LIBERTY UNIVERSITY

Graduate School

COURSE SYLLABUS

COLLEGE OF HEALTH SCIENCES
CENTER FOR COUNSELING AND FAMILY STUDIES

COUN 667: CLINICAL DIAGNOSIS AND TREATMENT PLANNING

FACULTY:
OFFICE:
PHONE:
E-MAIL:
OFFICE HRS: BY APPOINTMENT
SEMESTER:
TIME: M-TH = 8:15-4:30; F = 8:15-12:00
LOCATION OF CLASS:

I. COURSE DESCRIPTION

Students become knowledgeable of the principles of clinical diagnosis and the development of treatment plans. The current edition of the Diagnostic and Statistical Manual is emphasized, with consideration also given to dimensional, relational, and systemic issues important in diagnosis and treatment planning. (3 credit hours)

II. RATIONALE

The Center for Counseling and Family Studies is committed to preparing students who can adequately meet the demands of a world that is becoming more and more impaired by sin, dysfunction, and pathology. We desire students who can interview, evaluate, and treat clients professionally, effectively, and ethically without violating their biblical worldview and in a way that integrates that worldview into their work. The intent of this course is to prepare students for the pragmatics of their clinical work in practicum and internship environments. Christian counselors should be competent in all areas of clinical work regardless of the setting in which they work. Being able to conduct an appropriate, professional, and clinically sound interview is the basis of all counseling. Based upon the data obtained in the interview counselors must be able accurately diagnose and plan a course of treatment for clients, essential skills for all counselors.

III. PREREQUISITES

Because of the nature of this course is designed to provide applications of counseling knowledge the following courses are **prerequisites** before you can be accepted into this class: **COUN 501, 502, 503505, 510, 521, and 646 (you must have completed 646; this is non-negotiable).**

IV. MATERIALS LIST

A. Required Texts: (always get the most current edition)

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition, TR (DSM-IV-TR.)* Washington, D.C.: American Psychiatric Association. (ISBN: 0-89042-025-4, paperback)

Morrison, J. (2007). *Diagnosis made easier: Principles and techniques for mental health clinicians*. New York, NY: Guilford Press. (ISBN-10: 1-59385-331-9)

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatments: A comprehensive, systematic guide for treating mental disorders* (4th. ed). San Francisco, CA: Jossey-Bass. (ISBN-13: 978-0-470-8890-8)

Shea, S. C. (1998). *Psychiatric interviewing: The art of understanding for psychiatrists, psychologists, counselors, social workers, nurses, and other mental health professionals* (2nd ed.). Philadelphia, PA: Saunders. (ISBN-13: 978-0-7216-7011-9)

Zuckerman, E. L. (2010). *Conducting interview and writing psychological reports* (7th ed.). New York, NY: Guilford Press. (ISBN-13: 978-1-60623-874-5)

B. Recommended: (* indicates the best) (always get the most current edition)

Morrison, J. (2008). *The first interview*. New York, NY: Guilford Press. (ISBN: 1978-1-59385-636-6)

Othmer, E., & Othmer, S. (2003). *The clinical interview: Using DSM-IV(TR). Vol 1, Fundamentals*. Washington DC: American Psychiatric Association. (ISBN: 1-58562-051-3)

Pomeroy, E., & Wambach, K. (2003). *The clinical assessment workbook: Balancing strengths and differential diagnosis*. Pacific Grove, CA: Brooks/Cole Thomson Learning. (ISBN: 0-534-57843-8, paperback)

Ried, W., Sutton, B. J., & Balis, G. U. (1997). *The treatment of psychiatric disorders: Revised for the DSM-IV*. New York, NY: Brunner-Mazel. (ISBN: 0876307659)

Textbook Disclaimer Statement

The above texts provide information consistent with that required by state licensing boards in the class subject area. Liberty University does not necessarily endorse specific religious, philosophical, or political positions found in these texts.

NOTE: It is recommended (no longer required) that each student purchase *Therascribe* (a software package that helps you prepare treatment plans) for his/her practicum. It may behoove you to obtain a copy of it now so that you can get acquainted with it before entering your practicum. Moreover, you will most likely never get it cheaper than you can as a student. Contact the publisher Wiley to get the discounted rate (tell them you are a student at LU).

