



DEPARTMENT OF
PSYCHOLOGY
College of Liberal Arts
& Social Sciences

PSYC 6160 – Couple & Family Therapy II

Spring 2018 TH 140
Thursday, group supervision 12:30 – 3:30,
intervention/consultation 4-8:00

Instructor: Shelley A. Riggs, Ph.D.
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TA/TF: Jimmy McGuffin, M.S.
Office Hours: TH 324/Tue 10:00 – 12:00,
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Course Description: This course will combine didactic instruction with applied intervention and supervision. The focus will be on the application of principles of psychological counseling to facilitate constructive changes in the couple and family systems. Students will conduct couple/family assessments and therapy, and receive ongoing weekly group supervision and periodic live supervision. Therapeutic approaches will include EFT and structural family therapy.

Course Objectives: Students will...

1. demonstrate competence in basic family/couple counseling skills.
2. develop through practice skills in family/couple treatment planning and family therapy, primarily based in structural and EFT orientations.
3. gain experience in family/couple oriented assessment methods, report writing, and progress notes.
4. learn to recognize and address the impact of diversity issues on family/couple process and intervention.
5. attend to the special ethical concerns and responsibilities of family psychologists.
6. develop peer supervision and support skills.
7. gain experience in the integration of the scientist-practitioner model in single subject case design evaluation of family therapy effectiveness (i.e., pre- and post-treatment assessments).

Textbooks:

Hertlein, K.M., & Viers, D. (2005). *The couple and family therapist's notebook*. NY: Haworth. (HV)
Sherman, R., & Fredman, N. (1986). *Handbook of structured techniques in marriage and family therapy*. Levittown, PA: Brunner/Mazel. (SF)
Selected readings as assigned

Also from PSYC 6150:

Gehart, D. (2017/2018). *Mastering competencies in family therapy: A practical approach to theories and clinical case documentation, 3rd edition*. Belmont, CA: Brooks/Cole. [G]
Johnson, S.M. (2004). *The practice of emotionally focused marital therapy: Creating connection, 2nd ed.* Philadelphia, PA: Brunner/Mazel.
Minuchin, S. (1974). *Families and family therapy*. Cambridge, MA: Harvard University Press.

Recommended:

Minuchin, S. & Nichols, M.P. (1992/2008). *Family Healing: Strategies for Hope and Understanding*. Freepress.
Minuchin, S., Nichols, M.P., & Lee, W.Y. (2006). *Assessing Families and Couples: From Symptom to System*. Allyn & Bacon.

Course Requirements:

1. Act as Primary Couple/Family Therapist:

- a. Complete eight weekly family intervention sessions in the role of primary therapist (no session during spring break). You are not allowed to cancel a session – contact Dr. Riggs immediately in the event of severe illness or emergency. However, if your family cancels/no-shows, it may be possible to extend therapy by one week. Hopefully, this will not happen because all families are informed of the therapy days/times and have committed to 10 weeks of participation.
- b. Avail yourself to peer consultation and/or instructor supervision as least once per session.
- c. Record and review all your therapy sessions each week. It is not possible for everyone to show video each week in group supervision. Unless family treatment issues take precedence, student therapists not receiving live supervision from the instructor or TA one week will be expected to show 10-15 minutes of video in class the following week, averaging 4-5 recorded segments during the semester. The remainder of group supervision time will be devoted to discussion and feedback on other cases.



To get the most out of supervision, you should be prepared to start the video at the point in session where you think you have engaged successfully in a particular intervention strategy or alternatively where you became stuck and would like to consult for advice with your peers and supervisor. A balance between “yippee, look at me” and “help, help!” video is optimal.



- d. Meet 30 minutes per week with your consultant to discuss and plan *your* case. If you are a consultant to your consultant, you must meet for a minimum of 60 minutes (30 min per case) per week; if you’re paired with a different consultee, you will meet for 30 min. with the consultant and 30 min with the consultee. We **strongly recommend** scheduling the consultation session prior to completing your pre-session worksheets due Tuesday, because you should be discussing and making your plans with your consultant.
- e. If you feel the need for more focused supervision, make an individual appointment with the TA or Dr. Riggs as needed.
- f. Complete weekly pre-session worksheets. Keep a copy and turn in the original to the TA’s clinic box each Tuesday morning by 10:00 a.m. The TA will pass them on to Dr. Riggs.
- g. Complete ongoing progress notes of treatment in the Clinic’s electronic Titanium system (see manual). Use clearly identified DAP format with concise structural/EFT language – do NOT exceed one page (single-spaced, 12-pt font). Progress notes and reports must be ready for supervisor review by noon Tuesday following the session. Please do NOT sign the note – this will allow Dr. Riggs to make minor edits, then either approve or send back to you with comments/major revisions. You are expected to make necessary revisions and resubmit to Dr. Riggs within one week to maintain up-to-date electronic records.
- h. Complete 2 assessment reports (see #6). Label the first report “Intake/Pre-treatment Assessment Report” and label the second report “Post-treatment/Termination Report.”
- i. The WAI is to be completed by all adults in the family before the 2nd, 5th, and 8th sessions. For these sessions, the families should be told to arrive 15 minutes early to complete the WAI. *It is the clinician’s responsibility to ensure the WAI is completed and the data is entered into Titanium.*

