

CLINICAL PROGRAM HANDBOOK

Department of Psychology
Washington University in St. Louis

See also: *Guide to Graduate Training*, which provides policies and procedures for all graduate students in the Department of Psychology. The *Clinical Program Handbook* is a supplement to that guide and covers specific coursework and practicum experiences that are required for students in the Clinical Science training program.

Revised: April, 2011

Table of Contents

Training Philosophy of the Clinical Program	3
General Requirements for the Ph.D. in Psychology	3
Specific Requirements for the Clinical Training Program	4
Coursework	4
Clinical Training	6
Practicum Experiences	6
Psychological Service Center (PSC)	7
Prohibition of independent practice by students	8
Internship	8
Climate of the Training Program	9
Ongoing Evaluation and Disciplinary Procedures	10
Appendix A: Format for Log of Clinical Experience	12
Appendix B: Practicum Student Evaluation Form.....	19
Appendix C: Case Conference Instructions	22
Appendix D: Sexual Harassment Policy	25

Training Philosophy of the Clinical Science Program

The clinical psychology program is devoted to the promotion of an integration of science and practice. It is based on the clinical science model, with a clear emphasis on research. Our primary goal is to train clinical scientists who will lead the search for new knowledge regarding the assessment, understanding, and treatment of psychological disorders.

Research activities in the clinical area are closely tied to basic science areas in our Department. Our Department includes leading investigators in the psychology of aging, cognitive neuroscience, and personality research. The clinical area also has significant ties to psychologists in the Medical School who are concerned with psychological issues associated with medical problems (such as cardiovascular disease).

We are training a new generation of investigators to apply concepts and methods from basic behavioral science to the study of clinical problems, such as schizophrenia, personality disorders, eating disorders, social anxiety, depression, and problems of aging. Members of the core faculty are studying a variety of cognitive, emotional, and motivational processes as well as brain mechanisms that are associated with these phenomena.

Our students do not need to choose whether they will be scientists or practitioners. They see these roles as being inherently intertwined, thus they must be able to function in both worlds. We emphasize research and academic career goals for our students consistent with our view of the future needs of our profession. Some students elect careers in applied settings, however, and use their critical thinking skills in applied clinical work.

When you are admitted to the program, you are matched with a *faculty advisor* reflecting your research interests. Your faculty advisor, along with the other faculty members in the clinical area, form an *advisory committee* and provide you with a formal written evaluation at least once a year. The advisory committee is your primary source of guidance throughout your graduate training.

General Requirements for the Ph.D. in Psychology (all areas)

In most respects, the requirements for graduate students in the clinical training program are the same as those for students in other areas of the department. The department's *Guide to Graduate Training* provides a careful description of requirements, milestones, and procedures to be followed. Unless otherwise specified in this document, the department's general guidelines apply to clinical students. These include the Qualifying Research Project, the Subject Matter Exam, the Teaching

Requirement, and the Doctoral Dissertation. Please see the department's *Guide to Graduate Training* for an explanation of these requirements.

Specific Requirements for the Clinical Training Program

The training program in Clinical Psychology also includes some additional requirements that do not apply to graduate students in other areas of the department. The most important differences are the following: a) requirements regarding relevant coursework are more extensive for students in the clinical program, and b) clinical training, including a series of supervised practicum experiences, is required for students in the clinical program. Details of these components are elaborated below.

Coursework

All students must complete 72 credit hours of graduate level course work. A typical semester course load for the first two years is 12 hours, unless teaching and/or research responsibilities dictate a 9-hour load (e.g., students supported by teaching assistantships from the Graduate School may not enroll in more than 9 credit hours per semester).

CLINICAL CURRICULUM

<u>YEAR</u>	<u>FALL SEMESTER</u>	<u>SPRING SEMESTER</u>
1	Quantitative Methods Assessment I Advanced Psychopathology RESEARCH	Quantitative Methods Assessment II Intro to Psychological Treatments RESEARCH
	SEMINAR IN TEACHING OF PSYCHOLOGY (Summer after Year 1)	
2	Research Methods Basic Science 1 Practicum (at PSC) RESEARCH	Basic Science 2 Clinical Elective 1 Practicum (at PSC) RESEARCH
3	Ethical and Professional Issues Clinical Elective 2 Outside Practicum RESEARCH	Clinical Elective 3 Basic Science 3 Outside Practicum RESEARCH
4	DISSERTATION RESEARCH Teaching Experience (TA) Outside Practicum	DISSERTATION RESEARCH Teaching Experience Outside Practicum

You are expected to meet the following requirements:

1. Pass five core clinical courses:

- 5112 Psychological Assessment I
 - 5113 Psychological Assessment II
 - 537 Advanced Psychopathology
 - 540 Advanced Seminar in Clinical Psychology: Ethical and Professional Issues
 - 545 Introduction to Psychological Treatments
2. Pass two semesters of graduate statistics and one course in research methods. The statistics courses – Quantitative Methods I (Psychology 5066) and Quantitative Methods II (Psychology 5067) – are taken during the first year. The research methods course – Research Designs and Methods (Psychology 5011) – is taken during the first semester of the second year.
 3. A grade of at least B- in one graduate level course at Washington University in each of the following basic science areas:
 - a. Social and Personality Psychology
 - b. Biological-Neurological Aspects of Behavior
 - c. Cognitive, Learning, and Perception

To learn which courses fulfill these requirements, see the *Guide to Graduate Training*. Courses listed as applying to more than one area may be used to satisfy the course requirement in a single area only. The student may choose the area to which such courses will apply.
 4. All students in the clinical training program are required to attend the Clinical Science Seminar (Tuesday, 4-5 PM during the academic year). Like other students in the department, you are also required to attend at least one other scientific presentation each week throughout all years of graduate study. These might include brown bags hosted by other areas of the department, departmental colloquia, or presentations at the Medical School (e.g., grand rounds in psychiatry or talks at the Alzheimer’s Disease Research Center).