V. COURSE CONTENT

A. Review of the DSM.
B. Review conceptualization of mental disorder.
C. Discuss the role, value, purposes, and limitations of diagnosis in the counseling process.
D. Practice clinical interviewing skills.
E. Review diagnostic hierarchy.
F. Practice diagnosing.
G. Review basic assessment procedures.
H. Explain factors that contribute to or interfere with accurate assessment and diagnosis.
I. Review assessment of suicide, homicide, and active crisis.
J. Practice conducting a Mental Status Exam.
K. Review and apply Seligman's DO A CLIENT MAP.
L. Review and practice creating treatment plans.
M. Review American with Disabilities Act and Family Medical Leave Act and how they relate to working with clients.
N. Provide introduction to ICD, CPT codes, and managed care.
O. Review case management skills.
P. Review and discuss ethical issues (e.g., culture, gender, client welfare) in clinical diagnosis and treatment planning.

VI. MEAURABLE LEARNING OUTCOMES

The student should be able to:

A. Apply course readings and class lectures to clinical case studies (Program Learning Outcomes 1).

B. Apply appropriate clinical interviewing skills in an ethical and legal manner (Program Learning Outcomes 1, 4, & 5).

C. Conduct a psychosocial history in an ethical and legal manner (Program Learning Outcomes 1, 4, & 5).

D. Analyze, evaluate, and synthesize client data from a biopsychosocialspiritual perspective into a professional report that includes psychosocial history, diagnosis, and treatment planning (Program Learning Outcomes 1, 2, 3, & 5).

VII. COURSE REQUIREMENTS AND ASSIGNMENTS

Students are expected to understand and integrate course information through regular reading in assigned texts, class interaction, lectures, videotapes, demonstrations, and writings. **All written assignments are expected to be in APA** (6th edition) format.

A. **Pre-Class Work**:

1. ***Reading***. Students should complete ALL required textbook reading prior to the intensive. (Partially fulfills the requirements of Learning Outcomes A & D).

2. ***Chapter Summary***. Write a chapter summary for each chapter in the following texts: Morrison (2007), Seligman and Reichenberg (2007), and Shea (1998). The summary should include the major objectives of the chapter, key points, and a brief reflection of the chapter. The summary for each chapter should be approximately ½ page to 1 page (no more than 1 page). Write succinctly. Each textbook should begin on a separate page, but combine them into one document with an APA title page. (Partially fulfills the requirements of Learning Outcomes A & D).

   NOTE: As for the DSM-IV-TR, be sure to bring the large manual (not a condensed version) with you to class. Finally, bring 4 copies of the Mental Status Exam, which can be found in the worktext and on Blackboard to class as well. It is not necessary to print the entire worktext. (Partially fulfills the requirements of Learning Outcomes A).

B. **Intensive Week**:

1. ***Class Attendance***: Since this is a week intensive, missing one day is the equivalent of missing one-fifth of classes. Class attendance is expected since adult learning results from interaction with peers. Attendance will be taken each class as well as throughout the day. Leaving early and arriving late will be noted; two of either of them will result in a lower grade. (Partially fulfills the requirements of Learning Outcomes B, C, & D).

2. ***Class Participation***: Students will be evaluated on their contributions to class discussion (i.e., keeping up with the readings and actively participating in class role playing). Graduate students bear a responsibility for active and considerate participation in class activities. An open, curious, and honest attitude toward learning from others will facilitate development for all participants. See **Appendix A** for information about how this will be assessed. During class time students focus should be on class work (see Other Classroom Policies for more information. (Partially fulfills the requirements of Learning Outcomes B).

3. ***Role-Playing***. Students will role play a counselor and client using a variety of mental disorders throughout the week. Students will need to be prepared in advance of **each class** to portray an actual client so that another counselor may attempt to make an appropriate diagnosis and design a treatment plan. Please

make sure that you are consistent to the diagnosis and provide sufficient information in your responses for the counselor to make the diagnosis. You do not have to be obvious in your responses. Your ability to be imitate a real life client and your ability to be a professional interview will demonstrate your understanding of diagnostic criteria and interviewing skills. Moreover, your ability to write a professional report will demonstrate your ability to analyze, evaluate, and synthesize client data into an accurate diagnosis, develop appropriate treatment goals, apply relevant treatment strategies, and write a formal report. (Partially fulfills the requirements of Learning Outcomes A, B, C, & D)