- j. Consult with outside professionals/agencies as necessary AFTER obtaining the necessary release forms. For example, if there are school problems, it would likely be helpful to get the family's permission for school personnel to complete the TRF and/or speak with the therapist. If extra-familial professionals/agencies are involved, release forms are needed and all contacts should be sufficiently documented in Titanium.
- k. Any correspondence or other written material regarding the case must be signed by the primary therapist and the supervisor.

2. **Act as Peer Consultant:**

- a. The consultant role is to provide assistance, support, and a more objective view of the family process to the primary therapist.
- b. Assist the primary therapist with the pre- and post- assessments of the family. You are *required* to be present for your consultant's assessment in order to help with the administration, as well as to read, check and provide feedback on the primary therapist's assessment report in a timely manner so s/he can incorporate your feedback by the due date.
- c. Complete eight sessions behind the mirror in the role of consultant; observe all sessions, provide an ongoing record of the session for the primary therapist, and be available for the mid-session consultation each week.
- d. Complete evaluation form of each therapy session reflecting the therapist's strengths, weaknesses, and techniques used. Turn in the original to the TA's Clinic box each Tuesday by 10:00 a.m. with your pre-session worksheets, give a copy to your primary therapist and use as basis for feedback re: the session and recommendations for future implementation.
- e. Discuss pre-session/post-session goals with the primary therapist during the weekly meeting.

3. **All students:** Therapy will be scheduled each Thursday 4-8:00. You will be providing therapy one hour, in-vivo consulting for one hour, and participating in live supervision sessions for one hour in Rm 140. The off-hour is intended to give you a break (e.g., dinner, rest, reflection/debriefing), so do not plan your consultation hour for that time period. In live supervision, we will discuss the ongoing family therapy session and develop recommendations for the mid-session consultation so the consultant should be in 140 when their consultee's case is being viewed, then behind the mirror with TA at other times. For APPIC, live supervision sessions count toward supervision hours for both the therapist and observers.

4. **Initial Case Preparation:** If not done already, complete a blue sheet for your assigned case. The TA will provide you with a list of assessment instruments that should be administered; some will be administered in-house, others can be sent home for parents to complete prior to the assessment session. Create a pre-session packet of clinic forms and relevant assessment instruments (see assessment checklist). To avoid the labor of redacting identifying data later, fill in the "name" blank for each instrument with initials/age of the family member to complete it. On clinic forms, you should fill in the full name of the person(s) who will complete the forms you send in the packet.

- a. First Contact: After checking the availability of your peer consultant, contact by phone the couple/family on January 18th or 19th (do NOT delay this call) to schedule the initial intake/assessment session during the week of Jan 29- Feb 2 (possibly week before if the packets are mailed immediately and received/completed *before* the administration date).
 - i. Inquire regarding the general nature of the presenting problem but do NOT get into a long discussion with them on the phone.
 - ii. If TA has already identified an IP with the family during earlier communications, reconfirm this selection. If not, and if there are children, ask them to identify which child(ren) is(are) of most concern (IP). For assessment purposes, limit IP to one person unless significant concerns are noted for more than one family member.
 - iii. Obtain address and inform family that you will be sending them a packet of test instruments to complete *before* the intake/assessment session; mail packet ASAP.

Emphasize importance of completing the instruments and bringing them to the assessment session. Inform them that you have labeled each instrument with initials/age of the family member to complete it, then ask them to refrain from writing their names on any of the test instruments.

