PSY 6940/7940
Summer Therapy Practicum
Summer 2015

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Office: University Hall, Room 5280
Class Hours: Tuesdays 0800-1030, and by appointment
Location: UH6400
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It is expected that each student has read and thoroughly understands the APA Ethical Guidelines and the UT clinic manual.

Objective of Course:

The purpose of this course is for students to competently deliver treatment based on theory and empirical evidence This course will teach students how to implement skills in 1) assessing and diagnosing adult mental health outpatients, using standardized testing and structured diagnostic interviews, and 2) conduct evidence-based treatment using a cognitive-behavioral or interpersonal psychotherapy orientation Students will learn how to complete appropriate psychological reports and other required paperwork This course will involve bi-weekly group supervision and individual supervision on the off weeks

Specific Course Objectives:

Students finishing their second year should be able to

1. know how to choose an appropriate evidenced based treatment for each client
2. know when to seek supervision
3. know when to refer (with supervision) to other professionals.
4. Complete and forward progress notes within 24 hours from the associated session
5. complete intake summaries in a timely manner (i e , 1-3 sessions) A complete intake would include (1) a diagnostic evaluation (i e , you should be able to arrive at an appropriate diagnosis and rule-out related diagnoses), (2) a preliminary case conceptualization based on relevant theory, (3) treatment goals stated in measurable terms, and (4) a preliminary treatment plan derived from theory and research Students are to utilize the Clinic's Intake Summary Template
6. provide feedback to clients after completion of the intake This would include making sure that client understands the treatment plan, and the rationale behind the treatment plan and that there is agreement between the client and therapist on the goals and treatment plan The student should also know how to handle situations in which reasonable agreement cannot be reached
7. track and use outcome data to inform treatment
8. set an agenda with a client for a session

9 arrive at appropriate homework assignments in consultation with supervision team
10 use the literature to come to supervision with ideas for treatment planning
11 implement evidence based interventions and techniques as appropriate to client problem/goals at a beginner level

In addition to the skills for second year students, third year students should be able to
1 implement evidence based interventions as appropriate to client problem/goals at a more advanced level (e g , restructuring of core beliefs as opposed to only automatic thoughts)
2 work with client resistance or lack of client motivation in a way that is productive (at a beginner level)
3 *begin to be able to use unexpected session material (e g , crises) as a way to* achieve short and long-terms goals (i e , session goals and treatment goals) rather than allowing these events to result in a "nonproductive" session.
4 begin to develop plausible treatment plans based on theory and case conceptualization when evidenced based treatments are not available or have failed
5 know how to terminate treatment effectively and at an appropriate time (with *supervision*)

In addition to the skills for third year students, fourth and fifth year students should
1 be able to work with client resistance or lack of client motivation in a way that is productive (at a more advanced level)
2 be able to use unexpected session material (e g , crises) as a way to achieve short and long-terms goals (i e , session goals and treatment goals) rather than *allowing these events to result in a "nonproductive" session at a more advanced* level
3 complete the following readings and write a 2-page double spaced paper on your reaction to the readings and outline your approach to supervising supervisees readings and/or handouts will be provided periodically throughout the course

Training Goals:
All students are also expected to develop one or two training goals for themselves and to develop a plan, in consultation with the supervisory team, for meeting these goals Your training goal(s) should be developed to address a skill you know you need to work on An appropriate training goal is one that you could work on with the client(s) you are seeing or expect to see this semester and one that should help you across clients Remember, this goal is about your behavior, not your client's behavior Examples might include learning to end a session in a way that is productive or how to keep a session "on track" You should come to the second meeting prepared to discuss your goal(s) with the supervisory team

Attendance and Class Preparation Policy:
Attendance and participation is required If you are unable to attend a supervision meeting than you are required to email me in advance Please do not arrive late to meetings

We will be functioning as a supervisory *team* This means that you are responsible not only for the clients you are seeing but also for providing meaningful input on the cases being seen by everyone on the practicum team and for using supervision from the

instructor and your peers Supervision will involve diagnostic and assessment supervision of patient intakes, staffing of new cases, and other case presentations, as well as treatment supervision for discussing ongoing treatment cases, and review of audiotaped or videotaped patient sessions