You are responsible for the timely completion of these courses and are expected to maintain at least a B average. After completion of the 72 units of required coursework, you will need to register each semester of the remainder of your academic career for L33 884, Doctoral Continuing Student Status, which is considered an Audit for zero credits. You will receive a grade of either “L” for successful audit or “Z” for unsuccessful audit. Clinical students on *internship* (final year in

program) should discuss their registration individually with the Administrative Assistant for the Graduate Program.

Clinical Training

The goals of this program's clinical training are to expose students to a variety of assessment and intervention techniques guided by carefully supervised contact with clients who are grappling with a broad range of personal problems. This includes an exposure in clinical supervision to theory and research that guide the effectiveness of clinical practice and encourages students to develop an appreciation for the critical interplay between clinical research and practice combined with an awareness and sensitivity to the ethical and legal implications of their service commitments.

1. The definition of clinical assessment and intervention is broad; it includes assessments and interventions conducted in both clinical and research settings.
2. Learning about the principles of assessment and intervention is integrated with the students' clinical research training.
3. The focus is on familiarity with general principles of assessment and intervention approaches that can be used and adapted for specific clinical and research purposes.
4. Although course credit for practica is received in a specific semester (e.g., courses 563, 564, 5121), this is done for accounting purposes only. Clinical training is organized on a continuous basis.

Practicum Experiences

You will begin your psychological assessment training in the first semester of your first year and will complete much of it by the end of the first summer. Toward the end of the spring semester of the first year and continuing into the summer, students perform an entire assessment sequence (interview plus assessments of cognition, personality, psychopathology) for a client in the Department's Psychological Services Center (PSC) or another clinical setting and write an integrated report.

Your intervention training also begins in the first year with a general course (Introduction to Psychological Treatments) that covers fundamental approaches to psychotherapy. This course lays the foundation for a two-semester psychotherapy practica (563/564) that begins in the fall semester of your second year and takes place in the Psychological Service Center (PSC). Supervision for these practica is provided by core faculty members. The PSC practicum should consist of no more than 10

hours per week of training in a given academic year. Ten hours is the total amount of time you should spend at the PSC each week, including direct client contact, supervision, and paperwork.

Students may elect to take a second course on interventions (Interventions II) but this is not required. Options include: Empirically Supported Treatment in the Clinic (544), Clinical Interventions with Older Adults (588), and Neuropsychological Assessment and Intervention (5522).

Students are required to complete two years of practicum placement in the community during the third and fourth years of training. The sites for these experiences should be chosen carefully through discussion with your mentor and the Director of the Psychological Services Center. Students should consider the link between their own research interests and the clients with whom they would work at each site. It is also important to develop, across your years in the program, experience working in a variety of clinical settings (e.g., both inpatient and outpatient facilities, and with clients who experience a broad range of clinical problems). It is a mistake to become too specialized at this point in your training. Internships value breadth of experience. Each of your outside practicum experiences should consist of 10 hours per week of training for an entire academic year. Ten hours is the total amount of time you should spend at the practicum each week, including direct client contact, supervision, and paperwork.

Because the emphasis of this program is on training academic clinical researchers and not practicing clinicians, students are expected to accumulate approximately 1,000 to 1,200 total hours of clinical experience during their graduate training. These include direct client contact and supervision that occurs in the context of both clinical practica and research training.

Students are not required to engage in additional practicum experience beyond four years. Nevertheless, that option is available to students following discussion with their mentor and based on arrangements made with the Director of the PSC. Students must register for outside practica each semester (for noncredit) in which they are involved. Failure to register is grounds for probationary action.

Psychological Service Center (PSC)

Orientation to the PSC is scheduled through a special daylong workshop that informs students of the operating procedures for the PSC. All students attend this workshop prior to the beginning of their second year in the program. A detailed description of policies and procedures governing practice and behavior at the PSC is provided in the *PSC Manual*. Most clients are seen weekly on a year-round basis (12 months). Therefore, you are advised to organize your vacation

schedule so that no more than two consecutive sessions are missed. To aid in supervision, therapy sessions are either audio or video taped, with the written permission of the client.

Confidentiality must be closely monitored at all times. You must be certain that you are in private places before you discuss client information and then only with appropriate individuals. Client names should never be used in such discussions, and tapes must be carefully guarded. Client records are always housed in the PSC and are never to leave the premises.

Prohibition of independent practice by students

It is imperative that all students realize that any independent practice by clinical psychology students while enrolled in the Clinical Psychology Program of Washington University (e.g., hiring yourself out to give tests for a practice) is unequivocally prohibited because of serious ethical and legal implications for the student, the program, and the profession. This prohibition holds true for students who have previously received or concurrently receive a degree or license in an allied discipline (e.g., social work, counseling psychology, or psychiatric nursing). Students who have any questions as to the applicability of this policy to their own activities must discuss such activities with the Director of Clinical Training before engaging in such.

Internships

Students are expected to apply for internships whose goal is to train academic clinical psychologists. These include programs that belong to the Academy of Psychological Clinical Science (APCS). Such internships strongly value high quality research training, as evidenced by publications and conference presentations, as well as high quality clinical training. As such, the expected 1,000 to 1,200 pre-internship clinical hours (direct clinical contact hours plus supervision hours) will adequately serve to make our students highly competitive for such outstanding internships. Amounts in excess of this target are typically unnecessary and wasteful of personal resources needed for your ongoing research development.

The internship will take place no earlier than the fourth year of your graduate clinical training, with the majority of students participating during their sixth year. Students are strongly encouraged to have completed their dissertation defense prior to departing for internship. This situation allows students to devote full intellectual energy to their internships, thus making them more attractive to these prestigious training centers. Such students are also more likely to be eligible for postdoctoral fellowships that may become available at their training centers during their year of internship.

Before you may **apply** to and accept an APA-approved internship, the following requirements must be met:

1. All required courses are completed.
2. All required practica are completed.
3. The qualifying research project is completed.
4. The subject matter exam is passed.
5. A case conference must be presented in a Clinical Science Seminar. (Instructions are included in Appendix B).
6. The dissertation proposal has been approved.

Your dissertation proposal must be approved by October 1 of the year in which you plan to apply for internship.