- iv. Schedule the assessment and inform family that it will take approx. 2-3 hours *depending on the family composition and whether they complete the instruments mailed to them before the session*. So assessments should begin by 5:00 p.m.
 - v. If the IP is a child in school, inform them that the assessment packet will include a Release of Information form and request that the parent *immediately* sign and mail it to you, identifying the name(s) and address of teacher(s) who should complete a TRF.
 - b. Confirmation with client: Confirm the assessment date AND the first therapy session on Feb 8, repeating the Thursday time of the eight regular 50-min. sessions (no session during spring break). Remind them of the end date with the last assessment session the week of April 9-13 (or April 16-20 if a make-up therapy session was needed).
 - c. Schedule a clinic room accordingly (clinic classrooms are OK to administer paper/pencil tests, especially if it is big family). The 3 family rooms will be available for our class assessments each Thursday from 4-8:00. For those rooms at those times only, you need to coordinate with the TA so contact him ASAP. For other rooms and other times, you are responsible for scheduling the room(s).
 - d. Discuss with your consultant other instruments you may want to administer in session. If any are identified, please check with TA or instructor before administering.
5. ***Descriptive Summary, due 2/8:** For the class following the initial assessment, write a one-page descriptive summary of your family that includes: essential demographic data, one paragraph statement of referral problem and background, one paragraph initial clinical impressions, and structural hypotheses. Make a *deidentified* copy for the instructor, TA and each member of the class and be prepared to give a short presentation on your family on 2/8.
6. ***Two Family Assessment and Psychological Reports:** Conduct one pre-treatment and one post-treatment assessment and report on the couple/family for which you are the primary therapist.
- A. Pre-treatment Assessment
- a. Instruments from the mailed packet will hopefully already be completed when the family arrives; if not, the family must complete them during the pre-treatment assessment session (do not allow them to take the instruments home again).
 - b. Check with TA to determine what other assessment instruments to use, keeping in mind that we want to minimize the burden of completing multiple instruments (e.g., if possible limit IP to one child to reduce number of BASCs). Arrange for the test administration during the scheduled time; you will be assisted by your consultant but may need to request additional help from other class members or the TA. To reiterate, the pre-treatment assessment will take place the week of Jan 29- Feb 2. The descriptive summary is due the following week 2/8.
 - c. As consultants, each of you should read/edit the other's deidentified assessment draft *before* the initial deidentified draft of the formal report is turned in to the TA.
 - d. Please get the first draft submitted ASAP, *preferably by 2nd session* but absolutely no later than 3 weeks after date of test administration. After making the TA revisions, the second deidentified assessment draft is due to instructor no later than 3/8, *preferably before*.
- B. Post-treatment Assessment
- a. The post-treatment assessment will take place the week of April 9-13 (or April 16-20) and your post-treatment summary presentation will be the week following your post-treatment assessment session.
 - b. You will write and distribute another one-page deidentified summary describing course of treatment and the change/progress of the family as shown by the post-treatment assessment.

Your presentation will be 4/19 or 4/26 depending on assessment date. Graphic depictions of pre-/post-assessment data are expected for the presentations (e.g., powerpoint, handouts, etc).

- c. Please turn in the deidentified post-treatment assessment/termination report to TA ASAP after the assessment, but no later than April 26 regardless of assessment date; it will be returned to you for revisions May 3 and is due back in final, identified, signed letter-head form to Dr. Riggs' clinic box May 8. If additional changes are necessary, you will be notified and there must be a quick turn-around, i.e., no later than May 10 for the clinic's closing of files; if that's not possible, you will receive an "Incomplete" for the course until the file is complete and permanently closed (i.e., administrative closure not sufficient).
 - d. If you need to meet with Dr. Cox for closing files, you should make those appointments for May 10th or 11th.
 - e. Based on the family's preference, which you should note in the final progress note and the supervisor close request note, you can mail them the final report, leave it with clinic staff for the family to pick up, or you may give the report to the family at a feedback session either before the closing of the clinic in May or early summer. Note that your grade will not be assigned until the case file is closed (i.e., after feedback, if given).
- C. Procedures
- a. Place all raw testing data and a copy of the first drafts of reports (clearly labeled "DRAFT") in the client file.
 - b. NEVER take any original test data out of the clinic. Any work on the assessment done outside of the clinic must be **deidentified**.
 - c. After receiving feedback from your consultant, turn in a *deidentified* report draft with all *deidentified* test data/graphs (organized, clearly labeled, and paper clipped by instrument) to the TA in a manila envelope clearly marked **CONFIDENTIAL**. Include fall practice report with TA/instructor comments.
 - d. Remember that these reports will be going into the Clinic files and thus **standards for acceptable writing will be higher than for the CFT1 practice report** (i.e., accuracy of interpretation, professional language, appropriate integration of test data, suitable recommendations, etc). You are expected to learn from mistakes made in CFT1 report and not repeat them, so please turn in the practice report along with your current report. Please closely attend to accuracy and writing style, turn in your VERY BEST first draft already proof-read by your consultant and then make ALL corrections as requested.
 - e. Using TA comments/corrections, make the revisions, then turn in the *deidentified* data and BOTH the initial *deidentified* draft (with TA comments) AND revised *deidentified* second draft to Dr. Riggs in the same manila envelope within 1 week of receiving it from the TA.
 - f. Expect 2-3 revisions of assessment reports – the first draft will be reviewed/edited by the TA, who will return it to you for corrections; subsequent drafts will be edited by the instructor.
 - g. Replace initial draft in the client file with the final identified, approved, signed report.
 - h. At a minimum, the assessment will include a genogram, ecomap, structural map, family environment/process instrument, and appropriate self-reports (See final page of this syllabus). **Use the format and the feedback you received on your CFT1 report as a guide** to write the pre-treatment assessment report.
 - i. The final post-treatment report represents an update and expansion of the initial report. Thus, keep your initial report intact (do NOT alter!), with the exception of removing the initial treatment plan/recs section, and add the following sections:
 - i. *Course of treatment*: provide a narrative of the intervention and the family response to intervention.
 - ii. *Post-treatment assessment*: Use the same instruments administered at the pre-treatment assessment, except do not include a 2nd genogram, ecomap, or teacher