Students are expected to come to each class meeting prepared to

1 Give a brief (less than 5 minutes) synopsis of each case
2 Present outcome data for each case
3 **Show a videotape of each case.** You should be prepared (i e , have tape cued) to show tape of a point in session where the student experienced a problem (you want feedback) or to a place where you feel that things went well and you want the practicum team to be able to use your experience as a model
4 Submit paperwork
5 Submit completed Practicum Supervisor Log Book form

Progress Notes and Reports:
SOAP note format is required for all sessions You may not have a firm plan when you write the note (and we may change the plan after supervision) but you are expected to attempt to write a brief plan on your own

All paperwork should be completed prior to supervision This means that progress notes/reports for any session that took place or was scheduled to take place since the last class should be prepared prior to class Please note there should be a note in the file for every contact you have for a case (e g , if a client no shows, if you or the client cancels/reschedules an appointment, if you speak to the client (or anyone else regarding the client) on the phone)

You are required to complete intake summaries within 1-3 sessions, the treatment plan by the 4th session, quarterly summaries every 3 months from the first session, and termination/transfer summaries upon closure of cases Completion includes presentation to and discussion with the supervisor, with final revisions made before the deadline These timelines are in accordance with Clinic policies and procedures

No Show, Cancellation, and Late Arrival Policy:
You and your client must come to a recognition from the outset of treatment that therapeutic progress will be significantly hampered by inconsistent attendance Moreover, a client's failure to consistently attend sessions effectively robs you of an opportunity for training. Therefore, clients who have three "no call - no shows" in a semester will be terminated from treatment and will need to go back on the clinic wait-list if they wish to continue services The same is true for clients who consistently (i e , 3 or more times a semester) cancel sessions without rescheduling for the same week Client's who arrive more than 15 minutes late for a session should be asked to reschedule (and this would count as a cancellation) Exceptions, based on extenuating circumstances, will be made rarely so make sure you client is aware of these policies

Requirements and Grading:
Your grade will be based on participation, completion of paperwork (quality and timeliness) and your mastery of the goals outlined above

Progress notes will be completed within 24 hours of an associated appointment

Clinical contacts (e g. telephone contacts) require a note to be entered into the client's chart, and this note should be completed the same day of the contact Intake Summaries, Treatment Plans, Quarterly Summaries, and Termination/Transfer Summaries are to be completed within the timeframes stated earlier in this document (see Progress Notes and Reports)

The first time you do not comply with these timeframes you will receive a verbal and written warning. After the first infraction, each and every infraction will result in a half-letter grade reduction.

A special note about paperwork/client files As you know, client files contain personal, protected health-care information You should take your responsibility in caring for these files very seriously The Clinic uses an electronic health record (EHR) and this will serve as the primary location of your patient charts In the situation that a patient requires a paper chart (i e., raw testing data must be kept) ALL PAPER FILES SHOULD BE STORED IN THE FILE CABINET IN THE WORKROOM NO FILE SHOULD EVER LEAVE THE CLINIC OR BE STORED IN AN OFFICE/LAB IF AT ANY TIME ONE OF YOUR FILES CANNOT BE FOUND IN THE CLINIC AT THE END OF THE DAY OR IF IT IS DETERMINED THAT YOU HAVE REMOVED A FILE FROM THE CLINIC, YOU WILL RECEIVE AN "F" FOR THIS COURSE

Individual Supervision:
Individual supervision will be scheduled bi-weekly on off weeks from group supervision If you feel that you need additional supervision it is your responsibility to make me aware of this need and persist until your need is met

Individual supervision for 2nd (or in some cases 3rd year) students may be performed by a 4th year student Within the first two weeks of class, bring to my attention your desire and interest in receiving applied training in supervision, and although not guaranteed, we will explore the potential of offering this to you

