

Clinical Competency Examination Guidelines

AY 2009-2010

Overview

“THE CLINICAL COMPETENCY EXAMINATION (CCE) IS A SERIES OF COMPETENCY-BASED TASKS IN WHICH STUDENTS DEMONSTRATE TO THE FACULTY A MASTERY OF MAJOR CLINICAL ASSESSMENT AND THERAPY SKILLS.” (AU ACADEMIC CATALOG 09-10)

The Clinical Competency Examination (CCE) consists of a written case report and a transcript (both written and audio or visual) that is submitted to two clinical faculty members who will then conduct an oral examination with the student about the case. This format is designed to provide an assessment of students' knowledge and clinical reasoning ability within a conceptual model and to evaluate technical skills, relationship skills, and ability to communicate in both written and oral form. This format additionally allows the faculty to ensure that students are adequately prepared to begin their pre-doctoral internship (see Evaluation Section for a nationally recognized description of the skills necessary to begin internship). Students are expected to take the examination at the end of their third year of coursework. Students must submit a CCE Readiness Form (see Attachment) to the Clinical Training Office no later than March 2nd in order to take the exam during the standard exam period. In the event of failure, the student will be referred to the Student Professional Development Committee (SPDC) for remediation and support. The examination may be retaken once, on or before the next exam cycle with consideration of the student's remediation plan. If, after the second attempt, the examination is not successfully passed, the results of the examination will again be presented to the Student Professional Development Committee (SPDC) to determine further action.

Clinical Competency Examination Eligibility

The CCE evaluation criteria are designed to assess clinical competency at a level appropriate to students who have completed required coursework and practicum. Students are eligible to take the exam if they are in good academic standing in the doctoral program (a GPA of at least 3.0 on a scale of 4.0) and have successfully completed (or are expected to successfully complete) all course requirements [with the exception of Internship and possibly CRP] by the end of the Summer semester. In general students are highly encouraged to complete their CRP before going to internship.

Once a student has submitted the CCE Readiness Form, the Training Office will assign an Exam Committee to evaluate the student's written case report and to conduct the oral examination. Exam committees will consist of two clinical faculty members. A student's site supervisor and Practicum IV Seminar Leader is excluded from serving on a student's CCE Exam Committee.

The Exam Committee members serve only as examiners, not as advisors in preparation of the materials. The student should not consult with his/her assigned examiners about the content or structure of the examination. In the event that a student who previously failed the CCE is retaking the exam, no member of a previous exam committee may serve on the new committee.

CCE Committee Selection

By early March, each student planning to take the CCE during the standard exam period must submit a CCE Readiness Form (See Attachment) that indicates successful completion of all required coursework, the treatment modality of the case intended for presentation, and the theoretical orientation being used. This information is then utilized to match faculty expertise with the examinee's focus. The Training Office will assign an Exam Committee and will schedule a date and time for the oral examination. The student will be notified via Argosy email of their assigned examiners and the date and time of the exam.

Duties of Exam Committee Members

It is the responsibility of both examiners to review the student's written and recorded materials prior to the examination date. The committee will: query the student in a manner relevant to the case, including questions regarding the chosen theoretical approach, reformulations of case material and other psychological issues; evaluate and discuss the student's written and oral presentation; render an independent pass or fail judgment; and provide recommendations for further study, where warranted.

Immediately after the examination, the Examiners complete the Oral Examination Form and inform the student and the Clinical Training Office of the student's outcome. In the case of a split decision, the examination tape is kept for submission to a third, independent evaluator. Within 10 working days of the examination date, the examiners are responsible for submitting in writing to the Clinical Training Office, a copy of the CCE Evaluation Form and The Outcome Form (see Attachments). A copy of the written case material, along with these evaluation forms will then be placed in the student's training file. The audio/video material may then be returned to the student or destroyed by the Training Office. The tape of the examination itself will be collected by the examiners at the end of the oral examination. In the case of a split decision, the case materials and the exam tape will then be submitted to a third examiner typically the Chair or Associate Chair of the program.

The site supervisor, seminar leader, or any other appropriate person, may provide consultation

and supervision to the student with regard to any aspect of case selection and management. However, the student holds sole responsibility for organizing, conceptualizing, and communicating the case materials. The student's site supervisors may not serve as examination committee members, nor may they attend or participate in the oral examination.

STUDENT RESPONSIBILITIES

Overview

The site supervisor, seminar leader, or any other appropriate person, may provide consultation and supervision to the student with regard to any aspect of case selection and management. However, the student holds sole responsibility for organizing, conceptualizing, and communicating the case materials. The student's site supervisors may not serve as examination committee members, nor may they attend or participate in the oral examination.

Case Selection

The student should select a case for presentation that permits an adequate sampling of his or her knowledge and skill in the treatment modality used. The student must have served as the primary service provider. The case should demonstrate adequate pre-treatment evaluation, assessment, conceptualization and treatment planning, intervention, and termination management.

Students are not limited in their choice of client characteristics or problems, type or treatment modality or treatment setting. The client should have been seen for a minimum of six (6) sessions in order to ensure an adequate opportunity to demonstrate the skills listed above. The principal guideline for choosing a case should be that it fits within the framework of applied clinical psychology. For example, the student may choose a case which involves, but is not limited to: drug/alcohol group treatment, family therapy, rehabilitative psychology, forensic psychology, play therapy, long-term or short-term individual psychotherapy, or behavioral medicine.

