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Part I

Advanced Internship Program
The Advanced Internship Training Introduction

Students beginning Advanced Internship are expected to be on a site and currently seeing clients on a regular basis. Clients can consist of individuals, two or people in a relationship or a group. During this time the total hours needed to graduate will be completed. If the hours are not completed by the end of #597.3 additional internship courses will have to be taken to get credit for the additional logged hours.

Advanced Internship training includes Internship courses # 597.1, 597.2, 597.3 and #598. Orientation to Advanced Internship is required prior to attending #597.1. Student Services should be contacted to sign up for the orientation. Students are encouraged to meet with the Director of Student Services to review readiness for starting Advanced Internship.

Various forms are required for these courses and are located in the forms section.

- Advanced Internship (#597.1, 597.2 & 597.3): In the second year when taking Advanced Internship, students are required to have an active caseload of clients. A minimum of one new client presentation, (two preferred) must be presented for each section. A different case should be used for each course. Each course is one credit (one course per term) and is taken over three-three month terms. Students starting Advanced Internship must demonstrate that they are applying the techniques learned throughout the AGS program. If a student does not have the required clients, he or she takes additional intermediate courses until this requirement is met. These courses are graded Pass/Retake based on meeting all course requirements.

- Individual Clinical Instruction: Advanced students are also required to take course #598 in which they receive direct Internship from an AGS Clinical Instructor. This can be done any time following the completion of the first Advanced Internship course #597.1. Students work with one case over many weeks along with instruction by a clinical instructor.

Instructions for filling out the logs are found preceding the logs in the forms section.

Additional Requirements and Policies

Students must complete the Pre-Counseling Learning Contract with the supervisor when entering a new site. The form must be turned in to Student Services. The form is found in the forms section.
Malpractice insurance Requirement:

It is required that students purchase professional malpractice insurance upon entering the program and provide documented proof at each course registration. Forms are available at AGS from student services or in the Library or on line at AAMFT.org.

Confidential Case Materials Policy and Requirement:

AGS students follow ethical guidelines in course papers or where sharing client information in class when they use information obtained from clients or patients.
All students are responsible for knowing, understanding, and following this policy. Students who violate this policy may be subject to review. The policy is inserted below.

Pre-MA Degree/Pre-Licensed Private Clinical Practice by AGS Students:

The Adler Graduate School (AGS) strongly discourages private practice by AGS students who have not yet earned a counseling-related Master’s Degree. In general, AGS will not allow students engaged in their own private practices to use those experiences to satisfy AGS’ practicum/internship requirements.
September 2010

Policy on Student Use of Patient/Client Information:

AGS students are expected to adhere to the applicable ethical guidelines put forth by the American Association for Marriage and Family Therapy (AAMFT) and the American Counseling Association (ACA).

From time to time, students present to instructors and/or fellow students confidential client information, they have learned through their internships or other clinical settings. In presenting such information, students must follow AAMFT and ACA standards. For example, students should be familiar with AAMFT principle 2.3 which states:

“Marriage and family therapists use client and/or clinical materials in teaching, writing, consulting, research, and public presentations only if a written waiver has been obtained in accordance with sub-principle 2.2, or when appropriate steps have been taken to protect client identity and confidentiality.”

AGS considers information to be “protected” or "disguised" within the meaning of these guidelines, if there is no reasonable basis to believe that the information could be used to identify any individual and if the following steps are taken:

1. Last and first names are removed or changed.
2. Geographic references (such as references to the city and street address) are removed or changed.
3. All dates directly related to the individual are changed or removed, including birth date, admission date, discharge date, and age.
4. Any numbers that could be used to identify the individual are removed, such as social security numbers, telephone numbers, fax numbers, patient numbers, account numbers, medical records numbers, or any other unique identifying number or code.
5. Computer information such as e-mail addresses, URLs, and Internet Protocol numbers are removed.
6. All photographic images are removed.
7. All other information, which could reasonably be used to identify the individual, is removed or changed.

If students have questions regarding whether they have adequately disguised a client/patient, student, research participant, or organizational client, they must contact an AGS Clinical Instructor or the AGS Academic Vice President to discuss the situation.

Written and/or recorded materials containing confidential client information learned at an internship or other clinical setting is destroyed in a confidential manner (i.e. shredded and/or erased) once they have been used and are no longer necessary. In addition, confidential information about a client/patient should not be preserved in written documents (such as a Master's Project or class paper) unless the information is properly disguised and the client or patient has given written authorization for the use of such information.

Philosophy and Process Concerning Avoidance of Dual Relationships and Conflicts of Interest in the Implementation of AGS’ Internship Program

- AGS wants students to be exposed to a number of internship opportunities, including private practices and, more specifically, private practices run by Adlerian-trained clinicians.
- All AGS faculty members, staff and key volunteers (e.g., Board members) will fill out the Conflict of Interest Disclosure Statement associated with the School’s Conflict of Interest Policy.
- Everyone must watch for dual relationships that reflect power imbalances and other conflicts of interest – e.g., an internship host that is also a student’s classroom teacher.
- We acknowledge that not all dual relationships or other conflicts of interest are significant enough to be considered problems and not of sufficient intensity that they necessitate avoidance or dissolution. Some of these relationships are merely one AGS representative/partner providing two unique and valuable services, as opposed to being exploitive.
- When dual relationships are seen or other conflicts of interest that do require special attention, they must be considered on an individual basis to determine which ones are the types of dual relationships that should be avoided. This is addressed in the very comprehensive Conflict of Interest Policy.
- This process will insure a transparent process that protects both instructors/partners and students from power imbalances that might otherwise be improperly managed. This process will put those dual relationships and other conflicts of interest in the “light of day” so that the rare “bad” situations that should not occur are avoided.
- Although AGS’ control is limited and our relationships with internship hosts are largely based on the honor system, once host sites have been deemed qualified and once potential
conflicts of interest have been reviewed and deemed to not be an impediment to a relationship with AGS, the School will strive to provide oversight that will help in the anticipation and prevention of problems (e.g., internship hosts are not misinterpreting/mishandling billing for services provided by interns; internship hosts are not doing anything that is or will be perceived as financially exploitive; interns are not providing services in a fashion that will cause problems with Boards – now or in the future).
Licensing Internship plan for a regular **21 month program** (requires approximately an average of 6 hours a week on site.) Internship requirements are 6 credits obtained in conjunction with coursework while at the site. If coursework is complete and hours are not, then extra internship credits will be needed. The way the plan is executed will determine how financial aid will work. This plan is suited for those who begin interning in the first term.

<table>
<thead>
<tr>
<th>Term 1</th>
<th>Term 2</th>
<th>Term 3</th>
<th>Term 4</th>
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<tbody>
<tr>
<td>Internship</td>
<td>Course 591</td>
<td>Internship</td>
<td>Course 592</td>
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**Term 5**  
Course 597  
**Advanced Internship**  
15 hours  
1 credit  
One case study is required

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<tr>
<th>Term 6</th>
<th>Term 7</th>
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<tbody>
<tr>
<td>Course 597</td>
<td>Course 597</td>
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<tr>
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<td>Advanced Internship</td>
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<td>15 hours</td>
<td>15 hours</td>
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<tr>
<td>1 credit</td>
<td>1 credit</td>
</tr>
<tr>
<td>One case study is required</td>
<td>This course may be taken in Term 6 if hours will be done</td>
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</table>

Course 598, Individual Clinical Instruction may be taken as soon as 1 597 Advanced Internship class is completed.

LMFT students must complete 500 hours; 200 peer; 300 therapy with a minimum of 150 of the 300 as family or relationship hours.

LPC students must complete 700 hours; 550 peer and 150 therapy.

Dual licenses require 700 hours with 300 therapy and a minimum of 150 as relationship hours.  
Art therapy students must complete 700 hours with 350 as Art therapy.
Licensing Internship plan for a regular **18 month program** (requires approximately an average of 7 hours a week on site.) Internship requirements are 6 credits obtained in conjunction with coursework while at the site. If coursework is complete and hours are not then extra internship credits will be needed and it might take longer to graduate. The way the plan is executed will determine how financial aid will work. This plan is suited for those who begin interning in the first term and may be already in the field. This is the shortest time frame for the MA degree. Extra time may be needed to accumulate required relationship hours for MFT licensure.

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<th>Term 1</th>
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<tr>
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<td>Course 593 and 594</td>
<td>Course 597</td>
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<td>Internship</td>
<td>Internship</td>
<td>Advanced Internship</td>
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<th>Term 5</th>
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<td>Course 597</td>
<td>Course 597</td>
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<td>Advanced Internship</td>
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<td>1 credit</td>
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<tr>
<td>One case study is required</td>
<td>One case study is required</td>
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</table>

- Course 598, Individual Clinical Instruction may be taken as soon as 1597, Advanced Internship class is completed
- LMFT students must complete 500 hours; 200 peer; 300 therapy with a minimum of 150 of the 300 as family or relationship hours.
- LPC students must complete 700 hours; 550 peer and 150 therapy.
- Dual licenses require 700 hours with 300 therapy and a minimum of 150 as relationship Hours.
- Art therapy students must complete 700 hours with 350 as Art therapy.
Licensing Internship plan for a regular **21 month program** (requires approximately an average of 5 hours a week on site.) Internship requirements are 6 credits obtained in conjunction with coursework while on site. If coursework is complete and hours are not, then extra internship credits will be needed. The way the plan is executed will determine how financial aid will work. This plan is suited for those who begin interning in the second term who wish to finish in 21 months.

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<th>Term 2</th>
<th>Term 3</th>
<th>Term 4</th>
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<tr>
<td>No internship site</td>
<td>Course 591 Internship</td>
<td>Course 592 Internship</td>
<td>Course 593 and 594 Internship</td>
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<tr>
<td>One case study is required</td>
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<td>One case study is required</td>
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</table>

- Course 598, Individual Clinical Instruction may be taken as soon as one 597, Advanced Internship class is completed.
- LMFT students must complete 500 hours; 200 peer; 300 therapy with a minimum of 150 of the 300 as family or relationship hours.
- LPC students must complete 700 hours; 550 peer and 150 therapy.
- Dual licenses require 700 hours with 300 therapy and a minimum of 150 as relationship hours.
- Art therapy students must complete 700 hours with 350 as Art therapy.
Licensing Internship plan for a regular **21 month program** (requires approximately an average of 6 hours a week on site.) Internship requirements are 6 credits obtained in conjunction with the time spent taking classes. I coursework is complete and hours are not the extra internship credits will be needed. The way the plan is executed will determine how financial aid will work. This plan is suited for those who begin interning in the first term.

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<th>Term 1</th>
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<th>Term 3</th>
<th>Term 4</th>
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</thead>
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</table>

- Course 598, Individual Clinical Instruction may be taken as soon as 1 597, Advanced Internship class is completed.
- LMFT students must complete 500 hours; 200 peer; 300 therapy with a minimum of 150 of the 300 as relationship hours.
- LPC students must complete 700 hours; 550 peer and 150 therapy.
- Dual licenses require 700 hours with 300 therapy and a minimum of 150 as relationship hours.
- Art therapy students must complete 700 hours with 350 as Art therapy.
Licensing Internship plan for a regular **24 month program** (requires approximately an average of 5 hours a week on site.) Internship requirements are 6 credits obtained in conjunction with coursework while on site. If coursework is complete and hours are not, then extra internship credits will be needed. The way the plan is executed will determine how financial aid will work. This plan is suited for those who begin interning in the second term who wish to finish in 24 months.

<table>
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<tr>
<th>Term 1</th>
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<th>Term 3</th>
<th>Term 4</th>
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</thead>
<tbody>
<tr>
<td>No internship site</td>
<td>Course 591 Internship 7.5 hours ½ credit</td>
<td>Course 592 Internship 7.5 hours ½ credit</td>
<td>Course 593 Internship 7.5 hours ½ credit</td>
</tr>
<tr>
<td>Term 5</td>
<td>Term 6</td>
<td>Term 7</td>
<td>Term 8</td>
</tr>
<tr>
<td>Course 594 Internship 7.5 hours ½ credit One case study is required</td>
<td>Course 597 Advanced Internship 15 hours 1 credit One case study is required</td>
<td>Course 597 Advanced Internship 15 hours 1 credit One case study is required</td>
<td>Course 597 Advanced Internship 15 hours 1 credit One case study is required</td>
</tr>
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</table>

- Course 598, Individual Clinical Instruction may be taken as soon as 1 597, Advanced Internship class is completed.
- LMFT students must complete 500 hours; 200 peer; 300 therapy with a minimum of 150 of the 300 as relationship hours.
- LPC students must complete 700 hours; 550 peer and 150 therapy.
- Dual licenses require 700 hours with 300 therapy and a minimum of 150 as relationship hours.
- Art therapy students must complete 700 hours with 350 as Art therapy.
Part II

Advanced Internship Information
Advanced Internship (#597.1-3):

Advanced Internship is composed of three sequential, 1-credit courses, (597.1, 597.2 and 597.3). Each course is taken during one term and students receive one-credit for each course. Students entering Advanced Internship must have active cases and be prepared to demonstrate that the techniques learned throughout their graduate studies are being applied in sessions with clients. Students are required to present one new case per section for a total of three different cases.

Acceptable Clinical Activities:

This level of internship typically consists of 6-10 hours per week in on site involvement at the agency. There can still be activities designated from beginning and intermediate levels including involvement as a co-therapist with other qualified therapists for learning/training purposes. However the Adler Graduate Student is to be seeing three to six clients unassisted. This includes individual, group and relationship modes of therapy. Ideally, therapy will be conducted across a variety of modalities, including couples and family modalities. These clients typically are the subjects of the case histories that are brought to AGS’ Advanced Internship courses, where they are reviewed by clinical instructors and student peers.

Course Description: Students come to the first class session with a minimum of one case history using the format in this manual. Students bring 10 copies of the case history for class members. Each student presents the case to the class and describes what has been done so far to bring about client change. A release form must be signed by the client before the case is presented. Forms for this release and art therapy release forms are found in the forms section of this manual. The class discusses the case and offers helpful ideas on how to proceed. The student reports on progress with the cases in future class meetings. Role plays may be used to help develop therapeutic skills.

Course Requirements: Students meet for the required 15 hours of course Internship. If a class is missed, the student attends a make-up class at the end of the term and obtains proof of attendance. Students sign up for the make-up session and pay an additional fee.

It is required that students come to the first class with a minimum of one case history, two preferred of an active case and be prepared to present the case and progress to date. The case history outline in this manual must be followed and including birth order, and a minimum of three early recollections, or goal of misbehavior. A release of information form should be signed by the client prior to the presentation. See forms section.

Students are also required to complete a reading assignment and write the assigned paper. (See syllabus). Eighty or more hours of activity per term is recommended to complete the required 500 or 700 hours in approximately 2 years.

It is required that logged hours, assignment, supervisors evaluation and makeup form if a class was missed is to be turned in. A cover sheet stating the course, section, instructor and student’s name should be attached and turned in to the Instructor within 2 weeks of the completion of the applicable term. Proof of malpractice insurance should be provided at the beginning of class. If
paperwork is incomplete, it will be returned to the student and a grade of Incomplete will be given until all required materials are turned in.

Checklist for #597.1, 597.2, and 597.3:
____ Proof of current professional malpractice insurance must be submitted at the first class
____ Purchase book, if required
____ Develop a client load of three to six clients (preferably two for each course)
____ Be on a site during the course
____ Attend 15 hours of Internship course
____ Log approximately 80 hours on-site (See forms section)
____ Have site supervisor complete a supervisor evaluation form (See forms section)
____ Complete reading and written assignment (See syllabus)
____ Write up one or two case histories on one or two current clients, make 10 copies for the class, and present the cases in the first class
____ Report progress on the case at the next class
____ Complete Confidentiality Agreement with Client (Form is in Forms section)
____ If class is missed, attend a make-up class and provide proof of attendance.

Summary of Internship Requirements:

To satisfactorily complete the internship program, students must log 500 or 700 hours of on-site activity and complete 7 Internship courses (5 credits) plus 1 credit of 598 (See below) for graduation. Students must carry malpractice insurance throughout the time in the program.
Course 597—Advanced Internship
Course Syllabus

1. Course Designation:

1.1 Course Numbers 597-1, 597-2, and 597-3
   Prerequisite: 594 Intermediate Internship
1.2 Advanced Internship
1.3 Current internship placement required
1.4 This course will yield 1.0 credit per section.
1.5 Each section is comprised of a total of 15 seated hours in class: 7.5 hours during a week-end day, and two subsequent evening classes, 3.75 hours each. (In some sections, the course will be offered over four class periods of 3.75 hours each.)

2. Course Description:

This course offers students the opportunity to learn about typical problems brought to a therapist and Adlerian techniques that can be used in addressing those problems. Students continue to deepen their experience of providing therapy, building on their experience in previous internship courses. They first present their written case to the class and provide enough copies so that each student has a copy, as does the instructor. The instructor and other students provide feedback and suggestions prescribing how to further assist the client. Students then follow through with prescriptions given in class and present a verbal progress report during the next class period.

Students perform all of their duties in a professional manner. To that end, case notes and other documentation will be done in a timely manner and written in a clear, concise, and objective way.

All other paperwork (logs, supervisor evaluations, final papers) must be turned in to the instructor two weeks following the end of the term.

This is very important because being a professional therapist entails the provision of appropriate helpful therapy, and entails verbal and written evidence-based communication with other professionals, insurance agencies, governmental bodies, hospitals, and the court system, as well as the documentation of case notes. Since clients also have access to their charts, documentation must be written in an objective manner, based upon observable data, and respectful to the clients.

In this course, students write a formal case history and make at least one case presentation to the group during each class. Students use the case history form or model
used by the agency or internship site. If the site has no such format, use the AGS model case history form (found in the forms section). Additional material regarding Lifestyle will also be required in the case history: birth order, ER’s for adults, some form of genogram, and, for children, a mistaken goal of behavior. Case presentations will be made on current clients being seen at the internship site. A client is defined as an individual, two people in a relationship or a group.

It is extremely important that the content of the case be written in such a way as to protect the identity and the confidentiality of the client. Use a pseudonym and generic descriptors of any content that may betray confidentiality. Furthermore, all case histories must be gathered at the end of the presentation and kept in a secure place until the end of the course. At that time, confidential materials will be destroyed.

Different clients must be presented for each of the three 597 courses (i.e. no repeats). Students must put their name at the top of the case history. Bring 10 copies of the case history to the first class session.

3. Required Reading:


Other readings as assigned by the instructor.

4. Learning Outcomes:

Students refine their counseling style and apply more focused Adlerian techniques. They are comfortable in their role as therapist and are able to make appropriate assessments and interventions. They furthermore develop collegial communication styles which further their understanding of clients and the field of therapy—hence increasing social interest.

5. Assessment of Learning Outcomes:

Students present one to two cases from an Adlerian perspective and demonstrate Adlerian techniques.

All students submit the following documents:

- Copy of your professional malpractice insurance (submitted at first class).
- 2-3 pages, APA format paper integrating what was learned from required reading, class participation, and internship experiences.
- Signed logs of client contact hours for the current quarter
• Signed and completed site supervisor evaluation forms.  *If a student works at more than one site during a quarter, a site supervisor evaluation is required from each site. If a student leaves a site mid-term, a supervisor evaluation is still required.*

• All of these materials must be stapled together and submitted to the instructor two weeks following the end of the current quarter. *If a student is registered for two sections of internship within one quarter, each instructor must receive all logs and site supervisor evaluations.*

Students keep their own duplicate copies of logs and evaluations.

