Illustration of Solution-Focused Consultation**

Kelly is a second year literature/language teacher in an urban middle school. She has come to the counselor to discuss her student Jon, a 13-year-old European-American male. He was formally evaluated in fifth grade and found to have weaknesses in reading comprehension and to have attention problems. No specific learning disabilities were diagnosed. Kelly completed a consultation questionnaire 3 days earlier.

Unlike traditional consultation (Parsons, 1996) that begins with a thorough analysis of the teacher’s concerns, SFC emphasizes teacher goals, strengths, and previous successes. (Information in parentheses throughout this case identifies SFC techniques or discerns differences between this approach and more traditional consultation.)

*Counselor:* It’s good to see you, Kelly. How are you doing? I’m glad that we didn’t have to wait too long before we got together. What do you hope will happen as a result of our meeting today?

*Teacher:* Well, my fourth period class is driving me crazy. I’m tempted to ask for them all to disappear, but I doubt even you could pull that off. I’m so frustrated. I just feel like I’m losing control. I really thought that I had mastered this teaching stuff in my first year, but now I realize that last year I just had an exceptional bunch of kids.

*Counselor:* Well, I know they were a great bunch of kids, but I also know that you had many successes in your teaching. You started the After-School Study Hall and really helped some “kids” enjoy reading for the first time. I’ve heard from both teachers and parents that this year’s class has many students that require extra attention. The Inclusion teacher has shared with me the many ways you’re trying to tailor the curriculum to students’ individual learning needs, and haven’t you added coaching and graduate school to this year’s schedule? (Complimenting.)

*Teacher:* Yes, I know. Sometimes I don’t give myself credit for what I’ve accomplished in this short time. But I just really want to do well at this teaching thing, and right now it feels like I’m drowning.

*Counselor:* Yes, I can see that “drowning effect” in your whole demeanor. Let’s see what we can do to help you feel like you’re staying afloat. (Uses
consultee’s language and then restates it in the positive.) You remember that I talked about using a solution-focused approach with students at our first fall in-service meeting? Well, we’re going to do some of that same work here. The great thing about a solution-focused approach is that you can use the same language with some of the students we’ll be talking about. Tell me about what is happening in your class.

**Teacher:** Well, I feel like the class is running the show. No, maybe just one or two students, but everyone else is following them. I’m not consistent in my discipline. I say one thing, and then in the rush of the day, I don’t always follow through—especially with Jon. I know he has special learning needs, and I try to accommodate him, but he wants attention constantly. When I can’t give him what he wants, he takes over the class with his “comedy” and sabotages my lessons. I end up frazzled, and he’s done an entire “stand-up” routine!

**Counselor:** That sounds tough! How will you know when things are better for Jon in the classroom? (Briefer exploration of problem than traditional consultation.)

**Teacher:** When he’s tuned in?

**Counselor:** And what will he be doing when he’s tuned in? (Counselor in SFC approach helps the teacher to operationally define her goals for the student; the concreteness of these goals is further enhanced through goal-scaling.)

**Teacher:** Well, he’d be on task most of the time. He wouldn’t call out. He wouldn’t disrupt my class.

**Counselor:** OK, so he will be on task. He will raise his hand to ask for help and interact appropriately with his classmates and you. For example, use his comedy at the proper time. (Goals for student stated in the positive.) On a scale of one to ten, with ten meaning he’s in control of his problems and one meaning his problems are controlling him, where would you put him right now?

**Teacher:** About a four.

**Counselor:** Okay. Now let me ask you, how will you be when he’s tuned in? (Focus moves to consultee.)

**Teacher:** Well, I’ll be more relaxed, so I can focus on the content of the lesson. I will smile more. I will enjoy the students. I will try more creative teaching techniques.
Counselor: And on that same scale, with ten being in control and relaxed, and one being controlled by your problem, where are you right now?

Teacher: Well, I'm about a four, too.

Counselor: Now, let's go back to Jon. When was the last time you found him doing what you want, being tuned in?

Teacher: Boy, that's a hard one!

Counselor: Maybe he was doing it just a little. (Finding exceptions for the client.)

Teacher: Well, when he works with Cecily. She's shy, but a really good student. It seems that she almost has a calming effect on Jon. She doesn't buy into his comedy. When he works with her, or even sits near her, he seems to try to model her study habits.

Counselor: Good, what else?

Teacher: Well, when I shorten his task, or better, give him breaks to move around, that sometimes works. But sometimes he distracts other students.

Counselor: What do you need to do to make the shorter tasks and breaks happen again?

Teacher: We had a system we used at the beginning of the year where he worked for 15 minutes, took a short break, and then worked again. It worked pretty well until he started distracting others, so I just stopped it.

Counselor: What do you need to do to make it happen again?

Teacher: Oh, I don't know. Sometimes it seems like I'm batting my head against a wall, maybe I should start it again to work on the distractions. I should ask him what he needs during those breaks so he can get back to work fully.

Counselor: That's a great idea. You've got some really good ideas. And I really appreciate your openness to this process. So, if Jon is a four this week, what will have to happen for him to be a five by our next meeting?

Teacher: Well, I'll re-institute the work blocks, schedule some activities where he can work with Cecily, and talk to him about it.

Counselor: That's super! The last thing I want you to think about is this, and I don't necessarily want you to do anything about it yet. How can you be
different with Jon? It sounds like your relationship has carried a lot of friction. How can you react differently and really surprise him? Just think about it. Thanks for your time, and I’ll check with you mid-week.

**Case Discussion and Conclusions**

There are numerous solution-focused concepts and techniques illustrated in this case example. Discussed in sequence, the counselor freely gives compliments throughout the session while describing specific behaviors in her praise. There is minimal exploration of the problem before moving on to goal setting. The counselor effectively uses solution-focused language in goal setting by using presuppositional language, the words of the client (i.e., “drowning”), and stating the desired behaviors in positive language. Scaling is employed to gain a sense of baseline behaviors for the student and teacher. It is also used later in the session to help the teacher envision what small changes would look like. The counselor can come back to the earlier stated numbers in subsequent sessions to determine what progress has been made. The counselor and teacher firmly explore exceptions, choose the best solutions, and discuss a plan to implement them. Finally, the suggestion to do something different allows the teacher to try other behaviors (sometimes playfully out of character). In this case, when the teacher found Jon achieving his goal, she invited him to perform his comedy during the last 5 minutes of the period. This small change in the teacher’s demeanor helped change their relationship for the positive.

This article proposes a model of solution-focused consultation for school counselors. As counselors successfully integrate solution-focused interventions in their other roles and functions, expanding this approach to consultation makes sense. One of the benefits of SFC may be that the model can either be fully adopted by counselors or they may choose to “try out” aspects of the model (i.e., questionnaire, scaling, presuppositional language, etc.) while using more traditional consultation. Another benefit may be that teachers and parents can more easily transfer language and skills learned through this consultation approach to other problems and contexts. In order to ascertain the true benefits and effectiveness of such an approach, the next step in model development requires outcome research employing solution-focused consultation. Validating the usefulness of SFC will provide school counselors with another set of skills to effectively perform their job.

**Guidelines for Consultation**

The stages of consultation outlined by Meyers et al. (1979) and Kurpius, Fuqua, and Rozeck (1993) have been adapted here and serve as guidelines for the development of the consultation plan.
Preentry is considered part of the consultation process because it enables the consultant to assess the degree to which he or she is the proper fit for the consultation situation. According to Kurpius et al. (1993), preentry is the preliminary stage when the consultant forms a conceptual foundation to work from and through the process of self-assessment and is able to articulate to self and others who he or she is and what services he or she can provide. Kurpius et al. (1993, p. 601) suggested that throughout this self-assessment and reflective process, consultants should understand their beliefs and values, understanding how individuals, families, programs, organizations, or systems cause, solve, or avoid problems.

Furthermore, Kurpius et al. (1993) maintained that the preentry stage is essential for consultants to conceptualize the meaning and operation of consultation to themselves and be ready to do the same with their consultees or consultee system. To this end, the following questions are often helpful:

- What models, processes, theories, and paradigms do you draw on to conceptualize your model of helping?
- How do you define consultation to the consultee or consultee system?
- Do you see the process of consultation as triadic (consultant, consultee, client) or didactic (consultant and client)?
- When is having a vision, looking into the future, and planning a better intervention than cause-and-effect problem solving?
- What about acting as judge and evaluator of your consultees?

**Entry Into the System**

The consultant's entry into the system is a crucial step in determining the success or failure of consultation efforts. Gallessich (1982) delineated several steps in the process of formal entry into the system. For the external consultant, entry usually begins with the exploration of the match between the organization's needs and the consultant's skill. Discussions between the consultant and members of the organization center around descriptive information about the organization, its needs, and desired outcomes. The consultant's skill, style of consultation, and plan of how consultation efforts can be implemented in the setting are discussed and negotiated. Once the parties have agreed that consultation is indeed needed, the process proceeds to the negotiation of an informal or formal contract. The formulation of a contract follows the consultant's defining his or her function and role in the system. A clear understanding of the specific duties and functions of the consultant must be presented to personnel involved in the consultation effort. Negotiating a contract with key personnel serves to ensure that the highest level of administrators as well as subordinates participate in the consultation process. Involvement of all personnel provides a smooth transition into the system and lessens the amount of resistance that can be encountered.
The formal discussion of the contract should include the following:

- goals or intended outcomes of consultation,
- identity of the consultee,
- confidentiality of service and limits of confidentiality,
- time frame (How long will the service be provided to the organization? To the individual consultee?),
- times the consultant will be available,
- procedures for requesting to work with the consultant,
- ways to contact the consultant if needed,
- the possibility of contract renegotiation if change is needed,
- fees (if relevant),
- consultant’s access to different sources and types of information within the organization, and
- the person to whom the consultant is responsible (Brown, Pryzwansky, & Schulte, 1987, p. 137).

**Orientation to Consultation**

Orientation to consultation requires the consultant to communicate directly with key personnel in the system. Personnel need to know what to expect from the consultant and the consultant relationship. Initially the consultant, in establishing a working relationship, must discuss roles the consultant and consultees will play in the process. This enables all parties to share in the expression of their needs and preferences and creates an atmosphere of open discussion and communication. Typical questions addressed in the orientation include the following:

- What are the consultant’s expectations about consultation?
- What roles will the consultant and consultee assume in the consultative effort?
- What are the boundaries of the consultant’s interventions?
- What are the ethical concerns of the consultee?
- What are the guidelines of confidentiality?
- How long will the consultation take?
- What are the procedures governing the gathering of data?
- What are the guidelines for the giving and receiving of feedback?
- What are the procedures used in the assessment of the consultation plan?

**Problem Identification**

Once the consultant and consultee have oriented themselves to the process of consultation, the consultant needs to identify the problem(s) to be addressed. A first step in problem identification is to meet with the consultee to gather appropriate data. Problem identification begins with establishing goals and objectives to be accomplished in consultation. Specific outcomes to be expected and the
format for assessing outcomes are discussed. For example, questions to be considered might include the following:

- What are your general concerns about the problem?
- What needs to be accomplished to overcome your concerns?
- What role will the consultee play in overcoming the problem?
- What aspects of the consultee’s problem are most distressing?

**Consultation Intervention**

Having defined the problem and reviewed the data gathered with the consultee, the consultant proceeds with the development of a specific intervention plan. The plan will include the establishment of objectives, the selection of strategies to be implemented, and the assessment procedures to be followed. Bergan (1977) suggested the following four-point outline as part of implementing a consultation plan:

1. **Make sure the consultee and consultant agree on the nature of the problem:** Problem identification during the consultation process is critical to the overall success of consultation and sets the stage for the establishment of the consultant–consultee relationship. During the process, the consultant’s main priority is to assist the consultee in identifying and clarifying the main problem that is experienced by the client. According to Dustin and Ehly (1984), the skills and techniques of focusing, paraphrasing, setting goals, and showing empathy and genuineness are particularly valuable at this problem identification stage. These skills assist in the development of a plan based on authenticity and collaborative commitment between the consultant and consultee. According to Meyers et al. (1979), a major task of the consultant is to determine which of four levels of consultation is most appropriate in conceptualizing the problem. The specific consultative techniques will vary depending on whether the consultant chooses to respond with direct service to the client (level 1), indirect service to the client (level 2), direct service to the teacher (level 3), or direct service to the organization (level 4). Regardless of the level to be addressed, the consultant and consultee must agree on the nature of the problem.

2. **Complete either the setting and intrapersonal analysis or the skills analysis:** One role of the consultant is to help the consultee to accurately estimate the importance of situations, as well as to develop self-efficacy expectations regarding performance. Once performance of a productive behavior has been completed, self-evaluation based on reasonable standards must occur. These processes can be facilitated through modeling and feedback to the consultee. Often motivation can be enhanced by reminding the consultee about the possible positive outcomes of consultation, helping to set goals and correspond with his or her own standards and developing situations
that will build confidence that he or she can perform the skills needed to solve the problem (Brown et al., 1987, p. 284).

3. **Design a plan to deal with the identified problem:**
   a. establish objectives,
   b. select interventions,
   c. consider barriers to implementations, and
   d. select appropriate procedures.

   Once the problem has been identified, the consultant and consultee work to establish realistic goals—the objectives of the consortium effort. Setting realistic expectations for the outcomes of consultation implies communication about and knowledge of environmental consultee constraints. Furthermore, Bardon (1977) asserted that successful consultation requires consultees who are knowledgeable of the consultation process. Without this understanding, discordant expectations between consultant and consultee frequently will lead to resistance (Piersel & Gutkin, 1983). Gutkin and Curtis (1982) asserted that unless consultees actively contribute during consultation interactions, they often will be frustrated by recommendations that are inconsistent with their own thinking, feel little psychological ownership of treatment plans, and fail to expand their own professional skills. This agreement and acceptance of objectives of the consultation plan must be ensured before consultation interventions can be planned.

   The selection of intervention strategies should rest with the consultee (Bergan, 1977). The consultee involvement in the selection process will raise the client’s awareness of the problem and should enhance motivation by engaging clients in goal setting and evaluation. The major issue in selecting intervention strategies is their appropriateness to the setting and the amount of time needed to monitor strategies. Brown (1985, pp. 421–422), in his discussion of the training of consultants, suggested that the following questions be asked:
   a. Is the intervention technically correct?
   b. Why was the intervention selected over others?
   c. How much work and change will this intervention cause for the consultee? If the consultee involves the organization, what structure must change, and what are the sources of resistance to this change?
   d. How will the process and outcomes of the intervention be monitored?
   e. If this fails what is proposed?

   Reimers, Wacker, and Kepl (1987) suggested that a number of factors influence the selection of interventions. In general, the more severe the problem, the higher the acceptance level of all proposed treatments.

4. **Make arrangements for follow-up sessions with the consultee:** Successful termination of consultation includes the need on the part of the consultant to express an openness to work with the consultee again with other presenting problems. In addition, the collecting of data from the consultee on the
outcomes of change efforts can document effective consultation and justify its use in professional practice (Dustin & Ehly, 1984).

**Assessing the Impact of Consultation**

The success or failure of consultation interventions is determined by assessing the degree to which the results are congruent with the specific objectives. Data for making this determination comes from the observations that began during the entry process and have continued throughout the consultation process. Brown et al. (1987) suggested that steps in the evaluation process are as follows:

1. **Determine the purpose(s) of the evaluation:** The extent to which consultees provide or gather data affects their involvement at this point. The opportunity to make choices that will affect the time that needs to be directed to evaluation as well as to the types of information that are collected will contribute to the ownership of the evaluation. A major issue to be considered is the confidentiality of the information to be presented.
2. **Agree on measurements to be made:** The consultant and consultee must agree on methods and procedures of measurement. Measures must specifically address the objective and goals of the intervention plan.
3. **Set a data collection schedule:** The consultant and consultee must agree on a formalized calendar of data collection. The method of collection, the tasks assigned to each party, and the method for summarizing and reporting data are discussed.
4. **Develop a dissemination plan:** The dissemination plan, which includes the format in which data are reported, needs to be carefully considered by both parties. Issues surrounding the reporting of data, the individuals to whom data are reported, and the confidentiality of the data are agreed on and follow a predetermined plan of action.
5. **Concluding consultation:** The termination of the consultation process is as important as the initial entry into the system. An imperative step is for the consultant to provide the consultee with an open invitation to seek further assistance as the need arises. Follow-up of consultation activities ensures that the consultant and consultee have the opportunity to measure the effects of the process over time. The degree to which the termination process is perceived as a smooth transition can determine whether consultation services will be sought in the future (pp. 243–244).

The Consultation Rating Form (Form 9.1) is included in the Forms section at the end of this book for use by the site supervisor and university supervisor. This rating form can be used to evaluate consultation activities carried out by the counseling or psychology intern. The form can be used as either an interim or a final evaluation.
**Process and Content Models of Consultation**

The writings of Schein (1969, 1990) focused on the need for the helper or consultant to understand the basic assumptions he or she brings to the consultation relationship. Rockwood (1993), in a special issue of the *Journal of Counseling and Development*, discussed Schein's consultation models—examining content versus process components of problems and problem solving. The basic components and major assumptions of the Purchase-of-Expertise Model, Doctor–Patient Model, and Process Consultation Model are outlined next.

**The Purchase-of-Expertise Model**

The Purchase-of-Expertise Model makes the following assumptions:

1. The client has to have made a correct diagnosis of what the real problem is.
2. The client has identified the consultant's capabilities to solve the problem.
3. The client must communicate what the problem is.
4. The client has thought through and accepted all the implications of the help that will take place (Schein, 1978).

The Purchase-of-Expertise Model, a content-oriented approach, enables clients to remove themselves from the problem, relying on the skills and expertise of the consultant to fix the problem.

**The Doctor–Patient Model**

The Doctor–Patient Model also focuses on content and assumes that the diagnosis and prescription for the problem solution rest solely in the hands of the consultant:

1. The client has correctly interpreted the organizational assumptions and knows where the sickness is.
2. The client can trust the diagnosis.
3. The person or group defined as such will provide the necessary information to make the diagnosis.
4. The client will understand and accept the diagnosis, implement the prescription, and think through and accept the consequences.
5. The client will be able to remain healthy after the consultant leaves (Schein, 1978).

**The Process Consultation Model**

The Process Consultation Model focuses on how problems are solved in a collaborative effort:
1. The nature of the problem is such that the client not only needs help in making a diagnosis but would also benefit from participating in the making of the diagnosis.
2. The client has constructive intent and some problem-solving abilities.
3. Ultimately, the client is the one who knows what form of intervention or solution will work best in the organization.
4. When the client engages in the diagnosis and then selects and implements interventions, there will be an increase in his or her future problem-solving abilities (Schein, 1978).

Process consultation is systematic in that it accepts the goals and values of the organization as a whole and attempts to work with the client within those values and goals to jointly find solutions that will fit within the organizational system (Rockwood, 1993).

**Resistance to Consultation**

Resistance in consultative relationships is defined as “what occurs when the consultant is unsuccessful in influencing the consultee to engage actively in the problem solving process” (Piersel & Gutkin, 1983, p. 311). Berlin (1977) identified four types of resistance to consultation: inertia, active opposition, planned ineptitude, and feared loss of power. Similarly, Parsons and Meyers (1984) discussed four types of organizational resistance:

1. *The desire for systems maintenance:* The entrance of the consultant into the system requires the system to adapt to new input that drains energy and threatens the system. To avoid this pitfall, Parsons and Meyers (1984) suggested that the consultant should be careful not to threaten existing roles or challenge others' jobs or role definitions. The simpler the consultant's entry and the less change in structure, tone, process, or product it entails, the easier it will be for the consultant to avoid resistance based on system maintenance (p. 102).
2. *The consultant as the outsider:* The consultant often is viewed as an alien in the organization and is treated with suspicion and resistance. The consultant should become familiar with the institution's history, mission, philosophy, and procedures and increase his or her availability to and contact with the staff to reduce this outsider status.
3. *The desire to reject the new as nonnormative:* There often is a desire to maintain status quo by conforming to existing norms in the organization. The consultant must guard against tampering with time-honored programs, processes, and procedures. Consultant sensitivity to organizational vulnerability is essential.
4. The desire to protect one’s turf or vested interests: The consultant must recognize that his or her presence is often viewed as an intrusion on the consultee’s area of interest or professional responsibility. Involving the consultee in the process tends to lessen the resistance (pp. 102–106).

Similarly, a number of authors have identified specific variables that increase resistance to consultation. Lin and Zaltsman (1973) suggested that the more complex and involved the intervention, the more likely it is that it will meet with resistance. Kast and Rosenweig (1974) suggested that resistance is tied to the ability to change agents to accurately communicate the nature of interventions to consultees. Reimers et al. (1987) suggested that the less time and resources needed to implement interventions, the greater the acceptance. Bardon (1977) asserted that successful consultative interactions require consultees who are knowledgeable of consultation processes. Piersel and Gutkin (1983) maintained that discordant expectations between consultant and consultees will frequently lead to resistance.

Contracting and the Forces of Change in the Organization

Kurpius et al. (1993) suggested that an understanding of the cycles of change and the forces of change within the organization are helpful in gaining a better understanding of problems and culture surrounding the problem in the organization. Stages of change include the following:

1. Development: Help is needed at an early stage of a new problem or program.
2. Maintenance: Things are becoming stagnant and falling behind, needing help to improve. This stage shows signs of consultee desire and motivation for change.
3. Decline: Things are worse, and consultees recognize that they cannot solve the problem. Consultees may want a quick fix and have high expectations for the consultant.
4. Crisis: Consultees or consultee system is desperate for help. The consultant may look for dependency first, but it is important that consultees understand that their situation and the investment need to return to a stable state.

The forces of change within the system need to be understood for consultation to proceed. When the system is closed to change, and internal forces vary between being for or against change, there is usually little opportunity for change to occur. When the system recognizes that change is needed but forces for and against change are balanced, progress is possible but slow moving. When the forces for change are external to the members who prefer not to change, one can expect a high degree of conflict and slow change. Finally, when the members recognize the need for help and all want help to improve, then the best chance for successful helping occurs (Kurpius et al., 1993, p. 602).
These models can serve as a test of the feasibility of the consultant’s effort and the type of contract the consultant will implement. The formal discussion of the contract between the consultant and the consultee should include a number of critical questions to be answered before a contract is developed and implemented. According to Remley (1993), consultation contracts should do the following:

1. clearly specify the work to be completed by the consultant,
2. describe in detail any work products expected from the consultant,
3. establish a time frame for the completion of the work,
4. establish lines of authority and the person to whom the consultant is responsible,
5. describe the compensation plan for the consultant and the method of payment, and
6. specify any special agreement or contingency plans agreed on by the parties.

Remley (1993) suggested that some individuals complain that written contracts are too legalistic and signify a distrust between the consultant and the consultee. Consultation gives a business arrangement and should be entered into in a businesslike fashion. By reducing to written form agreements that have been reached by the parties, misunderstandings can be identified and resolved before further problems arise.

**Summary**

Consultation in schools and mental health agencies is a highly sought-after skill, and one with which counseling and psychotherapy interns should become familiar. In this chapter, the models and methods of consultation were presented to provide the student with an overview of the ways to organize and establish consultative relationships. The differences between mental health consultation and school consultation have been discussed, along with critical issues such as resistance. Systems and integrative approaches to consultation were chosen as representative samples of consultation strategies, and guidelines for consulting in the school were presented. This chapter also cited a form (Form 9.1) that can be used to assess the intern’s consultation activities and that can provide valuable feedback that can help the student to refine and enhance his or her consultation skills.

**Suggested Readings**


References


Part IV of the textbook addresses issues common in internship preparation and functioning. Chapter 10 addresses the selection and evaluation of an internship and the process of choosing one. This chapter also includes forms that the student can use in selecting an appropriate internship site. Chapter 11 is designed to provide the intern with a variety of interventions and strategies commonly employed in agency and school settings. Chapter 12 discusses essential forms that the student may use in assessing the internship experience as a whole, as well as a form that can be used by interns to evaluate their experience with individual clients.
Chapter 10
Preparation for Internship

This chapter addresses preparation for the internship component of the student’s training program. Emphasis is placed on the procedures for evaluating and obtaining internship placement in an agency or school setting. This section will provide the student with an overview of what are considered to be the fundamental steps in selecting and evaluating an internship placement.

The material in this section is structured based on the assumption that the student has completed all or almost all formal course work at the training institution and is completing his or her internship experience at an approved internship site. An important concept to note is that the internship experience is typically quite different from previous prepracticum and practicum experiences. In the internship, the major responsibility for the supervision of the intern falls on the site supervisor. Thus, the student needs to formalize the relationship with the site supervisor to ensure that the requirements of the internship are consistent with the goals of the institution and with the student’s personal and professional goals.

The transition from practicum to internship can create considerable concern for the student. Selecting an internship site without adequate knowledge of the requirements of both the university training program and the specific internship sites to be considered prevents the student from making an informed decision regarding placement. Although some students may view the selection process as an opportunity to explore experiences that are available for training and supervisions, other students often feel pressured to make a decision based on limited information without adequate thought and preparation.

Selection and Evaluation of an Internship Site

A major issue to be addressed by the prospective intern is the appropriateness of the internship experience in relationship to the student’s personal and professional goals. A well-recognized fact is that the completion of an internship experience
that meets the student’s career needs and program needs, in addition to providing good supervision and training, enhances the student’s professional viability.

The initial step in the selection of an internship site requires that the student gather as much information as possible about each potential internship site and personnel. In preparation, a number of questions need to be addressed:

■ Will the internship site provide me with a wide variety of professional activities in keeping with my training and professional goals?
■ Does the internship client or patient population represent the type of population with whom I desire to work?
■ Will I be exposed to all the activities that a regular employed staff member would experience?
■ Will I be provided with direct supervision by a trained qualified supervisor?
■ Have the internship site personnel had experience in working with interns, or is this the first time an intern has been placed there?
■ Do, or will, appropriate liaison activities occur between the university training program and the internship staff?

Answers to these questions enable the student to gain an initial overview of the proposed internship experience at one or more different sites. Consulting with university faculty, the internship coordinator, and other professionals is an invaluable source of internship information. Data about the type of setting, the client population, the types of services, and the staff size are in keeping with the student’s professional needs. Two forms are provided in the Forms section at the end of this book that can be used to gather appropriate information about potential internship sites. The Intern Site Preselection Data Sheet—School (Form 10.1) asks questions appropriate for positions in elementary-, middle-, secondary-, and college-level institutions, whereas the Intern Site Preselection Data Sheet—Clinical (Form 10.2) gathers information relevant to positions in a clinical agency setting. The information needed to complete the forms can be obtained by consulting with professionals familiar with the site, by informally visiting the site, or by writing to the site to obtain available descriptive materials and answers to specific questions.

Once the student has selected several possible internship sites, the next step in the process should be to set up a personal interview at each internship site that holds potential. Taking an interview helps the student to gain firsthand knowledge about the internship site and provides the opportunity to meet with the staff and other professionals.

Meeting with the agency director and internship supervisor provides the perspective intern with the opportunity to clarify what Faiver, Eisengalt, and Colonna (2000) said are the four factors to consider in choosing an internship: (a) your own needs and interests, (b) your counseling program guidelines, (c) the state regulations regarding licensure and certification, and (d) the educational opportunities at the internship site (p. 6).
The following are questions to be asked regarding these factors:

1. *My needs and interests:*
   - Will this experience provide me with the opportunities to meet my needs?
   - Does the internship experience provide the opportunity to pursue my interests?
   - Are my needs and interests compatible with the goals of the agency or school?
   - Which specific program activities seem to parallel my interests?

2. *My counseling program guidelines:*
   - Does this internship placement meet my program standards for an internship?
   - Will I be able to fulfill the internship requirements in a timely fashion?
   - What availability is there for direct and indirect counseling experiences?
   - Will there be an adequate supply of clients available to me?
   - What types of client problems are typical in this agency?
   - Will I be given an orientation to the philosophy, procedures, and practices of the agency?
   - Will I be involved in any paraprofessional activities? Errands? Photocopying? Filing? Answering phones?

3. *State regulations regarding licensure and certification:*
   - Does the internship site meet the requirements for licensure or certification?
   - Is my supervisor licensed or certified in my area of education and training?
   - Does my supervisor have special training in clinical supervision?
   - Will I be assured of regularly scheduled supervisory sessions?
   - Has my supervisor worked with interns in the past?

4. *Educational opportunities at the site:*
   - Will I be able to participate in in-service or staff meetings?
   - Will I be able to participate in a wide variety of professional activities?
   - Will I be viewed as a colleague? Intern? Paraprofessional?
   - Will I have the opportunity to consult with other professionals on the staff?
   - How are supervisors chosen?

These questions can help provide the intern with an overview of what to expect when completing an internship at this site. These questions are of paramount importance to determine how well the intern's needs and expectations can be met at this particular site. In addition, the intern must be prepared to answer specific and direct questions by internship directors or supervisors. The
following questions are examples of the types of questions frequently asked of perspective interns:

- Why did you choose our agency to do your internship?
- What types of professional experiences are you interested in? Least interested in?
- What is your experience level with the client population of this agency?
- From a knowledge base, how well do you understand this population?
- What is your therapeutic orientation? What made you choose that orientation?
- What are your therapeutic strengths?
- In which areas do you feel you need additional training or supervision?
- What is your attitude toward clinical supervision?
- What specific individual or group experiences are you expecting to participate in?
- How can the agency best meet your personal and professional needs?
- What do you consider to be a rewarding internship experience?
- What is your background in individual therapy? Group therapy? Psychological testing? Consulting? Case management?
- What specific skills do you bring to the agency and internship experience?
- How familiar are you with the ethical codes of counseling and psychology?
- Do you have personal liability insurance?

These critical questions serve a variety of purposes. Remember the agency is making a decision as to your fit within its system. Never forget that you are also making a critical decision regarding whether this placement meets your personal academic and professional needs.

**Lousy Supervision**

The literature on supervision is replete with articles that focus on the qualities and practices of good supervisors. However, there is a paucity of information dealing with ineffective supervision. Magnuson, Wilcoxon, and Norem (2000) published an article titled “A Profile of Lousy Supervision: Experienced Counselors’ Perspectives.” The article is a result of a study of 10 experienced clinical supervisors who were asked to respond to a number of prompts (e.g., “I am interested in knowing about things you might have experienced in supervision that hindered your learning and professional development”). In addition, participants were asked to describe or characterize lousy supervision. The following is an overview and summary of that study. According to the authors, the data yielded two broad categories of findings: (a) overarching principles of lousy supervision and (b) general spheres of lousy supervision.

The following are statements and comments that reflect the participants’ opinions regarding lousy supervision.
Overarching Principles

*Unbalanced:* This is an overemphasis on some elements of supervisory experiences and excluding others.

*Developmentally inappropriate:* This is the failure to recognize or respond to dynamics and changing needs of supervisees.

*Intolerant of differences:* This is the failure to allow the supervisee the opportunity to be innovative; supervisors were impatient, rigid, and inflexible.

*Poor model of professional or personal attributes:* This includes boundary violations, intrusiveness, and exploitation.

*Untrained:* The supervisors had inadequate training and a lack of professional maturity and were uncomfortable assuming supervisory responsibilities.

*Professionally apathetic:* The supervisors were lazy and not committed to the growth of the supervisees.

General Spheres

*Organization and administrative:* This includes a lack of supervisory guidelines, the neglect of initial assessment procedures to identify supervisee’s needs, a lack of continuity between sessions, and ineffective group supervision.

*Technically and cognitively unskilled practitioners, unskilled supervisors, and unreliable resources:* This includes a lack of therapeutic and developmental skills, a reliance on a single model of supervision, and a disregard for supervisee’s approach to counseling.

*Rational/affective:* This includes failing to humanize the supervisory process, being overly critical and providing little positive feedback, and having the inability to address personal concerns that hampered supervision.

These characteristics of a lousy supervisor are important to consider when approaching supervision. Unfortunately, ineffective supervisory methods become known after the supervision process has begun. However, it is important to note that supervisees who experience such inappropriate and nonprofessional supervisors should consult with their on-campus supervisor (or liaison), who can provide guidance in coping with the situation or reassign the supervisee to another supervisor.

The Internship Agreement

Prior to the start of the internship experience, a formal agreement is made between the student’s training program (college or university) and the agency or school in which the internship will take place. In most instances, training programs have internship agreements available that serve as the formal contract between the training program and the agency or school. The Internship Contract
(Form 10.3) is included in the Forms section of this book and may be adapted for use by either counseling or psychology interns.

**Intern Roles and Responsibilities**

The beginning intern approaches the internship experience with much anticipation and anxiety. A contributing factor to the intern's uneasiness is the lack of familiarity with the role and responsibilities of the organization. Initial confusion and anxiety are lessened when the student makes an early effort to understand the roles and responsibilities that interns are expected to perform in the organization. Similarly, the intern needs to fit his or her skills and competencies into the structure of the organization. Prior to the start of the internship experience, the intern needs to address a number of critical issues and questions about his or her role:

1. Do I understand the mission, purpose, and goals of the organization?
2. Do I understand the duties and responsibilities required by my university supervisor and my site supervisor?
3. Do I understand my position in the structure of the organization?
4. Am I capable of articulating what I consider to be my assets, strengths, and liabilities?
5. Do I understand the specific objective measures on which my performance will be evaluated?
6. Do I understand the legal, ethical, and liability issues regarding my work in the organization?
7. Do I have a contract or agreement that delineates my duties and responsibilities? (Form 10.3 is an example of a typical internship contract.)