C. **Post-Intensive Work**:

1. ***Role Play/Intake Paper***: During class time, each student will utilize a role-playing situation in which he/she will play the parts of client and counselor. Based upon that role-play, students are responsible for writing a professional psychosocial report (see **Appendix B**) and making a diagnosis as though referring the client to another counselor. The report should include most of the areas covered in a psychosocial history. (Partially meets Learning Objectives A, B, C, & D). Include the following:

   a. The report should include most of the areas covered in a psychosocial history. The headings of your paper should be those from the intake report, but do not write the paper in an outline fashion.

   b. You are to provide a five axial diagnosis and complete a treatment plan on your chosen individual.

   c. The paper should be written in narrative form. Discuss the person to the best of your ability, given the information obtained from the source(s).

   d. Attach the treatment plan as an appendix using a format that will be covered in class, but provide discussion in the body of the paper as to how you arrived at the goals and strategies.

   e. For the treatment plan, **you will need to develop two specific problems, 2 goals for each problem, at least 2 objectives for each goal, and provide at least 1 intervention per objective**. At least 1 objective in the treatment plan should address a spiritual need.

   f. Before providing the treatment plan state your theoretical perspective (if you are eclectic, describe specifically how you are—what theories do you incorporate and how do you incorporate them) so it is clear how you are evaluating and seeking to treat the person.

   g. You may wish to include other attachments such as a MSE.

   h. There is no page length for this assignment. Include a title page, abstract, and

references.

2. ***Final Examination***: On the last day of class, the final will be made available on Blackboard. The exam is to be completed at home. The examination will include several case studies with which students will complete a diagnosis and write a treatment plan. Since the exam is application-oriented, you may use your DSM and other resources, but **may not consult with anyone other person** other than the Holy Spirit for help. There is not time-limit for the exam.

   The purpose of the exam is to evaluate each student's ability to analyze, evaluate, and synthesize client data and then apply the diagnostic criteria to a series of case studies in order to arrive at an accurate multiaxial diagnosis. Moreover, it evaluates the student's ability to create appropriate treatment plans that are relevant to and adequately address a client's diagnosis. This assignment partially meets Learning Outcomes E & F**.**

NOTE: All assignments must be completed within four weeks of the intensive.

VIII. COURSE GRADING and POLICIES

A. Class Assignments and Related Points

ASSIGNMENT	POINTS	%
Class Participation:	**100 Points**	**10%**
Chapter Summaries:	**300 Points**	**30%**
Role-Play Paper:	**300 Points**	**30%**
Final Examination:	**300 Points**	**30%**
TOTAL	**1000 Points**	**100%**

B. Grading Scale (based upon an 8 point scale)

A	A-	B+	B	B-	C+
1000-940	939-920	919-900	899-860	859-840	839-820
C	C-	D+	D	D-	F
819-780	779-760	759-740	739-700	699-680	679-0

C. Grading Policies

1. **Late Papers:** It is the expectation that **all papers will be submitted on the due date assigned**. If something comes up that is "out of your control" and, therefore, you are unable to submit your paper on time, please contact your afternoon consultant **before the due date** to request a short extension on that particular assignment; granting an extension is at the discretion of the professor/consultant (extensions will not be granted for procrastination, poor time management, or other reasons in which you could control). For late papers

that are submitted without an approved extension, **the point reduction will be *5 points for each 24 hour period in which the assignment is late***.

2. For written assignments, part of your grade is based upon the quality of the writing. The professor/consultant reserves the right to grade poorly written papers with an "F," regardless of content. If necessary, get an editor or someone who writes well to read your papers.

3. Students who have English as a second language (ESL) may request additional time for assignments, but such requests must be in writing at least 2 weeks before the assignment is due.

IX. ATTENDANCE POLICIES

Only students present and on time will receive the maximum credit for this aspect of the course. Students must be present for the entire week of the intensive, no exceptions. Excused absences from the morning or afternoon sessions are reserved for unforeseen situations such as serious illness or for situations previously approved by the professor.

X. OTHER POLICIES

A. **Academic Misconduct:** Academic misconduct is strictly prohibited. See The Graduate Catalog for specific definitions, penalties, and processes for reporting.