Checklist for Students

Review CCE Guidelines (this document)

Select an appropriate client

Submit the CCE Readiness Form to the Director of Training by March 2nd

Select audio taped or videotaped session. Make one copy of session recording.

Transcribe the session recording. Make 3 copies of transcript and its analysis.

Prepare written case report. Make 3 copies of case report.

Practice for the oral presentation

Submit all materials (in 3 envelopes) to the Training Office on or before the given deadline.

Written Report Guidelines

Overview: The following categories should be addressed in structuring the written portions of the case presentation. The Exam Committee will use them in evaluating the student's performance. Adaptations of the content within the categories may be made depending on the particulars of the case. The student will submit a written case report of ten to twelve pages (max), double-spaced, using 12 pt font and one inch margins all around. The case report will include minimum of two (2) references of articles and/or books related to evidence based practice. The student will also submit a transcript, which depicts an entire therapy session and an analysis of the interventions. The written case report will include the following:

INITIAL HEADING

Date of report

Name of clinician

"Name" of client

Age of client

Date of start of treatment

Number of sessions to date

*Description of setting (e.g. "Inpatient psychiatric clinic") *DO NOT INCLUDE THE NAME OF THE TRAINING SITE*

IDENTIFYING INFORMATION

Age, sex, gender, race, sexual orientation, religion, language if other than English, marital/familial status, employment info/occupation, where/with whom the client lives.

REFERRING SOURCE AND REASON FOR REFERRAL

If the client is not seeking help on their own accord, but has been referred or mandated, indicate how and why they are there. In many cases this may simply state "self-referred".

PRESENTING PROBLEM PER CLIENT

The reason the client is seeking help. How does the client describe the problem, what is their evidence and experience of it (What symptoms does the person report? How severe are they? How chronic are they? When did they begin? How much are they interfering with functioning? Are they specific to certain situations or do they occur across situations?). Do they mention consequences of the problem or what they have done to address it? What are his or her beliefs

about what is wrong? About the appropriate treatment for his or her symptoms? Does he or she expect to get better? This should be relatively brief and be based on the client's report.

HISTORY OF PRESENTING PROBLEM

Why is the person seeking treatment now? In this section you are explaining the precipitating factors and symptoms that relate to the current presenting problem. If there is a significant history of the problem e.g. client was diagnosed as bipolar in his 20's and has had 3 hospitalizations in the past 5 years. Or, e.g. the client report's feeling depressed since childhood you can include this info in the PSYCHIATRIC history section.

PSYCHIATRIC HISTORY

(Client and Relevant Family): Include precipitating factors for seeking previous treatment, presenting problems, duration of treatment, therapist and client's manner of working together, and reason for termination. Explore the ways in which the client found previous treatment helpful or unhelpful. Also include, as relevant, history of suicidal ideation, homicidal ideation, domestic violence, childhood abuse, criminal history, legal history (if any are extensive then include in a separate section, i.e., trauma history). Include a description of their strengths and internal resources.

SOURCE(S) OF INFO

Bullet points defining sources of various information used in assessing case (could be as simple as "client/parent")

MENTAL HEALTH STATUS EXAM / BEHAVIORAL OBSERVATIONS

General components:

Begin this section with a vivid description of the client. Try to avoid subjective words like "attractive" and instead stick to what is observable... i.e., their, dress, body type, tattoos, piercing, posture, neat, dirty, etc. For example, "client wore a dirty t-shirt and had a foul odor". How do they carry themselves, sit and move? Do they have any anxious habits or gestures? What is their attitude toward you? Guarded, defensive, friendly, compliant, seductive, etc. Paint a picture of the client, we should be able to clearly visualize him/her and have a "feel" for them. (One paragraph).

Specific components:

Appearance: *the central consideration is whether the client's general appearance is appropriate or consistent with age, social position, socio-economic status, cultural and sub-cultural background and time of day.*

Behavior: This refers primarily to the client's conduct during the interview as observed by the interviewer. Reports of recent bizarre or unusual behavior from relatives or informed others should be included here. Two aspects of behavior are useful to distinguish: verbal (i.e., speech quality, speech quantity and language) and non-verbal (i.e., eye contact, facial expressions, motor activity, attitude, etc.)

Orientation: In most settings, orientation is indicated or charted as "orientated x3", i.e. the person is orientated to person, place, and time. Disorientation is most often associated with organic conditions, although it is not uncommon in severe functional disorders. Conventional wisdom suggests that disorientation problems occur most frequently with time, next with place, and least with person (associated with dissociative states and extreme impairment.)

Sensorium: This is a general term referring to the intactness of the physiological receptive system-hearing, vision, touch, and smell. It also refers to the general ability to attend and concentrate

Mood: Mood refers to the general or prevailing emotion displayed during the interview (i.e., calm, sad, cheerful, anxious, irritable, apathetic, etc.)

Affect: Affect refers to the range of emotions manifested during the interview (i.e., flat, blunted, labile, restricted, exaggerated, etc.)

Thought Content and Thought Process: Thought content refers to what the client discusses during the interview (i.e., preoccupations, delusions, compulsions, phobias, etc.) Thought Content additionally can describe patterns such as self-critical, self-doubting, blaming others or morbid thoughts, etc. Thought process refers to the mental activity as illustrated by the clients' language process (i.e., thought blocking, loosening of associations, flight of ideas, etc.) Thought process additionally describes the client's organization of ideas (i.e. logical, well-organized story-telling, rambling, tangential, etc.)

Insight: In general, "insight" refers to the clients' ability to consider himself and his situation in dynamic terms. The term also refers to his ability to be aware and observant of changes in his feeling state and behavior and his ability to place his behavior in some interpretive scheme.

