Psychology and Research in Education
PRE 949 Advanced Counseling Practicum I

Fall, 2008

Instructors: Karen D. Multon, Ph.D. and Lisa Casullo, Psychology Intern

Office hrs: by appointment--

Phone: 864-3577 (KM) **Email:** kmulton@ku.edu
Class Times: Mondays 8:00 to 10:40 **Location:** CAPS 2400

NOTE: Students are required to carry professional liability insurance during their enrollment in practicum. (This requirement was stated on your practicum pre-enrollment form.) Evidence of insurance coverage is to be presented to the instructor no later than the second class session. Insurance is available through the APA or ACA to student members. Students will not be permitted to begin seeing clients until proof of insurance coverage is provided. This is for your protection.

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"The major task of the maturing psychotherapist is to learn to tolerate uncertainty." (Yalom, 1980, p. 410)

The quote above reflects what I consider to be a major part of your learning this semester. Counseling is hard work and there are no easy answers. Each of you will develop personalized goals for this semester (in consultation with your individual on-site supervisor), that will reflect your current needs for growth.

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Course Objectives

Students will:

1. Continue to develop their counseling perspective(s) and techniques in service of that perspective.

2. Provide quality professional service to clients of the practicum site.

3. Develop and sustain a basic helpful relationship with clients that is characterized by respect, trust, warmth, and regard for the client as a person.

4. Focus and work on the central concerns of the client, hence minimizing the introduction of peripheral issues.

5. Separate personal concerns and agendas from those of the client.

6. Conceptualize the directions and processes single counseling sessions take as well as the overall course of counseling work.

7. Establish with clients appropriate, reasonable, and manageable goals.

8. Locate and use appropriate resources (i.e. referral sources, test information, etc.) when necessary.

9. Use a variety of strategies in appropriate ways

10. Actively participate in giving and receiving constructive comments regarding your work as well as that of other students in the course.

11. Develop a clear sense of ethical and professional conduct in your work.

This practicum builds upon previous practicum experiences. It is expected that your major focus will be on effectively using advanced counseling and diagnostic skills.

Practicum site expectations

The clinical and professional opportunities available to students on site will differ among the various sites. Since this is a counseling practicum, it is expected that the bulk of your time on-site will be spent counseling individuals--primarily in individual sessions, but it may also include counseling in groups. I also expect and hope that you will become involved in other aspects of your setting including, but not limited to: (a) attending case/staff conferences, (b) familiarizing yourself with the assessment tools and practices used in your setting (including DSM diagnoses), (b) involving yourself in programs the setting has in progress, (c) participating in organizational and administrative functions, (d) consulting with other personnel, and (e) familiarizing yourself with the setting's referral sources.

The actual numbers of clients you see, as well as any additional clinical/professional experiences in which you may be asked or required to participate, will be dictated by the setting. As a rule for this course, however, you are expected to be on-site the equivalent of at least one day (i.e., **8-10 hours**) per week and to carry an average on-site case load of **4** clients (i.e., 4 one-hour sessions) per week. (NOTE: Within some settings, counseling sessions must, out of necessity, be more limited in length. In such settings, you should expect to hold a greater number of appointments in order to accrue the necessary client contact hours.) Given the length of the academic term, this works out to an expectation of approximately **40-45** hours of direct client contact during the semester. Anything less than this may jeopardize your timely completion of this practicum. It is important that you make this an expectation for yourself, and that you share it with your on site supervisor. If you anticipate or find yourself having difficulty meeting this expectation, please let me know--IMMEDIATELY. Students are required to keep an ongoing

log of all of their practicum activities. Copies of the program's practicum documentation forms may be found in your student handbook.

Practicum activities are to be recorded on the appropriate Practicum Summary Sheet and signed by you. Please make a copy of these sheets for your records, as the original will be put in your departmental file. You might also give a copy to your academic advisor.