B. **Disability Statement:** Online students with a documented disability may contact the DLP Office of Disability Academic Support (ODAS) at dlpodas@liberty.edu to make arrangements for academic accommodations. Residential students with a documented disability may contact the Office of Disability Academic Support (ODAS) in TE 127 for arrangements for academic accommodations.

C. **Drop/Add Policy:** Consult the Graduate Catalog for drop/add policies.

D. **Dress Code:** Students are expected to maintain a neat, professional appearance while in class. Consult your department for additional guidelines.

E. **Classroom Policies**

1. Classroom policies will be established and enforced by the individual instructor.

2. **The inappropriate use of technology such as cell phones, iPods, laptops, etc in the classroom is not tolerated**. Becoming a professional is a process. It involves developing respect for yourself and others. It is important to establish a professional attitude and demeanor while in graduate school. Therefore, if you bring your computer to class it should only be used for material related to this class. **You should not be checking e-mail, instant-messaging, checking scores, stocks, or viewing anything other than that which pertains to this class**.

Staring at your computer or typing that is inconsistent with a presentation is disrespectful. Failure to comply with this policy will result in "0" points for class participation for the semester. Continuation of the practice may result in you receiving an "F" for the course.

3. Other disruptive behavior in the classroom is not tolerated. Students who engage in such misconduct will be subject to the penalties and processes as written in the Graduate *Liberty Way*.

F. **Dual Relationships and Limits of Confidentiality**

The faculty is responsible to interact with counseling students in a supervisory capacity or role. As such, faculty may provide students professional principles, guidance, and recommendations as it relates to the context of the student-client setting. The faculty is responsible to avoid dual relationships with students such as entering a student-counselor or student-pastor relationship. Thus, the faculty does not provide personal counseling addressing student personal problems. If a faculty member perceives that a student is in need of personal or professional counseling then that faculty member will recommend that the student pursue either pastoral or professional assistance from a counselor in their community.

In the event of a student's disclosure, either verbally or in writing, of either threat of serious or foreseeable harm to self or others, abuse or neglect of a minor, elderly or disabled person, or current involvement in criminal activity, the faculty, staff, administrator or supervisor will take immediate action. This action may include, but is not limited to immediate notification of appropriate state law enforcement or social services personnel, emergency contacts, and notification of the appropriate program chair or distance learning dean. The incident and action taken will become part of the student's personal record.

G. **Correspondence:** Students are expected to communicate in a professional manner at all times whenever emailing classmates, professors, or any employee of Liberty University. Because there is no accompany tone of voice, facial expressions or body language with email communications they can be more easily misinterpreted than face to face communication. Your emails should be courteous and well thought out to avoid knee-jerk responses that will be interpreted as flaming or sarcasm. Communicate complaints directly to the individual involved. Do not send a blanket email to everyone in the class or to administrative personnel until you have communicated your concerns directly to the person involved and allowed them time to respond. Do not post a message to the class on Blackboard that is more appropriate for an individual. Avoid offensive language of any kind.

H. **Communication**

1. **Electronic Communication:** all electronic communication must be done via your personal Liberty Email. I will communicate via your Liberty account and you are expected to communicate via my Liberty account (jcthomas2@liberty.edu).

2. **Face-to-Face Communication:** meetings will be scheduled during posted office hours in my office. Exceptions can be made as to time but no exceptions to place.

3. **Phone Conference:** Limited to emergencies only and time will be limited.

I. **FN" Policy**

Students who begin a course, but at some point in the semester cease attending, and do not provide official notification to withdraw, will be assigned a grade of **"FN"** at the discretion of the instructor, dated to the student's last date of academic activity. A grade of **"FN"** will be assigned when a student stops attending and/or participating in a class for a period of 21 consecutive days or longer. **"FN"** indicates that the student ceased attendance and failed to complete the course objectives. The last date of attendance will be based upon the last date that a student submitted an academic assignment (such as an examination, written paper or project, discussion board post, or other academic event). This will be the "Creation Date" of the assignment.

Before posting the **"FN"** the professor must email the student after noticing at least 14 days of nonattendance. The professor should utilize the template email provided below to communicate the seriousness of the **"FN"** grade to the student. After 21 days of nonattendance in which the student has not submitted course work or communicated with their professor, the professor should post the **"FN"** grade in the Post Final Grades area of Blackboard, along with the student's last date of attendance.