Most recent students have found that 10 to 12 applications are sufficient to obtain one of their top choice internships. Excessive numbers of applications are not only financially burdensome but also detract from your ongoing educational program. Early in the fall semester, the Clinical Director, as well as interested faculty advisors, meets with the students to assist in the application process. Students should register with APPIC when they are ready to begin this process.

During the internship year, students are required to register each semester. The appropriate registration should be discussed with the Graduate Program Assistant.

Climate of the Training Program

The faculty recognizes the complexity involved in training in clinical psychology and realizes that students learn best in a nurturing environment. Since the process of becoming a skilled clinical scientist is not always linear, students often learn by making mistakes. Such learning, of course, depends on the student's openness to supervision, self-scrutiny, and professional exchange with both supervisors and peers. We emphasize the importance of group collaboration among students and discourage competition. The faculty encourages students to provide emotional and intellectual support to each other during their graduate careers. We further recognize that interactions among students, faculty, and staff should be collegial and reflect the highest standards of the profession. Thus, the program is committed to the University's policy on sexual harassment. Any questions regarding boundary violations should immediately be brought to the attention of the Director of Clinical Training.

Ongoing Evaluation and Disciplinary Procedures

The nature of the clinical enterprise is such that training is more complex than many of the academic based skills, involving not only the acquisition of specific skills and techniques, but also the individual's character and innate talent for doing clinical work. Infrequently, students are found to be unacceptably limited in their ability to complete successfully the required clinical work, even though their academic and research skills are more than adequate for completion of the program.

These are the procedures that will be implemented for students experiencing personal, emotional, or personality problems that negatively affect their clinical work or academic performance. When the clinical faculty identifies a student struggling with personal and/or academic deficiencies that are interfering with his or her progress in the clinical program, a special faculty oversight committee will be convened to gather information and recommend appropriate action to the clinical faculty as a whole. The primary procedural steps are as follows:

1. Each spring semester the clinical faculty reviews, along with the student's academic advisor, the student's progress in the program.
2. If the clinical faculty believes that the student's problems are sufficiently serious to warrant action that might result in probation or removing the student from the clinical program, the clinical faculty will vote to convene an oversight committee to investigate the relevant problems and to offer recommendations.
3. A committee composed of faculty members who have not been involved directly with complaints regarding the student's performance will be assembled by the Director of Clinical Training. Every attempt will be made to assure that committee members are as impartial as possible. The committee will be composed of three clinical faculty members, either full-time, part-time, or adjunct.
4. The oversight committee will interview each of the faculty directly involved with the student to develop perspective on the issue[s].
5. The oversight committee will also interview the student in depth about his/her perception of the issue[s]. The committee will indicate to the student that it is empowered to gather information and to make recommendations.
6. After the relevant information has been obtained from different sources, the oversight committee will summarize and evaluate the material and make a recommendation to the Director of Clinical Training.

7. The Director of Clinical Training will place this matter on the agenda for a future clinical faculty meeting.
8. A clinical faculty quorum will discuss the committee's recommendation and vote on a course of action. The possible outcomes are:
 - a. No action warranted; student remains in good standing;
 - b. Recommendation that student make significant changes, possibly through assistance of professional help (psychotherapist or counselor);
 - c. Probationary status with clearly defined conditions to be met before removal from probation;
 - d. Recommendation for a leave of absence for a specified period;
 - e. Recommendation for termination from the clinical program.
9. Following this meeting, the Director of Clinical Training will meet with the student to communicate, both orally and in writing, the decision of the clinical faculty and to explain its implications.

The clinical faculty recognizes that these issues are complex and require rigorous adherence to principles of fairness. Disciplinary action (which has been extremely rare) generally arises only after repeated attempts of supervisors and faculty have been unsuccessful in assisting the student to modify problematic aspects of his/her conduct. If termination is recommended, the student may appeal to the Chair of the Psychology Department and/or the Dean of the Graduate School.

Issues involving academic integrity and accusations of plagiarism are dealt with through a standing University committee. Students should study the Graduate School's guidelines on plagiarism carefully, as ignorance is not an acceptable defense.

APPENDIX A

Format for Log of Clinical Experience

MONTHLY CLINICAL SERVICE DATA SHEET

PLACE SEEN _____ (Please state PSC or Outside Practicum)

STUDENT NAME _____ MONTH _____ YEAR _____

1. INTERVENTION
(see p. 7 for definitions)

Total # of hours
face-to-face

different individuals, couples,
families, or groups

*a. Individual Therapy

- *1) Older Adults (65+) _____
- *2) Adults (18-64) _____
- *3) Adolescents (13-17) _____
- *4) School-Age (6-12) _____
- *5) Pre-School Age (3-5) _____
- *6) Infants/Toddlers (0-2) _____

*b. Group Therapy (Count as one unit)

- *1) Adults _____
- *2) Adolescents (3-17) _____
- *3) Children (12 & under) _____

*c. Family Therapy (Count as one unit) _____

*d. Couples Therapy (Count as one unit) _____

e. School Counseling Interventions

- 1) Consultation _____
- 2) Direct Intervention _____
- 3) Other _____

f. Other Psychological Intervention

- 1) Medical / Health Related Interventions _____
- 2) Intake Interview / Structured Interview _____
- 3) Substance Abuse Interventions _____
- 4) Other Interventions _____

*Data needed for PSC Annual Report. If you don't need these data for your records, then you only need to fill out the items on pages 1 & 2 with * for the PSC.

- g. Other Psychological Experience with Students and/or Organizations:
- 1) Supervision of Other Students _____
 - 2) Program Development/ Outreach Programming _____
 - 3) Outcome Assessment of Programs or Projects _____
 - 4) Systems Intervention / Organizational Consultation / Performance _____
 - 5) Other _____

2. SUPPORT ACTIVITIES – How much time have you spent in support activities related to your intervention and assessment experience?

- | | | |
|---|-------|-------|
| a. Case Conferences | _____ | hours |
| b. Case Management/Consultation | _____ | hours |
| c. Didactic Training/Seminars/Grand Rounds | _____ | hours |
| d. Progress Notes/Clinical Writing/Chart Review | _____ | hours |
| e. Psychological Assessment Scoring/Interpretation and Report Writing | _____ | hours |
| f. Video-Audio-Digital Recording Review | _____ | hours |

Total Support Hours _____

***3. Psychological Assessment Experience:** This is the total number of face to face client contact hours administering and providing feedback to clients/patients. This does not include time spent scoring and/or report writing, which should be included under item #2 (Support Activities).