Students must keep their own copies of logs and evaluations.

6. Course Content:
   Presentation of case histories
   Brief lecture about specific techniques and process of treatment
   Feedback from fellow students
   Role playing the presenting case and appropriate techniques
   Focus on Lifestyle assessment to conceptualize psychotherapeutic interventions

Rev: 05/09
<table>
<thead>
<tr>
<th>CLIENT</th>
<th>THERAPIST'S APPROACH TO PROBLEM</th>
<th>THERAPIST'S CHALLENGES TO CHANGE</th>
</tr>
</thead>
</table>
| **LEVEL 1 (SITUATION)**  
Inputs situation: what is seen and heard.  
Outputs to therapist: Negative feelings, blame and being stuck. | **LEVEL 1 (SITUATION)**  
Do problem solving.  
Express understanding.  
Give encouragement. | **LEVEL 1 (SITUATION)**  
Challenge In the current situation:  
How did you set yourself up?  
What's your responsibility?  
Your an actor not reactor creating self fulfilling prophecy.  
How could you see it differently? |
| **LEVEL 2 (THOUGHTS)**  
Thoughts about situation, using private logic.  
Interpretation based on....  
I  
V | **LEVEL 2 (THOUGHTS)**  
Question  
How do you feel?  
Why do you feel that way?  
What's awful about that for you?  
or  
What do you think about that?  
What's so awful about that? | **LEVEL 2 (THOUGHTS)**  
Challenge what is faulty about this thinking.  
Challenge the interpretation in this situation - other possibilities. |
| **LEVEL 3 (BELIEFS)**  
Basic Core Beliefs  
What is the ultimate goal to achieve significance and belong? | **LEVEL 3 (BELIEFS)**  
Identify the basic core mistaken beliefs.  
Identify the fictive goal and the behaviors used to attain it. | **LEVEL 3 (BELIEFS)**  
Challenge the all or nothing beliefs about DOING _____ to be worthwhile and to belong or be inadequate.  
Challenge the goal: "Only If I _____, will I be worthwhile and belong".  
created by: Susan P. Brokaw |
TRACING FEELINGS TO BELIEFS

THOUGHT "A" ← __________________________ FEELING "A"
THOUGHT "B" ← __________________________ FEELING "B"
BELIEF "A" ← __________________________ FEAR FEELING "A"
BELIEF "B" ← __________________________ FEAR FEELING "B"
BELIEF "C" ← __________________________ FEAR FEELING "C"

QUESTIONS:

1. (RE: FEELING "A") WHY DO YOU FEEL SO STRONGLY ABOUT THAT? ANSWER IS THOUGHT "A".
2. (RE: THOUGHT "A") WHAT'S SO BAD ABOUT THAT TO YOU? ANSWER IS THOUGHT "B".
3. HOW DO YOU FEEL THAT (THOUGHT "B")? ANSWER IS FEELING "B".
4. (RE: FEELING "B") WHY DO YOU FEEL SO ____ (INSERT FEELING) ABOUT THAT? ANSWER IS ALWAYS/NEVER BELIEF "A".
5. WHAT'S SO SCARY ABOUT THAT? ANSWER IS ALWAYS/NEVER BELIEF "B".
6. AND WHAT IS SO SCARY ABOUT THAT? ANSWER IS ALWAYS/NEVER BELIEF "B".
7. AND WHAT IS REALLY SCARY (FEELING) ABOUT THAT? ANSWER IS BELIEF.

SUSAN P. BROKAW
6000 CHASKA RD. STE. 102
EXCELSIOR, MN 55331

July 2011 Revision
CHECKLIST FOR ATTENTION DEFICIT /HYPERACTIVITY DISORDERS

Developed by: Susan Pye Brokaw, AAMFT, LICSW

ATTENTION DEFICIT DISORDER (ADD)

INATTENTION: (Check each statement that applies)

_____ Often doesn’t stay on task.
_____ Mind wanders or shifts from current task to another before finished. Or switches subjects in middle of conversation.
_____ Often doesn’t listen when spoken to by others.
_____ Doesn’t pay close attention to details resulting in careless mistakes in paperwork or activities.

Results in:

_____ Doesn’t follow through on instructions, requests or directions. Results in unfinished or incomplete homework, chores or duties.
_____ Difficulty organizing tasks or activities (disorganized).
_____ Often feels overwhelmed and/or frustrated.
_____ Dislikes, avoids or reluctant to do tasks that demand sustained mental effort, concentration or organization skills, such as homework or paperwork.
_____ Easily distracted by trivial noises, events or anything more interesting than the current task. (May appear as daydreaming.)
_____ Forgetful (even of things that person wants to remember and are felt to be important.
_____ Doesn’t follow directions.
_____ Often loses things needed for task or activity such as pencils, books, papers, tools or keys.

TOTAL NUMBER OF SYMPTOMS THAT APPLY. IF THE TOTAL IS SIX OR MORE THERE IS A STRONG PROBABILITY OF ATTENTION DEFICIT DISORDER.

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

HYPERACTIVE: (Check each statement that applies)

_____ Often moving feet or hands or fidgets alot when seated.
_____ Overly talkative (motor mouth) unless involved in a stimulating, interesting and fast moving task such as video games, cartoons and computer programs.
_____ Overly active in situations where it isn’t appropriate. In adolescents and adults appears as restless feelings.
_____ Difficulty participating in activities that involve sitting quietly (or avoids them).
_____ Leaving seat at inappropriate times.
Often on the go, high energy, very active as if driven by a motor.

IMPULSIVE: (Check each statement that applies)

The impulsive person appears to act without thinking or doesn’t inhibit inappropriate behavior. There is an impatience and an inability to delay response.

A. Verbally Impulsive
   __ Often interrupts or speaks out of turn.
   __ Often blurts out answers before question is completed.
   __ Initiates conversation at inappropriate times.

B. Actively Impulsive
   __ Acts without thinking or without waiting turn.
   __ Often intrudes on and interrupts others activity.
   __ Acts impulsively in ways that could endanger self or others.

TOTAL NUMBER OF SYMPTOMS OF BOTH HYPERACTIVE AND IMPULSIVE. IF THIS TOTAL IS SIX OR MORE AND THE INATTENTION SECTION IS SIX OR MORE, THERE IS A STRONG PROBABILITY OF ATTENTION DEFICIT HYPERACTIVITY DISORDER.

To qualify as ADD or ADHD the following additional criteria must be met. Some of these symptoms must have been present before the age of seven with some impairment in two or more of the following: school, community activity, work or the home. There must also be evidence of clinically significant impairment in school, work or social functioning. These symptoms should not be apparent exclusively during the course of other psychological disorders and those disorders must be ruled out as the the primary cause of these symptoms. If Adolescents or adults have some symptoms but no longer meet the full criteria, they can be considered as in "Partial Remission".

To determine severity of ADD or ADHD, rate each item above: 0 - Not at all or rarely, 1 - Occasionally, 2 - Often, and 3 - Very Often. Total the 2’s and 3’s. Normal children will recieve 0’s.

This checklist can be used by parents, teachers and adolescents. It is based on the DSM IV criteria for ADHD.

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THE DISABILITY NAMED ADD
An Overview of Attention Deficit Disorders

Attention Deficit Disorder (ADD) is characterized by attention skills that are developmentally inappropriate, impulsivity, and hyperactivity. ADD is a neurobiological disorder that affects up to 5% of all American children. Without early identification and proper treatment, ADD can have serious consequences including school failure and drop out, depression, conduct disorders, failed relationships, and even substance abuse.

Until recently, it was believed that ADD symptoms disappeared in adolescence. It is now known that many symptoms continue into adulthood for 50-70% of individuals with ADD. Adults with ADD may experience difficulties at work and in relationships. They may also exhibit other emotional difficulties.

Medical science first noticed children exhibiting inattention, impulsivity, and hyperactivity in 1902. Since that time, the disorder has been given numerous names, including Minimal Brain Dysfunction and The Hyperkinetic Reaction of Childhood. In 1980, the diagnosis of Attention Deficit Disorder was formally recognized in the Diagnostic and Statistical Manual. 3rd edition (DSM III) — the official diagnostic manual of the American Psychiatric Association (APA).

The Disorder

ADD is a neurobiological disorder that interferes with a person's ability to sustain attention or focus on a task and to delay impulsive behavior.

ADD characteristics often arise in early childhood. It is marked by behaviors that are chronic, lasting at least six months with onset before age seven. Characteristics of children with ADD can include:

- fidgeting with hands or feet
- difficulty remaining seated
- difficulty following through on instructions
- shifting from one uncompleted task to another
- difficulty playing quietly
- interrupting conversations and intruding into other children's games
- appearing to be not listening to what is being said
- doing things that are dangerous without thinking about the consequences

Students with ADD have a greater likelihood of grade retention, school drop out, academic underachievement, and social and emotional adjustment difficulties. This is probably because ADD makes children vulnerable to failure in the two most important arenas for developmental mastery — school and peer relations.

A significant percentage — perhaps as many as 50% — of children with ADD are never properly diagnosed.

ADD is often inaccurately portrayed as a type of specific learning disability (SLD). It is not. Children with ADD are not unable to learn, but they do have difficulty performing in school due to poor organization, impulsivity, and inattention. However, some children with ADD also have a learning disability, further complicating identification and treatment.

Children with ADD do not routinely show signs of serious emotional disturbance (SED). However, if not properly diagnosed and treated, children with ADD can develop significant emotional difficulties, such as behavioral disorders, depression, and even substance abuse.

Many adults with ADD were never properly diagnosed as children. They grew up struggling with a neurobiological disability they didn't even know they had. Others were diagnosed as “hyperkinetic” or “hyperactive” and told their symptoms would disappear in adolescence. As a result, many developed other problems which masked the ADD.

Most adults with ADD are restless, easily distracted, have difficulty sustaining attention and concentrating, are impulsive and impatient, have frequent mood swings and short tempers, are disorganized and have difficulty planning ahead.

Adults with ADD often experience career difficulties. They may lose jobs due to poor job perfor-

Note: In this fact sheet, the term Attention Deficit Disorder (ADD) is used to include the distinct categories of Attention Deficit Hyperactivity Disorder and Undifferentiated Attention Deficit Disorder.
mance, attention and organizational problems, or relationship difficulties. On the other hand, adults who learn to adapt to their disability and to harness the energy and creativity that often accompanies ADD can thrive professionally.

The Cause

In 1990, the New England Journal of Medicine published the results of a landmark study in which researchers at the National Institute for Mental Health used advanced brain imaging techniques to compare brain metabolism between adults with ADD and adults without ADD. The study documented that adults with ADD utilize glucose — the brain’s main energy source — at a lesser rate than do adults without ADD. This reduced brain metabolism rate was most evident in the portion of the brain that is important for attention, handwriting, motor control and inhibition of responses.

These brain metabolism studies, combined with other data including family history studies and drug response studies, have convinced researchers that ADD is a neurobiological disorder and not caused by a chaotic home environment.

Diagnosis and Treatment

Determining if a child has ADD is a multifaceted process. Many biological and psychological problems can contribute to symptoms similar to those exhibited by children with ADD. For example, anxiety, depression and certain types of learning disabilities may cause similar symptoms.

A comprehensive evaluation is necessary to establish a diagnosis. Rule out other causes and determine the presence or absence of co-occurring conditions. Such an evaluation will often include intelligence testing plus the assessment of academic, social and emotional functioning and developmental abilities. Measures of attention span and impulsivity will also be used, as well as parent and teacher rating scales. A medical exam by a physician is also important.

Diagnosing ADD in an adult requires an examination of childhood, academic and behavioral history.

Treating ADD in children requires medical, psychological and educational intervention, and behavior management techniques. A multimodal treatment approach includes:

- parent training in behavior management
- an appropriate educational program
- individual and family counseling when needed
- medication when required

Psychostimulants are the most widely used medication for the management of ADD related symptoms. Between 70-80% of children with ADD respond positively to psychostimulant medications. These medications decrease impulsivity and hyperactivity, increase attention and, in some children, decrease aggression.

Behavior management is an important intervention with children who have ADD. The most important technique is positive reinforcement, in which the child is provided a rewarding response after a particular desired behavior is demonstrated.

Classroom success may require a range of interventions. Most children with ADD can be taught in the regular classroom with either minor adjustments to the classroom setting, the addition of support personnel, and/or “pull-out” programs that provide special services outside of the classroom. The most severely affected may require self-contained classrooms.

Adults with ADD can benefit from learning to structure their environment. Psychostimulant medications can also be effective with adults who have ADD. Vocational counseling is often an important intervention. Short-term psychotherapy can help the patient identify how his or her disability might be associated with a history of sub-par performance and difficulties in personal relationships. And extended psychotherapy can help address any mood swings, stabilize relationships, and alleviate guilt and discouragement.

Prognosis

Children with ADD are “at-risk” for school failure and emotional difficulties. However, with early identification and treatment, these children can succeed.

From 30-70% of children with ADD will continue to exhibit symptoms of ADD in adulthood.

Once properly diagnosed, adults with ADD can learn to adapt to their disability. Armed with an understanding of the disability and its implications, and with appropriate treatment, adults with ADD can succeed.

Suggested Reading


Need more information about Attention Deficit Disorders or the national organization dedicated to helping children and adults with ADD succeed? Call Children and Adults with Attention Deficit Disorders (CH.A.D.D.) at 305-587-3700, or write CH.A.D.D. at 499 Northwest 70th Avenue, Suite 109, Plantation, Florida 33317.

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CONFRONTATION TECHNIQUES
Lecture Dr. Shulman at Brief Psychotherapy Conference, Chicago.

Confrontation is a method or means of directing the patient's attention to the actual content of their actions or statements, the chosen coincidences, which he professes not to have perceived (not aware of them purposely), and to force him to pay attention to something of the here and now quality.

The difference between confrontation and interpretation is that some interpretations are also confrontations, but not all interpretations contain confrontation, and may not force the patient to pay attention to the here and now. Dr. Garner of the Chicago Medical School uses confrontation frequently to focus, to direct the approach to the problem, to get at the heart of something right away.

Example of interpretation:
"All right, you thought your mother wouldn't love you if you hated your little brother." This is an explanatory clarifying statement which can be made in certain interviewing situations.

Example of confrontation:
"How much longer do you intend to feel that way? How much longer are you going to believe that Mother will stop loving you if you hate your little brother?" This kind of questioning is used especially by those therapists who are "action-oriented", or group-oriented, who use confronting techniques, especially role-playing situations and want to give the patient a "here and now" situation.

Adlerians use a number of confronting techniques. Adlerian psychotherapy does not insist that the therapist be directive, but since it is the aim of the therapist to help the patient recognize mistaken goals, the process is different from that used by a therapist who is helping the client "work through" a conflict, and also different from the concept of inner conflict. In trying to help a patient see his mistaken ways of dealing with the world, the Adlerian uses the mirroring technique, showing him right on the spot what he is doing. These often become confrontation.

WHAT IS IT THAT THE THERAPIST CONFRONTS THE PATIENT WITH?

1. The subjective "mood" of the situation.
   Example: "From the way you wear your hair, without a lock out of place, I can see that you are afraid of falling apart."

   "From the look on your face, I can see that you don't believe a word I am saying."

   "From the way you talk about your husband, you must be very angry at him."
These are statements that give an indication of what the client is demonstrating at that moment.

2. The hidden reason or rationalization the person gives himself for his behavior. The patient's thinking is something like: "There is no hope for me, anyway." Or, "My wife doesn't deserve to have me treat her any better", or some sort of private thought like this, which he has some awareness of, but has not brought it into the front light of his awareness. The therapist confronts the patient regarding the reason he is giving himself for what he is doing at the moment, confronting him with the private justification (Dreikurs) and rationalization, or hidden reason for his behavior.

Examples: "I had so little sleep it would have done no good to go to work. I couldn't have gotten any work done at work anyway."

"I'm too nervous." "I'm too tired."

3. Private Logic, his private way of thinking about the world and dealing with the world which result in certain behavioral attitudes.

Examples: "If you put on dark glasses, how do you expect the world to look?"

"If you have already decided you have no chance in life, how do you expect to make it any better?"

"If you already feel that you can't be helped, then why are you here anyway?"

4. Confront him directly with his own responsibility for what has gone wrong, his own guilt, as Bauer says.

Pt.: "Why do people walk over me? I'm only trying to be a good guy."

Therapist: "Because you want them to walk over you. After all, it's a lot easier to be a good guy if other people walk over you than if you don't have people walk over you."

5. Private goals. Demonstrated by Dr. Dreikurs in his family interview session.

T.: "Why do you do this?"

Pt.: "I don't know."

T.: "Shall I tell you?...Could it be...Do you know why you do that?"
If you don't know, do you want me to tell you why I think you did it?” and then therapist may say: “Could it be...” or “Did you feel powerful when you got mother all upset? Didn't you enjoy it a little bit when all these people were making a fuss over you?”

Dr. Shulman here referred to Dr. Papanek's early recollection stories, about the patient who was sick, and the physician father had so much concern over her when she was taken to the emergency room. The therapist’s confronting statement in this instance might be: “Didn't you feel glad that you were able to get your father this concerned with you?”

Sometimes, instead of saying, “You did it for this reason”, the therapist may say: “You act according to a certain motto. For example, “I must never let anyone catch me making a mistake. I must always be right.” Or, “Above all, if anybody gets ahead of me, I have to get even.” And sometimes we stress this by giving the patient a certificate or plaque with the motto written on it.

6. In addition to this we confront the patient with his immediate behavior.

Examples: “When I asked you a question about your parents, you stopped talking, how come?”

“You just made a slip of the tongue. Did you catch it? I wonder what that means.”

“How do you feel about it right now when I am talking to you? A look just passed over your face. What went through your mind?”

“I notice you keep sweeping your legs, what does it mean?”

“Your face just turned red, what’s up?”

You are asking the patient to deal with his immediate behavior in the situation. First of all, you ask him to look at it. This is part of the mirror technique. It is especially used for confronting statements which call attention to patterns of self-defeating behavior. We hold it up for the patient to see what he is doing.

What is the patient doing each day to keep depressing himself? Instead of dwelling on the symptom, show the depressed patient how he himself keeps depressing himself every day.

Example: This once-depressed patient told me how depressed she felt, how all her thoughts were unpleasant.
T: What would you like to be doing most of all if you felt completely well?
Pt.: I'd like to be in Florida fishing.
T: Tell me about fishing. (And she spend about two minutes telling me about it.)
T: How do you feel now?
Pt.: Better.
T: Why do you think you feel better?
Pt.: I was talking about something I like.
T: All right, now tell me about your depression. (And she spent about two minutes telling me about her depression.) How do you feel now?
Pt.: I feel bad.
T: Why do you think that a few minutes ago you felt good, and now you feel bad?
Pt.: Well, it was what I was talking about.
T: Do you think you could make yourself feel better or make yourself feel worse by what you talk about?
Pt.: Well, maybe I can.
T: All right. Then all you need to do is spend the day talking to yourself about fishing, and you will feel better.

(I don't want us to expect the patient to immediately give up the depression so easily. After all, some of them work pretty hard to get depressed.)

The purpose of this exchange is to show the patient that he has some amount of control over what he feels by what he chooses to think about. Those of you who have read Albert Ellis recognize that this particular technique is pretty close to what he does.