Judgment: Judgment refers to the person's decision-making ability and his ability to carry out the practical affairs of living. Evaluating the client's approach to both current and past problems permits some determination about the adequacy of the decision making capacity.

Memory: Evaluation of memory is generally divided into (a) immediate, (b) recent, and (c) remote. There are no hard-and-fast criteria except for immediate memory which refers to the ability to recall things within 10 seconds of presentation.

CONTEXT AND BACKGROUND

BIOSOCIAL HISTORY

General Components: Birth/Developmental History, School/Academic History, Family History, Medical History, Substance Use/Abuse History, and Legal History.

Tell a rich story of the development of the client and relate the important events of the client's life, in order. Start at birth, give birth order context, discuss early developmental issues/ relational/ sexual identity issues/ employment issues/ the impact of culture, diversity and economic issues should be integrated and infused throughout not just noted separately. Describe development over time; how life has been shaped by these issues, chronology should be built into the developmental story. Do not interpret the meaning of events or patterns here—simply state how they are. Remember that this description should logically flow into your diagnosis and case formulation sections.

COURSE OF TREATMENT

This is not a week by week summary of what has gone on. Describe the therapeutic relationship and situation. Discuss how the person relates to you, how they see you, who are you to them? This discussion will include an analysis of the impact of cultural differences and/or similarities on the relationship. Describe how you feel: in this role, about how you are you pulled either emotionally or toward action, in the room with them and so on. Basically you are using your relationship with the client to glean info about how they relate to others and to themselves. Again, don't interpret the situation, just describe it.

DSM DIAGNOSES AND RATIONALE/DIFFERENTIAL DIAGNOSIS

List your 5-axis diagnosis, followed by your rationale and explanation of any rule outs. Rule outs should be the exception, not usual. Explain why the person should have XX diagnosis—how the circumstances of his/her life contribute to difficulties vs. just listing the DSM criteria. Remember to discuss the impact of the client's culture in your diagnostic rationale and/or your differential diagnosis.

THEORETICAL MODEL

Briefly describe your theory for conceptualizing this case.

CASE CONCEPTUALIZATION/FORMULATION

Begin by briefly restating the situation (one paragraph): who the client is and why they came to therapy.

Succinctly stated, a diagnostic formulation is an attempt to deepen our understanding of the client by placing the initial presenting problems in the broader context of characteristics, psychological strengths and vulnerabilities, which are collectively brought to bear in negotiating the demands of both internal and external reality. It should also point the way toward a treatment plan and may have implications for clinical interventions. A diagnostic formulation relies on two “levels” of information:

1. Content: what the client is able to tell you directly about the present problem, family history, interpersonal relationships, etc.

2. Process: what you can observe or assess about the client’s presenting challenges.

This section represents the core of the paper. You will conceptualize the case according to your theoretical model. There should be no new information added at this point, and other than the first paragraph (see below) there is no need to repeat things you have already said. Rather, you are trying to tie all the pieces together: past, present, symptoms, dynamics (meaning: relational patterns, self esteem, defenses, feelings, and beliefs.). You are trying to convey your empathy and understanding of the client and how and why they are struggling. You can include their ability to adapt and how their defenses have served them.

TREATMENT GOALS/PLAN

The treatment plan, including goals and appropriate intervention strategies, must be described fully. The student must be able to justify the treatment plan based on the conceptualization of the case, the theoretical model selected, and any pertinent empirical data regarding treatment efficacy.

TREATMENT APPROACH AND TECHNIQUES

Interventions during each phase of therapy must be described. The student must describe the intervention(s) in the specific session selected for presentation, and how these intervention(s) relate to the stated treatment goals. The student must analyze his or her behavior in the session with respect to the process and content of therapy. Examples of areas for critique include, but are not limited to: listening skills, empathy, structure, and confrontation. The critique should refer to specific interchanges between therapist and client(s) in the transcript/tape. Note: This description should match what you say and do in your transcript, as well as correspond clearly to your theoretical orientation and case formulation.

TRANSCRIPT

Present in two columns. Left column should show transcript. Right column should be used for your analysis of what you said and did and why as well as what you were thinking and feeling.

This analysis will include how you may have alternatively responded to the client (i.e. “if I had said ABCD, we may have been more able to XYZ” or “This response seemed disconnected from my general orientation” or “Here I missed an opportunity to explore the differences between us” -etc).

ORAL PRESENTATION GUIDELINES

Overview

At the beginning of the meeting, the student will be asked to present the panel with any updates in the work since the written report and to provide the examiners with relevant additions to the analysis in the written report. The oral presentation should build upon, but not repeat, the basic information conveyed in the written report. This brief presentation should not exceed ten minutes in length and should emphasize important reflections about the case that were not included or emphasized in the written report.

Oral Examination: The majority of the time is allotted to the critical evaluation of the student's ability to handle the committee's in-depth exploration of his or her knowledge, clinical reasoning, and clinical skills. The student is required to think on his or her feet, to consider and evaluate other possible interventions, to contrast modalities, to support or reformulate the approach taken, and to demonstrate knowledge of related psychological issues. A key component of the examination will be an assessment of the student's ability to apply his or her clinical knowledge to meet the needs of the case at hand. The examiners will ask questions based on their reading of the written report. These questions may include but are not limited to:

Basic questions about the client and reason for referral.

Questions about the conceptual formulation used in the case.

Questions about the student's understanding of the theoretical model chosen and how it applies to the case.