- *a. Psychological test administration (include symptom questionnaires, personality measures, achievement and intelligence tests), and providing feedback to clients/patients.

*Hours Spent with Client _____

- *b. Neuropsychological Assessment (include intellectual assessment in this category only when it was administered in the context of neuropsychological assessment involving evaluation of multiple cognitive, sensory, and motor functions).

*Hours Spent with Client _____

***4. SUPERVISION RECEIVED** (see p. 7 for definitions)

- *a. Number of actual hours spent in one-on-one, face-to-face supervision: _____
- b. Number of hours of peer supervision on specific cases: _____
- c. Number of hours of group supervision (this includes all of team time) _____

5. SUMMARY OF HOURS (for APPIC)

- a. Total Intervention and Assessment Hours (Items 1&3) _____
- b. Total Support Hours (Item 2) _____
- c. Total Supervision Hours (Item 4a) _____

*Data needed for PSC Annual Report. If you don't need these data for your records, then you only need to fill out the items on pages 1 & 2 with * for the PSC.

6. TREATMENT SETTINGS: How many hours have you spent in each of the following treatment settings? Please indicate the estimated total number of hours (including intervention and assessment, support, and supervision) spent in each of the following treatment settings for this month.

- PSC _____
- Community Mental Health Center _____
- Forensic/Justice setting _____
- Inpatient Hospital _____
- Outpatient Medical/Psychiatric _____
- Clinic & Hospital _____
- University Counseling Center _____
- VA Medical Center _____
- Schools _____

7. OTHER INFORMATION ABOUT CLINICAL EXPERIENCES

- a. Have you led or co-led any types of groups?
- b. Do you have experience with Managed Care Systems in a professional capacity? (Yes/No)
- c. Audio tape review with your supervisor (Yes/No)
- d. Videotape or digital recording review with your supervisor (Yes/No)
- e. Live/direct observation by supervisor (Yes/No)

Please indicate the number of clients/patients seen for each of the following diverse populations listed below:

Number of Clients Seen this Month	<u>Intervention</u>	<u>Assessment</u>
African-American / Black / African Origin	_____	_____
Asian-American /Asian Origin / Pacific Islander	_____	_____
Latino-a/Hispanic	_____	_____
American Indian /Alaska Native/Aboriginal Canadian	_____	_____
European Origin / White	_____	_____
Bi-Racial / Multi-racial	_____	_____
Heterosexual	_____	_____
Gay	_____	_____
Lesbian	_____	_____
Bisexual	_____	_____
Physical / Orthopedic Disability	_____	_____
Blind / Visually Impaired	_____	_____
Deaf / Hard of Hearing	_____	_____
Learning / Cognitive Disability	_____	_____
Developmental Disability(include MR & autism)	_____	_____
Serious Mental Illness (Psychotic or major mood disorders)	_____	_____
Other	_____	_____
Males	_____	_____
Females	_____	_____
Transgendered	_____	_____

You may download your own copy of the APPIC form from: <http://www.appic.org/>

PSC does not need the info on this page. You should itemize here only for your own personal use. APPIC does require this information.

TEST ADMINISTRATION

Please indicate all instruments used by you in your assessment experience, excluding practice administrations to fellow students. You may include any experience you have had with these instruments such as work, research, practicum, etc., other than practice administrations. To indicate that you administered, scored, interpreted, and wrote a report for a test, count in both columns. Please designate your experiences for the instruments listed below, without changing the sequence in which they are listed. Then, you may add as many additional lines (under “Other Tests”) as needed for any other tests that you have administered.

ADULT TESTS

<u>Name of Test</u>	<u># Clinically Administered and Scored</u>	<u># of Reports written with this measure</u>	<u># Administered as Part of a Research Project</u>
Symptom Inventories:			
Beck Anxiety Inventory	_____	_____	_____
Beck Depression Scale	_____	_____	_____
Geriatric Depression Scale	_____	_____	_____
Hamilton Depression Scale	_____	_____	_____
Other Self Report Measures	_____	_____	_____
Diagnostic Interview Protocols:			
DIS	_____	_____	_____
MINI	_____	_____	_____
SADS	_____	_____	_____
SCID	_____	_____	_____
SIDP	_____	_____	_____
Cognitive Assessment:			
Stanford-Binet	_____	_____	_____
TONI-3	_____	_____	_____
WAIS-III & WAIS-IV	_____	_____	_____
Neuropsychological Assessment:			
Bender Gestalt	_____	_____	_____
Boston Diagnostic Aphasia Exam	_____	_____	_____
Brief Rating Scale of Executive Function (BRIEF)	_____	_____	_____
Dementia Rating Scale II	_____	_____	_____
California Verbal Learning Test	_____	_____	_____
Continuous Performance Test	_____	_____	_____
Delis Kaplan Executive System	_____	_____	_____
Finger Tapping	_____	_____	_____
Grooved Pegboard	_____	_____	_____
Rey-Osterrieth Complex Figure	_____	_____	_____
Trailmaking A&B	_____	_____	_____
Weschler Memory Scale III & IV	_____	_____	_____
Wisconsin Card Sort	_____	_____	_____
Other	_____	_____	_____