Example: “Look, you just berated yourself again. Keep it up, and in five minutes you will really be depressed. Is that what you want?”

or

“Do you think you could stop berating yourself?”

or

“You have just spent 2/3 of your session with me complaining about your mother. What do you want to do? Spend the remainder of the session complaining about your mother, or do you want to spend it in therapy? Do you want to help yourself or do you just want to complain about what a victim you are? Unless you start talking to me about yourself, I cannot help you.”

See what a strong confrontation.
7. Confrontation is also a dramatic way of presenting alternatives. Certainly seen clearly in role-playing, where you give the patient an alternative role to play.

Example: “You are going to take an examination, and you are worried about the exam - afraid you will do poorly. Now you have a choice. You can study for the exam, or you can goof off, and pretend that you don't care. Which will it be? You make the choice.”

or

“You don't have to spend your life complaining about how much your brother makes. You can get a job, and tell him how and what you want to do about it.”

(One of the things you are saying to the patient is: Look at your choice.)

or

“O.K. You see what's going on - you now have insight. What are you going to do about it?”

or

“Patient says something like - I will have to do something about it, but I will just wait a bit.”

T: “How long do you plan to wait before you do it?”

Here is the nonsense statement calculated to provoke the patient to begin recognizing that it won't happen and there will be no change until he takes the first step to change.

8. Confront the patient with the fact that he has the responsibility for changing, and we will say to him: Do you want to change, or do you just want to sit and talk about it for awhile? The patient often says: “What should I do?” Adler would suggest a statement of irony.

Example: “Above all, don't do anything yet. After all, you have been this way for many years and another few moths won't hurt.”

Again the object is to tell the patient as clearly as possible that the responsibility for change is his.

The confrontation techniques that the therapist uses are for the purpose of creating an atmosphere of immediate challenge, which stirs him up - but stirs him up in connection with an important therapeutic issue.

It's an example of direct focusing and basically these techniques can be divided into 3 main issues that the therapists use.
1 - Issue of Insight - Confronting the patient in order to help the patient become aware of something.

2 - To help the patient to recognize where he is running away from his own responsibility and obligation to life. Adlerians talk about the life tasks - but we can also use Heidigger's concept as meaning or dassai - - the meaning of life - It is the task of life: giving it meaning.

Adlerians recognize that the patient is his own private meaning to his life. He has given it the wrong meaning - he is going after the wrong things. Why wrong? Because he has gotten into trouble.
And for the Adlerians (and remember Adler started out as a clinician) it is that meaning which one can give to life (which is not neurosis, not psychosis) which is ethical, moral and respectful of humanness and the Adlerians end up with social interest as being the mentally healthiest meaning one can give to life. It is the meaning that permits the most satisfying fulfillment of life.

3 - Wants the patient to recognize where the power to change lies. The moment of change is decided by the patient. So the confrontation reduces to the one used by ancient Hillel: - "If you're not going to do it now - then when?"
Prepared by Robert G. Bartholow, MSW

THE PARADOX IN PSYCHOTHERAPY: AN ADLERIAN PERSPECTIVE

As abridged from the Writings of Mozdzierz, et al., and from my professional experience.

The paradox is dialectics as applied to psychotherapy. It consists of seemingly self-contradictory and sometimes even absurd therapeutic interventions which are always constructively rationalizable, although sometimes very challenging, and which join rather than oppose symptomatic behavior while containing qualities of empathy, encouragement and humor, leading to social interest.

Adler was the first person in western civilization to use and write about a paradoxical strategy in terms of behavior change.

Dialectical thinking can be summarized in the idea that things are not what they seem -- "any statement can contain its opposite".

Jung stated - "Every psychological extremity secretly contains its own opposites, or stands in some sort of intimate and essential relation to it. The more extreme a position is the more easily may we expect a conversion of something into its opposite".

Adler reconciled contradictory behavior from the viewpoint of an inferred goal of overcoming.

Example: tears may exercise water power.

Suicide may be in a large part to hurt or accuse others.

Vanity could show itself thru rags.

Status can be sought by joining a counter-culture.

Psychotherapy also resorts to the paradox of dialectics by prescribing or encouraging the symptom itself.

Non specific Paradoxical Strategy

- The paradox appears to be a part of the relationship as well as part of the treatment techniques.
- In treatment the therapist is regarded as an obstacle, an obstruction, preventing the attainment of the superiority ideal along the path of the neurosis.
- Therefore most patients will attempt to depreciate or disqualify the therapist, to deprive him of his influence.
- The therapist must not counteract but should have a great deal of tact, renounce superior authority, be equally friendly at all times,
be alertly interested, and have the cool-headed feeling that he is facing a emotionally troubled person (suffering from a neurosis) with whom he must not fight, but who is always ready to start a fight - though he comes in ostensibly to be relieved of his symptomatic behavior. Don't falsely conclude that every patient coming in is ready to work on overcoming his difficulty.

- The patient will try to thwart the therapist and deprive him of his influence. He may resort to a variety of deprecatory tactics: doubt, criticism, fault-finding, forgetfulness, tardiness, special requests, negativism, stubborn retention of symptoms, relapses, etc.

- The patient's deprecatory tendencies are designed to rob the therapist of his influence by attempting to place the therapist in a one-up or a one-down position. If the therapist is one-down the patient has achieved socially useless neurotic superiority; if the patient is one-down little of a socially useful nature can be expected from his frame of reference.

- This is what the patient does in life and therapy and why he/she requires therapy.

- The therapist's job is always to awaken social interest by instilling cooperation and equality.

- The therapist has to neutralize and render ineffective the patient's system.

- Adler's example: a patient once asked me, smiling "Has anyone ever taken his life while being treated by you"? I answered him "Not yet, but I am prepared for this to happen anytime."

- The patient was attempting to intimidate and Dr. Adler was alert and unintimidated. His matter of fact and paradoxical response negated the neurotic's attempt at undermining him without negating the personhood of the neurotic.

- Another use of paradoxical strategy is the patient who tells the therapist "You're my last hope." The therapist responded "No, I'm not your last hope, maybe the next to the last. There may be others that can help you besides me."

- This patient was trying to shift all responsibility on to the therapist, a dependency maneuver that the therapist must not fall for.
**BECK INVENTORY**

INSTRUCTIONS: On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY! Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

<table>
<thead>
<tr>
<th>Statement</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<tbody>
<tr>
<td>1) I do not feel sad.</td>
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<tr>
<td>1) I feel sad.</td>
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<td>2) I am sad all the time and I can't snap out of it.</td>
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<td>3) I am so sad or unhappy that I can't stand it.</td>
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<td>2) I am not particularly discouraged about the future.</td>
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<td>1) I feel discouraged about the future.</td>
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<td>2) I feel I have nothing to look forward to.</td>
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<td>3) I feel that the future is hopeless and that things cannot improve.</td>
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<td>3) I do not feel like a failure.</td>
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<td>1) I feel I have failed more than the average person.</td>
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<td>2) As I look back on my life, all I can see is a lot of failures.</td>
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<td>3) I feel I am a complete failure as a person.</td>
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<td>4) I get as much satisfaction out of things as I used to.</td>
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<td>1) I don't enjoy things the way I used to.</td>
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<td>2) I don't get real satisfaction out of anything anymore.</td>
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<td>3) I am dissatisfied or bored with everything.</td>
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<td>5) I don't feel particularly guilty.</td>
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<td>1) I feel guilty a good part of the time.</td>
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<td>2) I feel quite guilty most of the time.</td>
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<td>3) I feel guilty all of the time.</td>
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<td>6) I don't feel I am being punished.</td>
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<td>1) I feel I may be punished.</td>
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<td>2) I expect to be punished.</td>
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<td>3) I feel I am being punished.</td>
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<td>7) I don't feel disappointed in myself.</td>
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<td>1) I am disappointed in myself.</td>
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<td>2) I am disgusted with myself.</td>
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<td>3) I hate myself.</td>
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<td>8) I don't feel I am any worse than anybody else.</td>
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<td>1) I am critical of myself for my weaknesses or mistakes.</td>
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<td>2) I blame myself all the time for my faults.</td>
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<tr>
<td>3) I blame myself for everything bad that happens.</td>
<td></td>
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</tr>
<tr>
<td>9) I don't have any thoughts of killing myself.</td>
<td></td>
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</tr>
<tr>
<td>1) I have thoughts of killing myself, but I would not carry them out.</td>
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<tr>
<td>2) I would like to kill myself.</td>
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<td></td>
</tr>
<tr>
<td>3) I would kill myself if I had the chance.</td>
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</tbody>
</table>
10) 0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

11) 0 I am no more irritated now than I ever am.
1 I get annoyed or irritated more easily than I used to.
2 I feel irritated all the time now.
3 I don't get irritated at all by the things that used to irritate me.

12) 0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13) 0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all anymore.

14) 0 I don't feel I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

15) 0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16) 0 I can't sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17) 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18) 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19) 0 I haven't lost much weight, if any, lately.
1 I have lost more than 5 pounds.
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less. Yes ___ No ___

20) 0 I am no more worried about my health than usual.
1 I am worried about physical symptoms such as aches and pains; or upset stomach; or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about physical problems that I cannot think about anything else.
21) 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

SCORING:
1-10 Normal
11-16 Mild
17-20 Borderline Clinical Depression
21-30 Moderate Clinical Depression
31-40 Severe Clinical Depression
Over 40 Extreme Clinical Depression
1. **KEEP A RECORD OF EVERYTHING YOU EAT.**
   A. Keep a record of what you eat and how you feel when you eat.
   B. Review the records regularly to identify patterns.

2. **ESTABLISH A SENSIBLE MEAL PLAN.**
   A. Decide ahead, when you will eat and when you will snack.
   B. Plan ahead, what you will eat at these times.
   C. Plan ahead for special situations, i.e., holidays.
   D. Stick to the meal plan every day.
   E. Get back on the meal plan, when something goes wrong.
   F. Plan not to vomit after eating planned meals.

3. **LEARN WHAT CIRCUMSTANCES CAUSE THE BEHAVIOR AND DEVELOP A PLAN TO PREVENT IT FROM HAPPENING.**
   A. Look for the situations where you have binged in the past.
   B. Develop a plan for how to deal with those situations.
   C. Create a plan for how to intervene if you are on the verge of bringing.
   D. Have a list of activities and do them, when tempted to binge.

4. **DISCOVER THE PROBLEMS THAT CAUSE YOU TO HAVE PROBLEMS WITH EATING AND LEARN TO SOLVE THE PROBLEMS USING SIX STEPS.**
   A. Make a list of things that upset you and cause you to binge.
   B. Use problem solving techniques to deal with these problems ahead of time.
   C. Practice this technique so it can be used when a problem comes up.

5. **ELIMINATE DIETING AND LEARN TO EAT A OCCASIONALLY THE FOODS YOU AVOID.**
   A. Plan to eat an adequate amount of food at planned times.
   B. Make lists of foods very difficult to eat, somewhat difficult and a little difficult.
   C. Plan a program to start including these foods in meal plans starting with the ones that are a little difficult.
   D. Learn to eat the foods you like in a controlled way.

6. **DISCOVER SOME OF THE BELIEFS THAT UNDERLIE YOUR EATING PROBLEMS AND MODIFY THE BELIEFS.**
   A. Is your worth based on your shape or weight.
   B. Have you resolved your mistaken beliefs about “control”.
   C. Can you eat normally without thinking about it? If not, continue this plan.

**BULIMIA NERVOSA & BINGE-EATING. BY: PETER J. COOPER**
Abandoned
Adequate
Adamant
Affectionate
Agony
Almighty
Ambivalent
Angry
Annoyed
Anxious
Apathetic
Astounded
Awed

Deceitful
Defeated
Delighted
Desirous
Despair
Destructive
Determined
Different
Diffident
Diminished
Discontented
Distracted
Draughted
Disturbed
Dominated
Divided
Doubtful

Eager
Ecstatic
Electrified
Empty
Enchanted
Energetic
Enervated
Enjoy
Envious
Excited
Evil
Exasperated
Exhausted

Fascinated
Fauning
Fearful
Flustered
Foolish
Frantic
Frustrated
Frightened
Free
Full
Fury
Gay
Glad
Good
Gratified
Greedy
Grief
Groovy
Guilty
Gullible

Happy
Hate
Heavenly
Helpful
Helpless
High
Homesick
Honored
Horrible
Hurt
Hysterical
Ignored
Immortal
Imposed upon
Impressed
Infatuated
Infuriated
Inspired
Intimidated
Isolated
Jealousy
Joyous
Jumpy

Kicky
Kind
Keen
Laconic
Lazy
Lecherous
Left out
Licentious
Lonely
Longing
Loving (love)
Low
Lustful

Mad
Maudlin
Mean
Melancholy
Miserable
Mystical
Naughty
Nervous
Nice
Niggardly
Nutty

Obnoxious
Obsessed
Odd
Opposed
Outraged
Overwhelmed

Pain
Panicked
Parsimonious
Peaceful
Persecuted
Petrified
Pity
Pleasant
Pleased
Precarious
Pressed
Pretty
Prim
Prissy
Proud

Quarrelsome
Queer

Rage
Rapture
Refreshed
Rejected
Relaxed
Relieved
Remorse
Restless
Reverent
Rewarded
Righteous

Sad
Sated
Satisfied
Scared
Screwed up
Servile
Settled
Sexy
Shocked
Silly
Skeptical

Wicked
Wonderful
Sated
Weepy
Worry(ied)

Zanie
<table>
<thead>
<tr>
<th>Tries To:</th>
<th>COMFORT</th>
<th>PLEASING</th>
<th>CONTROL</th>
<th>SUPERIORITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seek his comfort</td>
<td>(whatever comfort means to him)</td>
<td>Please others</td>
<td>A. Control self</td>
<td>Be better than others:</td>
</tr>
<tr>
<td></td>
<td>(Active: &quot;spoiled brat&quot;)</td>
<td>(Active: &quot;demand&quot;)</td>
<td>(usually passive)</td>
<td>Being more competent</td>
</tr>
<tr>
<td></td>
<td>(Passive: seek pleasure)</td>
<td>(Passive: evoke pity)</td>
<td>B. Control others</td>
<td>Being more good, more rich</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(Active: &quot;tyrant&quot;)</td>
<td>Being more useful</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(Passive: &quot;artful dodger&quot;)</td>
<td>Suffering more nobly-be a &quot;victim&quot; or a &quot;martyr&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>C. Control Situation</td>
<td></td>
</tr>
</tbody>
</table>

| Assets:                         | Easy going, few demands       | Friendly, considerate            | Leadership potential             | Knowledgeable, precise                   |
|                                 | Minds own business            | Non-aggressive                   | Organized, productive            | Idealistic, seeks perfection             |
|                                 | Peace maker, diplomat         | Compromises                      | Persistent                       | Stick-to-it-tiveness                     |
|                                 | Empathetic, mellow            | Likely to volunteer              | Assertive                       |                                          |
|                                 | More predictable              | Does what others expect          | Law abiding                     |                                          |

| Reaction To Others:             | Irritation                     | Feel pleased at first:           | Feel challenged                  | Feel inadequate                          |
|                                 | Annoyance                      | "He's a nice person"             | Feel challenged                  | "How do I measure up?"                   |
|                                 | Boredom                        | Later, exasperation &            | Feel tension                     | Feelings of inferiority                  |
|                                 |                                | despair at his demands           | Feel resistance                  | and guilt                                |
|                                 |                                | for approval                      | Feel frustration                 |                                          |

| Price One Pays:                 | Reduced productivity          | Reduction in growth              | Diminished creativity            | Feel overburdened                        |
|                                 | Not use his talents           | Discrepancy: self-ideal          | Lack of spontaneity              | Feel over-responsible                    |
|                                 |                                | vs. self-appraisal               | Social distance                  | Feel over-involved                       |

| Tries To Avoid:                | Stress                         | Rejection                        | Humiliation                     | Meaninglessness in life                  |
|                                 | Responsibility                 |                                | The unexpected                   | and its tasks                             |
|                                 | Expectations                   |                                | Fears ridicule                   |                                          |
|                                 | "Don't corner me!"             |                                |                                |                                          |

| Complains Of:                  | Diminished productivity       | Lack of respect for              | Lack of friends                  | Overload, lack of time                    |
|                                 | Impatience                     | self and others                 | Wants more closeness             | Uncertain of relationship with others, guilt feelings |
|                                 |                                |                                 | Feeling "uptight"(A)             |                                          |

| May Stem From:                 | Discomfort                     | "In enemy camp"                  | Tight controls                   | Shaming                                   |
|                                 | Pampering                      | (battered child)                 | Being overpowered                | Perfectionism                             |
|                                 |                                |                                 |                                |                                          |

| Similar to Goal                | I. Attention                   | IV. Inadequacy                   | II. Power                        | A mother who has "failed"                 |
|                                 | (Dreikurs)                     |                                 |                                 |                                          |

Movement:                        |                               |                                 |                                 |                                          |
THE SIX STEPS IN PROBLEM SOLVING

STEP I. DEFINE THE PROBLEM

THIS IS A CRITICAL STEP IN PROBLEM SOLVING. THINK ABOUT WHETHER THIS IS THE REAL PROBLEM OR WHETHER THERE IS ANOTHER PROBLEM THAT RESULTED IN THIS PROBLEM, WRITE DOWN EXACTLY WHAT THE PROBLEM IS, AS YOU SEE IT.

STEP II. LIST ALL POSSIBLE SOLUTIONS

THERE SHOULD BE A MINIMUM OF THREE AND OFTEN EIGHT OR MORE SOLUTIONS TO A PROBLEM. SOME SOLUTIONS MAY BE A COMBINATION OF SOLUTIONS. BRAINSTORM ALL THE POSSIBILITIES WITHOUT LIMITATIONS. YOU CAN CROSS OFF THE UNREALISTIC ONE’S LATER.

STEP III. EVALUATE EACH SOLUTION

ASK YOURSELF IF THE SOLUTION WILL BE POSSIBLE TO CARRY OUT AND WHETHER IT WILL BE FAIR. IN EVALUATING THE SOLUTIONS, OTHER POSSIBLE SOLUTIONS OFTEN ARE DISCOVERED. YOU MAY ALSO CHANGE OR MODIFY SOME SOLUTIONS.

STEP IV. DECIDE ON THE BEST SOLUTION

STEP V. USE THE SOLUTION

THINK ABOUT HOW YOU WILL IMPLEMENT THIS SOLUTION. HOW WILL YOU ACCOMPLISH IT? HOW WILL YOU CARRY OUT THIS SOLUTION? HOW WILL YOU DO IT, IF YOU DO NOT HAVE THE COOPERATION OF OTHERS?

VI. EVALUATE THE SOLUTION

SOLUTIONS DO NOT ALWAYS WORK OUT AS YOU EXPECT THEM TO. SO, IT MAY BE NECESSARY TO RECONSIDER AND DO SOME MORE PROBLEM SOLVING. DECISIONS CAN ALWAYS BE REVISED OR CHANGED. YOU MAY WISH TO RETURN TO THE LIST OF POSSIBLE SOLUTIONS AGAIN. OR YOU MAY DECIDE THAT THIS SOLUTION IS WORKING AND CONTINUE TO USE IT. YOU MAY ALSO DECIDE TO MAKE SOME MODIFICATIONS/CHANGES IN YOUR SOLUTION.

SUSAN PYE BROKAW
Part III

Individual Clinical Instruction Information
Individual Clinical Instruction #598:

Individual Clinical Instruction (#598) usually begins after attending one advanced Internship course. In #598, students receive Individual Clinical Instruction from an AGS Clinical Instructor. A Clinical Instructor may do co-therapy with a student and the client or observe/listen to and critique videotapes or audio-taped sessions with the student. When participation by a supervisor or taping is not allowed by the site, there will be case consultation. One case (client, two people in a relationship, or group) is seen over a period of weeks with clinical instruction occurring after or between sessions. The purpose of this Internship is to verify the application of Adlerian and general therapeutic competencies, and to discuss the application of competencies with the Clinical Instructor. The Clinical Instructor discusses student goals regarding these competencies and offers help with the case.

The Clinical Instructor is chosen by the student from the list of approved Clinical Instructors listed in this manual at the end of this section. The student is responsible for setting up the Internship and for providing the Clinical Instructor with a case history of the client (at least birth order and three early recollections or goals of misbehavior included), evaluation forms, and directions to the site prior to the beginning of clinical instruction.

Students satisfactorily complete 6 hours of Internship in which the application of Adlerian competencies are demonstrated. Students receive one credit for satisfactorily completing Individual Clinical Instruction (598).

Checklist

___Contact Clinical Instructor of choice for approval to proceed
When approved, the clinical instructor will notify the registrar that the student is approved to be registered for #598.

___Register for #598

___Establish a plan with the clinical supervisor and complete five meetings.

___Turn in the Student Evaluation of Internship Site form, found in the forms section, to the Clinical Instructor
Format for Individual Clinical Instruction (#598)

The student initiates an initial agreement with the client and the site supervisor to receive therapeutic services under Individual Clinical Instruction and obtains release of information forms. During the course of Individual Clinical Instruction, the student is expected to spend 4 to 10 sessions with one individual, couple, group, or family (with one backup in case of early termination).

There will be 6 hours of Internship. Students contact their chosen Clinical Instructor and reach an Internship agreement as to how to proceed & whether the instructor prefers taping or coming to the site if the site permits it.

Meeting #1 (30 minutes): Phone consultation with Clinical Instructor to:
- Review case history previously sent to Clinical Instructor
- Discuss the treatment plan
- Review competencies for future application in session
- Discuss the plan for the next client session

The student sees the client for one to two sessions, tapes one session, and submits the tape to the Clinical Instructor. If two or more sessions are held between tapings, the student must e-mail a brief summary of those sessions for instructor comment or suggestions for the next session.

Meeting #2 (90 minutes): Clinical Instructor and student review the tape.
- The student is prepared to:
  - Review the treatment plan and the plan for the taped session
  - Discuss at least one insight or strategy used to encourage change
  - Discuss the interfering beliefs revealed and plan to implement change
  - Discuss competencies used in the session
  - Discuss anything the student would have done differently in the session

- The Clinical Instructor:
  - Offers suggestions for next session
  - Evaluates whether the student is following the treatment plan and using competencies and techniques
  - Discusses the competencies the student can work on
  - Discusses the plan for the next session

The student sees the client for one to two additional sessions. The student obtains a minimum of three early recollections and birth order information (or the goal of misbehavior in children) and submits the tape to the Clinical Instructor. The student tapes one session (not collection of early recollections) unless the instructor prefers and the site allows an on site visit. If doing two sessions, the student must e-mail a brief summary of the session for instructor comment and suggestions for the next session.

Meeting #3 (90 minutes) Clinical Instructor and student do co-therapy or review tape
- Same format as second meeting
Discuss interpretation and beliefs in early recollections and how interfering beliefs are playing out in the current problems
Discuss how to encourage change in interfering beliefs and subsequent behavior

Student sees client for one or more additional sessions tapes a session and submits the tape to the Clinical Instructor. If doing two sessions, the student must e-mail a brief summary of the session to instructor for comment or suggestions for the next session.

Meeting #4 (90 minutes) This meeting includes the same elements as meeting #3.

Final Meeting (One hour)
Discuss previous session including insights and strategies used
Discuss overall progress made in therapy based on treatment plan
Discuss changes seen in the client as a result of therapy
Discuss competencies mastered and competencies to work on in the future.

I. Evaluation: Clinical Instructors want to see the application of therapy skills and techniques. Clinical Instructors want to see change in the client or an explanation of why change has not occurred. A pass or recommendation for additional Internship will be issued, as appropriate.
Alternate Plan: Crisis Counseling Individual Clinical Instruction

This plan is based on a 1 week crisis intervention model. There will also be 6 hours of Internship applied to the model. Students contact their chosen Clinical Instructor and reach a Internship agreement. Because Internship is intense over a short period of time, Clinical Instructors need as much notice as possible to assure that Internship can fit into their schedules.

Meeting #1 (30 minutes): Consultation with Clinical Instructor immediately after first session on day one to:
- Review case history previously sent to Clinical Instructor
- Discuss the treatment plan
- Review competencies for future application in session
- Discuss the plan for the next client session

Student sees the client for one session, tapes the session, and submits the tape to the Clinical Instructor

Meeting #2 (1½ hour consultation on day two):
- The student is prepared to:
  - Review the treatment plan and discuss a plan for the next taped session
  - Discuss at least one insight or strategy used to encourage change
  - Discuss the client’s interfering beliefs revealed and plan to implement change
  - Discuss competencies used in the session
  - Discuss anything the student would have done differently in the session

- The Clinical Instructor will:
  - Discuss suggestions for next session
  - Evaluate whether the student is following the treatment plan and using competency techniques
  - Discuss what competencies the student can work on
  - Discuss the plan for the next session

Student sees the client for two sessions, tapes second session, and submits the tape to the Clinical Instructor

Meeting #3 (1½ hours on day three): Review tape or do doubles therapy
- The student is prepared to:
  - Review the treatment plan and the plan for the taped session
  - Discuss at least one insight or strategy used to encourage change
  - Discuss client’s interfering beliefs and plan to implement change
  - Discuss the competencies used in the session
  - Discuss anything the student would have done differently in the session

- The Clinical Instructor:
  - Discusses suggestions for next session
  - Evaluates whether the student is following the treatment plan and using competency techniques
  - Discusses what competencies the student can work on
  - Discusses the plan for the next session
Meeting #4 (1 ½ hours on day four): Review a tape submitted to the Clinical Instructor and completed since the previous meeting
The student is prepared to:
Review the treatment plan and the plan for the taped session
Discuss at least one insight or strategy used to encourage change
Discuss client’s interfering beliefs and plan to implement change
Discuss the competencies used in the session
Discuss anything you would have done differently in the session
The Clinical Instructor:
Discusses suggestions for next session
Evaluates whether the student is following the treatment plan and using competency techniques
Discusses what competencies the student can work on
Discusses the plan for the next session

Meeting #5 (1 hour on day five): Final review of progress throughout the week and recommendations to client for future work
The student is prepared to:
Review the treatment plan and client progress
Discuss at least one insight or strategy used to encourage change
Discuss client’s interfering beliefs and plan to implement change
Discuss the competencies used in the session
Discuss anything the student would have done differently in the session
The Clinical Instructor:
Discusses suggestions for development of competencies
Evaluates whether the student is following the treatment plan and using competency techniques
Discusses what competencies the student can work on
Discusses the plan for the next session
Therapy Review
Discuss changes seen in the client as a result of therapy
Discuss competencies mastered and competencies to work on in the future

Evaluation: Clinical Instructors want to see the application of therapeutic skills and techniques. Clinical Instructors want to see change in the client or an explanation of why change has not occurred. This results in a pass or the need for additional Internship, as appropriate.
Course 598 – Individual Clinical Instruction

Course Syllabus

1. Course Designation:
   1.1 Course Number 598 Prerequisite: 597 Advanced Internship I
   1.2 Internship: Individual Clinical Instruction
   1.3 A faculty member will supervise the student doing counseling with one case that the student is presently seeing. This is for the purpose of assessing the competency of the student to help the student to recognize how Adlerian techniques would be helpful in this case and to encourage the student to work on weak competencies.
   1.4 This course will yield 1 credit.

2. Internship Description:
   This Internship offers students the opportunity to demonstrate that they have learned all the competencies needed to be an effective therapist with clients. They will also, through the experience learn about additional therapeutic approaches that could be helpful with each client and which competencies they should be working on.

3. Texts: None

4. Required Reading: None

5. Learning Outcomes:
   Students will have their competency confirmed and also learn how to use additional therapeutic approaches with the clients they are seeing.

6. Assessment of Learning Outcomes: the Clinical Instructor will observe the student doing therapy with clients and will give feedback to the student or review tapes with the student. An evaluation based on the feedback will be placed in the student internship file. The student will either pass or be asked to repeat the direct Internship after working on the weak competency areas.

7. Internship Content:
   Demonstration of additional techniques by the faculty by reviewing tapes or doing co-therapy with the student.
Post-Degree Students Only

Students who hold a previous master’s degree in counseling will take Advanced Group Internship (#597) for each term that they are clocking hours. Students submit a supervisor’s evaluation, completed assignments, and logs within 2 weeks following the end of the applicable term. A packet of instructions for post-degree students is available in the media center.
Clinical Internship Instructors

Following is a list of Clinical Instructors for #597 Advanced Internship and #598 Individual Clinical Instruction. You must register for these courses. Please call the clinical instructor directly to schedule 598 Individual Clinical Instruction sessions.

Trish Anderson, M.A., LMFT  
17113 Minnetonka Blvd. Ste 205  
Minnetonka, MN 55345  
W: (952) 933-4979  
F: (952) 475-4429  
tfanderson@visi.com

Roger Ballou, PhD, LMFT, LPC  
Adler Graduate School  
1550 East 78th Street  
Richfield, MN 55423  
(612) 861-7554  
BallouRA@aol.com

Marina Bluvshtein, PhD, LP, LMFT  
4900 Hwy 169 N. Ste 309  
New Hope, MN 55428  
W: (763) 231-0333  
drb@soulinmotion.us

Susan Pye Brokaw, MA, LMFT, LICSW  
14525 Hwy 7 #145-D  
Minnetonka, MN 55345  
W: (952) 933-9926  
H: (952) 474-3558  
pyebrokaw@aol.com

Richard Close  
1016 West 14 Street  
Hastings, M 55033  
651-437-1860  
richard3t@embarqmail.com

Catherine Hedberg, MA, LP  
311 Ramsey Street  
St. Paul, MN 55102  
W: (651) 222-3129  
catherinemhedberg@yahoo.com

Herbert H. Laube, PhD  
4006 Cedarwood Rd.  
St. Louis Park, MN 55416  
W: (952) 544-5719  
H: (952) 927-4746  
herblaube@aol.com

Jerome Truer, MA, LICSW  
5120 Nokomis Ave  
Minneapolis, MN 55417  
W: (612) 824-9745  
Truer02@aol.com

Daniel Zenga, Ed.D.  
227 Westwood Dr  
Mankato, MN 56001  
W: (507) 389-8407  
Dan.Zenga@co.Blue-Earth.mn.us

Art Therapy

Craig Balfany, MPS, ATR  
U of M Children’s Hospital  
W: (612) 273-2156  
crgbalf@aol.com

Erin Rafferty, LPC, ATR-BC  
U of M Medical Center  
Children’s Day Treatment Center  
W: (612) 273-5941  
ERAFFER1@Fairview.org
Part IV

Internship Site Information
Internship Site Information

Practicum/Internship Site Standards

The Adler Graduate School (AGS) is dedicated to the highest standards of ethicality and best practices in its practicum/internship program. These standards are applied to both the School itself and to affiliated sites. While the spirit of this commitment cannot be fully defined as to either prescribed or proscribed criteria/conditions, basic requirements of practicum/internship sites are identified below.

Requirements of affiliated practicum/internship sites include:

- Provide students and clients with a respectful, hospitable service/learning environment
- Clarity concerning expectations of students
- Clarity concerning expectations of sites
- Appropriate learning opportunities/assignments for students
- Learning opportunities/assignments designed to continuously advance students’ learning
- Appropriate depth and breadth of Internship for students
- Appropriate levels of training (complementing Internship) offered for students
- Legally/ethically acceptable fees and billing practices – when fees and billing are germane

Affiliated practicum/internship sites will not:

- Expose students to less than the highest standards of ethicality/best practices
- Work with students when a conflict of interest is evident
- Impose financial obligations on students (e.g., rent)
- Reduce any compensation/stipend that a student might otherwise earn by subtracting fees for things that are usual and customary components of practicum/internship sites such as space and Internship
- Expect students to recruit clients
- Expose students to or involve students in the use of illegal/unethical client fees and/or billing practices

September 2010

Pre-MA Degree/Pre-Licensed Private Clinical Practice by AGS Students

The Adler Graduate School (AGS) strongly discourages private practice by AGS students who have not yet earned a counseling-related Master’s Degree. In general, AGS will not allow students engaged in their own private practices to use those experiences to satisfy AGS’ practicum/internship requirements.
Field Site Faculty Liaison

Every site is assigned an AGS faculty liaison. If the liaison is unknown, contact Student Services for the faculty member’s name. If a student has a question or concern regarding the site or the site has a question or concern with the student, the faculty liaison is to be contacted to help resolve the situation.

Termination Protocol for Internships

- When leaving an internship – whether at the end of a pre-determined period of time or before the end of a pre-determined period of time – AGS students are expected to conduct themselves in a professional manner
- Communicate clearly with internship representatives/supervisors
- In the case of terminations which occur according to plan, confirm plans with representatives/supervisors and provide clients with appropriate notice
- Execute termination plans with clients according to professional standards and supervisor expectations
- In the case of terminations that might occur before the end of a pre-determined period of time, clearly/candidly discuss all appropriate issues/concerns with internship representatives/supervisors
- Seek amicable resolution regarding issues/concerns
- Include AGS representatives (e.g., internship liaison from AGS) in finding resolution, if possible
- Inform AGS representatives of resolution achieved, in case of terminations before the end of a pre-determined period of time
- Regardless of termination circumstances, upon termination with internship site, submit all appropriate information (e.g., evaluations, hours) to AGS representatives
PART V

LICENSURE
Explanation of Licensing Options:

- AGS requires a 48 credit MA – 13 courses and 6 credits of internship and a 3-credit Master’s Project.

- The LMFT Board requires 11 courses in 5 areas of competency, with a minimum of three courses in each of the following areas: human development; marriage and family systems; and marriage and family therapy. One course must be completed in research and one course in ethics. AGS requires two additional courses in the area of marriage and family therapy, resulting in the 13 courses needed for an MA.

- The BBHT Board requires ten courses for an LPC, with one course in each of the following ten areas of competency: human development; principles of etiology; family counseling and therapy; social and cultural issues; helping relationships; assessment and appraisal; research; ethics; career development; and group dynamics. AGS requires 3 additional Adlerian courses, resulting in the 13 courses necessary for an MA.

- The LPCC upgrade requires 24 additional credits, or 8 courses in 6 areas of competency, including principles of etiology (2 courses); cultural diversity; clinical interventions (2 courses); professional ethics; treatment planning; and evaluation methodologies. Some of these credits may come from courses already taken in AGS’ Master’s program and other courses will need to be added to accomplish the upgrade. For example, a second course in advanced skills is required, as is a psychopathology course. Two brand new courses will also be required, including Treatment Planning and Evaluation Methodologies of Interventions. If a student is not trained at AGS, depending on the transferability of credits, one may need to complete the entire 24-credit upgrade in order to be eligible for the LPCC.

- In Summary 11 courses in AGS’ MA program fulfill requirements for the LPC, LMFT and LPCC. More specifically, these eleven courses meet the requirements for the LMFT, with two more courses necessary for graduation from AGS. Ten of these 11 courses meet requirements for the LPC, with an additional 3 courses in Adlerian content necessary to meet AGS graduation requirements. Preparation for the LMFT and LPC licenses will lead to a 48 credit MA degree. If a student has been trained at AGS, the LPCC requires all of the 11 courses referred to above, plus the addition of four more courses to fulfill the missing requirements in the 24-credit upgrade described above. This MA degree would then equal 60 credits.

- The attached grid will be helpful in answering questions regarding other combinations of courses. In addition questions may be directed to AGS’ Director of Admissions and Student Services.
Licensure for Marriage and Family Therapy

Licensure for Marriage and Family Therapy (LMFT) may be something students are interested in pursuing.

**Contact the Board:** The first step is to contact Bob Butler at (612) 617.2220 at the MN Board of Marriage and Family Therapy and ask for the Permanent Rules or go to www.bmft.mn.us. This explains all the procedures and requirements for obtaining the LMFT license.

**Summary of LMFT Procedures:** The following is not a complete list of all requirements and procedures of the LMFT, but rather a sampling to let students know what is involved. If students are interested in LMFT, they are encouraged to contact the board to receive the Permanent Rules.

**Follow the LMFT Grid:** The Office of Student Services provides the LMFT grid to students interested in the LMFT. Obtain one early in the program and be sure to follow it. This is a useful planning tool. The LMFT grid is designed to help students complete the educational requirements for the LMFT.

**300 Pre-Degree Hours:** “A clinical practicum in marriage and family therapy of at least 300 hours of clinical client contact with individuals, couples and families for the purpose of assessment and intervention. Of the 300 hours, no more than 150 may be with individuals.” *(MN Board of Marriage and Family Therapy Permanent Rules, Pg. 6)*

**Written Examination:** The examination may be taken online three times a year. Requirements must be completed three months before the exam. Call Student Services for more details and dates.

**1000 Post-Degree Hours:** “In calculating two years of supervised post-graduate experience in marriage ad family therapy, the Board shall accept a minimum of 1000 hours of clinical client contact and 200 hours of Internship over a period of not less than 24 months. The applicant must demonstrate a least 500 hours of the clinical client contact required in the following categories of cases: unmarried couples, married couples, separating and divorcing couples, and family groups including children.” *(MN Board of Marriage and Family Therapy Permanent Rules, pg. 6-7)*

**LMFT Oral Examination:** The LMFT oral examination is taken after all the post-degree hours are completed and this is the last step before licensure. There is an application process for the LMFT oral examination. The oral examination is scheduled privately on a monthly basis.
### Licensing Explanations

<table>
<thead>
<tr>
<th>Category</th>
<th>Requirements</th>
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<td><strong>Marriage &amp; Family</strong></td>
<td><strong>Art Therapy</strong>&lt;br&gt;36 credits&lt;br&gt;36 credits of coursework&lt;br&gt;4000 hours, 1000 face-to-face&lt;br&gt;10 years or 200 hours of supervision, etc.&lt;br&gt;Art Clinic: 200 hours&lt;br&gt;2000 hours of anything that is counseling in nature under supervision. orals&lt;br&gt;40 courses Only&lt;br&gt;13. Clinical Interventions 6 cr.</td>
</tr>
<tr>
<td><strong>Counselor Education &amp; Supervision</strong></td>
<td><strong>Counselor Education &amp; Supervision</strong>&lt;br&gt;36 credits of coursework&lt;br&gt;14. Clinical Interventions 6 cr.</td>
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</table>
Marriage & Family Therapy Requirements for Licensure

5300.0130 REQUIREMENTS FOR LICENSURE.

Subpart 1. Requirements. To be eligible for licensure, an applicant must meet the following requirements:

A. complete the education requirements in Minnesota Statutes, section 148B.33, subdivision 1, clauses (5)(i) and (ii);

B. have obtained the age of majority, the age of majority being 18 years according to Minnesota Statutes, section 645.451, subdivision 5;

C. complete the experience requirements in Minnesota Statutes, section 148B.33, subdivision 1, clause (4), and defined in part 5300.0150;

D. provide evidence of meeting the requirements of Minnesota Statutes, section 148B.33, subdivision 1, clause (2), through endorsements from at least two individuals with the qualifications in part 5300.0230;

E. agree to conduct all professional activities as a licensed marriage and family therapist in accordance with the code of ethics for marriage and family therapists in part 5300.0350; and

F. pass both parts of the examination listed in part 5300.0240.

Subp. 2. Denial of licensure to applicant. An applicant who fails to meet all requirements in this part shall be denied a license.

5300.0150 EXPERIENCE REQUIREMENTS.

Subpart 1. Supervised experience required. The two years supervised, postgraduate experience required by Minnesota Statutes, section 148B.33, subdivision 1, clause (4), must meet the requirements in subparts 2 to 6.

Subp. 2. Years of experience; computation. In calculating two years of supervised postgraduate experience in marriage and family therapy, the board shall accept a minimum of 1,000 hours of clinical client contact including the assessment, diagnosis, and treatment of mental illness as specified in subpart 3 with 200 hours of Internship by a Minnesota licensed marriage and family therapist over a period of not less than 24 months. All additional work used to complete this two-year experience may be supervised in a legal and ethical manner by a licensed mental health professional listed in Minnesota Statutes, section 245.462, subdivision 18, clauses (1) to (5), or 245.4871, subdivision 27, clauses (1) to (5), or both.
Subp. 3. Clinical client contact; requirements. The applicant must demonstrate at least 500 hours of the clinical client contact required in the following categories of cases:

A. unmarried couples;

B. married couples;

C. separating and divorcing couples; and

D. family groups including children.

This contact shall include experience in the assessment, diagnosis, and treatment of mental illness.

Subp. 4. Internship; setting. The Internship by a Minnesota licensed marriage and family therapist shall take place in individual and group settings, according to items A and B.

A. The Individual Clinical Instruction shall take place in a setting in which a supervisor and not more than two supervisees are present.

B. The group Internship shall take place in a setting in which a supervisor and not more than six supervisees are present.

Subp. 5. Internship requirements. Internship must involve:

A. at least 200 hours of face-to-face contact between the supervisor and supervisee of which at least 100 hours must be in individual settings;

B. 100 hours of Internship per year; and

C. a focus on the raw data from the supervisee's clinical work that is made directly available to the supervisor through means of written clinical materials, direct observation, and audio or video recordings.

Subp. 6. Verifying supervised experience. A supervisee must verify the required supervised experience by completing a form supplied by the board. The form must be signed by the applicant's supervisor and be notarized. The form must include the setting, nature, and extent of the supervised experience, the time period involved, the number of hours of clinical client contact, the number of hours of Internship, and the name and qualifications of each supervisor.
148B.53 REQUIREMENTS FOR LICENSURE.

Subdivision 1. General requirements. (a) To be licensed as a licensed professional counselor (LPC), an applicant must provide evidence satisfactory to the board that the applicant:

(1) is at least 18 years of age;
(2) is of good moral character;
(3) has completed a master's or doctoral degree program in counseling or a related field, as determined by the board based on the criteria in paragraph (b), that includes a minimum of 48 semester hours or 72 quarter hours and a supervised field experience of not fewer than 700 hours that is counseling in nature;
(4) has submitted to the board a plan for Internship during the first 2,000 hours of professional practice or has submitted proof of supervised professional practice that is acceptable to the board; and
(5) has demonstrated competence in professional counseling by passing the National Counseling Exam (NCE) administered by the National Board for Certified Counselors, Inc. (NBCC) or an equivalent national examination as determined by the board, and ethical, oral, and situational examinations if prescribed by the board.

(b) The degree described in paragraph (a), clause (3), must be from a counseling program recognized by the Council for Accreditation of Counseling and Related Education Programs (CACREP) or from an institution of higher education that is accredited by a regional accrediting organization recognized by the Council for Higher Education Accreditation (CHEA). Specific academic course content and training must include course work in each of the following subject areas:

(1) the helping relationship, including counseling theory and practice;
(2) human growth and development;
(3) lifestyle and career development;
(4) group dynamics, processes, counseling, and consulting;
(5) assessment and appraisal;
(6) social and cultural foundations, including multicultural issues;
(7) principles of etiology, treatment planning, and prevention of mental and emotional disorders and dysfunctional behavior;
(8) family counseling and therapy;
(9) research and evaluation; and
(10) professional counseling orientation and ethics.

(c) To be licensed as a professional counselor, a psychological practitioner licensed under section 148.908 need only show evidence of licensure under that section and is not required to comply with paragraph (a), clauses (1) to (3) and (5), or paragraph (b).

(d) To be licensed as a professional counselor, a Minnesota licensed psychologist need only show evidence of licensure from the Minnesota Board of Psychology and is not required to comply with paragraph (a) or (b).

Subd. 2. [MS 2004] [Expired, 2003 c 118 s 7]
Subd. 3. Fee. Nonrefundable fees are as follows:

(1) initial license application fee for licensed professional counseling (LPC) - $150;
(2) initial license fee for LPC - $250;
(3) annual active license renewal fee for LPC - $250 or equivalent;
(4) annual inactive license renewal fee for LPC - $125;
(5) initial license application fee for licensed professional clinical counseling (LPCC) - $150;
(6) initial license fee for LPCC - $250;
(7) annual active license renewal fee for LPCC - $250 or equivalent;
(8) annual inactive license renewal fee for LPCC - $125;
(9) license renewal late fee - $100 per month or portion thereof;
(10) copy of board order or stipulation - $10;
(11) certificate of good standing or license verification - $25;
(12) duplicate certificate fee - $25;
(13) professional firm renewal fee - $25;
(14) sponsor application for approval of a continuing education course - $60;
(15) initial registration fee - $50;
(16) annual registration renewal fee - $25; and
(17) approved supervisor application processing fee - $30.

LPCC Requirements

148B.5301 LICENSED PROFESSIONAL CLINICAL COUNSELOR.
Subdivision 1. General requirements. (a) To be licensed as a licensed professional clinical counselor (LPCC), an applicant must provide satisfactory evidence to the board that the applicant:
(1) is at least 18 years of age;
(2) is of good moral character;
(3) has completed a master's or doctoral degree program in counseling or a related field, as determined by the board based on the criteria in items (i) to (x), that includes a minimum of 48 semester hours or 72 quarter hours and a supervised field experience in counseling that is not fewer than 700 hours. The degree must be from a counseling program recognized by the Council for Accreditation of Counseling and Related Education Programs (CACREP) or from an institution of higher education that is accredited by a regional accrediting organization recognized by the Council for Higher Education Accreditation (CHEA). Specific academic course content and training must include coursework in each of the following subject areas:
(i) helping relationship, including counseling theory and practice;
(ii) human growth and development;
(iii) lifestyle and career development;
(iv) group dynamics, processes, counseling, and consulting;
(v) assessment and appraisal;
(vi) social and cultural foundations, including multicultural issues;
(vii) principles of etiology, treatment planning, and prevention of mental and emotional disorders and dysfunctional behavior;
(viii) family counseling and therapy;
(ix) research and evaluation; and
(x) professional counseling orientation and ethics;
(4) has demonstrated competence in professional counseling by passing the National Clinical Mental Health Counseling Examination (NCMHCE), administered by the National Board for Certified Counselors, Inc. (NBCC) and ethical, oral, and situational examinations as prescribed by the board. In lieu of the NCMHCE, applicants who have taken and passed the National Counselor Examination (NCE) administered by the NBCC, or another board-approved examination, need only take and pass the Examination of Clinical Counseling Practice (ECCP) administered by the NBCC;

(5) has earned graduate-level semester credits or quarter-credit equivalents in the following clinical content areas as follows:
   (i) six credits in diagnostic assessment for child or adult mental disorders; normative development; and psychopathology, including developmental psychopathology;
   (ii) three credits in clinical treatment planning, with measurable goals;
   (iii) six credits in clinical intervention methods informed by research evidence and community standards of practice;
   (iv) three credits in evaluation methodologies regarding the effectiveness of interventions;
   (v) three credits in professional ethics applied to clinical practice; and
   (vi) three credits in cultural diversity; and

(6) has demonstrated successful completion of 4,000 hours of supervised, post-master’s degree professional practice in the delivery of clinical services in the diagnosis and treatment of child and adult mental illnesses and disorders, conducted according to subdivision 2.

(b) If coursework in paragraph (a) was not completed as part of the degree program required by paragraph (a), clause (3), the coursework must be taken and passed for credit, and must be earned from a counseling program or institution that meets the requirements of paragraph (a), clause (3).

Subd. 2. Internship. (a) To qualify as a LPCC, an applicant must have completed 4,000 hours of post-master’s degree supervised professional practice in the delivery of clinical services in the diagnosis and treatment of mental illnesses and disorders in both children and adults. The supervised practice shall be conducted according to the requirements in paragraphs (b) to (e).

(b) The Internship must have been received under a contract that defines clinical practice and Internship from a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6), or by a board-approved supervisor, who has at least two years of post licensure experience in the delivery of clinical services in the diagnosis and treatment of mental illnesses and disorders.

(c) The Internship must be obtained at the rate of two hours of Internship per 40 hours of professional practice. The Internship must be evenly distributed over the course of the supervised professional practice. At least 75 percent of the required Internship hours must be received in person. The remaining 25 percent of the required hours may be received by telephone or by audio or audiovisual electronic device. At least 50 percent of the required hours of Internship must be received on an individual basis. The remaining 50 percent may be received in a group setting.

(d) The supervised practice must include at least 1,800 hours of clinical client contact.
(e) The supervised practice must be clinical practice. Internship includes the observation by the supervisor of the successful application of professional counseling knowledge, skills, and values in the differential diagnosis and treatment of psychosocial function, disability, or impairment, including addictions and emotional, mental, and behavioral disorders.

Subd. 3. Conversion from licensed professional counselor to licensed professional clinical counselor. (a) Until August 1, 2011, an individual currently licensed in the state of Minnesota as a licensed professional counselor may convert to a LPCC by providing evidence satisfactory to the board that the applicant has met the following requirements:

1. is at least 18 years of age;
2. is of good moral character;
3. has a license that is active and in good standing;
4. has no complaints pending, uncompleted disciplinary orders, or corrective action agreements;
5. has completed a master's or doctoral degree program in counseling or a related field, as determined by the board, and whose degree was from a counseling program recognized by CACREP or from an institution of higher education that is accredited by a regional accrediting organization recognized by CHEA;
6. has earned 24 graduate-level semester credits or quarter-credit equivalents in clinical coursework which includes content in the following clinical areas:
   - diagnostic assessment for child and adult mental disorders; normative development; and psychopathology, including developmental psychopathology;
   - clinical treatment planning, with measurable goals;
   - clinical intervention methods informed by research evidence and community standards of practice;
   - evaluation methodologies regarding the effectiveness of interventions;
   - professional ethics applied to clinical practice; and
   - cultural diversity;
7. has demonstrated, to the satisfaction of the board, successful completion of 4,000 hours of supervised, post-master's degree professional practice in the delivery of clinical services in the diagnosis and treatment of child and adult mental illnesses and disorders; and
8. has paid the LPCC application and licensure fees required in section 148B.53, subdivision 3.

(b) If the coursework in paragraph (a) was not completed as part of the degree program required by paragraph (a), clause (5), the coursework must be taken and passed for credit, and must be earned from a counseling program or institution that meets the requirements in paragraph (a), clause (5).

(c) This subdivision expires August 1, 2011.

Subd. 4. Conversion to licensed professional clinical counselor after August 1, 2011. An individual licensed in the state of Minnesota as a licensed professional counselor may convert to a LPCC by providing evidence satisfactory to the board that the applicant has met the requirements of subdivisions 1 and 2, subject to the following:

1. the individual's license must be active and in good standing;
(2) the individual must not have any complaints pending, uncompleted disciplinary orders, or corrective action agreements; and

(3) the individual has paid the LPCC application and licensure fees required in section 148B.53, subdivision 3.

Subd. 5. Scope of practice. The scope of practice of a LPCC shall include all those services provided by mental health professionals as defined in sections 245.462, subdivision 18, and 245.4871, subdivision 27.

Subd. 6. Jurisdiction. LPCC's are subject to the board's statutes and rules to the same extent as licensed professional counselors.

History: 2007 c 123 s 40
Post Degree Requirements

148B.531, Minnesota Statutes 2007

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148B.531 POSTDEGREE COMPLETION OF DEGREE REQUIREMENTS FOR LICENSURE.
An individual whose degree upon which licensure is to be based included less than 48 semester hours or 72 quarter hours, who did not complete 700 hours of supervised professional practice as part of the degree program, or who did not complete course work in all of the content areas required by section 148B.53, subdivision 1, paragraph (b), may complete these requirements postdegree in order to obtain licensure, if:
(1) all course work and field experiences are completed through an institution of higher education that is accredited by a regional accrediting organization recognized by the Council for Higher Education Accreditation (CHEA) or through a counseling program recognized by the Council for Accreditation of Counseling and Related Education Programs (CACREP);
(2) all course work and field experiences are taken and passed for credit; and
(3) no more than 20 semester credits or 30 quarter credits are completed postdegree for purposes of licensure unless the credits are earned as part of an organized sequence of study.
History: 2005 c 147 art 5 s 3
PART VI
Forms
New Site Approval Form
(Approval process is initiated by student)

Student Name: ____________________________________________________________

Name of Site: ____________________________________________________________

Address: ______________________________________________________________

Street Address

City     State   Zip Code

Telephone Number: ______________________________________________________

Fax number: ____________________________________________________________

Contact person: _________________________________________________________

Phone #: ________________________ Fax #: ______________________________

E-mail address: _________________________________________________________

Description of site: _____________________________________________________

Description of duties/responsibilities: _____________________________________

Supervisor’s credentials: ________________________________________________

Internship Level:
☐ Beginning Intern (doing only peer counseling)
☐ Intermediate Intern (Doing co-therapy and/or gradually taking on therapy cases)
☐ Advanced Intern (Seeing three to six therapy cases)

AGS students are required to obtain insurance before beginning an internship.

Insurance Company: ______________________________________________________

Copy of Policy turned into Adler for files     Yes____    No____       Date________

This site is __________________☐ approved     ☐ not approved.

Signature of Academic VP: ____________________________ Date: __________

July 2011 Revision
Adler Graduate School
Student Internship - Site Supervisor Evaluation

Student's Name: _____________________________________________________
Internship Site: ____________________________________________________

Month/Year: __________

Supervisor’s Name: _________________________________________________ Phone: ___________________________

Internship Type: _____Peer/Support _____Therapy

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<th>Meets</th>
<th>Above</th>
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Please rate how well the student is meeting expectations:

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What is your overall impression of the student’s abilities, considering his/her current experience and training?

Other comments or concerns?

This student ____has ____has not satisfactorily completed this internship requirement.

__________________________________________________________ _______________________________
Supervisor’s Signature                                      Date

July 2011 Revision
## Student Internship - Site Supervisor Evaluation

**Student's Name:** _______________________________________________________

**Internship Site:** ___________________________________

**Month/Year:** _________

**Supervisor's Name:** _____________________________________________

**Phone:** ______________________

**Internship Type:** ____Peer/Support ____Therapy

### Please rate how well the student is meeting expectations:

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<td>Sensitivity to individual differences</td>
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<td>Sensitivity to contextual issues</td>
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<td>Knowledge of client population</td>
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<td><strong>Professional Skills</strong></td>
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<td>Treatment planning</td>
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<td>Professional administrative practices</td>
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<td>Quality of presentation/discussion</td>
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Please rate how well the student is meeting expectations:

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<tr>
<th></th>
<th>N/A</th>
<th>Below</th>
<th>Meets</th>
<th>Above</th>
<th>Exceptional</th>
<th>Notes</th>
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<td><strong>Clinical Skills</strong></td>
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<td>Ability to promote client growth/change</td>
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<td>Ability to identify ethical issues</td>
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<td>Handling of client dilemmas</td>
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<td>Self-confidence</td>
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<tr>
<td>Appropriate integration of theory and interventions</td>
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<td><strong>Professional Demeanor</strong></td>
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<td>Willingness to apply new ideas</td>
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<td>Ability to apply new ideas</td>
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<td>Responsiveness to Internship</td>
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<td>Recognition of personal limitations</td>
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<td>Identifies focus for self-growth</td>
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What is your overall impression of the student's abilities, considering his/her current experience and training?

Other comments or concerns?

This student ____has _____has not satisfactorily completed this internship requirement.

__________________________________________________________ _______________________________

Supervisor's Signature                                              Date

July 2011 Revision
Information for Logging Hours

School and Boards Requiring Logged Hours
Adler Graduate School requires 500 hours on a site of which 300 must be doing therapy. The Marriage and Family Licensing Board requires 300 pre-degree hours doing therapy, in which at least half must be doing relationship therapy. The Board of Behavioral Health and Therapy requires 700 pre-degree hours. All hours on the site can be counted. (ATCB) requires 700 pre-degree hours. 350 must be Art Therapy and 150 of that must be relational Art Therapy. The remaining 350 may be peer or other types of hours.

Sections on the Logging Form
There are four sections on the logging form.

The first section is used for logging all hours on site to meet AGS hour’s requirement of 500 hours.

The second section is for logging hours for the Minnesota Board of Marriage and Family Therapy. These hours will be a duplication of some hours recorded in the previous section. This section allows students to track the 300 pre-degree hours required for MFT licensing and must include 150 hours of relationship hours.

The third section is to record hours of supervision on or off site (not class time). There are two kinds of supervision. Individual supervision is face-to-face supervision with the supervisor. Group supervision is when a supervisor does face-to-face supervision with a group of students. One hour of supervision for every 20 hours of on site time is recommended.

The forth section is for the supervisor’s signature. There should always be a signature by a licensed supervisor. At times the on site supervisor is not licensed. In that case, the on-site supervisor should sign as the supervisor and the off-site licensed supervisor should sign in the licensed supervisor space.

Tracking Hours Requirement for AGS
There are a total of 500 hours required by AGS. Each month on site, all hours must be recorded for credit. An internship course must also be attended during the current three-month period. Each month the new hours are to be added to the previous accumulated hours to show the current total of cumulated hours to date. The final month should show that 500 hours have been accumulated or 700 for LPC and Art Therapy.

Definition of Terms
Therapy vs. peer counseling. Therapy is the process of changing maladaptive behavior and thinking by the intervention of the therapist. The student would be a lead therapist, a co-therapist or shadowing the lead therapist. Peer counseling is connecting with a client but not doing therapy. Some examples are: taking information, giving support and encouragement, leading or co-leading a support group and referring the client to resources where services can be obtained.
Peer Counseling: Any direct contact with clients that is not counseling, such as: doing intakes, answering crisis lines, and leading support groups.

All Other Staff Time: All time spent on site that is not with clients. It may include, training, paper work, meetings, etc.
Art Therapy: For Art Therapy students. Time spent doing art therapy

Individual Therapy: Face to face therapy done with an individual.

Relationship Therapy: Face to face therapy done with two people in a relationship. If two in a relationship are regularly being seen in sessions but on occasion one is seen alone to discuss the relationship, it can be counted as relationship therapy. For example: if a family is being seen, but a parent is seen alone to discuss a specific relationship issue, it can be counted as relationship therapy. Relationship hours may also be counted if people are living together in group homes, nursing homes and other long-term care facilities where the interaction becomes a family system.

Monthly Total: A total of all the hours accumulated for the current month

Previous Cum: All hours accumulated up to the current month

New Cum: The total of the current month’s hours and previous cumulated hours

Group Therapy (Individuals): Conducting group therapy with individuals, excluding support groups)

Group Therapy (Relationship): Conducting group therapy in which two or more people in a relationship are in the group.

Individual Clinical Instruction: Face-to-face supervision with the on-site or off-site supervisor.

Group Clinical Instruction: A group of students meeting with a supervisor for supervision.

Site Supervisor: An on-site supervisor who is supervising the student but is unlicensed. This signature is not acceptable unless a licensed supervisor also signs the form.

Licensed Supervisor: The licensed on-site or off-site supervisor (including type of license) who is supervising the student. All students must have a licensed supervisor sign log forms.

Rev. 6/11
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<th>Other</th>
<th>Individual</th>
<th>Individual Group</th>
<th>Relationship</th>
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New Cumulative ttl
Total Individual
Total Relationship

Site Supervisor Signature ___________________________ Date ______
Licensed Supervisor Signature ______________________ Date ______

At least one licensed signature required

One Hour for every 20 on site

Adler Graduate School Advanced Internship Manual 83
July 2011 Revision
Internship Log  
Level: Check One  591,2,3,4, ______  597 ______  598 ______

Name_____________________________  Internship Site________________________________  Term_______  Month_______  Year________

RECORD HOURS WORKED IN EACH CLASSIFICATION FOR ADLER GRADUATION REQUIREMENT  500 for LMFT  700 for LPC, LPCC

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<tr>
<th>Day of Month</th>
<th>Peer</th>
<th>Other</th>
<th>Individual</th>
<th>Individual Group</th>
<th>Relationship</th>
<th>Relationship Group</th>
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<tr>
<th>Total Relationship</th>
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Site Supervisor Signature____________________________Date____  Licensed Supervisor Signature__________________________Date____

At least one licensed signature required

Adler Graduate School
Advanced Internship Manual

July 2011 Revision
Adler Graduate School
597 Advanced Internship □ 597.1 □ 597.2 □ 597.3

Instructors: Use this form for documenting one case as it is presented and followed throughout the one credit of 597, or for the full scope of your work in 598.

Name of Student: _________________________________ Date: __________

Internship Type: □ Presentation □ Live □ Audio □ Video

Client Pseudonym(s)/Initials: _________________________________

**General Skills** Use the following rating scale:

5 exceptional 4 above average 3 satisfactory 2 below average 1 unsatisfactory

____ The student supplied a written social history following the guidelines.

____ The student has supplied a treatment plan

____ Joining and ability to establish rapport and maintain therapeutic relationship.

____ Demonstrates an ability to assess and hypothesize based on Adlerian principles

____ Demonstrates an understanding of intervention techniques by identifying and using techniques appropriate to the clinical issue and client goals

____ Possesses personal skills such as openness to feedback, ability to exhibit warmth, authenticity, curiosity, etc.

____ Demonstrates a sensitivity to contextual issues and knowledge of client population

____ Demonstrates an ability to identify legal and ethical issues

____ Demonstrates effective session management (focusing client, summarizing, homework, timely conclusion, etc.)

**Required Adlerian Skills (Rate on scale of 1-5)**

______ Student has collected lifestyle data (minimally ERs and birth order; for children, the goals of misbehavior)

______ Ability to discuss interpretation and beliefs in Early Recollections and how Lifestyle is playing out in the current problems

______ Ability to discuss how to encourage change in Lifestyle and behavior
_____ Ability to identify private logic and create plan to implement change

_____ At least one insight or strategy used to encourage change

_____ Specific interventions and skills used in the session as listed:

________________________________________________________________________

What does the student describe that he/she would have done differently in the session?

What skills and competencies will the student develop or work on?

How well did the student follow-through on recommendations between class meetings?

Is the student showing progress in clinical skills development? Describe.

Is the client is making satisfactory progress; if not for what reason(s)?

Instructor Signature ________________________________________________
Adler Graduate School
598 Direct Internship Evaluation

Instructors: Use this form for documenting one case as it is presented and followed throughout the one credit of 597, or for the full scope of your work in 598.

Name of Student: _________________________________ Date: __________

☐ Six Hours of Internship Completed

Internship Type:  ☐ Presentation  ☐ Live  ☐ Audio  ☐ Video

Client Pseudonym(s)/Initials: _________________________________

General Skills Use the following rating scale:

5 exceptional 4 above average 3 satisfactory 2 below average 1 unsatisfactory

_____ The student supplied a written social history following the guidelines.

_____ The student has supplied a treatment plan

_____ Joining and ability to establish rapport and maintain therapeutic relationship.

_____ Demonstrates an ability to assess and hypothesize based on Adlerian principles

_____ Demonstrates an understanding of intervention techniques by identifying and using techniques appropriate to the clinical issue and client goals

_____ Possesses personal skills such as openness to feedback, ability to exhibit warmth, authenticity, curiosity, etc.

_____ Demonstrates a sensitivity to contextual issues and knowledge of client population

_____ Demonstrates an ability to identify legal and ethical issues

_____ Demonstrates effective session management (focusing client, summarizing, homework, timely conclusion, etc.)

Required Adlerian Skills (Rate on scale of 1-5)

_____ Student has collected lifestyle data (minimally Ers and birth order; for children, the goals of misbehavior)

_____ Ability to discuss interpretation and beliefs in Early Recollections and how Lifestyle is playing out in the current problems
_____ Ability to discuss how to encourage change in Lifestyle and behavior
_____ Ability to identify private logic and create plan to implement change
_____ At least one insight or strategy used to encourage change
_____ Specific interventions and skills used in the session as listed:

What does the student describe that he/she would have done differently in the session?

What skills and competencies will the student develop or work on?

How well did the student follow-through on recommendations between class meetings?

Is the student showing progress in clinical skills development? Describe.

Is the client is making satisfactory progress; if not for what reason(s)?

___Attach Student Internship Site Evaluation

Instructor Signature ________________________________
Adler Graduate School
Case History Form
(For use in 594, 597 & Advanced Internship and 598 Individual Clinical Instruction)

This is a guide for the client case histories presented to the Advanced Internship and Direct Internship instructors. This report should be typewritten with the exception of the genogram. Headings should be used and information should be given in as brief a manner as possible. Be sure to refer to your Internship manual regarding confidentiality requirements as you prepare this document.

The following sections are required for all cases. At the end of this form, you will find additional data that are required based on the specific treatment modality, i.e. children, couples, or families.

Client Pseudonym(s)/Initials: _____________________________ Age(s): ____________

M___ or F: ___ Marital Status: _____________ Years Together: _______

Occupation(s): _____________________________________________________

Date of Initial Session: _________________ Number of sessions: ________

Genogram, Family Map or suitable alternative: Attach a genogram which includes at least three generations of the client family.

Referral and Presenting Problem: State briefly who referred the client for counseling (ex: self, physician, friend, relative) and the primary problem for which help is being sought (ex: discordant relationships, job problems, self esteem issues, depression, anxiety).

History of the Problem: How long has the client had this problem? When did it begin and under what circumstances? Describe its severity. Why is help being sought now? Discuss previous attempts at counseling.

Current Situation: Summarize pertinent information about the client’s work, living arrangements, and social situation.

Family History: Describe circumstances in which client was raised (OR family background and family history). Include birth order, economic class, social status, parental and sibling characteristics and interactions, and significant changes or stressors (positive or negative). Also include any history of chemical use or mental illness in the family. Identify strengths and vulnerabilities of the family and its members.

Social Adjustment: Describe peer relationships. Discuss the role client played in peer group and how he/she felt with peers. Describe relationships with family members.
School Adjustment: Describe academic record and behavioral adjustment. Identify special needs or disabilities.

Work Adjustment: Comment on work history. Emphasize ability to find and hold jobs, relationships with fellow workers and supervisors. Determine average length of stay on job and longest period of time in single job.

Marital History: Describe relationship histories beginning with length of courtships, length of marriages, prior marriages or significant relationships. Describe the marriages/relationships in terms of the nature of the relationship and whatever is deemed important and relevant (ex: type of communication, roles, abuse).

Lifestyle Assessment: For adults and teen clients, a minimum of family constellation and ordinal position, and three early recollections.

Treatment Plan: The plan should include client goals and methodology for achievement of goals, along with a multi-axial diagnosis.

Help Needed: Identify specific ways in which you would like assistance with this case (ex: diagnosis and assessment, treatment planning, role playing interventions and techniques)

ADDITIONAL DATA:

Children: Identify the mistaken goal amongst the four goals of misbehavior. Describe in detail the child’s school adjustment, special needs or disabilities, whether there has been out-of-home placement or adoption of this child or siblings. Identify whether there has been sexual activity, what the child’s hobbies and interests are, including use of technology and media.

Couples: Detailed characterization of this marital/committed relationship history. Identify whether either person has a history of or current mental illness, substance abuse, or other addictions. Describe whether there has been or currently is financial stress or domestic violence. Identify any military history and its impact on the relationship. Identify each person’s current investment in the relationship. Identify ages of children if applicable and describe the couple’s parenting relationship. Determine whether there have been any deaths in the couple’s created family.

Families: Provide detailed information about the family relationships, history of mental illness, sexual or physical abuse, children placed outside of the home, adoptions, deaths, miscarriages. Describe parenting styles and methods of discipline. Describe any unique alignments or estrangements.

Revised 10/08
ADLER GRADUATE SCHOOL

Life Style Assessment

By Robert G. Bartholow, MSW, Robert G. Willhite, MSW,
Revised 2006 by Susan Pye Brokaw, MA;
2011 by Jodi Wolf, MA

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   A. Members of your family of origin
   B. Client Data
   C. Sibling Interrelationships
   D. Parent Description
   E. Influential Adult figures
   F. Conclusions about Life
   G. Childhood Attributes

II. Development
   A. Sexual development
   B. Physical Development

III. Childhood: Dreams, Fears, Ambitions

IV. Adult: Dreams

V. Three Wishes, Current Aspirations

VI. Early Recollections

VII. Mistaken Core Beliefs

VIII. Strengths

IX. Life Style Assessment Summary

Revised 4/2011
<table>
<thead>
<tr>
<th>Client’s Name</th>
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<td>Date</td>
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<tr>
<td>Therapist</td>
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I. Family Constellation

A. Members of your family of origin: Give Name and Brief Description of each from your perspective as a child, including yourself.

Parents:

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<tr>
<th>Father</th>
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<th>Mother</th>
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Children: (Include brothers and sisters and self, in order of birth. Also indicate miscarriages, stillborn, and deceased siblings.)

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<tr>
<th>Children</th>
<th>Brief Description</th>
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Revised 4/2011
Genogram Worksheet
Complete per standard procedure
### B. Data on client as a child:

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| 1 | **Who was most like you?**  
   | **In what ways?**                                                                    |
| 2 | **Who was most different from you?**  
   | **In what ways?**                                                                    |
| 3 | **Grade school information:**  
<p>| <strong>Attitude about school?</strong>                                                          |
|   | <strong>Favorite subject?</strong>                                                              |
|   | <strong>Least liked subject?</strong>                                                            |
|   | <strong>Social situation?</strong>                                                               |
|   | <strong>Teachers pet?</strong>                                                                  |
| 4 | <strong>Sports interests or skills?</strong>                                                     |
| 5 | <strong>Childhood habits?</strong>                                                               |
| 6 | <strong>When a child, who had health problems, physical or emotional?</strong>                  |
| 7*| <strong>As a child, did you feel that boys or girls had advantages over the other?</strong>      |
| 8*| <strong>If a female, were you a tomboy in childhood?</strong>                                   |
| 9*| <strong>If male, did you think of yourself as a sissy?</strong>                                  |
| 10| <strong>Childhood spiritual or religious experiences, if any?</strong>                           |</p>
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<th>Question</th>
<th>Emotional</th>
<th>Physical</th>
<th>Sexual</th>
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<td>11 Did you, or any family member(s), experience any abuse (within or outside the family)?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>Give option to pass at this time</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>If client is uncomfortable</td>
<td>No</td>
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<td>No</td>
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<td>If so:</td>
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<tr>
<td>To whom?</td>
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<td>By whom?</td>
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<td>Elaborate?</td>
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<td>12 Who was most spoiled?</td>
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<td>By whom?</td>
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<td>How and for what reason?</td>
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<td>13 Who was most punished?</td>
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<td>By whom?</td>
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<tr>
<td>How and for what reason?</td>
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<td>14 Who in the family needed to be right?</td>
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<td>15 Who in the family felt keen about fairness and unfairness?</td>
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<td>16 Your role in peer group? (leader, middler, follower, outsider)?</td>
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<td>17 Childhood talents or accomplishments?</td>
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<td>18 Your parent’s method of disciplining?</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
C. Sibling Interrelationships:

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Who took care of whom?</td>
</tr>
<tr>
<td>2</td>
<td>Who played with whom?</td>
</tr>
<tr>
<td>3</td>
<td>Who got along best with whom?</td>
</tr>
<tr>
<td>4</td>
<td>Who fought and argued the most?</td>
</tr>
<tr>
<td>5</td>
<td>Who was helpful at home?</td>
</tr>
<tr>
<td>6</td>
<td>Who made mischief?</td>
</tr>
</tbody>
</table>

D. Description of your parents, as seen by you when you were a child:

<table>
<thead>
<tr>
<th></th>
<th>Father</th>
<th>Mother</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Current age if living</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>If deceased, when</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Age when client born</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Occupation</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Personality: traits admired, liked, disliked, feared</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>What was most important to them?</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Father</td>
<td>Mother</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>8. What behavior or attitude could win their praise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. What made them angry?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. What ways did they influence you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. What were their expectations of the children? Did you go along with or do opposite?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specific to:</td>
<td>Father</td>
<td>Mother</td>
</tr>
<tr>
<td>12. Relationship with the children?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Relationship with you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Which child was most like each parent? How?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Were you distant from either parent? Why?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. In whom did you confide in/ closest to?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. To whom did you go for comfort / support? Why?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
18. As a child, what kind of relationship did your parents have?

19. Who was dominant, made decisions; overt and covert?

20. Did they agree on discipline and raising the children?

21. Did they quarrel openly? About What?

22. How did the quarrels end?

23. How did your parents solve problems?

E. Additional adult figures who had a significant influence on your childhood

<table>
<thead>
<tr>
<th>Who?</th>
<th>Describe the relationship?</th>
<th>How did it influence you?</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>
F. Conclusions about Life; Considering your answers to the above, what did you learn about what conclusions you made as a child about:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yourself?</td>
<td></td>
</tr>
<tr>
<td>What males are like?</td>
<td></td>
</tr>
<tr>
<td>What females are like?</td>
<td></td>
</tr>
<tr>
<td>What marriage/relationship is like?</td>
<td></td>
</tr>
<tr>
<td>What parenting is like?</td>
<td></td>
</tr>
<tr>
<td>What family life is like?</td>
<td></td>
</tr>
</tbody>
</table>

G. Childhood Attributes

Using the following Childhood Attribute Assessment, rate you and your siblings from your perspective as a child.

- Put the name and +/- age of each child, including yourself in the box above the columns.
- Rate, (not rank) yourself and only those siblings who are within 5 years older or younger than yourself.
- Rate only the attributes that a given person is either (H) High or (L) Low in.
Family Constellation Worksheet
Life Style Assessment Section I (A-F)
# Childhood Attribute Assessment

<table>
<thead>
<tr>
<th>Achievement &amp; Success</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Intelligence</td>
<td>Successful</td>
<td></td>
</tr>
<tr>
<td>Grades</td>
<td>Helped at Home</td>
<td></td>
</tr>
<tr>
<td>Industrious</td>
<td>Looks</td>
<td></td>
</tr>
<tr>
<td>Standards re. Achievement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Special Characteristics</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tried to Please</td>
<td>Moody</td>
<td></td>
</tr>
<tr>
<td>Succeeded Pleasing</td>
<td>Used Others</td>
<td></td>
</tr>
<tr>
<td>Considerate</td>
<td>Sociable</td>
<td></td>
</tr>
<tr>
<td>Tried to be Good</td>
<td>Sought Attention</td>
<td></td>
</tr>
<tr>
<td>Selfish</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Right-Wrong Standards</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Obedient</td>
<td>Critical of Others</td>
<td></td>
</tr>
<tr>
<td>Openly Rebelled</td>
<td>Perfectionist</td>
<td></td>
</tr>
<tr>
<td>Covertly Rebelled</td>
<td>Tried to be Good</td>
<td></td>
</tr>
<tr>
<td>Standards re. Right/Wrong</td>
<td>Mischioves</td>
<td></td>
</tr>
<tr>
<td>Critical of Self/others</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interpersonal Tendencies</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Assertive</td>
<td>Fighter-Scrappy</td>
<td></td>
</tr>
<tr>
<td>Bossy-Dominating</td>
<td>Shy</td>
<td></td>
</tr>
<tr>
<td>Demanded Way</td>
<td>Suiked/Pouted</td>
<td></td>
</tr>
<tr>
<td>Got Way</td>
<td>Stubborn</td>
<td></td>
</tr>
<tr>
<td>Sense of Humor</td>
<td>Sensitive</td>
<td></td>
</tr>
<tr>
<td>Temper</td>
<td>Pited self</td>
<td></td>
</tr>
<tr>
<td>Competitive</td>
<td>Held Grudges</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attitudes &amp; Characteristics</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Idealistic</td>
<td>Self Confident</td>
<td></td>
</tr>
<tr>
<td>Materialistic</td>
<td>Insecure</td>
<td></td>
</tr>
<tr>
<td>Loner</td>
<td>Neat</td>
<td></td>
</tr>
<tr>
<td>Persistent</td>
<td>Gave Up Easily</td>
<td></td>
</tr>
<tr>
<td>Excitement Seeker</td>
<td>Dependent</td>
<td></td>
</tr>
<tr>
<td>Daring</td>
<td>Independent</td>
<td></td>
</tr>
<tr>
<td>Complained</td>
<td>Easy Going</td>
<td></td>
</tr>
<tr>
<td>Responsible</td>
<td>Impulsive</td>
<td></td>
</tr>
<tr>
<td>Withdrawn</td>
<td>Cautious</td>
<td></td>
</tr>
<tr>
<td>Chip on Shoulder</td>
<td>Worrier</td>
<td></td>
</tr>
<tr>
<td>Punished</td>
<td>Self Esteem</td>
<td></td>
</tr>
<tr>
<td>Spoiled</td>
<td>Inferiority Feelings</td>
<td></td>
</tr>
<tr>
<td>Pampered</td>
<td>Hid Feelings</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender Characteristics</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Athletic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masculine*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feminine*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Significant Childhood Attribute Worksheet
Life Style Assessment Section I (G)
**Family Constellation Interpretation Worksheet**  
Life Style Assessment Section I (A-G)

<table>
<thead>
<tr>
<th>Self Concept: “I am”</th>
<th>Self Ideal: “I should be” or “not be”</th>
<th>Environmental Evaluation: “Life is”</th>
<th>Ethical Convictions: Ethical &amp; moral “I should”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beliefs about myself; What I am/do What I like My Self image</td>
<td>Beliefs about myself; What I want to be/ should be What I ought to do My Self ideal</td>
<td>Beliefs outside of self; What men, women, people are What the world, life is like What I expect from people, life</td>
<td>(May/may not be society’s beliefs/values) Beliefs about; What is proper, right &amp; wrong; What I expect from myself and/or others</td>
</tr>
</tbody>
</table>

**Revised 4/2011**

July 2011 Revision
II. Development

A. Sexual development:

1. When did you first notice your sexual development?

2. How did you feel about it? Why?

3. Were you prepared for it?

4. When did you first have; if female - menstruation? If male- nocturnal emission? Were you prepared for it?

   How did you feel about it? Why?

   Have you had; if female - menstrual difficulties?

     if male- erectile dysfunction?

*5. If a boy, were you told you should have been a girl?

*6. If a girl, were you told you should have been a boy?
7. Review all 7 starred (*) LS Assessment items for gender beliefs and guiding lines to determine indication of Masculine Protest

8. As an adult have you experienced any sexual problems?

9. What is your sexual orientation?
   - Heterosexual  
   - Homosexual  
   - Bi-sexual  
   - Trans-sexual  
   How do you feel about your orientation?

B. Physical Development:

1. Any childhood health problems?

   If so, how were you treated by others?

2. How did you see your body image?

3. Did you have any disabilities?
Gender Guiding Line Worksheet
Life Style Assessment Sections I (A-G) and II (A-B)
### Gender Guiding Line Interpretation Worksheet

Life Style Assessment Sections I (A-G) and II (A-B)

<table>
<thead>
<tr>
<th>Self Concept: “I am”</th>
<th>Self Ideal: “I should be” or “not be”</th>
<th>Environmental Evaluation: “Life is”</th>
<th>Ethical Convictions: Ethical &amp; moral “I should”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beliefs about myself; What I am/do What I like My Self image</td>
<td>Beliefs about myself; What I want to be/ should be What I ought to do My Self ideal</td>
<td>Beliefs outside of self; What men, women, people are What the world, life is like What I expect from people, life</td>
<td>(May/may not be society’s beliefs/values) Beliefs about; What is proper, right &amp; wrong; What I expect from myself and/or others</td>
</tr>
</tbody>
</table>
III. Childhood Dreams

- Recall the earliest dream recollection(s), preferably before age 8.

- Using the Childhood Dream Recollection blank sheet, write down the specific incidents or happenings described in the dream, no matter how inconsequential it seems. Collect the feeling and reason for the feeling; then the most vivid moment and the feeling at that moment and reason for that feeling.

- Complete the Childhood Dream Interpretation Worksheet for the dream(s) to identify the ER beliefs; both accurate and mistaken.

- Determine the strengths revealed in the dream(s) and add them to list on the following ER Strength Worksheet.

Childhood Dream Recollection
# Childhood Dream Interpretation Worksheet
Life Style Assessment Section III

<table>
<thead>
<tr>
<th><strong>Self Concept:</strong> “I am”</th>
<th><strong>Self Ideal:</strong> “I should be” or “not be”</th>
<th><strong>Environmental Evaluation:</strong> “Life is”</th>
<th><strong>Ethical Convictions:</strong> Ethical &amp; moral “I should”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beliefs about myself;</td>
<td>Beliefs about myself;</td>
<td>Beliefs outside of self;</td>
<td>Beliefs about;</td>
</tr>
<tr>
<td>What I am/do</td>
<td>What I want to be/ should be</td>
<td>What men, women, people are</td>
<td>What is proper, right &amp; wrong;</td>
</tr>
<tr>
<td>What I like</td>
<td>What I ought to do</td>
<td>What the world, life is like</td>
<td>What I expect from myself and/or</td>
</tr>
<tr>
<td>My Self image</td>
<td>My Self ideal</td>
<td>What I expect from people, life</td>
<td>others</td>
</tr>
</tbody>
</table>

Revised 4/2011

July 2011 Revision
Childhood Fears:

Childhood Ambitions:
As a child, how did you answer, “What do you want to be when you grow up”?

IV. Adult Dreams:

Adult Dream Recollection
Not required for this Class

V. Three Wishes:
At this Point in Time:

1.

2.

3.

Current Aspirations:
VI. Early Recollections

- Collect a total of three different Early Recollections (one of each; the Basic, Brokaw and Willhite Methods) ☺ Be sure to follow the specific collection and transformation instructions given and demonstrated for each method.

For each Recollection;

- Recall the earliest recollection, preferably before age 8. Most people can recall incidents around ages 4, 5, and 6; some earlier.

- **Using the ER# blank worksheets**, write down the specific incidents or happenings described in the ER, no matter how inconsequential it seems. Collect the feeling and reason for the feeling; then the most vivid moment and the feeling at that moment and reason for that feeling.

- Complete the following **Early Recollection # Interpretation Worksheet** for each ER to identify the ER beliefs; both accurate and mistaken.

- Determine the strengths revealed in each of the three ER’s and add them to the **Strength Worksheet**.

*For class purposes, use and discuss only the pre transformational ER beliefs in the ER Worksheets, LS Summary and the Life Style Analysis.*
Early Recollection #1
### Early Recollection #1 Interpretation Worksheet
Life Style Assessment Section VI

<table>
<thead>
<tr>
<th>Self Concept: “I am” Beliefs about myself; What I am/do What I like My Self image</th>
<th>Self Ideal: “I should be” or “not be” Beliefs about myself; What I want to be/should be What I ought to do My Self ideal</th>
<th>Environmental Evaluation: “Life is” Beliefs outside of self; What men, women, people are What the world, life is like What I expect from people, life</th>
<th>Ethical Convictions: Ethical &amp; moral “I should” (May/may not be society’s beliefs/values) Beliefs about; What is proper, right &amp; wrong; What I expect from myself and/or others</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Early Recollection #2
Early Recollection #2 Interpretation Worksheet
Life Style Assessment Section VI

<table>
<thead>
<tr>
<th>Self Concept:</th>
<th>Self Ideal:</th>
<th>Environmental Evaluation:</th>
<th>Ethical Convictions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I am” Beliefs about myself; What I am/do</td>
<td>“I should be” or “not be” Beliefs about myself; What I want to be/should be What I ought to do My Self Ideal</td>
<td>“Life is” Beliefs outside of self; What men, women, people are What the world, life is like What I expect from people, life</td>
<td>Ethical &amp; moral “I should” (May/may not be society’s beliefs/values) Beliefs about; What is proper, right &amp; wrong; What I expect from myself and/or others</td>
</tr>
</tbody>
</table>
Early Recollection #3
<table>
<thead>
<tr>
<th>Self Concept:</th>
<th>Self Ideal: “I should be” or “not be”</th>
<th>Environmental Evaluation: “Life is”</th>
<th>Ethical Convictions: Ethical &amp; moral “I should”</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I am” Beliefs about myself; What I am/do What I like My Self image</td>
<td>Beliefs about myself; What I want to be/ should be What I ought to do My Self ideal</td>
<td>Beliefs outside of self; What men, women, people are What the world, life is like What I expect from people, life</td>
<td>Beliefs about; What is proper, right &amp; wrong; What I expect from myself and/or others</td>
</tr>
</tbody>
</table>
VII. Possible Mistaken Core Beliefs Worksheet (Always, Never, Only)
Include those drawn from all Life Style Assessment Sections

<table>
<thead>
<tr>
<th>Self Concept</th>
<th>Self Ideal</th>
<th>Environmental Assessment</th>
<th>Ethical Convictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I am”</td>
<td>“I should be” or “not be”</td>
<td>“Men, women, people are; life is”</td>
<td>Ethical and moral “I should”</td>
</tr>
</tbody>
</table>

Revised 4/2011
## Mistaken Core Beliefs Worksheet (Always, Never, Only)

**Only those Verified by Client**

Include those drawn from all Life Style Assessment Sections

<table>
<thead>
<tr>
<th>Self Concept</th>
<th>Self Ideal</th>
<th>Environmental Assessment</th>
<th>Ethical Convictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I am”</td>
<td>“I should be” or “not be”</td>
<td>“Men, women, people are; life is”</td>
<td>Ethical and moral “I should”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Revised 4/2011
VIII. STRENGTH WORKSHEET
Include strengths found in all sections of the Life Style Assessment
HUNCH WORKSHEET
Include hunches found in all sections of the Life Style Assessment

HUNCH:                                                                                           VERIFIED HUNCH:
IX. Life Style Assessment Summary

Complete this Life Style Assessment Summary using the all information acquired from LS Assessment data; including the Genogram, Attribute, Family Constellation, Gender Guiding Line, ER Strengths, Dream and Early Recollection Interpretation Worksheets, along with the verified the Mistaken Core Beliefs and Hunch Worksheet. These worksheets will help compile and condense the LS data and aid in identifying and summarizing Life Style Beliefs and the Fictive Goal. This summary is the foundation for the final Life Style Analysis paper. This is a rough draft and can be outline or bullet point format.

I. Family Constellation

- Birth Order: position, characteristics, 
  *Self Concept, Self Ideal*

- Parent models: regarding; gender, marriage/relationships, roles. 
  *Environmental Evaluation*
• Family Atmosphere: household climate; rules, parenting style, interactions btw siblings and parents & children.  
  *Environmental Evaluation*

• Family Values: importance or value placed on; ethnicity, family, religion, status, education, work, etc.  
  *Ethical Convictions*
II. Childhood Attributes

III. Development

How physical and sexual development influenced Life Style regarding gender beliefs, identity & sexual orientation:
IV. Early Recollection and Dream Interpretation:

- ER #1 Interpretation

- ER #2 Interpretation

- ER #3 Interpretation
V.  Fictive Goal and the Mistaken Beliefs used to achieve it:

I.  Identifying Life style:

(UG)  In order to ________________________________,

(FG)  I must be ____________________________ therefore (in conclusion)

(MB)  I must ________________________________.

* There are typically multiple Mistaken Beliefs supporting the Fictive Goal. As a continuation of above, list each of as many additional Mistaken Beliefs the client verified, as follows:

(MB)  I must ________________________________.

VI.  Strengths and Positive Qualities:

Additional Comments:
**PART 1: GENOGRAM FORMAT**

A. Symbols to describe basic family membership and structure (include on genogram significant others who lived with or cared for family members—place them on the right side of the genogram with a notation about who they are.)

- Male: □
- Female: ○
- Birth date → 43-75
- Death date ← Death = X

Index Person (IP): □

- Marriage (give date)
  - Husband on left, wife on right: □
  - Living together relationship or illness: □

- Marital separation (give date): □
- Divorce (give date): □

- Children: List in birth order, beginning with oldest on left:
- Adopted or foster children:

- Fraternal twins: □
- Identical twin: □

- Spontaneous abortion:
- Induced abortion:
- Stillbirth:

- Members of current IP household (circle them):

Where changes in custody have occurred, please note:

---

**Appendix**

B. Family interaction patterns. The following symbols are optional. The clinician may prefer to note them on a separate sheet. They are among the least precise information on the genogram, but may be key indicators of relationship patterns the clinician wants to remember:

- Very close relationship: □
- Conflictual relationship: ○
- Distant relationship: □
- Estrangement or cut off (give dates if possible): □
- Cut off 62-78

C. Medical history. Since the genogram is meant to be an orienting map of the family, there is room to indicate only the most important factors. Thus, list only major or chronic illnesses and problems. Include dates in parentheses where feasible or applicable. Use DSM-IV categories of recognized abbreviations where available (e.g., cancer: CA; stroke: CVA).

D. Other family information of special importance may also be noted on the genogram:

1) Ethnic background and migration date
2) Religion or religious change
3) Education
4) Occupation or unemployment
5) Military service
6) Retirement
7) Trouble with law
8) Physical abuse or incest
9) Obesity
10) Alcohol or Drug abuse (symbol = □)
11) Smoking
12) Dates when family members left home: LH ‘74.
13) Current location of family members

It is useful to have a space at the bottom of the genogram for notes on other key information: This would include critical events, changes in the family structure since the genogram was made, hypotheses and other notations of major family issues or changes. These notations should always be dated, and should be kept to a minimum, since every extra piece of information on a genogram complicates it and therefore diminishes its readability.
Adler Graduate School

Student Evaluation of Internship
Final Report

Student’s Name: ________________________________________________

Internship Level: ___________ Period Covered: ______________

Agency: ___________________________ Phone: ______________

Agency Address: ______________________________________________

Internship Supervisor: _________________________________________

Internship Supervisor’s Title: _________________________________

Part I: Briefly describe the clients served and the kinds of services offered.

Part II: Were you able to meet your goals? If yes, why; if not, why not?

A. Personal Goals

B. Professional Goals

Part III: Student’s Learning:

1. Briefly list the professional and personal growth you have experienced during this internship experience.
2. What do you consider to be your greatest strengths, both personal and professional?

3. What do you consider to be the personal and professional areas in which you need further growth?

4. What important factors regarding professional work environments, your professional needs, and personal issues will you consider in searching for subsequent internship sites or employment?

Part IV: Agency Learning Environment

Please rate the following aspects of the agency setting and learning environment.

1. Quality of interaction with and acceptance from other staff:
   Low 1 2 3 4 5 High

2. Quality of inservices:
   Low 1 2 3 4 5 High

3. Quality of consultations:
   Low 1 2 3 4 5 High

4. Quality of other educational programs:
   Low 1 2 3 4 5 High
5. Agency’s responsiveness to student’s education and learning:
   Low 1 2 3 4 5 High

6. Quality of Orientation and training procedures:
   Low 1 2 3 4 5 High

7. Were staff in general helpful:
   Low 1 2 3 4 5 High

8. Adequacy of office space and physical setting/equipment (i.e. phone, desk, supplies):
   Low 1 2 3 4 5 High

Part V: Learning Opportunities and Responsibilities

1. Were client assignments, groups and projects relevant to your learning goals available to you?
   _____yes  _____no

2. Was there an opportunity to work with diverse populations?
   _____yes  _____no

3. Were the level of skills required for the assignments appropriate for your ability and growth needs?
   _____yes  _____too advanced  _____too elementary

4. a. What proportion of your time was spent in direct work with individuals, families or groups?

   b. Describe how you were involved in the above:

5. Describe other activities in which you were involved:

6. To what extent were you able to integrate and apply theoretical material with applications?
Part VI: Supervisor:

1. a. Did you and your supervisor have a scheduled time to meet for conferences each week?
   
   _____yes  _____no

   b. Was this commitment kept regularly by the supervisor?
   
   _____yes  _____most of the time  _____no

   c. How frequently did you meet?

   d. How long, on average, were your meetings?

   e. Was your supervisor usually present at the agency during the hours that you were there?
   
   _____yes  _____sometimes  _____no

2. Comment on the following. The supervisor:

   a. Was clear and consistent about the expectations of this placement.

   b. Encouraged and engaged in mutual assessment of learning needs, expectations and progress on an on-going basis.

   c. Provided clear, understandable, feedback on an ongoing basis.

   d. Was accessible for support and consultation.
e. Facilitated the process of integration into the agency system.
   
   f. Encouraged critical assessment, implementation of techniques and evaluation of work with clients and groups.
   
   g. Facilitated learning of specific practice skills and techniques.
   
   h. Encouraged awareness of professional values & encouraged professional behavior consistent with those values.
   
   i. Was able to help integrate theoretical material with practical application.

3 a. Describe the general ways in which your supervisor approached your learning (e.g. case discussion, theoretical discussion, self-awareness, etc.):

   b. What techniques did your supervisor use to assess your performance? (e.g. process recordings, taped interviews)

4. Were there other staff at the agency who played a key role in your Internship and/or learning?
Part VII: Site

1. What are the major strengths of this site for interns:

2. Please comment on limitations of this setting in relation to your learning:

3. What suggestions do you have for improving the overall quality and effectiveness of this site?

4. Would you recommend that student interns be placed in this agency in the future?
   Yes, why? No, why

Signature: ____________________________
Student: ____________________________
Date: ____________________________

Adapted from guidelines associated with the College of St. Catherine and the University of St. Thomas School of Social Work.
Authorization Form for Use of Patient/Client Information

I understand that I will be receiving counseling services from an Adler Graduate School clinical intern while receiving services at ______________. I understand that as part of the intern's educational course work, he or she may present, orally and/or in written and/or recorded form, to instructors and/or other students, information about my counseling sessions, which may include personal information about me. I understand that this information will only be shared with others if the intern has “disguised” identifying information about me and other persons or organizations. I understand that information is considered "disguised" if there is no reasonable basis to believe that the information could be used to identify me and if the following steps are taken:

1) Last names are removed and first names are removed or changed.
2) Geographic references (such as references to the city and street address) are removed or changed.
3) All dates directly related to the individual are changed or removed, including birth date, admission date, discharge date and age.
4) Any numbers that could be used to identify the individual are removed, such as social security numbers, telephone numbers, fax numbers, patient numbers, account numbers, medical records numbers, or any other unique identifying number or code.
5) Computer information such as e-mail addresses, URLs and Internet Protocol numbers are removed.
6) All photographic images are removed.
7) All other information, which could reasonably be used to identify the individual, is removed or changed. I authorize the intern to present, orally and/or in written and/or recorded form, information about my counseling sessions, so long as such information is “disguised” as described above.

By: ____________________________

Date: ____________________________

Witness: ____________________________

Date: ____________________________
INTERNSHIP CLASS MAKE-UP

Date:_________________________________________________________

Student’s Name:________________________________________________

Internship Course Number:________________________________________

For ____Fall Term   ____Winter Term   ____Spring Term   ____Summer Term

Primary Instructor:_______________________________________________

Make-up Class Instructor:__________________________________________

This student has successfully completed the make-up class a make-up class.

Instructor Signature

ATTACH THIS FORM TO THE ASSIGNMENT PACKET WITH THE LOGS, EVALUATION AND PAPER AND SUBMIT TO YOUR INSTRUCTOR
APPENDIX A

AAMFT Code of Ethics

Preamble

The Board of Directors of the American Association for Marriage and Family Therapy (AAMFT) hereby promulgates, pursuant to Article 2, Section 2.013 of the Association's Bylaws, the Revised AAMFT Code of Ethics, effective July 1, 2001.

The AAMFT strives to honor the public trust in marriage and family therapists by setting standards for ethical practice as described in this Code. The ethical standards define professional expectations and are enforced by the AAMFT Ethics Committee. The absence of an explicit reference to a specific behavior or situation in the Code does not mean that the behavior is ethical or unethical. The standards are not exhaustive. Marriage and family therapists who are uncertain about the ethics of a particular course of action are encouraged to seek counsel from consultants, attorneys, supervisors, colleagues, or other appropriate authorities.

Both law and ethics govern the practice of marriage and family therapy. When making decisions regarding professional behavior, marriage and family therapists must consider the AAMFT Code of Ethics and applicable laws and regulations. If the AAMFT Code of Ethics prescribes a standard higher than that required by law, marriage and family therapists must meet the higher standard of the AAMFT Code of Ethics. Marriage and family therapists comply with the mandates of law, but make known their commitment to the AAMFT Code of Ethics and take steps to resolve the conflict in a responsible manner. The AAMFT supports legal mandates for reporting of alleged unethical conduct.

The AAMFT Code of Ethics is binding on Members of AAMFT in all membership categories, AAMFT-Approved Supervisors, and applicants for membership and the Approved Supervisor designation (hereafter, AAMFT Member). AAMFT members have an obligation to be familiar with the AAMFT Code of Ethics and its application to their professional services. Lack of awareness or misunderstanding of an ethical standard is not a defense to a charge of unethical conduct.