report. Report on the family member's subjective experience and family process status.

- iii. *Discussion of Pre/Post Assessment Data:* Interpret the data. Discuss the direction of change that is observed in your family following intervention from both the insider (self-report) and outsider (our evaluation of process/structure) perspectives. This will look somewhat similar to the results section of a journal article.
- iv. *Summary and recommendations*
- v. *Signatures of therapist, consultant, supervisor*

***Note: The TA can provide samples as templates for the written reports and presentations.**

7. Grading:

- a. At the end of the semester, all students will receive a written evaluation of their clinical performance.
 - b. The goal of this course is *learning* so every student who completes ALL of the above requirements, demonstrates commitment and motivation, responds appropriately to feedback from consultant and supervisor (i.e., accepts and *implements* recommended changes), and behaves in an ethical and professional manner as both therapist and consultant, will receive a letter grade of "A."
 - c. Students who do not complete any ONE of the above requirements to the satisfaction of the instructor will be given a warning and if it is a written assignment they will have the opportunity to redo the assignment.
 - d. Students who do not redo assignments sufficiently well, do not demonstrate committed and professional/ethical behavior, or do not try to implement recommended changes/interventions in their therapy sessions will earn a letter grade of "B" or less. Late assignments and absences will be noted and will substantially contribute to a grade of "B" or less.
 - e. A grade of "Incomplete" will be given to students who have not completed all written assignments and closed the case file by the end of the semester.
8. **Professional Conduct:** You are expected to behave as a professional throughout this course, in particular when interacting face-to-face with clients and relevant professionals. All phone contacts, appointments, records, release of information forms, progress notes, outside consultations, etc., are to be documented and handled ethically and responsibly.
9. The **Student Perception of Teaching (SPOT)** is a requirement for all organized classes at UNT. This short survey will be made available to you at the end of the semester, providing you a chance to comment on how this class is taught. I am very interested in the feedback I get from students, as I work to continually improve my teaching. I consider the SPOT to be an important part of your participation in this class.

The University of North Texas is on record as being committed to both the spirit and letter of federal equal opportunity legislation; reference Public Law 92-112 – The Rehabilitation Act of 1973 as amended. With the passage of new federal legislation entitled Americans with Disabilities Act (ADA), pursuant to section 504 of the Rehabilitation Act, there is renewed focus on providing this population with the same opportunities enjoyed by all citizens. As a faculty member, I am required by law to provide "reasonable accommodations" to students with disabilities, so as not to discriminate on the basis of that disability. Student responsibility primarily rests with informing faculty of their need for accommodation and in providing authorized documentation through designated administrative channels. Information regarding specific diagnostic criteria and policies for obtaining academic accommodations can be found at www.unt.edu/oda/apply/index.html. Also, you may visit the Office of Disability Accommodation in the University Union (room 321) or call (940) 565-4323.

- If you take an "I" (incomplete) in any course, you must complete the work and have the "I" removed within one year or the grade will automatically change to an "F" and you must reenroll in the course again.
- The guidelines outlined by the UNT Center for Students Rights & Responsibilities will be used to deal with any incidence of cheating and plagiarism.
- This syllabus does not constitute a contract and plans for this course may be modified during the semester.