Additional Course Requirements

1. Present at least two counseling tapes (video preferred) in class. A case formulation must be prepared for each tape presented and copies made to distribute to class members. (See attached case formulation outline)

2. Read two books of your choice on psychotherapy/counseling (see attached list for suggestions) and write a 2-4 page outline summarizing the book and giving your views of the material. You will be asked to briefly talk about each book in class (about 15 minutes). The due date will be discussed in class.

Supervision and Consultation: General guidelines

It is an expectation of this department that your practicum site will provide you with an on-site supervisor who will orient you to the setting, the clientele, the procedures and expectations for professionals operating in that setting, and who will be available to you on-site to assist you in handling immediate clinical concerns or problems with your clients. This person is your formal clinical supervisor—having direct legal and professional responsibility for your work with clients. If anything that is suggested in class or in your consultations should ever conflict with anything your site supervisor is telling you, it is YOUR responsibility to let me know that at once. None of us can afford for you to be receiving mixed signals about how you are to be handling your cases. The focus in our sessions is on generic skill development, though we are using your cases as a starting point for which skills to work on.

Your on-site supervisor and I have very clear dual obligations:

1. We have the obligation to you to provide you (within the constraints of time and resources) with the assistance you need to prepare for you to develop into a competent counselor. You are expected to be inquisitive and open, willing to take reasonable risks, gain in skill, and continue to develop a sense of professional competence. You, in turn, may expect us to provide you with assistance in developing your professional competencies and identity.

2. We also have an obligation to the clients who come to you for assistance--to assure to the best of our ability that the services that you render are appropriate and helpful. Although we are concerned about your development as a counselor, we must also be intensely concerned about the effects you have on your clients.

It is important for you to keep both of these obligations in mind as you receive supervisory feedback.

Practicum Seminar

The practicum seminar (our class session) will include (a) a discussion of practicum/counseling issues and book reviews; (b) individual case presentations, and group case consultation; and (3) brief lectures by one of the co-leaders (KM or LC) on topics the class decides are important. With regard to the case presentations, the following guidelines are offered:

1. We generally will use a rotation system for in-class presentations; however, you should feel free to present any cases with which you are experiencing difficulties or concerns, even if it is not your week to present.

2. Please come prepared to review your current cases with the class each week. This means that you will be able to summarize your cases to date, provide your conceptualization of each case, discuss the rationale for the work you are doing with each client, and request the necessary feedback and assistance that will enable you to continue productive work with these clients.

3. Regarding your formal case presentations, please review each session prior to class and prepare your formulation with copies for everyone. Although it may be tempting to present your best work, it will be more beneficial to your learning and development as a counselor if you use these opportunities to present areas, issues or interactions on which you believe you need work or assistance.

4. When your classmates are making case presentations, you are expected to act as consultants to them. This means that you will listen attentively and offer honest, constructive feedback regarding their work.

Individual Supervision and Case Consultation

On-site supervisors should provide you with regular (e.g., weekly) individual supervision. If additional on-site supervision is available to you, take it. Clinical supervision is always a premium professional learning opportunity.

Evaluation

Grading for the course is **S-F**. In certain exceptional circumstances, a grade of **I** (incomplete) may be assigned. Evaluation is also based on student's performance and contributions to various in-class activities. These activities include: (a) scheduled presentations of case to the class, (b) in-class involvement and constructive participation regarding other student's cases and presentations, and (c) being prepared during individual supervisory sessions

The previously noted course objectives provide the framework for evaluative judgments concerning students' clinical performance in the course.

In the end, the largest part of one's final evaluation will reflect where you are in your development as a counselor/psychologist by considering the course objectives in two ways:

1. How much and what kinds of progress has the student made?
2. Where is the student at the end of the course?

Please complete the following and return to me as soon as possible (but no later than the next class session):

Name ____

Phone ______________________________ Email ____________________

Practice site

Name of site ____

Address ____

____

Supervisor ____

Title: ____

Phone ____

E-mail ____

Days/Hours on site ____

Case Formulation Outline for Class Presentations

For class presentations, prepare a brief (1-2 pages) summary of your session with copies for each person in the class. Use the following format:

Client: (use an initial only) **Age:** **Sex:**
Session #: **Session Date:**
Any other relevant data: (e.g., lives in dorm; freshman)

I. Presenting Complaints

-use illustrative quotes from the client
-list only complaints from that particular session
-if the quotes aren't completely self-explanatory, then add any needed additional information

Examples:

A. "My boyfriend broke up with me and I feel lost without him."
B. "Everytime I take a test, I feel like my mind goes blank."