**Individual Performance Plan**

Having reviewed his or her professional role and knowing the specific tasks that are required, the intern needs to formulate a tentative plan for carrying out the internship. Egan (1987) pointed to the need for the student to develop an *individual performance plan* when entering a system. Egan's categories have been adapted here to provide suggestions; the intern should use and adapt this list to build an individual performance plan specific to his or her goals.

- **Establish essential linkage:** The intern develops a plan that is linked to the overall mission, strategic plans, and major aims of the organization. The plan is developed in keeping with the university program requirements and the intern's personal training needs.
- **List all personal performance areas:** The intern lists all tasks for which he or she is responsible either alone or with others. Specific behaviors should be identified and planned.
Prepare for Internship

- **Identify key performance areas**: The intern determines the areas in the agency in which he or she can become a major contributor. Consideration is given to the student’s perceived strengths and competencies.

- **Set priorities**: The intern develops objectives in each performance area and determines some of the critical accomplishments in that area. Specific objectives that are attainable in a planned time period are specified.

- **Develop personal performance indicators**: The intern lists the formative and summative measures that can be used to indicate personal progress and accomplishments (Egan, 1987, pp. 9–17).

The completion of an individual performance plan allows the intern to enter into his or her internship armed with information essential to the successful completion of the experience (see the Individual Performance Plan form [Form 11.2]).

In summary, understanding his or her roles and responsibilities in the organization enables the intern to avoid any role conflict and prevent other professionals from having different expectations of the intern. A clear understanding of the division of responsibilities and a well-developed performance plan enables the intern to work collaboratively and cooperatively with other helping professionals in the agency or institution.

**Beginning Counselor Supervision**

Counselor supervision is an interactional process between an experienced person (supervisor) and a supervised subordinate (supervisee). Hart (1982) defined supervision as an “ongoing educational process in which one person in the role of supervisor helps another person in the role of supervisee acquire appropriate professional behavior through an examination of the supervisee’s professional activities” (p. 12). According to Bradley (1989), counselor supervision has three main purposes: “Facilitation of the counselor’s personal and professional development, promotion of counselor competencies, and promotion of accountable counseling and guidance services and programs” (p. 8).

To meet these ends, the supervisor must be a serious, committed professional who has chosen counseling and supervision as a long-term career goal (Hart, 1982). Similarly, the supervisor needs to help the new supervisee to ease into the process of supervision. The supervisor often effectively accomplishes the following means of assisting:

1. communicating a caring, empathic, and genuine understanding of the supervisee;
2. providing security to the supervisee as he or she faces training anxieties and vulnerabilities;
3. recognizing typical organizational and role responsibilities required of the supervisee;
4. understanding the supervisee rather than judging the supervisee’s behavior in the early stages of supervision;
5. helping the supervisee identify strengths and weakness in an attempt to change or modify these behaviors;
6. attending to and accepting the supervisee’s needs;
7. permitting the supervisee to problem solve, experiment, and make mistakes; and
8. helping to foster the development of a professional identity in the supervisee.

Helping the intern ease into the process of direct service, while at the same time encouraging the supervisee to test his or her skills and competencies, contributes significantly to development of professional and personal confidence in the supervisee.

**Stages of Internship**

The intern is reminded that all beginning interns will experience a variety of feelings and emotions as they go through their internship experience. Sweitzer and King (1999) divided the internship experience into five stages, which we discuss next.

**Anticipation**

The initial stage of the internship is often filled with optimism and energy but also with anxiety. This stage is sometimes referred to as the “What If?” stage. Typically, interns are concerned that they may not be able to handle the situation. “What if they won’t listen to me?” and “What if they don’t like me?” are questions they frequently ask themselves. The interns may have concerns about what is expected of them, as well as concerns about what their supervisor thinks of them. In this stage task accomplishment is relatively low in that the interns may not be learning the things they want to learn. However, anxiety can be lessened when the interns clearly define their goals and the skills needed to reach them. Setting realistic expectations for their experience and working on being accepted by and developing good relationships with supervisors, coworkers, and staff can help relieve interns initial anxiety.

**Disillusionment**

It is not uncommon for interns to experience a sense of disappointment or disillusionment about the internship experience once it begins. What interns anticipate about the internship and what they actually experience can be quite different. Generally, if the interns’ concerns in the anticipation stage are addressed, they are less likely to encounter a different reality than they expected. This stage focuses
on many of the concerns the students had in the anticipation stage. According to Sweitzer and King (1999, p. 62), this stage is referred to as the “What’s Wrong?” stage. Feelings associated with this stage can include frustration, disappointment, and sadness. Frequently, these feelings are directed toward the supervisor, coworkers, clients, or even oneself. This stage can be a positive or a negative experience. The feelings associated with it can be quite negative in the sense that interns may not be learning as effectively as possible or, worse, may find that termination or renegotiation of the internship is required. On the positive side, though, this type of experience is often beneficial in that working through these issues encourages interns to grow both professionally and personally.

**Confrontation**

The way to get past disillusionment is by acknowledging and confronting problems. According to Sweitzer and King (1999), moving through this stage involves interns taking a look at their expectations, goals, and skills. Although interns may have set goals that seemed reasonable when they set them, experience may show that some of them are not realistic or the opportunities have changed. This is also a time for interns to reexamine and perhaps take the necessary steps to bolster their support system (p. 62). As these issues are resolved, the morale and efficiency of the interns tend to increase. Interns need to keep working at the issues that are raised. As they confront the issues, they may feel more independent and more effective. Success is achieved by confronting one’s problems, not by ignoring them.

**Competence**

With the growth of competence comes a higher sense of morale and an increased investment in the internship experience. Interns’ trust in themselves, their supervisor, and their coworkers increases to the point where they consider themselves to be more of a professional than an apprentice. They need to be aware that stresses of time management may cause them to feel pushed and pulled in many directions. Outside pressures of managing home, school, and internship can become overwhelming if interns strive for perfection rather than excellence in these areas.

**Culmination**

The culmination of the internship experience can give rise to a number of conflicting emotions. Having pride in accomplishments and feelings of guilt about not having more time to give to clients are conflicting feelings that can be upsetting as well as confusing. Addressing these concerns will enable interns to focus their feelings. Finding satisfying ways to say good-bye to clients, coworkers, and supervisors provides closure to the internship experience.
Internship Experience

The beginning internship student is often unaware of what to expect in clinical supervision. “What will my supervisor expect of me?” “How am I going to be evaluated?” “What is my supervisor’s style?” These questions are frequently a source of anxiety and apprehension on the part of the supervisee. Answering these questions can help to alleviate some of the anxiety associated with entering into the supervisory process. This section of the text has been developed to help the intern become familiar with a variety of issues that confront each and every beginning counselor.

Supervisees: What Should I Look for in Supervision?

There are many strategies and methods available to supervisors for use in counseling supervision. It is helpful for interns to become aware of what approaches or methods their supervisor will use. Interns need to understand the manner in which they are going to be supervised and evaluated. Answers to the following questions will be helpful in understanding what will occur during supervision.

- **Will my supervisor view actual counselor–client interactions?** Assessment of actual counseling behavior with clients allows for corrective measures to be taken and increases the likelihood of successful outcomes. Good supervisors avail themselves of the opportunity to observe their supervisees by examining counselor–client sessions by use of audiotapes, videotapes, and one-way mirrors. This provides for immediate feedback and corrective strategies.

- **Does my supervisor know my current developmental level, skill level, and learning style?** Discussing these important issues with the supervisor is essential to becoming comfortable with the supervisory process. Being on the same page with the supervisor is essential for effective supervision.

- **What method of supervision is my supervisor using?** Knowledge of and familiarity with the supervisor’s methods and strategies can significantly reduce a supervisee’s performance anxiety.

- **Is my supervisor empathic? Open? Flexible?** Good supervisors respect their supervisees and are sensitive to individual differences (age, race, gender) and concerns.

- **Does my supervisor seem comfortable with authority and evaluative functions?** Knowing the type and frequency of evaluative methods to be employed is helpful in adjusting to the supervisor and his or her style of supervision.

- **Does my supervisor have the time to provide me with quality supervision?** It is essential that the supervisee feel confident that an appropriate amount of individual supervision is planned.

- **Does my supervisor show enthusiasm about supervising my internship?** Supervisor enthusiasm is an important ingredient in the reduction of supervisee anxiety.
Supervisee: How Am I to Be Evaluated?

Anxiety about the evaluation practices of the supervisor is a realistic concern for the intern. Basically, it is the task of the supervisor to employ a series of informal and formal measurements that result in a judgment that the intern is ready to practice counseling independently (McGahie, 1991). Typically, formative evaluations (observation, feedback, modeling, etc.) take place throughout the duration of the supervisor–supervisee relationship and, it is hoped, lead the supervisee toward skill improvement and positive counseling results. Summative evaluations (final evaluation, evaluation of performance objectives), known by the supervisee from the start of supervision, are the supervisor’s final statements as to the overall effectiveness of the internship experience.

Harris (1994) summarized sources that reflect requisite skills and knowledge for effective evaluative practices (Bernard & Goodyear, 1992; McGahie, 1991; Stoltenburg & Delworth, 1987). The following is a summary of those practices:

- The supervisor will clearly communicate criteria to the supervisee and develop a mutually agreed-on contract.
- The supervisor will identify and communicate strengths and weaknesses of supervisees. Ethical guidelines require ongoing feedback on performance.
- The supervisor will use constructive feedback techniques during evaluations. Corrective feedback is “heard” when a positive supervisory–supervisee relationship is formed.
- The supervisor will utilize specific behavioral, observable feedback dealing with counseling skills and techniques.
- The supervisor will use interpersonal process recall to raise supervisee’s awareness about personal developmental issues.
- The supervisor will employ multiple measures of supervisee counseling skills (client rating scales, behavioral scales, audio- and videotape, etc.).
- The supervisor will maintain a series of work samples for use in summative evaluation.
- The supervisor will use a developmental approach that emphasizes progression toward desired goals.

Following this structured approach tends to lessen anxiety for both the supervisor and the supervisee while providing a formative and summative means to assess supervisee performance and contributing to the supervisee’s sense of effectiveness and worth.

Summary

The essential steps in the process of selecting and evaluating an internship site were discussed in this chapter. Students will benefit from the interview guide
presented and should take time to familiarize themselves with the questions presented before meeting with the director of a potential internship site. We also addressed the roles and responsibilities of the internship students and the stages of internship, as well as the types and methods of supervision that they may encounter. It is important for students to understand the various supervision models and the ways in which they, as interns, will be evaluated prior to beginning an internship, as this knowledge will help to reduce anxiety and increase effective learning in the internship setting. The forms cited in this chapter will be of use to students in their preselection planning and will help them to determine if a particular site will be able to meet their educational and professional needs.

**Suggested Readings**


### References


The Council for Standards for Human Service Education (CSHSE), using the terms fieldwork and internship synonymously, defined the internship experience in the following way: The advanced or culminating agency-based experience that occurs toward the end of students' college or university experience. This usually requires the supervision from agency personnel and the college or university faculty, including regularly scheduled meetings with a faculty member. The experience provides a bridge between the academic experience and later professional employment (CSHSE, 1995, p. 12). The Council for Accreditation of Counseling and Related Educational Programs (CACREP) defined the internship experience in the following way:

Professional practice, which includes practicum and internship, provides for the application of theory and the development of counseling skills under supervision. The experience will provide the opportunity opportunities to counsel clients who represent the ethnic and demographic diversity of their community. (CACREP, 2007, p. 14)

The internship is intended to reflect the comprehensive work experiences of a professional counselor appropriate to the designated program area (e.g., mental health, school, college, community, career, gerontological) (CACREP, 2007, p. 15). The students receive both on-site and on-campus supervision. The American Psychological Association's (APA's) accreditation guidelines for doctoral-level internship in professional psychology (implemented in January 2008) identify the following criteria: The internship is an organized, structured, and programmed sequence of supervised training experiences of greater depth and intensity than practicum training. Supervision is regularly scheduled at a minimum of 4 hours per week, at least 2 of which are in individual supervision. The program requires
that interns demonstrate intermediate to advanced skill, competency, and knowledge in “theories and methods of assessment/diagnosis and effective intervention including empirically supported treatments: theories and/or methods of consultation, evaluation and supervision; strategies of scholarly inquiry; issues of cultural and individual diversity to all of the above” (APA, 2007, p. 2).

It can be concluded from these statements that the internship experience provides students with the opportunity to translate what they have learned in their training program into effective methods of counseling. The steps in the learning process can help interns recognize that internship experiences follow a learning sequence that can be planned for. Kizer (2000), in a text titled *Getting the Most From Your Human Services Internship: Learning From Experience*, suggested that a knowledge of some of the predictable ways in which internships develop can help the intern master the challenges of each stage of the process. The following is a summary of the stages and challenges of the internship experience:

**Stage 1**—This first stage occurs well before the student begins the internship. As discussed in earlier chapters, this stage consists of all the work that has been previously accomplished by the student and faculty member. Preselecting the internships site, obtaining information about the agency, and preparing for the first day at the internship are characteristics of this stage.

**Stage 2**—Initiation (orientation) stage: This is the stage in which the intern becomes familiar with the agency. In this stage, the intern is eager to get started. However, the supervisor might suggest an “easing in” period of reading and observing before any direct service is provided. At this time, the intern can approach the supervisor about concerns about the need for more structure and direction and building a trusting relationship with him or her. Interns need to avoid rushing to judgment about their internship placement. All organizations and agencies have strengths and weaknesses. It is more appropriate for the intern to determine what can be learned and how to learn it than to be critical of the placement site. In a similar fashion, interns can avoid early judgments about supervisors by examining their behavior and attitudes about the internship and how they may be affecting the internship experience.

**Stage 3**—Working stage: Along with the establishment of relationships and the understanding of the intern’s roles and responsibilities, this stage is characterized by the achievements of learning goals and the accomplishment of agency work. The intern functions more autonomously and usually feels comfortable about asking and receiving constructive feedback. The level of increased comfort and confidence enables the intern to focus on practice skills, learn about the agency, develop professional responsibilities, learn to use supervision effectively, and handle everyday tasks of the internship.

**Stage 4**—Termination: The planning and anticipation of ending the internship begins. Depending on the nature of relationships that have been established, this can be a rather emotional period of time for the intern. Personal
reflection by the intern is an important step in the termination process: “How well did I perform?” “What have I learned?” “What do I regret about my internship?” “What do I value from the experience?” These questions are important in reviewing and capturing the internship experience. The manner in which termination occurs speaks to the intern’s ability to handle closure. Positive termination requires thoughtful reflection about the internship experience.

**Field-Site-Based Supervision**

CACREP guidelines require that the intern student receive weekly interaction with an average of 1 hour per week of individual and/or triadic supervision performed by the site supervisor throughout the internship. The site supervisor has a master’s degree in counseling or a related profession, appropriate certification and/or licenses, at least 2 years of pertinent professional experience in the student’s program area, and relevant training in counseling supervision (CACREP, 2007, p. 14). The site supervisor provides orientation and consultation and facilitates professional developmental opportunities for the intern. The intern becomes familiar with a variety of professional activities, which, in addition to direct service, includes record keeping, assessment practices, supervision, information and referral, in-service and staff meetings, and consulting. Form 12.5 in the Forms section at the end of this book provides the format to document intern site activities.

The professional psychology internship designed in accordance with the APA accreditation guidelines takes place at accredited site-based programs. The supervision and training activities take place at the site and are evaluated by the site supervisor and coordinator as approved by the on-campus site coordinator. APA site programs have designated intern-training supervisors who are doctoral-level psychologists and appropriately credentialed. The site program issues a certification of completion to interns who successfully complete the internship (APA, 2007, pp. 2–5).

**On-Campus Supervision**

CACREP accreditation guidelines recommend both field-site- and campus-based supervision of interns. Program faculty members who are individual and/or group supervisors must have a doctoral degree, relevant counseling experience and appropriate credentials, and/or demonstrated competence in counseling. On-campus supervision averages 1.5 hours per week of group supervision by a faculty member. Many programs also require weekly on-campus individual supervision.

On-campus group supervision includes regular reviews of the intern’s counseling practice with clients and consulting practices relevant to the site. Group
supervision also provides consultation and problem solving for interns regarding field site concerns. Typical concerns are about getting sufficient individual and group counseling opportunities and gaining experience in the full range of counseling activities provided by the site. Special topics regarding ethics, legal issues, or work with crisis and special populations often arise. Supervisors and interns are referred to chapters 6, 7, and 8 in this text for reference and a review of materials relevant to these concerns. Finally, the group supervisor provides activities and processes that facilitate the cognitive skill development of interns. Regular case conceptualization presentations and review of clinical case notes are included in the group supervision process. The intern's personal theory of counseling can be refined and articulated through the inclusion of these activities. The authors recommend that both individual and group supervision be structured around the four components of counselor performance skills, counselor cognitive skills, self-awareness skills, and counselor developmental level. These four components are fully described in chapter 5. We suggest that on-campus group supervision begin with a review of this material and that individual intern goals for supervision be stated.

Supervisor–Supervisee Relationship

By the time the counselor trainee enters the internship, he or she has had previous field-site- and campus-based individual and group supervision. The counselor trainee has also been evaluated as ready to proceed to internship and thus has demonstrated competency in basic counseling skills and the ability to use some theory-based counseling techniques and can open and close sessions and manage continuity between sessions. He or she has demonstrated basic cognitive skills of identifying relevant client information and can conceptualize client's concerns and dynamics in the context of a beginning articulation of a personal theory of counseling. The beginning intern realizes that his or her own personal dynamics affect the counseling session. The supervisor–supervisee interaction has progressed to the point where the trainee shows moderate to low levels of anxiety during supervision and also demonstrates low to moderate levels of dependency on the supervisor for the direction of the counseling process. At the outset, the intern wavers on his or her levels of confidence and level of dependence on the supervisor. It is reasonable to expect that the supervisor will modify the emphasis on basic performance skills and move toward more emphasis on conceptualization skills and self-awareness. The qualities of developing mutual trust and deepening the dialogue about the counseling work are implicit goals to be realized in this supervisor–supervisee relationship at this level. Scott (1976) recognized the goal of establishing a collegial relationship where there is a shared responsibility for understanding the counseling work. The inability to achieve or sustain the goal of collegiality in the supervisor–supervisee relationship can be interpreted as resistance and must be addressed. Bradley and Gould
(1994) identified resistance as games played by supervisees in an attempt to elicit control over the supervisory process. Kadushin (1968) defined four categories of games supervisees play:

1. manipulating the level of demands placed on the supervisee;
2. redefining the relationship by the supervisee’s attempting to make the supervisory relationship more ambiguous;
3. reducing the power disparity by the supervisee’s focusing on the supervisor’s knowledge base to prove that he or she is “not so smart”; and
4. controlling the situation, thus directing the supervisor away from the supervisee’s performance.

It should be remembered that resistance is quite common in supervision and that resolving resistance aids the establishment of a positive supervisor–supervisee relationships. Resistance can be redirected to provide a positive supervisory relationship. Focusing on the sources of resistance coupled with describing and interpreting resistance in the supervisee can help reduce this common problem.

Models of Supervision

Leddick (1994) suggested that the focus of early counselor training was on the efficacy of a particular theory of counseling, such as behavioral, psychodynamic, or client centered. Supervision norms were typically conveyed indirectly during the rituals of an apprenticeship. As supervision became more purposeful, however, three types of models emerged. The following is a summary of those three models:

- **Developmental models** suggest that we are continually growing, in growth spurts and patterns, and thus the object of supervision is to maximize growth and identity in the future. Developmental models suggest that attention be directed toward the understanding of the development level of the supervisee. According to Stoltenburg and Delworth (1987), supervisees are grouped as beginning, intermediate, or advanced. Within each level is a trend to begin in a rigid, shallow, imitative way and then develop more competence, self-reliance, and self-assurance. Particular attention is paid to self-awareness and awareness of others, motivation, and autonomy. Beginners tend to rely on their supervisors to diagnose clients and establish therapeutic plans. Intermediate-level supervisees rely on supervisors for help in gaining a better understanding of a difficult client. Advanced-level supervisees tend to function independently and seek consultation when appropriate and to feel a sense of responsibility for their correct and incorrect decisions in therapy.

- **Integrated models of supervision** tend to employ multiple therapeutic orientations. An example by Bernard and Goodyear (1998) is the discrimination model, which purports to be atheoretical. This model focuses on three
supervisory roles: (a) teacher—when a supervisor lectures, instructs, or
informs supervisees; (b) counselor—when the supervisor assists the supervi-
see in seeing his or her blind spots; and (c) consultant—when the supervisor
acts as a colleague during cotherapy. In addition, the discrimination model
focuses on three areas of skill building: process (how communication is con-
veyed), conceptualization (application of a particular theory to a particular
case), and personalization (body language, eye contact, etc.).

Orientation-specific models of supervision allow the supervisee to adapt a
particular brand of therapy, such as client centered, Adlerian, or cognitive.
These models assume the best supervision is the analysis of practice for true
adherence to the therapy.

The supervision approaches of psychodynamic, behavioral, cognitive, and dis-
crimination models are reviewed in chapter 5. Also included here is information
regarding the triadic model of supervision, which is recommended for use by the
field site supervisor in the current CACREP guidelines (June 2007). Scott is famil-
 iar with the variation of the triadic model of supervision that was used by the
University of Pittsburgh Counselor Education Program during her tenure there.
The model was proposed and articulated by C. Gordon Spice, Ph.D. (professor
emeritus in the Department of Psychology in Education, University of Pittsburgh).
Spice and Spice (1976) recommended that the triadic supervision model be used
in peer supervision practice for counselors in training. Very few professional
articles or research is available that describes the use of this model. A more
recent variation of the triadic model is described in an article by Stinchfield, Hill,
and Kleist (2007), titled “The Reflective Model of Triadic Supervision: Defining an
Emerging Modality.” This variation is called the reflective model of triadic super-
vision (RMTS) and introduces components from the use of reflecting teams in
family therapy. The reader is referred to this article for an in-depth discussion of
this model.

**The Triadic Model of Supervision**

In the triadic model of supervision, three roles are designated: the role of super-
visor, the role of supervisee, and the role of observer/commentator. For supervi-
sion of interns, the field site supervisor takes the role of supervisor. In this role
the supervisor reviews the intern’s work sample (a video- or audiotape, case
presentation, clinical notes together with a tape). The supervisor then gives feed-
back to the supervisee regarding (a) what is particularly well done in the work
sample, (b) what has need for improvement, and (c) what is unclear or confusing
in the work sample. An example of this feedback is as follows: The supervisor
stated, “Your use of the basic empathy skills and confrontation skills was excel-
 lent. I particularly liked the way you confronted the client about the contradiction
between his values and his behaviors. It didn’t come across as blameful. You do
need to review your use of questions. Too many questions in a row sounds more like an interrogation. What I'd really like to focus on in this supervisory session is the theoretical approach you have in mind in working with this client. It is not clear to me how you see his concerns in relationship to making better decisions and healthier choices.” Discussion then follows, with clarification and expansion of the possible ways of viewing the client as the topic.

Two interns take the roles of supervisee and observer/commentator; they alternate taking the role of supervisee in one session and the role of observer/commentator at the next supervisory session. The supervisee provides the work sample, and the observer/commentator focuses on the communication and interpersonal dynamics going on between the supervisor and the supervisee. Before the close of the supervisory session, the observer shares his or her comments about what he or she saw in the interaction. An example of the observer’s comment is as follows: To the supervisee, “I noticed that you seemed a bit defensive when the supervisor asked you to clarify what you meant when describing better decisions.” Or “The two of you seemed to be going all around the subject of the client’s concerns, but you never gave specifics.”

Use of this framework can have many variations for supervision. Some uses are within small group supervision where the several members of the group take on the observer role, or those observers each focus on a different aspect of the supervision interaction and then share observations. This facilitates a deepening of the supervisory process and provides an opportunity to summarize the interaction process. Practicing professional counselors can also use this model when meeting for collegial peer supervision in the workplace.

During the internship, the on-campus group and/or individual supervision serves the unique training function of facilitating the integration of the various components of counseling training in one course. The supervisor introduces a variety of activities and processes that intertwine the following components:

1. forming a therapeutic relationship;
2. facilitating the client’s healthy emotional development;
3. viewing the client and the counseling process through the lens of several theoretical perspectives;
4. identifying personalization or self-awareness related to values, beliefs, understanding, and the internal trigger points related to the counseling process;
5. fostering maturation of the supervision process;
6. developing a personal theory of counseling; and
7. supporting the developmental and/or remedial goals of counseling by consulting with others who also influence the healthy development of the client.

What makes the focus on these various components more powerful, in the context of supervision, is that the awareness, understandings, and insights are examined in direct relationship to the counselor’s actual behavior with clients.
Managing the supervision process so that these goals (awareness, understanding, and insight) are realized is quite complex. The authors suggested the metaframe of viewing the counselor trainee’s progress in terms of counseling performance skills (what the counselor does while counseling), counselor cognitive skills (how the counselor thinks about what he or she does), self-awareness skills (how the counselor’s personal meanings and dynamics affect the counseling), and developmental level (how the counselor functions in supervision regarding dependence and autonomy). We reviewed this frame in chapter 5.

When the supervisor and intern mutually understand the full range of components that are part of the supervisory process, less resistance is likely to occur when the supervision moves beyond just focusing on learning diagnostic and interaction skills. The intern’s self-assessment within each of the skill components provides a preparation for understanding the complexities and subtleties of professional counseling practice. When the counselor trainee is in the beginning phase of preparation—at the clinical practice level of prepracticum and practicum—the trainee needs “an environment with large amounts of support, direct instruction, and structure, and minimal amount of challenge and personal exploration” (Pearson, 2001, p. 174). As the trainee progresses to internship, he or she is likely to be at the intermediate level of development. The needs of the intern fluctuate between feeling dependent and wanting autonomy and wanting to improve awareness of client relationship dynamics. The supervisor generally reduces the amount of direct instruction and the degree of structure and provides a challenge relative to support and begins to examine the counselor’s personal reactions to clients (p. 175).

The preceding commentary is intended to set the stage for the intern as he or she anticipates what to expect in the process of internship supervision.

**Extending the Intern’s Theory-Based Techniques**

The practicum or internship student in mental health agencies is frequently confronted with the reality of having to use treatment methods capable of delivering low-cost, quality mental health services. The need to employ brief therapeutic strategies in counseling has exploded onto the scene as a result of our present-day managed care environment. Time-limited interventions and role flexibility in practice are clearly required in an age of managed mental health care (Mash & Hunsley, 1993).

The following sections of the text are designed to provide internship students with a sampling of the varied approaches to brief therapy. In some cases, students will be familiar with and have training in these models. In other cases, this section might provide students their first exposure to models of brief therapy. In any case, students need to become familiar with and skilled in the implementation of brief therapeutic interventions and strategies.
Solution-Focused Brief Therapy

Solution-focused brief therapy is based on the research of de Shazer and associates (de Shazer, 1989, 1990; de Shazer & Berg, 1985), who developed a model of therapy that was intentionally brief by design and was based on “focused solution development.” Some of the guiding principles of solution-focused therapy include the following:

1. the notion that the power of resistance need not be a part of effective therapy but can be replaced by cooperation;
2. the principle that solution-focused therapy is intended to help clients become more competent at living their lives day by day; accordingly, this conception involves normalizing behavior and the constructing of new meaning from behavior (Fleming, 1998);
3. the belief that client–therapist interactions are directed by three rules: (a) if it ain’t broke, don’t fix it; (b) once you know what works, do more of it; and (c) if it doesn’t work, don’t do it again, do something else (de Shazer, 1990, pp. 121–124).

Treatment planning in solution-focused therapy is based on the understanding that clients must be customers for change and the realization of the existence of exceptions to their problems when they occur. Treatment plans become a source of documentation of treatment appropriateness, efficacy, and accountability (Fleming, 1998).

The client–therapist relationship is essential for the development of therapeutic intervention. According to de Shazer (1990), clients are visitors, complainants, or customers, depending on both their views of themselves in relation to their problem and their willingness to take an active part in doing something to solve the problem. Customers are usually those individuals who are willing to do something about their problems. Customers are asked to do something and follow through by taking an active part in their own improvement. Similarly, what clients do to improve their situation between the time of the telephone call for an appointment and the first session can be important to the therapist in his or her search for exceptions to the problem. According to Fleming (1998), the underlying assumption of the solution-focused model is that clients come to therapy because they have a complaint, a problem, or both. Problems do not occur all the time. When clients choose to do something differently, in a way that does not involve the problem, problem behavior is less likely to occur, and exception behavior is more likely to be observed (de Shazer & Berg, 1985).

Both the client and the therapist construct exception behavior while exploring what happens when the problem does not occur (Gingerich, de Shazer, & Weiner-Davis, 1988). According to Fleming (1998), another guiding principle of solution-focused therapy is to help the client become more competent at living life day by day. Using the EARS—elicit, amplify, reinforce, and start
again—approach, the therapist elicits dialogue about exception behavior and positive thoughts and behaviors that the client reports about himself or herself and others. This process helps the client progress toward goal attainment. Reinforcing what the client has done to improve the situation by attaching positive thoughts and behaviors to his or her goals helps the client realize that his or her action makes a difference.

De Shazer (1990) employed what he called the miracle question: “Let’s suppose tonight while you’re asleep a miracle happens that solves all the problems that brought you here. How would you know that this miracle really happened? What would be different?” The therapist uses exception questions and coping questions to get the client to examine his or her attempts at coping. The therapist believes that by asking solution-focused questions, clients become more aware of their resources and strengths and can use them to make better choices for themselves. Finally, the central focus of brief therapy is centered on specific, concrete, and behavioral goals. Talking about goals and the steps taken to achieve them is essential for positive outcomes. Both the client and the therapist need to know where they are going and how they are going to get there for brief therapy to be successful.

Strategic Solution-Focused Therapy

“What’s the trouble?” “If it works, do more of it.” “If it doesn’t work, don’t do it anymore. Do something different.” These are some of the guiding principles of strategic solution-focused therapy. This method, developed by Quick (1998), combines the theories and procedures of brief strategic therapy (Fisch, Weakland, & Segal, 1982) and solution-focused therapy (de Shazer, 1984).

“What’s the trouble?” and “Do something different” are principles derived from brief strategic therapy, a model developed at the Mental Research Institute in Palo Alto, California, in the 1960s and 1970s, which stressed the idea that people generally attempt to solve problems by doing what makes sense to them. In contrast, the “If it works, do more of it” principle comes from a model developed at the Brief Family Therapy Center in Milwaukee, Wisconsin, in the 1970s and 1980s.

The strategic solution-focused model integrates these parent models in two main ways: (a) by combining brief strategies of focusing on clarification of the problem with the solution-focused emphasis on elaboration of the solution, and (b) by blending the solution-focused emphasis on maintaining what works with the strategic emphasis on interrupting what doesn’t work. Strategic solution-focused therapy is always tailored to the needs of the client. The following is a summary of some of the major principles and techniques of strategic solution-focused therapy as presented by Quick (1998).

The initial step in strategic solution-focused therapy is clarifying the client’s complaint and identifying the highest priority problem. The highest priority
problem is the one problem to resolve to make the biggest positive difference in the client’s life. The therapist wants to know the who, what, when, and where of what happened. Does the client’s complaint result in a behavioral excess or deficit? The therapist’s focus is to try to clarify what happened at this particular time that makes this problem an immediate issue. The therapist wants to clarify the client’s expectations of how therapy is supposed to be helpful. Clarification of the primary problem is an important consideration throughout therapy. It is the therapist’s job to find out from the client what problems or issues should be the focus in sessions.

The next step is the elaboration of the solution. “What will be different in the client’s life?” “What will let the client know that things are moving in the right direction?” “What will be the first signs of change?” A focused inquiry invites the client to amplify the solution scenario, elaborating on what will be different as a result of lasting changes (Quick, 1998, pp. 527–529). When the solution has been elaborated, the therapist invites the client to describe how he or she has begun to make the positive changes happen. If the primary problem has been identified, the focus shifts to what will be different when that specific issue is resolved.

The next step is assessing what has already been done and suggested in previous attempts to solve the problem. “What has been done?” “What have you tried?” The therapist focuses on specific attempts at problem solution. The therapist looks for main themes among attempted solutions, particularly unsuccessful ones, in an attempt to avoid trying them again. Near the end of the session, the therapist asks if the client wants feedback or input. The therapist will also compliment the client on realizations that he or she has made in the session. This suggestion component of therapy depends on what has or has not worked for the client. If things are working out, the suggestion may be to continue and amplify existing behaviors. On the other hand, if attempted solutions are not working, the suggestion may be designed to interrupt the behavior. General or specific suggestions may be offered to the client by the therapist. “Keep doing what works for you, or do something different.” It is important to remember that the needs of the client and the interval between sessions are highly variable. Termination might include encouragement to continue doing what works or to slowly make additional changes.

**Major Approaches to Brief Therapy**

Steenbarger (1992), in an article titled “Toward Science–Practice Integration in Brief Counseling and Therapy,” outlined the major approaches to brief therapy. The following is a summation of important features of different approaches to brief therapy.
Psychodynamic Approaches to Brief Therapy

Psychodynamic approaches to brief therapy focus on the therapeutic relationship as a change context. Furthermore, they de-emphasize the interpretive content of what the client says as a source of change and strive to produce relationship experiences that have an impact on the client.

Interpersonal Dynamic Brief Therapy

This approach views therapy as an experiential process in which corrective emotional experiences (Alexander & French, 1946) rather than verbal interpretations are the crucial elements for change. The focus in interpersonal dynamic brief therapy is on creating conditions wherein client’s maladaptive patterns can be enacted in the helping relationship.

Interpersonal Psychotherapy

This approach emphasizes the social origins of the client’s complaint (Cornes, 1990). Interpersonal psychotherapy de-emphasizes the relationship as a change vehicle and focuses instead on nonjudgmental exploration, encouragement of affect, and direct behavior change techniques (Klerman, Weissman, Rounsaville, & Chevron, 1984).

Cognitive Behavioral Counseling

The cognitive approach comprises several different schools of thought. These schools focus on learned cognitive and behavioral patterns as the primary source of distress (Steenbarger, 1992).

Cognitive Restructuring Brief Therapy

This approach emphasizes the acquisition of new beliefs and thought patterns. The central notion is that clients build internal “schemas” of self and the world to organize their perceptions (Goldfried, 1988; Moretti, Feldman, & Shaw, 1990). Early experiences can lead to the development of negative schemas, which can affect one’s perception of self, world, and future. According to Beck (Beck, Rush, Shaw, & Emery, 1979), the counselor collaboratively helps the client to marshal evidence that disconfirms negative schemas.

Rational Emotive Therapy

According to Steenbarger (1992), Albert Ellis, the founder of rational emotive therapy, took a different restructuring approach to brief therapy. The focus in rational emotive therapy is on identifying faulty beliefs as a link between activating events
and emotional behavioral consequences. Challenging, confronting, and disputing irrational beliefs is an attempt to reshape irrational thought patterns. Ellis, unlike Beck, relied on confrontation rather than on collaborative helping to get at the client’s irrational thoughts (Steenbarger, 1992).

**Coping Skills Brief Therapy**

This method represents a teaching approach to counseling in which clients learn to solve difficult life problems and cope with anticipated stresses (Steenbarger, 1992). The focus of this approach to brief therapy is on the use of cognition and behavioral methods in the development of life skills that promote self-efficacy (Bandura, 1977). Coping skills brief therapy relies heavily on in-session and between-session exercises.

**Tactical Brief Therapies**

These therapies are derived from systems-based family therapies that use prescribed experiences to affect client functioning. Two major schools of tactical brief therapies are as follows:

- **Task-centered therapies:** These therapies focus on the use of structured homework assignments of (a) observational or monitoring tasks to enhance client awareness, (b) experiential tasks aimed at arousing an emotional state, and (c) incremental tasks geared to alter behavior in a step-by-step fashion. It is the out-of-session tasks that are primarily facilitative of change (Wells, 1982).
- **Strategic brief counseling:** This approach emphasizes prescribed client enactments as change vehicles for the purpose of recontextualizing a problem. Strategic counselors observe that problems are typically maintained by the solutions sought by clients, creating circular patterns of distress. The goal, then, is to interrupt the attempted solution so that a circular pattern of distress cannot be maintained. The goal of therapy is to show clients, through experience, that their problems are artifacts of context.

According to Steenbarger (1992), reviewing the practice literature (Budman & Gurman, 1988; Butcher & Koss, 1978; Koss & Butcher, 1986) reveals a number of features common to the various schools of brief therapy. The following is a summary of those features.

- Brief therapies limit change efforts to focal patterns that are identified early in the counseling process.
- Brief counselors are active in their role as interveners, maintaining the therapeutic focus and actively employing confrontations, interpretations, refractions, and direct exercises to instigate change.
- Brief therapies are present centered.
Brief therapy interventions are designed to facilitate a high level of client experiencing in the session.

Brief therapists actively encourage client expectations for change.

Brief therapies are structured around the initial evaluation of the client, the initiation of change-oriented interventions, and efforts to extend initial changes.

The authors suggest that students revisit the Counseling Techniques List (Form 5.2). This will allow interns to check out and expand their knowledge of counseling techniques and to interpret again their own counseling and treatment approaches.

Developing the Intern’s Personal Theory of Counseling

By the time counselor trainees have progressed to internship, they are typically able to begin integrating life experiences, graduate school learning, and professional practices into a personal theory of counseling (Skovholt & Ronnestad, 1992). Internship supervisors are encouraged, therefore, to use this hands-on experience and knowledge the trainees are required to revisit, critically examine, and discuss their personal theory of counseling (Spruill & Benshoff, 2000). The personal theory of counseling continues evolving after graduation and, it is hoped, throughout their professional lives. Spruill and Benshoff (2000) viewed the process of developing a personal theory of counseling as sequential. Initial phases emphasize the examination of personal beliefs. Phase 2 emphasizes increasing knowledge of counseling theories while integrating this knowledge with personal beliefs. Phase 3 (the internship phase) emphasizes the development of a personal theory of counseling. Using a set of theory-building questions during supervision can be useful for integrating theoretical knowledge with personal beliefs and practice viewpoints. Piercy and Sprenkle (1988) suggested questions that can be used during supervision as students present their work. Questions include, “What are the major goals of your treatment plan?” and “What personal qualities do you believe are important for the therapist to demonstrate in treatment?” Other such questions are presented in the sections regarding case presentation in chapters 4 and 5. The focus of these questions is on appropriateness of approaches used and consistency with personal beliefs. Spruill and Benshoff (2000) suggest an activity where peers try to identify the beliefs and orientation of students after viewing or listening to samples of their counseling. They then critique the usefulness of different theoretical approaches. This can be a helpful approach to theory development.

Case documentation and case conceptualization formats were presented in chapters 4 and 5. These approaches can be integrated into the supervision process to strengthen cognitive skill development. Prieto and Scheel (2002) proposed the STIPS format of case note writing to increase counselor trainees’ conceptualization skills. The STIPS format consists of five major sections:
1. **Signs and symptoms:** This is a record of the client’s current level of functioning and clinical signs and symptoms (this is conducted in a mental status format).

2. **Topics of discussion:** The major issues discussed in sessions are recorded. Any changes in the client’s issues since the previous session are noted.

3. **Interventions:** What specific interventions were used in this session in relation to identified problems or targeted goals?

4. **Progress and plan:** This is a brief summary of the specific progress the client has made toward treatment goals and the outcome of any interventions since the previous session. (Summative outcomes should be noted every three to five sessions.)

5. **Special issues:** This is the red-flag section where critical clinical issues are recorded, such as suicide ideation, harm to others, child safety and abuse, referral for hospitalization, or medication.

---

**Assessment in Internship**

The internship for CACREP-accreditation programs requires 600 on-site hours with a minimum of 240 counseling contact hours. The internship occurs toward the end of the training program and typically includes half-time presence at the site for two full semesters or full-time presence at the site for one full semester. The field site supervisor usually performs on-site supervision for the duration of the internship. The on-campus supervisor may or may not be the same person across two semesters.

**Self-Assessment**

The intern is directed to review the information regarding self-assessment that was provided for the practicum student in chapter 5. Many of the forms and processes mentioned there can also apply to intern self-assessment. The interns can use the standardized assessment forms contained in the text, or they can use their own narrative related to their understanding of their progress in each of the four identified skill areas. During the second half of the internship (typically the second semester), the intern is likely to begin some consulting activities. Chapter 9 provides a review of consulting functions and models used by mental health and school counselors. Assessment forms regarding the consulting function have been included at the end of this book. Although the intern may choose to use the standardized assessment forms provided in the text and other sources, the authors recommend that the midterm and end-of-term summative evaluation take the form of a narrative work review often used in the corporate world. Form 11.1 illustrates the format recommended for use in these summative evaluations.
During the midterm and end-of-term evaluation conference with the supervisor, both the supervisor and the supervisee complete Form 11.1. In their meeting they review the areas of agreement and difference between the two evaluations. Future goals are discussed and committed to. In the event that the supervisee is falling behind in a skill area, remedial recommendations are agreed on. Such recommendations can include additional on-campus individual supervision, formal writing about the personal theory of counseling related to specific theory-development questions, or personal counseling or therapy to resolve personal issues that complicate the counseling process.

Field Site Supervisor Evaluation of the Intern

The field site supervisor can evaluate the intern using the standardized Student Evaluation Form (Form 12.2). Narrative comments in response to each of the identified skill areas can also be included in the evaluation. If the site supervisor is properly oriented to the skill areas, he or she may be invited to respond to and submit evaluations for Form 12.2.

Faculty Supervisor Evaluation of the Intern

The supervisor is encouraged to keep weekly or bimonthly notes of formative evaluation observations and feedback given to the intern as part of the ongoing supervision interaction. A useful format is to organize these comments according to the four proposed skill development areas. As suggested in chapter 5, in the section on the evaluation of practicum students, several referral sources regarding standardized assessment forms and the forms included in the text (e.g., Form 5.8) are noted. For the summative evaluations that occur at the midpoint and end of each semester of internship, we suggest a process much like the work performance review utilized in the corporate world. In the work performance review, both the intern and the supervisor prepare a written narrative in the format provided in Form 11.1. This format includes a brief narrative regarding the intern’s demonstrated skills within each of the four skill development areas discussed in the text. After the narrative, the supervisor identifies the evaluation level achieved on a scale from 1 (needs improvement) to 5 (excellent). Future goals within the skill areas are then identified. When the supervisor and intern meet for the evaluation (for approximately 30 minutes), they compare each review for areas of agreement and differences. Future goals are discussed in relationship to the evaluation. These goals are accepted or revised and committed to. In the case of a supervisee falling behind in a skill area, remedial recommendations are agreed on. These recommendations may include additional on-campus supervision, formal writing about the personal theory of counseling in response to specific theory-development questions, and personal counseling or therapy. In the final
semester of internship, the skill and theory area of consulting is added. This area may be evaluated in the narrative process or by using the Student Evaluation Form (Form 12.2 in Chapter 12). The culminating counseling performance review occurs at the end of the internship and need not include future training goals. The field site supervisor evaluation is added to the on-campus site supervisor evaluation information. The on-campus supervisor issues the final grade for the internship.

**Summary**

Successful completion of the internship indicates that the intern has demonstrated sufficient skill and mastery in each of the skill areas to allow the program to recommend, with confidence, that he or she is ready to function independently as an entry-level counselor.

**Form 11.1**

**Mid Term and End Term Summative Review of Intern Skill Levels**

(1= needs improvement; 3= Average; 5= Excellent)

<table>
<thead>
<tr>
<th>Narrative</th>
<th>Evaluation Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Performance</td>
<td></td>
</tr>
<tr>
<td>Skills</td>
<td></td>
</tr>
</tbody>
</table>

**Future Goal**

____________________________________________________________________________________

<table>
<thead>
<tr>
<th>Cognitive</th>
<th>1 2 3 4 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling</td>
<td></td>
</tr>
<tr>
<td>Skills</td>
<td></td>
</tr>
</tbody>
</table>

**Future Goals**

____________________________________________________________________________________

<table>
<thead>
<tr>
<th>Self Awareness</th>
<th>1 2 3 4 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills</td>
<td></td>
</tr>
</tbody>
</table>

**Future Goal**

____________________________________________________________________________________

<table>
<thead>
<tr>
<th>Developmental Level</th>
<th>1 2 3 4 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Future Goals

Consulting Theory And Practice (Second Semester) Cognitive Counseling Skills

Developmental Level

Suggested Readings


References


Chapter 12

Final Evaluations

The preceding chapters in this text primarily addressed facilitating a student’s process through the practicum and internship experiences. Theoretical aspects integral to the counselor’s training were integrated with various forms and sample formats to maximize the learning process for practicum students and interns.

This chapter is organized to help those involved in the practicum and internship to formally evaluate them. This process will help practicum students and interns determine their strengths and weaknesses. It also serves as a vehicle to help site personnel formally evaluate their training structures.

The Monthly Practicum Log (Form 2.7) permits the student to quantify the number of hours spent in particular counseling areas while in the practicum. The practicum student should detail the time spent in the various training activities. The student should have his or her supervisor sign the practicum log monthly in recognition of these activities.

The function of the remaining evaluation forms (Forms 12.1 through 12.5) is explained in the following information:

- The Internship Log (Form 12.1) parallels the function of the practicum log and is used by interns.
- The Student Evaluation Form (Form 12.2) complements the practicum and internship logs. The supervisor utilizes this form to evaluate the student’s work in each relevant and appropriate category.
- The Client’s Personal/Social Satisfaction With Counseling Assessment form (Form 12.3) allows the practicum student’s or intern’s clients to address the degree of satisfaction experienced during the counseling process. The student should have his or her client fill out and sign the form when counseling has been terminated.
- The Student Counselor Evaluation of Supervisor form (Form 12.4) is completed by the practicum student or intern at the midpoint and conclusion of
the supervisory contract. Both the student and his or her supervisor should sign the form.

- The Site Evaluation Form (Form 12.5) is to be used so that site personnel and university program faculty can assess the quality of their training sites.

These final evaluation forms are included because they are similar to those typically used in agencies and schools. The final assessment by the student, supervisor, and client at the culmination of the internship experience is a crucial component of the training process and is an excellent opportunity for these individuals to evaluate the internship as a whole. It is only through a final assessment of the internship that the student is truly able to reflect on the material and skills learned. In the same way, feedback provided by the client and supervisor is instrumental in communicating to the student which skills have been used effectively and which need to be further refined. The student or supervisor might consider adapting these forms to address the specific and particular needs of the internship experience.
Appendices

Appendix I  Alphabetical Listing of *Diagnostic and Statistical Manual of Mental Disorders–Text Revision* Diagnoses and Codes
Appendix II  Numerical Listing of *Diagnostic and Statistical Manual of Mental Disorders–Text Revision* Diagnoses and Codes
Appendix III  Psychiatric Medications
Appendix IV  American Counseling Association: Meeting HIPAA Requirements—Notice of Privacy Practices and Client Rights Document
Appendix V  Sample Adolescent Informed Consent Form
Appendix I

Alphabetical Listing of Diagnostic and Statistical Manual of Mental Disorders–Text Revision Diagnoses and Codes

Note. NOS = not otherwise specified.

V62.3 Academic Problem
V62.4 Acculturation Problem
  Acute Stress Disorder
  Adjustment Disorders
309.9 Unspecified
309.24 With Anxiety
309.0 With Depressed Mood
309.3 With Disturbance of Conduct
309.28 With Mixed Anxiety and Depressed Mood
309.4 With Mixed Disturbance of Emotions and Conduct
V71.01 Adult Antisocial Behavior
995.2 Adverse Effects of Medication NOS
780.93 Age-Related Cognitive Decline
300.22 Agoraphobia Without History of Panic Disorder
  Alcohol
305.00 Abuse
303.90 Dependence
291.89 Induced Anxiety Disorder
291.89 Induced Mood Disorder
291.1 Induced Persisting Amnestic Disorder
291.2  Induced Persisting Dementia
Induced Psychotic Disorder
291.5  With Delusions
291.3  With Hallucinations
291.89 Induced Sexual Dysfunction
291.89 Induced Sleep Disorder
303.00 Intoxication
291.0  Intoxication Delirium
291.9  Related Disorder NOS
291.81 Withdrawal
291.0  Withdrawal Delirium
294.0  Amnestic Disorder Due to … [Indicate the General Medical Condition]
294.8  Amnestic Disorder NOS
Amphetamine (or Amphetamine-Like)
305.70 Abuse
304.40 Dependence
292.89 Induced Anxiety Disorder
292.84 Induced Mood Disorder
Induced Psychotic Disorder
292.11 With Delusions
292.12 With Hallucinations
292.89 Induced Sexual Dysfunction
292.89 Induced Sleep Disorder
292.89 Intoxication
292.81 Intoxication Delirium
292.9  Related Disorder NOS
292.0  Withdrawal
307.1  Anorexia Nervosa
301.7  Antisocial Personality Disorder
293.84 Anxiety Disorder Due to … [Indicate the General Medical Condition]
300.00 Anxiety Disorder NOS
299.80 Asperger's Disorder
Attention-Deficit/Hyperactivity Disorder
314.01 Combined Type
314.01 Predominantly Hyperactive-Impulsive Type
314.00 Predominantly Inattentive Type
314.9  Attention-Deficit/Hyperactivity Disorder NOS
299.00 Autistic Disorder
301.82 Avoidant Personality Disorder
V62.82 Bereavement
296.80 Bipolar Disorder NOS
Bipolar I Disorder, Most Recent Episode Depressed
296.56 In Full Remission
296.55 In Partial Remission
296.51  Mild
296.52  Moderate
296.53  Severe Without Psychotic Features
296.54  Severe With Psychotic Features
296.50  Unspecified
296.40  Bipolar I Disorder, Most Recent Episode Hypomanic
       Bipolar I Disorder, Most Recent Episode Manic
296.46  In Full Remission
296.45  In Partial Remission
296.41  Mild
296.42  Moderate
296.43  Severe Without Psychotic Features
296.44  Severe With Psychotic Features
296.40  Unspecified
       Bipolar I Disorder, Most Recent Episode Mixed
296.66  In Full Remission
296.65  In Partial Remission
296.61  Mild
296.62  Moderate
296.63  Severe Without Psychotic Features
296.64  Severe With Psychotic Features
296.60  Unspecified
296.7   Bipolar I Disorder, Most Recent Episode Unspecified
       Bipolar I Disorder, Single Manic Episode
296.06  In Full Remission
296.05  In Partial Remission
296.01  Mild
296.02  Moderate
296.03  Severe Without Psychotic Features
296.04  Severe With Psychotic Features
296.00  Unspecified
296.89  Bipolar II Disorder
300.7  Body Dysmorphic Disorder
V62.89  Borderline Intellectual Functioning
301.83  Borderline Personality Disorder
780.59  Breathing-Related Sleep Disorder
298.8  Brief Psychotic Disorder
307.51  Bulimia Nervosa
Caffeine
292.89  Induced Anxiety Disorder
292.89  Induced Sleep Disorder
305.90  Intoxication
292.9  Related Disorder NOS
Cannabis
305.20 Abuse
304.30 Dependence
292.89 Induced Anxiety Disorder
   Induced Psychotic Disorder
292.11 With Delusions
292.12 With Hallucinations
292.89 Intoxication
292.81 Intoxication Delirium
292.9 Related Disorder NOS
293.89 Catatonic Disorder Due to … [Indicate the General Medical Condition]
299.10 Childhood Disintegrative Disorder
V71.02 Child or Adolescent Antisocial Behavior
307.22 Chronic Motor or Vocal Tic Disorder
307.45 Circadian Rhythm Sleep Disorder
   Cocaine
305.60 Abuse
304.20 Dependence
292.89 Induced Anxiety Disorder
292.84 Induced Mood Disorder
   Induced Psychotic Disorder
292.11 With Delusions
292.12 With Hallucinations
292.89 Induced Sexual Dysfunction
292.89 Intoxication
292.81 Intoxication Delirium
292.9 Related Disorder NOS
292.0 Withdrawal
294.9 Cognitive Disorder NOS
307.9 Communication Disorder NOS
   Conduct Disorder
312.81 Childhood-Onset Type
312.82 Adolescent-Onset Type
312.89 Unspecified Type
300.11 Conversion Disorder
301.13 Cyclothymic Disorder
293.0 Delirium Due to … [Indicate the General Medical Condition]
780.09 Delirium NOS
297.1 Delusional Disorder
   Dementia Due to Creutzfeldt-Jakob Disease
294.10 Without Behavioral Disturbance
294.11 With Behavioral Disturbance
   Dementia Due to Head Trauma
294.10 Without Behavioral Disturbance
294.11 With Behavioral Disturbance
Dementia Due to HIV Disease
294.10 Without Behavioral Disturbance
294.11 With Behavioral Disturbance
Dementia Due to Huntington’s Disease
294.10 Without Behavioral Disturbance
294.11 With Behavioral Disturbance
Dementia Due to Parkinson’s Disease
294.10 Without Behavioral Disturbance
294.11 With Behavioral Disturbance
Dementia Due to Pick’s Disease
294.10 Without Behavioral Disturbance
294.11 With Behavioral Disturbance
Dementia Due to … [Indicate Other General Medical Condition]
294.10 Without Behavioral Disturbance
294.11 With Behavioral Disturbance
Dementia NOS
Dementia of the Alzheimer’s Type, With Early Onset
294.10 Without Behavioral Disturbance
294.11 With Behavioral Disturbance
Dementia of the Alzheimer’s Type, With Late Onset
294.10 Without Behavioral Disturbance
294.11 With Behavioral Disturbance
301.6 Dependent Personality Disorder
300.6 Depersonalization Disorder
311 Depressive Disorder NOS
315.4 Developmental Coordination Disorder
799.9 Diagnosis Deferred on Axis II
799.9 Diagnosis or Condition Deferred on Axis I
313.9 Disorder of Infancy, Childhood, or Adolescence NOS
315.2 Disorder of Written Expression
312.9 Disruptive Behavior Disorder NOS
300.12 Dissociative Amnesia
300.15 Dissociative Disorder NOS
300.13 Dissociative Fugue
300.14 Dissociative Identity Disorder
302.76 Dyspareunia (Not Due to a General Medical Condition)
307.47 Dyssomnria NOS
300.4 Dysthymic Disorder
307.50 Eating Disorder NOS
787.6 Encopresis, With Constipation and Overflow Incontinence
307.7 Encopresis, Without Constipation and Overflow Incontinence
307.6 Enuresis (Not Due to a General Medical Condition)
302.4 Exhibitionism
315.31 Expressive Language Disorder
Factitious Disorder
300.19 With Combined Psychological and Physical Signs and Symptoms
300.19 With Predominantly Physical Signs and Symptoms
300.16 With Predominantly Psychological Signs and Symptoms
300.19 Factitious Disorder NOS
307.59 Feeding Disorder of Infancy or Early Childhood
625.0 Female Dyspareunia Due to … [Indicate the General Medical Condition]
625.8 Female Hypoactive Sexual Desire Disorder Due to … [Indicate the General Medical Condition]
302.73 Female Orgasmic Disorder
302.72 Female Sexual Arousal Disorder
302.81 Fetishism
302.89 Frotteurism
Gender Identity Disorder
302.85 in Adolescents or Adults
302.6 in Children
302.6 Gender Identity Disorder NOS
300.02 Generalized Anxiety Disorder
305.30 Abuse
304.50 Dependence
292.89 Induced Anxiety Disorder
292.84 Induced Mood Disorder
292.89 Induced Psychotic Disorder
292.11 With Delusions
292.12 With Hallucinations
292.89 Intoxication
292.81 Intoxication Delirium
292.89 Persisting Perception Disorder
292.9 Related Disorder NOS
301.50 Histrionic Personality Disorder
307.44 Hypersomnia Related to … [Indicate the Axis I or Axis II Disorder]
302.71 Hypoactive Sexual Desire Disorder
300.7 Hypochondriasis
313.82 Identity Problem
312.30 Impulse-Control Disorder NOS
305.90 Abuse
304.60 Dependence
292.89 Induced Anxiety Disorder
292.84 Induced Mood Disorder
292.82 Induced Persisting Dementia
Induced Psychotic Disorder
292.11  With Delusions
292.12  With Hallucinations
292.89  Intoxication
292.81  Intoxication Delirium
292.9   Related Disorder NOS
307.42  Insomnia Related to … [Indicate the Axis I or Axis II Disorder]
312.34  Intermittent Explosive Disorder
312.32  Kleptomania
315.9   Learning Disorder NOS
        Major Depressive Disorder, Recurrent
296.36  In Full Remission
296.35  In Partial Remission
296.31  Mild
296.32  Moderate
296.33  Severe Without Psychotic Features
296.34  Severe With Psychotic Features
296.30  Unspecified
        Major Depressive Disorder, Single Episode
296.26  In Full Remission
296.25  In Partial Remission
296.21  Mild
296.22  Moderate
296.23  Severe Without Psychotic Features
296.24  Severe With Psychotic Features
296.20  Unspecified
608.89  Male Dyspareunia Due to … [Indicate the General Medical Condition]
302.72  Male Erectile Disorder
607.84  Male Erectile Disorder Due to … [Indicate the General Medical
        Condition]
608.89  Male Hypoactive Sexual Desire Disorder Due to … [Indicate the
        General Medical Condition]
302.74  Male Orgasmic Disorder
V65.2   Malingering
315.1   Mathematics Disorder
        Medication-Induced
333.90  Movement Disorder NOS
333.1   Postural Tremor
293.9   Mental Disorder NOS Due to … [Indicate the General Medical
        Condition]
319     Mental Retardation, Severity Unspecified
317     Mild Mental Retardation
315.32  Mixed Receptive-Expressive Language Disorder
318.0   Moderate Mental Retardation
293.83  Mood Disorder Due to … [Indicate the General Medical Condition]
<table>
<thead>
<tr>
<th>Code</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>296.90</td>
<td>Mood Disorder NOS</td>
</tr>
<tr>
<td>301.81</td>
<td>Narcissistic Personality Disorder</td>
</tr>
<tr>
<td>347</td>
<td>Narcolepsy</td>
</tr>
<tr>
<td>518.21</td>
<td>Neglect of Child</td>
</tr>
<tr>
<td>995.52</td>
<td>Neglect of Child (if focus of attention is on victim) Neuroleptic-Induced</td>
</tr>
<tr>
<td>333.99</td>
<td>Acute Akathisia</td>
</tr>
<tr>
<td>333.7</td>
<td>Acute Dystonia</td>
</tr>
<tr>
<td>332.1</td>
<td>Parkinsonism</td>
</tr>
<tr>
<td>333.82</td>
<td>Tardive Dyskinesia</td>
</tr>
<tr>
<td>333.92</td>
<td>Neuroleptic Malignant Syndrome</td>
</tr>
<tr>
<td>305.1</td>
<td>Dependence</td>
</tr>
<tr>
<td>292.9</td>
<td>Related Disorder NOS</td>
</tr>
<tr>
<td>292.0</td>
<td>Withdrawal</td>
</tr>
<tr>
<td>307.47</td>
<td>Nightmare Disorder</td>
</tr>
<tr>
<td>V71.09</td>
<td>No Diagnosis on Axis II</td>
</tr>
<tr>
<td>V71.09</td>
<td>No Diagnosis or Condition on Axis I</td>
</tr>
<tr>
<td>V15.81</td>
<td>Noncompliance With Treatment</td>
</tr>
<tr>
<td>300.3</td>
<td>Obsessive-Compulsive Disorder</td>
</tr>
<tr>
<td>301.4</td>
<td>Obsessive-Compulsive Personality Disorder</td>
</tr>
<tr>
<td>V62.2</td>
<td>Occupational Problem</td>
</tr>
<tr>
<td>Opioid</td>
<td></td>
</tr>
<tr>
<td>305.50</td>
<td>Abuse</td>
</tr>
<tr>
<td>304.00</td>
<td>Dependence</td>
</tr>
<tr>
<td>292.84</td>
<td>Induced Mood Disorder</td>
</tr>
<tr>
<td>292.11</td>
<td>Induced Psychotic Disorder</td>
</tr>
<tr>
<td>292.12</td>
<td>Induced Hallucinatory Disorder</td>
</tr>
<tr>
<td>292.89</td>
<td>Induced Sexual Dysfunction</td>
</tr>
<tr>
<td>292.89</td>
<td>Induced Sleep Disorder</td>
</tr>
<tr>
<td>292.89</td>
<td>Intoxication</td>
</tr>
<tr>
<td>292.81</td>
<td>Intoxication Delirium</td>
</tr>
<tr>
<td>292.9</td>
<td>Related Disorder NOS</td>
</tr>
<tr>
<td>292.0</td>
<td>Withdrawal</td>
</tr>
<tr>
<td>313.81</td>
<td>Oppositional Defiant Disorder</td>
</tr>
<tr>
<td>625.8</td>
<td>Other Female Sexual Dysfunction Due to ... [Indicate the General Medical Condition]</td>
</tr>
<tr>
<td>608.89</td>
<td>Other Male Sexual Dysfunction Due to ... [Indicate the General Medical Condition]</td>
</tr>
<tr>
<td>608.89</td>
<td>Other (or Unknown) Substance</td>
</tr>
<tr>
<td>305.90</td>
<td>Abuse</td>
</tr>
<tr>
<td>304.90</td>
<td>Dependence</td>
</tr>
<tr>
<td>292.89</td>
<td>Induced Anxiety Disorder</td>
</tr>
</tbody>
</table>
Appendix I

292.81 Induced Delirium
292.84 Induced Mood Disorder
292.83 Induced Persisting Amnestic Disorder
292.82 Induced Persisting Dementia
   Induced Psychotic Disorder
292.11 With Delusions
292.12 With Hallucinations
292.89 Induced Sexual Dysfunction
292.89 Induced Sleep Disorder
292.89 Intoxication
292.9 Related Disorder NOS
292.0 Withdrawal
   Pain Disorder
307.89 Associated With Both Psychological Factors and a General Medical Condition
307.80 Associated With Psychological Factors
   Panic Disorder
300.21 With Agoraphobia
300.01 Without Agoraphobia
301.0 Paranoid Personality Disorder
302.9 Paraphilia NOS
307.47 Parasomnia NOS
V61.20 Parent–Child Relational Problem
V61.10 Partner Relational Problem
312.31 Pathological Gambling
302.2 Pedophilia
310.1 Personality Change Due to … [Indicate the General Medical Condition]
301.9 Personality Disorder NOS
299.80 Pervasive Developmental Disorder NOS
V62.89 Phase of Life Problem
   Phencyclidine (or Phencyclidine-Like)
305.90 Abuse
304.60 Dependence
292.89 Induced Anxiety Disorder
292.84 Induced Mood Disorder
   Induced Psychotic Disorder
292.11 With Delusions
292.12 With Hallucinations
292.89 Intoxication
292.81 Intoxication Delirium
292.9 Related Disorder NOS
315.39 Phonological Disorder
V61.12 Physical Abuse of Adult (if by partner)
V62.83 Physical Abuse of Adult (if by person other than partner)
995.81 Physical Abuse of Adult (if focus of attention is on victim)
V61.21 Physical Abuse of Child
995.54 Physical Abuse of Child (if focus of attention is on victim)
307.52 Pica
304.80 Polysubstance Dependence
309.81 Posttraumatic Stress Disorder
302.75 Premature Ejaculation
307.44 Primary Hypersomnia
307.42 Primary Insomnia
318.2 Profound Mental Retardation
316 Psychological Factor Affecting Medical Condition
Psychotic Disorder Due to … [Indicate the General Medical Condition]
293.81 With Delusions
293.82 With Hallucinations
298.9 Psychotic Disorder NOS
312.33 Pyromania
313.89 Reactive Attachment Disorder of Infancy or Early Childhood
315.00 Reading Disorder
V62.81 Relational Problem NOS
V61.9 Relational Problem Related to a Mental Disorder or General Medical Condition
V62.89 Religious or Spiritual Problem
299.80 Rett's Disorder
307.53 Rumination Disorder
295.70 Schizoaffective Disorder
301.20 Schizoid Personality Disorder Schizophrenia
295.20 Catatonic Type
295.10 Disorganized Type
295.30 Paranoid Type
295.60 Residual Type
295.90 Undifferentiated Type
295.40 Schizophreniform Disorder
301.22 Schizotypal Personality Disorder Schizophrenia
Sedative, Hypnotic, or Anxiolytic
305.40 Abuse
304.10 Dependence
292.89 Induced Anxiety Disorder
292.84 Induced Mood Disorder
292.83 Induced Persisting Amnestic Disorder
292.82 Induced Persisting Dementia
Induced Psychotic Disorder
292.11 With Delusions
292.12 With Hallucinations
292.89 Induced Sexual Dysfunction
292.89  Induced Sleep Disorder
292.89  Intoxication
292.81  Intoxication Delirium
292.9   Related Disorder NOS
292.0   Withdrawal
292.81  Withdrawal Delirium
313.23  Selective Mutism
309.21  Separation Anxiety Disorder
318.1   Severe Mental Retardation
V61.12  Sexual Abuse of Adult (if by partner)
V62.83  Sexual Abuse of Adult (if by person other than partner)
995.83  Sexual Abuse of Adult (if focus of attention is on victim)
V61.21  Sexual Abuse of Child
995.53  Sexual Abuse of Child (if focus of attention is on victim)
302.79  Sexual Aversion Disorder
302.9   Sexual Disorder NOS
302.70  Sexual Dysfunction NOS
302.83  Sexual Masochism
302.84  Sexual Sadism
297.3   Shared Psychotic Disorder
V61.8   Sibling Relational Problem
Sleep Disorder Due to … [Indicate the General Medical Condition]
780.54  Hypersomnia Type
780.52  Insomnia Type
780.59  Mixed Type
780.59  Parasomnia Type
307.46  Sleep Terror Disorder
307.46  Sleepwalking Disorder
300.23  Social Phobia
300.81  Somatization Disorder
300.82  Somatoform Disorder NOS
300.29  Specific Phobia
307.3   Stereotypic Movement Disorder
307.0   Stuttering
307.20  Tic Disorder NOS
307.23  Tourette’s Disorder
307.21  Transient Tic Disorder
302.3   Transvestic Fetishism
312.39  Trichotillomania
300.82  Undifferentiated Somatoform Disorder
300.9   Unspecified Mental Disorder (nonpsychotic)
306.51  Vaginismus (Not Due to a General Medical Condition)
         Vascular Dementia
290.40  Uncomplicated
290.41 With Delirium
290.42 With Delusions
290.43 With Depressed Mood
302.82 Voyeurism
Appendix II

Numerical Listing of Diagnostic and Statistical Manual of Mental Disorders–Text Revision Diagnoses and Codes

To maintain compatibility with ICD-9-CM (International Classification of Diseases–Coding Manual), some DSM-IV diagnoses share the same code numbers. These are indicated in this list by brackets. Note: NOS = not otherwise specified.