<u>Name of Test</u>	<u># Clinically Administered and Scored</u>	<u># of Reports written with this measure</u>	<u># Administered as Part of a Research Project</u>
Measures of Academic Functioning:			
Strong Interest Inventory	_____	_____	_____
WIAT	_____	_____	_____
Wide Range Assessment of Memory & Learning	_____	_____	_____
Woodcock Johnson III	_____	_____	_____
WRAT-4	_____	_____	_____
Other	_____	_____	_____
Personality Inventories:			
MMPI-2	_____	_____	_____
Personality Assessment Inventory	_____	_____	_____
Other	_____	_____	_____
<u>CHILD AND ADOLESCENT TESTS</u>			
Achenbach System of Empirically Based Assessment	_____	_____	_____
Behavior Assessment System of Children (BASC)	_____	_____	_____
Other	_____	_____	_____
Symptom Inventories:			
Barkley-Murphy Checklist for ADHD	_____	_____	_____
Conner's Rating Scales	_____	_____	_____
Other	_____	_____	_____
Diagnostic Interview Protocols:			
DISC	_____	_____	_____
Kiddie-SADS	_____	_____	_____
Other	_____	_____	_____
Cognitive Assessment:			
Bayley Scales of Infant	_____	_____	_____
Differential Abilities Scale II	_____	_____	_____
Mullen Scales of Early Learning	_____	_____	_____
Stanford-Binet 5	_____	_____	_____
WPPSI-III	_____	_____	_____
WISC-IV	_____	_____	_____
Other	_____	_____	_____
Neuropsych Assessment Measures:			
Bender Gestalt	_____	_____	_____
Development Test of Visual Motor Integration (Berry)	_____	_____	_____
BRIEF	_____	_____	_____
Children's Memory Scale	_____	_____	_____
Continuous Performance Test	_____	_____	_____
Delis Kaplan Executive Function System	_____	_____	_____
NEPSY-II	_____	_____	_____
Rey-Osterreith Complex Figure	_____	_____	_____

<u>Name of Test</u>	<u># Clinically Administered and Scored</u>	<u># of Reports written with this measure</u>	<u># Administered as Part of a Research Project</u>
---------------------	---	---	---

Measures of Academic Functioning:

WIAT	_____	_____	_____
Wide Range Assessment of Memory & Learning	_____	_____	_____
Woodcock Johnson III	_____	_____	_____
WRAT-4	_____	_____	_____

Personality Inventories:

MAPI	_____	_____	_____
MMPI-A	_____	_____	_____

INTEGRATED REPORT WRITING

How many supervised integrated psychological reports have you written for each of the following populations? An integrated report includes a history, an interview, and at least two tests from one or more the following categories: personality assessments (objective, self-report, and/or projective), intellectual assessment, cognitive assessment, and/or neuropsychological assessment. These are synthesized into a comprehensive report providing an overall picture of the patient. An intake report that you write for a PSC client does count as an integrated report.

- a. Adults: _____
- b. Children / Adolescents: _____

DEFINITION OF TERMS FOR DOCUMENTING PRACTICUM EXPERIENCE

Only count hours for which you received formal academic training and credit or which were program-sanctioned experiences.

Practicum hour - A practicum hour is a clock hour. A 45 – 50 minute client/patient hour may be counted as one practicum hour. Practicum hours must be supervised. Please round to the nearest whole number.

- 1. THERAPY or ASSESSMENT EXPERIENCE** – These are actual clock hours in direct service to clients/patients. Hours should not be counted in more than one category. Time spent gathering information about the client/patient, but not in the actual presence of the client/patient, should instead be recorded under item 2 (“Support Activities”).
- 2.** For the first column, count each hour of a group, family, or couples session as one practicum hour. For example, a two-hour group session with 12 adults is counted as two hours. For the second column, count a couple, family, or group as one (1) unit. For example, meeting with a group of 12 adults over a ten-week period counts as one (1) group.
- 3. SUPERVISION RECEIVED** – Supervision is divided into one-to-one, group, and peer supervision/consultation. Supervision provided to less advanced students should be counted in item 1h-1. Item 4a: Hours are defined as regularly scheduled, face-to-face individual supervision with specific intent of overseeing the psychological services rendered by the student.

APPENDIX B

Practicum Student Evaluation Form

Name of Student: _____ Year Level: _____

Name of Supervisor _____

Time Period of Evaluation _____

Number of Clients _____ Practicum Site PSC

1. Relationship and Interpersonal Skills	NA	B	M	E
a) With patients/clients:				
i) Ability to form a working alliance/establish rapport.				
ii) Ability to deal with conflict, negotiate differences.				
iii) Ability to understand and maintain appropriate professional boundaries.				
b) With supervisors, the ability to make effective use of supervision, including:				
i) Ability to prepare for supervision.				
ii) Ability/willingness to accept supervisory input, including direction and ability to follow through on recommendations.				
iii) Ability to self-reflect and self-evaluate clinical skills including using good judgment as to when supervisory input is necessary.				
c) With support staff:				
i) Ability to be respectful of support staff roles and persons.				

Comments: (e.g., does student participate in psychotherapy team or make a contribution to the practicum site?)

NA = not applicable, don't know, or insufficient information to rate
 B = below expectations

2. Psychological Assessment Skills	NA	B	M	E
a) Ability to utilize systematic approaches to gathering data to inform clinical decision making.				
b) Ability to integrate assessment data from different sources to formulate diagnoses.				

Comments: (e.g., does student know how to use and interpret appropriate test materials?)

3. Intervention skills	NA	B	M	E
a) Ability to do empathetic listening, frame problems, etc.				
b) Ability to formulate and conceptualize cases.				
c) Ability to plan treatments and carry them out.				
d) Knowledge of empirically supported treatments.				
e) Ability to assess treatment progress and outcome.				

Comments: (e.g., can student diagnosis and then treat?)

4. Diversity – Individual and Cultural Differences	NA	B	M	E
a) Knowledge of self (one’s own attitudes, stimulus value) as one operates in the clinical setting with diverse others.				
b) Understanding the need to consider cultural differences in all aspects of professional psychological work.				
c) Ability to work effectively with diverse others in assessment, treatment and consultation.				

Comments:

- NA = not applicable, don’t know, or insufficient information to rate
- B = below expectations
- M = meets expectations
- E = exceeds expectations

5. Ethics	NA	B	M	E
a) Knowledge of ethical/professional codes, standards and guidelines; knowledge of HIPAA relevant to the practice of psychology.				
b) Seeks appropriate information and consultation when faced with ethical issues.				

Comments:

6. Professional Development	NA	B	M	E
a) Timeliness: completing professional tasks in allotted/appropriate time (e.g., evaluations, chart notes, reports).				
b) Arriving promptly at meetings and appointments.				
c) Demonstrates an ability to consult effectively with relevant third parties, i.e., mental health professionals (e.g., psychiatrists, social workers), primary care physicians, family members (including parents and romantic partners as appropriate), and teachers.				