Questions concerning the therapeutic interventions that would include specific discussion of the treatment goals, specific intervention strategies employed, as well as published empirical support for treatment decisions.

Questions about termination rationalization/plan.

Questions about possible ethical implications or dilemmas.

Questions about cultural issues and how diversity is addressed and handled in the work.

Questions regarding assessment and differential diagnosis.

In all cases, the committee is free to explore and test the student until the committee is satisfied that it can render an accurate decision. It is at the discretion of the committee to determine how the oral examination is structured.

AUDIO TAPED OR VIDEOTAPED SESSION

An audio tape, CD, or videotape of a therapy session must be submitted to the Exam Committee at the same time as the written case material. A single copy of the recording is sufficient as it will be shared by the two examiners. A written consent for recording must be present in the client's clinical chart at the practicum site.

The student is responsible for submitting a recording of adequate quality to enable the examiners to hear the audio recorded therapy session; a written transcript will not suffice as a substitute for a recording of inadequate quality. The student's interpersonal skills as a therapist must be demonstrated on the recording. Otherwise, the recording will not be acceptable (e.g., a tape of relaxation or hypnosis exclusively would not be acceptable). Presentation of inaudible recordings may result in postponement of the CCE until such time as an adequate quality recording can be provided. In some instances, either recording is not allowed by an agency, or it is determined by the student and his or her supervisor that recording would compromise the therapeutic process or therapeutic relationship. In such cases, the rationale for not recording must be addressed in the written case presentation and a letter from the supervisor must be included that documents the agency's policy.

METHOD OF EVALUATION

EVALUATION OF THE CCE

Each of the following criteria is designed to evaluate the student's written and oral performance in one or more of the following areas: knowledge-based clinical reasoning, technical skills, relationship skills and formal communication skills. These criteria are intended to represent minimal proficiency in each area outlined. The student must pass each of the following by the end of the oral presentation to pass the CCE. Please see the Clinical Competency Exam Evaluation Form (attached) for the overall evaluation categories. The faculty examiners will additionally be utilizing the nationally recognized Developmental Achievement Levels', which describe the competencies that should be mastered prior to attending internship in further detail:

From the National Council of Schools and Programs in Professional Psychology document: Competency Developmental Achievement Levels (DALs) of the National Council of Schools and Programs in Professional Psychology July 29, 2009

Developmental Achievement Levels

Interviewing and Relationships

A. Knowledge

1. Working knowledge of models and techniques of clinical interviewing (e.g., structured, semi-structured, mental status exams)
2. Knowledge of the content of psychosocial history and mental status exam

B. Skills

1. Ability to conduct a detailed assessment interview and gather data for a psychosocial history and mental status exam
2. Ability to assist client and referral source in developing a referral question and clarifying limitations of assessment
3. Ability to obtain historical information from collateral sources and to integrate it with self-report data
4. Ability to consult with supervisor as appropriate

C. Attitude

1. Willingness to tolerate ambiguity, conflict and stress

Case Formulation

A. Knowledge

1. Working knowledge of diagnostic systems and awareness of the strengths and weaknesses of those systems
2. Working knowledge of models of psychological strength and psychological problems

B. Skills

1. Ability to generate differential diagnostic possibilities
2. Ability to communicate findings in written form
3. Ability to identify strengths and weaknesses of individuals and systems being assessed
4. Ability to conduct a feedback session with the client and other relevant parties

C. Attitude

1. Willingness to think critically and with an open mind about alternative

hypotheses

Psychological Testing

A. Knowledge

1. Knowledge of constructs and theories underlying tests and testing methods
2. Knowledge of strengths, weaknesses and limits of applicability of standard intellectual and personality measures
3. Knowledge of the methods of norming tests and implications for test usage with diverse populations
4. Knowledge of constructs and theories underlying psychological tests and psychological testing methods

B. Skills

1. Ability to administer and score intellectual and personality measures and to begin the process of integrated interpretation, under supervision
2. Ability to identify appropriate measures and sources of information for referral questions in order to answer the questions
3. Ability to identify and adapt assessment methods for unique individual, with supervision
4. With supervision, ability to use critical thinking in evaluating all sources of data in order to prepare an integrative report and offer feedback

C. Attitude

1. Respect for value of psychological testing and assessment

Ethics and Professionalism

A. Knowledge

1. Knowledge of legal and ethical principles and guidelines involved in assessment and knowledge of potential courses of action

B. Skills

1. Ability to identify potential legal and ethical issues and address these, with supervision

C. Attitude

1. Willingness to critically examine test results, in light of diverse populations and normative data
2. Willingness to examine the applicability of ethical and legal issues in the context of assessment with diverse population

Professional Demeanor

A. Knowledge

1. Knowledge of how relationships are central to the multiple roles of professional psychologists
2. Knowledge of norms for professional relationships

B. Skills

1. Demonstration of comfort and confidence in role of psychology trainee and recognition of when that comfort and confidence is lacking

C. Attitude

1. Initiation of integration between professional identity and sense of self

Self

A. Knowledge

1. Knowledge of theories and models for personal and cultural identity

B. Skills

1. Ability to identify own strengths and weaknesses vis a vi relationship
2. Engagement in appropriate self care especially as it relates to ability for professional relationships
3. Awareness of biases and blind spots with regard to relationships
4. Participation in honest and productive self reflection
5. Comfort in varying roles, or ability to address its lack
6. Ability to recognize, tolerate, & use one's affect in professional relationships