II. Dates of Onset and Precipitating Events

-for each complaint listed above, you must list the date of onset and what happened to precipitate the complaint
-if the client doesn't know (or you forgot to ask) just list "not sure" or make an educated guess

Examples:

A. last Friday evening; boyfriend called her and told her he wanted to break up
B. Monday morning during a biology exam; remembers feeling like this during science or math tests since 8th grade; precipitating event during 8th grade

III. Defenses

-list defense mechanisms you note during this session with an example or explanation for each one listed (see next page for more complete list)

Examples:

A. Regression: cried when talking about boyfriend
B. Vagueness: account of telephone conversation with boyfriend was devoid of details
C. Reversal: laughed when she talked about her mind going blank during the test
D. Generalization: "Everyone blanks out on a science test!"

IV. Predisposing Influences

-list any possible childhood influences on the complaints presented in this session

Examples:

A. Mother told her as a child that girls weren't good in science or math

V. Questions

-list 1 to 3 (no more than that) questions that you have after the session

Example:

A. Possible dependent traits?

EGO DEFENSE MECHANISMS

FUNCTION: COPE WITH ANXIETY & PREVENT EGO FROM BEING OVERWHELMED

There are many types of defense mechanisms. Below is a list of the most common types.

A. REPRESSION: INVOLUNTARY REMOVAL OF EVENTS FROM CONSCIOUSNESS (EX: 1ST FIVE YEARS)

B. DENIAL: CONSCIOUS OR PRE-CONSCIOUS LEVELS (EX: DENIAL OF LOVED ONE'S DEATH)

C. REACTION FORMATION: ACTIVELY EXPRESS THE OPPOSITE IMPULSE (EX: HATE COVERED BY FACADE OF LOVE)

D. PROJECTION: ATTRIBUTE TO OTHERS ONE'S OWN UNACCEPTABLE DESIRES AND IMPULSES (EX: SEES A PARTICULAR PERSON AS HATING, YET REALLY HATES THAT PERSON)

E. DISPLACEMENT: IMPULSES MOVED TO SAFER TARGET (EX: MAN TAKES OUT ANGER WITH BOSS ON HIS WIFE)

F. RATIONALIZATION: EXPLAIN AWAY PAIN (EX: A WOMAN WHO DOES NOT GET A JOB SHE APPLIED FOR MAY SAY SHE NEVER WANTED IT ANYWAY)

G. SUBLIMATION: DIVERTING UNACCEPTABLE IMPULSES INTO SOCIALLY ACCEPTABLE CHANNELS (EX: AGGRESSIVE IMPULSES CHANNELED INTO ATHLETIC ACTIVITIES)

H. REGRESSION: TO AN EARLIER PHASE OF DEVELOPMENT WHEN LIFE WAS "EASIER" (EX: WEEPING)

I. INTROJECTION: TAKING IN (SWALLOWING) THE VALUES OF OTHERS (EX: THE ABUSED CHILD ABUSES OTHERS)

J. IDENTIFICATION: MEANS OF ENHANCING SELF-WORTH BY IDENTIFYING WITH SUCCESSFUL CAUSES, ORGANIZATIONS, OR PEOPLE

K. SPLITTING THE AFFECT: NO EMOTIONAL RESPONSE TO A PAINFUL EVENT

L. MINIMIZATION: ATTEMPTS TO MINIMIZE THE IMPORTANCE OF AN EVENT

M. UNDOING: TO NEGATE AN ACT OR THOUGHT (EX: UNAVAILABLE FATHER SHOWERS CHILD WITH MATERIAL GOODS)

Suggested Books

The following list is intended to serve as a guide for your selection of books to further your learning. It is certainly not "complete". I strongly encourage you to read widely and to re-read materials as you gain more experience as a counselor. I have chosen books that focus on interventions for individual counseling, although sections on theory may also be included.