PSY 6160 – Marriage and Family Therapy II
TENTATIVE CLASS SCHEDULE

	<u>Class Activities/Readings</u>	<u>Therapy Activities</u>	course procedures & r
1/18	Orientation to course procedures	Contact family and mail pre-session packet	
1/25	Intake, Interview, Assessment; Review G	(possible pre-tx assessment session)	
2/1	Intensive Structural Therapy; Fishman, SF 3	Pre-Treatment Assessment Session	
2/8	Presentation of Cases; SF4, HV 9 <i>Descriptive Summaries due</i>	Therapy Session 1	
2/15	Presentations; Minuchin & Fishman <i>Pretx assmt to consultant, TA if possible</i>	Therapy Session 2	
2/22	Group Supervision; HV 10, 15 <i>1st pretx draft to TA, 3 wks after admin</i>	Therapy Session 3	
3/1	Group Supervision; SF 5	Therapy Session 4	
3/8	Group Supervision; SF 6 <i>Pretx assmt draft to Riggs (if not before)</i>	Therapy Session 5	
3/15	<i>Spring Break – No class, no therapy</i>		
3/22	Group Supervision <i>Pretx assmt revisions ongoing</i>	Therapy Session 6	
3/29	Group Supervision <i>Final Pretx assmt draft to Riggs</i>	Therapy Session 7	
4/5	Group Supervision <i>Final Pretx assmt report placed in file</i>	Therapy Session 8	
4/12	Group Supervision	Post-Treatment Assessment Session OR Make-up Session (if family cancelled)	
4/19	Post-Treatment Summary Presentations	Post-Treatment Assessment Session (if last session was 4/12)	
4/26	Post-treatment Summary Presentations <i>Post-tx Assmt reports due (no extension for later Assmt session)</i>		
5/3	Termination & Wrap-up; <i>Post assmt reports returned, due back 5/8</i>	Plan optional feedback session After report approved, close file	

Family Assessment and Report

At a minimum, the following is required (also see description from PSYC 6150):

- clinical interview and behavioral observations (pre-treatment only)
- genogram, ecomap (pre-treatment only)
- structural maps
- Family Environment Scale (FES/CFES)
- If applicable, other possible measurement instruments include:
 - Dyadic relationship self-report for adult partners – Dyadic Adjustment Scale
 - FAM-dyadic for other relationship partners when those relationships seem pertinent to the presenting problem, e.g. sibling or parent-child relationships
 - Parenting Stress Index (PSI) – long form (do NOT use short form) or SIPA for adolescent
 - Age-relevant child measures (e.g., *Adult Informant*: BASC or CBCL; *Child*: BASC or YSR, Kinetic Family Drawing, Parent Perception Inventory); *NOTE: Adults and children should use same family of instruments; use BASC-PRS/SRP unless age limits prevent it.*
 - Adult/adolescent personality and mental health self-report - Myers-Briggs, BSI
 - Attachment measures (pre-treatment only) –
 - Adults: Experiences in Close Relationships Scale (ECR) for romantic attachment and possibly Parental Bonding Instrument (PBI) for childhood attachment to parents.
 - Children: Inventory of Parent and Peer Attachment (IPPA) for children 12-20, or the People in My Life – short form (PIML) for children 8-11 years of age. Request these from the TA.
 - Please note that if the instruments are applicable to the family you select, you will be expected to use them in the assessment. For example, for a two-parent household with children, in addition to the required instruments, you will be expected to use a partner self-report, PSI, informant report for child, child report for child, one adult self-report for each adult. However, for a single-parent family, you obviously would not use a partner self-report. Reports and interviews with adult informants outside the family (e.g., teachers, grandparents) are optional, but can be very helpful.
 - Consult with TA and get the TA's approval of instruments before administration.

The pre-treatment assessment report should include the following sections:

- *Identifying Information* - family member names, sexes, ages, IP, family structure (e.g., intact, single-parent, remarried), therapist name, supervisor name, date of report
- *Presenting Concern* – Describe presenting problem (i.e., IP symptoms) and identify referral source
- *Sources of Information* – list all interviews and instruments and the dates of each
- *Family Background Information* – additional demographic information (e.g., ethnicity, SES, employment status, etc.) and other relevant information re: the family and/or family members, such as the family life cycle stage, developmental levels of members, intergenerational family history of mental disorders and other pertinent factors, mobility, religious affiliation if any.
- *Contextual Analysis* – interview and ecomap findings; describe social supports and/or stressors, neighborhood/school/work impact, cultural/societal factors and/or stressors
- *Test Results and Clinical Impressions* – Report and interpret testing results re: individual personality and symptoms/diagnoses, family structure and process, including system and subsystem characteristics, family interaction patterns, strengths/resources, challenges, coping strategies, (would expect subheadings for this section)
- *Treatment Plan & Recommendations* – structural/EFT hypotheses and goals, planned interventions directly based on the hypotheses and goals