7. Ability to seek support when needed, including being able to collaborate, do a realistic self assessment, and recognize relationship ruptures

C. Attitude

1. Ability to tolerate ambiguity in relationships, including not knowing and not having the answers
2. Attainment of a strong sense of self

Others

A. Knowledge

1. Knowledge of, and respect for, the complexity of diversity across different cultural groups, and perspectives
2. Understanding of a systems perspective and the contextual nature of relationships
3. Acquisition of a broad fund of knowledge of personality styles and ability to adjust relationships based on those styles
4. Knowledge of norms in a variety of contexts (broadly defined, and relevant to student's specialty and previous work, cultural, professional, by setting)
5. Attainment of a theoretical understanding of how relationships apply

Treatment

B. Skills

1. Ability to evaluate norms in a variety of contexts (broadly defined, and relevant to student's specialty and previous work, cultural, professional, by setting)
2. Application of contextual information to adjust and enhance professional relationships

C. Attitude

1. Recognition of autonomy and values differences of client

2. Appreciation of other disciplines and professions

Interpersonal Connection

A. Knowledge

1. Knowledge of therapeutic alliance
2. Knowledge of groups and their dynamics
3. Knowledge of the importance and process of metacommunication, reflexivity or processing of relationships
4. Awareness of the possibility of taking a metaperspective on, or stepping back to view, oneself and one's relationships

B. Skills

1. Ability to form a therapeutic alliance
2. Basic ability to engage others around difficult issues
3. Basic ability to work with others to reflect upon the nature of one's relationship with them
4. Beginning ability to negotiate/accept disagreements
5. Developing ability for metacommunication to repair or learn about relationship ruptures
6. Ability to communicate hope

C. Attitude

1. Attainment of a strong sense of flexibility within relationships including intervening flexibility
2. Commitment to serving the needs of the client (not own needs)
3. Curiosity and openness regarding interpersonal exchange
4. Openness to giving and receiving feedback

Cultural Adaptability

A. Knowledge

1. Explicit exploration of issues of power and privilege
2. Empathic understanding of marginalization and differences in worldviews

B. Skills

1. Attainment of flexible verbal and nonverbal skills
2. Ability to negotiate expectations for working together given similarities and differences
3. Ability to self-reflect and self-correct with help from others

C. Attitude

1. Valuation of ICDs within the relationship
2. Valuation of non-defensive and honest dialogue regarding ICDs
3. Valuation of self-correction with help from others

Ethics

A. Knowledge

1. Understanding of legal & ethical requirements of the profession and how they relate to developing professional relationships
2. Knowledge of common ethical dilemmas within populations in their experience

B. Skills

1. Ability to articulate some understanding of the legal and ethical requirements of a professional psychologist and see how they relate to developing professional relationships
2. Ability to recognize ethical dilemmas and relational issues involved with them
3. Ability to usually engage in self-correction of inconsistencies in verbal and nonverbal behavior and in use of power

C. Attitude

1. Recognition of others' autonomy and differences
2. Demonstration of respect for self, others and the profession both verbally and nonverbally

Intervention Planning

A. Knowledge

1. Knowledge of ways biopsychosocial factors create and maintain risk and protective factors involved in mental health
2. Knowledge of theories and their application
3. Understanding of history, benefits & limitations of Evidence Based Practice (EBP) and other interventions

B. Skills

1. Ability to prioritize biopsychosocial factors maintaining the presenting problem
2. Ability to apply a theory to guide interventions in treatment plan
3. Ability to apply increasingly sophisticated interviewing skills across broader range of populations & settings
4. Ability to modify case formulation in collaboration with supervisor
5. Ability to collaborate with clients on treatment plan & orient client to treatment process
6. Ability to explain rationale for selection of treatment strategy and Ability to change as necessary
7. Ability to utilize appropriate interventions with clients based on diagnostic considerations
8. Ability to conceptualize a case from one theoretical model

C. Attitude

1. Openness to: multidisciplinary consultation, multiple sources of information & scientific inquiry
2. Appreciation of affective nature of treatment and potential ambiguity, Ambivalence and negative feeling states

3. Belief in possibility of change & attitude of hope & optimism
4. Increased acceptance of use of self as instrument of change
5. Deepened appreciation of client's life experience

Intervention Implementation

A. Knowledge

1. Expanding knowledge of appropriate treatment interventions for various clients & presenting problems, based in the scientific literature and clinical experience
2. Advanced knowledge of therapeutic processes
3. Growing awareness of one's personal abilities and limits in regard to various interventions
4. Advanced knowledge of issues & tasks in termination

B. Skills

1. Increased mastery of communication and relational skills
2. Ability to carry out more complex interventions in context of a working professional relationship
3. Ability to build and maintain a treatment alliance
4. Ability to consider various interventions for client & presenting problem
5. Ability to prioritize problems to be addressed
6. Ability to plan, evaluate or modify interventions using supervision, consultation and/or the literature
7. Ability to be reflective and mindful of one's abilities and limits, and how they affect interventions and outcomes
8. Ability to reflect more globally on one's own self in relation to clinical work
9. Ability to terminate appropriately, with sensitivity to the issues at hand

C. Attitude

1. Desire to help others resolve problems within the bounds of a professional relationship
2. Appreciation of client strengths, resiliency and effectiveness
3. Appreciation of the value of continued new experiences and learning
4. Willingness to explore attitudes and feelings about therapeutic process issues
5. Desire to explore one's own role and influence in the clinical encounter
6. Appreciation of the value of receiving supervision, consultation and guidance
7. Openness to reflecting on clinical errors and a desire to adjust interventions as necessary
8. Openness to negative or critical feedback
9. Appreciation of the empirical basis for clinical intervention, and a desire to integrate this with professional experience

Intervention Evaluation

A. Knowledge

1. Knowledge of research methodology
2. Knowledge of broad repertoire of conceptual/theoretical frames that inform and structure intervention evaluation

B. Skills

1. Ability to ask for, incorporate & implement critical feedback
2. Ability to monitor ongoing treatment program
3. Ability to seek evidence for and against treatment effectiveness
4. Ability to discriminate errors in outcome assessment measures

C. Attitude

1. Openness and non defensiveness of examining one's own attitudes, behaviors & impact on others
2. Appreciation of the impact of one's internal states on assessment of clinical outcomes
3. Tolerance of ambiguity and affect
4. Willingness to incorporate & discern multiple perspectives & approaches to evaluation

Ethics

A. Knowledge

1. Expanded knowledge of ethical/legal guidelines based on real experience with clients
2. Knowledge of practice management skills across various settings
3. Knowledge of strategies for self-reflection and self-care
4. Increased knowledge of specific licensure requirements
5. Awareness of clinical interests and strengths
6. Awareness of the legal and ethical considerations in handling special situations (e.g., homicidality, suicidality, abuse, neglect, ethical challenges), and the need for supervision in handling them

B. Skills

1. Ability to apply the ethical/legal guidelines to real clients with supervisory assistance
2. Demonstration of professional management skills in applied setting with regular supervision
3. Ability to observe and discuss one's responses to therapeutic interventions of clients with supervision

4. Ability to recognize special situations (e.g., homicidality, suicidality, abuse, neglect, ethical challenges), report them when appropriate, and with supervision, address them clinically

C. Attitude

1. Valuation of ethical/legal guidelines
2. Appreciation of practice management skills across various settings
3. Willingness to self-reflect through supervision
4. Appreciation of the concept of lifelong learning
5. Internalized sense of professional responsibility and ethics

Clinical Competency Exam

OUTCOME

The committee members will review the written materials and the recording prior to the meeting. Prior to inviting the student into the room for the oral exam, the Exam Committee members discuss their initial evaluation of the criteria relating to the written materials and the recording and decide on specific areas to be explored during the oral exam. The student's performance on the oral exam may compensate for some difficulties in the written and/or recorded portions of the exam.

During the oral exam, the committee will ask questions in order to arrive at independent ratings of "Sufficient Progress", "Outstanding Progress" or "Insufficient Progress" for each of the criteria outlined in the CCE Evaluation Form. Once each member is satisfied that he or she is able to rate the student in each of the areas, the student is excused and the committee meets to arrive at a consensual rating. The committee is encouraged to call the student back if more information is needed to reconcile a discrepancy in ratings. If no agreement can be reached, the tape of the oral examination itself as well as all written materials and the recording of the session will be submitted to a third evaluator to resolve the discrepancy. If the Exam Committee reaches consensus the CCE Outcome Form will indicate:

Pass with Distinction: This indicates superior performance beyond the student's developmental level in the program. Evidence of diagnostic skill, therapeutic effectiveness and outstanding clinical judgment and competence is demonstrated throughout the CCE evaluation process. The student is well prepared to enter the next level of training. A Pass with Distinction which is

rarely given, indicates exemplary understanding, knowledge base, and integration of theory and practice.

Pass: This indicates an appraisal that the student's overall performance is comparable to other students at her or his developmental level in the program. The student has demonstrated developmentally appropriate proficiency according to the guidelines, and is prepared to enter the next level of training. Students have demonstrated the ability to integrate theoretical knowledge and case material into a cohesive and organized assessment or case summary.

Pass Pending Revision: This indicates an appraisal that the student's written manuscript or oral defense contained some weakness or inadequacy. The written document may display poor professional writing skills or sloppiness, or there may be inadequate display of knowledge or conceptual ability. There must be adequacy of content at the deep structure level and sufficient demonstration of competence in assessment and intervention, albeit with some weaknesses, to justify a decision of Pass Pending Revision rather than Failure. Based on feedback from the examiners, the student must complete revisions as required within 30 days of the examination. Upon successful completion of revision, the result is passing. If the revisions are not completed or are not satisfactory, the decision will revert to Fail.

Fail: This indicates an appraisal that the student's written manuscript and or oral presentation and defense, demonstrates deficiencies. The student has not demonstrated sufficient competence in assessment, intervention, clinical judgment or skill. Submission of a document that does not meet the standards of graduate study may result in a Failure. These deficiencies indicate that the student has not yet mastered the body of knowledge or clinical skill to enter a clinical internship. A plan of remediation is warranted.

Failure and Remediation Policy:

If a student fails the exam, he or she will be referred to the Student Professional Development Committee in order to establish a remediation plan. Once the remediation process is complete, the student may apply to retake the examination on or before the next exam cycle. During the remediation process, the student may make use of all training resources available at Argosy University/San Francisco Bay Area, including advanced practicum experiences and seminars, coursework and advisement with faculty. The student is encouraged to obtain written and oral feedback from the exam committee following the examination and to discuss this feedback with his/her advisor, seminar leader, and other faculty as appropriate.

The student is encouraged to obtain consultation regarding all phases of the remediation process from his or her advisor and other faculty as appropriate. It is each student's

responsibility to fully participate in implementing the remediation process. Students may be required to fully pass the exam before being cleared to begin an internship. A student failing the CCE twice will be referred to the SPDC for further action and a referral to the Student Conduct Committee, which may include a possible recommendation for a dismissal from the program.