Psychoanalytic/Psychodynamic

Basch, M. F. (1992). Practicing psychotherapy. New York: Basic Books.

Basch, M. F. (1985). Understanding psychotherapy. New York: Basic Books.

Elson, M. (Ed.) (1987). The Kohut seminars on self psychology and psychotherapy with adolescents and young adults. New York: Norton and Company.

Fromm-Reichmann, F. (1960). Principles of intensive psychotherapy. Chicago: University of Chicago Press.

Greenson, R. R. (1967). The technique and practice or psychoanalysis (Vol. 1). New York: International Universities Press.

Hamilton, N. G. (1990). Self and others: Object relations theory in practice. Northvale, NJ: Jason Aronson, Inc.

Horowitz, M. J. (1989). Nuances of technique in dynamic psychotherapy. Northvale, NJ: Jason Aronson, Inc.

Karasu, T. B. (1992). Wisdom in the practice of psychotherapy. New York: Basic Books.

Strupp, H. H. & Binder, J. L. (1984). Psychotherapy in a new key: A guide to time-limited dynamic psychotherapy. New York: Basic Books.

Teyber, E. (1992). Interpersonal process in psychotherapy: A guide for clinical training. Pacific Grove, CA: Brooks/Cole Publishing Company.

Wolf, E. S. (1988). Treating the self: Elements of clinical self psychology. New York: The Guilford Press.

Humanistic/Existential

Perls, F. S., Hefferline, R., & Goodman, P. (1951). Gestalt therapy. New York: Dell.

Polster, E., & Polster, M. (1973). Gestalt therapy integrated: Contours of theory and practice. New York: Vintage Books.

Rogers, C. R. (1942). Counseling and psychotherapy. Boston: Houghton Mifflin.

Rogers, C. R. (1951). Client-centered therapy. Boston: Houghton Mifflin.

Cognitive/Behavioral

Bandura, A. (1969). Principles of behavior modification. New York: Holt, Rhinehart & Winston.

Beck, A. T. (1976). Cognitive therapy and the emotional disorders. New York: International Universities Press.

Beck, A., T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). Cognitive therapy of depression. New York: Guilford.

Ellis, A. (1970). The essence of rational psychotherapy: A comprehensive approach to treatment. New York: Institute for Rational Living.

Lazarus, A. A. (1976). Multimodal behavior therapy. New York: Springer.

Meichenbaum, D. (1977). Cognitive-behavior modification. New York: Plenum.

Meichenbaum, D. (1985). Stress inoculation training. New York: Pergamon Press.

Specific Topics

Atkinson, D. R., Morton, G., & Sue, D. W. (1993). Counseling American minorities: A cross-cultural perspective (4th ed.). Madison, WI: Brown & Benchmark.

Briere, J. N. (1992). Child abuse trauma: Theory and treatment of the lasting effects. Newbury Park, CA: Sage Publications.

Kaufman, G. (1989). The psychology of shame: Theory and treatment of shame-based syndromes. New York: Springer Publishing Company.

Morrison, A. P. (1989). Shame: The underside of narcissism. Hillsdale, NJ: The Analytic Press.

Westerlund, E. (1992). Women's sexuality after childhood incest. New York: W. W. Norton and Company.

Miscellaneous (These books do not provide specific information about interventions, but are useful for diagnosis, report writing, etc.)

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed.TR). Washington, D.C.: Author.

Hersen, M., & Turner, S. M. (Eds.) (1991). Adult psychopathology and diagnosis (2nd ed.). New York: Jon Wiley and Sons.

Millon, T. (1981). Disorders of personality: DSM III: Axis II. New York: John Wiley and Sons.

Zuckerman, E. (1989). The clinician's thesaurus: A guidebook for writing psychological reports and other evaluations. Pittsburg: The Three Wishes Press.