Comments:

- NA = not applicable, don't know, or insufficient information to rate
- B = below expectations
- M = meets expectations
- E = exceeds expectations

Student's strengths _____

Areas for improvement _____

APPENDIX C

Case Conference Advice and Outline

- i. Make sure you review your clinical case conference presentation with your clinic supervisor in advance.
- ii. To protect the patient's anonymity, use a fake name or a fake initial. There may be details you want to leave out or change to make sure the patient can not be identified.
- iii. Not all of this outline can be covered for every patient, or useful for every case conference.
- iv. Keep in mind that you are trying to teach something (as opposed to sharing frustration about a complicated or difficult case or looking for additional supervision). It's a good idea to focus on a case with a positive outcome to illustrate the use of a valid assessment device or an effective treatment procedure. Remember that many of the people in the audience will have little clinical experience.
- v. Be sure your talk is grounded in the research literature about this problem, its assessment and its treatment. What do we know about this disorder? How is it best treated?

FORMAT FOR CLINICAL CASE CONFERENCE

1. Relevant Data (sections A, B, D, & E should take 15 minutes or less)
 1. Age, sex, race/ethnicity, education, intelligence, occupation, current family situation, religion, sexual orientation.
 2. Reason for and details of coming to therapy and referral source.
 3. Any other information necessary at this point for proper orientation of the audience.
2. Present Problems
 1. Major symptoms, patient's chief complaint (in the patient's own words), information from reports.
 2. Behavioral observations, including mental status, level of cooperativeness.
 3. Onset and course of disorder.
 4. Obvious or documented etiological factors or precipitating events. (What were the circumstances that led the patient to seek professional help at the time s/he did? Often the problem existed for a period of time but the decision to seek help is precipitated by a very recent event.)
 5. Previous hospitalizations and/or treatment for present disorder. Include medication.
 6. Concomitant or complicating organic disease.

3. Rationale for Presenting this Case
 1. What unique or special features does this case demonstrate? What data from the professional and scientific literature bear on the issues raised by this case? A brief review of the pertinent literature is appropriate at this point.
 2. What questions are raised but not answered by the psychological and other data available concerning the patient?
 3. What specific questions are raised to be discussed or answered?

4. Past History: Describe pertinent details in the following major areas of the patient's life history. Note the patient's age at the time of the significant events.
 1. Childhood: family, siblings, other important figures, peer relationships, neurotic symptoms (enuresis, fire setting, cruelty to animals, nightmares, fears, temper tantrums).
 2. School: academic performance, disciplinary problems, relationships with teachers and peers.
 3. Vocational Experience: frequent job changes, periods of unemployment, problems at work.
 4. Military Service: branch of service, adjustment, advancement, disciplinary problems, type of discharge.
 5. Sexual Experience: orientation, problems, concerns.
 6. Relationship History: intimate relationships, children, separations, problems, dissatisfactions.
 7. Religion/Spirituality: childhood experience, current practices and beliefs.
 8. Medical History: head injuries, other neurological problems, significant medical illnesses, operations, current medications.
 9. Drug and Alcohol History: first use, most recent use, previous treatment, related social/legal problems.
 10. Psychiatric History: previous treatment and outcome, modality and therapeutic orientation.
 11. Other areas of importance in the patient's life: current social situation, living arrangements, etc.
 12. Diversity: Is there a cultural context in which the patient's troubles/concerns take place? Or can you address this as a source of strength for the patient?

5. Family History: Nervous or emotional illnesses in family of origin; other illnesses; also age, occupation, educational and economic status of parents and siblings; circumstances of any deaths in the family, especially suicides.

6. Videotape of patient if possible (you can really only do this if you know your audience is appropriate and all from the clinical psychology program)

7. Psychological Assessment in Reasonable Detail (test data)
 1. Intellectual functioning
 2. Personality (generally the major area to be covered). In presenting and interpreting the psychometric data, reference to recent research and other literature bearing on test interpretation, etc., is quite appropriate at this point. This could include data from structured interviews or MMPI results.
 3. Symptom – specific assessments

8. Diagnostic Impressions (Axis I and II are most important. Axis III, IV, and V should be listed but not necessarily discussed)
 1. State the most likely DSM-IV-TR diagnosis
 - i. Axis I
 - ii. Axis II
 2. Any rule-out diagnoses?
 3. Case Conceptualization: Discuss a theoretical formulation on the nature of the patient's difficulties (i.e., what is wrong and how you think it got that way). Be concise.

9. Treatment Plan
 1. Make a list of about 3-5 specific problems that should be improved with therapy (e.g., inability to sleep, excessive drinking, inability to work, hopelessness, low self-esteem, unresolved grief, unresolved feelings of anger, unresolved dependency needs, etc.)
 2. Treatment plan (based on the problem list above):
 - i. Describe the goals and specific theoretical approach used. Think in terms of an empirically supported treatment or an evidence based practice model.
 - ii. Describe specific procedures or interventions that will be used (or were used).
 - iii. Suggested course (i.e., prognosis, and likely timing of improvements).
 - iv. Unresolved questions.

10. Course of Treatment
 1. If you are far along into the course of treatment with the patient, describe what happened.
 2. Assessments used to document treatment progress.

APPENDIX D

Sexual Harassment*

Washington University is committed to having a positive learning and working environment for its students, faculty, and staff and will not tolerate sexual harassment. Sexual harassment is an attack on the dignity of individuals and the integrity of the University as an institution of learning. Academic freedom can exist only when every person is free to pursue ideas in a non-threatening, non-coercive atmosphere of mutual respect. Sexual harassment is reprehensible and threatening to the careers, educational experience and well-being of all members of our community. Sexual harassment is a form of discrimination that violates University policy. It is also illegal under state and federal law.

