Counseling Practicum I

Lecture 8

Record Keeping

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Introduction

It is one thing to conduct counseling for clients and another challenging thing doing it professionally. Most beginning counselors are not fully aware of ethical standards and legal implications in the counseling profession. It is during supervision sessions that the same is communicated by the supervisor. One of the ways to show case ethical practice is the way the beginning counselor uses the counseling professional documents in client work. This lecture illustrates the sample documents used in counseling practice (Jungers & Scott, Practicum and Internship : Textbook and Resource Guide for Counseling and Psychotherapy, 2019).

Expected Learning Outcomes

At the end of this lecture, you will be able to:

(i) Identify common professional documents used during internship practicum

(ii) Explain the functions of professional documents used in counseling practice

Document I: Contract Form

This document also referred to as consent form differs from one organization to another, use and style of counseling. Some consent forms have details that are contained in the intake form while some have details limited to just contracting. General information in some consent forms include norms to be observed during counseling, session duration, cost per session, other parties to be contacted, next of kin contact and time schedule, relevant significant contacts, role of the client and counselor, provision for therapy termination, details of issues presented for therapy among others. The contract form seeks to minimize interaction between the client and the counselor, with an aim of getting the client's consent before the client feels vulnerable in the presence of a counselor who is /or a stranger to the client. Other details contained in a consent form may include a part for signing to commit the client and the therapist, confidentiality clause and any other agreement points (Corey, 2009).

Document II: Client Intake Form

This document is used during intake session. In most situations it is also used to conduct initial client assessment for promoting effective diagnosis and quality treatment planning. The activities in completing this document include:

Getting the client's personal data,

Personal	**Social**	**Education**	**Career/Job**

Age, marital status, gender, children, residence, reason for seeking therapy , referral agency	Social networks (relatives, support groups, welfare) Referral agency, Contact persons	Level, certification, grade, competencies	Vocation, career, expertise, self-employment, employer

Assessing family history

Inquire about the client's family of origin (if possible, pick information about the client, children if any, parents, siblings and ask for unique information with patterns that can inform more on the client's issues. This helps you to pick negative patterns that could have played a role in perpetuating the client's psychological distress. Some of the patterns may include anger issues, separation and divorce, drug abuse, violence among others Some positive patterns like skills and competencies in certain areas may include sports, athletics, medicine, teaching, entrepreneurship, creativity, innovations, and research (Ronnestad & Skovholt, 2003)

Drawing therapy expectations and goals

This entails asking the client what they expect to gain form therapy. This helps formulate the therapy goals both from the client and you as the therapist.

Tracking developmental path

This will require you to take history about your client in different developmental stages to pick challenges they experienced, how the resolved them and what is remaining as unfinished business. Most of the unfinished business form background for psychological conflict and distress. This helps you to see what to resolve first and avoid piling up of psychological distress.

Assessing cultural background

This may include finding out about the ethnic background, cultural traditional practices, beliefs, and affiliations and how they inform the behavior of the client in relations to what they bring for therapy. Some cultural beliefs and practices that sideline some people from others may indeed contribute to abuse of their rights. Then this could be true of your client.

Documenting interests, habits, hobbies, and routine habits

A client will reveal how they spend their time when they share their routine habits and behavior. Some are productive while some are destructive. You can also pick who they spend time with and how they impact their lives in return.

Clinical Assessment and diagnosis

This will entail you using all the knowledge learned relevantly in assessing the client's issues, needs, opportunities and underlying issues. Making a diagnosis may require you to take the DSM – tool and relate with the client's signs and symptoms. You can correlate

thus with the theoretical constructs too. This level requires expertise, experience and consultation during internship to avoid making the wrong diagnosis hence inappropriate ineffective treatment. Suitable treatment planning is best informed by appropriate clinical assessment and diagnosis. Appropriate treatment planning is derived from appropriate treatment goal setting translating to appropriate treatment implementation and positive treatment outcome (Borders DiAnne & Brown, 2022).