Clinical Axioms from: Karasu, T. B. (1992). Wisdom in the practice of psychotherapy. New York: Basic Books.

1. "Theories of psychotherapy should anchor, not drown, the therapist."
2. "A patient is a sufferer who cannot cope and who believes in the therapist."
3. "Diagnosis in psychotherapy means understanding human conditions that are both unique and universal."
4. "Behind the question, What do I want? is the larger question, Who am I?--or even Am I?"
5. "Patients come to treatment in search of a substitute object, if not a substitute self."
6. "The therapist must establish a psychologically safe environment, wherein anything can be said and any feeling experienced."
7. "The therapist establishes the optimum therapeutic environment through a balance of neutrality and empathy."
8. "The therapist and the patient need to share a view--or myth--of illness and its cure."
9. "A shared myth between the therapist and patient may be culturally inherited, but their shared intention must be mutually cultivated."
10. "By heightening or lowering arousal, the therapist enters the patient's world."
11. "The therapist's suspended attention is not only objective but empathic."
12. "The therapist who "completely understands" the patient has stopped listening."
13. "Therapists tend to underestimate the power of listening and overestimate the power of speaking."
14. "Do not strangle the patient's questions by answering them."
15. "The therapist's silence is intended to facilitate treatment; the patient's silence unintentionally resists it."
16. "Silence is not always golden; it can be misused by the therapist and misunderstood by the patient."
17. "Behind the patient's silence is a wish to be understood without verbalizing."
18. "The therapist and the patient develop a communicative intimacy that does not exist in other relationships.
19. "The patient's patterns of relatedness determine the moment-to-moment course of the therapeutic relationship."
20. "The patient's undue dependency on or failure to get close to the therapist represent two sides of a rapprochement conflict."
21. "The therapist's failure to facilitate transference may reflect excessive activity; failure to establish an empathic bond reflects insufficient feeling for the patient."
22. "Psychotherapy communication can begin only where ordinary conversation leaves off."
23. "Only the unconscious can reach the unconscious."
24. "Anything that can't be said concisely is best not said at all."
25. "The therapist must develop a latency of response, then work further to shorten the time."
26. "The patient will be both eager for and resistant to change; the therapist must accept the patient's whole while rejecting dysfunctional parts."
27. "The therapist never rests in the presence of negative transference."
28. "Positive transference can be perilous and is the main culprit in benign premature termination, acting out, and prolonged dependency."
29. "The therapist may be deceived by positive transference of any stage of the therapy, when the therapist's self-image matches the patient's tranferential disposition."
30. "The therapist's failure to distinguish actual negative feelings from negative transference will enrage the patient and bring the treatment to a rapid end."
31. "The therapist's failure to distinguish actual positive feelings from positive transference will diminish the patient and bring the session to a slow end."
32. "The beginning and ending of sessions tend to be untidy and must be tied together."
33. "Exit and entrance lines reflect the transferential themes of separation and intimacy."
34. "The therapist must not have a private agenda."
35. "The therapist's task is to experience the patient's dilemma, not to solve the patient's problems."
36. "The careful interpretation meets four criteria: optimum timing, minimum dosage, concrete detail, and individual focus."
37. "Theory-driven interpretations are impersonal and alienating to the patient."
38. "Every interpretation is incorrect on some level."
39. "The therapist's technique bends under the weight of the patient's weakness.
40. "All interpretations are deprivations: good ones bring disappointment and bad ones cause disengagement."
41. "The interpretation of symptoms may dissolve resistance, but the interpretation of character traits may generate it."
42. "Minimum cues should not be met with even minimum confrontations."
43. "Good moments and sudden insights may deceive the patient and derail the therapist."
44. "The success of psychotherapy can be attributed to the patient and its failure to the therapist."
45. "Only when the patient becomes more vulnerable within treatment will he or she become less vulnerable outside treatment."
46. "Therapy, like all relationships, is time-limited."
47. "Psychotherapy is like a slow-cooking process that has no microwave substitute."
48. "Every therapist must be prepared for the element of surprise--which can only come in the psychotherapy experience itself."