Students who receive a grade of **"FN"** may appeal to their professor to have the grade removed to allow a resumption of work in the course. This appeal must be communicated in written form to the faculty member within 1 week of the notification of the **"FN"** grade being posted. The faculty member will confer with their Associate Dean in order to review and make a determination concerning the status of the appeal.

X. CALENDAR

Pre-Intensive	Complete the Reading of ALL required textbooks Complete Chapter Summaries		
	Come Prepared to Play a Client		
INTENSIVE WEEK:			
Session	**Date**	**Topic**	**Activity**
1	9-Jan	• Definitions and Concepts • Advantages and Disadvantages of Diagnosing • Overview of DSM • Application: Practice Diagnosing	● Brief student introduction ● Jeopardy Game #1 ● Do written cases 1, 2, 3
2	10-Jan	• Discuss the Nature of Mental Disorders • Discussion the Role of Assessment • Conduct a Mental Status Exam • Application: Practice Diagnosing	● Demonstration/Practice of MSE ● DVD 1: Vignettes 1-3 ● Students are told to be prepared for a role play (pick from Mood, Anxiety, Adjustment, or Substance Abuse)
3	11-Jan	• Discuss Clinical Interviewing • Active Crisis Assessment • Suicide and Homicide Assessment • Application: Practice Diagnosing and Interviewing	● Demonstration of a clinical Interview ● DVD 1: 5, 7; DVD 2: 1 ● Role play interview ● Comps Overview (11:30 am)
4	12-Jan	• Discuss and Demonstrate Treatment Planning • Discuss Ethical Issues in Assessment, Diagnosis, and Treatment Planning • Application: Role Planning, Diagnosing, and Treatment Planning	● P/I Overview (9am) ● Practice treatment planning ● DVD 2: 3, 6, 7
5	13-Jan	• Conduct a Full Psychosocial Assessment (Role-Play) • Debrief Experience • Application: Case Studies	● Role play for paper ● Case Studies: 4, 9, 12
Post-Intensive	28-Jan	Role Play Paper (due by 11:59 pm)	
	9-Mar	COUN 667 Final Exam (due by11:59 pm)	

XI. BIBLIOGRAPHY

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Appendix A

GUIDE FOR ASSESSING CLASS PARTICIPATION

This course is structured so that we can learn not only from textbooks and articles, but also from one another. Student-to-student and group interaction and learning is invaluable. Class participation assesses your contribution to the learning experience of your classmates. Participation may include comments, questions, statements, discussions, etc., and may occur in large or small group discussions. It also has to do with timeliness of attendance and appropriateness of interaction.

Recognition is given to the fact that individual learning styles vary. Some people tend to be more vocal and active in class than others are. This does not necessarily mean that those who have been most vocal have contributed more to the overall learning experience of the class than those who have been quieter. In fact, being too vocal could potentially lower your participation score, particularly if the contribution is more like a soliloquy or personal attack. It is the *quality* of the participation that is evaluated, not necessarily the *quantity*. This includes, but is not limited to, the degree to which the student:

- Brings clarity to issues being discussed
- Relates issues to biblical/scriptural/Christian principles and experience
- Rationally defends her/his position, particularly using behavioral science findings
- Raises new and novel, yet relevant, points
- Critically evaluates the views of self and others
- Takes leadership within small group activities/discussions

Your class attendance and contribution is worth 10% of your total grade. Students with a sound grasp of materials and a demonstrated ability to analyze those materials at a satisfactory to average level for graduate students can be expected to receive a grade of “B”. The grade of “A” will be reserved to designate excellence. This will require not only a sound grasp of materials and the demonstration of an ability to analyze them at a graduate level, but also a clear capacity to synthesize and critique the materials and apply the principles for effective problem solving. There is no predetermined number of students who will receive each grade.

Appendix B

Intake Report

****CONFIDENTIAL****

NAME: **DOB:** **AGE:**
SSN: **SEX:**
DATE OF INTAKE: **DATE OF REPORT:**
INTERVIEWER:

Identifying Information and Reason for Referral

NOTE: Do not write up your report with the bullet as shown below. The bullets are only for ease of reading purposes. Write your report in paragraph and narrative fashion)

- **Client name**
- **Age**
- **Sex**
- **Racial/Ethnic information**
- **Martial Status**
- **Referral source (and telephone number, when possible)**
- **Reason for referral (why has the client been sent to you [e.g., consultation, clinical intake, counseling])**
- **Presenting complaint (use a quote from the client to describe the complaint)**

Behavioral Observations (include Mental Status Exam)

- **Appearance upon presentation (including comments about hygiene, eye contact, body posture, and facial expressions)**
- **Quality and quantity of speech and responsivity to questioning**
- **Client description of mood (use a quote in the report when appropriate)**
- **Primary thought content (including presence or absence of suicide ideation)**
- **Level of cooperation with the interview**
- **Estimate of adequacy of the data obtained**

History of the Present Problem(s)

- **Include one paragraph describing the client's presenting problems and associated current stressors**
- **Include one or two paragraphs outlining when the problem initially began and the course or development of the symptoms**
- **Repeat, as needed, paragraph-long descriptions of additional current problems identified during the intake interview (client problems are usually organized using diagnostic—DSM—groupings, however, suicide ideation, homicide ideation, relationship problems, etc., may be listed)**
- **Follow, as appropriate, with relevant negative or rule-out statements (e.g.,**

with a clinically depressed client, it is important to rule out mania: "The client denied any history of manic episodes)

Treatment (Psychiatric) History and Family Treatment (Psychiatric) History

- **Include a description of previous clinical problems or episodes not included in the previous section (e.g., if the client is presenting with a problem of clinical anxiety, but also has a history of treatment for an eating disorder, the eating disorder should be noted here)**
- **Description of previous treatment received, including hospitalization, medications, psychotherapy or counseling, case management, etc.**
- **Include a description of all psychiatric and substance abuse disorders found in all blood relatives (i.e., at least parents, siblings, grandparents, and children, but also possibly aunts, uncles, and cousins)**
- **Also include a list of any significant major medical disorders in blood relatives (e.g., cancer, diabetes, seizure disorders, thyroid disease)**

Relevant Medical History

- **List and briefly describe past hospitalizations (include having babies) and major medical illnesses (e.g., asthma, HIV positive, hypertension)**
- **Include a description of the client's current health status (it's good to use a client quote or physician quote here)**
- **Current medications, dosages, and frequency)**
- **Primary Care Physician (and/or specialty physician) and telephone numbers**

Development History
(This section does not need to focus heavily on childhood or adolescence history except in child and adolescent cases in which pre-natal through adolescence should be addressed)

- **Situation surrounding pregnancy**
- **Information pertaining to birth**
- **Social, behavioral, and cognitive milestones**
- **Educational History (for adults include interaction with peers, people in authority, academic performance, and extra-curricular activities—e.g., sports, clubs)**

Social and Family History

- **Early memories/experiences (including, when appropriate, descriptions of parents and possible abuse or childhood traumatization)**
- **Employment history**
- **Military history**
- **Romantic relationship history**
- **Sexual history**
- **Aggression/violence history**

- **Alcohol/Drug history (if not previously covered as a primary problem area)**
- **Legal history**
- **Recreational history**
- **Spiritual/Religious history (when dealing with Christian clients discuss salvation experience, Christian life development, church attendance, etc.)**
- **Support system (Network)**

Current Situation and Functioning

- **A description of typical daily activities**
- **Assessment of life/character skills (e.g., problem-solving, conflict resolution skills, negotiation skills, empathy, fairness, cooperation,)**
- **Self-perceived strengths and weaknesses**
- **Ability to complete normal activities of daily living (ADLs)**
- **General assessment of coping skills (e.g., stress management skills, emotional regulation ability)**

Diagnostic Impressions
(This section should include a discussion of diagnostic issues and your rationale)

- **Brief discussion of diagnostic issues**
- **Multiaxial diagnosis (all 5 axes)**

Case Formulation and Treatment Plan

- **Include a paragraph description of how you conceptualize the case. This description will provide a foundation for how you will work with this person. For example, a behaviorist will emphasize reinforcement contingencies that have influenced the client's development of symptoms and that will likely aid in alleviation of client symptoms. Alternatively, a psychoanalytically oriented interviewer will emphasize personality dynamics and historically significant and repeating relationship conflicts)**
- **Include a paragraph description (or smile list) of recommended treatment approaches.**

_____ _____

Signature **Date**
(Print name and title under line in place of "signature")