Emergency Situations:
In an emergency you should first try to get in touch with me I can be contacted at 419 290 8489(cell) If you are unable to get in touch with me you should contact Dr Jon Elhai 419 266 6662 Your third option is contacting the main office and/or clinic office (x2717, x2721) Sabrina Nabors, the Clinic Manager, may be able to provide assistance in contacting a clinical supervisor Finally, calling 911 is an option

Evaluations:
We will complete the clinic practicum evaluation form at the end of the summer session that you are enrolled in It is your responsibility to arrange a time at the end of the semester to complete and review this evaluation Remember, these evaluations are formative, they are meant to give you feedback to further your development as a clinician

I may also ask you at times to obtain feedback from your client(s) using the attached evaluation form This form should be returned directly to me in a sealed envelope You may also decide to use this form to obtain feedback from your client at any time

Note: This syllabus may be appended by the instructor if necessary. Students are responsible for any changes made

EVALUATION FORM

1. Do you understand your treatment plan and why your therapist has recommended this treatment plan?

2. Did the therapist explain to you what you were going to do in the session and why?

   Were you encouraged to ask questions and, if so, were they answered to your satisfaction?

3. Do you feel like you accomplished something in session today (moved toward your treatment goals)?

4. Do you feel comfortable with your therapist?

   What does he/she do to make you feel comfortable?

   What could he/she do to make you feel more comfortable?

5. Is your the therapist professional? Do you trust this person with your healthcare needs? (please give examples of professional or nonprofessional behavior)

6. What other information do you think is important for the therapist to know?

7. What, if anything are you supposed to do before your next session.

EXAMPLE OF A SOAP NOTE

Client: Madeline
Date: January XX, XXXX

Session 1

S Madeline (26yo F) presents for initial visit for depression. PT sx include: low mood, anhedonia, irritability, hypersomnia, psychomotor retardation, fatigue, and rumination. PT reported that symptoms began approx. 8 months ago following relocation out of state for work, with gradual increasing severity, along with ongoing stressors (work stress, relationship stress). Rumination, fatigue, and anhedonia are PT's primary sx complaint; and attempted coping includes distraction, frequent naps, social isolation from significant other has proven maladaptive per PT report. PT reports no past/current psychological or medical complaints or Tx for presenting issue.

Treatment Interventions Used: Supportive Psychotherapy

O
Orientation & Cognition: Oriented x3. Thought processes normal and appropriate to situation.
Mood, Affect: mildly depressed, affect appropriate to situation.
Appearance: Normal.
Harm to self or others: Denied SI/HI.
Substance abuse: Not assessed.
Medication use: diphenhydramine 25mg. qhs prn

A Client diagnosed with Major Depressive Disorder - moderate, primary complaint rumination and fatigue, with very limited effective coping repertoire. PT would benefit from CBT for depression, emphasizing CT and BA components, consider adjunctive SSRI. PT motivated for CBT treatment

P
1. Follow-up: weekly sessions of time-limited CBT, emphasize CT and BA
2. Medication Plan: consider SSRI, provide psychoeducation
3. Behavioral Plan: review handout on CBT & come to session 2 with questions; self monitoring form of NATs

Comment [JL1]: Session #

Comment [JL2]: First visit or follow-up visit for chief complaint/diagnosis/problem

Comment [JL3]: Symptoms and chief complaint

Comment [JL4]: Timeline of symptoms with co-occurring stressors

Comment [JL5]: target symptoms and coping strategies and their effect

Comment [JL6]: 3-6 sentences max

Comment [JL7]: What is going on and WHY you think it is happening Integrates S and O and presents where treatment should proceed and tied into patient motivation

Comment [JL8]: State disorder or impression target symptoms, and why symptoms persist

Comment [JL9]: Identify empirically-supported treatment or evidence-based treatment approach

General Practicum Supervision Log Book

Therapist: **Supervision Date:**

Supervisor: **Type of Supervision:**

Client Caseload

Clinical activity (e.g. client contact during past week):

Brief record of content of discussions:

Plan for follow-up activity and/or next supervision session:

Comments regarding therapist's clinical competency and professional development: