THE UNIVERSITY of TENNESSEE CHATTANOOGA

Counseling Program Practicum & Internship Resource Handbook

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University of Tennessee at Chattanooga

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UNIVERSITY OF TENNESSEE AT CHATTANOOGA
COUNSELOR EDUCATION PROGRAM

Introduction

Welcome to your first clinical experience in the counseling program! We as a faculty are thrilled to see you embark on the next phase of your journey towards becoming a professional counselor. To this end, we have prepared the following as a resource for you so that your transition to clinical work will be easier.

As you begin your clinical work, it is important to remember yourself in the process of becoming a professional counselor. So we will begin the course by not only covering the basic resources that you will need over the next semester, but we will also begin tailoring a personal wellness plan that you will utilize over the next sixteen weeks. The purpose of this plan is to begin integrating your overarching professional practice with the necessary tools that all counselors need to prevent burnout throughout the course of your professional life. As you are the main mechanism for performing your job, it is an ethical imperative that you keep yourself healthy in order work optimally with your clients.

In leafing through this booklet, you will see many resources that have been compiled for you. Included is a therapy processing model, a mental status examination and web resources, along with many other resources that will be of interest to you. However, the resources contained herein are not exhaustive, nor should they be relied upon as the only ones that you will need through the course of your clinical experiences. Therefore, please be aware that many more resources exist that will enhance your practice and you are encouraged to find and utilize them in order to maximize your practicum and internship experience.

We look forward to your progress in this journey,

The UTC Counseling Faculty

UTC Counseling Program Mission Statement

The primary purpose of the UTC Counseling Program is to train knowledgeable, competent, skillful professional counselors to provide services in both human service agencies and educational settings. This program is based on a developmental process emphasizing skill development at early stages progressing to a strong theoretical base, an ethical and professional orientation, and cultural sensitivity. The program will be delivered based on regional demographics representative of diversity and cultures within the community. In the training of future clinical mental health counselors and professional school counselors, courses will provide a learning environment with emphasis on an understanding of diversity and development of skills necessary to work effectively with individuals from various cultures within the region and beyond.

The Supervision Process

The Supervision process is designed to offer counseling students an opportunity to demonstrate skills acquired in the classroom to actual counseling situations during practicum and internship. During these experiences, students are supervised by University and Site Supervisors and receive feedback concerning themselves, clients, the counseling process, and professional issues. They also learn the importance of supervision and the need for continued learning while in the role of a professional counselor. Students are urged to participate actively in the process, seek supervision to enhance their skill level, and to integrate their learning and personality.

In order to maximize this experience, the following guidelines are recommended for students:

- Be prepared to record all counseling sessions with clients for whom you have permission. Working with supervisors to prepare your approach to clients in securing this permission will help decrease "recording anxiety" for your clients and for you.
- Be prepared for all supervision sessions. Prior to any supervision session, formulate questions about clients, your reactions to the session, the process of counseling, theory and interventions, then be ready to ask these questions of your supervisor. Make good use of your supervision time by having recorded segments cued and ready to play.
- Be prepared to receive constructive and supportive supervisory feedback. In group supervision sessions, be prepared to exchange constructive and supportive feedback with your peers.
- Early in the semester, formulate learning goals for supervision with your University Supervisor.
- Work to develop open and honest interactions in the supervisory relationship. As a parallel to the counseling relationship, supervision is a confidential relationship from which you may get just as much benefit as you are willing to put into it.

Recommendations for Supervision:

1. You should schedule supervision sessions with your site supervisors. It is recommended that you schedule a regular time each week to meet with your supervisor. Try to avoid short sessions in passing with your supervisor.

2. Make sure that your supervisor is listening to your recorded sessions. Be proactive by submitting the recordings to your supervisor and requesting feedback.

Due Process

Evaluation of a student's performance is continuous throughout her or his participation in the program. It involves consideration of the student's academic performance as well as that in laboratory, practicum, and internship classes.

A student may be dropped from a course and/or a program if the welfare of the student's clientele, prospective clientele, or the functioning of a school or agency is, in the judgment of the program faculty, in jeopardy as a result of the student's behavior. The Program has the authority to withdraw a student from a Practicum or Internship if it is believed that the student's performance constitutes a detriment to the clients <u>or</u> the site <u>or</u> the university. This would usually include consultation with the supervisors at both the site and the university. If such removal is deemed necessary, the student will be given a grade of "NC" for the course. (Review the Graduate Catalog on the S/NC grading policies).

Recording of your counseling sessions is a requirement so that quality supervision may be provided. Each counseling session or recording that you plan to use in a supervision presentation, should be previewed thoroughly. Make notes reflecting important content and questions for supervision. Depending on your supervisor's requirement, you will be asked to present specific portions of your recording without time-consuming hunting.

In order to ensure a clear, audible recording, it is suggested that you:

- Use an extension microphone. The self-contained condenser microphones pick up too much machine noise. A multi-directional microphone is usually acceptable, and can be readily purchased at local audio shops.
- Purchase a digital recorder. The advantages are numerous, 1. Better quality sound, 2. Generally smaller, 3. Batteries last longer, 4. Can be edited much easier, and 5. The final product can be emailed.
- Place the recorder close by so that you maintain control of the recording process. Do not place it on any metal or hard surface, as it tends to amplify vibrations.
- Make a practice recording, in the setting where the actual recording will take place. Ascertain the best positioning for both the recorder and the microphone; in order to avoid mechanical errors or distractions during the session. It is important to test the performance of your recorder and microphone <u>prior to your live session</u>.
- Contact your University Supervisor or Advisor as soon as possible if there is a problem with recording at the site.

Confidentiality

One of the most important aspects of counseling is confidentiality. It is also a crucial component of the trust building process. The following is a listing of important concerns:

- It is imperative that you have a working knowledge of the regulations regarding confidentiality of notes, files, and/or recording at your site. If possible, obtain a written copy of these regulations.
- Since recording is required in the supervisory process, it is your responsibility to get your client's written permission to record. In the case of a minor client you must obtain a written permission form from a parent or guardian. This consent form should explain the limits of confidentiality and should state clearly that the recording will be used for supervision purposes. Many sites have consent forms for your use or sample forms can be found in the Appendix section of this handbook.
- Practicum/Internship students are expected to conduct themselves professionally. All information shared in your supervision group is to be kept strictly confidential by all group members.
- Do NOT use client surnames or other readily identifiable information. Do NOT put client names on anything you turn in.

The importance of confidentiality cannot be stressed enough. It is **YOUR** responsibility to protect recordings against misuse or loss.

Diversity

Students should choose a field placement site that provides opportunities for exposure to a wide range of clients, including clients who represent the various ethnic groups and demographic diversity of the community.

Practicum/Internship Student Guidelines

The student agrees to the following guidelines:

- Be aware of your responsibilities for Practicum/Internship participation, including learning the policies and procedures within the organization, site expectations, rules and other regulations.
- Ask before acting.
- Abide by the ethical standards developed by the American Counseling Association (ACA), and the American School Counselor Association (ASCA).
- Obtain liability insurance.
- Follow the administrative policies, standards, and practices of the site.
- Report to the Site on time and follow all established regulations during the regularly scheduled operating hours of the Site.
- Conform to the standards and practices of the University while training at the Site.
- Keep in confidence all medical and health information pertaining to clients.

Assessment/Evaluation Rubric: Student Continuous Improvement/Wellness Plan

Student: _____ **Semester:** _____

University Professor: _____

Accreditation/Credentialing/Ethical Significance

Competencies for Counselors of the Twenty-First Century
***Continuous Improvement*:** The pre-service counselor realizes that she or he is in the initial stages of a lifelong learning process and that self reflection is one of the key components of that process (while, their concentration is of necessity, inward and personal, the role of colleagues and school-based improvement activities increases as time passes). I find this unclear and inconsequential – in my opinion it needs to be clarified or eliminated The counselor's continued professional improvement is characterized by self-reflection, working with immediate colleagues and teammates, and meeting the goals of a personal professional development plan.

Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2009) Standard II.1h: Ethical standards of ACA and related entities, and applications of ethical and legal considerations in professional counseling

American Counseling Association (ACA; 2005) *Codes of Ethics C.2.f: Continuing Education*: Counselors recognize the need for continuing education to acquire and maintain a reasonable level of awareness of current scientific and professional information in their field of activity. They take steps to maintain competence in the skills they use, are open to new procedures, and keep current with the diverse populations with whom they work.

American School Counselor Association (ASCA; 2004) *Ethical Standards E.1.c*: The professional school counselor strives through personal initiative to maintain professional competence including technological literacy and to keep abreast of professional information. Professional and personal growth is ongoing throughout the counselor's career.

As stated in professional school counselor preparation standards (CACREP, 2009) and ethical codes (ACA, 2005; ASCA, 2004), it is imperative that school counselors in-training develop plans to support their continuous professional and personal development and improvement. What do the standards/ethical codes state for Clinical Mental Health Counselors? The highlighted section could be deleted and the paragraph could begin with the next sentence. To support this goal, students are required to construct a professional Continuous Improvement/Wellness Plan. From a holistic (bio-psycho-social-spiritual) perspective, the student-interns' Continuous Improvement/Wellness Plan should include current, near future (within a year), and future (next five years) goals to support their physiological, psychological, social, vocational/professional, and spiritual well-bring. Student Continuous Improvement/Wellness Plans should be written in behavioral terms and related to time (e.g., I will attend an American School Counselor Association national conference by July 2011). Furthermore, the Continuous Improvement/Wellness Plan is unique to the individual student; thus, should be developed based on each student-interns' professional and personal goals.

Example Student Wellness Plan

Major Objective	Goals
Physical Health and Nutrition	1. Eat fruits and veggies (4x's a week) 2. No Starchy Carb's 4 days a week 3. Run 2x's a week
Leisure	1. Read a book (one a month) 2. Go to bed by 10:30-11pm during the week 3. Go for a hike or walk 3-5x's a month
Relationships	1. Call/Email VA friends once a month 2. Go walking with friends 2x's a month 3. Dinner with friends 3x's a month
School/Work Pursuits	1. Pass NCE/Start supervision for licensure 2. Plan out to-do list every day before leaving 3. Plan out sessions with kids on Monday
Spirituality	1. Take 30 minutes to read/listen to music/hike/walk 2. Journal once every couple weeks 3. Go hiking/walking 3x's a month

Student Wellness Plan

Major Objective	Goals
Physical Health and Nutrition	
Leisure	
Relationships	
School/Work Pursuits	
Spirituality	

Wellness Goals Assessment

Wellness Plan Element	Success in Achieving Goals (Scale from 1-10)	Consequences of Achieving Goals (Pos.); and of not Achieving Goals (Neg.)
Physical Health & Nutrition		
Leisure		
Relationships		
School/Work Pursuits		
Spirituality		

Wellness Plan Rubric

Elements of Improvement / Wellness Plan	Reference to Time	Acceptable (*20 points*)	Unacceptable (*0 points*)	Score Circle One
Physiological Goals: What will the student do to support his or her physiological well-being?	Current Near future Future	Physiological goals were well-written, clear, relevant, achievable, measurable, and bound to time.	Physiological goals were poorly-written, unclear, not relevant, unachievable, ambiguous, and not bound to time.	20 / 0
Psychological Goals: What will the student do to support his or her psychological well-being?	Current Near future Future	Psychological goals were well-written, clear, relevant, achievable, measurable, and bound to time.	Psychological goals were poorly-written, unclear, not relevant, unachievable, ambiguous, and not bound to time.	20 / 0
Social Goals: What will the student do to support his or her social well-bring?	Current Near future Future	Social goals were well-written, clear, relevant, achievable, measurable, and bound to time.	Social goals were poorly-written, unclear, not relevant, unachievable, ambiguous, and not bound to time.	20 / 0
Vocational / Professional Goals: What will the student do to support his or her vocational / professional well-being?	Current Near future Future	Vocational / Professional goals were well-written, clear, relevant, achievable, measurable, and bound to time.	Vocational / Professional goals were poorly-written, unclear, not relevant, unachievable, ambiguous, and not bound to time.	20 / 0
Spiritual Goals: What will the student do to support his or her spiritual well-being?	Current Near future Future	Spiritual goals were well-written, clear, relevant, achievable, measurable, and bound to time.	Spiritual goals were poorly-written, unclear, not relevant, unachievable, ambiguous, and not bound to time.	20 / 0

Case Note Format – DAP *

D **"Data"**	Subjective and objective data about the client Subjective - what client can say or *feel* Objective - observable, behavioral by therapist Standard I ' sentence, progress on presenting problem, review of HW Description of both the content and process of the session
A **"Assessment"**	Intervention, assessment -what's going on? Working hypotheses, gut hunches "Depression appears improved this week" "more resistant ... less involved... "
P **"Plan"**	Response or revision What you're going to do about it Next session date-"couple will call in four weeks" Any topics to be covered in next session(s), and HW given
** Note: A blank DAP Note form can be found in the Appendices*	

1/27/97 (D) Met with Sally and Joe for one hour, 4' session, V. Thomas supervised. Joe reported that he was sleeping less and able to concentrate more at work, but does not think it is due to starting Prozac two weeks ago. Both Sally and Joe report an increase in the frequency and effectiveness of their communication due to their "speaker-listener" HW. Sally stated that "Joe still doesn't seem to open up that much." Joe disagrees with Sally's assessment and feels that he is really "spilling his guts." The rest of the session focused on their differing views of openness and possible relationship to family-of-origin issues *(note: you may want to list these).* During this discussion Sally interrupted Joe four times to add to his statement; after the fourth time Joe sat quietly and stated Sally could finish for him. Sally shouted at Joe that he was a quitter and after a few moments apologized. (A) Joe's symptoms of depression appear to be lessening. Couple has improved their communication style, but have not rebuilt their trust and safety. Sally continues to view Joe as not trying and thus not caring. (P) Next session scheduled for 2/3 at 6pm. Continue work on building safety for communication. HW: What did you learn about being a husband/wife from your parents?

2/3/97 (D) Met with Sally and Joe for one hour, 5' session, V. Thomas supervised. Joe started the session enthusiastically reporting that they had a "GREAT week." Joe noted that they did not talk for three days after the last session, but each had done their HW. On Friday night they each started to talk about feeling hurt and not cared for which resulted in crying and "snuggling all night long." Joe continued to report that the last few days was just like when they first met. Sally stated she had enjoyed their time together, but was afraid it was "just a phase" and that it would go away. Focus of the rest of the session was on how they created this special time, and how it could be maintained *(note.-you want to list their ideas),* (A) Joe is no longer reporting any symptoms of depression, but still does not think the Prozac is helping. Sally seems reserved, and appears to be reacting to Joe's euphoric state about the relationship. (P) Next session scheduled for 2/10 at 6pm, May need to prepare Sally and Joe for when the euphoria goes away. Continue to work on safety, get back to last HW on FOO issues. HW: Continue with the List HW of what did you learn from your parents about being a husband/wife.

Case Presentation Example

Note: A blank copy of the Case Presentation form can be found in the Appendices

Student's Name: **Date of Presentation:** 4/13/2011

Client Information (No identifying info, please):

Age: 17 Sex: Female
Family Constitution: DCS custody- Mother is involved for family sessions
Occupation or Grade if in School: 10th grade

Does client appear Developmentally on Target? YES

Previous Diagnosis? ODD / Bipolar Disorder

Stage of Change: Action/Maintenance

Presenting Problem:

Client's View of the Problem: She has an unstable mood and needs medication to be "normal"

Family Members'/Friends' View of the Problem: Mother reports that teen needs to learn to control her emotions; mother believes the problem is her bipolar disorder.

Counselor's View of the Problem: Client is not taking responsibility for her choices and actions and is making excuses for her behavior. Client is basing her opinion of herself on what mother, other clinicians, and present counselor have told her in the past.

Other's View (i.e. court, school personnel, medical professionals): Unknown.

Focus of Session (Goal of session): Discussion of pt's feelings surrounding having to be here at the facility longer than planned; also talked about feelings surrounding biological mother sabotaging her foster home placements.

How does this session fit with overall goal of treatment for this client? She is at the end of her treatment here, but is now facing problems with her biological mother trying to prevent her from being released to a foster home placement. This session is about dealing with her emotions/feelings surrounding the roadblocks that are now in front of her.

Counseling Theory: CBT

Techniques Used: Active Listening, Open Ended Questions, Positive reinforcement, reflection of feeling and confrontation.

Therapeutic Intent underlying Techniques: To let the client know I was listening and that what she is saying is heard and is important. To help client make the connection that this

resident is a lot like her mother and that is the reason for her going back to her old patterns. Understanding this will help her be able to recognize triggers and use appropriate coping skills to deal with emotions.

Reason for Selection of Recorded Segment to be Presented: This is towards the end of the session; her group was going on a outing. I selected this section, because this patient really started to get into what she was feeling about having to be here longer than expected and having foster homes drop her because he mother made false allegations against pt.

Supervision Needs:

What feedback would you like from the group: Any suggestions on things I could do to improve my counseling skills. Alternatively, ways to use my theory are always welcome.

What was particularly challenging for you in this session? Focusing her in on the session, she was distracted by the group outing that was happening on this day.

What do you feel were your areas of strength? I think my area of strength was getting her to talk, using open ended questions. I think she knows I am here to really listen to what she is saying.

What do you feel were your areas of need/improvement? I need to continue to work on going deeper with the clients, in terms of reflecting meaning.

Clinical MH Counseling Oral Case Presentation Rubric

Name: _____

Total Score: Satisfactory (16 or better)/Unsatisfactory (15 or below)
Turned in on time? ❑ Y ❑ N

Areas of Competency	Below Expectations	Meets Expectations	Exceeds Expectations	Score
Delivery/Eye Contact CMCH: D.7	Student mumbles words and reads material directly from page with minimal eye contact/Recording is inaudible/no documentation	Student's voice is clear and can be heard by most audience members; maintains eye contact for most of presentation/Recording is not audible in parts/limited documentation	Student's voice is clear and can be heard by all audience members; maintains eye contact with few glances at notes/Recording is fully audible/fully documented	2 1 0
Content Structure and Performance	Student does not have a grasp of information presented and does not give logical sequence for audience to follow	Student is at ease with material and audience is given a logical sequence of events to follow	Student presents material in an engaging manner and demonstrates full knowledge in explanations and elaborations	2 1 0
Personal Data about the client CMHC: D.2; D.4	Student give 2-3 pertinent demographic information, with limited information about current functioning	Student gives all available demographic information, includes current level of functioning, diagnosis, stage of change and other resources that can be of use to client	Student gives all available demographic information, includes current level of functioning, diagnosis, stage of change and other resources that can be of use to client. Student projects client functioning and likelihood for change in the next four weeks	5 2 0
Summarizing the Clients History CMHC: D.3; D.5; D.6	Student has limited history and no background information about the client.	Student gives history and background information about the client, includes complicating factors and previous approaches. (Such as Addiction Assessment; Suicidal/Homicidal Ideation)	Student gives history and background information about the client, includes complicating factors and previous approaches (Such as Addiction Assessment; Suicidal/Homicidal Ideation). Includes a strengths-based wellness assessment of client's personal attributes that could be utilized in future interventions	5 2 0
Summarizing Stage of Change and Co-Occurring D/O CMHC: D.8	Student has limited information about client's stage of change and co-occurring diagnoses	Student gives information about client's stage of change and co-occurring diagnoses	Student gives information about client's stage of change and co-occurring diagnoses; gives insights into client's movement from one stage to another	4 2 0

- Exceeds Expectations: Demonstrates evidence of strong knowledge, skills and dispositions in this area.
- Meets Expectations: Demonstrates evidence of satisfactory knowledge, skills and dispositions in this area.
- Below Expectations: Demonstrates evidence of limited knowledge, skills, and dispositions in this area.
- No evidence: Does not demonstrate evidence of knowledge, skills, and dispositions in this area.

School Counseling Oral Case Presentation Rubric

Name: _____

Total Score: Satisfactory (16 or better)/Unsatisfactory (15 or below)
Turned in on time? ❑Y ❑N

Areas of Competency	Below Expectations	Meets Expectations	Exceeds Expectations	Score
Delivery/Eye Contact	Student mumbles words and reads material directly from page with minimal eye contact/Recording is inaudible	Student's voice is clear and can be heard by most audience members; maintains eye contact for most of presentation/Recording is not audible in parts	Student's voice is clear and can be heard by all audience members; maintains eye contact with few glances at notes/Recording is fully audible	2 1 0
Content Structure and Performance	Student does not have a grasp of information presented and does not give logical sequence for audience to follow	Student is at ease with material and audience is given a logical sequence of events to follow	Student presents material in an engaging manner and demonstrates full knowledge in explanations and elaborations	2 1 0
Personal Data about the client SC: F.3	Student give 2-3 pertinent demographic information, with limited information about current functioning	Student gives all available demographic information, includes current level of functioning, demonstrates competency in relation to diversity, equity, and opportunity in student learning and development	Student demonstrates advanced skills when presenting client demographic information, includes current level of functioning, demonstrates competency in relation to diversity, equity, and opportunity in student learning and development.	5 2 0
Summarizing the Clients History SC: H.4	Student has limited history and no background information about the client.	Student gives history and background information about the client, includes complicating factors and previous approaches. (Such as Addiction Assessment; Suicidal/Homicidal Ideation). Student makes appropriate referrals when necessary.	Student gives history and background information about the client, includes complicating factors and previous approaches (Such as Addiction Assessment; Suicidal/Homicidal Ideation). Student makes appropriate referrals when necessary. Includes a strengths-based assessment of client's personal attributes that could be utilized in future interventions.	5 2 0
Advocacy SC: B.2; H.5; L.2	Student has limited information about how to advocate for the learning and academic experiences of clients.	Student understands the importance of advocating for the learning and academic experiences necessary to promote the academic, career, and personal/social development of students.	Student understands importance of advocating for learning & academic experiences necessary to promote the academic, career, & personal/social development of students. Student advocates for client when possible.	4 2 0

- Exceeds Expectations: Demonstrates evidence of strong knowledge, skills and dispositions in this area.
- Meets Expectations: Demonstrates evidence of satisfactory knowledge, skills and dispositions in this area.
- Below Expectations: Demonstrates evidence of limited knowledge, skills and dispositions in this area.
- No Evidence: Does not demonstrate evidence of knowledge, skills and dispositions in this area.

COUN5440 - Theoretical Orientation Paper Grading Rubric

Student: _____

Grading Criteria	Poss Pts	Pts Given
Articulation of how the theory will be incorporated into the authors work as a mental health professional:	**30**	
Selection of one of the theories presented in the textbook, or otherwise given permission by instructor:	**5**	
Information about the theory:	**25**	
The development of human nature/personality	5/25	
The development of abnormalities	5/25	
The counselor-client relationship	5/25	
How change occurs in counseling	5/25	
The role of the counselor	5/25	
Use of source material:	**20**	
The use of at least one original source	5/20	
Minimum inclusion of seven references	5/20	
Citation/references used appropriately	5/20	
Citation/reference in APA Format	5/20	
Length is 7-10 pages (excluding Cover & Reference pages, no abstract required):	**5**	
Use of APA format and general grammar:	**15**	
Spelling	5/15	
Grammar	5/15	
Format	5/15	
Total Points	**100**	

Comments:

What is the purpose of including this grading rubric? Don't we just need the generic theory paper grading rubric?

Therapy Processing Model

Week No.	Therapy Process	Student Process	Client Process
1.	Relationship Building	Intake	Giving history of past functioning
2.	Relationship Building/ Assessment Stage/ Goal Setting	Intake/Formulating Goals	Giving story of current functioning and desires for change
3.	Assessment Stage/Goal Setting	Asking questions and paraphrasing to get content of client's story	Telling the story of current functioning and how it is an issue
4.	Goals/Intervention and Action Stage	Reflecting feelings and summarizations	Client continues to tell story, begins to feel dissonance
5.	Intervention and Action Stage	Continue to reflect feelings, summarizations-begin reflecting meaning ***Students are conceptualizing this case in terms of their personal theory***	Client continues to have dissonance; begins thinking about the goals of therapy
6.	Intervention and Action Stage	Begin to use confrontation skills, enhance efficacy and self-esteem of clients	Working towards the goals of therapy
7.	Intervention and Action Stage	Utilize advanced skills to further client's progress towards goals Examples: Focusing on the client; boiling down the problem; Giving advice; Giving information; alternate Interpretation; Brainstorming	Client will alternately feel anxiety/frustration/joy/ excitement as he/she attempts to work towards goals of therapy (Client is not limited to these emotions as they progress)
8.	Intervention and Action Stage	Utilize advanced skills to further client's progress towards goals	Client continues to oscillate between feelings
9.	Intervention and Action Stage	Utilize advanced skills to further client's progress towards goals	Client continues to oscillate between feelings

10.	Intervention and Action Stage	Utilize advanced skills to further client's progress towards goals	Client's emotions are beginning to stabilize as they experience greater levels of competence with goals
11.	Intervention and Action Stage/ Maintenance	Utilize advanced skills to further client's progress towards goals/ Empower client, focus on the successes of goal attempts	Client's emotions are beginning to stabilize as they experience greater levels of competence with goals; begin to focus client on how to maintain their new way of being
12.	Maintenance	Empower client, focus on the successes of goal attempts	Continue to focus client on how to maintain their new way of being.
13.	Maintenance/ Outcome Evaluation	Empower client, focus on the successes of goal attempts; Utilize outcome evaluation (scaling questions, pen & paper tests; client satisfaction questionnaire)	Continue to focus client on how to maintain their new way of being; Determine what interventions have been ultimately successful for them, begin to take a view of client's experience of the therapy process
14.	Outcome/ Evaluation/ Termination	Utilize outcome evaluation; Resolve unfinished business between counselor and client; what goals were met, which were not; Work on clients knowledge of when/if they need to come back for counseling	Determine what interventions have been ultimately successful for them, begin to take a view of client's experience of the therapy process; Work towards the end of therapeutic relationship
15.	Termination	Resolve unfinished business between counselor and client; what goals were met, which were not; Work on clients knowledge of when/if they need to come back for counseling. Celebrate the successes of the counselor/client relationship	End the therapeutic relationship

Mental Status Evaluation

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A mental status examination is an important component of a thorough psychosocial evaluation. Information for the mental status examination is gathered through the clinical interview with the client. It allows for a comprehensive evaluation of the client presentation.

One important goal of the mental status examination is to have a parsimonious description of the client's presentation. A trained mental health professional should be able to read the results of the mental status examination and have a clear understanding of the client's presentation, presenting issue, and results of the evaluation. Another important goal is that the mental status evaluation is invaluable in helping you conceptualize, diagnose and present the case in a clear, specific, and succinct client introduction during case presentations.

I hope the following is helpful in better understanding this process including its write-up.

The major areas of the mental status examination include:

- General identifying information
- Appearance
- Attitude
- Affect
- Mood
- Thought process and Speech
- Perception and Cognition
- Orientation
- Memory and Recall
- Intellectual
- Insight and Judgment

Important Note: When reporting the results of your evaluation it should be based on objective information from your observations and what client reported. Examples of how you would write up your results will be provided for each section and for the entire evaluation.

General Identifying Information

- Age
- Gender
- Marital status
- Race
- One to two sentence on the client's reasons for coming in.

e.g., The client is it 27 year-old single Hispanic female who reported coming to counseling due to feelings of depression stemming from the unexpected breakup of a three year relationship.

Appearance: The client's appearance is an important aspect when evaluating your client. Below are adjectives to describe what is observed. Sometimes it is helps to clarify your observations.

- Dress: Unkempt, unclean, disheveled, neat
- Clothing and/or grooming is atypical or eccentric
- Note any unusual physical characteristics (e.g. scar, deformity, etc.)
- Psychomotor agitation or psychomotor retardation
- Posture: erect, tense, relaxed, or lying down
- Facial expression: fixed, changing, angry, perplexed, sad, happy, or suspicious

e.g., Her dress was disheveled and she appeared unclean with dirt under her fingernails. She had bruises on her lower arm and presented with marked psychomotor agitation during the interview with constant wringing of her hands, shuffling of her feet, and changing positions in her seat. Her posture was tense and her facial expression was sad.

Attitude: What was the client's attitude towards you during the interview?

- Composed, polite, reserved, indifferent, silent, scared, sad, happy, carefree
- Cocky, angry, sarcastic, uncooperative, cooperative, dramatic, withdrawn, passive
- Impulsive, manipulative, defensive, demanding, antagonistic, aggressive, etc.

e.g., Although her attitude appeared withdrawn and passive, she was cooperative.

Affect: The client's affect is how they are presenting their emotions. This is important to note because their affect can sometimes be very different than what they are reporting. When evaluating affect you need to note:

- Their affect: depressed, anxious, worried, paranoid, dysphoric, euphoric, expansive
- Any changes in affect: Was their affect stable during the interview or were there any sudden or unusual changes noted?
- Appropriateness of affect: Was their affect appropriate to situation and to what they are presenting?

e.g., Her affect was depressed throughout the entire interview with no changes even when she was reporting on recent pleasant experiences. It was appropriate to her situation and content of her presenting information.

Mood: When evaluating and reporting the client's mood, it is important to examine what clients report their mood to be and the results of your evaluation (DSM based) of their mood (e.g. depression, anxiety, mania, etc.). Basically, this is where you are evaluating for the presence of a mood disorder. Some important notes:

- Ask the client how they are feeling and follow up with a thorough DSM-based evaluation.
- Ask specifically about onset duration, and changes in intensity of mood
- Ask specifically about suicidal or homicidal ideations (past or current)
- It is also beneficial to ask about any sudden changes in mood or symptoms of mania.
- Descriptors of mood:
    - Dysphoria - unpleasant such as depressed, anxious, or irritable
    - Elevated - more cheerful than normal

- Euphoric - exaggerated feeling of well-being (implies pathology)
- Euthymic - in the normal range
- Expansive - lack of restraint ill expressing feelings: often, an over-evaluation of one's importance
- Irritable

e.g., She reported her mood to be “okay.” However, she admitted to feelings of dysphoria and sadness the past three weeks since the breakup with no changes in intensity; decreased sleep with middle-insomnia: anhedonia; and decreased appetite, energy and concentration. She denied any current or previous homicidal ideations and denied any suicidal ideations at this time, although she reported suicidal thoughts with no attempt ten years ago after the break-up of a two-year long relationship. The client also denied symptom of mania,

Thought Process and Speech: Generally, there are no specific questions to ask when evaluating thought process and speech. However, with some clients (e.g., recent head injury. transient ischemic attacks (TIA or mini-stroke), or other clients that may be concerned about their cognitive functioning), you can ask direct questions related to their symptoms. In general, you are paying attention to their thought process and speech during the entire evaluation and summarizing in this part of the mental status exam. Although concerns in this area are not always pathological, thought process and speech problem can indicate symptoms of acquired cognitive impairment (e.g., dementia, head injury), mania, or the presence of psychotic symptoms (e.g., responding to internal stimuli).
Thought Process:

- Logical
  - Tangential- the connection between two ideas is not present making the content of what they are saying difficult to follow. Speech can be tangential.
  - Circumstantial- inclusion of trivial details to the point that the content of what they are saying is difficult to understand. Speech can be circumstantial.
  - Blocking - Sudden interruptions in the client's train of thought or sudden stoppage of speech without any apparent reason. Can be indicative of schizophrenia.
  - Looseness of Associations - similar to tangential
- Speech
  - Goal directed
  - Mute
  - Tangential and circumstantial
  - Echolalia - repeating what is said by others in an echoing fashion. Indicative of organic mental problems and schizophrenia.
  - Incoherent speech - Speech is disorganized due to loose associations, being tangential or circumstantial or some other speech or thought process impairment to the point where it is not understandable. Indicative of severe psychopathology.
  - Perseveration - repeating the same words, phrase or idea over and over. Indicative of organic problem or severe psychopathology.
  - Word Salad - words are extremely disconnected. Extreme form of tangential speech.

    - Flight of ideas - almost continues now of accelerated speech and usually present with tangential and circumstantial speech. Present in mania, organic and psychotic disorders.
    - Confabulation - fabrications, usually to make up gaps from impaired memory.
    - Clanging - Word choice based on sound rather than meaning (e.g. "Who? Boo hoo, I have a clue.") Present in organic disorders and schizophrenia.
    - Logorrhea - a.k.a., volubility; profuse, coherent and logical speech. Present in mania and anxiety.
    - Pressured speech - logorrhea that is difficult to interrupt.
- Types of aphasia - usually seen in organic problem and brain injuries. Most likely will not see unless you are working in a psychiatric hospital, rehabilitation hospital, or if you are working in a rehabilitation counseling setting with brain injury patients. However, it is still good information to know.
    - Motor aphasia - understanding remains but ability to speak is lost.
    - Sensory aphasia - loss of ability to comprehend the meaning of words or use of objects.
    - Nominal aphasia - difficulty finding the right name for an object.
    - Syntactical aphasia - inability to arrange words in proper sequence.

e.g., The client's thought process was logical and her speech was goal-directed, however, when confronted on her psychomotor agitation, her thought process and speech both became somewhat tangential.

Perception and Cognition: A client's thought process and speech can suggestion concerns with perception and cognition requiring more in depth investigation. As with thought process and speech, the therapist has to pay dose attention to the client's speech and thought process to evaluate perception and cognition. However, it is also important to ask specific questions to fully evaluate for the following:

- Delusion of ____:
    - Grandeur - exaggerated self-perception.
    - Control - false feeling that one is being: controlled by someone else.
    - Infidelity - derived from pathological jealousy, this is a false belief that one is being cheated on.
    - Self-accusation - false feelings of remorse (e.g. she died because I yelled at her).
    - Persecution - false belief that one is being persecuted.
    - Reference - false belief that the behaviors of others is referring to oneself.
    - Paranoid ideation - over suspiciousness usually leading to delusions of persecution.
    -
- A general questions such as the following can capture many of the different types of delusions presented:
    - "Do you ever feel like people are after you or out to get you?"
    - "Have you ever thought people were able to community with you in unusual ways such as through a television or some way other than speech?"
    - "Have you been experiencing anything unusual or out of the ordinary or has anything unusual or out of the ordinary happened to you recently or in the past?

    - "Have you seen anything that you were concerned was not there or heard voices when no one was present?"
- Preoccupation of thought - content of client's speech and thought process is centered on one topic, area, or idea.
- Hypochondria - exaggerated concern about one's health unfounded in medical pathology.
- Obsession - pathological persistence of a thought feeling, or impulse than cannot be consciously eliminated.
- Phobia - pathological dread of some specific type of stimulus, situation, or event.
    - Acrophobia – heights.
    - Agoraphobia - open places.
    - Algophobia – pain.
    - Claustrophobia - closed spaces.
    - Xenophobia- strangers.
    - Zoophobia – animals.
- Hallucinations: false sensory perceptions no associated with real external stimuli.
    - Hypnogogic hallucinations - false sensory perceptions occurring halfway between falling asleep and being awake.
    - Auditory hallucinations - false auditory perceptions.
    - Visual hallucinations - false visual perceptions.
    - Olfactory hallucinations - false perception of smells.
    - Gustatory hallucinations - false perception of taste.
- Hysteria: characterized by the use of the defense mechanism of conversion to deal with emotional conflicts leading to the development of physical symptoms involving voluntary muscles on special sense organs.

e.g., She denied any auditory or visual hallucinations and delusions during the interview. However, she was preoccupied with her ex-boyfriend and his current relationship status.

Orientation: this area is more relevant in an in-patient setting. In an outpatient setting, it is somewhat unusual to have a client that is not oriented to time, person, place, or situation.

- Time - time of day within an hour, day, date, and year.
- Place - city, state, their current residence, or where they are at time of interview.
- Person – who they are by name.
- Situation - the situation they are in (e.g., counseling).

e.g., She was oriented to person, place, time, and situation.

Memory/Recall: Along with orientation, memory/recall is examined more thoroughly in in-patient settings. Usually, the client will be asked to remember three words at the onset of the interview (e.g., ball, flag, and tree) knowing they will be asked to recall them. At some interval (five minutes, ten minutes), you ask the client to recall the words. You would then report, "The client recalled two out of three at five minutes." In an outpatient setting, you want to ask questions or pay attention to responses related to remote memory and recent memory.

- Remote memory - relevant past history such birthdays, anniversaries, jobs held, some family history, significant mental health or medical issues, etc.

- Recent memory - events of the day or past few days.

e.g., There was no evidence of disturbances related to remote or recent memory.

Intellectual: As with orientation and memory/recall, evaluating intellectual functioning is done more thoroughly in inpatient settings. This can be assessed via calculations (asking the client to count backwards from 100 by 7s), spelling (spelling a simple word, such as "world," forward and then backwards to evaluate concentration), general information (state capital of state residing in, name of governor, name of most recent three Presidents), meaning of proverbs (people in glass houses shouldn't throw stones; don't cry over spilled milk), similarities (table and chair, dog and cat, car and train), or differences (chair and stool, lie and mistake).

In an outpatient setting, you would consider age, educational experience, work experience, and previous levels of functioning to gauge if their intellectual functioning is within a reasonable range.

e.g., Her intellectual functioning appeared within normal limits considering her age, educational level and occupational experiences.

Insight and Judgment: Technically, insight and judgment is considered part of intellectual functioning. However, it is often times not given enough attention in outpatient settings so I have decided to tease it out as a separate section.

Insight relates to the client's understanding of their situation, illness, behaviors, or presenting issues and concerns. It can be assessed by asking the client questions about their presenting issues and behaviors. It can also be gauged by the client's responses to questions during the interview indicating a certain level of insight to their situation. (e.g., Client in the midst of a manic or hypo-manic episode wanting to leave the session early to attend a job interview).

Closely related to insight judgment reflects the client's perceptions of real or imagined situations and behaviors in those situations. Both insight and judgment can be considered good, fair, and poor with some type of supporting behavioral observation, if possible.

e.g., The client's insight and judgment were evaluated as fair to poor evidenced in her hiding out in her ex-boyfriend's backyard with the hopes that they will get back together.

As you can see, going through this process provides the counselor with a comprehensive understanding of the client's presenting issues. Also, the counselor can now conceptualize and present their client in a logical, clinical, and parsimonious manner. Now, if we take the sample statements at the end of each section and put them together, you will have the following narrative that can be presented in written or orated form during a case presentation:

> *The client is a 27 year-old single Hispanic female who reported coming to counseling due to feelings of depression stemming from the unexpected breakup of a three year relationship. Her dress was disheveled and she appeared unclean with dirt under her fingernails. She had bruises on her lower arm and presented with marked psychomotor*

agitation during the interview with constant wringing of her hands, shuffling of her feet, and changing positions in her seat. Her posture was tense and her facial expression was sad. Although her attitude appeared withdrawn and passive, she was cooperative.

Her affect was depressed throughout the entire interview with no changes even when she was reporting on recent pleasant experiences. It was appropriate to her situation and content of her presenting information. She reported her mood to be "okay." However, she admitted to feelings of dysphoria and sadness the past three 'weeks since the breakup with no changes in intensity; decreased sleep with middle-insomnia, Anhedonia, and decreased appetite, energy and concentration. She denied any current or previous homicidal ideation, and denied any suicidal ideations at this time, although she reported suicidal thoughts with no attempt ten years ago after the break-up of a two year-relationship. The client also denied symptom of mania.

The client's thought process was logical and her speech was goal-directed. However, when confronted on her psychomotor agitation, her thought process and speech both became somewhat tangential. She denied any auditory or visual hallucinations and delusions during the interview. However, she was preoccupied with her ex-boyfriend and his current relationship status. She was oriented to person, place, time, and situation. There was no evidence of disturbances related to remote or recent memory. Her intellectual functioning appeared within normal limits considering her age, educational level and occupational experiences. The client's insight and judgment were evaluated as fair to poor evidenced in her hiding out in her ex-boyfriends backyard with the hopes that they will get back together.

Not only does putting all the areas together provide a logical summary of the client's presentation, the counselor familiar with the above information can respond more logically to questions on different aspects of the client's presentation.

Example a:
Supervisor: How has your client's mood changed since you first saw her two weeks ago?
Counselor: Two weeks ago she reported her mood to be "okay" although she admitted to feelings of sadness and dysphoria the past three weeks, middle insomnia, Anhedonia, and decreased appetite, energy, and concentration. This past session she reported improvements in her sleep and appetite and improvements in her feelings of sadness that she attributes to more hope for the future.

Comment: Sometimes beginning counselors will go with the client's report of their feelings vs. reporting what the client said and conducting their own evaluation. As therapy progresses, the more specific assessment and diagnostic information to more clear you're reporting on client improvement

Example b:
Supervisor: Was there any indication of suicidal ideation?
Counselor: During the initial appointment two weeks ago, the client denied any suicidal ideations at that time. However, she did report suicidal ideations without attempt ten years ago after a relationship breakup.

Comment: There are some important issues with this example. First, the phrase "at this time" is critical. This lets the reader know you asked the question then vs. going on someone else's reports. Also, it is imperative to state the "client reported no" or "denied any" suicidal (or homicidal) ideations "at this time." Just because a client says they are not suicidal doesn't mean they are not suicidal. By leaving out the phrase "client reported no" or "client denied any" you are taking full ownership of knowing that the client is absolutely not suicidal. Not possible, but you will be held very liable. Thirdly, it is equally as important to ask about prior suicidal (or homicidal) ideations. With this client, we know to be on the lookout for suicidal ideations because that is how she responded to a similar breakup.

Therapeutic Forces/Curative Factors

Kelman (1963)	
Compliance	Agreement with group for approval
Identification	Accepting of influence from others
Internalization	Integrating others' values with one's own

Olsen (1970)	
Commitment	Accept need for help, willing to talk about behavior and change
Expectations	Clients function better when they know what is expected of them
Responsibility	Increased responsibility for self, others improves chances for growth
Intellectualization	Acquiring knowledge leads to insight
Reality testing	Person can test responses in a safe atmosphere
Transference	Emotional attachments develop which are re-creations from client's past
Security	Members feel free to share themselves with the group
Tension	Usually required for growth
Group norms	Clients usually change when they understand and accept the condition of the group

Corsini and Rosenberg (1955)	
Acceptance	Sense of belonging, enhances self-esteem and encourages change in behavior
Altruism	Similar to acceptance, but involves wanting to do something for someone else
Universalization	Acquiring such knowledge frequently leads to insight
Reality testing	Person can test responses in a safe atmosphere
Attractiveness	The more attractive the group, the greater the influence on the members
Belonging	Required for change
Interaction	Relationships arising within the group foster openness to interpersonal experience
Spectator therapy	Member gains from observing other group members
Ventilation	Catharsis

Yalom (1995)	
Instillation of hope	Faith in itself can be therapeutic
Universality	Provides a powerful source of relief
Imparting information	Didactic instruction or advice
Altruism	Clients receive through giving
Corrective recapitulation of primary family group	Early familial conflicts are relived *correctively*
Development of socializing techniques	Learning directly or indirectly
Imitative behavior	Usually in the earlier group stages
Interpersonal learning	Importance of social relationships; corrective emotional experience; the group as a social microcosm
Group cohesiveness	Group members exhibit greater acceptance, intimacy, and understanding toward one another
Catharsis	Not in itself sufficient for therapeutic change
Existential factors	Concerns of death, isolation, freedom, and meaninglessness

Identifying Your Feelings

Afraid	You're scared of what life will be like now. You may be fearful about your ability to cope emotionally, or you may be uncertain about practical concerns like money, raising the children, or where you'll live. You may just feel afraid, without really knowing why.
Angry	Anger often feels like a physical thing. Your muscles tense up and you may feel like yelling at someone or hitting something. Your rage may be aimed at yourself or your lost loved one, or you may find yourself getting angry at other people, society, or your spiritual beliefs.
Anxious	Anxiety is distinct from fear and is often a generalized feeling. If you're afraid, at least you know what scares you. If you're anxious, on the other hand, you're likely to feel agitated without knowing exactly why. You may experience cold sweats, hyperactivity, or edginess.
Ashamed	You may feel that you should be getting over your feelings, or may be ashamed to show them in front of family, friends, and others. You may also harbor feelings about death, or the fact that you are still alive, that feel shameful to you and are difficult to share with others.
Bitter	Life may feel very unjust, and you may feel cheated and disappointed. You may feel jealous and resentful toward others who still have what has been taken from you, and you may feel victimized by fate.
Confused	You may be unsure of what you're feeling, or your feelings may change quickly. Your thoughts may be unfocused and it may be difficult to concentrate; or you may have a hard time knowing what to do and how best to make decisions.
Depressed	Depression can be a general mood of melancholy, or a full-blown experience that is all-encompassing and seems to have no end. In a major depression your mood, appetite, sleep, memory, and ability to concentrate are seriously impaired. You may feel the impulse to do self-destructive things in an effort to find relief.
Despairing	Here you feel a sense of futility. It seems as though things will never get better, and the distress caused by the death may feel unbearable. Although you want to, you may not be able to get your feelings out by crying, or you may be unable to stop crying.
Detached	You feel disconnected from the death and detached from life in general. The experience seems unreal, as if it were happening to someone else. You simply pass through life each day, your actions detached from your thoughts and feelings.
Guilty	You may feel that you could have done more to help your loved one or to prevent the death. You may feel intense regret about the way you behaved toward your loved one, or promises you never kept. You may also feel guilty about negative feelings you harbor toward your loved one, or mixed feelings about the death itself. It is also common for the bereaved to feel guilty when they begin to laugh and find pleasure in life once again, or begin new relationships. Or you may experience survivor guilt – a sense of remorse that you remain alive while your loved one has died.

Helpless	Things seem out of your control. You may think that if you were powerless to prevent the death, then you can't handle anything. You can't cope with the practicalities of everyday life, and feel unable to control or manage your feelings.
Hopeless	Life has no meaning. It seems there is no point to anything, and things will never get better. Your feelings and the tasks you face seem insurmountable, and you feel unable to ever overcome your loss.
Lonely	There is no one that can understand your pain. There seems to be no one to share things with or seek comfort from. These feelings may make you feel like withdrawing even from those around you, or from the world at large.
Lost	Everything that you used to believe in is gone. You aren't sure where you fit in the world, or who you are. If you are religious or spiritual, your faith is shaken. If you are not, you feel it unwise to ever have faith in a world where nothing seems permanent.
Numb	You are shut down emotionally. You feel nothing. Everything is flat. Although you might be able to function and get through each day, it sometimes seems as if you are sleep-walking through life, unable to feel your emotions.
Overwhelmed	You simply can't cope with the barrage of emotions, thoughts, and changes facing you. You feel like running away, or escaping by using alcohol of drugs. You want someone to come and rescue you, and make it all go away.
Preoccupied	You can't stop thinking about your loss. Perhaps you keep replaying certain scenes over and over in your mind, or agonize about who you might lose next. You can't concentrate on your everyday responsibilities or engage in a conversation without your mind wandering. Intrusive memories keep surfacing no matter what you do.
Sad	Sorrow and heartbreak color everything. You feel your loss deeply, and it affects and pervades all you do. It is a mood that simply won't go away.
Shocked	You are bewildered and confused. Even if you were prepared for the death, the situation doesn't seem real. The finality of the situation leaves you feeling stunned, and you may not be able to accept that your loved one is gone. You keep hoping to wake up from a bad dream.
Vulnerable	Your faith in your own invulnerability is shattered. You are constantly aware of your own mortality and the mortality of other important people in your life. You feel exposed, without protection, to whatever destiny or life hands you.
Yearning	You long for the deceased. It hurts so much that you feel a constant pit in your stomach. You are constantly aware of the absence of your loved one, and you feel empty. Nothing can fill the void.

Psychiatric Medications

Trade Name	Generic Name	FDA Approved Age
Combination Antipsychotic &Antidepressant Medication		
Symbyax (Prozac & Zyprexa)	fluoxetine & olanzapine	18+
Antipsychotic Medications		
Abilify	aripiprazole	10+ for bipolar disorder, manic or mixed episodes; 13 to 17 for schizophrenia &bipolar;
Clozaril	clozapine	18+
Fanapt	iloperidone	18+
fluphenazine (generic only)	fluphenazine	18+
Geodon	ziprasidone	18+
Haldol	haloperidol	3+
Invega	paliperidone	18+
Loxitane	loxapine	18+
Moban	molindone	18+
Navane	thiothixene	18+
Orap (for Tourette's)	pimozide	12+
perphenazine (generic only)	perphenazine	18+
Risperdal	risperidone	13+ for schizophrenia; 10+ for bipolar mania & mixed episodes; 5 to 16 for irritability associated with autism
Seroquel	quetiapine	13+ for schizophrenia; 18+ for BPD; 10-17 for tx of manic & mixed episodes of BPD.
Stelazine	trifluoperazine	18+
thioridazine (generic only)	thioridazine	2+
Thorazine	chlorpromazine	18+
Zyprexia	olanzapine	18+ ; ages 13-17 as second line tx for manic or mixed episodes of bipolar disorder &schizophrenia.
Antidepressant Medications (also used for anxiety disorders)		
Anafranil (tricyclic)	clomipramine	10+ (for OCD only)
Asendin	amoxapine	18+
Aventyl (tricyclic)	nortriptyline	18+
Celexa (SSRI)	citalopram	18+
Cymbalta (SNRI)	duloxetine	18+
Desyrel	trazodone	18+
Effexor (SNRI)	venlafaxine	18+
Elavil (tricyclic)	amitriptyline	18+
Emsam	selegiline	18+
Lexapro (SSRI)	escitalopram	18+ ; 12 - 17 (for major depressive disorder)
Ludiomil (tricyclic)	maprotiline	18+
Luvox (SSRI)	fluvoxamine	8+ (for OCD only)
Marplan (MAOI)	isocarboxazid	18+
Nardil (MAOI)	phenelzine	18+
Norpramin (tricyclic)	desipramine	18+
Pamelor (tricyclic)	nortriptyline	18+
Parnate (MAOI)	tranylcypromine	18+
Paxil (SSRI)	paroxetine	18+
Pexeva (SSRI)	paroxetine-mesylate	18+
Pristiq	desvenlafaxine (SNRI)	18+
Prozac (SSRI)	fluoxetine	8+
Remeron	mirtazapine	18+
Sarafem (SSRI)	fluoxetine	18+ for premenstrual dysphoric disorder

Sinequan (tricyclic)	doxepin	12+
Surmontil (tricyclic)	trimipramine	18+
Tofranil (tricyclic)	imipramine	6+ (for bedwetting)
Tofranil-PM (tricyclic)	imipramine pamoate	18+
Vivactil (tricyclic)	protriptyline	18+
Wellbutrin	bupropion	18+
Zoloft (SSRI)	sertraline	6+ (for OCD only)
Mood Stabilizing &Anticonvulsant Medications		
Depakote	divalproex sodium (valproic acid)	2+ (for seizures)
Eskalith	lithium carbonate	12+
Lamictal	lamotrigine	18+
lithium citrate (generic only)	lithium citrate	12+
Lithobid	lithium carbonate	12+
Neurontin	gabapentin	18+
Tegretol	carbamazepine	any age (for seizures)
Topamax	topiramate	18+
Trileptal	oxcarbazepine	4+
Anti-anxiety Medications (All of these anti-anxiety medications are benzodiazepines, except BuSpar)		
Ativan	lorazepam	18+
BuSpar	buspirone	18+
Klonopin	clonazepam	18+
Librium	chlordiazepoxide	18+
oxazepam (generic only)	oxazepam	18+
Tranxene	clorazepate	18+
Valium	diazepam	18+
Xanax	alprazolam	18+
ADHD Medications (All of these ADHD medications are stimulants, except Intuniv &Straterra.)		
Adderall	amphetamine	3+
Adderall XR*	amphetamine	6+
Concerta	methylphenidate (long acting)	6+
Daytrana	methylphenidate patch	6+
Desoxyn	methamphetamine	6+
Dexedrine	dextroamphetamine	3+
Dextrostat	dextroamphetamine	3+
Focalin	dexmethylphenidate	6+
Focalin XR*	dexmethylphenidate	6+
Intuniv	guanfacine	6+
Metadate ER*	methylphenidate	6+
Metadate CD	methylphenidate	6+
Methylin	methylphenidate (oral solution &chewable tablets)	6+
Ritalin	methylphenidate	6+
Ritalin SR	methylphenidate	6+
Ritalin LA	methylphenidate (long-acting)	6+
Strattera	atomoxetine	6+
Vyvanse	lisdexamfetamine dimesylate	6+

Note: Er and XR stand for Extended Release formula; Downloaded: 08/01/2011 at http://www.nimh.nih.gov/health/publications/mental-health-medications/complete-index.shtml

Mental Health Destinations on the Internet

Hundreds of web sites now present information about the diagnosis and treatment of mental disorders both for practitioners, clients and their families. Most web sites contain information for all of these constituencies. We have included some of the best sites available; however, some information and treatments may not be accurately or fully described. Other treatments are controversial and are not accepted standards of practice. Individuals with mental disorders should receive face to face treatment by a licensed mental health professional. We have avoided sites where treatment is offered online or through sales of books and materials. Most information about childhood disorders can be found in the section on children and adolescents. Although every effort has been made to ensure the accuracy of these websites, there is no guarantee that the sites will continue to exist.

Web Sites for Practitioners

Mental Health Net (http://mentalhelp.net/)**:** Mental Health Net is one of the most visited sites by practitioners and clients. It is an excellent place to start looking especially for a less common disorder. There are about 20 major mental disorders for which there are chat rooms, support services and resources listed. About 200 other disorders are also listed but in somewhat less detail. For professionals, there are links to assessment, cognitive therapy, neuropsychology, ethics and news events related to mental health. Practitioners should visit the reading room for the quarterly online magazine, chats and interesting updates.

Mental Health Matters (http://www.mental-health-matters.com/): This web site describes itself as "mental health and mental illness information and resources for professionals, consumers and families. There is a special section on caregiver support. There are links to more than 20 categories of mental disorders. In addition, there are pages for mental health advocacy, legal/ ethical issues, electronic journals in mental health, research and data base sites, recent articles, self-help and toll-free numbers for mental health organizations including suicide lines.

Internet Mental Health (http://www.mentalhealth.com/): This is one of the most important sites on the web for mental health practitioners. It is a 'free encyclopedia of web information on mental health." Started by a Canadian psychiatrist, Mental Health Net contains information about psychotropic medications including dosage and side effects. Included are the fifty most common mental disorders and for each gives the following information: Description, Diagnosis Treatment, Research, Booklets, Magazines, Other Web Pages and Links. There is also an online magazine.

Continuing Medical Education (http://www.cmellc.com/):

Mental Health & Psychology Resources Online (http://psychcentral.com/resources/**)**: Since 1991, Dr. John Grohol has been compiling and updating links to mental health issues for clinicians, clients and family members. The site contains 1,268 links grouped into 16 sub-categories from licensure to depression to relationships.

Baldwin's Trauma Information Pages (http://trauma-pages.com/): David Baldwin is a psychologist who shares clinical and research information on trauma and posttraumatic stress

disorder. The site includes information about trauma, links to trauma resources, sources of support, a Trauma Bookstore, Disaster Handouts and links.

SleepNet (http://www.sleepnet.com/): Visitors will find links to over 100 sleep disorders related sites including sleep apnea, insomnia and narcolepsy. In addition, there are links to professional organizations, a "snoozepaper" with news and tips, research links, support groups and sleep laboratory information.

Key sites for client information

Since there are so many internet sites for mental disorders, a good place to begin are the first four sites in the "Web Sites for Practitioners." These sites have information for clients and client families. Some more specific sites for clients are listed below. Again, be aware that there are links that offer "virtual counseling" over the internet and even group counseling in a chat room. In those situations, verifying the credentials of the counselor is difficult if not impossible. At present, there seems to be no advantage to such counseling other than convenience and significant risks may be involved.

The American Academy of Child and Adolescent Psychiatry (AACAP) (http://www.aacap.org/): This site is designed to serve both AACAP members, parents and families. Information is provided to aid in the understanding and treatment of the developmental, behavioral, and mental disorders which affect an estimated 7 to 12 million children and adolescents at any given time in the United States. You will find information on child and adolescent psychiatry, fact sheets for parents and caregivers, current research, practice guidelines, managed care information, and more.

Alcoholics Anonymous (http://www.alcoholics-anonymous.org/): Alcoholics Anonymous (AA), founded in 1935, has helped more than 2 million people with alcohol abuse/dependence. This website has much of the traditional information from AA including facts about alcoholism, information for families and teens, resources for professionals, a newsletter, and information on meeting places and dates.

Alzheimer's Association (http://www.alz.org): Since 1980, the Alzheimer's Association has organized families and caregivers of Alzheimer's clients. The site provides information about causes and treatments and ways to gain access to support.

Anxiety Disorders Association of America (http://www.adaa.org/): This site provides resources for professionals and non-professionals about anxiety disorders. Anxiety Disorders Association of America (ADAA) promotes the prevention and cure of anxiety disorders and works to improve the lives of all people who suffer from them. The site has consumer resources, message boards, and chats.

The Anxiety-Panic Internet Resource (TAPIR) (http://www.algy.com/anxiety/): TAPIR is a grassroots organization composed of volunteers but has no official status as a non-profit. It is designed for individuals interested in anxiety disorders such as panic attacks, phobias, shyness, generalized anxiety, obsessive-compulsive behavior and post traumatic stress. There is a

comprehensive set of links to anxiety sites but much information can be obtained by searching the vast resources on the site itself.

Bipolar Disorders Information Center (http://www.cmellc.com/topics/bipolar.html): This website provides information about Bipolar Disorder and includes chat forums, treatment information and other support. It contains links and information for both professionals and non-professionals.

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD) (http://www.chadd.org/): CHADD is a national organization with over 32,000 members and more than 500 chapters nationwide. Its mission is to provide support and information to individuals, families and communities about Attention-Deficit/ Hyperactivity Disorder (ADHD). The website offers fact sheets, news releases, research studies, and links on ADHD.

Andrew's Depression Page (http://home.avvanta.com/~charlatn/Depression.html): A depression sufferer named Andrew manages this site. There are useful links for clients and client families as well as frequently asked questions about depression, suicide and medications.

International Society for the Study of Dissociation (ISSD) (http://www.issd.org/): The ISSD is a nonprofit professional society that promotes research and training in the identification and treatment of dissociative disorders, provides professional and public education about dissociative states, and serves as a catalyst for international communication and cooperation among clinicians and researchers working in this field. The website contains education, guidelines for treatment, and conference information.

National Institute of Mental Health –Public Information **(**http://www.nimh.nih.gov/index.shtml): NIMH disseminates public information about the causes, symptoms and treatment of the major mental disorders. Materials are in Spanish and English and can be copied and downloaded for dissemination.

The Obsessive-Compulsive Foundation (http://www.ocfoundation.org/): The Obsessive-Compulsive Foundation (OCF) is an international not-for-profit organization composed of people with obsessive compulsive disorder (OCD) and related disorders, their families, friends, professionals and other concerned individuals. The website has information for both professionals and the public about OCD, treatment, and medication. This is a good site for clients or other non-professionals.

Schizophrenia.com (http://www.schizophrenia.com): This is a site for people with schizophrenia and their families. There is a free e-mail newsletter, a message board, chats, and information about the diagnosis, medications, success stories, support groups and means for getting financial support. There are links to 200 web sites.

Professional Organizations

American Counseling Association http://www.counseling.org/ The American Counseling Association (ACA) is an organization of counseling professionals who work in educational, health care, residential, private practice, community agency, government, and business and industry settings. Its mission is "to enhance human development throughout the life span and to promote the counseling profession." The website contains links to divisions, conference information, an online newsletter, and information for the public.

American Mental Health Counselors Association http://www.amhca.org/ American Mental Health Counselors Association (AMHCA) is now a separate organization from the American Counseling Association although some ties still exist. The mission of AMHCA is "to enhance the profession of mental health counseling through licensing, advocacy, education and professional development." The web site contains links to state chapters, client information and related mental health areas. AMHCA holds an annual convention and publishes *The Journal of Mental Health Counseling* quarterly.

American School Counselor Association http://www.schoolcounselor.org/ The American School Counselor Association (ASCA) supports school counselors' efforts to help students focus on academic, personal/social and career development so they achieve success in school and are prepared to lead fulfilling lives as responsible members of society. ASCA provides professional development, publications and other resources, research and advocacy to more than 25,000 professional school counselors around the globe.

Codes of Ethics

In general, the codes of ethics of the major professional organizations do not make distinctions in ethical behavior of clinicians when treating mental disorders versus other kinds of problems.

American Counseling Association (ACA) – Code of Ethics
The ACA Code of Ethics and Standards for Practice can be found at the following link:
http://www.counseling.org/resources/codeofethics/TP/Home/CT2.aspx

American Mental Health Counselors Association (AMHCA) – Code of Ethics
The AMHCA code of ethics can be found by going to AMHCA's home page and then to the "About AMHCA" tab:
http://www.amhca.org/

America School Counselors Association (ASCA) – Code of Ethics
The ASCA code of ethics can be found by going to the provided link:
http://www.schoolcounselor.org/content.asp?contentid=173

Appendices

Practicum or Internship Site Information Sheet

❑ COUN 5550 Practicum or ❑ COUN 5590 ❑ COUN 5720/5700/5710 Internship

Student: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ UTC ID No: _____

Email Address: _____

Practicum/Internship Site Name: _____

Practicum/Internship Site Street Address: _____

City: _____ State: _____ Zip: _____

Site Supervisor: _____ Site Phone: _____

Site Supervisor's Degree: _____ Site Supervisor's Lic: _____

Site Supervisor's Email: _____

Briefly describe your site: (i.e., population served, mission, staff, etc.) _____

List your weekly hours at your site:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Other Information: _____

Hours Log - Monthly

❑ Practicum ❑ Internship	❑ CMHC ❑ School

Student: _____

Month: _____ Year: _____ Semester: _____

Total Direct Service Activities: _____ Total Indirect Service Activities: _____

Direct Service Activities	Week: ____ From: _____ To: _____	Week: ____ From: _____ To: _____	Week: ____ From: _____ To: _____	Week: ____ From: _____ To: _____	Week: ____ From: _____ To: _____	Monthly Totals
Intake Interview						
Individual Counseling						
Group Counseling						
Couple Counseling						
Family Counseling						
Intervention						
Career Counseling						
Conjoint Counseling						
Crisis Intervention						
Class Room Guidance						
Other Clinical Work						
Total Direct Hours						

Indirect Service Activities	Week: ____ From: _____ To: _____	Week: ____ From: _____ To: _____	Week: ____ From: _____ To: _____	Week: ____ From: _____ To: _____	Week: ____ From: _____ To: _____	**Monthly Totals**
Case Consultation						
Individual Supervision (On-Site)						
Individual Supervision (University)						
Group Supervision						
Staff Meetings						
Report Writing						
Case Notes						
Professional Meetings						
Educational Sessions						
Other Indirect Activities						
Total Indirect Hours						

_____ _____ _____

On-Site Supervisor **University Supervisor** **Student**

Supervision Summary Log

❑ CMHC ❑ School

Student: _____

This form is a running total of the hours that will document the completion of the 700-hour field experience. You will need to complete the appropriate information, and collect appropriate signatures each semester you participate in either Practicum or Internship. After completing all of the required hours, you need to collect the signature of the Program Director. Please ensure that the final form has original signatures, no copies will be accepted. You may want to create more than one master form with original signatures for your records.

❑ PRACTICUM HOURS

_____ _____
On-Site Supervisor Signature Date

_____ _____
University Supervisor Signature Date

Total Indirect Hrs (60 Req): ☐ Total Direct Hrs (40 Req): ☐ Total Contact Hrs (100 Req): ☐

❑ INTERNSHIP I HOURS (300/2 Semesters)

_____ _____
On-Site Supervisor Signature Date

_____ _____
University Supervisor Signature Date

Total Indirect Hrs (180 Req): ☐ Total Direct Hrs (120 Req): ☐ Total Contact Hrs (300 Req): ☐

❑ INTERNSHIP II HOURS (300/2 Semesters)

_____ _____
On-Site Supervisor Signature Date

_____ _____
University Supervisor Signature Date

Total Indirect Hrs (180 Req): ☐ Total Direct Hrs (120 Req): ☐ Total Contact Hrs (300 Req): ☐

❑ INTERNSHIP HOURS (600/1 Semester)

_____ _____
On-Site Supervisor Signature Date

_____ _____
University Supervisor Signature Date

Total Indirect Hrs (360 Req): ☐ Total Direct Hrs (240 Req): ☐ Total Contact Hrs (600 Req): ☐

TOTAL PROGRAM HOURS

Total Indirect Contact Hrs: ☐ Total Direct Contact Hrs: ☐ Total Contact Hrs: ☐

_____ _____
Student's Signature Date

_____ _____
Counseling Program Director Date

Professional Fitness Review Form

Student: _____ Faculty: _____

Semester: _____ Year: _____

Course(s) enrolled: _____

Evaluation Criteria

1. No opportunity to observe, 2. Does not meet criteria for program level, 3. Meets criteria only minimally or inconsistently for program level, 4. Meets criteria consistently at program level, 5. Exceeds criteria consistently at program level

PROFESSIONAL FITNESS CATEGORIES:

• **Professional Responsibility**	
The student relates to peers, professors and others in an appropriate professional manner.	① ② ③ ④ ⑤
The student does not exploit or mislead other people during or after professional relationships.	① ② ③ ④ ⑤
The student applies legal and ethical standards during the training program.	① ② ③ ④ ⑤
• **Competence**	
The student takes responsibility for compensating for his/her deficiencies.	① ② ③ ④ ⑤
The student provides only those services and applies only those techniques for which he/she is qualified by education, training or experience.	① ② ③ ④ ⑤
The student demonstrates basic cognitive skills and appropriate affect in response to clients.	① ② ③ ④ ⑤
• **Comportment**	
The student demonstrates appropriate self-control (such as anger control, impulse control) in interpersonal relationships with faculty, peers, and clients.	① ② ③ ④ ⑤
The student demonstrates honesty and fairness both personally and professionally.	① ② ③ ④ ⑤
The student is aware of his/her own belief systems, values, and limitations do not actively affect his/her professional work.	① ② ③ ④ ⑤
The student demonstrates the ability to receive, integrate, and utilize feedback from peers, teachers, and supervisors.	① ② ③ ④ ⑤
• **Integrity**	
The student does not make statements that are false, misleading, or deceptive.	① ② ③ ④ ⑤
The student respects the fundamental rights, dignity, and worth of all people.	① ② ③ ④ ⑤
The student respects the rights of individuals to privacy, confidentiality, and choices regarding self-determination.	① ② ③ ④ ⑤
The student respects cultural, individual, and role differences, including those due to age, gender, race, ethnicity, national origin, religion, sexual orientation, physical ability/disability, language, and socioeconomic status.	① ② ③ ④ ⑤
The student behaves in accordance with the programs accepted code(s) of ethics/standards of practice.	① ② ③ ④ ⑤
• **Performance in Coursework**	
The student displays a desire to learn and grow as a professional counselor.	① ② ③ ④ ⑤
The student attends class regularly and demonstrates a positive attitude toward class and coursework.	① ② ③ ④ ⑤
The student demonstrates open-mindedness and flexibility related to information presented in course(s).	① ② ③ ④ ⑤
The student possesses the cognitive abilities to be successful in coursework.	① ② ③ ④ ⑤

Release Form - Adult

University of Tennessee at Chattanooga

School of Education

The School of Education at the University of Tennessee at Chattanooga requires all students to participate in a field placement. As part of this placement, students are required to record and submit audio/video recordings of their counseling sessions. All audio/video recordings will be kept confidential. However, these audio/video recordings will be reviewed by the student's supervisors to evaluate their progress. In order to secure this sensitive information, students will electronically submit the records via UTC's Blackboard system, which is kept secured on the University's private server. In addition, the recordings may occasionally be used to demonstrate progress and provide feedback from peers. After the student has completed her/his placement, all recordings will be destroyed. We appreciate your willingness to participate in this aspect of your counselor's development. We feel that it will benefit everyone concerned.

I agree to allow _____ (Counselor's Name) to record and submit ❑ audio ❑ video (please check one) recordings as part of the requirements for Practicum/ Internship in the Graduate Counseling Program at University of Tennessee at Chattanooga. I understand that the audio/video recordings will be reviewed by program supervisors only and will be destroyed by the counselor upon completion of the field placement.

Client's Signature	Date
Counselor's Signature	Date
Supervisor's Signature	Date

Release Form - Minor

University of Tennessee at Chattanooga

School of Education

The School of Education at the University of Tennessee at Chattanooga requires all students to participate in a field placement. As part of this placement, students are required to record and submit audio/video recordings of their counseling sessions. All audio/video recordings will be kept confidential. However, these audio/video recordings will be reviewed by the student's supervisors to evaluate their progress. In order to secure this sensitive information, students will electronically submit the records via UTC's Blackboard system, which is kept secured on the University's private server. In addition, the recordings may occasionally be used to demonstrate progress and provide feedback from peers. After the student has completed her/his placement, all recordings will be destroyed. We appreciate your willingness to participate in this aspect of your counselor's development. We feel that it will benefit everyone concerned.

I agree to allow _____ (Counselor's Name) to record and submit ❑ audio ❑ video (please check one) recordings as part of the requirements for Practicum/ Internship in the Graduate Counseling Program at University of Tennessee at Chattanooga. I understand that the audio/video recordings will be reviewed by program supervisors only and will be destroyed by the counselor upon completion of the field placement.

Client's Signature	Date
Parent's/Guardian's Signature	Date
Counselor's Signature	Date
Supervisor's Signature	Date

Site Supervisor Evaluation of Student

❑ **Midterm Eval** ❑ **Final Eval** ❑ **Practicum** ❑ **Internship**

Student: _____ Semester: _____ Year: _____

Site Supervisor: _____ Evaluation Date: _____

Days worked per week: _____ Total Hours Completed: _____

Please rate the student according to the following scale, being as fair and objective as possible. This evaluation is meant to be shown to the student and used for their skill development. Thank you for your cooperation.

1 = Poor 2 = Weak 3 = Average 4 = Strong 5 = Excellent

Ability to take initiative and perform independently	①	②	③	④	⑤	N/A
Promptness and dependability	①	②	③	④	⑤	N/A
The capacity to accept and profit from corrective feedback	①	②	③	④	⑤	N/A
Actively seeks supervision when necessary	①	②	③	④	⑤	N/A
Ability to grasp and successfully adapt to new situations	①	②	③	④	⑤	N/A
Ability to establish and maintain rapport	①	②	③	④	⑤	N/A
Ability to successfully relate to diverse types of clients.	①	②	③	④	⑤	N/A
Ability to match individual needs to appropriate individual and/or group settings and services.	①	②	③	④	⑤	N/A
Ability to function as a team member	①	②	③	④	⑤	N/A
An overall understanding of the organization and functions of the school or agency	①	②	③	④	⑤	N/A
Potential for overall success as a future counselor in a setting similar to the site	①	②	③	④	⑤	N/A

Please respond to the following:

Identify areas that may be considered strengths for this student: _____

Identify areas that may be considered weaknesses for this student: _____

I certify that I have completed this evaluation and discussed it with the student.

_____ _____
Site Supervisor's Signature Date

I certify that I have reviewed this evaluation with my site supervisor.

_____ _____
Student's Signature Date

Student Evaluation of Supervisor

❑ Site Supervisor ❑ University Supervisor ❑ Practicum ❑ Internship

Supervisor: _____ Semester: _____ Year: _____

For each item, rate your Supervisor's skills on a scale of 1 to 4.

1 = Strongly Disagree 2 = Disagree 3 = Agree 4 = Strongly Disagree

I. My Supervisor:				
a. Gave me feedback, about my role as a counselor, which was accurate and useable	①	②	③	④
b. Helped me clarify issues that my client brought into the session	①	②	③	④
c. Assisted me in understanding my own feelings about the client and his/her issues	①	②	③	④
d. Encouraged me to develop a plan to work with specific clients	①	②	③	④
II. My Supervisor Helped Promote:				
a. Professional standards by encouraging certification/licensure/accreditation by applicable state or national bodies	①	②	③	④
b. Legal and ethical practice by discussing and by modeling appropriate ethical behaviors	①	②	③	④
III. I Felt:				
a. My Supervisor respected me and was concerned with my professional growth	①	②	③	④
b. My Supervisor served as an appropriate professional role model	①	②	③	④
c. My supervision sessions allowed for both personal and professional growth	①	②	③	④
IV. My Supervisor Helped Me:				
a. To focus on specific counseling strategies to assist the client	①	②	③	④
b. To develop techniques to resolve conflict	①	②	③	④

Comments: _____

Student Site Evaluation Form

Please complete the following evaluation of your site placement. Students who are considering this site for their field experience may view this evaluation. Your name is optional.

Site Name: _____

Supervisor Name: _____

Please describe briefly the responsibilities/counseling activities you participated in at your site. Please be specific.

1. How would you rate your overall experience at this site?
   ① Poor **② Satisfactory** **③ Above Average** **④ Excellent**
   Please explain your rating.

2. How would you rate the quality of the supervision you received at this site?
   ① Poor **② Satisfactory** **③ Above Average** **④ Excellent**
   Please explain your rating.

3. Please describe the strengths of a field placement at this site.

4. Please describe the limitations of a field placement at this site.

5. Please describe any areas that the counseling program and/or site can make to improve the quality of the field placement.

6. How conducive was this site at meeting the requirements of this class (e.g., availability of clients, openness to conducting groups, taping sessions, etc.)?

7. Would you recommend this site to another student? ❑ **Yes** ❑ **No**

DAP Notes

Counselor: _____ **DAP Note #** _____

Session No: _____ **Session Date:** _____

Data:

Assessment:

Plan:

Case Presentation

Student's Name: _____ Date of Presentation: _____

Client Information (No identifying info, please):

Age: _____ Sex: _____
Family Constitution:
Occupation or
Grade if in School:

Does client appear Developmentally on Target?

Previous Diagnosis?

Presenting Problem:

Client's View of the Problem:

Family Members'/Friends' View of the Problem:

Counselor's View of the Problem:

Other's View (i.e. court, school personnel, medical professionals):

Focus of Session (Goal of session):

How does this session fit with overall goal of treatment for this client?

Counseling Theory:

Techniques Used:

Therapeutic Intent underlying Techniques

Reason for Selection of Recorded Segment to be Presented:

Supervision Needs:

What feedback would you like from the group?

What was particularly challenging for you in this session?

What do you feel were your areas of strength?

What do you feel were your areas of need/improvement?

Goals for Supervision

❑ Practicum ❑ Internship

Student: _____ Date: _____

Each student enters a practicum or internship with various skill levels and needs for development. These goals are designed to give you direction to your development as a professional counselor. In the space given, please address each area of development based on your needs. Then, rank each goal as to priority during supervision (1= high priority; 4 = lower priority).

1. Skill Oriented Goals **Rank:** _____

What skills, techniques, or strategies do you wish to develop during your placement?

2. Case Conceptualization Goals **Rank:** _____

What case conceptualization skills would like to acquire during your placement?

3. Professional Behavior Goals **Rank:** _____

What professional behaviors would you like to acquire during your placement?

4. Personal Oriented Goals **Rank:** _____

What personal goals/self-awareness do you wish to develop during your placement?

Group Expectations

❑ Practicum ❑ Internship

Student: _____ Date: _____

My expectations for (and of) myself in these group supervision meetings are . . .

My expectations of my peers are . . .

My expectations of the group supervision leader are . . .

If these group supervision meetings are successful, I hope to . . .

learn the following:

offer the following:

Recording Evaluation Form

Student: _____ Program: ❑ CMHC ❑ School

Recording No: _____ Time of Session: _____

1. Was the recording audible? ❑ Yes ❑ No
2. Was the recording critique completed and turned in on time? ❑ Yes ❑ No
3. Intern's conceptualization of the case was appropriate ① ② ③ ④ ⑤
4. Intern's selection of appropriate theories and techniques ① ② ③ ④ ⑤
5. Intern's application of said theories and techniques ① ② ③ ④ ⑤
6. Supervisor's overall rating of the session ① ② ③ ④ ⑤

Recordings have been evaluated based on the following criteria, on a 1-5 scale (1 = poor/unsatisfactory; 2 = weak/ needs improvement; 3 = average/satisfactory; 4 = good; 5 = excellent). Your ranking on this scale is not as important as demonstrating improvement and growth from the beginning of the internship to the end of the internship. You will also receive constructive feedback in the form of notes taken from your sessions either at the end of this ranking, or written directly on your recording critique

Intern demonstrates an appropriate level of skill development:	1	2	3	4	5	N/A
Opening of the session was structured, friendly, and pleasant.						
Establishes good rapport with clients.						
Reflects feelings of client.						
Communication between counselor/client was meaningful.						
Demonstrates active listening skills (attends to nonverbals).						
Is sensitive to needs of client.						
Is sensitive to individual differences and flexible in the client/counselor relationship.						
Confronts appropriately when necessary.						
Uses appropriate challenging skills.						
Uses appropriate goal setting skills.						
Demonstrates empathic response to client.						
Summarizes appropriately by pulling together the important elements of a session.						
Is effective clarifying the message provided by client.						
Demonstrates appropriate immediacy (appropriately provides feedback about what is occurring at the present time in the relationship or in the session).						
Self-disclosure is appropriate and used for the benefit of the client.						
Appropriately uses open-ended questions (what, where, when, who, how) to encourage clients to express themselves.						
When conducting groups, is able to link similar feelings and concerns occurring among group members.						
Closing of the session was appropriate (use of summary to provide closure).						
Student conducts him/herself in an ethical manner with both clients and colleagues.						
Student demonstrates professional identity that is appropriate to the site, and in accordance with professional standards/guidelines.						

Recording Evaluation Form

Client Problem(s)/Issue(s):
General Notes:
Problem Areas:
Effective Skill(s)/Technique(s):

Recording Review Form

Recording No. _____

Student: _____ Supervisor: _____

Date of Session: _____ Time in Session: _____ Session No. with Client: _____

Brief client background information (demographics, presenting concern/issues):
Brief summary of the session (theoretical approach, techniques used):
Describe the focus/goals of the session:
Issues to be discussed in supervision (please complete thoughtfully):
Personal views on performance as counselor:

University Supervisor Evaluation of Student

❑ Midterm Eval ❑ Final Eval ❑ Practicum ❑ Internship

Student: _____ Semester: _____ Year: _____

University Supervisor: _____ Evaluation Date: _____

Course ID: _____

1 = Poor	**2 = Weak**	**3 = Average**	**4 = Strong**	**5 = Excellent**	
Establishes good rapport with clients.	①	②	③	④	⑤ N/A
Reflects feelings of client and focuses on client needs when appropriate.	①	②	③	④	⑤ N/A
Assists clients in planning effective goals and objectives for counseling.	①	②	③	④	⑤ N/A
Can identify his/her own professional and personal strengths and weaknesses.	①	②	③	④	⑤ N/A
Uses appropriate counseling skills (i.e., empathy, probes, open-ended questions.)	①	②	③	④	⑤ N/A
Challenges the client when applicable, using appropriate challenging responses.	①	②	③	④	⑤ N/A
Is prepared for supervision sessions, having submitted tapes and critiques for review completed and in a timely manner.	①	②	③	④	⑤ N/A
Attended group supervision on a regular basis, not missing excessively.	①	②	③	④	⑤ N/A
Responds to feedback in a non-defensive manner.	①	②	③	④	⑤ N/A
Ability to interact productively with supervisors and other interns.	①	②	③	④	⑤ N/A

Please check the appropriate response:

❑ This student has made satisfactory progress at this point in this course and is recommended for continuation in this course.

❑ This student has NOT made satisfactory progress at this point in this course and is NOT recommended for continuation in this course.

Other pertinent comments: _____

_____ University Supervisor's Signature _____ Date

_____ Student's Signature _____ Date

Highlights of the 2005 ACA Code of Ethics

Harriet L. Glosoff and Michael M. Kocet

Note: The following article is an abbreviated version of the 2005 ACA Code of Ethics. It was downloaded from http://www.counseling.org/Resources/CodeofEthics/TP/HOME/CT2.aspx, on 10 April, 2010. To obtain a full copy of the ACA Code of Ethics go to the above listed link.

The American Counseling Association recently adopted a new Code of Ethics, effective July 1, 2005. For a code of ethics to be useful to a group of professionals, it must be a living document, one that is updated to reflect changes in society and the profession. The process of revising a code affords professional organizations an opportunity to examine current practices and clinical, social, and ethical issues faced by its members. Since ACA, then the American Personnel and Guidance Association, adopted its first Code of Ethics in 1963, the Code has been revised approximately every 7 to 10 years. The purpose of this article is to provide a brief overview of the revision process and some of the changes that were made to the 1995 Code of Ethics and Standards of Practice.

Revision Process

In 2002 David Kaplan, then ACA president, appointed the following members to serve on the ACA Ethics Code Revision Taskforce: John Bloom, Tammy Bringaze, Rocco Cottone, Harriet Glosoff, Barbara Herlihy, Michael Kocet (Chair), Courtland Lee, Judy Miranti, Christine Moll, and Vilia Tarvydas. The taskforce members were assisted by two doctoral students, Anna Harpster and Michael Hartley, who served as note-takers during the process.

The revision process took approximately 3 years, with taskforce members initially meeting for telephone conference calls approximately once a month. The committee communicated regularly between meetings by e-mail and worked in subcommittees to review sections of the Code and to draft recommended changes. The entire group discussed all recommendations and made revisions to each section. As they continued in their work, the taskforce members met at least biweekly to create a draft code of ethics that was published in Counseling Today and posted on the ACA Web site. ACA provided members with the opportunity to provide feedback to the taskforce. In addition, the taskforce sought guidance from ACA leadership and from outside experts as they worked on sections of the draft. Finally, ACA sponsored town hall meetings at the 2004 and 2005 national conventions during which ACA members met with the taskforce, discussed highlights of the draft document, and provided feedback.

In comparing the 1995 Code of Ethics and Standards of Practice and the 2005 ACA Code of Ethics, readers will note many differences. It is beyond the scope of this article to present a comprehensive comparison of the two documents. Instead, we call your attention to a few major differences in the 2005 ACA Code of Ethics.

Introduction to the Code of Ethics

The 2005 ACA Code of Ethics consists of the same eight main sections as the 1995 document with some changes in the titles. Following are the eight areas with differences in the titles of the 1995 sections, if any, in parentheses:

A. The Counseling Relationship;

B. Confidentiality, Privileged Communication, and Privacy (Confidentiality);
C. Professional Responsibility;
D. Relationship with Other Professionals;
E. Evaluation, Assessment, and Interpretation;
F. Supervision, Training, and Teaching (Teaching, Training, and Supervision);
G. Research and Publication; and
H. Resolving Ethical Issues.

Readers of the new Code will notice there is no longer a reference to Standards of Practice, which was part of the title of the 1995 document. The intent of the Standards of Practice was to offer a concise outline of minimum expectations for ethical behaviors, more behavioral than aspirational in nature. Rather than finding the Standards helpful, however, individuals found these confusing in terms of using the document in their day-to-day lives and their ethical decision-making processes. Further, people were unclear of how the Standards of Practice were used in adjudication of accused violations of the Code of Ethics. Based on feedback, the Standards of Practice were integrated into the body of the 2005 Code.

Preamble and Purposes

The Preamble has been updated to address issues of cultural context and values that inform the development and interpretation of the 2005 Code. In addition, another new feature of the Code is the section that outlines five main purposes of the ACA Code of Ethics as follows: (1) to enable the association to clarify to current and future members, and to those served by members, the nature of the ethical responsibilities held in common by its members; (2) to support the mission of the association; (3) to establish principles that define ethical behavior and best practices; (4) to serve as an ethical guide designed to assist members in constructing a professional course of action that best serves those utilizing counseling services and best promotes the values of the counseling profession; and (5) to serve as the basis for processing of ethical complaints and inquiries initiated against members of the association. In presenting the purposes of the 2005 Code, ACA includes a discussion of the new introductions to each section.

The introductions now found at the beginning of each of the eight sections are meant to set a tone for each section. Each introduction "helps set the tone for that particular section and provides a starting point that invites reflection on the ethical mandates contained in each part of the ACA Code of Ethics" (ACA, 2005, p. 3). In addition to asking counselors to reflect on ethical mandates presented in the Code, the new introduction to the Code notes that counselors should recognize that there are reasonable differences of opinion regarding which values, ethical principles, and ethical standards should be applied when faced with ethical dilemmas. Counselors are now expected to be familiar with a credible model of ethical decision making that "can bear public scrutiny and its application" (ACA, 2005, p. 3).

One charge given to the taskforce by the ACA Governing Council was for the members to draft recommended changes to the 1995 Code with special (but not exclusive) consideration of cultural and social justice issues faced by counselors in today's complex world. Before presenting a few highlights of changes in each of the eight sections, we briefly review some ways that cultural issues are infused in the 2005 Code.

Multicultural and Diversity Issues

As noted, an important component threaded through the 2005 ACA Code of Ethics is an emphasis on multicultural and diversity issues facing counseling professionals. The majority of introductory statements speak specifically to ethical obligations of counselors to consider cultural contexts related to the standards in the related sections. For example, the introduction to Section G, Research and Publications, ends with "Counselors minimize bias and respect diversity in designing and implementing research programs" (ACA 2005, p. 16).

Following are just a few examples of ways in which issues of culture, diversity, and social justice are addressed in the new ACA Code of Ethics. Standard A.1.d. was changed from "Family Involvement" to "Support Network Involvement" and broadens the concept of family to include any person from the perspective of the client who plays a central role in that person's life. New Standard A.10.e. Receiving Gifts states that "Counselors understand the challenges of accepting gifts from clients and recognize that in some cultures, small gifts are a token of respect and showing gratitude." The 2005 Code also brings attention to the need for counselors to be aware of and sensitive to cultural meanings of confidentiality and privacy as well (see Standard B.1.a.Multicultural/Diversity Considerations). Just one more example of the recognition of how cultural and social issues affect the counseling relationship is the new Standard E.5.c., which directs counselors to "recognize historical and social prejudices in the misdiagnosis and pathologizing of certain individuals and groups and the role of mental health professionals in perpetuating these prejudices through diagnosis and treatment." We now briefly highlight some other changes and new standards in each of the sections.

Section A

ACA made several additions to this section. The standards related to boundary issues between counselors and clients and counselors and former clients seem to reflect a paradigm shift that is taking place in the counseling profession. Previously, there was an emphasis on the need to avoid any type of nonprofessional relationship with clients with no recognition that not all types of "dual relationships" may be harmful. The 2005 Code contains a new standard, A.5.d., which speaks, albeit with cautions, to potentially beneficial interactions between counselors and clients that go beyond the traditional professional counseling relationship. Please consult standard A.5.d. to learn more about potentially beneficial relationships and factors that should be considered. Another change related to boundary issues is in Standard A.5.b., which changes the prohibition on having sexual or romantic relationships with former clients from 2 to 5 years while expanding the language to include such relationships with romantic partners or family members of former clients.

A significant addition to the 2005 ACA Code of Ethics is Section A.9., which provides guidance to counselors serving clients who are terminally ill. The American Counseling Association is one of the few national mental health organizations to specifically address end-of-life care in its Code of Ethics. In doing so, ACA does not endorse one way of approaching this sensitive issue. Rather it directs counselors to take measures that enable clients

1. to obtain high quality end-of-life care;
2. to exercise the highest degree of self-determination possible;
3. to be given every opportunity to engage in informed decision making regarding their end-of-life care; and to

4. receive complete and adequate assessment regarding their ability to make competent, rational decisions on their own behalf from a mental health professional who is experienced in end-of-life care practice. (A.9.a., p. 5)

Counselors facing end-of-life issues are also ethically responsible for seeking supervision and consultation to help clients receive competent care from a wide range of professionals.

Section A.12. Technology Applications greatly expands on the same section in the 1995 Code. ACA integrated the Ethical Standards for Internet Online Counseling adopted by ACA in 1999 into the new Section A.12. and broadened the ethical use of technology in research, record keeping, and the provision of services to consumers.

Section B

One major change in Section B is an increased discussion of privacy and confidentiality when working with clients who are minors or adults who cannot give informed consent. Standards B.5.a., B.5.b., and B.5.c. outline the need for counselors to protect the confidentiality of such clients and to include clients in decisions about the disclosure of confidential information while being "sensitive to the cultural diversity of families" and respecting "the inherent rights and responsibilities of parents/guardians over the welfare of their children/charges." Counselors are expected to "work to establish, as appropriate, collaborative relationships with parents/guardians to best serve clients."

Although we cannot review all the changes in Section B, there are two that we want to bring to the attention of readers. First, Standard B.3.f., also new to the 2005 Code of Ethics, reminds counselors that they are required to protect the confidentiality of deceased clients. Second, there is a significant change related to family counseling. Standard B.2.b. (Family counseling) of the 1995 Code stated that "…information about one family member cannot be disclosed to another member without permission. Counselors protect the privacy rights of each family member." Standard B.4.b. of the 2005 ACA Code of Ethics, now called Couples and Family Counseling, addresses the need of counselors to "clearly define who is considered 'the client' and to discuss expectations and limitations of confidentiality" and to "seek agreement and document in writing such agreement among all involved parties having capacity to give consent, concerning each individual's right to confidentiality and any obligation to preserve the confidentiality of information known."

Section C

More detailed language was added to this section on counselor impairment in Standard C.2.g. In addition to counselors being responsible to seek assistance for problems that reach the level of professional impairment, we are now also ethically obligated to "assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted." In addition, a section was added that addresses the importance of all counseling professionals, regardless of setting, to create a plan for the transfer of clients and records to an appropriate colleague in the event of a counselor's incapacitation, death, or termination of practice (Standard C.2.h.).

Another addition to the ACA Code of Ethics is Standard C.6.e. Scientific Bases for Treatment Modalities. Although the 1995 Code directed counselors to monitor their effectiveness, it did not speak to our responsibility to base techniques and treatment plans on theory and/or empirical or scientific results. Standard C.6.e. further states that "counselors who

do not must define the techniques/procedures as ‘unproven’ or ‘developing’ and explain the potential risks and ethical considerations of using such techniques/procedures and take steps to protect clients from possible harm.”

Section D

Counselors across work settings are often part of interdisciplinary teams. There are several new standards that address responsibilities to develop and strengthen relationships with colleagues from other disciplines to best serve clients (Standard D.1.b.); to keep the focus on the well-being of clients by “drawing on the perspectives, values, and experiences of the counseling profession and those of colleagues from other disciplines” (Standard D.1.c.); and to clarify professional roles, parameters of confidentiality, and ethical obligations of the team and its members (Standards D.1.d., D.1.e.).

Section E

One noteworthy change in this section is the terminology used. For example, the word tests used in the 1995 Code has been replaced with the word assessment, which has a broader, more holistic meaning. There are two other significant changes from the 1995 document. The first is the addition of Standard E.5.c., which we previously discussed. The second is the acknowledgement that over the past 10 years, counselors have increased their presence in legal proceedings including forensic evaluations. This led to the inclusion of new Standards E.13.a. through E.13.d. that address the need for counselors to understand their primary obligations when conducting forensic evaluations, how these obligations differ from those involved in counseling, and their responsibility to explain this to clients. The new standards also prohibit counselors from conducting forensic evaluations with clients they are counseling or have counseled and to “avoid potentially harmful professional or personal relationships with family members, romantic partners, and close friends of individuals they are evaluating or have evaluated in the past” (Standard E.13.d.).

Section F

This section has been reorganized since 1995 and greatly expanded in terms of noting ethical obligations of counselors who supervise counseling students, trainees, and staff. It now includes many of the standards noted in the 1993 Ethical Guidelines for Counseling Supervisors published by the Association for Counselor Education and Supervision (a division of ACA). Section F focuses on counselor supervision and client welfare across settings, informed consent in the supervisory relationship, competence of counseling supervisors, supervisor responsibilities, potentially harmful and beneficial relationships between supervisors and supervisees and between faculty members and students, student welfare and orientation, self-growth experiences, impairment of counseling students and supervisees, ethical evaluation of the performance of supervisees and students, and endorsement of supervisees and students. The changes are too substantial to review in this article, and we encourage counselors, supervisors, supervisees, counselor educators, and counseling students to closely review this section.

Section G

Readers will notice that the term research subjects used in the 1995 Code of Ethics and Standards of Practice has been replaced with the term research participants, meant to be more inclusive and less clinically detached. This section provides guidance to counselors in the appropriate handling of records during the research process, informed consent with research participants, and confidentiality of people involved with research projects. Although research is often conducted by faculty members of counselor education programs, there are counselors practicing in a variety of settings who also engage in research. According to new Standard G.1.c., when these "independent researchers do not have access to an Institutional Review Board (IRB)," they have an ethical obligation "to consult with researchers who are familiar with IRB procedures to provide appropriate safeguards" for research participants. Section G also addresses issues related to publication. There is a new standard specifically stating that counselors do not plagiarize the work of others (Standard G.5.b.). In addition, Standard G.4.e. from the 1995 Code, which addressed the professional review of material submitted for publication, has been expanded in the new Standard G.5.h.

Section H

The 2005 ACA Code of Ethics provides greater clarity to counselors about ways to address potential conflicts between ethical guidelines and legal requirements. Standard H.1.b. notes that in such situations, counselors "make known their commitment to the ACA Code of Ethics and take steps to resolve the conflict. If the conflict cannot be resolved by such means, counselors may adhere to the requirements of law, regulations, or other governing legal authority." Another change in this section is the expanded list of potential agencies/organizations to which information regarding suspected or documented ethical violations may be reported to include "state or national committees on professional ethics, voluntary national certification bodies, state licensing boards, or. . . the appropriate institutional authorities" (Standard H.2.c.). Finally, there is a new standard (H.2.g.) that protects the rights of ACA members who have made or been the subject of an ethics complaint.

Conclusion

As previously mentioned, our intent in writing this article is to provide a brief overview of the revision process and a general overview of some changes that were made to the 1995 Code of Ethics and Standards of Practice. We believe it is critical for counselors, as well as an ethical obligation, to thoroughly review the entire 2005 ACA Code of Ethics to understand how to apply the new Code to their day-to-day practice. No code of ethics can address any and all situations that counselors may face. Consulting with ethics experts in the field on specific standards, therefore, becomes quite important. One way of doing this is to ask the ACA Ethics Committee for a formal interpretation of the 2005 ACA Code of Ethics by submitting a scenario and question(s) about specific standards to the ACA Ethics Committee staff liaison.

References

American Counseling Association. (1995). Code of ethics and standards of practice. Alexandria, VA: Author.

American Counseling Association. (2005). ACA Code of ethics. Alexandria, VA: Author.

ASCA Ethical Standards for School Counselors

Downloaded from www.schoolcounselor.org/content.asp?contentid=173, 27 March, 2010

ASCA's Ethical Standards for School Counselors were adopted by the ASCA Delegate Assembly, March 19, 1984, revised March 27, 1992, June 25, 199, June 26, 2004, and 2010.
This is not the most recent edition of the ethical codes. Need to download the 2010 revised version.

Preamble

The American School Counselor Association (ASCA) is a professional organization whose members are certified/licensed in school counseling with unique qualifications and skills to address the academic, personal/social and career development needs of all students. Professional school counselors are advocates, leaders, collaborators and consultants who create opportunities for equity in access and success in educational opportunities by connecting their programs to the mission of schools and subscribing to the following tenets of professional responsibility:

- Each person has the right to be respected, be treated with dignity and have access to a comprehensive school counseling program that advocates for and affirms all students from diverse populations regardless of ethnic/racial status, age, economic status, special needs, English as a second language or other language group, immigration status, sexual orientation, gender, gender identity/expression, family type, religious/spiritual identity and appearance.
- Each person has the right to receive the information and support needed to move toward self-direction and self-development and affirmation within one's group identities, with special care being given to students who have historically not received adequate educational services: students of color, low socio-economic students, students with disabilities and students with nondominant language backgrounds.
- Each person has the right to understand the full magnitude and meaning of his/her educational choices and how those choices will affect future opportunities.
- Each person has the right to privacy and thereby the right to expect the counselor-student relationship to comply with all laws, policies and ethical standards pertaining to confidentiality in the school setting.

In this document, ASCA specifies the principles of ethical behavior necessary to maintain the high standards of integrity, leadership and professionalism among its members. The Ethical Standards for School Counselors were developed to clarify the nature of ethical responsibilities held in common by school counseling professionals. The purposes of this document are to:

- Serve as a guide for the ethical practices of all professional school counselors regardless of level, area, population served or membership in this professional association;
- Provide self-appraisal and peer evaluations regarding counselor responsibilities to students, parents/guardians, colleagues and professional associates, schools, communities and the counseling profession; and
- Inform those served by the school counselor of acceptable counselor practices and expected professional behavior.

A.1. Responsibilities to Students

The professional school counselor:

a. Has a primary obligation to the student, who is to be treated with respect as a unique individual.

b. Is concerned with the educational, academic, career, personal and social needs and encourages the maximum development of every student.
c. Respects the student's values and beliefs and does not impose the counselor's personal values.
d. Is knowledgeable of laws, regulations and policies relating to students and strives to protect and inform students regarding their rights.

A.2. Confidentiality

The professional school counselor:
a. Informs students of the purposes, goals, techniques and rules of procedure under which they may receive counseling at or before the time when the counseling relationship is entered. Disclosure notice includes the limits of confidentiality such as the possible necessity for consulting with other professionals, privileged communication, and legal or authoritative restraints. The meaning and limits of confidentiality are defined in developmentally appropriate terms to students.
b. Keeps information confidential unless disclosure is required to prevent clear and imminent danger to the student or others or when legal requirements demand that confidential information be revealed. Counselors will consult with appropriate professionals when in doubt as to the validity of an exception.
c. In absence of state legislation expressly forbidding disclosure, considers the ethical responsibility to provide information to an identified third party who, by his/her relationship with the student, is at a high risk of contracting a disease that is commonly known to be communicable and fatal. Disclosure requires satisfaction of all of the following conditions:

- Student identifies partner or the partner is highly identifiable
- Counselor recommends the student notify partner and refrain from further high-risk behavior
- Student refuses
- Counselor informs the student of the intent to notify the partner
- Counselor seeks legal consultation as to the legalities of informing the partner

d. Requests of the court that disclosure not be required when the release of confidential information may potentially harm a student or the counseling relationship.
e. Protects the confidentiality of students' records and releases personal data in accordance with prescribed laws and school policies. Student information stored and transmitted electronically is treated with the same care as traditional student records.
f. Protects the confidentiality of information received in the counseling relationship as specified by federal and state laws, written policies and applicable ethical standards. Such information is only to be revealed to others with the informed consent of the student, consistent with the counselor's ethical obligation.
g. Recognizes his/her primary obligation for confidentiality is to the student but balances that obligation with an understanding of the legal and inherent rights of parents/guardians to be the guiding voice in their children's lives.

A.3. Counseling Plans

The professional school counselor:
a. Provides students with a comprehensive school counseling program that includes a strong emphasis on working jointly with all students to develop academic and career goals.
b. Advocates for counseling plans supporting students right to choose from the wide array of options when they leave secondary education. Such plans will be regularly reviewed to update students regarding critical information they need to make informed decisions.

A.4. Dual Relationships

The professional school counselor:
a. Avoids dual relationships that might impair his/her objectivity and increase the risk of harm to the student (e.g., counseling one's family members, close friends or associates). If a dual relationship is unavoidable, the counselor is responsible for taking action to eliminate or reduce the potential for harm. Such safeguards might include informed consent, consultation, supervision and documentation.
b. Avoids dual relationships with school personnel that might infringe on the integrity of the counselor/student relationship

A.5. Appropriate Referrals

The professional school counselor:
a. Makes referrals when necessary or appropriate to outside resources. Appropriate referrals may necessitate informing both parents/guardians and students of applicable resources and making proper plans for transitions with minimal interruption of services. Students retain the right to discontinue the counseling relationship at any time.

A.6. Group Work

The professional school counselor:
a. Screens prospective group members and maintains an awareness of participants' needs and goals in relation to the goals of the group. The counselor takes reasonable precautions to protect members from physical and psychological harm resulting from interaction within the group.
b. Notifies parents/guardians and staff of group participation if the counselor deems it appropriate and if consistent with school board policy or practice.
c. Establishes clear expectations in the group setting and clearly states that confidentiality in group counseling cannot be guaranteed. Given the developmental and chronological ages of minors in schools, the counselor recognizes the tenuous nature of confidentiality for minors renders some topics inappropriate for group work in a school setting.
d. Follows up with group members and documents proceedings as appropriate.

A.7. Danger to Self or Others

The professional school counselor:
a. Informs parents/guardians or appropriate authorities when the student's condition indicates a clear and imminent danger to the student or others. This is to be done after careful deliberation and, where possible, after consultation with other counseling professionals.
b. Will attempt to minimize threat to a student and may choose to 1) inform the student of actions to be taken, 2) involve the student in a three-way communication with parents/guardians when breaching confidentiality or 3) allow the student to have input as to how and to whom the breach will be made.

A.8. Student Records

The professional school counselor:
a. Maintains and secures records necessary for rendering professional services to the student as required by laws, regulations, institutional procedures and confidentiality guidelines.
b. Keeps sole-possession records separate from students' educational records in keeping with state laws.
c. Recognizes the limits of sole-possession records and understands these records are a memory aid for the creator and in absence of privilege communication may be subpoenaed and may become educational records when they 1) are shared with others in verbal or written form, 2) include information other than professional opinion or personal observations and/or 3) are made accessible to others.

d. Establishes a reasonable timeline for purging sole-possession records or case notes. Suggested guidelines include shredding sole possession records when the student transitions to the next level, transfers to another school or graduates. Careful discretion and deliberation should be applied before destroying sole-possession records that may be needed by a court of law such as notes on child abuse, suicide, sexual harassment or violence.

A.9. Evaluation, Assessment and Interpretation

The professional school counselor:

a. Adheres to all professional standards regarding selecting, administering and interpreting assessment measures and only utilizes assessment measures that are within the scope of practice for school counselors.

b. Seeks specialized training regarding the use of electronically based testing programs in administering, scoring and interpreting that may differ from that required in more traditional assessments.

c. Considers confidentiality issues when utilizing evaluative or assessment instruments and electronically based programs.

d. Provides interpretation of the nature, purposes, results and potential impact of assessment/evaluation measures in language the student(s) can understand.

e. Monitors the use of assessment results and interpretations, and takes reasonable steps to prevent others from misusing the information.

f. Uses caution when utilizing assessment techniques, making evaluations and interpreting the performance of populations not represented in the norm group on which an instrument is standardized.

g. Assesses the effectiveness of his/her program in having an impact on students' academic, career and personal/social development through accountability measures especially examining efforts to close achievement, opportunity and attainment gaps.

A.10. Technology

The professional school counselor:

a. Promotes the benefits of and clarifies the limitations of various appropriate technological applications. The counselor promotes technological applications (1) that are appropriate for the student's individual needs, (2) that the student understands how to use and (3) for which follow-up counseling assistance is provided.

b. Advocates for equal access to technology for all students, especially those historically underserved.

c. Takes appropriate and reasonable measures for maintaining confidentiality of student information and educational records stored or transmitted over electronic media including although not limited to fax, electronic mail and instant messaging.

d. While working with students on a computer or similar technology, takes reasonable and appropriate measures to protect students from objectionable and/or harmful online material.

e. Who is engaged in the delivery of services involving technologies such as the telephone, videoconferencing and the Internet takes responsible steps to protect students and others from harm.

A.11. Student Peer Support Program

The professional school counselor:

Has unique responsibilities when working with student-assistance programs. The school counselor is responsible for the welfare of students participating in peer-to-peer programs under his/her direction.

B. Responsibilities to Parents/Guardians

B.1. Parent Rights and Responsibilities
The professional school counselor:
a. Respects the rights and responsibilities of parents/guardians for their children and endeavors to establish, as appropriate, a collaborative relationship with parents/guardians to facilitate the student's maximum development.
b. Adheres to laws, local guidelines and ethical standards of practice when assisting parents/guardians experiencing family difficulties that interfere with the student's effectiveness and welfare.
c. Respects the confidentiality of parents/guardians.
d. Is sensitive to diversity among families and recognizes that all parents/guardians, custodial and noncustodial, are vested with certain rights and responsibilities for the welfare of their children by virtue of their role and according to law.

B.2. Parents/Guardians and Confidentiality
The professional school counselor:
a. Informs parents/guardians of the counselor's role with emphasis on the confidential nature of the counseling relationship between the counselor and student.
b. Recognizes that working with minors in a school setting may require counselors to collaborate with students' parents/guardians.
c. Provides parents/guardians with accurate, comprehensive and relevant information in an objective and caring manner, as is appropriate and consistent with ethical responsibilities to the student.
d. Makes reasonable efforts to honor the wishes of parents/guardians concerning information regarding the student, and in cases of divorce or separation exercises a good-faith effort to keep both parents informed with regard to critical information with the exception of a court order.

C. Responsibilities to Colleagues and Professional Associates

C.1. Professional Relationships
The professional school counselor:
a. Establishes and maintains professional relationships with faculty, staff and administration to facilitate an optimum counseling program.
b. Treats colleagues with professional respect, courtesy and fairness. The qualifications, views and findings of colleagues are represented to accurately reflect the image of competent professionals.
c. Is aware of and utilizes related professionals, organizations and other resources to whom the student may be referred.

C.2. Sharing Information with Other Professionals
The professional school counselor:
a. Promotes awareness and adherence to appropriate guidelines regarding confidentiality, the distinction between public and private information and staff consultation.
b. Provides professional personnel with accurate, objective, concise and meaningful data necessary to adequately evaluate, counsel and assist the student.
c. If a student is receiving services from another counselor or other mental health professional, the counselor, with student and/or parent/guardian consent, will inform the other professional and develop clear agreements to avoid confusion and conflict for the student.

d. Is knowledgeable about release of information and parental rights in sharing information.

D. Responsibilities to the School and Community

D.1. Responsibilities to the School

The professional school counselor:
a. Supports and protects the educational program against any infringement not in students' best interest.
b. Informs appropriate officials in accordance with school policy of conditions that may be potentially disruptive or damaging to the school's mission, personnel and property while honoring the confidentiality between the student and counselor.
c. Is knowledgeable and supportive of the school's mission and connects his/her program to the school's mission.
d. Delineates and promotes the counselor's role and function in meeting the needs of those served. Counselors will notify appropriate officials of conditions that may limit or curtail their effectiveness in providing programs and services.
e. Accepts employment only for positions for which he/she is qualified by education, training, supervised experience, state and national professional credentials and appropriate professional experience.
f. Advocates that administrators hire only qualified and competent individuals for professional counseling positions.
g. Assists in developing: (1) curricular and environmental conditions appropriate for the school and community, (2) educational procedures and programs to meet students' developmental needs and (3) a systematic evaluation process for comprehensive, developmental, standards-based school counseling programs, services and personnel. The counselor is guided by the findings of the evaluation data in planning programs and services.

D.2. Responsibility to the Community

The professional school counselor:
a. Collaborates with agencies, organizations and individuals in the community in the best interest of students and without regard to personal reward or remuneration.
b. Extends his/her influence and opportunity to deliver a comprehensive school counseling program to all students by collaborating with community resources for student success.

E. Responsibilities to Self

E.1. Professional Competence

The professional school counselor:
a. Functions within the boundaries of individual professional competence and accepts responsibility for the consequences of his/her actions.
b. Monitors personal well-being and effectiveness and does not participate in any activity that may lead to inadequate professional services or harm to a student.
c. Strives through personal initiative to maintain professional competence including technological literacy and to keep abreast of professional information. Professional and personal growth are ongoing throughout the counselor's career.

E.2. Diversity

The professional school counselor:
a. Affirms the diversity of students, staff and families.

b. Expands and develops awareness of his/her own attitudes and beliefs affecting cultural values and biases and strives to attain cultural competence.
c. Possesses knowledge and understanding about how oppression, racism, discrimination and stereotyping affects her/him personally and professionally.
d. Acquires educational, consultation and training experiences to improve awareness, knowledge, skills and effectiveness in working with diverse populations: ethnic/racial status, age, economic status, special needs, ESL or ELL, immigration status, sexual orientation, gender, gender identity/expression, family type, religious/spiritual identity and appearance.

F. Responsibilities to the Profession

F.1. Professionalism
The professional school counselor:
a. Accepts the policies and procedures for handling ethical violations as a result of maintaining membership in the American School Counselor Association.
b. Conducts herself/himself in such a manner as to advance individual ethical practice and the profession.
c. Conducts appropriate research and report findings in a manner consistent with acceptable educational and psychological research practices. The counselor advocates for the protection of the individual student's identity when using data for research or program planning.
d. Adheres to ethical standards of the profession, other official policy statements, such as ASCA's position statements, role statement and the ASCA National Model, and relevant statutes established by federal, state and local governments, and when these are in conflict works responsibly for change.
e. Clearly distinguishes between statements and actions made as a private individual and those made as a representative of the school counseling profession.
f. Does not use his/her professional position to recruit or gain clients, consultees for his/her private practice or to seek and receive unjustified personal gains, unfair advantage, inappropriate relationships or unearned goods or services.
F.2. Contribution to the Profession
The professional school counselor:
a. Actively participates in local, state and national associations fostering the development and improvement of school counseling.
b. Contributes to the development of the profession through the sharing of skills, ideas and expertise with colleagues.
c. Provides support and mentoring to novice professionals.

G. Maintenance of Standards

Ethical behavior among professional school counselors, association members and nonmembers, is expected at all times. When there exists serious doubt as to the ethical behavior of colleagues or if counselors are forced to work in situations or abide by policies that do not reflect the standards as outlined in these Ethical Standards for School Counselors, the counselor is obligated to take appropriate action to rectify the condition. The following procedure may serve as a guide:
1. The counselor should consult confidentially with a professional colleague to discuss the nature of a complaint to see if the professional colleague views the situation as an ethical violation.

2. When feasible, the counselor should directly approach the colleague whose behavior is in question to discuss the complaint and seek resolution.
3. If resolution is not forthcoming at the personal level, the counselor shall utilize the channels established within the school, school district, the state school counseling association and ASCA's Ethics Committee.
4. If the matter still remains unresolved, referral for review and appropriate action should be made to the Ethics Committees in the following sequence:

- state school counselor association
- American School Counselor Association

5. The ASCA Ethics Committee is responsible for:

- educating and consulting with the membership regarding ethical standards
- periodically reviewing and recommending changes in code
- receiving and processing questions to clarify the application of such standards; Questions must be submitted in writing to the ASCA Ethics chair.
- handling complaints of alleged violations of the ethical standards. At the national level,

complaints should be submitted in writing to the ASCA Ethics Committee, c/o the Executive Director, American School Counselor Association, 1101 King St., Suite 625, Alexandria, VA 22314.

Notes