290.40 Vascular Dementia, Uncomplicated
290.41 Vascular Dementia, With Delirium
290.42 Vascular Dementia, With Delusions
290.43 Vascular Dementia, With Depressed Mood
291.0 Alcohol Intoxication Delirium
291.0 Alcohol Withdrawal Delirium
291.1 Alcohol-Induced Persisting Amnestic Disorder
291.2 Alcohol-Induced Persisting Dementia
291.3 Alcohol-Induced Psychotic Disorder, With Hallucinations
291.5 Alcohol-Induced Psychotic Disorder, With Delusions
291.81 Alcohol Withdrawal
291.89 Alcohol-Induced Anxiety Disorder
291.89 Alcohol-Induced Mood Disorder
291.89 Alcohol-Induced Sexual Dysfunction
291.89 Alcohol-Induced Sleep Disorder
291.9 Alcohol-Related Disorder NOS
292.0 Amphetamine Withdrawal
292.0 Cocaine Withdrawal
292.0 Nicotine Withdrawal
292.0 Opioid Withdrawal
292.0 Other (or Unknown) Substance Withdrawal
292.0 Sedative, Hypnotic, or Anxiolytic Withdrawal
292.11 Amphetamine-Induced Psychotic Disorder, With Delusions
292.11 Cannabis-Induced Psychotic Disorder, With Delusions
292.11 Cocaine-Induced Psychotic Disorder, With Delusions
292.11 Hallucinogen-Induced Psychotic Disorder, With Delusions
292.11 Inhalant-Induced Psychotic Disorder, With Delusions
292.11 Opioid-Induced Psychotic Disorder, With Delusions
292.11 Other (or Unknown) Substance-Induced Psychotic Disorder, With Delusions
292.11 Phencyclidine-Induced Psychotic Disorder, With Delusions
292.11 Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder, With Delusions
292.12 Amphetamine-Induced Psychotic Disorder, With Hallucinations
292.12 Cannabis-Induced Psychotic Disorder, With Hallucinations
292.12 Cocaine-Induced Psychotic Disorder, With Hallucinations
292.12 Hallucinogen-Induced Psychotic Disorder, With Hallucinations
292.12 Inhalant-Induced Psychotic Disorder, With Hallucinations
292.12 Opioid-Induced Psychotic Disorder, With Hallucinations
292.12 Other (or Unknown) Substance-Induced Psychotic Disorder, With Hallucinations
292.12 Phencyclidine-Induced Psychotic Disorder, With Hallucinations
292.12 Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder, With Hallucinations
292.81 Amphetamine Intoxication Delirium
292.81 Cannabis Intoxication Delirium
292.81 Cocaine Intoxication Delirium
292.81 Hallucinogen Intoxication Delirium
292.81 Inhalant Intoxication Delirium
292.81 Opioid Intoxication Delirium
292.81 Other (or Unknown) Substance-Induced Delirium
292.81 Phencyclidine Intoxication Delirium
292.81 Sedative, Hypnotic, or Anxiolytic-Induced Delirium
292.82 Inhalant-Induced Persisting Dementia
292.82 Other (or Unknown) Substance-Induced Persisting Dementia
292.82 Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Dementia
292.83 Other (or Unknown) Substance-Induced Persisting Amnestic Disorder
292.83 Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Amnestic Disorder
292.84 Amphetamine-Induced Mood Disorder
292.84 Cocaine-Induced Mood Disorder
292.84 Hallucinogen-Induced Mood Disorder
292.84 Inhalant-Induced Mood Disorder
292.84 Opioid-Induced Mood Disorder
292.84 Other (or Unknown) Substance-Induced Mood Disorder
292.84 Phencyclidine-Induced Mood Disorder
292.84 Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder
292.89 Amphetamine-Induced Anxiety Disorder
292.89 Amphetamine-Induced Sexual Dysfunction
292.89 Amphetamine-Induced Sleep Disorder
292.89 Amphetamine Intoxication
292.89 Caffeine-Induced Anxiety Disorder
292.89 Caffeine-Induced Sexual Dysfunction
292.89 Caffeine-Induced Sleep Disorder
292.89 Caffeine Intoxication
292.89 Cannabis-Induced Anxiety Disorder
292.89 Cannabis Intoxication
292.89 Cocaine-Induced Anxiety Disorder
292.89 Cocaine-Induced Sexual Dysfunction
292.89 Cocaine-Induced Sleep Disorder
292.89 Cocaine Intoxication
292.89 Hallucinogen-Induced Anxiety Disorder
292.89 Hallucinogen Intoxication
292.89 Hallucinogen Persisting Perception Disorder
292.89 Inhalant-Induced Anxiety Disorder
292.89 Inhalant Intoxication
292.89 Opioid-Induced Sexual Dysfunction
292.89 Opioid-Induced Sleep Disorder
292.89 Opioid Intoxication
292.89 Other (or Unknown) Substance-Induced Anxiety Disorder
292.89 Other (or Unknown) Substance-Induced Sexual Dysfunction
292.89 Other (or Unknown) Substance-Induced Sleep Disorder
292.89 Other (or Unknown) Substance Intoxication
292.89 Phencyclidine-Induced Anxiety Disorder
292.89 Phencyclidine Intoxication
292.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder
292.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Sexual Dysfunction
292.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Sleep Disorder
292.89 Sedative, Hypnotic, or Anxiolytic Intoxication
292.9 Amphetamine-Related Disorder NOS
292.9 Caffeine-Related Disorder NOS
292.9 Cannabis-Related Disorder NOS
292.9 Cocaine-Related Disorder NOS
292.9 Hallucinogen-Related Disorder NOS
292.9 Inhalant-Related Disorder NOS
292.9 Nicotine-Related Disorder NOS
292.9 Opioid-Related Disorder NOS
292.9 Other (or Unknown) Substance-Related Disorder NOS
292.9 Phencyclidine-Related Disorder NOS
292.9 Sedative-, Hypnotic-, or Anxiolytic-Related Disorder NOS
293.0 Delirium Due to … [Indicate the General Medical Condition]
293.81 Psychotic Disorder Due to … [Indicate the General Medical Condition], With Delusions
293.82 Psychotic Disorder Due to … [Indicate the General Medical Condition], With Hallucinations
293.83 Mood Disorder Due to … [Indicate the General Medical Condition]
293.84 Anxiety Disorder Due to … [Indicate the General Medical Condition]
293.89 Catatonic Disorder Due to … [Indicate the General Medical Condition]
293.9 Mental Disorder NOS Due to … [Indicate the General Medical Condition]
294.0 Amnestic Disorder Due to … [Indicate the General Medical Condition]
294.10 Dementia Due to … [Indicate the General Medical Condition], Without Behavioral Disturbance
294.10 Dementia of the Alzheimer’s Type, With Early Onset, Without Behavioral Disturbance
294.10 Dementia of the Alzheimer’s Type, With Late Onset, Without Behavioral Disturbance
294.11 Dementia Due to … [Indicate the General Medical Condition], With Behavioral Disturbance
294.11 Dementia of the Alzheimer’s Type, With Early Onset, With Behavioral Disturbance
294.11 Dementia of the Alzheimer’s Type, With Late Onset, With Behavioral Disturbance
294.8 Amnestic Disorder NOS
294.8 Dementia NOS
294.9 Cognitive Disorder NOS
295.10 Schizophrenia, Disorganized Type
295.20 Schizophrenia, Catatonic Type
295.30 Schizophrenia, Paranoid Type
295.40 Schizophreniform Disorder
295.60 Schizophrenia, Residual Type
295.70 Schizoaffective Disorder
295.90 Schizophrenia, Undifferentiated Type
296.00 Bipolar I Disorder, Single Manic Episode, Unspecified
296.01 Bipolar I Disorder, Single Manic Episode, Mild
296.02 Bipolar I Disorder, Single Manic Episode, Moderate
296.03 Bipolar I Disorder, Single Manic Episode, Severe Without Psychotic Features
296.04 Bipolar I Disorder, Single Manic Episode, Severe With Psychotic Features
296.05 Bipolar I Disorder, Single Manic Episode, In Partial Remission
296.06 Bipolar I Disorder, Single Manic Episode, In Full Remission
296.20 Major Depressive Disorder, Single Episode, Unspecified
296.21 Major Depressive Disorder, Single Episode, Mild
296.22 Major Depressive Disorder, Single Episode, Moderate
296.23 Major Depressive Disorder, Single Episode, Severe Without Psychotic Features
296.24 Major Depressive Disorder, Single Episode, Severe With Psychotic Features
296.25 Major Depressive Disorder, Single Episode, In Partial Remission
296.26 Major Depressive Disorder, Single Episode, In Full Remission
296.30 Major Depressive Disorder, Recurrent, Unspecified
296.31 Major Depressive Disorder, Recurrent, Mild
296.32 Major Depressive Disorder, Recurrent, Moderate
296.33 Major Depressive Disorder, Recurrent, Severe Without Psychotic Features
296.34 Major Depressive Disorder, Recurrent, Severe With Psychotic Features
296.35 Major Depressive Disorder, Recurrent, In Partial Remission
296.36 Major Depressive Disorder, Recurrent, In Full Remission
296.40 Bipolar I Disorder, Most Recent Episode Hypomanic
296.40 Bipolar I Disorder, Most Recent Episode Manic, Unspecified
296.41 Bipolar I Disorder, Most Recent Episode Manic, Mild
296.42 Bipolar I Disorder, Most Recent Episode Manic, Moderate
296.43 Bipolar I Disorder, Most Recent Episode Manic, Severe Without Psychotic Features
296.44 Bipolar I Disorder, Most Recent Episode Manic, Severe With Psychotic Features
296.45 Bipolar I Disorder, Most Recent Episode Manic, In Partial Remission
296.46 Bipolar I Disorder, Most Recent Episode Manic, In Full Remission
296.50 Bipolar I Disorder, Most Recent Episode Depressed, Unspecified
296.51 Bipolar I Disorder, Most Recent Episode Depressed, Mild
296.52 Bipolar I Disorder, Most Recent Episode Depressed, Moderate
296.53 Bipolar I Disorder, Most Recent Episode Depressed, Severe Without Psychotic Features
296.54 Bipolar I Disorder, Most Recent Episode Depressed, Severe With Psychotic Features
296.55 Bipolar I Disorder, Most Recent Episode Depressed, In Partial Remission
296.56 Bipolar I Disorder, Most Recent Episode Depressed, In Full Remission
296.60 Bipolar I Disorder, Most Recent Episode Mixed, Unspecified
296.61 Bipolar I Disorder, Most Recent Episode Mixed, Mild
296.62 Bipolar I Disorder, Most Recent Episode Mixed, Moderate
296.63 Bipolar I Disorder, Most Recent Episode Mixed, Severe Without Psychotic Features
296.64 Bipolar I Disorder, Most Recent Episode Mixed, Severe With Psychotic Features
296.65 Bipolar I Disorder, Most Recent Episode Mixed, In Partial Remission
296.66 Bipolar I Disorder, Most Recent Episode Mixed, In Full Remission
296.7 Bipolar I Disorder, Most Recent Episode Unspecified
296.80 Bipolar Disorder NOS
296.89 Bipolar II Disorder
296.90 Mood Disorder NOS
297.1 Delusional Disorder
297.3 Shared Psychotic Disorder
298.8 Brief Psychotic Disorder
298.9 Psychotic Disorder NOS
299.00 Autistic Disorder
299.10 Childhood Disintegrative Disorder
299.80 Asperger’s Disorder
299.80 Pervasive Developmental Disorder NOS
299.80 Rett’s Disorder
300.00 Anxiety Disorder NOS
300.01 Panic Disorder Without Agoraphobia
300.02 Generalized Anxiety Disorder
300.11 Conversion Disorder
300.12 Dissociative Amnesia
300.13 Dissociative Fugue
300.14 Dissociative Identity Disorder
300.15 Dissociative Disorder NOS
300.16 Factitious Disorder With Predominantly Psychological Signs and Symptoms
300.19 Factitious Disorder NOS
300.19 Factitious Disorder With Combined Psychological and Physical Signs and Symptoms
300.19 Factitious Disorder With Predominantly Physical Signs and Symptoms
300.21 Panic Disorder With Agoraphobia
300.22 Agoraphobia Without History of Panic Disorder
300.23 Social Phobia
300.29 Specific Phobia
300.3 Obsessive-Compulsive Disorder
300.4 Dysthymic Disorder
300.6 Depersonalization Disorder
300.7 Body Dysmorphic Disorder
300.7 Hypochondriasis
300.81 Somatization Disorder
300.82 Somatoform Disorder NOS
300.82 Undifferentiated Somatoform Disorder
300.9 Unspecified Mental Disorder (nonpsychotic)
301.0 Paranoid Personality Disorder
301.13 Cyclothymic Disorder
301.20 Schizoid Personality Disorder
301.22 Schizotypal Personality Disorder
301.4 Obsessive-Compulsive Personality Disorder
301.50 Histrionic Personality Disorder
301.6 Dependent Personality Disorder
301.7 Antisocial Personality Disorder
301.81 Narcissistic Personality Disorder
301.82 Avoidant Personality Disorder
301.83 Borderline Personality Disorder
301.9 Personality Disorder NOS
302.2 Pedophilia
302.3 Transvestic Fetishism
302.4 Exhibitionism
302.6 Gender Identity Disorder in Children
302.6 Gender Identity Disorder NOS
302.70 Sexual Dysfunction NOS
302.71 Hypoactive Sexual Desire Disorder
302.72 Female Sexual Arousal Disorder
302.72 Male Erectile Disorder
302.73 Female Orgasmic Disorder
302.74 Male Orgasmic Disorder
302.75 Premature Ejaculation
302.76 Dyspareunia (Not Due to a General Medical Condition)
302.79 Sexual Aversion Disorder
302.81 Fetishism
302.82 Voyeurism
302.83 Sexual Masochism
302.84 Sexual Sadism
302.85 Gender Identity Disorder in Adolescents or Adults
302.89 Frotteurism
302.9 Paraphilia NOS
302.9 Sexual Disorder NOS
303.00 Alcohol Intoxication
303.90 Alcohol Dependence
304.00 Opioid Dependence
304.10 Sedative, Hypnotic, or Anxiolytic Dependence
304.20 Cocaine Dependence
304.30 Cannabis Dependence
304.40 Amphetamine Dependence
304.50 Hallucinogen Dependence
304.60 Inhalant Dependence
304.60 Phencyclidine Dependence
304.80 Polysubstance Dependence
304.90 Other (or Unknown) Substance Dependence
305.00 Alcohol Abuse
305.1 Nicotine Dependence
305.20 Cannabis Abuse
305.30 Hallucinogen Abuse
305.40 Sedative, Hypnotic, or Anxiolytic Abuse
305.50 Opioid Abuse
305.60 Cocaine Abuse
305.70 Amphetamine Abuse
305.90 Caffeine Intoxication
305.90 Inhalant Abuse
305.90 Other (or Unknown) Substance Abuse
305.90 Phencyclidine Abuse
306.51 Vaginismus (Not Due to a General Medical Condition)
307.0 Stuttering
307.1 Anorexia Nervosa
307.20 Tic Disorder NOS
307.21 Transient Tic Disorder
307.22 Chronic Motor or Vocal Tic Disorder
307.23 Tourette’s Disorder
307.3 Stereotypic Movement Disorder
307.42 Insomnia Related to … [Indicate the Axis I or Axis II Disorder]
307.42 Primary Insomnia
307.44 Hypersomnia Related to … [Indicate the Axis I or Axis II Disorder]
307.44 Primary Hypersomnia
307.45 Circadian Rhythm Sleep Disorder
307.46 Sleep Terror Disorder
307.46 Sleepwalking Disorder
307.47 Dyssomnia NOS
307.47 Nightmare Disorder
307.47 Parasomnia NOS
307.50 Eating Disorder NOS
307.51 Bulimia Nervosa
307.52 Pica
307.53 Rumination Disorder
307.59 Feeding Disorder of Infancy or Early Childhood
307.6 Enuresis (Not Due to a General Medical Condition)
307.7 Encopresis, Without Constipation and Overflow Incontinence
307.80 Pain Disorder Associated With Psychological Factors
307.89 Pain Disorder Associated With Both Psychological Factors and a General Medical Condition
307.9 Communication Disorder NOS
308.3 Acute Stress Disorder
309.0 Adjustment Disorder With Depressed Mood
309.21 Separation Anxiety Disorder
309.24 Adjustment Disorder With Anxiety
309.28 Adjustment Disorder With Mixed Anxiety and Depressed Mood
309.3 Adjustment Disorder With Disturbance of Conduct
309.4 Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
309.81 Posttraumatic Stress Disorder
309.9 Adjustment Disorder Unspecified
310.1 Personality Change Due to … [Indicate the General Medical Condition]
311 Depressive Disorder NOS
312.30 Impulse-Control Disorder NOS
312.31 Pathological Gambling
312.32 Kleptomania
312.33 Pyromania
312.34 Intermittent Explosive Disorder
312.39 Trichotillomania
312.81 Conduct Disorder, Childhood-Onset Type
312.82 Conduct Disorder, Adolescent-Onset Type
312.89 Conduct Disorder, Unspecified Onset
312.9 Disruptive Behavior Disorder NOS
313.23 Selective Mutism
313.81 Oppositional Defiant Disorder
313.82 Identity Problem
313.89 Reactive Attachment Disorder of Infancy or Early Childhood
313.9 Disorder of Infancy, Childhood, or Adolescence NOS
314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type
314.01 Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type
314.9 Attention-Deficit/Hyperactivity Disorder NOS
315.00 Reading Disorder
315.1 Mathematics Disorder
315.2 Disorder of Written Expression
315.31 Expressive Language Disorder
315.32 Mixed Receptive-Expressive Language Disorder
315.39 Phonological Disorder
315.4 Developmental Coordination Disorder
315.9 Learning Disorder NOS
316 … [Specified Psychological Factor] Affecting … [Indicate the General Medical Condition]
317 Mild Mental Retardation
318.0 Moderate Mental Retardation
318.1 Severe Mental Retardation
318.2 Profound Mental Retardation
319 Mental Retardation, Severity Unspecified
332.1 Neuroleptic-Induced Parkinsonism
333.1 Medication-Induced Postural Tremor
333.7 Neuroleptic-Induced Acute Dystonia
333.82 Neuroleptic-Induced Tardive Dyskinesia
333.90 Medication-Induced Movement Disorder NOS
333.92 Neuroleptic Malignant Syndrome
333.99 Neuroleptic-Induced Acute Akathisia
347 Narcolepsy
607.84 Male Erectile Disorder Due to … [Indicate the General Medical Condition]
608.89 Male Dyspareunia Due to … [Indicate the General Medical Condition]
608.89 Male Hypoactive Sexual Desire Disorder Due to … [Indicate the Medical Condition]
608.89 Other Male Sexual Dysfunction Due to … [Indicate the General Medical Condition]
625.0 Female Dyspareunia Due to … [Indicate the General Medical Condition]
625.8 Female Hypoactive Sexual Desire Disorder Due to … [Indicate the General Medical Condition]
625.8 Other Female Sexual Dysfunction Due to … [Indicate the General Medical Condition]
780.09 Delirium NOS
780.52 Sleep Disorder Due to … [Indicate the General Medical Condition]. Insomnia Type
780.54 Sleep Disorder Due to … [Indicate the General Medical Condition]. Hypersomnia Type
780.59 Breathing-Related Sleep Disorder
780.59 Sleep Disorder Due to … [Indicate the General Medical Condition]. Mixed Type
780.59 Sleep Disorder Due to … [Indicate the General Medical Condition]. Parasomnia Type
780.99 Age-Related Cognitive Decline
787.6 Encopresis, With Constipation and Overflow Incontinence
799.9 Diagnosis Deferred on Axis II
799.9 Diagnosis or Condition Deferred on Axis I
995.2 Adverse Effects of Medication NOS
995.52 Neglect of Child (if focus of attention is on victim)
995.53 Sexual Abuse of Child (if focus of attention is on victim)
995.54 Physical Abuse of Child (if focus of attention is on victim)
995.81 Physical Abuse of Adult (if focus of attention is on victim)
995.83 Sexual Abuse of Adult (if focus of attention is on victim)
V15.81 Noncompliance With Treatment
V61.10 Partner Relational Problem
V61.12 Physical Abuse of Adult (if by partner)
V61.12 Sexual Abuse of Adult (if by partner)
V61.20 Parent–Child Relational Problem
V61.21 Neglect of Child
V61.21 Physical Abuse of Child
V61.21 Sexual Abuse of Child
Appendix II

V61.8 Sibling Relational Problem
V61.9 Relational Problem Related to a Mental Disorder or General Medical Condition
V62.2 Occupational Problem
V62.3 Academic Problem
V62.4 Acculturation Problem
V62.81 Relational Problem NOS
V62.82 Bereavement
V62.83 Physical Abuse (if Adult (if by person other than partner)
V62.83 Sexual Abuse of Adult (if by person other than partner)
V62.89 Borderline Intellectual Functioning
V62.89 Phase of Life Problem
V62.89 Religious or Spiritual Problem
V65.2 Malingering
V71.01 Adult Antisocial Behavior
V71.02 Child or Adolescent Antisocial Behavior
V71.09 No Diagnosis on Axis II
V71.09 No Diagnosis or Condition on Axis I
Appendix III

Psychiatric Medications

Traditionally, counselor training programs have not focused on psychopharmacology as a major content area of training. Philosophical as well as ethical issues regarding the use of medications are contributing factors in the lack of training in this area.

Unfortunately, today’s counselors in both schools and agencies are confronted with the fact that a portion of their clientele may be taking medications or is in need of medications to function more effectively. It is, therefore, critical that counselors have at least a rudimentary understanding of the types of medications commonly prescribed and their uses in treating mental health issues. Counselors are expected to consult and cooperate with other mental health professionals in the treatment of clients. Familiarity with medications is especially helpful in understanding the pharmacological treatment regimens prescribed for clients by physicians and psychiatrists.

The following listing of medications, used in the treatment of mental health issues, is provided for the purposes of

- providing interns in schools and agencies with a listing of common psychoactive medications used in the treatment of mental disorders;
- familiarizing the intern with basic pharmacological terms, symbols, and definitions;
- providing interns with suggested readings to help in their understanding of psychopharmacological treatment; and
- encouraging interns to learn more about the use and abuse of medications.

The number and types of medications used for the treatment of mental health issues are vast. The following is a representative sampling of the more commonly used medications in the United States.
Antidepressant Medications

Classes of Antidepressants

Tricyclic Antidepressants (TCAs): All TCAs have the same basic chemical structure and are related to the phenothiazine class of antipsychotics (Olen, Hebel, Dombeck, & Kastrup, 1993). TCAs are 65% to 75% effective in relieving the somatic features associated with depression. TCAs have been shown to be effective in treating both endogenous and exogenous depression (Joyce & Paykel, 1989). TCAs are often prescribed for patients with decreased appetite, weight loss, early morning awakening, lack of interest in people and environment, and a family history of depression (Buelow, Hebert, & Buelow, 2000). Specific effects of TCAs include the following:

- mood elevation
- increase in physical activity and mental alertness
- improvement in sleep and appetite
- no elevation of mood in nondepressed subjects (American Medical Association, 1983).

<table>
<thead>
<tr>
<th>Trade Name</th>
<th>Generic Name</th>
<th>Daily Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adapin</td>
<td>Doxepin</td>
<td>100–200 mg.</td>
</tr>
<tr>
<td>Anafranil</td>
<td>Clomipramine</td>
<td>150–200 mg.</td>
</tr>
<tr>
<td>Asenden</td>
<td>Amoxepine</td>
<td>200–300 mg.</td>
</tr>
<tr>
<td>Aventyl</td>
<td>Nortriptyline</td>
<td>75–150 mg.</td>
</tr>
<tr>
<td>Elavil</td>
<td>Amitriptyline</td>
<td>100–200 mg.</td>
</tr>
<tr>
<td>Norpramin</td>
<td>Desipramine</td>
<td>100–200 mg.</td>
</tr>
<tr>
<td>Pameloer</td>
<td>Desipramine</td>
<td>75–150 mg.</td>
</tr>
<tr>
<td>Petrofrane</td>
<td>Desipramine</td>
<td>75–150 mg.</td>
</tr>
<tr>
<td>Surmontil</td>
<td>Trimipramine</td>
<td>100–200 mg.</td>
</tr>
<tr>
<td>Tofranil</td>
<td>Imipramine</td>
<td>100–200 mg.</td>
</tr>
<tr>
<td>Vivactil</td>
<td>Protriptyline</td>
<td>100–200 mg.</td>
</tr>
</tbody>
</table>

Note: See Olen et al. (1993).

Serotonin Specific Reuptake Inhibitors (SSRIs): SSRIs, or second-generation antidepressants, have fewer side effects than TCAs and monoamine oxidase inhibitors (see below). Generally, SSRIs cause less weight gain and less sedation and hypotension than TCAs. In addition, SSRIs are less lethal when taken in overdose.
### New Generation Antidepressants

<table>
<thead>
<tr>
<th>Trade Name</th>
<th>Generic Name</th>
<th>Daily Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellbutrin</td>
<td>Bupropion</td>
<td>100–300 mg.</td>
</tr>
<tr>
<td>Desyrel</td>
<td>Trazodone</td>
<td>150–300 mg.</td>
</tr>
<tr>
<td>Serzone</td>
<td>Nefazodone</td>
<td>300–600 mg.</td>
</tr>
<tr>
<td>Remeron</td>
<td>Merlazapine</td>
<td>200 mg.</td>
</tr>
</tbody>
</table>

**Note:** See Gitlin (1996).

### Monoamine Oxidase Inhibitors (MAOIs):** MAOIs are indicated for some patients who are unresponsive to other antidepressants. Because their side-effects profile and a potential for serious interaction with other drugs and food, MAOIs are not used as a first drug of choice when treating depression (Buelow & Buelow, 2000).

<table>
<thead>
<tr>
<th>Trade Name</th>
<th>Generic Name</th>
<th>Daily Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marplan</td>
<td>Isocarboxazid</td>
<td>45–90 mg.</td>
</tr>
<tr>
<td>Nardil</td>
<td>Phenelzine</td>
<td>10–30 mg.</td>
</tr>
<tr>
<td>Parnate</td>
<td>Tranylcypromine</td>
<td>10–30 mg.</td>
</tr>
</tbody>
</table>
Trade Name | Generic Name | Daily Dosage
--- | --- | ---
Klonipin | Clonazepam | 0.25–1.5 mg.
Dalmane | Flurazepam | 15–30 mg.
Halcion | Triazolam | 0.125–0.5 mg.
Librium | Chlordiazepoxide | 15–300 mg.
Prosom | Estazolam | 1–2 mg.
Restoril | Temazepam | 0.15–30 mg.
Serax | Oxazepam | 30–120 mg.
Tranxene | Chlorazepate | 15–60 mg.
Valium | Diazepam | 20–40 mg.
Xanax | Alprazolam | 0.5–1.5 mg.

Antianxiety Agents Other Than Benzodiazepines

Trade Name | Generic Name | Daily Dosage
--- | --- | ---
Adapin | Doxepin | 25–499 mg.
Sinequan | Doxepin | 25–400 mg.
Atarax | Hydroxyzine | 100–400 mg.
Buspar | Buspirone | 15–30 mg.

Antipsychotic Medications

Phenothiazines are the oldest type of antipsychotics and are often referred to as tranquilizers or neuroleptics. Phenothiazines are typically used in the treatment of positive symptoms of schizophrenia. Today, *neuroleptic* is the term used to describe the phenothiazines and Haldol. These medications induce in schizophrenia a “neuroleptic state” that is characterized by decreased agitation, aggression, and impulsiveness, as well as a decrease in hallucinations and delusions and, generally, less concern with the external environment (Buelow, Hebert, & Buelow, 2000, p. 66).

Trade Name | Generic Name | Daily Dosage
--- | --- | ---
Mellaril | Thioridazine | 200–700 mg.
Prolxin | Fluphenazine | 1–20 mg.
Appendix III

<table>
<thead>
<tr>
<th>Trade Name</th>
<th>Generic Name</th>
<th>Daily Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serentil</td>
<td>Mezoridazine</td>
<td>75–300 mg.</td>
</tr>
<tr>
<td>Stelazine</td>
<td>Trifluoperazine</td>
<td>6–20 mg.</td>
</tr>
<tr>
<td>Thorazine</td>
<td>Chlorpromazine</td>
<td>300–800 mg.</td>
</tr>
<tr>
<td>Tindal</td>
<td>Acetophenazine</td>
<td>60–120 mg.</td>
</tr>
<tr>
<td>Trilafon</td>
<td>Perphenazine</td>
<td>8–40 mg.</td>
</tr>
<tr>
<td>Vesprin</td>
<td>Triflupromazine</td>
<td>100–150 mg.</td>
</tr>
</tbody>
</table>

*Note: See Olen et al. (1993).*

**Thioxanthenes:** The chemical structure of the thioxanthenes is similar to that of the phenothiazines.

<table>
<thead>
<tr>
<th>Trade Name</th>
<th>Generic Name</th>
<th>Daily Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Navane</td>
<td>Thiothixene</td>
<td>6–30 mg.</td>
</tr>
<tr>
<td>Taractan</td>
<td>Chlorprothixene</td>
<td>500–600 mg.</td>
</tr>
</tbody>
</table>

**Other Antipsychotic Medications**

<table>
<thead>
<tr>
<th>Trade Name</th>
<th>Generic Name</th>
<th>Daily Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loxitane</td>
<td>Loxapine</td>
<td>60–199 mg.</td>
</tr>
<tr>
<td>Moban</td>
<td>Molindone</td>
<td>50–100 mg.</td>
</tr>
</tbody>
</table>

**Second-Generation Antipsychotics**

These antipsychotic medications are effective without the risk of neuroleptic syndrome (a severe, life-threatening complication of using antipsychotic drugs). Second-generation antipsychotic medications are effective for the treatment of the negative symptoms of schizophrenia, such as social withdrawal, blunt affect, decreased motivation, and impoverished speech.

<table>
<thead>
<tr>
<th>Trade Name</th>
<th>Generic Name</th>
<th>Daily Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clorazil</td>
<td>Clozapine</td>
<td>400–600 mg.</td>
</tr>
<tr>
<td>Risperdal</td>
<td>Riisperidone</td>
<td>4–6 mg.</td>
</tr>
<tr>
<td>Serlect</td>
<td>Sertindole</td>
<td>6–20 mg.</td>
</tr>
<tr>
<td>Seroquel</td>
<td>Quetiapine</td>
<td>300–600 mg.</td>
</tr>
<tr>
<td>ZYPREXA</td>
<td>Olanzapine</td>
<td>5–20 mg.</td>
</tr>
</tbody>
</table>
**Antipsychotic Medications (Alphabetical by trade name)**

<table>
<thead>
<tr>
<th>Trade Name</th>
<th>Generic Name</th>
<th>Initial Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abilify</td>
<td>Aripiprazole</td>
<td>10–15 mg.</td>
</tr>
<tr>
<td>Clorazil</td>
<td>Clozapine</td>
<td>12.5 mg./bid</td>
</tr>
<tr>
<td>Geodon</td>
<td>Ziprasidone</td>
<td>20 mg./bid</td>
</tr>
<tr>
<td>Haldol</td>
<td>Haloperidol</td>
<td>1–6 mg./divided</td>
</tr>
<tr>
<td>Loxitane</td>
<td>Loxapine</td>
<td>60–199 mg.</td>
</tr>
<tr>
<td>Mellaril</td>
<td>Thioridazine</td>
<td>50–100 mg.</td>
</tr>
<tr>
<td>Moban</td>
<td>Molindone</td>
<td>50–100 mg.</td>
</tr>
<tr>
<td>Navane</td>
<td>Thiothixene</td>
<td>6–30 mg.</td>
</tr>
<tr>
<td>Prolixin</td>
<td>Fluphenazine</td>
<td>1–20 mg.</td>
</tr>
<tr>
<td>Risperdal</td>
<td>Riisperidone</td>
<td>2 mg./divided/bid</td>
</tr>
<tr>
<td>Serentil</td>
<td>Mezoridazine</td>
<td>50 mg./tid</td>
</tr>
<tr>
<td>Serlect</td>
<td>Sertindole</td>
<td>20–24 mg.</td>
</tr>
<tr>
<td>Seroquel</td>
<td>Quetiapine</td>
<td>100–150 mg.</td>
</tr>
<tr>
<td>Stelazine</td>
<td>Trifluoperazine</td>
<td>6–20 mg.</td>
</tr>
<tr>
<td>Taractan</td>
<td>Chlorprothixene</td>
<td>500–600 mg.</td>
</tr>
<tr>
<td>Thorazine</td>
<td>Chlorpromazine</td>
<td>30–75 mg.</td>
</tr>
<tr>
<td>Tindal</td>
<td>Acetophenazine</td>
<td>60–120 mg.</td>
</tr>
<tr>
<td>Trilafon</td>
<td>Perphenazine</td>
<td>4–8 mg./tid</td>
</tr>
<tr>
<td>Vesprin</td>
<td>Triflupromazine</td>
<td>100–150 mg.</td>
</tr>
<tr>
<td>Zyprexa</td>
<td>Olanzapine</td>
<td>5–10 mg.</td>
</tr>
</tbody>
</table>

**Lithium**

Lithium is used predominantly in the treatment of mood disorders. The two most common uses of the drug are for the treatment of acute mania and the preventative treatment of bipolar disorder.
Special Populations: Psychopharmacological Treatments for Children and Adolescents

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major depression</td>
<td>Antidepressants</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>Lithium</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>Antipsychotics</td>
</tr>
<tr>
<td>Autistic disorder</td>
<td>Antipsychotics</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder</td>
<td>SSRIs</td>
</tr>
<tr>
<td>Separation anxiety disorder</td>
<td>Imipramine and benzodiazepines</td>
</tr>
<tr>
<td>Attention-deficit/hyperactivity disorder (ADHD)</td>
<td>Ritalin, Dexadrine, and Cylert</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>Lithium, beta blockers, and Clonidine</td>
</tr>
<tr>
<td>Tourette's syndrome</td>
<td>Haldol and Clonidine</td>
</tr>
<tr>
<td>Enuresis</td>
<td>Tricyclics</td>
</tr>
</tbody>
</table>

Note: See Gitlin (1996).