This policy applies to all members of the Washington University community. It allocates responsibilities for helping to ensure that University policy is fairly applied, explains the process by which complaints of sexual harassment may be brought forward and provides sanctions for sexual harassment, which may range from reprimands to termination or dismissal, depending upon the severity of the offense. If you believe you have been sexually harassed, or you have been falsely accused of sexual harassment, the procedures set out below describe options about what you can do and where you can get help. Those charged with implementation of this Policy will, whenever appropriate, encourage and assist those who believe they may have been sexually harassed to pursue the assorted informal means outlined below for securing the cessation of unwelcome and offensive conduct.

Sexual harassment is defined as any unwelcome sexual advance, request for sexual favor, or other unwelcome verbal or physical conduct of a sexual nature, whether committed on or off campus, when:

1. submission to such conduct is made, either explicitly or implicitly, a term or condition of an individual's academic advancement;
2. submission to or rejection of such conduct by an individual is used as the basis or threatened to be used as the basis for academic decisions or assessments affecting an individual; or
3. such conduct has the purpose or effect of unreasonably interfering with an individual's educational performance or creating an intimidating or hostile environment for learning. Such conduct will typically be directed against a particular individual or individuals and will either be abusive or severely humiliating or will persist despite the objection of the person targeted by the speech or conduct.

Sexual harassment can be verbal, visual, physical, or communicated in writing or electronically. Some conduct obviously constitutes sexual harassment – such as a threat that a grade will depend on submission to sexual advance. But whether particular conduct constitutes sexual harassment will often depend upon the specific context of the situation, including the participants' reasonable understanding of the situation, their past dealings with

each other, the nature of their professional relationship (e.g., supervisor-subordinate, colleague, etc.) and the specific setting. The inquiry can be particularly complex in an academic community, where the free and open exchange of ideas and viewpoints preserved by the concept of academic freedom may sometimes prove distasteful, disturbing or offensive to some.

Sexual harassment includes, but is not limited to:

- Requests for sexual favors
- Hugging, rubbing, touching, patting, pinching, or brushing another's body
- Inappropriate whistling or staring
- Veiled suggestions of sexual activities
- Requests for private meetings outside of class or business hours for other than legitimate mentoring purposes
- Use in the classroom of sexual jokes, stories or images in no way germane to the subject of the class
- Remarks about a person's body or sexual relationships, activities, or experience
- Use of inappropriate body images to advertise events

Members of the University community can expect to be free from sexual harassment and thus all members of the University community should guard against it. The fact that someone did not intend to sexually harass an individual is generally not considered a sufficient defense to a complaint of sexual harassment, although the reasonableness or the accused's perceptions may be considered. In most cases, it is the effect and characteristics of the behavior on the complainant, and whether a reasonable person, similarly situated, would find the conduct offensive, that determines whether the behavior constitutes sexual harassment.

Confidentiality

The University will strive to protect, to the greatest extent possible, the confidentiality of persons reporting harassment and of those accused of harassment. Because the University has an obligation to address sexual harassment, however, the University cannot guarantee complete confidentiality where it would conflict with the University's obligation to investigate meaningfully or, where warranted, take corrective action. Even when some disclosure of the University's information or sources is necessary, it will be limited to the extent possible. The University will, to the extent permitted by law, keep confidential all records of complaints, responses and investigations. The records maintained by the Sexual Harassment Response Coordinator shall be available only to the Coordinator and, to the extent necessary, to administrators and other supervisors charged with responding to allegations of harassment. Allegations of sexual harassment shall not be placed in student records unless, after appropriate investigation, such allegations have been sustained. Records of allegations maintained by the Coordinator which do not lead to formal hearings will be discarded after five years unless there are additional, more recent complaints against the same person. Any records maintained by the Coordinator concerning an allegation about

which an accused person was not given reasonably timely notice and an opportunity to respond shall not be used to justify or enhance a sanction, other than an oral or written warning, imposed for a different instance of harassment.

If you want to discuss possible harassment in a more confidential setting or clarify your feelings about whether and how you wish to proceed, you may want to consult a social worker, therapist or member of the clergy, who is permitted, by law, to assure greater confidentiality. Clergy and counseling resources on campus are listed in Bearing, Ternion and Safety and Security on the Danforth Campus. In addition, any member of the University community may contact the Student Counseling Services at 935-5980 for a confidential discussion and, if desired, referral to off-campus resources.

Seeking Advice; Making a Complaint

If you believe that you have been sexually harassed, you have a number of response options, both formal and informal. Some people may wish to pursue informal means instead of, or before, making a formal complaint; others will not. If an informal procedure is ineffective, the formal procedures will remain open to you. You should select the route you feel most appropriate for your circumstances. However you wish to proceed, you may consult at any time with the Danforth or Medical Center Sexual Harassment Response Coordinator (listed in the Appendix below), whose responsibilities include assisting students and faculty with sexual harassment issues, be they general or specific, formal or informal. You may wish to work with the Coordinator to select an approach.

A. Informal Procedures – if you feel comfortable dealing with the situation:

(Without assistance)

1. Clearly say “no” to the person whose behavior is unwelcome.
2. Communicate either orally or in writing with the person whose behavior is unwelcome. The most useful communication will have three parts:
 - (a) A factual description of the incident(s), including date, time, place, and specific action.
 - (b) A description of the writer’s feelings, including any consequences of the incident.
 - (c) A request that the conduct cease. Frequently, such a communication will cause the unwelcome behavior to stop, particularly where the person may not be aware that the conduct is unwelcome or offensive.

(With assistance)

3. Ask the person’s supervisor, e.g., department chair, dean, director, housing office representative, academic advisor, or resident advisor to speak to the person whose behavior was unwelcome. The purpose of such conversations is the cessation of the unwelcome behavior.

4. Consult with the Coordinator or one of the Sexual Harassment Response Advisors listed in the Appendix below and specifically charged with responding to sexual harassment inquiries and complaints. These individuals are thoroughly familiar with University policy on sexual harassment and are available to consult with victims of sexual harassment, those charged with sexual harassment, witnesses and supervisors of parties to a complaint. They can provide information about informal actions that might remedy the situation and discuss University policy on sexual harassment and procedures for resolving complaints.
5. As the Coordinator to mediate or arrange for mediation. Mediation is discussion and negotiation, with the help of a third party, designed to permit the parties to reach a mutually agreeable resolution of dispute. If a person complaining of sexual harassment seeks mediation, the person accused of harassment agrees, and the Coordinator concludes that mediation would be consistent with the University's legal obligations in responding to and preventing sexual harassment, the Coordinator may mediate or arrange for mediation.