The process for filing, investigating, and resolving complaints of unethical conduct is described in the current Procedures for Handling Ethical Matters of the AAMFT Ethics Committee. Persons accused are considered innocent by the Ethics Committee until proven guilty, except as otherwise provided, and are entitled to due process. If an AAMFT Member resigns in anticipation of, or during the course of, an ethics investigation, the Ethics Committee will complete its investigation. Any publication of action taken by the Association will include the fact that the Member attempted to resign during the investigation.
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1. Responsibility to clients
2. Confidentiality
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8. Advertising

Principle I

Responsibility to Clients

Marriage and family therapists advance the welfare of families and individuals. They respect the rights of those persons seeking their assistance, and make reasonable efforts to ensure that their services are used appropriately.

1.1. Marriage and family therapists provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, or sexual orientation.

1.2. Marriage and family therapists obtain appropriate informed consent to therapy or related procedures as early as feasible in the therapeutic relationship, and use language that is reasonably understandable to clients. The content of informed consent may vary depending upon the client and treatment plan; however, informed consent generally necessitates that the client: (a) has the capacity to consent; (b) has been adequately informed of significant information concerning treatment processes and procedures; (c) has been adequately informed of potential risks and benefits of treatments for which generally recognized standards do not yet exist; (d) has freely and without undue influence expressed consent; and (e) has provided consent that is appropriately documented. When persons, due to age or mental status, are legally incapable of giving informed consent, marriage and family therapists obtain informed permission from a legally authorized person, if such substitute consent is legally permissible.

1.3. Marriage and family therapists are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships with clients that could impair professional judgment or increase the risk of exploitation. Such relationships include, but are not limited to, business or close personal relationships with a client or the client’s immediate family. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists take appropriate precautions.

1.4. Sexual intimacy with clients is prohibited.
1.5 Sexual intimacy with former clients is likely to be harmful and is therefore prohibited for two years following the termination of therapy or last professional contact. In an effort to avoid exploiting the trust and dependency of clients, marriage and family therapists should not engage in sexual intimacy with former clients after the two years following termination or last professional contact. Should therapists engage in sexual intimacy with former clients following two years after termination or last professional contact, the burden shifts to the therapist to demonstrate that there has been no exploitation or injury to the former client or to the client’s immediate family.

1.6 Marriage and family therapists comply with applicable laws regarding the reporting of alleged unethical conduct.

1.7 Marriage and family therapists do not use their professional relationships with clients to further their own interests.

1.8 Marriage and family therapists respect the rights of clients to make decisions and help them to understand the consequences of these decisions. Therapists clearly advise the clients that they have the responsibility to make decisions regarding relationships such as cohabitation, marriage, divorce, separation, reconciliation, custody, and visitation.

1.9 Marriage and family therapists continue therapeutic relationships only so long as it is reasonably clear that clients are benefiting from the relationship.

1.10 Marriage and family therapists assist persons in obtaining other therapeutic services if the therapist is unable or unwilling, for appropriate reasons, to provide professional help.

1.11 Marriage and family therapists do not abandon or neglect clients in treatment without making reasonable arrangements for the continuation of such treatment.

1.12 Marriage and family therapists obtain written informed consent from clients before videotaping, audio recording, or permitting third-party observation.

1.13 Marriage and family therapists, upon agreeing to provide services to a person or entity at the request of a third party, clarify, to the extent feasible and at the outset of the service, the nature of the relationship with each party and the limits of confidentiality.

**Principle II**

**Confidentiality**

Marriage and family therapists have unique confidentiality concerns because the client in a therapeutic relationship may be more than one person. Therapists respect and guard the confidences of each individual client.

2.1 Marriage and family therapists disclose to clients and other interested parties, as early as feasible in their professional contacts, the nature of confidentiality and possible limitations of the
clients’ right to confidentiality. Therapists review with clients the circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. Circumstances may necessitate repeated disclosures.

2.2 Marriage and family therapists do not disclose client confidences except by written authorization or waiver, or where mandated or permitted by law. Verbal authorization will not be sufficient except in emergency situations, unless prohibited by law. When providing couple, family or group treatment, the therapist does not disclose information outside the treatment context without a written authorization from each individual competent to execute a waiver. In the context of couple, family or group treatment, the therapist may not reveal any individual’s confidences to others in the client unit without the prior written permission of that individual.

2.3 Marriage and family therapists use client and/or clinical materials in teaching, writing, consulting, research, and public presentations only if a written waiver has been obtained in accordance with Sub principle 2.2, or when appropriate steps have been taken to protect client identity and confidentiality.

2.4 Marriage and family therapists store, safeguard, and dispose of client records in ways that maintain confidentiality and in accord with applicable laws and professional standards.

2.5 Subsequent to the therapist moving from the area, closing the practice, or upon the death of the therapist, a marriage and family therapist arranges for the storage, transfer, or disposal of client records in ways that maintain confidentiality and safeguard the welfare of clients.

2.6 Marriage and family therapists, when consulting with colleagues or referral sources, do not share confidential information that could reasonably lead to the identification of a client, research participant, supervisee, or other person with whom they have a confidential relationship unless they have obtained the prior written consent of the client, research participant, supervisee, or other person with whom they have a confidential relationship. Information may be shared only to the extent necessary to achieve the purposes of the consultation.

**Principle III**

**Professional Competence and Integrity**

Marriage and family therapists maintain high standards of professional competence and integrity.

3.1 Marriage and family therapists pursue knowledge of new developments and maintain competence in marriage and family therapy through education, training, or supervised experience.

3.2 Marriage and family therapists maintain adequate knowledge of and adhere to applicable laws, ethics, and professional standards.

3.3 Marriage and family therapists seek appropriate professional assistance for their personal problems or conflicts that may impair work performance or clinical judgment.
3.4 Marriage and family therapists do not provide services that create a conflict of interest that may impair work performance or clinical judgment.

3.5 Marriage and family therapists, as presenters, teachers, supervisors, consultants and researchers, are dedicated to high standards of scholarship, present accurate information, and disclose potential conflicts of interest.

3.6 Marriage and family therapists maintain accurate and adequate clinical and financial records.

3.7 While developing new skills in specialty areas, marriage and family therapists take steps to ensure the competence of their work and to protect clients from possible harm. Marriage and family therapists practice in specialty areas new to them only after appropriate education, training, or supervised experience.

3.8 Marriage and family therapists do not engage in sexual or other forms of harassment of clients, students, trainees, supervisees, employees, colleagues, or research subjects.

3.9 Marriage and family therapists do not engage in the exploitation of clients, students, trainees, supervisees, employees, colleagues, or research subjects.

3.10 Marriage and family therapists do not give to or receive from clients (a) gifts of substantial value or (b) gifts that impair the integrity or efficacy of the therapeutic relationship.

3.11 Marriage and family therapists do not diagnose, treat, or advise on problems outside the recognized boundaries of their competencies.

3.12 Marriage and family therapists make efforts to prevent the distortion or misuse of their clinical and research findings.

3.13 Marriage and family therapists, because of their ability to influence and alter the lives of others, exercise special care when making public their professional recommendations and opinions through testimony or other public statements.

3.14 To avoid a conflict of interests, marriage and family therapists who treat minors or adults involved in custody or visitation actions may not also perform forensic evaluations for custody, residence, or visitation of the minor. The marriage and family therapist who treats the minor may provide the court or mental health professional performing the evaluation with information about the minor from the marriage and family therapist’s perspective as a treating marriage and family therapist, so long as the marriage and family therapist does not violate confidentiality.

3.15 Marriage and family therapists are in violation of this Code and subject to termination of membership or other appropriate action if they: (a) are convicted of any felony; (b) are convicted of a misdemeanor related to their qualifications or functions; (c) engage in conduct which could lead to conviction of a felony, or a misdemeanor related to their qualifications or functions; (d) are expelled from or disciplined by other professional organizations; (e) have their licenses or
certificates suspended or revoked or are otherwise disciplined by regulatory bodies; (f) continue to practice marriage and family therapy while no longer competent to do so because they are impaired by physical or mental causes or the abuse of alcohol or other substances; or (g) fail to cooperate with the Association at any point from the inception of an ethical complaint through the completion of all proceedings regarding that complaint.

Principle IV

Responsibility to Students and Supervisees

Marriage and family therapists do not exploit the trust and dependency of students and supervisees.

4.1 Marriage and family therapists are aware of their influential positions with respect to students and supervisees, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships that could impair professional objectivity or increase the risk of exploitation. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists take appropriate precautions.

4.2 Marriage and family therapists do not provide therapy to current students or supervisees.

4.3 Marriage and family therapists do not engage in sexual intimacy with students or supervisees during the evaluative or training relationship between the therapist and student or supervisee. Should a supervisor engage in sexual activity with a former supervisee, the burden of proof shifts to the supervisor to demonstrate that there has been no exploitation or injury to the supervisee.

4.4 Marriage and family therapists do not permit students or supervisees to perform or to hold themselves out as competent to perform professional services beyond their training, level of experience, and competence.

4.5 Marriage and family therapists take reasonable measures to ensure that services provided by supervisees are professional.

4.6 Marriage and family therapists avoid accepting as supervisees or students those individuals with whom a prior or existing relationship could compromise the therapist’s objectivity. When such situations cannot be avoided, therapists take appropriate precautions to maintain objectivity. Examples of such relationships include, but are not limited to, those individuals with whom the therapist has a current or prior sexual, close personal, immediate familial, or therapeutic relationship.

4.7 Marriage and family therapists do not disclose supervisee confidences except by written authorization or waiver, or when mandated or permitted by law. In educational or training settings where there are multiple supervisors, disclosures are permitted only to other professional colleagues, administrators, or employers who share responsibility for training of the supervisee. Verbal authorization will not be sufficient except in emergency situations, unless prohibited by law.

July 2011 Revision
Principle V

Responsibility to Research Participants

Investigators respect the dignity and protect the welfare of research participants, and are aware of applicable laws and regulations and professional standards governing the conduct of research.

5.1 Investigators are responsible for making careful examinations of ethical acceptability in planning studies. To the extent that services to research participants may be compromised by participation in research, investigators seek the ethical advice of qualified professionals not directly involved in the investigation and observe safeguards to protect the rights of research participants.

5.2 Investigators requesting participant involvement in research inform participants of the aspects of the research that might reasonably be expected to influence willingness to participate. Investigators are especially sensitive to the possibility of diminished consent when participants are also receiving clinical services, or have impairments which limit understanding and/or communication, or when participants are children.

5.3 Investigators respect each participant’s freedom to decline participation in or to withdraw from a research study at any time. This obligation requires special thought and consideration when investigators or other members of the research team are in positions of authority or influence over participants. Marriage and family therapists, therefore, make every effort to avoid multiple relationships with research participants that could impair professional judgment or increase the risk of exploitation.

5.4 Information obtained about a research participant during the course of an investigation is confidential unless there is a waiver previously obtained in writing. When the possibility exists that others, including family members, may obtain access to such information, this possibility, together with the plan for protecting confidentiality, is explained as part of the procedure for obtaining informed consent.

Principle VI

Responsibility to the Profession

Marriage and family therapists respect the rights and responsibilities of professional colleagues and participate in activities that advance the goals of the profession.

6.1 Marriage and family therapists remain accountable to the standards of the profession when acting as members or employees of organizations. If the mandates of an organization with which a marriage and family therapist is affiliated, through employment, contract or otherwise, conflict with the AAMFT Code of Ethics, marriage and family therapists make known to the organization their commitment to the AAMFT Code of Ethics and attempt to resolve the conflict in a way that allows the fullest adherence to the Code of Ethics.
6.2 Marriage and family therapists assign publication credit to those who have contributed to a publication in proportion to their contributions and in accordance with customary professional publication practices.

6.3 Marriage and family therapists do not accept or require authorship credit for a publication based on research from a student’s program, unless the therapist made a substantial contribution beyond being a faculty advisor or research committee member. Coauthorship on a student thesis, dissertation, or project should be determined in accordance with principles of fairness and justice.

6.4 Marriage and family therapists who are the authors of books or other materials that are published or distributed do not plagiarize or fail to cite persons to whom credit for original ideas or work is due.

6.5 Marriage and family therapists who are the authors of books or other materials published or distributed by an organization take reasonable precautions to ensure that the organization promotes and advertises the materials accurately and factually.

6.6 Marriage and family therapists participate in activities that contribute to a better community and society, including devoting a portion of their professional activity to services for which there is little or no financial return.

6.7 Marriage and family therapists are concerned with developing laws and regulations pertaining to marriage and family therapy that serve the public interest, and with altering such laws and regulations that are not in the public interest.

6.8 Marriage and family therapists encourage public participation in the design and delivery of professional services and in the regulation of practitioners.

**Principle VII**

**Financial Arrangements**

Marriage and family therapists make financial arrangements with clients, third-party payors, and supervisees that are reasonably understandable and conform to accepted professional practices.

7.1 Marriage and family therapists do not offer or accept kickbacks, rebates, bonuses, or other remuneration for referrals; fee-for-service arrangements are not prohibited.

7.2 Prior to entering into the therapeutic or supervisory relationship, marriage and family therapists clearly disclose and explain to clients and supervisees: (a) all financial arrangements and fees related to professional services, including charges for canceled or missed appointments; (b) the use of collection agencies or legal measures for nonpayment; and (c) the procedure for obtaining payment from the client, to the extent allowed by law, if payment is denied by the third-party payor. Once services have begun, therapists provide reasonable notice of any changes in fees or other charges.
7.3 Marriage and family therapists give reasonable notice to clients with unpaid balances of their intent to seek collection by agency or legal recourse. When such action is taken, therapists will not disclose clinical information.

7.4 Marriage and family therapists represent facts truthfully to clients, third-party payors, and supervisees regarding services rendered.

7.5 Marriage and family therapists ordinarily refrain from accepting goods and services from clients in return for services rendered. Bartering for professional services may be conducted only if: (a) the supervisee or client requests it, (b) the relationship is not exploitative, (c) the professional relationship is not distorted, and (d) a clear written contract is established.

7.6 Marriage and family therapists may not withhold records under their immediate control that are requested and needed for a client’s treatment solely because payment has not been received for past services, except as otherwise provided by law.

**Principle VIII**

**Advertising**

Marriage and family therapists engage in appropriate informational activities, including those that enable the public, referral sources, or others to choose professional services on an informed basis.

8.1 Marriage and family therapists accurately represent their competencies, education, training, and experience relevant to their practice of marriage and family therapy.

8.2 Marriage and family therapists ensure that advertisements and publications in any media (such as directories, announcements, business cards, newspapers, radio, television, Internet, and facsimiles) convey information that is necessary for the public to make an appropriate selection of professional services. Information could include: (a) office information, such as name, address, telephone number, credit card acceptability, fees, languages spoken, and office hours; (b) qualifying clinical degree (see subprinciple 8.5); (c) other earned degrees (see subprinciple 8.5) and state or provincial licensures and/or certifications; (d) AAMFT clinical member status; and (e) description of practice.

8.3 Marriage and family therapists do not use names that could mislead the public concerning the identity, responsibility, source, and status of those practicing under that name, and do not hold themselves out as being partners or associates of a firm if they are not.

8.4 Marriage and family therapists do not use any professional identification (such as a business card, office sign, letterhead, Internet, or telephone or association directory listing) if it includes a statement or claim that is false, fraudulent, misleading, or deceptive.
8.5 In representing their educational qualifications, marriage and family therapists list and claim as evidence only those earned degrees: (a) from institutions accredited by regional accreditation sources recognized by the United States Department of Education, (b) from institutions recognized by states or provinces that license or certify marriage and family therapists, or (c) from equivalent foreign institutions.

8.6 Marriage and family therapists correct, wherever possible, false, misleading, or inaccurate information and representations made by others concerning the therapist's qualifications, services, or products.

8.7 Marriage and family therapists make certain that the qualifications of their employees or supervisees are represented in a manner that is not false, misleading, or deceptive.

8.8 Marriage and family therapists do not represent themselves as providing specialized services unless they have the appropriate education, training, or supervised experience.

This Code is published by:
American Association for Marriage and Family Therapy
112 South Alfred Street, Alexandria, VA 22314
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Fax: (703) 838-9805
www.aamft.org

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Violations of this Code should be brought in writing to the attention of:

AAMFT Ethics Committee
112 South Alfred Street, Alexandria, VA 22314
Phone: (703) 838-9808
Fax: (703) 838-9805
email: ethics@aamft.org
Appendix B
Mandated Reporting Responsibilities

In the state of Minnesota all licensed mental health professionals are mandated by law to override confidentiality and report mandated information to an appropriate government agency or state licensing board.

The laws regarding the definitions of reportable violations and the circumstances under which an intern or licensed mental health professional is required to report, are complex and extensive. These are available for Adler students to review via each Minnesota state licensing board’s website, or by searching the laws online under the “Revisor of Statutes, State of Minnesota.” Mandatory reporting is a legal term which establishes the requirement that interns and licensed mental health professionals will, upon discovery of reportable information, override confidentiality between themselves and their client(s) and report the information to an appropriate governmental agency, licensing board, law enforcement, or any appropriate combination of these.

Failure to report is a violation of the law and can result in serious and lasting consequences including prosecution, fines, suspension of license, or its permanent revocation. In addition, the clinician may be open to litigation by the effected parties.

Under Minnesota state law the following are reportable:

1) Physical, sexual, or emotional/psychological abuse of a minor under the age of 18. This can include medical, educational, or physical neglect.
2) Physical, sexual, emotional, or financial abuse of an elder on the part of that elder’s designated caregiver. This can include intentional or unintentional neglect of the elder.
3) Prenatal exposure to a controlled substance (including alcohol) on the part of the mother when the pattern of use is habitual and excessive.
4) Threats of violence on the part of a client when there is a specifically named individual whom the client states he or she intends to harm or kill.
5) Statements on the part of a client that he or she intends to commit self-harm or suicide.
6) Impaired behavior on the part of another therapist or other mandated professional that is discovered directly or through a client’s report. This includes other therapists, teachers, and clergy members.

Child and elder abuse should be reported to the county in which you are practicing. For children contact Child Protective Services. For elders contact county social services. These reports must be made within 24 hours of the discovery.

Prenatal exposure to a controlled substance on the part of a pregnant mother should be reported to Child Protective Services in the county in which you practice within 24 hours. Threats of violence made by the client you are seeing should be reported to the party who has been named in the threat, and also to law enforcement immediately.

A client who states the intent to harm or kill him or herself should be evaluated using an accepted risk management assessment protocol. If the client needs emergency services or an inpatient evaluation and will agree to it, transportation from your office should be arranged.
immediately. If the client refuses needed emergency services and leaves your office, contact law enforcement immediately.

Impaired professionals should be reported to your licensing board as a starting point. They will advise of you further steps.

Interns who encounter any of the above circumstances, or others that seem questionable should not hesitate to consult immediately with an on-site supervisor, an AGS clinical instructor, or the agencies listed above for each circumstance. These agencies and boards are available for consultation and should be called for input and direction for determining if a situation is reportable. They are glad to do this and welcome such calls.

If an intern or licensed mental health professional makes a report in good faith they remain free from litigation even if the reported situation turns out not to be true.

This review is not intended as medical or legal advice, nor as a substitute for appropriate clinical supervision or consultation regarding specific cases.