Medication Dosage Schedule

<table>
<thead>
<tr>
<th>Schedule</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qid: four times a day</td>
<td>ac: before meals</td>
</tr>
<tr>
<td>Tid: three times a day</td>
<td>pc: after meals</td>
</tr>
<tr>
<td>Bid: two times a day</td>
<td>qd: every day</td>
</tr>
</tbody>
</table>

Note

These lists of medications were adapted from the following sources:


By now, most mental health professionals should have some working knowledge of the impact of HIPAA (Health Insurance Portability and Accountability Act of 1996) on the health care delivery system. Whether seeing your physician, going to the hospital, or following whatever compliance plan your agency or workplace has implemented, in the practice of counseling, HIPAA regulations are in force and must be dealt with.

Most counselors who have a limited practice or are seeking to enter private practice ask us in our private practice seminars if they need to be “HIPPA compliant.” Legally, it depends on if you are considered a “covered entity.” Covered entities are providers who transmit any protected health information in electronic form. Even if you are not considered a covered entity now, if you plan to be in practice for the next 5 to 10 years, you probably will be. We recommend being HIPAA compliant as a smart decision. We believe that being HIPPA compliant demonstrates to your clients that you take your professionalism and your clients’ privacy and rights very seriously. Moreover, even if you aren’t considered a covered entity and elect not be compliant, the act still impacts release of information, record keeping, and confidentiality. To sum it up: just do it.

There are many areas of HIPAA compliance: electing a privacy officer, reviewing business contracts for disclosure of protected health information, and developing policies and procedures, to name a few. We will focus on NOTICE OF PRIVACY PRACTICES and CLIENT RIGHTS. These two components of HIPAA compliance are given to the client (and you have in writing that the client read
them and received a copy of them) before your initial session. They need to be in plain language that is not intimidating.

**Notice of Privacy Practices**

As a counselor, you are required by HIPAA to provide a document that explains to potential clients how you and your practice will handle the release of confidential information. At the top (header) of your HIPAA NOTICE OF PRIVACY PRACTICES document you are mandated to include the following statement:

> THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Next, you need to print the effective date. This would be the date you started your practice or the mandated date of compliance (April 14, 2003) for an existing practice.

Following the date should be a statement outlining that you release information only in accordance with state and federal laws and the ethics of the counseling profession.

After the above information, you need a statement declaring that this notice describes your policies related to the use and disclosure of the client’s healthcare information. Also include the following paragraph:

> Use and disclosure of protected health information for the purposes of providing services. Providing treatment services, collecting payment, and conducting health care operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

The body of the document needs to include information in the following four sections (with examples):

**Treatment:** Use and disclose health information to
- Provide, manage, or coordinate care
- Consultants
- Referral sources

**Payment:** Use and disclose health information to
- Verify insurance and coverage
- Process claims and collect fees

**Health Care Operations:** Use and disclose health information for
- Review of treatment procedures
- Review of business activities
Appendix IV

- Certification
- Staff training
- Compliance and licensing activities

Other Uses and Disclosures Without Your Consent
- Mandated reporting
- Emergencies
- Criminal damage
- Appointment scheduling
- Treatment alternatives
- As required by law

Incorporating the above information will communicate to your client what happens with the health care information he or she shares with you. All this can be documented on one side of a page. Most counselors then include the following client rights information on the back of the Notice of Privacy Practice document. That way, it is all on one piece of paper. Clients need to sign and date that they have read and received a copy of the document. You can have a line in your informed consent document for them to sign and give the client a copy, or clients can sign and date this form, with one copy for the client and the other placed in the record.

Client Rights

In the Notice of Privacy Practices, counselors are required to inform clients as to their rights under state and federal laws. You will need to include information in the following eight sections (with examples):

Right to request where we contact you
- Home yes or no
- Work yes or no
- Cell phone yes or no
- If not, how may we contact you? _______________________

Right to release your medical records
- Written authorization to release records to others
- Right to revoke release in writing
- Revocation is not valid to the extent that you have acted in reliance on such previous authorization

Right to inspect and copy your medical billing records
- Right to inspect and copy records
- Counselor may deny this request
- Charges for copying, mailing, etc.
Right to add information to or amend your medical records
- May request to amend record
- Number of days to decide
- May deny the request
- If denied, right to file disagreement statement
- Disagreement statement and your response will be filled in the record
- Amendment request must be in writing

Right to accounting of disclosures
- For a 6-year period beginning with date the counselor came into compliance (no later than April 14, 2003)
- Exceptions
  - Disclosure for treatment, payment, or health care operations
  - Disclosures pursuant to a signed release
  - Disclosure made to client
  - Disclosures for national security or law enforcement

Right to request restrictions on uses and disclosures of your health care information
- Must be in writing
- You are not obligated to agree

Right to complain
- Please contact you first
- If not satisfied, right to complain to the U.S. Department of Health and Human Services
- No retaliation

Right to receive changes in policy
- May request any future changes
- Request to privacy officer

Hopefully, this information is of value to you, whether you are drafting policies to open a new practice or are benchmarking your existing documents. Please keep in mind that this information is our interpretation of how HIPAA impacts the practice of counseling. Please review your own documentation with an attorney. This information provided is for reference and does not constitute rendering of legal advice by Norman C. Dasenbrook, Robert J. Walsh, or the American Counseling Association.

Copyright January 5, 2005 by Robert J. Walsh, MA, NCC, LCPC, and Norman C. Dasenbrook, MS, LCPC (all rights reserved). Reprinted with permission.
Appendix V

Sample Adolescent Informed Consent Form

Your Letterhead

Privacy of Information Shared in Counseling/Therapy:
Your Rights and My Policies

What to Expect

The purpose of meeting with a counselor or therapist is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to a counselor or therapist about these problems. Or you may be here because your parent, guardian, doctor, or teacher had concerns about you. When we meet, we will discuss these problems. I will ask questions, listen to you, and suggest a plan for improving these problems. It is important that you feel comfortable talking to me about the issues that are bothering you. Sometimes these issues will include things you don’t want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor or therapist. Privacy, also called confidentiality, is an important and necessary part of good counseling.

As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your written consent to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with me in a therapy session. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below.
When Confidentiality Cannot Be Maintained

I cannot maintain confidentiality if the following occurs:

- You tell me you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself.
- You tell me you plan to cause serious harm or death to someone else who can be identified, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform your parent or guardian, and I must inform the person whom you intend to harm.
- You are doing things that could cause serious harm to you or someone else, even if you do not intend to harm yourself or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.
- You tell me you are being abused—physically, sexually, or emotionally—or that you have been abused in the past. In this situation, I am required by law to report the abuse to the Virginia Department of Social Services.
- You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement unless the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.

Communicating With Your Parent(s) or Guardian(s)

Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent or guardian would not approve of or would be upset by—but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian.

Example: If you tell me that you have tried alcohol at a few parties, I would keep this information confidential. If you tell me that you are drinking and driving or that you are a passenger in a car with a driver who is drunk, I would not keep this information confidential from your parent/guardian. If you tell me, or if I believe based on things you’ve told me, that you are addicted to alcohol, I would not keep this information confidential.
Example: If you tell me that you are having protected sex with a boyfriend or girlfriend, I would keep this information confidential. If you tell me that, on several occasions, you have engaged in unprotected sex with people you do not know or in unsafe situations, I would not keep this information confidential. You can always ask me questions about the types of information I would disclose. You can ask in the form of “hypothetical situations”; in other words, “If someone told you that they were doing ________, would you tell their parents?”

Even if I have agreed to keep information confidential—to not tell your parent or guardian—I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent or guardian and will help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, to help them know how to be more helpful to you.

You should also know that, by law in Virginia, your parent or guardian has the right to see any written records I keep about our sessions. It is extremely rare that a parent or guardian would ever request to look at these records.

Communicating With Other Adults

School: I will not share any information with your school unless I have your permission and permission from your parent or guardian. Sometimes I may request to speak to someone at your school to find out how things are going for you. Also, it may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, I will discuss it with you and ask for your written permission. A very unlikely situation might come up in which I do not have your permission but both your parent or guardian and I believe that it is very important for me to be able to share certain information with someone at your school. In this situation, I will use my professional judgment to decide whether to share any information.

Doctors: Sometimes your doctor and I may need to work together, for example, if you need to take medication in addition to seeing a counselor or therapist. I will get your written permission and permission from your parent or guardian in advance to share information with your doctor. The only time I will share information with your doctor even if I don't have your permission is if you are doing something that puts you at risk for serious and immediate physical or medical harm.

Minor’s Signature ____________________________ Date ________________

Parent’s Signature ____________________________ Date ________________

Parent’s Signature ____________________________ Date ________________
Note. This is a sample form, designed for training purposes. To the best of our knowledge, it is consistent with Virginia laws and regulations. For use in your own setting, this form must be personalized to reflect your state’s laws and your own policies about confidentiality.

**Drafted for the Center for Ethical Practice**

*by Sherry Kraft, Ph.D.*

She can be reached by contacting the Center for Ethical Practice or at (434) 296-6872.

Note. The items below are consistent with Virginia law. You must tailor this to match your own state laws and your own personal policies and intentions about confidentiality and disclosure. With its narrow margins, this handout can be a two-sided page informing patients of your policies, plus a separate signature page for obtaining consent.

**Letterhead**

“Notice of Privacy Practices”

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**I. Confidentiality**

As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions; your diagnosis, functional status, symptoms, prognosis, and progress; and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship (by signing the attached general consent form) or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

**II. “Limits of Confidentiality”**

Possible Uses and Disclosures of Mental Health Records Without Consent or Authorization

There are some important exceptions to this rule of confidentiality—some exceptions created voluntarily by my own choice, [some because of policies in this
office/agency], and some required by law. If you wish to receive mental health services from me, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.

I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy or because it is legally required:

*Emergency*: If you are involved in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.

*Child Abuse Reporting*: If I have reason to suspect that a child is abused or neglected, I am required by Virginia law to report the matter immediately to the Virginia Department of Social Services.

*Adult Abuse Reporting*: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected, or exploited, I am required by Virginia law to immediately make a report and provide relevant information to the Virginia Department of Welfare or Social Services.

*Health Oversight*: Virginia law requires that licensed psychologists [social workers] report misconduct by a health care provider of their own profession. By policy, I also reserve the right to report misconduct by health care providers of other professions. [Note. Virginia law requires that licensed counselors report misconduct by any mental health care provider.] By law, if you describe unprofessional conduct by another mental health provider of any profession, I am required to explain to you how to make such a report. If you are yourself a health care provider, I am required by law to report to your licensing board that you are in treatment with me if I believe your condition places the public at risk. Virginia licensing boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct.

*Court Proceedings*: If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so you can file a motion to quash (block) the subpoena. However, while awaiting the judge's decision, I am required to place said records in a sealed envelope and provide them to the Clerk of Court. In Virginia, parents' therapy records may not be used as evidence (i.e., are privileged) in child custody cases, but a child's records do not have that same protection. In civil court cases, therapy information or records are not protected by patient–therapist privilege in child abuse cases, in cases in which your mental health is an issue, or in any case in which the judge deems the information to
be “necessary for the proper administration of justice.” In criminal cases, Virginia has no statute granting therapist–patient privilege, although records can sometimes be protected on another basis. Protections of privilege may not apply if I do an evaluation for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

**Serious Threat to Health or Safety:** Under Virginia law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death to an identified or to an identifiable person and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include (1) warning the potential victim(s) or the parent or guardian of the potential victim(s), if under 1B, (2) notifying a law enforcement officer, or (3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate serious threat to your own health and safety.

**Workers’ Compensation:** If you file a workers’ compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

**Records of Minors:** Virginia has a number of laws that limit the confidentiality of the records of minors. For example, parents, regardless of custody, may not be denied access to their child’s records, and Children Service Bureau (CSB) evaluators in civil commitment cases have legal access to therapy records without notification or consent of parents or child. Other circumstances may also apply, and we will discuss these in detail if I provide services to minors. [Note. For adolescents in psychotherapy, also see the Sample Adolescent Consent Form, to be signed by the minor and parent.]

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

**III. Patient’s Rights and Provider’s Duties**

**Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me (1) what information you want to limit; (2) whether you want to limit my use, disclosure, or both; and (3) to whom you want the limits to apply.
Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

Right to an Accounting of Disclosures: You generally have the right to receive an accounting of disclosures of PHI for which you have provided neither consent nor authorization (as described in section III of this notice). On your written request I will discuss with you the details of the accounting process.

Right to Inspect and Copy: In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative proceeding.

Right to Amend: If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, you must make your request in writing and submit it to me. In addition, you must provide a reason that supports your request. I may deny your request if you ask me to amend information that (1) was not created by me (I will add your request to the information record); (2) is not part of the medical information kept by me; (3) is not part of the information that you would be permitted to inspect and copy; or (4) is accurate and complete.

Right to a Copy of This Notice: You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

EFFECTIVE DATE: __________________
Letterhead

**Patient’s Acknowledgment of Receipt of Notice of Privacy Practices**

Please sign and print your name and date this acknowledgment form.

I have been provided a copy of [Dr. Fisher’s] Notice of Privacy Practices.

We have discussed these policies, and I understand that I may ask questions about them at any time in the future.

I consent to accept these policies as a condition of receiving mental health services.

Signature: ____________________________________________

Printed Name: _________________________________________

Date: _______________________________________________
### Index

**A**

- ABC model of crisis intervention, 302
- *ACA code of ethics*, 152–194
  
  - confidentiality, privileged communication, and privacy, 162–167
  - counseling relationship, 154–161
  - evaluation, assessment, and interpretation, 174–178
  - glossary of terms, 194–195
  - Preamble, 152–153
  - professional responsibility, 168–171
  - Purpose, 152–153
  - relationships with other professionals, 172–173
  - research and publication, 186–191
  - resolving ethical issues, 192–193
  - supervision, training, and teaching, 179–185
- Academy of Clinical Mental Health Counseling, 17
- accreditation and certification, 10–13
- addiction
  
  - dependence, 295
  - physical dependency, 295
  - psychological dependency, 295
- *Addiction Severity Index* (ASI), 298–299
- adolescent informed consent form, sample of (Appendix V), 455–462
- advocacy, 194
- African Americans, 27
- Alabama, 340
- Alabama Department of Education, 340
- American Association for Marriage and Family Therapy (AAMFT), 9, 14, 18
- American Association of Pastoral Counselors (AAPC), 9, 10, 16
- American Counseling Association (ACA), 9–10, 23, 144–145, 147, 151–152, 171, 252, 257
- code of ethics, 37, 64, 141, 148, 153–154, 168, 172, 179, 184, 192–195, 252
- Governing Council, 152
- specialties, 144
- American Mental Health Association, ethical codes of, 141
- American Mental Health Counseling Association (AMHCA), 151, 243, 252
- Board of Directors, 243
- By-Laws, 243
- Code of Ethics of, 223, 239, 241, 254
- National Committee on Ethics, 243
- American Personnel and Guidance Association, 9, 10
- American Psychiatric Association, 60, 84
- American Psychological Association (APA), 9, 14, 19, 21, 83, 145, 151, 196, 202, 251, 257
- accreditation guidelines for doctoral-level internships, 393–394, 395
- APA Ethics Committee, 196
- code of ethics, 141, 148, 195, 199, 202, 205–206, 210, 222–223, 252
- code of ethics and conduct, 253
- Council of Representatives, 222
- Ethical Principles of Psychologists and Code of Conduct, general principles, 223
- practicum guidelines, 28
- termination of membership, 198
- American School Counselors Association (ASCA), 340
- child abuse and neglect and, 287
- analytical thinking model (ATM), 86
- anitxiety medications
Index

antianxiety agents other than benzodiazepines, 446
anxiolytics or minor tranquilizers, 445
antidepressants, classes of, 444
serotonin specific reuptake inhibitors (SSRIs), 444–445
tricyclic antidepressants (TCA's), 444
antidepressants, new generation, 445
monoamine oxidase Inhibitors (MAOIs), 445
antipsychotic medications
alphabetical list by trade name, 448
other antipsychotic medications, 447
phenothiazines, 446–447
second-generation antipsychotics, 447
thioxanthenes, 447
anxiolytics or minor tranquilizers, 445
benzodiazepines (BDZs), 445–446
appendices, 417–462
Aristotle, 150
assent, 194
assessment
ACA code of ethics and, 174–178
in counseling (practicum), 79–81
initial client interaction and, 44–45
in internship, 407
assessment activities, 46–49
assessing the client's mental status, 47
mental status categories of assessment, 48
obtaining authorizations, 46
obtaining information from the client and others, 47
recording psychosocial history, 49
assessment and evaluation in practicum, 129–131
self-assessment, 129–131
assessment techniques
ethics and, 231–233
Association for Counselor Education and Supervision (ACES) guidelines, 99
authorizations, obtaining, 46
Axis I, 251
Axis II, 251

B

basic listening responses, 78
benzodiazepines (BDZs), 445–446
Brief Family Therapy Center in Milwaukee, Wisconsin, 402
brief therapy
cognitive behavioral counseling, 404
cognitive restructuring brief therapy, 404
coping skills brief therapy, 405
interpersonal dynamic brief therapy, 404
interpersonal psychotherapy, 404
major approaches to, 403–405
psychodynamic approaches to, 404
rational emotive therapy, 404
tactical brief therapies, 405
buprenorphine, 296

C

CACREP-accredited counseling programs, 143
California Association of Counselor Education and Supervision (ACES), 10
California Supreme Court, 283
Caplan, Gerald, 331
case conceptualization
analytical thinking model, 86
applying theory to individuals, 89–90
Inverted Pyramid Method, 89
“Linchpin” Model, 88
models of case conceptualization, 86–89
Stevens and Morris model, 86–87
treatment planning and, 85–89
case laws, 248
case notes, 52
case summary, 131
outline, 67–69
certified clinical mental health counselor (CCMHC), 17
certified rehabilitation counselor (CRC), 18
child abuse, 287–294
counseling the sexually abused, 293–294
interviewing children who may have been sexually abused, 291–292
recognizing child abuse, 288–289
reporting, 291
reporting form, 291
signs of emotional maltreatment, 290
signs of neglect, 289
signs of physical abuse, 289
signs of sexual abuse, 290
child abuse, recognizing, 288–289
the child, 288, 289
the parent, 288, 289
children who may have been sexually abused, interviewing, 291–292
before the interview, 292
interviewing the child, 292
civil law, 248
client, 194
client, initial interaction with, 43–45
establishing a therapeutic alliance, 43
initial contact, structuring, and assessment, 44–45
client folders, 50
client progress, monitoring and evaluating, 49–52
building a client folder, 50
case notes, 52
client record keeping, 51
client records, malpractice and, 259
client release form, 47
client rights, 451, 453–454
(American Counseling Association)
Appendix IV, 451–454
clients, potentially dangerous, 282
assessing danger to others, 285–287
patient's past criminal acts, 287
the Tarasoff case, 282–284
clients, potentially harmful to self, 269–280
characteristics of potential harm to self, 272
definition of suicide, 269
ethical mandates and danger to self, 270
terventions, 278
legal mandates and danger to self, 271
myths about suicide, 269
risk factors for suicide, 276–277
school-based suicide prevention programs, 279
suicide crisis, 277
suicide intervention in the school, 280–281
warning signs of suicide, 277–278
when you fear someone commit suicide, 274–276
client's mental status, assessing, 47
client's personal/social satisfaction with
counseling Assessment, 415
clients' rights
ethics and, 228
closed question, 78–79
Coconut Grove fire (Boston, MA), 302
code of ethics, 2005, 147
code of ethics: main sections, 147
new key areas, 147
purpose of the code, 147
Code of Ethics: Ethical Challenges in a
Complex World, 2005, 147
Code of Ethics of the American Health
Counselors Association, 2000 Revision,
clinical issues, 224–235
preamble, 223
professional issues, 235–243
Code of Ethics of the American Health
Counselors Association, 2000 Revision:
Clinical Issues, 224–235
clients' rights, 228
confidentiality, 229–230
consulting, 235
pursuit of research activities, 234
utilization of assessment techniques,
231–233
welfare of the consumer, 224–227
Code of Ethics of the American Health
Counselors Association, 2000 Revision:
Professional Issues, 235–243
competence, 235–236
internet on-line counseling, 242
moral and legal standards, 239
private practice, 240
professional relationships, 237
professional responsibility, 239
public statements, 241
resolution of ethical problems, 243
supervisee, student, and employee
relationships, 238
codes of ethics, 148–149
definitions: ethics, morality, and law, 148
ethics and counseling, 148
multiplicity and confusion, 144
cognitive behavioral counseling, 404
brief therapy and, 404
cognitive counseling skills, 125–126
cognitive restructuring brief therapy, 404
Commission on Accreditation for Marriage and
Family Therapy Education (COAMFTE),
9, 10, 14, 19
community counseling, 11
Community Mental Health Centers Act of 1963,
302
competence
ethics and, 235–236
Complete Psychotherapy Treatment Planner,
The (by Jongsma and Peterson), 93
computers, malpractice and, 260
confidentiality, 250, 263
ACA code of ethics and, 162–167
ethics and, 229–230
privileged communication, 263
consent to waiver, 261
constitutional laws, 248
consultation
assessing the impact of, 367
orientation to, 364
process and content models of, 368
resistance to, 369
consultation, guidelines for, 362–369
assessing the impact of consultation, 367
consultation intervention, 365–366
the doctor-patient model, 368
entry into the system, 363
orientation to consultation, 364
problem identification, 364
process and content models of consultation, 368
the process consultation model, 368
the purchase-of-expertise model, 368
resistance to consultation, 369
consultation intervention, 365–366
consultation rating form, 340, 367
consulting
ethics and, 235
stages of, 338
consulting in schools and mental health agencies
contracting and the forces of change in the organization, 570
definition, 332
models and methods, 331–378
consumers, welfare of
ethics and, 224–227
contracting for therapy
malpractice and, 261
contracting for therapy, malpractice and, 261
contracts, theory of, 257
coping skills brief therapy, 405
Council for Accreditation of Counseling and Related Educational Programs (CACREP), 9–11, 13, 17, 19, 21, 25, 143, 147, 393
accreditation guidelines, 395
accreditation guidelines for doctoral-level internships, 407
practicum guidelines, 28
triadic model of supervision, 398
Council for Rehabilitation Counseling Certification (CRCC), 144
Council for Standards for Human Service Education (CSHSE), 393
Council on Rehabilitation Education (CORE), 9, 10, 15, 16, 18, 144
counseling performance skills
basic and advanced helping skills, 108
philosophy and theories of counseling, 110–113
theory-based techniques, 109
counseling psychologists
accreditation and certification standards for, 14
counseling relationship
ACA code of ethics and, 154–161
counseling techniques list, 120–125, 406
counselor, 194
risk management and, 256
counselor certification
accreditation and certification standards for, 17
counselor competence scale, 136
counselor educator, 194
counselor supervisor, 194
counselor training programs checklist, 27
counseling practice and supervision, 27
curricular issues, 27
minority representation, 27
multicultural issues and, 27
research, 27
student and faculty competency evaluation, 27
Cowell Memorial Hospital, 283
criminal law, 248
crisis, 308
crisis intervention, 302–316
ABC model of, 302
Gilliland and James Model, 304–305
Kanel Model, 303
a model for teachers, 306–308
teacher guidelines for crisis response, 308–316
“Crisis Intervention: A Model for Teachers”, 302
Crisis Intervention Strategies (Gilliland and James), 302
crisis response, 316
addressing student reactions during a crisis, 313–314
behaviors/reactions teachers can expect from students after a crisis, 309–312
crisis and crisis response, 308
crisis response plan, 308
personal reactions teachers can expect after a crisis, 312
referring students for individualized assessment and intervention, 315
teacher guidelines for, 308–316
crisis response plan, 308
culture, 194
danger to others, assessing, 285–287
  the first stage: assessment, 285
  the second stage: selecting a course of action, 286
  the third stage: monitoring the situation, 287
danger to self, 272
  characteristics of, 272
  clients and, 274–276
  ethical mandates and, 270
  harm to self, 272–273
  legal mandates and, 271
DAP notes (Data Assessment and Plan), 55
DCT-based consultation steps, 345–346
defamation of character, 258
defendant, 248
Department of Education, 14
dependence, 295
Developmental Counseling and Therapy as a Model for School Counselor Consultation with Teachers (Elisha Clemens), 340
developmental counseling and therapy (DCT), 342
  model for consultation, 342
developmental level, 129
diagnosis in counseling, 82–85
  diagnostic classification system, 84
  DSM-IV codes and classification, 85
  severity and course modifiers, 84
Diagnostic and Statistical Manual of Mental Disorders-Text Revision Diagnoses and Codes, numerical listing (Appendix II), 431–441
Diagnostic and Statistical Manual of Mental Disorders-Text Revision Diagnoses and Codes, alphabetical listing (Appendix I), 419–430
Diagnostic and Statistical Manual of Mental Disorders-Text Revision (DSM-IV-TR), 60
  codes and classification, 63, 85
  five axes employed in, 84
  severity and course modifiers, 84
discovery process, 249
diversity, 194
doctor-patient model of consultation, 368
drug abuse screening test-20, 298–299

elementary school counseling referral form, 47
England, suicide in, 271
ethical decision making, 144–145
ethical issues, 146–147
  2005 code of ethics, 147
  ACA code of ethics and, 192–193
  ethics and the law, 147
ethics and the law, 147
ethics and the law, 201–221
ethics, 149
  in counselor education, 143–246
  in the law and, 142–266
ethics, 149
  in counselor education, 143–246
  in the law and, 142–266
examinee, 194

F
faculty supervisor evaluation of the intern, 408
False Claims Act of 1986, 252
Federal Child Abuse Prevention and Treatment Act, 291
fetal alcohol syndrome/effects (FAS/FAE), 60
  field-site supervisor evaluation of the intern, 408
fieldwork, 393
final evaluations, 415–416
forensic evaluation, 195
functional outcomes reporting (FOR), 55

G

gerontological specialization in community counseling, 12
Getting the Most from Your Human Services Internship: Learning From Experience (Kizer), 394
Gilliland and James Model of crisis intervention, 304–305
glossary of terms, *ACA code of ethics* and, 194–195
goal statement, 136
goal statement agreement, 132–133, 135
peer assessment, 133–134
sample, 130, 131
Gold, Stuart, 283
guidelines for interns working with special populations and crisis, 269–329

H

Haldol, 446
*Handbook of Counseling Supervision* (Borders & Leddick), 134
Hansen and Freimuth’s seven step model, 73–75
harm to others form, 287
Health Insurance Portability and Accountability Act of 1996, 451
helping skills, 108
hepatitis B and C, 297
HIPAA requirements, meeting
client rights (American Counseling Association) Appendix IV, 451–454
notice of privacy practices (American Counseling Association) Appendix IV, 451–454
Hippocratic oath, 151
Hispanic Americans, 27
HIV/Aids, 297

I

IEP (individual educational programs), 55
individual performance plan, 384
individual psychotherapy notes form, 49
information from the client and others, obtaining, 47
informed consent, malpractice and, 262
initial client contact, 76–78
asking appropriate questions, 78
basic helping skills, 77
initial intake form, 47
intermittent explosive disorder, 63
intern roles and responsibilities, 384
individual performance plan, 384
Intern Site Preselection Data Sheet — Clinical, 380
Intern Site Preselection Data Sheet — School, 380
International Classification of Diseases-Coding Manual (ICD-9-CM), 431
International House, Berkeley, 282
internet on-line counseling, ethics and, 242
interns
developing personal theory of counseling, 406
theory-based techniques and, 400–405
interns, supervision of
general spheres, 383
“lousy”, 382–383
overarching principles, 383
internship, 393
preparation for, 379–392
internship, stages of, 386–387
anticipation, 386
competence, 387
confrontation, 387
culmination, 387
dissillusionment, 386
internship agreement, 383
internship experience, 269–373, 388–389
evaluation, 389
supervision, 388
internship log, 415
internship site, selection and evaluation of, 379–381
interpersonal dynamic brief therapy, 404
interpersonal psychotherapy, 404
brief therapy and, 404
interpretation, *ACA code of ethics* and, 174–178
interventions
danger to self and, 278
solution focused vs. traditional, 354

J

Joint Commission of Accreditation of Healthcare Organizations (JCAHO), 55
Joint Commission on Accreditation of Hospitals, 60
Index

Journal of Educational and Psychological Consultation, 336
jurisdiction, 249

K

Kahn, Beverly B., 345–346
Kanel Model of crisis intervention, 303

L

Lanterman Petris Short Bill of 1968, 302
law, 149, 247–250, 248
confidentiality and privileged communication, 249–250
malpractice and, 258
steps in a lawsuit, 249
types of laws, 248
lawsuits
malpractice and, 258
reasons for, 258
legal issues, 247–268
liability insurance, 261
claims-based policy, 261
malpractice and, 261
occurrence-based policy, 261
tail-coverage insurance, 261
libel, 258
Likert Scale Practicum Counselor Evaluation Form, 135
lithium
acute mania and, 448
bipolar disorders and, 448
Long Island, 308

M

malpractice, 257–263
client records, 259
contracting for therapy, 261
elements of, 257–263
informed consent, 262
liability insurance, 261
policy development, 259
reasons for lawsuits, 258
release of information, 263
the use of computers, 260
managed care and the counselor, 251–252
“Managed Mental Health Care: Intentional Misdiagnosis of Mental Disorders for Reimbursement” (Braun and Cox), 252
marriage and family counseling or therapy, 12
marriage and family therapists, accreditation and certification of, 14
Maryland Court of Appeals, 280, 282
Marywood University, 28
Meeting HIPAA Requirements — Notice of Privacy Practices and Client Rights Document
Appendix IV: American Counseling Association, 451–454
Mental Health Act of 1962, 331
mental health consultation, 335–337
consultation, 335
consultation or collaboration?, 337
internal versus external consultation, 336
Mental Health Consultation and Collaboration (Caplan and Caplan), 336
mental health counseling, 12
mental health law, 248
mental health status checklist, 47
Mental Research Institute in Palo Alto, California, 402
mental status, categories of assessment, 48
methadone, 296
Mid Term and End Term Summative Review of Intern Skill Levels, 409–410
Minnesota Coalition Against Sexual Assault, 293
minority/diversity competence, 195
minority/diversity counseling, 195
Model of Solution-Focused Consultation for School Counselors, A (Beverly B. Kahn), 345–346
monozmine oxidase Inhibitors (MAOIs), 445
monthly practicum log, 415
Moore, Lawrence, 283
moral and legal standards, ethics and, 239
morality, 149
multiple relationships, risk management and, 253–255

N

narrative notes, 55
National Board of Certified Counselors (NBCC), 16, 144
National Certified School Counselor (NCSC), 22
National Committee for Quality Assurance, 66
National Counselor Examination (NCE), 17
National Institute on Drug Abuse, 297
National Suicide Prevention Lifeline, 276
Native Americans, 27
natural law, 247
neuroleptic, 446
neuroleptic syndrome, 447
neurotransmitters, 276

New Handbook of Counseling and Supervision
(Borders & Brown), 135
notice of privacy practices, 451–453
(American Counseling Association)
Appendix IV, 451–454

O
open question, 78–79

P
Pacific Islanders, 27
parental release form, 47
pastoral counselors, accreditation and certification of, 16
phenothiazines, 446, 446–447
philosophy and theories of counseling, 110–113
philosophy-theory-practice continuum, 73–74
structured and unstructured interviews, 75
physical abuse of adult, 63
physical dependency, 293
plaintiff, 248
Poddar, Prosenjit, 282, 283
policy development
malpractice and, 259
policy development, malpractice and, 259
practicum
concepts in, 29–31
content issues, 43–72
definitions of, 6
negotiating placement, 27–28
preparation for, 21–42
process issues, 73–98
practicum, phases of, 6–9
development reflected in supervisor interaction, 9
development reflected in the learning process, 8
development reflected in the program structure, 7
practicum, suggested course requirements, 32–40
class meetings, 33
counseling sessions, 33
documenting practicum activities, 40
individual supervision sessions, 34
tape critiques, 34–39
practicum experience, 1–141
definitions, phases, and standards, 3–20
practicum experience, beginning, 101–104
consulting faculty and site supervisors, 104
getting started, 101
knowing what to do, 102
self-trust and inner voice, 103
using the right techniques, 103
what if I say something wrong?, 102
practicum site
client population, 26
guidelines for choosing, 21–26
professional affiliations of the site, 22
professional practices of the site, 23
professional staff and supervisor, 22
site administration, 24
theoretical orientation of the site and supervisor, 26
training and supervision values, 25
practicum students
monitoring the professional development of, 99–142
role and function of, 29, 99
prepracticum considerations, 3–5
questions for the practicum professor, 4
questions for the practicum site supervisor, 5
questions for the practicum student, 4
standards set by accrediting agencies, 5
standards set by certifying boards, 5
standards set by professional organizations, 5
standards set by university programs, 5
pretrial hearing, 249
privacy, 250
ACA code of ethics and, 162–167
private practice, ethics and, 240
privilege, 250
privileged communication, ACA code of ethics and, 162–167
problem identification, consultation and, 364
problem-oriented medical records (POMR), 55–56
procedural and issue-specific skills, 125–129
cognitive counseling skills, 125–126
developmental level, 129
self-awareness, 127–128
process and evaluation in internship, 393–414
process consultation model, 368
processing interview notes [practicum], 55–66
professional affiliations of the site, 22–23
professional counselors, 10–13
accreditation and certification of, 10–13
community counseling, 11
gerontological specialization in community counseling, 12
Index

marriage and family counseling or therapy, 12
mental health counseling, 12
school counseling, 13
student affairs practice in higher education, 13
counseling performance skills, 108–113
professional practices of the site, 23–24
professional relationships, ethics and, 237
professional responsibility, ACA code of ethics and, 168–171
professional responsibility, ethics and, 239
"Profile of Lousy Supervision: Experienced Counselors' Perspectives, A" (Magnuson, Wilcoxon, and Norem), 382
psychiatric medications, 443–449
antianxiety medications, 445
antidepressants, classes of, 444–445
antipsychotic medications, 446
list of (Appendix III), 443–449
Lithium, 448
medical dosage schedule, 449
new generation antidepressants, 445
special populations: psychopharmacological treatments for children and adolescents, 449
psychological dependency, 295
psychopharmacological treatments for children and adolescents, 449
psychosocial history form, 49
psychosocial history, recording, 49
public statements, ethics and, 241
purchase-of-expertise model, consultation and, 368
purpose, ACA code of ethics and, 152–153

R
rational emotive therapy, 404
brief therapy, 404
Recording Guidelines for Social Workers by Wilson, 86
recovery, stages of, 298
early recovery, 298
last recovery stage, 298
maintenance stage, 298
middle recovery stage, 298
stabilization, 298
transition, 298
reflective model of triadic supervision (RMTS), 398
regulations, 248
rehabilitation counselors, accreditation and certification of, 15
relationships with other professionals, ACA code of ethics and, 172–173
relative goal emphasis in supervision, 130
release of information
malpractice, 263
malpractice and, 263
reporting therapeutic process, 69–70
research activities, pursuit of ethics and, 234
research and publication, ACA code of ethics and, 186–191
resolution of ethical problems ethics and, 245
risk management
the counselor and, 256
multiple relationships and, 253–255

S
sample practicum syllabus, 36–40
schizophrenia, neuroleptic state and, 446
school consultation, 337–361
school counseling, 13
secondary school counseling referral form, 47
second-generation antipsychotics, 447
Selective Theories Sorter (STS), 115–119
self assessment of basic helping skills and procedural skills, 130
self awareness Likert scale, 131
self rating by the student counselor, 130
self-assessment, 407
self-awareness, 127–128
Seligman, “DO A CLIENT MAP”, 92
serious depression, suicide and, 278
serotonin specific reuptake inhibitors (SSRIs), 444–445
“Seven P’s of Treatment Planning” (by Sperry), 94
site administration, 24–25
site evaluation form, 416
site supervisor’s evaluation of student counselor’s performance, 136
slander, 258
SOAP notes (subjective objective assessment and plan), 55, 56–57, 64
assessment, 64
general guidelines for, 64
guidelines for, 65
objective, 59
plan, 60
Index

scenario and sample SOAP notes, 62
subjective, 57–58
summarization of definitions and examples, 62
using the format, 56–58
writing case notes with, 54
solution-focused brief therapy, 401
Spice, C. Gordon, 398
standards in accreditation and certification for
practicum and internship, 9–17
counseling psychologists, 14
counselor certification, 17
implications, 18
marriage and family therapists, 14
pastoral counselors, 16
professional counselors, 10–13
rehabilitation counselors, 15
state departments of education, 28
state licensing boards, 28
statutory laws, 248
STIPS format of case note writing, 406–407
strategic brief counseling, 405
strategic solution-focused therapy, 402
Structured Peer Group Supervision Model (Borders), 134
structuring, and assessment
initial client interaction and, 44–45
student affairs practice in higher education, 13
student counselor evaluation of supervision form, 415
student evaluation form, 408, 409, 415
students, 195
behaviors/reactions after a crisis, 309–312
reactions during a crisis, 313–314
referring for individualized assessment and intervention, 315
subpoena, 249
substance abuse, 295–302
alcohol and drug abuse, 295
assessment form, 298–299
assessment instruments, 298
counseling recommendations, 299–300
preventing relapse, 301
recovery, 297–298
substance dependence, 296
treatment, 296
understanding addiction, 295
suicidal behavior, 274
ideation, 274
suicidal gestures, 274
suicide attempts, 274
suicide
definition of, 269
myths about, 269
risk factors for, 276–277
warning signs of, 277–278
suicide, fears that someone may commit
in acute crisis, 275
be willing to listen, 275
seek professional help, 275
take it seriously, 275
treatment follow up, 276
suicide, risk factors for, 276–277
demographics, 277
general predisposition, 276
impulsivity, 277
neurotransmitters, 276
past history of attempted suicide, 276
psychiatric disorders, 276
suicide, warning signs of, 277–278
observable signs of serious depression, 278
suicide consultation form, 279
suicide contract, 279
suicide crisis, 277
changes in behavior, 277
intense affective state in addition to depression, 277
precipitating event, 277
suicide intervention in the school, 280–281
suicide lethality, 273
high, 273
low, 273
moderate, 273
very high, 273
suicide prevention programs, school-based, 279
suicide risk, 277
supervisee, student, and employee relationships, 238
supervisees, 195
supervision
ACA code of ethics and, 179–185
approaches to, 106–107
beginning counselor, 385
behavioral model, 107
on campus, 395
cognitive model, 107
discrimination model of, 107
field-site based, 395
psychodynamic model, 106
supervision, models of, 397–399
developmental, 397
integrated, 397–398
orientation-specific, 398
triadic, 398–399
supervisor assessment, 135
supervisor-supervisee relationship
  internship and, 396
  practicum and, 105

T

tactical brief therapies, 405
tape critique form, 35
Tarasoff, Tatiana (Tanya), 282
  Brazil, 283
  case, 272, 282–284
    the events, 282
    implications of, 283
    post-Tarasoff, 284
    what Tarasoff did not require, 284
  v. Regents of the University of California, 1974 (Tasaroff I), 283
  v. Regents of the University of California, 1976 (Tasaroff II), 283
  case, 284, 285
task-centered therapies, 405
teachers
  guidelines for crisis response, 308–316
  model for crisis intervention, 306–308
  personal reactions after a crisis, 312
  teaching, 195
  ACG code of ethics and, 179–185
techniques used in counseling and psychotherapy, 114–124
  “The Reflective Model of Triadic Supervision: Defining an Emerging Modality”
  (Stinchfield, Hill, and Kleist), 398
  theoretical orientation of the site and supervisor, 26
theories of counseling and psychotherapy, overview of, 111–114
Theory and Practice of Mental Health Consultation, The (Caplan), 331, 333
time-based techniques, 109
  interns and, 400–405
  major approaches to brief therapy, 403–405
  solution-focused brief therapy, 401
  strategic solution-focused therapy, 402
  therapeutic alliance
    client, initial interaction with, 43
  therapeutic progress report, 70
  therapy notes, 131
    form, 53
thioxanthenes, 447
torts, 257
  “Toward Science-Practice Integration in Brief Counseling and Therapy” (Steenbarger), 403
  training, 195
    ACG code of ethics and, 179–185
    supervision values and, 25–26
treatment planning, 91–95
  goal setting in counseling, 95
tricyclic antidepressants (TCAs), 444
tuberculosis, 297

U

United States
  African American population of, 26
  Aleut population of, 26
  American Indian population of, 26
  Eskimo population of, 26
  Hispanic population, 26
  non-Hispanic White population, 26
University of California, Berkeley, 282
  Cowell Memorial Hospital, 283
University of Georgia, 261
University of Pittsburgh Counselor Education Program, 398
U.S. Bureau of the Census (1992), 26
U.S. Advisory Board on Child Abuse and Neglect, 287
  use of computers, malpractice and, 260

W

Weekly Schedule (Practicum), 41
Wellesley Project (Cambridge, MA), 302
Whiston, 75–76
FORMS
Dear Practicum Site Supervisor,

The enclosed contract is designed to formalize the arrangement between ______________________ (university program) and __________________________ (practicum site) for student counselors enrolled in the practicum at _______________ __________________________ (university). The practicum activities have been selected based on APA and CACREP guidelines, state licensing or certification requirements, and the university and program faculty recommendations.

If the guidelines, agreements, and practicum activities are followed closely, the student counselor should have the opportunity to demonstrate counseling competencies at an increasing level of complexity in the amount of time contracted. We realize that a practicum site may not be able to provide access for the student to every activity because of the differences that exist in individuals and institutions. The contract for each practicum experience will indicate those activities that can be provided.

We appreciate and thank you for your interest and cooperation in helping to prepare professional counselors and psychologists.

Sincerely,

________________________________
(Name of professor)

________________________________
(Phone number)
PRACTICUM CONTRACT

This agreement is made on ______ by and between ___________________________ (date) (field site) and ___________________________. The agreement will be effective for a period from _______ to ________ for ________ per week for _______________________.

Starting Date (university program) Ending Date (number of hours) Student Name

Purpose

The purpose of this agreement is to provide a qualified graduate student with a practicum experience in the field of counseling or psychology.

The University Program Agrees

1. to assign a university faculty liaison to facilitate communication between university and site;
2. to provide the site prior to placement of the student the following information:
   a. a profile of the student named above and
   b. an academic calendar that shall include dates for periods during which student will be excused from field supervision;
3. to notify the student that he or she must adhere to the administrative policies, rules, standards, schedules, and practices of the site;
4. that the faculty liaison shall be available for consultation with both site supervisors and students and shall be immediately contacted should any problem or change in relation to student, size, or university occur; and
5. that the university supervisor is responsible for the assignment of a fieldwork grade.

The Practicum Site Agrees

1. to assign a practicum supervisor who has appropriate credentials, time, and interest for training the practicum student;
2. to provide opportunities for the student to engage in a variety of counseling activities under supervision and for evaluating the student's performance (suggested counseling experiences included in the “Practicum Activities” section);
3. to provide the student with adequate work space, telephone, office supplies, and staff to conduct professional activities;
4. to provide supervisory contact that involves some examination of student work using audio- or videotapes, observation, and/or live supervision; and
5. to provide written evaluation of student based on criteria established by the university program.
Within the specified time frame, ___________________________ (site supervisor) will be the primary practicum site supervisor. The training activities (checked below) will be provided for the student in sufficient amounts to allow an adequate evaluation of the student’s level of competence in each activity.

___________________________________________ (faculty liaison) will be the faculty liaison with whom the student and practicum site supervisor will communicate regarding progress, problems, and performance evaluations.

### Practicum Activities

<table>
<thead>
<tr>
<th></th>
<th>6. Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Referrals</td>
</tr>
<tr>
<td></td>
<td>Professional team collaboration</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>7. Psychoeducational activities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Parent conferences</td>
</tr>
<tr>
<td></td>
<td>Outreach</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>8. Career counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>9. Individual supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>10. Group or peer supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Case conferences or staff meetings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>12. Other (please list) ________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practicum site supervisor</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>_________________________</td>
<td>_______</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Student</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>________________________</td>
<td>______</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Faculty liaison</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>______________________</td>
<td>______</td>
</tr>
</tbody>
</table>

Form 2.2, p. 2 of 2
STUDENT PROFILE SHEET

Directions: The student counselor is to submit this form in duplicate to the university practicum liaison, who will submit one copy to the field site.

Practicum Student Counselor/Psychologist

Name ________________________________________________________________
Address _______________________________________________________________
_____________________________________________________________________
Telephone: (home) _____________________________________________________
(office)  _____________________________________________________

Date __________________________

I hold the degree of _______________________________________________ from 
______________________________________________ and have completed the 
following courses as part of the __________________________ (degree) 
program, with a major in _________________________________ from 
__________________________________________.

<table>
<thead>
<tr>
<th>Course</th>
<th>Credit Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychology of Human Development</td>
<td></td>
</tr>
<tr>
<td>Tests and Measurements</td>
<td></td>
</tr>
<tr>
<td>Psychology of Learning</td>
<td></td>
</tr>
<tr>
<td>Personality Development</td>
<td></td>
</tr>
<tr>
<td>Counseling Skills</td>
<td></td>
</tr>
<tr>
<td>Career Development</td>
<td></td>
</tr>
<tr>
<td>Intro to Counseling</td>
<td></td>
</tr>
<tr>
<td>Legal and Ethical Issues</td>
<td></td>
</tr>
<tr>
<td>Theories of Counseling</td>
<td></td>
</tr>
<tr>
<td>Process and Techniques of Group Counseling</td>
<td></td>
</tr>
</tbody>
</table>

Other (please specify) __________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Professional and nonprofessional work experience _________________________
_____________________________________________________________________
_____________________________________________________________________

Form 2.3, p. 1 of 1
STUDENT/PRACTICUM/INTERNSHIP AGREEMENT

Directions: Student is to complete this form in duplicate and submit a copy of this agreement to the university practicum supervisor or internship coordinator.

1. I hereby attest that I have read and understood the American Psychological Association and the American Counseling Association ethical standards (chapter 6 in this manual) and will practice my counseling in accordance with these standards. Any breach of these ethics or any unethical behavior on my part will result in my removal from practicum/internship and a failing grade, and documentation of such behavior will become part of my permanent record.

2. I agree to adhere to the administrative policies, rules, standards, and practices of the practicum/internship site.

3. I understand that my responsibilities include keeping my practicum/internship supervisor(s) informed regarding my practicum/internship experiences.

4. I understand that I will not be issued a passing grade in practicum/internship unless I demonstrate the specified minimal level of counseling skill, knowledge, and competence and complete course requirements as required.

Signature ____________________________

Date ________________________________
TAPE CRITIQUE FORM

________________________________________
Student counselor's name

________________________________________
Client I.D. & no. of session

Brief summary of session content:

________________________________________
________________________________________
________________________________________

Intended goals:

________________________________________
________________________________________
________________________________________

Comment on positive counseling behaviors:

________________________________________
________________________________________
________________________________________

Comments on areas of counseling practice needing improvement:

________________________________________
________________________________________
________________________________________

Concerns or comments regarding client dynamics:

________________________________________
________________________________________
________________________________________

Plans for further counseling with this client:

________________________________________
________________________________________
________________________________________

Tape submitted to _______________________

Date _________________________________
# WEEKLY SCHEDULE

<table>
<thead>
<tr>
<th>Day of week</th>
<th>Location</th>
<th>Time</th>
<th>Practicum activity</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Student counselor name ________________________________________________________

Week beginning _______________________ Ending ________________________
<table>
<thead>
<tr>
<th>Month of</th>
<th>Intake Interview</th>
<th>Individual Counseling</th>
<th>Group Counseling</th>
<th>Psycho-educational Testing</th>
<th>Report Writing</th>
<th>Consultation</th>
<th>Occupational Testing</th>
<th>Psycho-educational Consultation</th>
<th>Case Conference</th>
<th>Other (Specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1</td>
<td>Dates:</td>
<td>Total:</td>
<td>hours:</td>
<td>Date:</td>
<td>Date:</td>
<td>Total:</td>
<td>hours:</td>
<td>Date:</td>
<td>Date:</td>
<td>Date:</td>
</tr>
<tr>
<td>Week 2</td>
<td>Dates:</td>
<td>Total:</td>
<td>hours:</td>
<td>Date:</td>
<td>Date:</td>
<td>Total:</td>
<td>hours:</td>
<td>Date:</td>
<td>Date:</td>
<td>Date:</td>
</tr>
<tr>
<td>Week 3</td>
<td>Dates:</td>
<td>Total:</td>
<td>hours:</td>
<td>Date:</td>
<td>Date:</td>
<td>Total:</td>
<td>hours:</td>
<td>Date:</td>
<td>Date:</td>
<td>Date:</td>
</tr>
<tr>
<td>Week 4</td>
<td>Dates:</td>
<td>Total:</td>
<td>hours:</td>
<td>Date:</td>
<td>Date:</td>
<td>Total:</td>
<td>hours:</td>
<td>Date:</td>
<td>Date:</td>
<td>Date:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Form 2.7, p. 1 of 1
PARENTAL RELEASE FORM

Parent’s name _________________________________________________________

Address __________________________________________________________________

Phone _________________________ (home)   ______________________  (office)

The Graduate Department of Counseling and Psychology at ________________
College/University conducts a Counseling Practicum Course each semester at
the college/university. The Counseling Practicum Course is an advanced course
in counseling required of all degree candidates in the Counseling Program at
______________ College/University. Students are required to
audiotape and/or videotape counseling sessions as part of their course and
degree requirements.

_________________________________ (student’s name) would like to work with
your son/daughter, a student at ___________________________________ School.

The counseling sessions conducted with your child will be audiotaped and/or
videotaped and will be reviewed by the student’s supervisor, ________________
______________________. All audiotapes and videotapes made will be erased at
the completion of your child’s involvement in the program.

We hope that you will take the opportunity to have your child become involved
in the Counseling Program. If you are interested in having your child participate,
please sign the form where indicated.

Thank you for your cooperation.

Parent’s signature _____________________________________________

Date ________________________________
CLIENT RELEASE FORM

Graduate Department of Counseling and Psychology

____________________________________________

(name of college/university)

I, _____________________________________, agree to be counseled by a practicum/intern student in the Department of Counseling and Psychology at ___________________________ College/University.

I further understand that I will participate in counseling interviews that will be audiotaped, videotaped, and/or viewed by practicum/intern students through the use of one-way observation windows.

I understand that I will be counseled by a graduate student who has completed advanced course work in counseling/therapy.

I understand that the student will be supervised by a faculty member or site supervisor.

Client’s signature  ______________________________________________________

Age ________________________________   Date  ___________________________

Counselor’s signature  ___________________________________________________
INITIAL INTAKE FORM

Name _____________________________________________  Date ____________
Address ___________________ City __________________ State ___  Zip ___________
Telephone (home) _____________________  (work) ________________________
Therapist's name __________________________  Date ____________

Identifying Information

Age ____________ Date of birth _____ / _____ / ______ Place ____________________
Sex: Male ______ Female ______ Height _____ ft. _____ in. Weight _________ lbs.
Race: White ____ Black ____ Asian ____ Hispanic ____ Other ________________
Marital status: M _________ S _________ D _________ W _________ Sep _________
If married, spouse's name ___________________________________ Age ________
Occupation __________________________  Employer ________________________
Occupation (spouse) __________________  Employer ________________________
Referral source: Self ___________________  Other ___________________________
Name of referral source _________________________________________________
Address of referral source _______________________________________________

Treatment History (General)

Are you currently taking medication?   Yes _____ No _____
If yes, name(s) of the medication(s) ________________________________
Dosage of medication(s) _____________________________________________
Provider of medication(s) _____________________________________________
Have you received previous psychiatric treatment?  Yes _____ No _____
If yes, name provider ________________________________________________
Dates of service ___________________ Location __________________________
Reason for termination of treatment ________________________________
Presenting problem or condition (current) ______________________________
Presenting factors (contributors) _________________________________________
Symptoms (describe) __________________________________________________
_____________________________________________________________________
Acute ___________________  Chronic ____________________

Form 3.3, p. 1 of 2
Family History (General)

Father’s name _______________________ Age ____ Living ____ Deceased ____
Occupation __________________________ Full-time ____ Part-time ____
Mother’s name ______________________ Age ____ Living ____ Deceased ____
Occupation __________________________ Full-time ____ Part-time ____

Brother(s)/sister(s)
Name ______________________________ Age ____ Living ____ Deceased ____
Name ______________________________ Age ____ Living ____ Deceased ____
Name ______________________________ Age ____ Living ____ Deceased ____

Educational History (General)

<table>
<thead>
<tr>
<th>Name of institution</th>
<th>Location</th>
<th>Dates</th>
<th>Degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>College</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Graduate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Employment History (General)

<table>
<thead>
<tr>
<th>Title/description</th>
<th>From when to when</th>
<th>Full- or part-time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ELEMENTARY SCHOOL COUNSELING REFERRAL FORM*

(Confidential information to be supplied by teacher or counselor.)

Date referral received ________________

Teacher's name ___________________________ Date __________

Principal's name ___________________________ Date __________

Child's name ___________________________ Date __________

Grade ________ Section ________ Date of birth _______ Age _______

Test Results

IQ _______ Present grade level ________

Group _______ Individual _______ Math ________ Reading ________

Father's name ___________________ Mother's name ___________________

Address ___________________________ Address ___________________________

Phone number ____________________ Phone number _____________________

Have you had a discussion with the child's parent(s) regarding this referral?  
Yes ___ No ___

What was the parent’s reaction to your referring the child for counseling?  
Positive _______ Neutral _______ Negative _________

To your knowledge, has the child received counseling services in the school or 
out of school?  Yes ___ No ___

If yes, supply counselor or agency name _________________________________

Does the child presently qualify for or receive any special education services?  
Yes ___ No___

If so, give dates ___________________________________________________________________________

Have the child's parents requested counseling? Yes ___ No ___

Have you discussed your concerns about the child with the building principal?  
Yes ___ No ___

Have you discussed your concerns about the child with the multidisciplinary 
team (child study team)?  Yes ___ No ___

* Form developed by Dale Malecki, elementary counselor, Abington Heights School District, Clark’s 
Summit, PA. Used with permission.
## Student’s Present Functioning
(as you perceive it)

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Above average</th>
<th>Average</th>
<th>Below average</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reading</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mathematics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Language arts</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Social studies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>General learning rate</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>On-task behavior</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Self-directed learner</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Follows directions (oral)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Follows directions (written)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Attention span</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Completes assignments</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Returns homework</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Works well with others</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Obeys classroom rules</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Motor coordination</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Self-image development</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Adult relationships</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Peer relationships</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Attitude toward school</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Shows enthusiasm for learning</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Participates in class</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Possible Evidence of
(check if appropriate)

- **Daydreams** ______________________
- **Worries** _________________________
- **Easily distracted** _____________
- **Lacks assertiveness** ____________
- **Absenteeism** _____________
- **Impulsive behavior** ____________
- **Withdrawn** _____________
- **Poorly motivated** ____________
- **Family problems** _____________
- **Inappropriate academic placement**
- **Preoccupied** _____________

Form 3.4, p. 2 of 3
Other Variables
(check if appropriate)

Vision ____________________________ Stature ____________________________
Hearing __________________________ Hygiene ____________________________
Speech ____________________________ Other (please specify) _____________

Special skills, talents, or competencies this child has _______________________
______________________________________________________________________

Reason for referral (based on your observation) ____________________________
______________________________________________________________________

What strategies or techniques have you tried with this child? _________________
______________________________________________________________________

Comments and recommendations __________________________________________
______________________________________________________________________

Please indicate a time(s) that will be convenient for you to have a conference
with me.

Monday Period _________ Time _________
Tuesday Period _________ Time _________
Wednesday Period _________ Time _________
Thursday Period _________ Time _________
Friday Period _________ Time _________

Thank you for taking the time to share this information with me.

Signature ____________________________ Date ________________

(elementary counselor)
ELE ME NTA RY SCHOO L COUNSELING REFERRAL SHORT FORM*

Student name ________________________________________________________________
Date of birth ______________________________________________________________
Teacher ________________________________________________________________

Parent/guardian(s) _________________________________________________________
Home ________________________________________________________________
Home phone ______________________ Work phone ______________________

Please check those behavioral dynamics placing this child at risk as a member of your class:

___ appears unable to sit still       ___ fails to complete seat work
___ unable to wait patiently       ___ inconsistent homework
___ appears easily distracted       ___ procrastinates, wastes time
___ distracts others               ___ appears inattentive during class
___ does not work well with peers       ___ seems reluctant to participate in class
___ has difficulty with rules       ___ seems preoccupied/worries

Present level of functioning in your classroom:

___ Reading       ___ Science       ___ Language arts
___ Health      ___ Math        ___ Social studies

*Note: These marks can be an approximation of upcoming report card grades

Please list any and all remedial or support services presently being provided.
Please include days and times.

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

* Form developed by Jennifer Williams, Gabrielle Vanan, Marywood University counseling interns, and Robert Lavelle, elementary school counselor, Riverside School District, Taylor, PA. Used with permission.
Please discuss briefly the maladaptive issue(s) placing the child at risk. Please be specific.

______________________________________________________________________  
______________________________________________________________________  
______________________________________________________________________  
______________________________________________________________________  

Please specify the replacement behavior(s) that you see necessary for improved performance of this child as a member of your class.

______________________________________________________________________  
______________________________________________________________________  
______________________________________________________________________  
______________________________________________________________________  

Thank you for taking the time to complete this referral.

Person making this referral:  

____________________________________  
Signature  

____________________________________  
Title  

____________________________________  
Date
ELEME NTARY SCHOOL COUNSELING REFERRAL
SHORT FORM

We, the parents of _____________________________________________________,
acknowledge and approve of our child being seen by the elementary school
counselor. The counselor may engage our child in any activities he deems
appropriate in encouraging positive, lasting behavioral change.

_____________________________________
Parent Signature

_____________________________________
Date

OR

We, the parents of _____________________________________________________,
acknowledge but disapprove of our child being seen by the elementary school
counselor. We decline the offer of services at this time, but reserve the opportu-
nity to reconsider services at a later date.

_____________________________________
Parent Signature

_____________________________________
Date
SECONDARY SCHOOL COUNSELING REFERRAL FORM

(Confidential information to be supplied by teacher or counselor.)

Date referral received __________

Teacher's name __________________________ Date ___________________
Principal's name __________________________ School ___________________
Child's name __________________________________________________________
Grade __________________________ Date of birth _________________________

Test Results

IQ _______ Group _______ Individual ________

If the child has ever been retained, indicate grade __________________________

Father's name _____________________ Mother's name _____________________
Address __________________________ Address ___________________________
Phone number ____________________ Phone number _____________________

Have you had a discussion with the child's parent(s) regarding this referral?
Yes ___ No ___

What was the parent's reaction to your referring the child for counseling?
Positive _______ Neutral _______ Negative ________

To your knowledge, has the child received counseling services in the school or
out of school? Yes ___ No ___
If yes, supply counselor or agency name ________________________________

Does the child presently qualify for or receive any special education services?
Yes ___ No___
If so, give dates _______________________________________________________

Has the student had a psychoeducational assessment done? Yes ___ No ___
If so, give date ________________________________________________________

Have student's parents requested counseling? Yes ___ No ___

Have you discussed your concerns about the child with your supervisor/principal?
Yes ___ No ___
Student’s Present Functioning
(as you perceive it)

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Above average</th>
<th>Average</th>
<th>Below average</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-directed learner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention span</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of writer assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-image</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitude toward authority</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer relationships</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Works well with others</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completes assignments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follows classroom rules</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please Check
(if appropriate)

|                          |           |               |         |               |      |
| Aggressive              |           | Personable    |         | Engaging      |      |
| Assertive               |           | Shy           |         | Ambitious     |      |
| Noncompliant            |           | Dependent     |         | Impulsive     |      |
| Disregard for rights    |           | Depressed     |         | Preoccupied   |      |
| Self-confident          |           | Avoidant      |         | Motivated     |      |
| Withdrawn               |           | Friendly      |         | Distractable  |      |
| Argumentative           |           | Social        |         |               |      |

Special skills, talents, or competencies this student has __________________________
________________________________________________________________________________

Reason for referral (based on your observations) __________________________
________________________________________________________________________________

What interventions have you tried with this student? __________________________
________________________________________________________________________________

Comments and recommendations __________________________
________________________________________________________________________________

Signature ___________________________ Date _____________

Position ___________________________
## MENTAL STATUS CHECKLIST

### Appearance and Behavior

<table>
<thead>
<tr>
<th></th>
<th>Check if applies</th>
<th>Circle</th>
<th>Therapist’s Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Posture</td>
<td>Normal</td>
<td>Limp, rigid, ill at ease</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Gestures</td>
<td>Normal</td>
<td>Agitated, tics, twitchies</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Grooming</td>
<td>Neat</td>
<td>Well groomed, disheveled, meticulous</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Dress</td>
<td>Dirty, careless</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Casual</td>
<td>inappropriate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Formal</td>
<td>seductive</td>
<td></td>
</tr>
<tr>
<td>5. Facial</td>
<td>Appropriate</td>
<td>Poor eye contact, dazed, staring</td>
<td></td>
</tr>
<tr>
<td></td>
<td>expression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Speech</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Pace</td>
<td>Normal</td>
<td>Retarded, pressured, blocking</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Volume</td>
<td>Normal</td>
<td>Soft, very loud, monotone</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Form</td>
<td>Logical</td>
<td>Illogical, rambling,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rational</td>
<td>incoherent, coherent</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Clarity</td>
<td>Normal</td>
<td>Garbled, slurred</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Content</td>
<td>Normal</td>
<td>Loose, associations, rhyming, obscene</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Attention/Affect/Mood

<table>
<thead>
<tr>
<th>Check if applies</th>
<th>Circle</th>
<th>Therapist's Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Attention</td>
<td>Normal</td>
<td>Short span, hyper,</td>
</tr>
<tr>
<td></td>
<td>Alert</td>
<td>alert, distractible</td>
</tr>
<tr>
<td>2. Mood</td>
<td>Normal</td>
<td>Elated, euphoric,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>agitated, fearful,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>hostile, sad</td>
</tr>
<tr>
<td>3. Affect</td>
<td>Appropriate</td>
<td>Inappropriate,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>shallow, flat,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>intense</td>
</tr>
</tbody>
</table>

### Perception and Thought Content

<table>
<thead>
<tr>
<th>Check if applies</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hallucination</td>
<td>________________________________</td>
</tr>
<tr>
<td>a. Auditory</td>
<td>________________________________</td>
</tr>
<tr>
<td>b. Visual</td>
<td>________________________________</td>
</tr>
<tr>
<td>c. Tactile</td>
<td>________________________________</td>
</tr>
<tr>
<td>d. Gustatory</td>
<td>________________________________</td>
</tr>
<tr>
<td>e. Olfactory</td>
<td>________________________________</td>
</tr>
<tr>
<td>2. Delusion</td>
<td>________________________________</td>
</tr>
<tr>
<td>a. Paranoid</td>
<td>________________________________</td>
</tr>
<tr>
<td>c. Grandiose</td>
<td>________________________________</td>
</tr>
<tr>
<td>e. Control</td>
<td>________________________________</td>
</tr>
<tr>
<td>g. Insertion</td>
<td>________________________________</td>
</tr>
<tr>
<td>i. Thought withdrawal</td>
<td>________________________________</td>
</tr>
<tr>
<td>3. Illusions</td>
<td>________________________________</td>
</tr>
<tr>
<td>a. Visual</td>
<td>________________________________</td>
</tr>
<tr>
<td>b. Auditory</td>
<td>________________________________</td>
</tr>
</tbody>
</table>
Describe __________________________________________________________
__________________________________________________________________

4. Other derealization
   a. Phobias __________________
   b. Obsessions _______________
   c. Compulsions _______________
   d. Ruminations _______________

Describe __________________________________________________________
__________________________________________________________________

5. Suicide/homicide
   Ideation __________________
   Plans ______________

Describe __________________________________________________________
__________________________________________________________________

**Orientation**

Oriented × 3  Yes ____ No ____

Disoriented to:  Time _________ Place _________ Person _________

**Judgment**

Intact _____________ Impaired ___________

Describe __________________________________________________________
__________________________________________________________________

**Concentration/Memory**

1. Memory  Intact _____________ Impaired ___________
2. Immediate recall  Good _____________ Poor ______________
3. Reversals  Good _____________ Poor ______________
4. Concentration  Good _____________ Poor ______________

**Abstract Ability**

1. Similarities  Good ____ Poor ____ Bizarre ____
2. Absurdities  Recognized ____ Not recognized____
3. Proverbs  Appropriate ____ Literal ____ Concrete ____ Bizarre ____

**Insight**

Good ____ Fair ____ Poor ____ Absent ____
PSYCHOSOCIAL HISTORY

Directions: Practicum/internship students should complete this form prior to the initiation of therapy and after completion of the Initial Intake Form.

I. Identifying Information

Name __________________________________ Age ______________ 
Address _______________________________ Date of birth ______________ 
Phone ___________ Cell Phone ____________ Marital status _____________

II. Presenting Problem/Complaint

Nature of complaint? ________________________________________________ 
__________________________________________________________________
When did the problem begin? (date of onset) __________________________
How often does it occur? (be specific) _________________________________
How does it affect your daily functioning? _____________________________
__________________________________________________________________
Are there events, situations, and person(s) that precipitate it? ____________ 
__________________________________________________________________

Symptoms:

Acute (describe) _____________________________________________________
__________________________________________________________________
Chronic (describe) ___________________________________________________
__________________________________________________________________
Previous treatment (list by whom, outcome, and reason(s) for termination of 
treatment) _________________________________________________________
__________________________________________________________________
__________________________________________________________________

Medical:

Physician's name ____________________________________________________
Treatment dates from ________________________ to _____________________
Describe __________________________________________________________________
__________________________________________________________________

Psychiatric:

Therapist's name ____________________________________________________
Treatment dates from ________________________ to _____________________
Substance usage __________________________________________________________________
__________________________________________________________________
III. Developmental History

Pregnancy _________________________________________________________
_________________________________________________________________

Delivery __________________________________________________________
_________________________________________________________________

Infancy (developmental milestones) _________________________________
_________________________________________________________________

Middle childhood (developmental milestones) __________________________
_________________________________________________________________

Young adulthood (developmental milestones)
_________________________________________________________________

IV. Family History

Where were you born and raised? _________________________________

What culture/ethnic group do you identify with? ______________________

What is your primary language? ___________________________________

Parent (names, ages, occupations) _________________________________
_________________________________________________________________

Were your parents married?  Yes____  No____

Do they remain married?  Yes____  No____

If divorced, how were you affected by it? _____________________________
_________________________________________________________________

Who was primarily responsible for your upbringing?  __________________

Describe the relationship between your parents _______________________
_________________________________________________________________

Describe your relationship with parents _____________________________
_________________________________________________________________

Do you feel supported by your family?  Explain _______________________
_________________________________________________________________

Do you feel loved in your family? Explain _____________________________
_________________________________________________________________

Describe how love was expressed in your family ______________________
_________________________________________________________________

Who was the disciplinarian in your family? __________________________

How was discipline handled? ______________________________________
Were you physically, verbally or emotionally abused in any way? ____________
___________________________________________________________________

Describe your best memory ____________________________________________
___________________________________________________________________

Describe your worst memory _________________________________________
___________________________________________________________________

V. Educational/Occupational History

Education (highest grade achieved) ________________________________
Describe your school performance ________________________________
___________________________________________________________________

Did you take any special classes? Explain __________________________
___________________________________________________________________

Did you have any special needs? _________________________________
___________________________________________________________________

Do you have adequate reading skills? Yes____ No____
Do you have adequate math skills? Yes____ No____

Occupational

Usual occupation _________________________________________________

Present status: Employed?___ Unemployed?___ Full time___ Part time ___

Job satisfaction: Good___ Fair___ Poor___

Estimate the number of jobs that you have held _______________________

Longest continued employments (dates) _______________________________

Reason(s) for leaving? Explain ______________________________________
___________________________________________________________________

VI. Health History

What impact does your present concern have on your employment?
None ____ Terminated ____ Absenteeism ____ Tardiness ____ Laid off ____
Poor work performance ____ Conflict with fellow workers ____
Conflict with employer ____
Childhood diseases (list) _________________________________________
___________________________________________________________________
Surgeries? _________________________________________________________
__________________________________________________________________
__________________________________________________________________
Current health (describe) ____________________________________________
__________________________________________________________________
__________________________________________________________________
Family health (grandparents, parents, children) _________________________
__________________________________________________________________
__________________________________________________________________
Current medications (prescribed and over the counter). List ______________
__________________________________________________________________
__________________________________________________________________
Do you have any chronic medical problems? ___________________________
__________________________________________________________________
Do you have any bio-medical problems requiring medical monitoring?_____
__________________________________________________________________

VII. Marital History

Single ____ Married ____ Separated ____ Divorced ____ Widowed ____
Common law ____
Years married? ______________
Number of children (names and ages) _________________________________
__________________________________________________________________
__________________________________________________________________
Problems, stressors in the relationship? Explain________________________
__________________________________________________________________
__________________________________________________________________
Your perception of sexual relationship (attitudes/behavior) _____________
__________________________________________________________________
__________________________________________________________________
Have you ever been physically or emotionally abused in the relationship?
__________________________________________________________________
__________________________________________________________________

VIII. Additional Information

Information that has not been covered that you feel is an important consider-
eration in your treatment (explain, be specific) _________________________
__________________________________________________________________
__________________________________________________________________
THERAPY NOTES

Therapist's name _______________________ Agency/school ________________
Therapist's phone ______________________

CLIENT IDENTIFYING DATA

Client's name __________________________ Age _______ Sex _______
Date of session __________________________ Session number _______
Taping: Audio ___________________________ Video ______________________

Presenting/current concern

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Key issues addressed

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Summary of the session

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Diagnostic impression(s)

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Treatment plan/objectives

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
THERAPEUTIC PROGRESS REPORT

Date _____________

Therapist’s name _________________ Client’s name _________________

Therapist’s phone _________________ Client’s age _________________ Sex ________

Sessions to date with client ______________________________________________
(n u m b e r)

Client’s presenting complaint ____________________________________________
______________________________________________________________________
______________________________________________________________________

Therapeutic summary __________________________________________________
______________________________________________________________________
______________________________________________________________________

Methods of treatment __________________________________________________
______________________________________________________________________
______________________________________________________________________

Duration of treatment __________________________________________________
______________________________________________________________________
______________________________________________________________________

Current status _________________________________________________________
______________________________________________________________________
______________________________________________________________________

Treatment recommendations ____________________________________________
______________________________________________________________________
______________________________________________________________________

_______________________________________
Therapist’s signature

_______________________________________
Supervisor’s signature
SELF-ASSESSMENT OF BASIC HELPING SKILLS
AND PROCEDURAL SKILLS

Purposes
1. To provide the trainee with an opportunity to review levels of competency in the performance skill areas of basic helping skills and procedural skills.
2. To provide the trainee with a basis for identifying areas of emphasis within supervision.

Directions
Circle a number next to each item to indicate your perceived level of competence.

Basic Helping Skills

<table>
<thead>
<tr>
<th>Item</th>
<th>Poor</th>
<th>Average</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ability to demonstrate active attending behavior</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Ability to listen to and understand nonverbal behavior</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Ability to listen to what client says verbally, noticing mix of experiences, behaviors, and feelings</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Ability to understand accurately the client's point of view</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Ability to identify themes in client's story</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Ability to identify inconsistencies between client's story and reality</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Ability to respond with accurate empathy</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Ability to ask open-ended questions</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Ability to help clients clarify and focus</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. Ability to balance empathic response, clarification, and probing</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Ability to assess accurately severity of client's problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Ability to establish a collaborative working relationship with client</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Ability to assess and activate client's strengths and resources in problem solving</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. Ability to identify and challenge unhealthy or distorted thinking or behaving</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. Ability to use advanced empathy to deepen client's understanding of problems and solutions</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. Ability to explore the counselor–client relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. Ability to share constructively some of own experiences, behaviors, and feelings with client</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Basic Helping Skills</td>
<td>Poor</td>
<td>Average</td>
<td>Good</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
<td>------</td>
<td>---------</td>
<td>------</td>
</tr>
<tr>
<td>18. Ability to summarize</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. Ability to share information appropriately</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20. Ability to understand and facilitate decision making</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21. Ability to help clients set goals and move toward action in problem solving</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>22. Ability to recognize and manage client reluctance and resistance</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>23. Ability to help clients explore consequences of the goals they set</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>24. Ability to help clients sustain actions in direction of goals</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>25. Ability to help clients review and revise or recommit to goals based on new experiences</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedural Skills</th>
<th>Poor</th>
<th>Average</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>26. Ability to open the session smoothly</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>27. Ability to collaborate with client to identify important concerns for the session</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>28. Ability to establish continuity from session to session</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>29. Knowledge of policy and procedures of educational or agency setting regarding harm to self and others, substance abuse, and child abuse</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>30. Ability to keep appropriate records related to counseling process</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>31. Ability to end the session smoothly</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Trainee's signature: ________________________________________________________________

Supervisor's signature: ____________________________________________________________

Date ______________________
COUNSELING TECHNIQUES LIST

Directions

1. First, examine the techniques listed in the first column. Then, technique by technique, decide the extent to which you use or would be competent to use each. Indicate the extent of use or competency by circling the appropriate letter in the second column. If you do not know the technique, then mark an “X” through the “N” to indicate that the technique is unknown. Space is available at the end of the techniques list in the first column to add other techniques.

2. Second, after examining the list and indicating your extent of use or competency, go through the techniques list again and circle in the third column the theory or theories with which each technique is appropriate. The third column, of course, can be marked only for those techniques with which you are familiar.

3. The third task is to become more knowledgeable about the techniques that you do not know—the ones marked with an “X.” As you gain knowledge relating to each technique, you can decide whether you will use it and, if so, with which kinds of clients and under what conditions.

4. The final task is to review the second and third columns and determine whether techniques in which you have competencies are within one or two specific theories. If so, are these theories the ones that best reflect your self-concept? Do those techniques marked reflect those most appropriate, as revealed in the literature, for the clients with whom you want to work?

Key

<table>
<thead>
<tr>
<th>N = None</th>
<th>M = Minimal</th>
<th>A = Average</th>
<th>E = Extensive</th>
</tr>
</thead>
</table>

Be = Behavioral Modification (Wolpe)       Ps = Psychoanalytic (Freud)
Cl = Client Centered (Rogers)             RE = Rational Emotive Therapy (Ellis)
Co = Conjoint Family (Saur)               TA = Transactional Analysis (Berne)
Ex = Existential (May)                    TF = Trait Factor (Williamson)
GE = Gestalt (Perls)                      CT = Cognitive Therapy (Beck)
Lo = Logo (Frankl)                        |

<table>
<thead>
<tr>
<th>Technique</th>
<th>Extent use or competency</th>
<th>Theory with which technique is most appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptance</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Active imagination</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Active listening</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Advice giving</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Alter-ego</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Technique</td>
<td>Extent use or competency</td>
<td>Theory with which technique is most appropriate</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>--------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Analysis</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Analyzing symbols</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Assertiveness training</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Audiotape recorded models</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Authoritarian approach</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Aversion-aversive conditioning</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Behavior modification</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Bibliotherapy</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Break-in, break-out</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Bumping in a circle</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Cajoling</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Case history</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Catharsis</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Clarifying feelings</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Cognitive restructuring</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Commitment</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Conditioning techniques</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Confession</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Confrontation</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Congruence</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Contractual agreements</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Cotherapist</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Counterpropaganda</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Countertransference</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Crying</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Decision making</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Democratic</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Desensitization</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Detailed inquiry</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Diagnosing</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Doubling</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Dream interpretation</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Dreaming</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Drugs</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Empathy</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Encouragement</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Environmental manipulation</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Explaining</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Fading</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Family chronology</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Family group counseling</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Technique</td>
<td>Extent use or competency</td>
<td>Theory with which technique is most appropriate</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>--------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Fantasizing</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Feedback</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Filmed models</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>First memory</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Free association</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Frustration</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Game theory techniques</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Group centered</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Group play</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Homework</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Hot seat</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Identification of an animal, defend it</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Identification of self as great personage</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Imagery</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Inception inquiry</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Informativity</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Interpersonal process recall (IPR)</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Interpretation</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Irrational behavior identification</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Laissez-faire groups</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Life space</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Live models</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Magic mirror</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Misinterpretation, deliberate</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Modeling</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Multiple counseling</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Natural consequences</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Negative practice</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Negative reinforcement</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Orientative</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Paradoxical intention</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Play therapy</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Positive regard</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Positive reinforcement</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Predicting</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Probing</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Problem solving</td>
<td>N M A E</td>
<td>Be Co Ex Ge Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Technique</td>
<td>Extent of use or competency</td>
<td>Theory with which technique is most appropriate</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Processing</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Prognosis</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Progressive relaxation</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Projection</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Psychodrama</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Punishment</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Questioning</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Rational</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Reality testing</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Reassurance</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Recall</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Reciprocity of affect</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Reconciliation</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Reeducation</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Reflection</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Regression</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Reinforcement</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Relaxation</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Release therapy</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Restatement of content</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Reward</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Rocking or cradling above head trust</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Role playing</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Role reversal</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Self-modeling</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Sensitivity exercises</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Sensitivity training</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Shaping</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Silence</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Simulation</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Sociodrama</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Sociometrics</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Stimulation</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Structuring</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>SUD (subjective unit of discomfort)</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Summarization</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Supporting</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Systematic desensitization</td>
<td>N M A E</td>
<td>Be Cl Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
</tbody>
</table>

Form 5.2, p. 4 of 5
<table>
<thead>
<tr>
<th>Technique</th>
<th>Extent use or competency</th>
<th>Theory with which technique is most appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Termination</td>
<td>N M A E</td>
<td>Be Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Transference</td>
<td>N M A E</td>
<td>Be Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Transparency</td>
<td>N M A E</td>
<td>Be Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Trust walk</td>
<td>N M A E</td>
<td>Be Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Urging</td>
<td>N M A E</td>
<td>Be Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Value clarification</td>
<td>N M A E</td>
<td>Be Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Value development</td>
<td>N M A E</td>
<td>Be Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Verbal shock</td>
<td>N M A E</td>
<td>Be Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Vicarious learning</td>
<td>N M A E</td>
<td>Be Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>Warmth</td>
<td>N M A E</td>
<td>Be Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td>ADD YOUR OWN:</td>
<td>N M A E</td>
<td>Be Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td></td>
<td>N M A E</td>
<td>Be Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td></td>
<td>N M A E</td>
<td>Be Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
<tr>
<td></td>
<td>N M A E</td>
<td>Be Co Ex GE Lo Ps RE TA TF CT</td>
</tr>
</tbody>
</table>
SELF-RATING BY THE STUDENT COUNSELOR*

Suggested Use: The student counselor may use this sheet as a self-evaluation after a therapy session.

Date __________

Student counselor’s name _______________________________________________

Client’s name _________________________________________________________

Directions: The student counselor is to answer each question following a therapy session. The questions serve as a self-rating initiator and may enable the student counselor to determine means for improvement in his/her counseling.

Preparation for the Interview

1. Was I physically in good condition and mentally alert? ________ ________ ________

2. Did I schedule sufficient time for the interview? ________ ________ ________

3. Was provision made for privacy and reasonable freedom from interruption? ________ ________ ________

4. Did I have the physical space arranged where we met so as to suggest welcome and an atmosphere conducive to counseling? ________ ________ ________

5. Did I have a background of available data about the client that would help me to understand him or her better in the interview but would not prejudice me? ________ ________ ________

6. Did I have and understand information so as to personalize information processes with the client? ________ ________ ________

7. Had I previously established a reputation for seeing the client’s point of view, being genuinely helpful, and not disclosing confidence? ________ ________ ________

Comments:

Beginning the Interview

1. Was I sensitive to the client, and did I use an appropriate approach? ________ ________ ________

2. Was I able to create a psychological atmosphere in which the client was stimulated to take responsibility for thinking through the situation? ________ ________ ________

3. Was I successful in maintaining open communication between us? ________ ________ ________

Comments:

### Development of the Interview

1. Did the client feel freedom to express negative feelings? _____  _____  _____
2. Did the client have the opportunity to release tension? _____  _____  _____
3. Was my attitude one of reflecting objectivity while expressing caring? _____  _____  _____
4. Was I sincere, and did I show genuine respect for the client? _____  _____  _____
5. Was my own attitude, so far as I know, free from bias? _____  _____  _____
6. Did I follow the leads suggested by the client? _____  _____  _____
7. Did I help the client to clarify and expand positive feelings? _____  _____  _____
8. Did the client establish a more forward-looking, positive, hopeful attitude during the interview or series of interviews? _____  _____  _____
9. Was I able to assist in information processing by the client? _____  _____  _____
10. Was information provided in a manner that caused the client to move forward realistically in his or her thinking? _____  _____  _____

Comments:

### Planning for Next Session

1. Was I able to identify areas with which to follow through for the next session? _____  _____  _____
2. Was I able to help the client gain a clear view of what might be done in the next session? _____  _____  _____
3. Did I establish a definite meeting time and place for the next session with the client? _____  _____  _____
4. Have I identified techniques that might be considered for the next session? _____  _____  _____
5. Have I identified the materials and/or preparation I will need for the next session? _____  _____  _____

Comments:
PEER RATING FORM

Purposes
1. To provide the trainee with additional sources of feedback regarding skill development.
2. To provide the rater with the opportunity to increase knowledge and recognition of positive skill behavior.

Directions
1. The trainee submits this sheet once a week to be completed by peer who reviews the trainee’s tapes. The particular skills the counselor is working on are identified by the counselor trainee.
2. The peer writes remarks once a week on all tapes reviewed, rating performance on the targeted skill behavior.
3. The information is cumulative to aid in review of progress.

Counselor’s name ______________________________________________________

Targeted skills (to be identified by counselor) ______________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Remarks (based on all tapes reviewed during the week) _____________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Signature of rater ______________________________________________________

Date ______________________________________________________
GOAL STATEMENT AGREEMENT

Directions: The student completes the agreement in duplicate and submits one copy to the supervisor.

Student's name ______________________  Supervisor's name ______________________

Date submitted ________________________

<table>
<thead>
<tr>
<th>Short-Term Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-awareness skills</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Counseling performance skills</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Cognitive counseling skills</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Developmental level</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Long-Term Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-awareness skills</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Counseling performance skills</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Cognitive counseling skills</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Developmental level</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
INTERVIEWER RATING FORM
Rating of a Counseling Session Conducted by a Student Counselor*

Client’s name or identification __________________________________________

Student counselor’s name ______________________________________________

Check one:
___ Audiotape ___ Videotape ___ Observation ___ Other (specify) ____________

Signature of supervisor or observer _______________________________________

Date of interview ________________

Directions: Supervisor or peer of the student counselor marks a rating for each item and as much as possible provides remarks that will help the student counselor in his or her development.

<table>
<thead>
<tr>
<th>Specific Criteria</th>
<th>Rating (best to least)</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Opening: Was opening unstructured, friendly, and pleasant? Any role definition needed? Any introduction necessary?</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
<tr>
<td>2. Rapport: Did student counselor establish good rapport with client? Was the stage set for a productive interview?</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
<tr>
<td>3. Interview responsibility: If not assumed by the client, did student counselor assume appropriate level of responsibility for interview conduct? Did student counselor or client take initiative?</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
<tr>
<td>4. Interaction: Were the client and student counselor really communicating in a meaningful manner?</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
<tr>
<td>5. Acceptance/permissiveness: Was the student counselor accepting and permissive of client’s emotions, feelings, and expressed thoughts?</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
<tr>
<td>6. Reflections of feelings: Did student counselor reflect and react to feelings or did interview remain on an intellectual level?</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
</tbody>
</table>

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7. Student counselor responses:</strong> Were student counselor responses appropriate in view of what the client was expressing or were responses concerned with trivia and minutia? Meaningful questions?</td>
<td>5 4 3 2 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>8. Value management:</strong> How did the student counselor cope with values? Were attempts made to impose counselor values during the interview?</td>
<td>5 4 3 2 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>9. Counseling relationship:</strong> Were student counselor–client relationships conducive to productive counseling? Was a counseling relationship established?</td>
<td>5 4 3 2 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>10. Closing:</strong> Was closing initiated by student counselor or client? Was it abrupt or brusque? Any follow-up or further interview scheduling accomplished?</td>
<td>5 4 3 2 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>11. General techniques:</strong> How well did the student counselor conduct the mechanics of the interview?</td>
<td>5 4 3 2 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Duration of interview: Was the interview too long or too short? Should interview have been terminated sooner or later?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Vocabulary level: Was student counselor vocabulary appropriate for the client?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Mannerisms: Did the student counselor display any mannerisms that might have conversely affected the interview or portions thereof?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Verbosity: Did the student counselor dominate the interview, interrupt, override, or become too wordy?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Silences: Were silences broken to meet student counselor needs, or were they dealt with in an effectual manner?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments for student counselor assistance:** Additional comments that might assist the student counselor in areas not covered by the preceding suggestions.
SITE SUPERVISOR’S EVALUATION OF STUDENT COUNSELOR’S PERFORMANCE*

Suggested use: This form is to be used to check performances in counseling practicum. The form may be completed after each supervised counseling session or may cover several supervisions over a period of time. The form is appropriate for individual or group counseling.

Alternate use: The student counselor may ask a peer to observe a counseling session and mark the evaluation.

Name of student counselor ____________________________________________________________

Name or identifying code of client _____________________________________________________

Date of supervision __________ or period covered by the evaluation ________________________

Directions: The supervisor, following each counseling session that has been supervised or after several supervisions covering a period of time, circles a number that best evaluates the student counselor on each performance at that point in time.

<table>
<thead>
<tr>
<th>General Supervision Comments</th>
<th>Poor</th>
<th>Adequate</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demonstrates a personal commitment in developing professional competencies</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Invests time and energy in becoming a counselor</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Accepts and uses constructive criticism to enhance self-development and counseling skills</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Engages in open, comfortable, and clear communication with peers and supervisors</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Recognizes own competencies and skills and shares these with peers and supervisors</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Recognizes own deficiencies and actively works to overcome them with peers and supervisors</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Completes case reports and records punctually and conscientiously</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The Counseling Process</th>
<th>Poor</th>
<th>Adequate</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Researches the referral prior to the first interview</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Keeps appointments on time</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Begins the interview smoothly</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Explains the nature and objectives of counseling when appropriate</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Is relaxed and comfortable in the interview</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Communicates interest in and acceptance of the client</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Facilitates client expression of concerns and feelings</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Focuses on the content of the client’s problem</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Reprinted by permission from Dr. Harold Hackney, assistant professor, Purdue University. This form was designed by two graduate students based on material from Counseling Strategies and Objectives, 1973, by H. Hackney and S. Nye. Englewood Cliffs, NJ: Prentice Hall. This material was taken from "Evaluation of Student Counselors and Supervisors," pp. 265–274, in K. Dimick and F. Krause (Eds.), Practicum Manual for Counseling and Psychotherapy, 1980. Muncie, IN: Accelerated Development.
16. Recognizes and resists manipulation by the client  
17. Recognizes and deals with positive affect of the client  
18. Recognizes and deals with negative affect of the client  
19. Is spontaneous in the interview  
20. Uses silence effectively in the interview  
21. Is aware of own feelings in the counseling session  
22. Communicates own feelings to the client when appropriate  
23. Recognizes and skillfully interprets the client's covert messages  
24. Facilitates realistic goal setting with the client  
25. Encourages appropriate action-step planning with the client  
26. Employs judgment in the timing and use of different techniques  
27. Initiates periodic evaluation of goals, action-steps, and process during counseling  
28. Explains, administers, and interprets tests correctly  
29. Terminates the interview smoothly  

The Conceptualization Process

30. Focuses on specific behaviors and their consequences, implications, and contingencies  
31. Recognizes and pursues discrepancies and meaning of inconsistent information  
32. Uses relevant case data in planning both immediate and long-range goals  
33. Uses relevant case data in considering various strategies and their implications  
34. Bases decisions on a theoretically sound and consistent rationale of human behavior  
35. Is perceptive in evaluating the effects of own counseling techniques  
36. Demonstrates ethical behavior in the counseling activity and case management

Additional comments and/or suggestions ________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Date ______________ Signature of supervisor _____________________________________________
or peer _____________________________________________

My signature indicated that I have read the above report and have discussed the content with my site supervisor. It does not necessarily indicate that I agree with the report in part or in whole.

Date ______________ Signature of student counselor ________________________________________

Form 5.7, p. 2 of 2
COUNSELOR COMPETENCY SCALE*
For the Analysis and Assessment of Counselor Competencies

<table>
<thead>
<tr>
<th>Counselor Competency</th>
<th>Analysis</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Skill value to interview</td>
<td>Proficiency</td>
</tr>
<tr>
<td></td>
<td>Nonessential</td>
<td>Important</td>
</tr>
</tbody>
</table>

**Personal Characteristics**

1. Social responsibility: The counselor states, and his/her past experiences show, that he/she is interested in social change. 

2. People oriented: The counselor is people oriented as demonstrated by his/her past experiences and by his/her present social interactions. 

3. Fallibility: The counselor recognizes that he/she is not free from making errors. 

4. Personal problems: The counselor's personal problems are kept out of the counseling session. 

5. Modeling: The counselor models appropriate cognitive processes, behaviors, and feelings during the counseling session. 

6. Nondefensive: The counselor gives and receives feedback to and from his/her clients, peers, and supervisor without making excuses or justifications.
   
   Other ________________________________________________________________  
   Other ________________________________________________________________  
   Other ________________________________________________________________  

7. Evaluation: The counselor's theoretical frame of reference includes a means for describing the cognitive, behavioral, and/or affective change(s) that take place in determining the effectiveness of the selected counseling strategy. 

8. Diagnosis: Regardless of his/her theoretical orientation, the counselor can identify maladaptive symptomatology consistent with his/her theoretical frame of reference. 

9. Theory: The counselor states his/her assumptions about human behavior, through which he/she will incorporate or abstract his/her empirical findings and through which he/she will make predictions concerning his/her client. 

---

* This scale is an altered version of the “Survey of Counselor Competencies,” developed by Dennis B. Cogan, Department of Counselor Education, Arizona State University, Tempe. This material was taken from Appendix A, pp. 482–490, in J. Boyd (Ed.), *Counselor Supervision*, 1978. Muncie, IN: Accelerated Development.
10. Theory: The counselor explains human behavior from at least two theories of personality.

11. Prioritizing: The counselor decides on which problem, when presented with more than one, to deal with first according to his/her theoretical frame of reference.

12. Interpretation: The counselor provides the client with a possible explanation for, or relationships between, certain behaviors, cognitions, and/or feelings.

13. Prognosis: The counselor can make an evaluation of the client’s potential for successful treatment consistent with theoretical frame of reference.

14. Interactions: The counselor describes the interactions that take place between the counselor and client consistent with his/her theoretical frame of reference.

15. Defense mechanisms: The counselor is aware of the defense mechanisms used by the client as well as the purpose they serve, and can help the client substitute more appropriate ones.


17. Natural consequences: The counselor understands the concept of “natural consequences.”

18. Environmental manipulation: The counselor understands the concept of environmental manipulation.

19. Test selection: The counselor selects an appropriate test(s) according to his/her theoretical frame of reference.

20. Inferences: The counselor provides an explanation for and the functional use of the client’s behaviors, cognitions, and/or feelings consistent with his/her theoretical frame of reference and how they might influence the counseling process.

Other ________________________________

Other ________________________________

Other ________________________________

21. Open-ended question: The counselor asks the client a question that cannot be answered by a yes or no, and the question does not provide the client with the answer.

22. Minimal verbal response: The counselor uses “mmmh, oh, yes” to communicate to the client that he/she is listening without interrupting the client’s train of thought or discourse.

23. Genuineness: The counselor’s responses are sincere and appropriate.
24. Positive regard: Without interjecting his/her own values, the counselor communicates respect and concern for the client's feelings, experiences, and potentials.

25. Language: The counselor uses terminology that is understood by the client.

26. Clarification: The counselor has the client clarify ambiguous cognitions, behaviors, and/or feelings.

27. Paraphrasing: Without changing the meaning, the counselor states in fewer words what the client has previously stated.

28. Summarizes: The counselor combines two or more of the client's cognitions, feelings, and/or behaviors into a general statement.

29. Restatement: The counselor conveys to the client that he/she has heard the content of the client's previous statement(s) by restating in exactly or near exact words that which the client has just verbalized.

30. Empathic understanding: The counselor's responses add noticeably to the expressions of the client in such a way as to express feelings at a level deeper than the client was able to express for himself/herself.

31. Reflection: From nonverbal cues the counselor accurately describes the client's affective state.

32. Perceptions: The counselor labels his/her perceptions as perceptions.

33. Confrontation: The counselor confronts the client by stating the possible consequences of his/her behaviors, cognitions, feelings.

34. Supportive: The counselor makes statements that agree with the client's cognitions, accepts the client's behavior, and/or shares with the client that his/her feelings are not unusual.

35. Probing: The counselor's statement results in the client providing additional information about his/her cognitions, providing behaviors, and/or feelings.

36. Disapproval: The counselor makes a statement that conveys disapproval of one or more of the client's cognitions, behaviors, and/or feelings.

37. Advice giving: The counselor shares with the client which alternative he/she would select if it were his/her decision to make.

Other ________________________________________

Other ________________________________________

Other ________________________________________

Form 5.8, p. 3 of 8
Counseling Skills

38. Voice: The counselor's tone of voice and rate of speech is appropriate to the client's present state and/or counseling session.

39. Eye contact: The counselor maintains eye contact at a level that is comfortable for the client.

40. Initial contact: The counselor greets the client in a warm and accepting manner through some accepted form of social greeting (handshake, nod of head, etc.).

41. Activity level: The counselor maintains a level of activity appropriate to the client during the counseling session.

42. Physiological presence: The counselor's body posture, facial expressions, and gestures are natural and congruent with those of the client's.

43. Counselor disclosure: The counselor shares personal information and feelings when it is appropriate in facilitating the counseling process.

44. Silence: The counselor does not speak when appropriate in facilitating client movement.

45. Accenting: From the client's previous statement, behavior, and/or feeling, the counselor repeats or accentuates the same, or has the client repeat or accentuate the statement, behavior, and/or feeling.

46. Objectivity: The counselor has sufficient control over his/her feelings and does not impose his/her values on the client.

47. Probing: The counselor avoids bringing up or pursuing areas that are too threatening to the client.

48. Resistance: The counselor is able to work through the client's conscious opposition to the counseling process.

49. Verbosity: The counselor speaks when it is necessary, does not inappropriately interrupt the client or verbally dominate the counseling session.

50. Attending: The counselor's attention is with the client's cognitions, behaviors, and/or feelings during the counseling session in accord with his/her stated theoretical frame of reference.

51. Transference: The counselor is able to work through feelings directed at him/her by the client which the client originally had for another object or person.

52. Countertransference: The counselor is aware of and is able to correct his/her placing his/her own wishes on the client.
53. Manipulation: The counselor recognizes the client's attempt at influencing the counselor for his/her own purpose.

54. Factors: The counselor explores and is aware of socioeconomic, cultural, and personal factors that might affect the client's progress.

55. Dependency: The counselor encourages the client to be independent, does not make decisions for the client or accept responsibility for the client's behaviors, cognitions, and/or feelings.

56. Theory: The counselor can work with clients from at least two theories of counseling.

57. Alternative exploration: The counselor, with the client, examines the other options available and the possible consequences of each.

58. Implementation: The counselor helps the client put insight into action.

59. Distortions: The counselor explains to the client his/her previously distorted perceptions of self and the environment.

**Personal Characteristics**

60. Motivation: The counselor can verbally confront the client with his/her lack of goal-directed behavior.

61. Case history taking: The counselor obtains factual information from the client that will be helpful in developing a course of action for the client consistent with his/her theoretical frame of reference.

62. Insight: The counselor helps the client become more aware of his/her cognitive, behavioral, affective, and spiritual domain.

63. Structure: The counselor structures the ongoing counseling sessions so there is continuity from session to session.

64. Inconsistencies: The counselor explores with the client contradictions within and/or between client behaviors, cognitions, and/or affect.

65. Refocusing: The counselor makes a statement or asks a question that redirects the client to a specific behavior, cognition, or feeling.

66. Goals: The counselor, with the client, establishes short- and long-range goals that are congruent with societal goals and are within the client's potential.
67. Reinforcement: The counselor identifies and uses reinforcers that facilitate the identified client goals.

68. Flexibility: The counselor changes long- and short-term goals within a specific session or during the overall counseling process as additional information becomes available.

69. Behavioral game: The counselor can develop specific plans, which can be observed and/or counted, for changing the client's behavior(s).

70. Strategy: The counselor's course of action is consistent with the counselor's stated theory of counseling.

71. Termination: The counselor resolves the client's desire for premature termination.

72. Emergencies: The counselor can handle emergencies that arise with the client.

73. Termination: The counselor ends each session and the counseling relationship on time or at a point at which the client is comfortable with the issues that have been explored.

74. Termination: The counselor advises the client that he/she may return in the future.

75. Periodic evaluation: With the client, the counselor periodically evaluates the progress made toward the established goals.

76. Fantasy: The counselor has the client use his/her imagination to gain insight and/or move toward the client's established goals.

77. Homework: The counselor appropriately assigns work to the client that is to be completed outside the counseling session.

78. Problem solving: The counselor teaches the client a method for problem solving.

79. Test interpretation: The counselor interprets test(s) according to the procedures outlined in the test manual.

80. Role playing: The counselor helps the client achieve insight by acting out conflicts and/or situations unfamiliar to him/her.

81. Desensitization: The counselor can apply a purposeful technique to reduce the level of anxiety that the client is experiencing.

82. Dreams: The counselor works with the client's dreams in a manner consistent with his/her stated theoretical frame of reference.
83. Contracts: The counselor makes a contractual agreement with the client.

Other

Adjunctive Activities

84. Case notes: The counselor is able to communicate in a clear concise manner initial, ongoing, and summary case notes.

85. Staffing: The counselor can staff a case in a clear and concise manner by presenting an objective description of the client, significant information, goals for the client, strategy to be used, and a prognosis for the client.

86. Test administration: The counselor can administer test(s) according to the procedures in the test manual.

87. Diagnosis: The counselor identifies cognitions, behaviors, and/or feelings in the client important in making a diagnosis according to the Diagnostic and Statistical Manual of Mental Disorders.

88. Appointments: The counselor is on time for his/her appointments with clients, peers, and supervisors.

89. Informs: The counselor provides the client with factual information.

90. Organized: The counselor effectively organizes and completes the assigned work within the prescribed time limits of the setting in which he/she is employed.

91. Dress: The counselor's attire is appropriate to the client population and work setting being served.

92. Responsibilities: The counselor can clarify the role responsibilities he/she and the client have in the counseling relationship according to his/her theoretical frame of reference.

93. Atmosphere: Within the limits of his/her work setting, the counselor provides an atmosphere that is physically and psychologically comfortable for the client.

94. Cancellations: The counselor notifies the client as soon as possible when he/she will be unable to keep an appointment.
95. Competency: The counselor is aware of and does not go beyond his/her counseling abilities.

Other ________________________________________
Other ________________________________________
Other ________________________________________

Ethical Standards

96. Professionalism: The counselor maintains a professional relationship with the client in accord with APA and/or ACA ethical standards.

97. Ethics: The counselor adheres to the ethical standards outlined by the APA and/or ACA.

98. Confidentiality: The counselor adheres to the ethical standards of confidentiality as outlined by the APA and/or ACA.

Other ________________________________________
Other ________________________________________
Other ________________________________________
SUICIDE CONSULTATION FORM

Directions: Student will complete this form when working with potentially suicidal client. The student will take this information to his or her supervisor for consultation, collaborate on a treatment plan, and place in client’s file.

Part I

Name of institution ____________________________________________________
Intern’s name ________________________ Supervisor’s name _________________
Supervisor’s professional degree __________________________________________
Supervisor is licensed in _______________ Supervisor is certified in ___________
Client’s name ______________________________________ Client’s age __________
If the client is a minor, has the parent signed a consent form? ________________
When was the counseling initiated? Month ________ Day ________ Year _______
Where was counseling initiated? _________________________________________
Number of times you have seen this client ________________________________

Part II

Check the presenting symptoms often associated with a suicidal client.

Client is between the ages of 14 and 19. Yes _____ No _____
Client is depressed. Yes _____ No _____
If Yes, include a description of the client’s depressive behavior:
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Has a previous attempt of suicide occurred? Yes _____ No _____
If Yes, how long ago was the attempt? _____________________________________
Is the client abusing alcohol? Yes _____ No _____
If Yes, how much does he or she drink? _________________________________
______________________________________________________________________

Is the client abusing some other substance? Yes _____ No _____
If Yes, what other substance? ______________________________
______________________________________________________________________
Is rational thinking lost? Yes _____ No _____

If Yes, explain how this behavior is manifested:
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Does the client have little social support? Yes _____ No _____

How does the client spend his or her time?
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Does the client have an organized suicide plan? Yes _____ No _____

If Yes, what is the plan?
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

If there is a plan, does it seem irreversible, for example, gunshot?
Yes _____ No _____

Is the client divorced, widowed, or separated? Yes _____ No _____

Is the client physically sick? Yes _____ No _____

If Yes, describe the symptoms:
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Does the client have sleep disruption? Yes _____ No _____
If Yes, describe the disruption: __________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
Has the client given his/her possessions away? Yes _____ No _____
Does the client have a history of previous psychiatric treatment or hospitalization? Yes _____ No _____
If Yes, describe for what the client was hospitalized: ________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
Does the client have anyone near him or her to intervene? Yes _____ No _____

Part III
Describe and summarize your interactions with the client. What are his or her basic problems? What is your goal with the client? What techniques are you using?
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Form 8.1, p. 3 of 4
Describe your supervisor's reaction to the problem:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

________________________________
Supervisor's signature

What are your plans for the client?  ______________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Form 8.1, p. 4 of 4
SUICIDE CONTRACT*

1. I, _________________________________, agree not to kill myself, attempt to kill myself, or cause harm to myself during the next period of time, from _________________ to _________________, the time of my next appointment.

2. I agree to get enough sleep and to eat well.

3. I agree to get rid of things I could use to kill myself (e.g., my guns, pills, etc.).

4. I agree that if I have a bad time and if I feel that I might hurt myself, I will call __________________________, my counselor, immediately at #_______________, or the Crisis Center (or Suicide Prevention Center), at #______________.

5. I agree that these conditions are part of my counseling contract with___________________.

Signed  _________________________________________   Date  _____________
Witnessed  ____________________________________   Date  _______________


Form 8.2, p. 1 of 1
HARM TO OTHERS FORM

Directions: Student completes the form prior to supervisory sessions and records supervisor's comments and reactions; student and supervisor then sign the completed form. The student should keep the form in his or her confidential records.

1. Student's name ____________________________________________________
   Client's name ____________________________________________________

2. Number of times the client has been seen ___________________________

3. Dates client has been seen __________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________

Client’s presenting problem __________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________

4. Type of therapy given ______________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________

5. What did the client do or say to make the counselor concerned that he or she could represent a “harm to others”? ___________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________

Form 8.3, p. 1 of 2
6. Was a specific victim(s) named? ______________________________________

7. If the victim was not named, what was the relationship of the client to the victim? _____________________________________________________

8. If the victim was not named, did the counselor suspect who the person was? ____________________________________________________________________________

9. Was a clear threat made? ____________________________________________

10. Is serious danger present? ___________________________________________ 
________________________________________________________________________
________________________________________________________________________

11. Is the danger believed to be imminent? _______________________________
If so, why? __________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
If not, why not? __________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

12. Supervisor’s reaction/advice? _________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
What plan of action is to be taken? _________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

_______________________________________
Student’s signature

_______________________________________
Supervisor’s signature

_______________________________________
Date of conference
CHILD ABUSE REPORTING FORM

Practicum counselor and position ____________________________
Date and time ____________________________________________
Alleged perpetrator ___________________________ DOB __________
   Address __________________________________________ S.S. # __________
Alleged victim _______________________________ DOB __________
   Address __________________________________________ S.S. # __________
Information obtained from ___________________________ DOB __________
   Address __________________________________________
   Relationship to alleged perpetrator ___________________________
   Relationship to alleged victim ___________________________
   Brief description of incident or concern ________________________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
   Incident(s) ongoing? ___________ Or specific date ________________
   Reported to immediate supervisor on __________________________
   Supervisor's name and position ________________________________
   Reported to children and youth services on _______ Time __________
   Children and youth worker's name _____________________________
   Alleged perpetrator aware of report? Yes ___________ No ___________
   Alleged victim aware of report? Yes ___________ No ___________
   Alleged perpetrator in counseling? Yes ___________ No ___________
   Where _______________________________________________________
   Alleged victim in counseling? Yes ___________ No ___________
   Where _______________________________________________________
   Results ___________________________________________________________________
   ___________________________________________________________________
   Student counselor's signature ________________________________
   Field supervisor's signature _________________________________

cc: Client's file
    Agency file
SUBSTANCE ABUSE ASSESSMENT FORM

Directions: Student asks the client the specific questions addressed on the form. Student, client, and supervisor should sign the form. The completed form is kept in the student's confidential file.

1. What substances do you or have you used? ____________________________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________

2. How long have you used (beginning with experimentation)? _____________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________

3. How often are you high in a week? ________________________________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________

4. How many of your friends use? ________________________________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________

5. Are you on medication? ________________________________
   ___________________________________________________________________

6. Do you have money for chemicals? How much? ____________________
   ___________________________________________________________________

7. How much do you spend for chemicals in a month (if you were to pay for all the chemicals)? ________________________________
   ___________________________________________________________________

8. Who provides if you are broke? ________________________________
   ___________________________________________________________________
9. Have you ever been busted (police, school, home, DWIs)? ___________
________________________________________________________________

10. Have you lost a job because of your use? ______________
________________________________________________________________
________________________________________________________________
________________________________________________________________

11. What time of day do you use? ____________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

12. Do you use on the job or in school? _______________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

13. Does it take more, less, or about the same amount of the substance to get you high? ___________________________________________________________________
________________________________________________________________
________________________________________________________________

________________________________________________________________
________________________________________________________________

15. Do you sneak using? How do you do it? ______________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

16. Do you hide things? ____________________________
________________________________________________________________

17. Do you have rules for using? What are they? How did they come about? _____
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

Form 8.5, p. 2 of 5
18. Do you use alone? ________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
19. Have you ever tried to quit? _________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
20. Have you had any withdrawal symptoms? _____________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
21. Have you lost your “good time highs”? ________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
22. Have you ever thought about suicide? _________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
23. Do you mix your chemicals when using? ______________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
24. Do you ever shift from one chemical to another? Yes ________ No ________
What happened that made you decide to shift? ____________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
25. Do you avoid people who don’t use? _________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
26. Do you avoid talking about chemical dependency? ______________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
27. Have you done things when using that you are ashamed of? Yes ___ No ___
   What happened? ______________________________________________________
   ______________________________________________________
   ______________________________________________________

28. Who is the most important person in your life, including yourself? _________
   ______________________________________________________

29. How are you taking care of him or her? _______________________________
   ______________________________________________________
   ______________________________________________________

30. On a scale of 1 (low) to 10, how is your life going? _________________
   Explain ______________________________________________________
   ______________________________________________________

31. Are there any harmful consequences you are aware of in your chemical use
   other than those touched upon? ______________________________________
   ______________________________________________________
   ______________________________________________________

32. Do you think your chemical is harmful to you? Yes ____ No ____
   Do you think you have a chemical problem? Yes ____ No ____
   Explain ______________________________________________________
   ______________________________________________________
   ______________________________________________________

_______________________________________
Student’s signature

_______________________________________
Client’s signature

_______________________________________
Supervisor’s signature

_______________________________________
Date
CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, __________________________, authorize ____________________________ (name or general designation of program making disclosure) to disclose to ____________________________ (name of person or organization to which disclosure is to be made) the following information: __________________________ (nature of the information, as limited as possible).

The purpose of the disclosure authorized herein is to __________________________ (purpose of disclosure, as specific as possible).

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows: __________________________ ________ (specification of the date, event, or condition upon which this consent expires).

Date _________________

Signature of participant ____________________________
Signature of parent, guardian,
or authorized representative when required ____________________________
CONSULTATION RATING FORM

Directions: For each of the following questions please rate the degree to which you feel consultation was successful on the following scale:

1. Highly successful
2. Moderately successful
3. Neutral
4. Not successful

The consultant clearly defined his or her role to the staff. _____________
The consultant emphasized the importance of the services offered on a request or voluntary basis. _____________
The consultant explained the rationale for his or her consultative approach. _____________
The consultant encouraged open discussion of any problems or observations about the process of consultation. _____________
The consultant was open to suggestions and recommendations from the consultee. _____________
The consultant explained and described the steps in the consultation process. _____________
The consultant spent time carefully gathering data from the consultee. _____________
The consultant intervened with direct services to the consultee. _____________
The consultant intervened with indirect services to the consultee. _____________
The consultant was successful in identifying the problem. _____________
The consultant defined the problem in terms of the person in the environment. _____________
The consultant defined the problem in terms of lack of skill, lack of knowledge. _____________
The consultant defined the problem in terms of broader organizational problems or issues. _____________
The consultant made specific recommendations for change. _____________
The consultant provided a variety of interventions and strategies in problem solving. _____________
The consultant evaluates the impact of his or her consultation efforts in a formal manner. _____________
The consultant provides feedback to the consultee about the assessment of the consultation process. _____________
The consultant encouraged follow-up of the consultation relationship. _____________
The consultant encouraged independent problem solving by the consultee. _____________
INTERN SITE PRESELECTION DATA SHEET—SCHOOL

Name of school ________________________________________________________________
Address ___________________________________________________________________
____________________________________________________________________________
Level: Elementary ______ Middle ______ Secondary ______ College ______
Student population __________________________ Staff size ________________________

Type of Direct Service Provided

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual counseling</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Group counseling</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Classroom guidance</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Adaptive programs</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Career counseling</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Psychological services</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Social services</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Intern Experience Provided (Direct Service)

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual counseling</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Group counseling</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Classroom guidance</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Adaptive programs</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Career counseling</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Psychological services</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Social services</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Administrative Experience

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake interviewing</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Testing</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Scoring</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Interpreting</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Report writing</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Treatment planning</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Consultation</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Referral</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Case summaries</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>SAP program</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Staff meetings</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Scheduling</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Parent conferencing</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Form 10.1, p. 1 of 2
### Supervision Provided

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual supervision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group supervision</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Education Provided

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional training seminars</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-service training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research opportunities</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**INTERN SITE PRESELECTION DATA SHEET—CLINICAL**

Name of agency ________________________________________________________

Address __________________________________________________________________

Type of agency __________________ Staff size ______________________

Client/patient population ________________________________________________

<table>
<thead>
<tr>
<th>Type of Direct Service Provided</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Addiction therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical therapy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Intern Experience Provided (Direct Service)**

<table>
<thead>
<tr>
<th>Inpatient therapy</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Addiction therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family therapy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Administrative Experience**

<table>
<thead>
<tr>
<th>Intake interviewing</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpreting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report writing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Record keeping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case summaries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff meetings</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Form 10.2, p. 1 of 2
### Supervision Provided

<table>
<thead>
<tr>
<th>Supervision Type</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct supervision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Education Provided

<table>
<thead>
<tr>
<th>Education Type</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional training seminars</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-service training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research opportunities</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
INTERNSHIP CONTRACT

This agreement is made this _______ day of _________________________, by
and between ________________________________________________________
(hereinafter referred to as the AGENCY/INSTITUTION/SCHOOL) and ________
__________________________________________________________ (hereinafter
referred to as the UNIVERSITY). This agreement will be effective for a period
from _____________ to _____________ for student ________________________.

Purpose

The purpose of this agreement is to provide a qualified graduate student with an
internship experience in the field of counseling/therapy.

The UNIVERSITY Shall Be Responsible for the Following:

1. Selecting a student who has successfully completed all of the prerequisite
courses and the practicum experience.
2. Providing the AGENCY/INSTITUTION/SCHOOL with a course outline for
the supervised internship counseling that clearly delineates the responsibili-
ties of the UNIVERSITY and the AGENCY/INSTITUTION/SCHOOL.
3. Designating a qualified faculty member as the internship supervisor who
will work with the AGENCY/INSTITUTION/SCHOOL in coordinating the
internship experience.
4. Notifying the student that he or she must adhere to the administra-
tive policies, rules, standards, schedules, and practices of the AGENCY/
INSTITUTION/SCHOOL.
5. Advising the student that he or she should have adequate liability and acci-
dent insurance.

The AGENCY/INSTITUTION/SCHOOL Shall Be Responsible for the Following:

1. Providing the intern with an overall orientation to the agency's specific ser-
vice necessary for the implementation of the internship experience.
2. Designating a qualified staff member to function as supervising counselor/therapist for the intern. The supervising counselor/therapist will be responsible, with the approval of the administration of the AGENCY/INSTITUTION/SCHOOL, for providing opportunities for the intern to engage in a variety of counseling activities under supervision, and for evaluating the intern's performance. (Suggested counselor/therapist experiences are included in the course outline.)

Equal Opportunity

It is mutually agreed that neither party shall discriminate on the basis of race,
color, nationality, ethnic origin, age, sex, or creed.
Financial Agreement

Financial stipulations, if any, may vary from one AGENCY/INSTITUTION/SCHOOL to another. If a financial stipulation is to be provided, the agreement is stipulated in a separate agreement and approved by the intern, the AGENCY/INSTITUTION/SCHOOL, and the UNIVERSITY.

Termination

It is understood and agreed by and between the parties hereto that the AGENCY/INSTITUTION/SCHOOL has the right to terminate the internship experience of the student whose health status is detrimental to the services provided the patients or clients of the AGENCY/INSTITUTION/SCHOOL. Furthermore, it has the right to terminate the use of the AGENCY/INSTITUTION/SCHOOL by an intern if, in the opinion of the supervising counselor/therapist, such person's behavior is detrimental to the operation of the AGENCY/INSTITUTION/SCHOOL and/or to patient or client care. Such action will not be taken until the grievance against any intern has been discussed with the intern and with UNIVERSITY officials.

The names of the responsible individuals at the two institutions charged with the implementation of the contract are as follows:

__________________________________  __________________________________
Internship supervisor at the UNIVERSITY  Agency supervising counselor/therapist
__________________________________  __________________________________
at the AGENCY/INSTITUTION/SCHOOL

In witness whereof, the parties hereto have caused this contract to be signed the day and year first written above.

__________________________________  __________________________________
AGENCY/INSTITUTION/SCHOOL  Witness
(Administrator)

__________________________________  __________________________________
UNIVERSITY (Representative)  Witness
MID TERM AND END TERM SUMMATIVE REVIEW OF INTERN SKILL LEVELS

(1= Needs improvement; 3= Average; 5= Excellent)

<table>
<thead>
<tr>
<th>Narrative</th>
<th>Evaluation Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Performance</td>
<td></td>
</tr>
<tr>
<td>Skills</td>
<td></td>
</tr>
</tbody>
</table>

Future Goal

____________________________________________________________________________________

Cognitive Counseling Skills

____________________________________________________________________________________

Future Goals

____________________________________________________________________________________

Self Awareness Skills

____________________________________________________________________________________

Future Goal

____________________________________________________________________________________

Developmental Level

____________________________________________________________________________________

Future Goals

____________________________________________________________________________________

Consulting Theory And Practice (Second Semester)

____________________________________________________________________________________
INDIVIDUAL PERFORMANCE PLAN

This form is to be completed prior to the start of your internship experience. This form must be signed by both your program supervisor and your on-site supervisor.

Student name _____________________ Address __________________________
Phone ____________________________ SSN ______________________________
Name of site __________________________ Location ______________________
Name of site supervisor _________________________ Phone ________________
Internship beginning date _______________ Ending date ___________________

How does your plan meet the needs of the internship site and your program requirements? Discuss. __________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Please list the activities that you will be doing during your internship.
Individual counseling __________ Group counseling __________
Intake interviewing __________ testing __________ consulting __________
Administrative duties _______________ Other (describe) _________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

What areas do you see as your strengths and weaknesses?
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
Discuss specific cognitive skills and performance skills that you want to enhance during your internship experience.

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

What are your specific objectives you plan on accomplishing during your internship? Discuss. __________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Discuss the formative and summative measures that will be used to assess your performance in the internship. __________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Summary: _____________________________________________________________
____________________________________________________________________
____________________________________________________________________

Program supervisor _______________ Date ________________
On-site supervisor _______________ Date ________________
**INTERNSHIP LOG**

**Directions:**
1. Record the dates of each week at the site where indicated.
2. Record the total number of hours per week for each activity under the appropriate column.
3. Total the number of hours for the week at the bottom of the week's column.
4. At the end of the month, total the hours spent in each activity by adding the hours across each activity; indicate the total in the monthly totals column.
5. Get the supervisor's signature. Keep this in your file to be submitted to the university internship coordinator at the completion of the internship.

<table>
<thead>
<tr>
<th>Activities</th>
<th>Week 1 From: To:</th>
<th>Week 2 From: To:</th>
<th>Week 3 From: To:</th>
<th>Week 4 From: To:</th>
<th>Monthly totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake interview</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual counseling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group counseling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family counseling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consulting/ intervention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychoeducation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Career counseling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report writing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case conference</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervision</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weekly totals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Intern's name __________________________ Date __________________________

Address _______________________________ Address ________________________
**STUDENT EVALUATION FORM**

**Directions:** The site supervisor is to complete this form in duplicate. One copy is to go to the student; the other copy is sent to the faculty liaison. The areas listed below serve as a general guide for the activities typically engaged in during counselor/psychologist training. Please rate the student on the activities in which he or she has engaged using the following scale:

- **A** = Functions extremely well and/or independently.
- **B** = Functions adequately and/or requires occasional supervision.
- **C** = Requires close supervision in this area.
- **NA** = Not applicable to this training experience.

<table>
<thead>
<tr>
<th>Student name</th>
<th>Supervisor signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Site</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Training Activities**

- [ ] 1. Intake interviewing
- [ ] 2. Individual counseling/psychotherapy
- [ ] 3. Group counseling/psychotherapy
- [ ] 4. Testing: Administration and interpretation
- [ ] 5. Report writing
- [ ] 6. Consultation
- [ ] 7. Psychoeducational activities
- [ ] 8. Career counseling
- [ ] 9. Family/couple counseling
- [ ] 10. Case conference or staff presentation
- [ ] 11. Other (please list) ______________________________
        ____________________________________
        ____________________________________
        ____________________________________

Form 12.2, p. 1 of 2
Compared with other graduate students in counseling at this level of training and experience, this student performs at the following level (check) one:

- [ ] 99th %ile
- [ ] 80th %ile
- [ ] 60th %ile
- [ ] 40th %ile
- [ ] 20th %ile

**Additional Comments**

Please use the additional space for any comments that would help us evaluate the student's progress. Student may comment upon exceptions to ratings, if any.
CLIENT’S PERSONAL/SOCIAL SATISFACTION WITH COUNSELING ASSESSMENT*

Client name ___________________  Counselor name ________________________
Client ID number _________  Counselor ID number ________________________
Date ____________________

Directions: Please read each of the following questions carefully and circle the response for each one that most nearly reflects your honest opinion.

1. How much help did you get with your concern?  
   1. None  
   2. A little  
   3. Some  
   4. Much  
   5. All I needed

2. How satisfied are you with the relationship with your counselor?  
   1. Not at all  
   2. Slightly  
   3. Some  
   4. Pretty well  
   5. Completely

3. How much help have you received with concerns other than your original reasons for entering counseling?  
   1. None  
   2. A little  
   3. Some  
   4. Much  
   5. All I needed

4. How do you feel now compared to when you first came to counseling?  
   1. Much worse  
   2. A little worse  
   3. The same  
   4. Quite a bit better  
   5. Greatly improved

5. How much has counseling helped you in understanding yourself?  
   1. None  
   2. A little  
   3. Moderately  
   4. Quite a bit  
   5. Greatly

6. How willing would you be to return to your counselor if you wanted help with another concern?  
   1. Unwilling  
   2. Reluctant  
   3. Slightly inclined  
   4. Moderately willing  
   5. Very willing

* Used by permission from Dr. Roger Hutchinson, professor of psychology-counseling and director, Counseling Practicum Clinic, Department of Counseling Psychology and Guidance Services, Ball State University. This form originally was printed in chapter 10 of the Practicum Manual for Counseling and Psychology, 1980, by K. Dimick and F. Krause. Muncie, IN: Accelerated Development.
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
</table>
| 7. How willing would you be to recommend your counselor to one of your friends? | 1. Unwilling  
2. Reluctant  
3. Slightly inclined  
4. Moderately willing  
5. Very willing |
| 8. How much did your counselor differ from what you might consider to be an ideal counselor? | 1. Greatly  
2. In many ways  
3. Somewhat  
4. A little  
5. Not at all |
| 9. Based on your experience at this clinic, how competent did you judge the counselors to be? | 1. Incompetent  
2. Little competence  
3. Moderately competent  
4. Competent  
5. Highly competent |
| 10. To what extent could the relationship you had with your counselor have been improved? | 1. Greatly  
2. Quite a bit  
3. Moderately  
4. Slightly  
5. Not at all |
| 11. How sensitive was your counselor to the way you felt? | 1. Insensitive  
2. Slightly insensitive  
3. Sometimes sensitive  
4. Usually sensitive  
5. Very sensitive |
| 12. To what extent do you still lack self-understanding about things that trouble you? | 1. Great  
2. Quite a bit  
3. Moderate  
4. Slight  
5. Not at all |
| 13. If counseling were available only on a fee-paying basis, how likely would you be to return if you had other concerns? | 1. I would not return  
2. It would be unlikely for me to return  
3. I might return  
4. I probably would return  
5. I would return |
| 14. In general, how satisfied are you with your counseling experience? | 1. Not satisfied  
2. Moderately dissatisfied  
3. Slightly satisfied  
4. Moderately satisfied  
5. Completely satisfied |
| 15. What was the technique most used by your counselor? | 1. Left it to me  
2. Interested listener  
3. Gave opinions and suggestions  
4. Gave interpretations  
5. Counselor was vague and unclear |
16. Give your reactions while being counseled.

1. Found it unpleasant and upsetting at times
2. Found it very interesting, enjoyed it
3. Got angry often at my counselor
4. Often felt discouraged at lack of progress
5. Felt relaxed and looked forward to sessions
6. Felt that I could not get my story across, that I couldn’t get the counselor to understand me
**STUDENT COUNSELOR EVALUATION OF SUPERVISOR**

**Suggested use:** The practicum or internship supervisor can obtain feedback on the supervision by asking student counselors to complete this form. The evaluation could be done at midterm and/or final. The purposes are twofold: (1) to provide feedback for improving supervision and (2) to encourage communication between the supervisor and the student counselor.

**Directions:** The student counselor is to evaluate the supervision received. Circle the number that best represents how you, the student counselor, feel about the supervision received. After the form is completed, the supervisor may suggest a meeting to discuss the supervision desired.

Name of practicum/internship supervisor ____________________________

Period covered: from ______________________ to ______________________

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Poor</th>
<th>Adequate</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Gives time and energy in observations, tape processing, and case conferences.</td>
<td>5 6</td>
<td>1 2</td>
<td>3 4</td>
</tr>
<tr>
<td>2.</td>
<td>Accepts and respects me as a person.</td>
<td>5 6</td>
<td>1 2</td>
<td>3 4</td>
</tr>
<tr>
<td>3.</td>
<td>Recognizes and encourages further development of my strengths and capabilities.</td>
<td>5 6</td>
<td>1 2</td>
<td>3 4</td>
</tr>
<tr>
<td>4.</td>
<td>Gives me useful feedback when I do something well.</td>
<td>5 6</td>
<td>1 2</td>
<td>3 4</td>
</tr>
<tr>
<td>5.</td>
<td>Provides me the freedom to develop flexible and effective counseling styles.</td>
<td>5 6</td>
<td>1 2</td>
<td>3 4</td>
</tr>
<tr>
<td>6.</td>
<td>Encourages and listens to my ideas and suggestions for developing my counseling skills.</td>
<td>5 6</td>
<td>1 2</td>
<td>3 4</td>
</tr>
<tr>
<td>7.</td>
<td>Provides suggestions for developing my counseling skills.</td>
<td>5 6</td>
<td>1 2</td>
<td>3 4</td>
</tr>
<tr>
<td>8.</td>
<td>Helps me understand the implications and dynamics of the counseling approaches I use.</td>
<td>5 6</td>
<td>1 2</td>
<td>3 4</td>
</tr>
<tr>
<td>9.</td>
<td>Encourages me to use new and different techniques when appropriate.</td>
<td>5 6</td>
<td>1 2</td>
<td>3 4</td>
</tr>
<tr>
<td>10.</td>
<td>Is spontaneous and flexible in the supervisory sessions.</td>
<td>5 6</td>
<td>1 2</td>
<td>3 4</td>
</tr>
<tr>
<td>11.</td>
<td>Helps me define and achieve specific concrete goals for myself during the practicum experience.</td>
<td>5 6</td>
<td>1 2</td>
<td>3 4</td>
</tr>
<tr>
<td>12.</td>
<td>Gives me useful feedback when I do something wrong.</td>
<td>5 6</td>
<td>1 2</td>
<td>3 4</td>
</tr>
<tr>
<td>13.</td>
<td>Allows me to discuss problems I encounter in my practicum setting.</td>
<td>5 6</td>
<td>1 2</td>
<td>3 4</td>
</tr>
</tbody>
</table>

* Printed by permission from Dr. Harold Hackney, assistant professor, Purdue University. This form was designed by two graduate students based on material drawn from Counseling Strategies and Objectives, by H. Hackney and S. Nye, 1973. Englewood Cliffs, NJ: Prentice Hall. This form originally was printed in chapter 10 of the Practicum Manual for Counseling and Psychotherapy, by K. Dimick and F. Krause, 1980. Muncie, IN: Accelerated Development.
14. Pays appropriate amount of attention to both my clients and me. 1 2 3 4 5 6
15. Focuses on both verbal and nonverbal behavior in me and in my clients. 1 2 3 4 5 6
16. Helps me define and maintain ethical behavior in counseling and case management. 1 2 3 4 5 6
17. Encourages me to engage in professional behavior. 1 2 3 4 5 6
18. Maintains confidentiality in material discussed in supervisory sessions. 1 2 3 4 5 6
19. Deals with both content and effect when supervising. 1 2 3 4 5 6
20. Focuses on the implications, consequences, and contingencies of specific behaviors in counseling and supervision. 1 2 3 4 5 6
21. Helps me organize relevant case data in planning goals and strategies with my client. 1 2 3 4 5 6
22. Helps me to formulate a theoretically sound rationale of human behavior. 1 2 3 4 5 6
23. Offers resource information when I request or need it. 1 2 3 4 5 6
24. Helps me develop increased skill in critiquing and gaining insight from my counseling tapes. 1 2 3 4 5 6
25. Allows and encourages me to evaluate myself. 1 2 3 4 5 6
26. Explains his or her criteria for evaluation clearly and in behavioral terms. 1 2 3 4 5 6
27. Applies his or her criteria fairly in evaluating my counseling performance. 1 2 3 4 5 6

ADDITIONAL COMMENTS AND/OR SUGGESTIONS

______________________________  ______________________________
Date                          Signature of practicum student/intern

My signature indicates that I have read the above report and have discussed the content with my supervisee. It does not necessarily indicate that I agree with the report in part or in whole.

______________________________  ______________________________
Date                          Signature of supervisor

Form 12.4, p. 2 of 2
SITE EVALUATION FORM

Directions: The student completes this form at the end of the practicum and/or internship. This should be turned in to the university supervisor or internship coordinator as indicated by the university program.

Name ___________________________  Site ______________________________
Dates of placement ________________  Site supervisor __________________
Faculty liaison ______________________

Rate the following questions about your site and experiences with the following scale:

A. Very satisfactory  B. Moderately satisfactory  C. Moderately unsatisfactory  D. Very unsatisfactory

1. ______  Amount of on-site supervision
2. ______  Quality and usefulness of on-site supervision
3. ______  Usefulness and helpfulness of faculty liaison
4. ______  Relevance of experience to career goals
5. ______  Exposure to and communication of school/agency goals
6. ______  Exposure to and communication of school/agency procedures
7. ______  Exposure to professional roles and functions within the school/agency
8. ______  Exposure to information about community resources
9. ______  Rate all applicable experiences that you had at your site:
   ______   Report writing
   ______   Intake interviewing
   ______   Administration and interpretation of tests
   ______   Staff presentation/case conferences
   ______   Individual counseling
   ______   Group counseling
   ______   Family/couple counseling
   ______   Psychoeducational activities
   ______   Consultation
   ______   Career counseling
   ______   Other __________________________

10. ______  Overall evaluation of the site

Comments: Include any suggestions for improvements in the experiences you have rated moderately (C) or very unsatisfactory (D).
Practicum and Internship
Textbook and Resource Guide for Counseling and Psychotherapy

“This book is important to counselor educators and others who seek an empirical model for the overall clinical experience of counseling students. Boylan and Scott apply relevant research findings to inform us of how distinctively defined a supervised clinical learning experience must be in counselor education programs.”

—Jack L. Shortridge, EdD, Regional Counseling Director, Webster University

“Drs. Boylan and Scott’s revised edition is an incredible compendium of both necessary and essential information for the Practicum and Internship counseling student. It provides students with a concise and in-depth review of the critical knowledge and skills vital to their field competencies. Given the masterful integration of theory and practice, I recommend this book for adoption in Practicum and Internship courses in any and all CACREP Counseling Programs.”

—John J. Lemoncelli, EdD, Assistant Chair and Professor, Psychology and Counseling Department, Marywood University

About the Book

Completely revised and updated, the fourth edition of Practicum and Internship continues in the tradition of the previous editions as a popular and highly useful textbook and resource guide. It continues to be a comprehensive resource for students and their supervisors throughout the counseling and psychotherapy process, providing thorough coverage of both the theoretical and practical aspects of the practicum and internship process.

This text guides students through the important pre-professional training experiences, from the selection of an appropriate practicum site to the final evaluation of the internship. Organizing the content into four sections for clarity and ease of use, the authors discuss all the relevant information regarding the practicum experience, preparation for the internship, the internship experience and evaluation, and important ethical and legal considerations.

New in this edition are a listing and description of the various counseling theories and techniques; a section on crisis intervention and response; detailed guidelines for school mental health consultation; and forms for evaluating performance, cognitive, and consulting skills.

Forms are provided at the end of the book for the student’s use in site selection, assessment, client treatment, and performance feedback and evaluation. These forms are also included in electronic format on an accompanying CD to allow students to modify and reuse them.

About the Authors

John C. Boylan, Ph.D., is currently teaching part time in the Department of Psychology and Sociology at Coastal Carolina University in Conway, South Carolina, and the Graduate Counseling Program at Webster University in Myrtle Beach, South Carolina. He is a licensed psychologist, certified school counselor, and certified sex therapist.

Judith Scott, Ph.D., is a licensed psychologist and Professor Emeritus of the Department of Psychology in Education at the University of Pittsburgh. Dr. Scott maintains a private practice that specializes in outpatient individual psychotherapy in women’s issues and fertility counseling.