Appeals of CCE Decisions

While engaging with the SPDC, a student may submit a written appeal to the program chair no later than 15 days after receiving the exam results. The program chair or assistant program chair will then review all student materials, the evaluation reports and the recorded exam session itself. The program chair would then make recommendations to the SPDC.

After the chairs review, any student wishing to pursue an appeal of his or her Exam Committee's decision, or who believes that they have been treated in a biased fashion, or without due process, should consult the section of the Argosy University Academic Catalog regarding appeals.

References

Relevant resources for case formulation, outcome literature, and therapy from different perspectives.

**** Also, additional CCE reference materials are available in the library.****

Case Formulations - General

*Eells, T. (Ed), (2007). *Handbook of psychotherapy case formulation, 2nd ed.* NY: Guilford.
CCE RC 473.C37 H46 2007

(Chapters on theoretical case formulation, consult this first, as it presents some classic articles on approach to formulation in beginning of text.)

Paniagua, F., (2001). *Diagnosis in a multicultural context: A casebook for mental health professionals.* Sage. **CCE RC 455.4 E8 P36 2001 (Bookrack on Windowsill)**

Psychodynamic Therapy and Case Formulation

Berzoff, J., Flanagan, L., & Hertz, P., (2008). *Inside out and outside in: Psychodynamic clinical theory and practice in contemporary multicultural contexts, 2nd ed.* NY: Jason Aronson.
CCE RC 489.P72 B47 2008 (Bookrack on Windowsill)

Casement, P. (2002). *Learning from our mistakes: Beyond dogma in psychoanalysis and psychotherapy.* NY: Guilford. (Jargon free book looks at therapy from client and therapist angles.) **CCE RC 506.C3196 2002 (Bookrack on Windowsill)**

Freud, S.(1978).*The question of lay analysis: Conversations with an impartial person.* Anchor Books. **CCE BF 173.F632 1964 (Bookrack on Windowsill)**

*McWilliams, Nancy. (1999). *Psychoanalytic case formulation,* NY: Guilford.
(Psychodynamic formulation) **CCE RC473 .C37 M38 1999 (3 copies-1 on Reserve; 1 in GC & 1 on Bookrack on Windowsill)**

McWilliams, Nancy. (1994). *Psychoanalytic diagnosis: understanding personality structure in the clinical process.* NY: Guilford Press. **CCE 4 (3 copies- 1 on Reserve; 1 in GC & 1 on Bookrack on Windowsill)**

McWilliams, Nancy. (2004). *Psychoanalytic psychotherapy: A practitioner's guide.* Guilford, NY. **RC504.M33 2004 (2 copies-1 on Reserve &1 in GC)**
(Very clear approach to dynamic therapy.)

Schafer, R.(1983). *The analytic attitude.* Kamaac Books. **RC509 S347 1993**
(Classic book on therapist attitude from dynamic perspective.)

St. Clair, M. & Wigren, J. (2004). *Object relations and self psychology - An introduction*, 4th ed. Wadsworth. **BF 175.5 .O24 S7 2004 (Reserve)**

Cognitive Behavioral Therapy & Case Formulation

Beck, J. S. (1995). *Cognitive therapy: Basics and beyond*. NY: Guilford.
CCE RC 489 .C63 B43 1995 (1 copy in GC; 1 on Bookrack on Windowsill)

*Bruch, M. & Frank W. Bond, F.W. (Eds), (1998). *Beyond diagnosis: Case formulation approaches in CBT* John Wiley & Sons. **CCE RC 473 .C37 B49 1998 (Bookrack on Windowsill)**

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. NY: Guildford. **RC 569.5 .B67 L56 1993**

*Persons, J. B. (1989). *Cognitive therapy in practice: A case formulation approach*. W. Norton, NY. **CCE RC 489 .C63 P47 1989 (Bookrack on Windowsill)**

Family Therapy & Case Formulation

Gehart, D. R & Tuttle, A. R (2003). *Theory-based treatment planning for marriage and family therapists: Integrating theory and practice*. Pacific Grove, CA: Brooks/Cole-Thomson Learning. **RC 488.5 .G4187 2003**

Griffin, W. A. & Greene, S. M. (1999). *Models of family therapy: The essential guide*. Philadelphia, PA: Taylor & Francis. **CCE RC 488.5 G753 1999 (Bookrack on Windowsill)**

Home, A. M. (2000). *Family counseling and therapy*, 3rd ed. Belmont, CA: Brooks/Cole. **RC 488.5 .H63 2000**

McGoldrick, M., Giordano, I., & Pearce, I. K. (2005). *Ethnicity and family therapy*, 3rd ed. NY: Guildford. **RC451.5 .A2 .E83 2005 (3 copies)**

McGoldrick, M., Gerson, R, & Shellenberger, S. (2000). *Genograms: Assessment and intervention*, 2nd ed. NY: Norton Professional Books. **RC 488.5 M395 1999**

Morgan, A. (2000). *What is narrative therapy: An easy-to-read introduction*. Adelaide, South Australia: Dulwich Centre. **RC489 .S74 M67 2000 (1 copy in Reference)**

Minuchin, S. (1998). *Family healing: Strategies for hope and understanding*. NY: The Free Press. **CCE RC488.5 M555 1998 (Bookrack on Windowsill)**

Napier, A. Y. with Whitaker, C. (1998, reissue). *The family crucible: The intense experience of family therapy*. NY: Harper Paperbacks. **RC 488.5 .N361 1978**

Existential & Humanistic Therapy

Bugental, James F. T. (1999). *Psychotherapy isn't what you think: Bringing the psychotherapeutic engagement into the living moment*. SF: Zeig, Tucker & Theisen.
CCE RC 489 .E93 B84 1999 (Bookrack on Windowsill)

(see www.Psychotherapy.net, Articles sections, for last chapter of this book.)