B. Formal Procedures

1. Whether or not you have attempted to resolve a sexual harassment claim through informal means, you may initiate a formal sexual harassment grievance proceeding by filing written complaint. This process may lead to a formal hearing at which evidence will be considered and witnesses heard. If this is the course you wish to take, the Coordinator can assist you in filing a complaint.
2. Complaints against faculty or staff:
 - (a) Faculty and Administrative Affirmative Action Committee (complaints by faculty and administrators)
 - (b) Title IX Grievance Committee (complaints by students)
 - (c) Human Resources Advisory Committee (complaints by staff)

All of these committees may be contacted:
c/o Office of Human Resources
North Brookings Hall, Room 126
Campus Box 1184
935-5990

Hearing procedures are set out in the Washington University Discrimination and Sexual Harassment Hearing Procedures. These procedures may be obtained from the Office of Human Resources or from any Sexual Harassment Response Coordinator or Advisor.

3. Complaints against students or student groups:

Office of the Judicial Administrator
Women's Building, Room B2
Campus Box 1136
935-4062

Hearing procedures are set out in the University Judicial Code, found in Bearings and Washington University Faculty Information. These procedures may also be obtained from the University Judicial Administrator or from the Sexual Harassment Response Coordinators or Advisors.

Whether or not you choose to file a complaint, the University may be required, or may otherwise deem it necessary and protective of the academic community, to commence its own investigation.

Protection of Rights

The University will not tolerate retaliation or discrimination against persons who report or charge sexual harassment or against those who testify, assist or participate in any investigation, proceeding, or hearing involving a complaint of sexual harassment. In this context, retaliation means speech or conduct that adversely affects another's terms or conditions of employment or education and is motivated by an intent to harm the targeted person because of his or her participation in the filing or investigation of an allegation of sexual harassment. Any such retaliation – or any encouragement of another to retaliate – is a serious violation of University policy and law, independent of whether the particular claim of sexual harassment is substantiated. If you believe you have been subjected to retaliation in violation of this rule, you may use the procedures described above to complain and see redress.

The University seeks to protect the rights of all persons, accusers and accused, to fair procedures. Accusations of sexual harassment typically have injurious far-reaching effects on the careers and lives of accused individuals. Allegations of sexual harassment must be made in good faith and not out of malice. Knowingly making a false or frivolous allegation of sexual harassment, whether in a formal or informal context, will be treated as a serious offense under this policy and, where it applies, the University Judicial Code. If you believe you have been falsely accused of sexual harassment you may use the procedures of this policy or the University Judicial Code, where applicable, to seek redress.

Obligations of Vigilance and Reporting

The University can respond to specific instances and allegations of harassment only if it is aware of them. The University therefore encourages anyone who believes that he or she has experienced sexual harassment to promptly come forward with inquiries, reports, or complaints and to seek assistance from the University. In addition, any University employee who becomes aware of instances or allegations of sexual harassment by or against a person

under his or her supervisory authority must report it to those charged with responding to such allegations and reports: the appropriate dean, director, or department head or other similar administrator or to the Sexual Harassment Response Coordinator or one of the Advisors. It shall be the responsibility of these individuals to respond to allegations and reports of sexual harassment or refer them to other University officials for such response.

The University can respond to specific instances and allegations of harassment only if it is aware of them. The University therefore encourages anyone who believes that he or she has experienced sexual harassment to promptly come forward with inquiries, reports, or complaints and to seek assistance from the University. In addition, any University employee who becomes aware of instances or allegations of sexual harassment by or against a person under his or her supervisory authority must report it to those charged with responding to such allegations and reports: the appropriate dean, director, or department head or other similar administrator or to the Sexual Harassment Response Coordinator or one of the Advisors. It shall be the responsibility of these individuals to respond to allegations and reports of sexual harassment or refer them to other University officials for such response.

Possible Sanctions

Possible sanctions for a person found guilty of behavior in violation of this policy include, but are not limited to, the following:

- ❖ Oral or written reprimand, placed in the personnel file
- ❖ Required attendance at a sexual harassment sensitivity program
- ❖ An apology to the victim
- ❖ Oral or written warning
- ❖ Loss of salary or benefit, such as sabbatical or research or travel funding transfer or change of job, class or residential assignment or location (i.e., removing the person from being in a position to retaliate or further harass the victim)
- ❖ Fine
- ❖ Demotion
- ❖ Suspension, probation, termination, dismissal or expulsion

While counseling is not considered a sanction, it may be offered or required in combination with sanctions. Where alcohol is involved in the sexual harassment, such counseling may include an alcohol abuse program.

If students or student groups are guilty of sexual harassment, any of the sanctions set forth in the University Judicial Code may also be invoked.

Education

The best way to deal with sexual harassment is to prevent it. Education is essential to

eliminating sexual harassment. Washington University has developed an ongoing training program. Please call a Sexual Harassment Response Coordinator or Advisor to find out more about these programs, what sexual harassment is, how to respond to it, and what to do when someone asks for advice about sexual harassment.

Appendix: Sexual Harassment Coordinators and Advisors

(as of January 2006)

Danforth Campus

Coordinator: Ann B. Prenatt, 935-7746

Advisors: Lorraine Goffe-Rush (complaints by faculty, staff, and others), 935-8046
Kathy Steiner-Lang (complaints by students and others), 935-5910
John Drobak (complaints by faculty and others), 935-6487

Medical Campus

Coordinator: Legail Chandler, 362-4900

Advisors: Apryle Cotton (complaints by faculty, staff, and others), 362-7198
Dr. Leslie Kahl (complaints by students and others), 362-7481
Sandra Sledge (complaints by staff and others), 362-4937

* Appendix on Sexual Harassment abridged from the Washington University's Policies & Procedures, Policy on Sexual Harassment website: <http://wustl.edu/policies/sexharas.html>