Other areas may be included in an intake /initial assessment form may include, medical history, drug abuse history, legal history, psychiatric history, mental health assessment and recommendations for therapy.

Document III: Client Case Record Workbook

The interns need to record the client's information as gathered during the sessions. At times it is a small, printed notebook with summary guidelines where an intern just fills in the information. The function is to track client's clinical movement in therapy, accreditation purpose, referral, legal requirement and as a clinical supervision requirement. Some details in the case notebook are also found in the intake and supervision form. The client code is meant to conceal the identity of the client to the third party; it is an ethical practice requirement for the safety of the client (Mc Leod, 2013).

Counseling Progress Case Notes Guide

May include a section for your name, client's name (for confidentiality you can code), date, session number, out of possible total sessions, venue (location), the supervisor's

name (site or school supervisor), session objectives, case summary, presenting problems, case formulation, clinical assessment, diagnosis and treatment goals/plans, implementation and techniques used, realized goals and this unrealized. There is a section for self-evaluation (done very honestly) and one for supervisor's remarks and areas you may need help from the supervisor or supervision group (Jungers & Scott, Securing a Practicum and Internship Site, 2019).

Document IV: Internship Log in Sheet

This document indicates in summary the work covered by the intern during the practicum. It outlines the different sections or departments the intern served; type of counseling done, hours covered in each category, supervision received during the week and proof of supervision sessions attended and work done by appending relevant signatures. Document (a) is mostly used during internship while form (b) is used for accreditation purpose or clinical supervision and monitoring of client progress in normal practice.

Dates (By Week)	One-on-one Counseling	Group Counseling	Seminars Workshops Talks, community service	Weekly Supervision (Hours – site and school)	Total Hours for the Week	Site Supervisors Signature

Document V: Termination Summary Report

Details include name of the counselor, date (start and end dates), supervisor, client code, initial reason for seeking counseling, number of sessions structure, treatment goals set, Treatment goals that were achieved, those not achieved, reasons for terminating counseling (is it end of therapy, dissatisfaction, need for specialized care, client's wish?), current client's status and your own observation. In case of referrals made indicate who or where, sign the document and the clients to sign as well (Corey, 2009).

Community Service Activity Guide for Interns

Step 1: Identify the community (age, group, institution, physical setting – village, town, school)

Step 2: Needs assessment what the community needs (type of psychosocial need, counseling need, education, training, coaching)

Step 3: Objectives and Strategies to address the needs (do you need resource mobilization- human, material, mode of delivery, approaches applied)

Step 4: Community service work plan (showing the programme with time allocation (day, date, month), resources required, objectives, monitoring and evaluation methods)

Step 5: Follow up plan (when, how and dates)

GROUP COUNSELING GUIDE FOR INTERNS

STAGE	OBJECTIVE	ACTIVITY
STAGE 1	**To plan how the group will be processed**	**Pre –group planning** • **who are the members** • **purpose** • **No.of sessions** • **duration** • **regularity screening of members** • **venue** • **facilitators** • **type of group (open/closed, homogenous** • **evaluation methods** • **cost implications**
STAGE 2	**To project the big picture for the group**	• **identifying possible topics** • **prioritizing topics** • **work plans are drawn**
STEP 3	**To plan how each session is conducted**	• **consider stage of the group** • **format of the group** • **mapping phases of the group and what happens in each phase** •
STEP 4	**To evaluate the outcomes**	• **drawing an evaluation and monitoring plan for the group**

Supervision Log in Form

This has key information like, client's code, therapy attendance dates, counseling setting (individual, group, couple, family), venue, total number of hours, presenting issues,

assessment and diagnosis, therapeutic intervention, supervisor's name and sign, intern's name, site supervisor's name, and signature.

Conclusion

The documents we have discussed are among the main ones a student going for therapy needs to be familiar with and apply during practicum. Regular consultation with the site and program/school supervisor will help the student in mastering how to use the documents. The templates can be developed with the information given as a guide.

References

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