*Bugental, J. T. (1992). *The art of the psychotherapist*. NY: W.W. Norton. **RC 480 .B75 1987**

Maslow, Abraham H. (1968). *Toward a psychology of being, 2nd ed.* NY: Van Nostrand Reinhold.
BF 698 .M338 1968 (2copies)

May, R. (1969). *Love and will*. NY: Norton. **BF 692 .M34 1969**

"Yalom, I. (2002). *The gift of therapy: An open letter to a new generation of therapists and their patients*. NY: Perennial Currents. **RC 480 .Y35 2002**

*Yalom, I. (1980). *Existential psychotherapy*. NY: Basic Books.
RC 489 .E93 Y34 1980 (2 copies)

Outcomes & Empirical Work on Psychotherapy

Carr, A. (2000). *What works with children and adolescents? A critical review of psychological interventions with children, adolescents and their families*. NY: Routledge.
REF RJ504. W53 2000

Christophersen, E. R. & Mortweet, S. L. (2001). *Treatments that work with children: empirically supported strategies for managing childhood problems*. Washington DC: American Psychological Association. **RJ 499 C492 2001**

Duncan, B. L., Miller, S. D., & Sparks, J. A. (2004). *The heroic client: A revolutionary way to improve effectiveness through client-directed, outcome-informed therapy*. San Francisco: Jossey-Bass/Wiley **RC 481.D86. 2004**

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (2009). *The heart and soul of change: Delivering what works in therapy (2nd ed.)*. Washington, DC: American Psychological Association. **REF RC480.52 H43. 2010 (1 copy in Reference)**

*Fonagy, P., Target, M., Cottrell, D., Phillips, J., & Kurtz, Z. (2005). *What works for whom? : A critical review of treatments for children and adolescents*. NY: Guilford.
RC 480.52 .R669 2005

*Hubble, M., Duncan, B. & Miller, S. (Eds), (1999). *The heart and soul of change: What works in therapy*. Washington DC: American Psychological Association. **RC 480.52 .H43 1999**

Kazdin, A. E. & Weiss, J. R. (2003). *Evidence-based psychotherapies for children and adolescents*, Guilford Press, NY. **REF RJ 504 .E95 2003**

*Nathan, P. E. & Gorman, J. A. (Eds), (2007). *A guide to treatments that work*, 3rd ed. Oxford University Press. **CCE RC 480.5 .G85 2007 (Bookrack on Windowsill)**

*Norcross, J. E. Beutler, L. E., & Levant, R. E. (Eds), (2005). *Evidence-based practices in mental health: debate and dialogue on the fundamental questions*. Washington DC: American Psychological Association.
RC 455.2.E94 E955 2006 (3 copies-1 in GC, 1 on Bookrack on Windowsill, & 1 on Reserve)

*Norcross, J. N. (2002). *Psychotherapy relationships that work: Therapists contributions and responsiveness to patients*. Oxford University Press.
CCE RC 480.8 P78 2002 (Bookrack on Windowsill)

Wampold. B. E. (2001). *The great psychotherapy debate: models, methods, and findings*. NY: Lawrence Erlbaum Associates. **CCE RC437.5 .W35 2001 (Bookrack on Windowsill)**

Psychotherapy – General

Bender, S. & Messner, E. (2002). *Becoming a therapist: What do I say, and why?* NY: Guilford.
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Budman, S. H. & Gunnan, A. S. (1988). *Theory and practice of brief therapy*. NY; Guilford.
CCE RC 480.55 .B83 1988 (Bookrack on Windowsill)

*Gi1, E. (1991). *The healing power of play*. NY: Guilford.
CCE RJ 507.A29 G55 1991 (Bookrack on Windowsill)

Miller, W. R., Rollnick, S., & Conforti, K. (2002). *Motivational interviewing: Preparing people for change*, 2nd ed. NY: Guilford. **RC 533 .M56 2002**

*Pipes & Davenport. (1999). *Introduction to psychotherapy: Common clinical wisdom*, 2nd ed. Prentice Hall College Division. **RC 480 .P48 1999**

*Sharma, Sohan. (1995)~ *The therapeutic dialogue: A guide to humane and egalitarian psychotherapy*. Jason Aronson, NY.

Winston, A., Rosenthal, R.N., Pinsky, H., & Winston, A.M. (2004). *Introduction to supportive psychotherapy*. NY: American Psychiatric Association.
CCE RC 489 .S86 W55 2004 (Bookrack on Windowsill)

Ethics & Law

American Psychological Association. APA Ethics site: <http://www.apa.org/ethics>

California Board of Psychology. <http://www.psychboard.ca.gov/index>

California Psychological Association: <http://www.cpapsych.org/>

Fisher, Celia. (2009). *Decoding the ethics code: A practical guide for psychologists*. NY: Sage.
REF BF 76.4 .F57 2009 (2 copies)

Nagy, Thomas F. (2004). *Ethics in plain English: An illustrative casebook for psychologists, 2nd ed.*
Washington DC: APA. **REF BF 76.4 .N34 2005**